## AGENDA

### PRELIMINARY BUSINESS
(Chair – James Kay)

1.1 Apologies for Absence

   - Dr P Naylor, Dr S Well, Dr J Oates

1.2 Chair’s Announcements

1.3 Declarations of Interest

1.4 Comments/questions from members of the public

1.5 Patient Story
   (Lorna Quigley)

1.6 Minutes and Action Points of Last Meeting – held on 6th May 2014
   (All)
   - Matters Arising
   - Action Points

### ITEMS FOR APPROVAL

2.1 Financial Plan
   (Mark Bakewell)

2.2 2 & 5 Year Plan Update
   (Mark Bakewell)

2.3 Annual Reports, Annual Governance Statement & Financial Statements
   (Mark Bakewell & Paul Edwards)

   - External Audit Findings Report

   - Letter of Representation

### ITEMS FOR DISCUSSION

3.1

### ITEMS FOR INFORMATION

4.1 Performance Report - QPF
   (Lorna Quigley)

4.2 WHCC Consortia
   (Andrew Cooper)

### ITEMS FOR NOTING

5.
5.1 Corporate Calendar (Paul Edwards)

5.2 Subgroups (Ratified Minutes):


Wirral GPCC Consortium of: 11.03.2014

Audit Committee of 03.04.2014

6. RISK REGISTER

Current Risk Register

7. ANY OTHER BUSINESS

7.1

8. End DATE AND TIME OF NEXT MEETING

Tuesday 1st July 2014
2pm – 4pm
Duncan Room OMH

Please forward any apologies to Allison.hayes@nhs.net

**Latest submission date for papers is Friday 20th June 2014**

Wirral Clinical Commissioning Group – Future Meetings 2014

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Time</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday</td>
<td>1st July</td>
<td>2pm – 5pm</td>
<td>Nightingale Room</td>
</tr>
<tr>
<td>Tuesday</td>
<td>5th August</td>
<td>2pm – 5pm</td>
<td>Nightingale Room</td>
</tr>
</tbody>
</table>
Present:

Dr P Jennings (PJ)   Chairman
Dr A Mantgani (AM)   Chief Clinical Officer
Lorna Quigley (LQ)   Head of Quality & Performance
Mark Bakewell(MB)   Chief Finance Officer
Dr P Naylor (PN)   Consortium Chair
Dr J Oates (JO)   Consortium Chair
Dr D Jones (DJ)   GP Executive (WHCC)
Dr M Green (MG)   Consortium Chair
James Kay (JK)   Lay Member (Audit & Governance)
Paul Edwards (PE)   Head of Corporate Affairs
Dr S Wells (SWel)   GP Executive (WHCC)
Andrew Smethurst (AS)   Secondary Care Doctor
Simon Wagener (SW)   Lay Member (Patient Champion)
Andrew Cooper (AC)   Consortium Chief Officer (WHCC)
Dr A Ali (AA)   GP Executive (WGPC)
Iain Stewart (IS)   Consortium Chief Officer (WACC)
Christine Campbell (CC)   Consortium Chief Officer (WGPC)

In Attendance:

Allison Hayes (AJH)   Executive Assistant

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td>GB14-15/007</td>
<td>Preliminary Business</td>
</tr>
<tr>
<td>1.1 Apologies for absence</td>
<td>Apologies for Absence were received from: Dr H McKay, Fiona Johnstone and Graham Hodkinson.</td>
</tr>
<tr>
<td>1.2 Chair’s Announcements</td>
<td>Chair welcomed all members to the meeting. 3 members of the public attended the meeting.</td>
</tr>
<tr>
<td>1.3 Declarations of Interest</td>
<td>There were no declarations of interest.</td>
</tr>
<tr>
<td>1.4 Comments/questions from members of the public</td>
<td>The Chair welcomed the members of the public present and invited any questions/comments. Mr Ousey, a patient from Eastham Group Practice addressed the Governing Body and raised concerns he had with regards to applying for an operation through NHS Choices.</td>
</tr>
</tbody>
</table>
highlighted the lack of communication between systems and departments and sought a direction of travel from the Board.

Chair thanked Mr Ousey for addressing the Board and for sharing his personal experience with the group. Chair then briefly explained the rational regarding individual funding requests (IFR) and requested that Mr Ousey liaise with AJH in order to pass on his concerns for the CCG to progress with.

Dr R Williams, Chair of LMC Wirral, addressed the Governing Body on behalf of the LMC members. Dr Williams asked the Board to consider the LMC attending future meetings without having voting rights.

Chair thanked Dr Williams for his attendance and informed him that the Governing Body will respond in due course.

Governing Body members were asked to consider the LMCs request.

Chair read out a statement on behalf of Healthwatch Wirral requesting a non-voting membership on the Governing Body Board. Chair informed members that this was to be debated under AOB.

1.5 Patient Story

Due to technical difficulties the Patient Story was deferred.

1.6 Minutes and Action Points of the last meeting held on 1st April 2014 & matters arising:

The minutes of the previous meeting held on 1st April were agreed as a true and accurate record notwithstanding grammatical/typographical errors which will be rectified.

Action – AJH to rectify errors.

Action Points - Please refer to the attached sheet.

- CSU SLA – GB 12-13/164 – LQ: CSU SLA to be reviewed on a quarterly basis and presented to the Governing Body by Lorna Quigley, with procurement options considered as part of the review process. – Next review – August 2014.

GB14-15/008

2.0 Items for Approval

2.1 Wirral Clinical Commissioning Group Constitution

PE informed the Governing Body of the process for making Constitutional amendments and that the next window for submission was in June. He highlighted that there were three main areas that had been proposed for amendment: 1) Membership, in light of NHS England guidance that precluded ‘non-voting member status’ and a request for Local Medical Committee representation, 2) the eligibility criteria for the Chair election process to allow for any Governing Body GP to stand and 3) updated Terms of Reference to mainly reflect consistency and internal CCG changes. PE explained that PJ had written to practices for comments as per the usual process and no feedback had been received.

SW stated that the question of LMC representation should be fully debated under agenda item 7. AA and JO stated that they felt that more consultation was needed in regard to membership...
Members felt that given that further consortia Terms of Reference changes were likely to be needed and a further proposal to alter the Approval Committee was also forthcoming, it would be more appropriate to include these changes and undertake further practice engagement ahead of the November submission date. Members therefore agreed that the submission would be postponed until November to allow further changes to be incorporated and engage with practices on these proposals.

2.2 Safeguarding Annual Report and Policy

LQ gave an overview of the Safeguarding annual report and policy and asked Governing Body members to note the work that is being carried out.

The purpose of the annual report is to provide assurance to NHS WCCG Governing Body that the work taking place regarding safeguarding children and adults at risk within Wirral is operating in accordance with statutory guidance and takes account of our responsibility to assure that the organisations that we commission have effective safeguards in place and provide the highest possible standards of care.

The purpose of the policy is to outline the way Wirral CCG will meet its statutory duties and responsibilities to safeguard and promote the welfare of adults and children. The policy details the roles and responsibilities of the organisation and its staff to safeguard the public as a commissioning organisation or employee. The policy provides guidance to staff on the steps to take if they have concerns about the welfare of a child or young person.

The Governing Body were asked to note the contents of the reports and accept assurances that the CCG is meeting its statutory responsibilities in relation to safeguarding children and adults at risk.

SW queried how the public could be trained and how well NHS Wirral are engaging with the public with regards to safeguarding and highlighted typing and grammatical errors within the report.

The Governing Body noted the contents of the report and the significant improvement made and agreed for the policy to stand in its current form.

2.3 SLA between CSU and the CCG

LQ provided members with details regarding the commissioning intentions in relation to the service level agreement between the CSU and the CCG.

LQ explained that the principle is that the CCG choose how and from whom they access their commissioning support. It is critical that any changes that the CCG wishes to make to their commission support arrangements is viable, that the new arrangements represent value for money and improves quality of service in the local health community.

The aim of the paper is to provide the Governing Body with an update in relation to the Performance of the CSU in relation to the SLA, the guidance from NHS England and the direction of travel the CCG wishes to take.

The 3 service lines that the CCG wish to bring in house are:

- Business Intelligence
- Elements of Customer Solutions Centre (Complaint Handling, Freedom of Information requests, MP letters, Serious Incidents, Interface Incidents and Subject Access Requests)
- Financial Management Services (Contract monitoring elements)
Members sought clarification around the risks regarding viability to the CSU by withdrawing the above services and MB provided clarification around this and informed members that the CSU are carrying out a review regarding sustainability regarding the services.

SWels raised concerns regarding TUPE issues and the effect this can have on staff.

The Governing Body were happy for the SLA to proceed and noted the contents of the report.

### 2.4 Approvals Committee Proposal

JK gave an overview of the proposal to seek further strength in lay membership of the Approvals Committee by the addition of two further members from within the existing Audit Committee membership which itself has been recently strengthened by the addition of three further members.

AM gave his support to the proposal and highlighted the input from Public Health. AA also gave his support for the proposal but stated that medical input should be more prominent without conflict of interest.

Members discussed the voting split and how the need for a majority of voting members who are free from any potential perception of conflict of interest.

The Governing Body were asked to approve the paper and note that amendments are to be submitted in November in relation to the NHS Wirral Constitution.

### GB14-15/009

#### 3.0 Items for Discussion

There were no items for discussion.

### GB14-15/010

#### 4.0 Items for Information

##### 4.1 Integrated Finance and Performance Report

MB presented a report on the financial activity of the Governing Body for the year 2013/14 and highlighted the financial performance against budgeted allocation for 2013/14 as at Month 12 (March)

**Month 12 Financial Performance**

- Planned year to date surplus - £6.575m
- Revised surplus - £4.575m (4<sup>th</sup> quarter amendment)
- Draft Year End Position - £4.751m (£176k underperformance)
- External Audit currently onsite reviewing financial statements and associated documents (annual report, remuneration)

**Month 12 Financial Update headline Movements and Year end Position**

- **NHS Contracts**
  - Year end £6.5m over performance
  - WUTH (36.3m) excludes winter pressures and other individual items

- **Non- NHS Contracts**
  - Year end £2.2m over performance (Spire £1.6m)
  - Prescribing – further increase in February actuals
**Ref No.**

<table>
<thead>
<tr>
<th>Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Year end £0.75m over performance</td>
</tr>
<tr>
<td>- Commissioned out of hospital</td>
</tr>
<tr>
<td>- Year end £0.57m over performance (slight improvement in month in respect of Funded Packages of care)</td>
</tr>
<tr>
<td>- Intermediate Care/Re-ablement</td>
</tr>
<tr>
<td>- Year end (£0.3m) under performance</td>
</tr>
<tr>
<td>- Other</td>
</tr>
<tr>
<td>- Year end (£7.4m) under performance</td>
</tr>
<tr>
<td>- Release of contingency</td>
</tr>
<tr>
<td>- Slippage in non-recurrent (headroom)</td>
</tr>
<tr>
<td>- Running costs</td>
</tr>
<tr>
<td>- Year end (£0.5m) under performance</td>
</tr>
</tbody>
</table>

The Governing Body was asked to note the finance report today.

LQ presented a report on the activity performance for month 11 (February)

Areas included:

- Family and Friend Tests
- NWAS turnaround times
- Delivering same sex accommodation
- Diagnostic tests
- MRSA
- Referral to treatment – NHS Constitution

SW sought clarification around Health Care Associated Infection figures and LQ clarified the areas reported.

Members of the Governing Body noted the report.

The Governing Body was asked to note the finance report today.

LQ presented a report on the activity performance for month 10 (January)

Areas included:

- Family and Friends test
- NWAS turnaround times
- Delivering Same Sex Accommodation
- Diagnostic tests
- MRSA
- Referral to treatment – NHS Constitution

4.2 Committee Reports

PE provided the Governing Body members with details of the committee structures that enable the CCG to deliver its statutory duties. The series of reports defines the key duties of each committee followed by a narrative outlining how those duties have been discharged throughout the 2013-14 financial year.

The following committee reports were noted by the Governing Body:

- Audit Committee and Chairs Report – members are to be changed from Lay Advisors to Lay Members
• Quality Performance and Finance (QPF)
• Remuneration Committee
• Approvals Committee – members are to be changed from Lay Advisors to Lay members
• WGPCC Consortia – SW suggested that more information around patient engagement is contained within the report in relation to individual PPGs.
• WACC Consortia – COPD service is to be considered as a patient story for Governing Body.
• WHCC Consortia – responsibilities of Board members have been amended to reflect consistency across the divisions. Details of practice service advice leaflets were highlighted and results from an urgent care questionnaire. AS suggested using a more constructive form of language in the report. JK suggested including Bi-gender information and the need to take on board patient education access to services across Wirral.

PE congratulated the committees on their work and for demonstrating to the public how the CCG is an organisation operates.

Members suggested that the Clinical Strategy Group should be included next year.

The Governing Body noted and acknowledged the contents of the reports.

5.0 Items for Noting

5.1 HR Policies

PE gave an overview of the following HR Policies and the process of approval the polices had gone through:

• Work Experience
• Recruitment and Selection
• Learning And Development
• Career Breaks

PE briefly updated members around recent work experience cases that the CCG had participated in and informed members of the positive experiences gained by both the CCG and the individuals involved.

AM suggested that although learning may have been identified in an employee’s PDR (Personal Development Record) it is not always necessary for the CCG to fund these. PE clarified the details regarding this.

The Governing Body noted the reports.

5.2 Subgroups (Ratified Minutes):

Governing Body members were asked to note the following subgroups minutes:

• Wirral Health Commissioning Consortium of: 19.03.2014
• QPF Committee of: 25.02.2014
• Approvals Committee of: 25.02.2014
• Audit Committee of: 30.01.2014 – JK informed members that due to timings of meetings a
summary of minutes will now be presented to the Governing Body. Members agreed that all future meetings minutes will be presented at Governing Body however committee reports in relation to infrequent meetings will contribute towards the process also.

**Emergency Planning Response and Resilience (EPRR)**

PE gave an overview of the EPRR end of year report for 2013/14. The report illustrates the responsibilities if the CCG in relation to EPRR and how the CCG is meeting the requirements of those responsibilities in partnership with Cheshire and Merseyside Commissioning Support Unit (CSU). The report also details information regarding the services provided by the CSU, EPRR training undertaken by CCG colleagues, EPRR Strategic Planning Support provided and further information relating to EPRR Governance Assurance.

JK raised concern about how the CSU tests and assures the policy and requested a meeting with PE to discuss this further.

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
</tr>
</thead>
</table>
| GB14-15/012 | **6.0 Risk Register**  
**Items to be included on the Risk Register**  
All items on the Governing Body Risk Register were reviewed and noted today.  
Areas included:  
- LD and the absence of a Partnership Board  
- Safeguarding and the completion of the GP assurance toolkit  
- Finance and availability of resources – transitional and contingency  
- Finance and availability of resources – demand management  
- Constitution amendments |

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
</tr>
</thead>
</table>
|         | **7.0 Any other Business**  
**LMC and Healthwatch applications regarding ‘in attendance’ membership on the Governing Body**  
Chair gave feedback to the group regarding the roles of ‘in-attendance’ members and clarified how they would fit into the Governing Body structure. Members agreed should there be support and agreement for the LMC to attend, this should be to an officer of the LMC and that it should be the same person to attend each meeting to ensure consistency.  
SWel suggested that the LMC need to have a greater understanding of the CCG Governing Body and further discussions took place regarding the need to articulate the rationale for any changes to Governing Body attendance and that the CCG is consistent with their message.  
CC also highlighted the need to provide the reason behind any change and supports the LMC with their application to become a member of the CCG.  
LQ observed the consistency of the attendance from LMC representative and questioned how to incorporate other membership bodies/organisations to the CCG should they want to apply.  
IS stated that the LMC had used the phrase ‘to be representative of Practices views’ and stated that the CCG Governing body consists of 9 GP members who already carry out this function on behalf of the Wirral practices. MG highlighted difficulties in relation to current Governing Body members being democratically elected as a voting member on a board and queried the role the LMC would have by attending meetings.  
AM raised concerns with regards to a member of the LMC attending Private Business due to corporate governance issues. DJ supports the proposal for the LMC not to attend Private |
Business however he feels that we need to demonstrate that their attendance works initially and that this should take place in the Public session of the meeting.

PJ made a proposal to invite an LMC representative to attend the public part of future Governing Body meetings and as non-voting member – 7 members agreed, 2 abstained.

JK then proposed the same status for Healthwatch Wirral and the need to clarify who attends. All members of the Governing Body agree to this proposal.

The board meeting ended at approximately 16.30pm

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Business however he feels that we need to demonstrate that their attendance works initially and that this should take place in the Public session of the meeting.</td>
</tr>
<tr>
<td></td>
<td>PJ made a proposal to invite an LMC representative to attend the public part of future Governing Body meetings and as non-voting member – 7 members agreed, 2 abstained.</td>
</tr>
<tr>
<td></td>
<td>JK then proposed the same status for Healthwatch Wirral and the need to clarify who attends. All members of the Governing Body agree to this proposal.</td>
</tr>
<tr>
<td></td>
<td>The board meeting ended at approximately 16.30pm</td>
</tr>
</tbody>
</table>

**8.0 Date and Time of Next Meeting**

The date and time of the next meeting is **Tuesday 3rd June 2014 at 2pm – 5pm at OMH, Duncan Room**

please contact Allison.hayes@nhs.net with any apologies or agenda items.

Board meeting ended at: 16:30pm
Wirral Clinical Commissioning Group

Governing Body

Draft Action Points re Meeting of 6th May 2014 (Public Session)
Albert Lodge
2pm

Outstanding Actions from: 1st April

<table>
<thead>
<tr>
<th>Topics Discussed</th>
<th>Item Number/Ref</th>
<th>Action Points</th>
<th>Responsibility</th>
<th>Action Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSU SLA</td>
<td>• GB 12-13/164</td>
<td>• CSU SLA to be reviewed on a quarterly basis and presented to Governing Body by Lorna Quigley, with procurement options considered as part of the review process</td>
<td>• Lorna Quigley</td>
<td>• August 2014</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>• GB 13-14/014</td>
<td>• PE to bring Assurance Framework back to Governing Body on a quarterly basis – follow up for May 2014.</td>
<td>• Paul Edwards</td>
<td>• June 2014</td>
</tr>
<tr>
<td></td>
<td>(2.8)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

New Actions from: 06.05.2014

<table>
<thead>
<tr>
<th>Topics Discussed</th>
<th>Minute</th>
<th>Action Points</th>
<th>Responsibility</th>
<th>Action Target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minutes and Action</td>
<td></td>
<td>• AJH/PE to rectify grammatical errors and agreed amendments to minutes of 4th March and EGBM 20th March.</td>
<td>• AJH/PE</td>
<td>• 06.05.2014</td>
</tr>
<tr>
<td>Points of the last</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>meeting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Agenda Items for next meeting / Decisions to note for next meeting / Date & time of next meeting

The date of the next meeting is Tuesday 3rd June 2014 at 2pm at OMH, Duncan Room. Agenda items and apologies are to be sent to: Allison.hayes@nhs.net
# NHS Wirral CCG Budgeted Expenditure 2014/15

<table>
<thead>
<tr>
<th>Agenda Item:</th>
<th>2.1</th>
<th>Reference:</th>
<th>GB14-15/0014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report to:</td>
<td>Governing Body</td>
<td>Meeting Date:</td>
<td>3rd June 2014</td>
</tr>
<tr>
<td>Lead Officer:</td>
<td>Mark Bakewell – Chief Financial Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributors:</td>
<td>Emma Shanks, Louise Morris, David Miles</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Governance:
- **Link to Commissioning Strategy**: Sound financial control is essential to the CCG strategy and is directly linked to the delivery of the CCG Commissioning and Operational Plans for the financial year.
- **Link to current governing body Objectives**: Achieve financial control total with sound financial management demonstrated by meeting its statutory duties.

## Summary:
This report and appendices set out the summary financial plan for the CCG for 2014/15 including level of required surplus.

- Proposes financial management arrangements for splits between Governing Body (Federated Levels) and Consortia Levels.
- Proposes the basis for the apportionment of Consortia Level budgets on a “fair-share” basis.

## Recommendation:
- **To Approve**: ✔
- **To Note**: 
- **Comments**: 

## Next Steps:
Approval of the detailed budgets will form the basis for in–year monitoring at the respective levels to ensure delivery of required financial position.

---

*This section is an assessment of the impact of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.*

### What are the implications for the following (please state if not applicable):

| **Financial** | The report sets out the financial plan for the CCG and gives approval to relevant budget managers to incur expenditure based on the financial plan. |
| **Value For Money** | All expenditure plans are subject to an ongoing value for money review. |
| **Risk** | The report details the key financial risks for the financial years and these will |
be monitored in year as part of the reporting process

**Legal**

Legal advice is sought on financial issues as and when required.

**Workforce**

The financial plan includes budgeted “running costs” expenditure and is reflective of the respective workforce implications in these areas.

**Equality & Human Rights**

Financial Plans will consider as appropriate the equality impact assessment for proposals within the budgeted expenditure.

**Patient and Public Involvement (PPI)**

Budgets include funding to ensure continued involvement of patients and public in CCG decisions.

**Partnership Working**

The CCG works with a number of NHS Trusts and the Local Authority across a range of its commissioning budgets.

**Performance Indicators**

The plan reflects the planned achievement of statutory financial duties.

---

Do you agree that this document can be published on the website?  
(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions)

Yes

---

This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path ie. other papers that are directly related to the current paper under discussion.

<table>
<thead>
<tr>
<th>Report Name</th>
<th>Reference</th>
<th>Submitted to</th>
<th>Date</th>
<th>Brief Summary of Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headline Financial Plan</td>
<td></td>
<td>Quality, Performance and Finance Committee</td>
<td>28th January 2014</td>
<td></td>
</tr>
<tr>
<td>Headline Financial Plan</td>
<td></td>
<td>Quality, Performance and Finance Committee</td>
<td>25th February 2014</td>
<td></td>
</tr>
</tbody>
</table>

---

**Private Business**

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The definition of "prejudicial" is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

If a report is deemed to be for private business, please note that the tick in the box, indicating whether it can be published on the website, must be changed to a x.

If you require any additional information please contact the Lead Director/Officer.
NHS Wirral Clinical Commissioning Group

Financial Plan 2014/15 Update

Introduction


2. Headline Financial plans have been presented to the Quality, Performance and Finance Committee and Governing Body between January and March based on the application of the guidance received. This paper presents the final budget values for the 2014-15 financial year and associated risks.

Headline Plan Deliverables

3. Update of Financial Plan for finalised contract values is still consistent with Business Planning Rules on the basis of the following.

4. Each commissioning organisation should plan to make a cumulative surplus at the end of 2014/15 of at least 1 per cent of revenue, including any historic surplus not drawn down. Plans continue to assume that this will be carried forward into 2015/16.

5. In 2014/15, there is a requirement across all commissioning organisations to set aside 1.5 per cent of recurrent resource for non-recurrent expenditure.

6. Clinical commissioning groups are asked to hold a contingency of at least 0.5 per cent of recurrent revenue within their plans to determine locally the contingency required to mitigate risks within the local health economy. This is in addition to 1.5 per cent ring fenced non-recurrent funds.

7. The financial values associated with these planning requirements are as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pt 4 Surplus (at least 1% of revenue)</td>
<td>£4.684</td>
</tr>
<tr>
<td>Pt 5 Non-Recurrent Expenditure</td>
<td>£6.955</td>
</tr>
<tr>
<td>Pt 6 Contingency (at least 0.5%)</td>
<td>£3.000</td>
</tr>
</tbody>
</table>

8. Final Budget Values (based on contract figures) are set with a level of Risk and required QIPP delivery (see Financial Risk section).

Summary of Resources

9. Summary of anticipated resources is as per below table one below and based on an overall allocation in 2014-15 financial year of £468.4m.
Table 1 – Summary of Resources

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>13/14 Recurrent Baseline Programme Resource</td>
<td>£446.176</td>
</tr>
<tr>
<td>14/15 Growth</td>
<td>£9.564</td>
</tr>
<tr>
<td>Revised Recurrent Programme Resource</td>
<td>£455.740</td>
</tr>
<tr>
<td>Non-Recurrent Programme Resource</td>
<td>£4.684(* b/f interim surplus 2013/14 – capped to 1% surplus)</td>
</tr>
<tr>
<td><strong>Total Programme Resource</strong></td>
<td><strong>£460.424</strong></td>
</tr>
<tr>
<td>Running Cost Allocation (Recurrent)</td>
<td>£7.929</td>
</tr>
<tr>
<td><strong>Total Allocation</strong></td>
<td><strong>£468.353</strong></td>
</tr>
</tbody>
</table>

a) Recurrent / Non-Recurrent Resources

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent (Inc Running Cost)</td>
<td>£463.699</td>
</tr>
<tr>
<td>Non-Recurrent</td>
<td>£4.684</td>
</tr>
<tr>
<td><strong>Total Allocation</strong></td>
<td><strong>£468.353</strong></td>
</tr>
</tbody>
</table>

Surplus Requirements

10. The requirement for surplus is as per table two below

1% Surplus of recurrent resource= £4,684, therefore required expenditure = £463,736

In order to meet headroom requirements of 2.5% therefore

<table>
<thead>
<tr>
<th>Table 2 - Surplus</th>
<th>Recurrent £m</th>
<th>Non-Recurrent £m</th>
<th>Total £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource (exc Running Costs)</td>
<td>455.740</td>
<td>4.684</td>
<td>460.424</td>
</tr>
<tr>
<td>Expenditure (exc Running Costs)</td>
<td>444.148</td>
<td>11.592</td>
<td>455.740</td>
</tr>
<tr>
<td>(Surplus) / Deficit*</td>
<td>(11.592)</td>
<td>6.908</td>
<td>(4.684)</td>
</tr>
</tbody>
</table>

* Assume Running Costs breakeven vs allocation of £7.929

Headroom Requirements

11. The requirement for recurrent headroom is as per the below

2.5% surplus in 2014/15 financial year (of recurrent resource) = (£11.592)

1.5% Headroom (non-recurrent requirement for ccg’s) = (£6.955)

1% for Transformation – Call to Action = (£4.637)
2014-15 Expenditure

12. As outlined above, in order for the CCG to deliver its surplus position of £4.684m then its overall programme expenditure budget for 2014-15 financial year is required to be set at £455.8m (based on the resource assumptions of £460.5m) and an assumption that the running cost expenditure matches the allocation of £7.929m

13. This paper outlines the headline approach for the setting of the CCG Budgets for 2014/15 and has been guided by the following principles:

   a) The methodology used is consistent, fair and transparent and agreed by the Wirral CCG Governing Body.

   b) Based on a continuation of the approach in 2013/14 with certain budgets deemed appropriate to be managed at consortia / practice level based on the information available and others managed at a federated level where they relate to a Wirral wide service or cannot be directly influenced by practice based decisions.

   c) Any QIPP schemes / other financial risks will be delivered and mitigated against by the actions taken through CCG direction or via contract performance

14. Budget Values are predominantly based on agreed contract values from negotiations with providers (either directly or via associate commissioner arrangements) and have been built up using broadly using 2013/14 forecast outturn as at Month 11 (February) and application of tariff adjustments as per national guidance and other further planning assumptions.

15. There does remain some residual contract funding issues in particular with regards to the funding / transfer of vascular surgery between Wirral University Teaching Hospitals NHS Foundation Trust and Countess of Chester NHS Foundation Trust.

16. A number of planning assumptions have been included (predominantly regarding Demand Management schemes, and controlling expenditure in prescribing and Commissioned Out of Hospital Care) in order to achieve the CCG’s required financial position. These will be detailed further in the QIPP and Financial Risk sections of this report.

17. In line with 2013-14 financial year, the CCG will need to decide how it wishes to report and monitor its budgeted expenditure in order to meets its target surplus position within its forecast resource availability.

18. Table three below and supporting appendices A and B propose (based on the previous year) the categorisation of expenditure for reporting / monitoring purposes

<table>
<thead>
<tr>
<th>Table Three</th>
<th>£ Million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme Budgets</td>
<td></td>
</tr>
<tr>
<td>NHS Contracts</td>
<td>331.5</td>
</tr>
<tr>
<td>Non NHS Contracts</td>
<td>16.7</td>
</tr>
<tr>
<td>Prescribing</td>
<td>56.8</td>
</tr>
<tr>
<td>Commissioned Out of Hospital</td>
<td>35.2</td>
</tr>
<tr>
<td>Intermediate, Social Care &amp; Reablement</td>
<td>3.7</td>
</tr>
<tr>
<td>Other Commissioning Expenditure</td>
<td>4.9</td>
</tr>
<tr>
<td>CCG Reserves (inc Contingency and 2% Headroom)</td>
<td>6.8</td>
</tr>
<tr>
<td>PROGRAMME TOTAL</td>
<td>455.8</td>
</tr>
</tbody>
</table>
19. Appendix B details the splits of those budgets to be managed at a governing body (or federated level) and those budgets (traditionally cost per case activity “PbR style or prescribing costs) managed at a consortia level on the following key principles.

**Consortia Level**
- Cost per Case Activity including PbR / Non-PbR Contracts where patient level data is available
- Prescribing Budgets (where practice’s can influence direct expenditure)
- Consortia Service Development Budgets

**Federated Level**
- Wirral Wide Services
- Cannot be influenced directly by Practice Decisions
- Prescribing Budgets (where practice’s cannot influence direct expenditure e.g. Amber Drugs)
- Commissioned Out of Hospital Budgets including Continuing Health and Joint Funded Packages of Care

**Contract Expenditure**

20. Table Four provides details on planned expenditure across NHS and Non-NHS Providers and reflect contract agreements as appropriate

21. A number of demand management assumptions have been assumed within these figures as per the QIPP and Financial Risks section of the report

<table>
<thead>
<tr>
<th>Table Four Contract Expenditure &gt; £1m</th>
<th>£ m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Contracts</strong></td>
<td></td>
</tr>
<tr>
<td>Wirral University Teaching Hospital NHS Foundation Trust</td>
<td>221.500</td>
</tr>
<tr>
<td>Wirral Community NHS Trust</td>
<td>45.329</td>
</tr>
<tr>
<td>Cheshire &amp; Wirral Partnership NHS Foundation Trust</td>
<td>32.200</td>
</tr>
<tr>
<td>North West Ambulance Service</td>
<td>11.028</td>
</tr>
<tr>
<td>Royal Liverpool &amp; Broadgreen University Hospitals NHS Trust</td>
<td>6.328</td>
</tr>
<tr>
<td>Aintree University Hospitals NHS Foundation Trust</td>
<td>2.476</td>
</tr>
<tr>
<td>Countess of Chester NHS Foundation Trust (excludes vascular)</td>
<td>1.964</td>
</tr>
<tr>
<td>Liverpool Womens NHS Foundation Trust</td>
<td>2.273</td>
</tr>
<tr>
<td>Liverpool Heart &amp; Chest NHS Foundation Trust</td>
<td>1.280</td>
</tr>
<tr>
<td>Alder Hey Childrens NHS Foundation Trust</td>
<td>1.918</td>
</tr>
<tr>
<td>South Staffordshire and Shropshire Healthcare NHS Foundation Trust</td>
<td>1.492</td>
</tr>
<tr>
<td><strong>Non-NHS Contracts</strong></td>
<td></td>
</tr>
<tr>
<td>PCMH - WGPCC</td>
<td>1.016</td>
</tr>
<tr>
<td>Spire - Murrayfield</td>
<td>4.856</td>
</tr>
<tr>
<td>Spa Medica</td>
<td>1.085</td>
</tr>
<tr>
<td>One to One Midwifery</td>
<td>1.329</td>
</tr>
<tr>
<td>Assura</td>
<td>1.947</td>
</tr>
<tr>
<td>St Johns Hospice (Wirral)</td>
<td>1.591</td>
</tr>
</tbody>
</table>
Prescribing

22. The Prescribing Budget for 2014-15 has been based on the principle of the 2013-14 forecast outturn position with an number of additional adjustments for price growth and efficiency as per the financial planning assumptions

23. 2013-14 prescribing expenditure was over the original budgetary allocation by £749k, this being split between practice level of £494k and federated level (centrally charged drugs £256k)

24. The 2014-15 expenditure budget has been set based upon the month 11 (February) pro-rata forecast outturn position, plus net 1% growth (+5% uplift in prices less 4% efficiency in prescribing costs) of £557k

25. An additional value of circa £0.6m has been included for full year impact and new prescribing costs in 2014-15 and also a planning assumption regarding demographic growth. These will be apportioned on the basis of Astro-PU's).

26. Practice Level prescribing will be managed at consortia level. In terms of budgets managed at a federated level, “Amber” and “Centrally Charged” will continue to managed at a governing body level along with other residual items.

27. A further planning assumption has been included (further detail in QIPP / financial risk section) that overall expenditure can be managed down to 13/14 outturn levels.

Commissioned Out of Hospital

28. Commissioned Out of Hospital expenditure continues to be a significant area of risk for the CCG (further detail included in financial risk section)

29. Initial financial planning assumptions were based on budgeted expenditure in this area being based on Month 11 forecast Outturn figures, with a small adjustment for demographic growth and a 2% anticipated rise in expenditure in this area.

30. A planning assumption has been included (further detail in QIPP / financial risk section) that overall expenditure can be managed down to 13/14 outturn levels.

Intermediate, Social Care & Reablement

31. The 2014-15 financial year is the initial period of the Better Care Fund Arrangements between NHS Wirral CCG and Wirral Local Authority. A number of budgeted expenditure areas that the CCG continues to hold the resource for are included within this section (in particular Reablement & Carers Funding)

32. Discussions are ongoing with regards to establishing the financial flows and monitoring arrangement for this financial year, ahead of the new arrangements in 2015-16 where the CCG’s resource will be top sliced into a pooled budget arrangement 9again to be determined)

Local Enhanced Services

33. Local Enhanced Services (LES) are commissioned by the CCG for 2014-15 and include a number of schemes that are a continuation from previous financial years for 2014-15, these include
34. The remainder of the recurrent LES budget (circa £1.6m) has been assigned for new schemes which are currently under discussion and are as a direct result of the conclusion of a number of other historic LES schemes (e.g. End of Life, CKD, Diabetes, Osteoporosis, Choose & Book, VDP).

GP IT

35. Responsibility for the operational management of GP IT services, along with the appropriate funding has been devolved to CCG’s to be managed on behalf of NHS England.

36. Table five below indicates the resource allocation received and initial expenditure plans based on recurrent expenditure.

37. The CCG will continue to work with Cheshire and Merseyside CSU to manage these elements as appropriate. The resource is anticipated to be allocated to CCG’s in July (currently excluded from above resource assumptions).

<table>
<thead>
<tr>
<th>Table 5 GP IT Costs 2014 / 2015</th>
<th>Wirral CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT Support Services (SLA with CMCSU)</td>
<td>£542,674</td>
</tr>
<tr>
<td>EMIS</td>
<td>£48,187</td>
</tr>
<tr>
<td>In Practice Systems</td>
<td>£24,282</td>
</tr>
<tr>
<td><strong>sub-total (System Maintenance and Support Contracts)</strong></td>
<td><strong>£72,469</strong></td>
</tr>
<tr>
<td>Data Lines</td>
<td></td>
</tr>
<tr>
<td><strong>sub-total (Telephony)</strong></td>
<td><strong>£5,400</strong></td>
</tr>
<tr>
<td>Docman</td>
<td></td>
</tr>
<tr>
<td><strong>sub-total (Other Software)</strong></td>
<td><strong>£55,175</strong></td>
</tr>
<tr>
<td>Network Maintenance</td>
<td>£26,000</td>
</tr>
<tr>
<td>N3 VPN Tokens</td>
<td>£24,371</td>
</tr>
<tr>
<td>EPO (AV Software)</td>
<td>£16,260</td>
</tr>
<tr>
<td>Extended XP Support Agreement</td>
<td>£1,786</td>
</tr>
<tr>
<td><strong>sub-total (Other)</strong></td>
<td><strong>£68,417</strong></td>
</tr>
<tr>
<td><strong>Contingency</strong></td>
<td>£95,264</td>
</tr>
<tr>
<td><strong>Total Anticipated Expenditure 2014_2015</strong></td>
<td><strong>£839,398</strong></td>
</tr>
<tr>
<td><strong>Confirmed Budget 2014/2015</strong></td>
<td><strong>£839,398</strong></td>
</tr>
</tbody>
</table>
Reserves

38. The financial planning assumptions as per previous headline financial plans presented to the CCG are based on the below earmarked reserves and planned non-recurrent expenditure.

39. These reserves values take into account resolution of required contract values / anticipated expenditure for the 2014-15 financial year but are before planning assumption adjustments as described in Financial Risks section.

Recurrent

40. The CCG will hold a number of recurrent reserves for earmarked issues as itemised in the table six below (including contingency).

41. Utilisation of Over 75’s funding as per NHS England Planning Guidance is still to be confirmed

<table>
<thead>
<tr>
<th>Table 6</th>
<th>£ million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent Reserves Control -14/15</td>
<td>2.596</td>
</tr>
<tr>
<td>Contingency</td>
<td>3.000</td>
</tr>
<tr>
<td>Interim Arrangements for ‘111’ Transition</td>
<td>0.482</td>
</tr>
<tr>
<td>Advancing Quality Contribution</td>
<td>0.190</td>
</tr>
<tr>
<td>AQUA Contribution</td>
<td>0.040</td>
</tr>
<tr>
<td>Military Veterans Commissioning Contribution</td>
<td>0.043</td>
</tr>
<tr>
<td>CCG Baseline Reserve (Allocation Issues to be resolved)</td>
<td>1.254</td>
</tr>
<tr>
<td>Other Commitments</td>
<td>0.073</td>
</tr>
<tr>
<td><em>(QIPP GAP) see Risks</em></td>
<td><em>(4.140)</em></td>
</tr>
<tr>
<td>&gt;75 Funding (based on planning guidance) * 1</td>
<td>1.656</td>
</tr>
</tbody>
</table>

42. Based on these planning assumptions there remains a QIPP gap of £4.140 million which equates to 0.9% of overall recurrent resource.

Non-Recurrent

43. In line with above planning assumptions, the CCG has earmarked non-recurrent investment as itemised in the table seven below

<table>
<thead>
<tr>
<th>Table 7</th>
<th>£ million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Recurrent Reserves Control -14/15</td>
<td>4.303</td>
</tr>
<tr>
<td>Continuing Healthcare Restitution Reserve</td>
<td>2.000</td>
</tr>
<tr>
<td>(Includes notified top slice of £1.7m)</td>
<td></td>
</tr>
<tr>
<td>Demand Management Scheme Reserve</td>
<td>0.990</td>
</tr>
<tr>
<td>Prescribing Incentive Scheme</td>
<td>0.500</td>
</tr>
<tr>
<td>CCG Contribution to Vascular reconfiguration</td>
<td>0.200</td>
</tr>
<tr>
<td>Other Non-Recurrent Service Developments</td>
<td>0.613</td>
</tr>
<tr>
<td>Inc BME / ARBD/ IT / Shared Care</td>
<td></td>
</tr>
</tbody>
</table>
44. With regards to overall required non-recurrent investment as per the summary on page 2. Table Eight provides an overall summary

<table>
<thead>
<tr>
<th>Table 8</th>
<th>£ million</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Recurent Transformational</strong></td>
<td></td>
</tr>
<tr>
<td>Non-Recurent Funding committed through contracts and in contract values</td>
<td></td>
</tr>
<tr>
<td>Wirral University Teaching Hospitals NHS Foundation Trust</td>
<td>6.956</td>
</tr>
<tr>
<td>Wirral Community NHS Trust</td>
<td>0.156</td>
</tr>
<tr>
<td>Cheshire &amp; Wirral Partnership NHS Foundation Trust</td>
<td>0.177</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7.289</td>
</tr>
<tr>
<td><strong>Non-Recurent Reserves Control -14/15</strong></td>
<td></td>
</tr>
<tr>
<td>Continuing Healthcare Restitution Reserve (Includes notified top slice of £1.7m)</td>
<td>2.000</td>
</tr>
<tr>
<td>Demand Management Scheme Reserve</td>
<td>0.990</td>
</tr>
<tr>
<td>Prescribing Incentive Scheme</td>
<td>0.500</td>
</tr>
<tr>
<td>CCG Contribution to Vascular reconfiguration</td>
<td>0.200</td>
</tr>
<tr>
<td>Other Non-Recurent Service Developments Inc BME / ARBD/ IT / Shared Care</td>
<td>0.613</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4.303</td>
</tr>
<tr>
<td><strong>Overall non-recurrent expenditure</strong></td>
<td>11.592</td>
</tr>
</tbody>
</table>

**Financial Risks**

45. The CCG’s delivery of its financial requirements as outlined earlier in this document is subject to a number of risks. Predominantly these are focused around activity based variations with cost per case activity drivers where there may be a growth in demand or mix in the planned levels of care (applicable to PbR / Prescribing expenditure)

46. As outlined during the 2013-14 financial year there are additional financial risks regarding the ongoing pressures in respect of continuing healthcare and health contributions to packages of care with the local authority.

47. The key financial Risks are identified as per the table below and again are before any planning assumptions
Secondary Care Activity, in particular
Wirral University Teaching Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th>Key Issues:</th>
<th>WUTH Contract Value £221.5m (contract value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Demand</td>
<td>Performance against Non-Elective Block</td>
</tr>
<tr>
<td>High Cost Drugs</td>
<td>Non-PbR Performance</td>
</tr>
</tbody>
</table>

Prescribing

| Planned Expenditure £56.8m (as per assumptions above) |

Continuing Healthcare / Packages of Care

| Planned Expenditure £35.2m (as per assumption above) |

Other Unknowns – Earmarked reserves and Non-Recurent Investments

111 Transitional Arrangements with NHS Wirral Community Trust

Deprivation of Liberty – Court Ruling

Financial Consequences, Impact of requirements on service providers

Year on Year Demand

48. A key part of the CCG’s future financial planning assumptions will need to address the increasing healthcare expenditure across a wide range of areas. Table Nine below indicates levels of expenditure in each of the respective financial years.

<table>
<thead>
<tr>
<th>Table 9 Comparative CCG Expenditure 2011/12 – 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
</tr>
<tr>
<td>£ million</td>
</tr>
<tr>
<td>WUTH</td>
</tr>
<tr>
<td>CT</td>
</tr>
<tr>
<td>CWP</td>
</tr>
<tr>
<td>Other NHS</td>
</tr>
<tr>
<td>Non-NHS</td>
</tr>
<tr>
<td>Prescribing</td>
</tr>
<tr>
<td>CHC / Packages</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td><strong>Total Programme</strong></td>
</tr>
</tbody>
</table>

* Includes Winter Pressures Funding

49. It should be noted that the above table is included for indicative purposes and the caveats regarding 2012/13 when drawing direct comparisons being
i. The last year of the PCT and subsequent changes to Baseline Allocation
ii. Changes to Specialised Commissioning Arrangements
iii. Availability of non-recurrent resources from PCT surplus etc
iv. Tariff deflator applied in each of the respective years

50. The CCG has seen significant increases in expenditure in Non-NHS contracts in particular over the last 3 financial years. As can be seen by the graph below

51. Further analysis of CCG’s equivalent programme spend over the last 3 years shows a marginal rise in the % of overall expenditure at Wirral University Teaching Hospitals NHS Foundation Trust (WUTH), decrease at Cheshire & Wirral Partnership NHS Foundation Trust and in particular a growth in expenditure relating to Continuing Healthcare and Packages of care.
52. The CCG holds a contingency reserve in line with planning guidance. It should be noted however that, although the CCG’s financial plans for a contingency in 2014-15 (3.0m) are higher than the minimum requirements at 0.5% (2.2m), this is still lower than those held in 2013-14 (4.0m) and given the increases in activity based contracts and growing pressures from other areas this may not prove to be sufficient to cover any significant movements away from planned levels of expenditure as per this plan.

**Deprivation of Liberty Court Ruling**

53. On 19 March 2014, the Supreme Court handed down its judgment in the case of “P v Cheshire West and Chester Council and another” and “P and Q v Surrey County Council”.

54. The judgment is important for deciding whether arrangements made for the care and/or treatment of an individual who might lack capacity to consent to those arrangements amount to a deprivation of liberty: it has widened and clarified the definition of deprivation of liberty.

55. A deprivation of liberty in such a situation must be authorised in accordance with one of the following legal regimes: a deprivation of liberty authorisation or Court of Protection order under the Mental Capacity Act Deprivation of Liberty Safeguards, or (if applicable) under the Mental Health Act 1983, or, in some rare situations, under the inherent jurisdiction of the High Court.

56. It is likely that the ruling will have a number of financial consequences to the health and social care system (as yet to be confirmed) and this will increase levels of risk from a financial and operational implementation perspective that will need to be closely monitored.

**QIPP Gap**

57. As per ‘Reserves’ section above, resolution of contract values results in a resource gap in budgeted expenditure. This will require a targeted action plan by the CCG in and be the basis of the QIPP plan for 2014-15 financial year.

58. Based on the planning assumptions contained within this paper this equates to a gap of £4.1m.

59. The basis for the CCG’s QIPP plan will therefore be focused around key areas and risks of financial expenditure and structured as follows with anticipated expenditure impact as per each of the following schemes if management action is successful.

i. **Impact of Demand Management on Non-Wirral NHS Providers**

   £0.175m – Based on an impact of 1% across all expenditure

ii. **Impact of Demand Management on Non-NHS Providers**

   £2.277m – Based on reduction in expenditure to 13/14 contract plan levels for following providers
iii. Maintain Prescribing Expenditure at 2013-14 Outturn Levels

£0.611m – Reduction in Expenditure,

iv. Maintain Commissioned Out of Hospital Expenditure at 2013-14 Outturn Levels

£1.173m - Reduction in Expenditure

60. Further QIPP Initiatives are currently under negotiation with Wirral University Teaching Hospitals NHS Foundation Trust as part of on-going contractual discussions with estimated impact in the region of £0.5m

61. These planning assumptions do increase the level of financial risk to the CCG and the impact of the demand management / planning assumptions will require detailed planning and monitoring throughout the financial year

62. The CCG will require a robust QIPP management plan in order to manage this level of financial risk and will need to be closely monitored during the financial year through relevant QIPP meetings reporting to the Quality, Performance and Finance Committee. Further detail of these initiatives will be required in order to be able to monitor against planned reductions in expenditure.

63. It is proposed that these ‘QIPP’ planning assumptions are adjusted for in addition to the previous financial plan methodology (outturn with appropriate tariff and other adjustments) in order to establish an operational budget for 2014-15 or for alternative schemes to be developed (subject to contractual agreement) in order to support the required planning assumptions and delivery of CCG financial requirements.

Running Costs

64. The CCG’s Running Cost Allocation for 2014-15 financial year is £7.929m which is a reduction from the allowance in 2013-14 of £7.997m as a results of NHS England approach regarding efficiency requirements.

65. The CCG’s planned expenditure for 2014-15 financial year is as per below, but will need to mindful that in 2015-16 the running cost allocation reduces further to £7.085m (in respect of the 10% reduction notified in the NHS England Planning Guidance) and further planned reductions in expenditure are required in order to ensure expenditure is in line with the notified allocation.

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG Running Cost Allocation</td>
<td>£7.929m</td>
</tr>
<tr>
<td>CCG Internal Costs</td>
<td>£4.239m</td>
</tr>
<tr>
<td>C&amp;M CSU SLA</td>
<td>£3.689m</td>
</tr>
</tbody>
</table>
Total Expenditure £7.929m

66. With regards to the Cheshire & Merseyside Commissioning Support Unit (C&MCSU) service level agreement, negotiations are continuing with regards to the 2014-15 SLA and relevant prices for provision.

67. The value included below is prior to amendments in SLA price (due to apportionment changes), any respective changes to buy / share / do decisions and also excludes any ‘stranded’ costs that the CCG may have incur as a result of any exit management arrangements.

68. The CCG continues to fund a number of areas of ‘admin’ expenditure (e.g Medicines Management, Continuing Healthcare, Safeguarding) from with its running cost allocation rather than utilisation of its programme resources.

Other Issues

Fair Share Approach

69. In previous years a “fair shares” approach has been adopted for allocating budget between to the practices of the respective consortia of the clinical commissioning groups (and prior to that within Practice Based Commissioning groups) which remains in line with the recommended national approach. This methodology used a pre-populated toolkit to allow apportionment of budget share at practice level.

70. The fair shares methodology takes into account a number of factors to calculate and apportion the amount of resource considered to be a fair proportion of the overall value. Each budget is run through the toolkit process to generate the considered appropriate resource for each practice for that particular area. Consortia budgets are then derived from the aggregation of the relevant practice budgets.

71. This methodology continues to be recommended as a national approach and the fair share formula has been updated for the 2014-15 financial year to coincide with changes made to the CCG’s allocation formula (as advised by ACRA – Advisory Committee for Resource Allocation)

72. The Clinical Commissioning Group will need to decide if for those budgets that are to be managed at a divisional level (as referenced earlier in this paper) they wish to continue with the fair share methodology or wish to adopt a different approach.

73. It is proposed if the fair share approach is once again adopted that the most recent practice populations used to feed the toolkit (e.g. as at April 2014) and these will not be adjusted mid-year unless there is a “significant” change to a practice population.

74. Appendix A provides an apportionment of the budgets to be managed at divisional level using the proposed fair share methodology and further detail in Appendix C.

Service Development Funding

75. There are some further issues that remain to be explored as part of budget setting process for 2014-15 and will require further analysis before conclusion. Due to timings this has not been possible to be agreed prior to finalisation of baseline plan agreement in a timely manner.
76. In particular these relate to the previous year funding ‘virements’ made between consortia service development budgets as a result of increases in consortia delegated commissioning budgets for Any Qualified Provider Contracts (in particular regarding Physiotherapy, Primary Care Mental Health contracts, Diagnostics etc).

77. These issues require resolution and will impact on consortia service development budgets and associated commissioning plans for 2014-15 financial year.

**Recommendations**

78. NHS Wirral CCG’s Governing Body is asked to:

   i. Approve Budgeted Expenditure Plans
   ii. Note the updated budgetary assumptions for the 2014-15 financial year
   iii. Approve the financial management arrangements for budgetary control between federated (governing body) budgets and consortia level.
   iv. Note use of earmarked reserves (both recurrent / non-recurrent)
   v. Note the financial risks in particular regarding QIPP gap and potential CCG actions
   vi. Approve Planning assumptions to reduce financial expenditure to close QIPP Gap
   vii. Note the challenges with regards to running cost allocations in 2015-16
   viii. Approve the use of the available fair share toolkit to apportion budgets between consortia as applicable

Mark Bakewell
Chief Financial Officer
NHS Wirral Clinical Commissioning Group

14th May 2014
## Appendix A – Breakdown of Budget Values by Category

<table>
<thead>
<tr>
<th>NHS Contracts</th>
<th>£</th>
<th>Split</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wirral University Teaching Hospital NHS Foundation Trust</td>
<td>221,500,000</td>
<td>Consortia</td>
</tr>
<tr>
<td>Wirral Community NHS Trust</td>
<td>45,329,496</td>
<td>Consortia</td>
</tr>
<tr>
<td>Cheshire &amp; Wirral Partnership NHS Foundation Trust</td>
<td>32,200,294</td>
<td>Consortia</td>
</tr>
<tr>
<td>North West Ambulance Service</td>
<td>11,028,239</td>
<td>Federated</td>
</tr>
<tr>
<td>Royal Liverpool &amp; Broadgreen University Hospitals NHS Trust</td>
<td>6,327,592</td>
<td>Consortia</td>
</tr>
<tr>
<td>Aintree University Hospitals NHS Foundation Trust</td>
<td>2,476,247</td>
<td>Consortia</td>
</tr>
<tr>
<td>Liverpool Women's NHS Foundation Trust</td>
<td>2,272,855</td>
<td>Consortia</td>
</tr>
<tr>
<td>Non Contracted Activity (various providers)</td>
<td>2,226,195</td>
<td>Consortia</td>
</tr>
<tr>
<td>Countess of Chester NHS Foundation Trust</td>
<td>1,963,616</td>
<td>Consortia</td>
</tr>
<tr>
<td>Alder Hey Childrens NHS Foundation Trust</td>
<td>1,918,444</td>
<td>Consortia</td>
</tr>
<tr>
<td>South Staffordshire and Shropshire Healthcare NHS Foundation Trust</td>
<td>1,492,127</td>
<td>Consortia</td>
</tr>
<tr>
<td>Liverpool Heart &amp; Chest NHS Foundation Trust</td>
<td>1,279,862</td>
<td>Consortia</td>
</tr>
<tr>
<td>St Helen's &amp; Knowsley NHS Trust</td>
<td>546,616</td>
<td>Consortia</td>
</tr>
<tr>
<td>University Hospital of South Manchester NHS Foundation Trust</td>
<td>218,839</td>
<td>Consortia</td>
</tr>
<tr>
<td>Clatterbridge Cancer Centre NHS Foundation Trust</td>
<td>193,420</td>
<td>Consortia</td>
</tr>
<tr>
<td>Central Manchester University Hospitals NHS Foundation Trust</td>
<td>186,103</td>
<td>Consortia</td>
</tr>
<tr>
<td>MH NCAs (Various Providers)</td>
<td>110,949</td>
<td>Consortia</td>
</tr>
<tr>
<td>Salford Royal NHS Foundation Trust</td>
<td>89,592</td>
<td>Consortia</td>
</tr>
<tr>
<td>Warrington &amp; Halton Hospitals NHS Foundation Trust</td>
<td>79,340</td>
<td>Consortia</td>
</tr>
<tr>
<td>Liverpool Community Health NHS Trust</td>
<td>46,730</td>
<td>Consortia</td>
</tr>
<tr>
<td>Wrightington, Wigan and Leigh NHS Foundation Trust</td>
<td>41,590</td>
<td>Consortia</td>
</tr>
<tr>
<td><strong>Total NHS Contracts</strong></td>
<td><strong>331,528,146</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Non- NHS Contracts

<table>
<thead>
<tr>
<th>Non- NHS Contracts</th>
<th>£</th>
<th>Split</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spire - Murrayfield</td>
<td>4,855,784</td>
<td>Consortia</td>
</tr>
<tr>
<td>St John's Hospice (Wirral)</td>
<td>1,673,956</td>
<td>Federated</td>
</tr>
<tr>
<td>One to One Midwifery</td>
<td>1,329,168</td>
<td>Consortia</td>
</tr>
<tr>
<td>Spa Medica</td>
<td>1,084,611</td>
<td>Consortia</td>
</tr>
<tr>
<td>PCMH - WGPCC</td>
<td>1,015,864</td>
<td>Consortia</td>
</tr>
<tr>
<td>AQP Physio</td>
<td>845,622</td>
<td>Consortia</td>
</tr>
<tr>
<td>PCMH - WACCG</td>
<td>582,904</td>
<td>Consortia</td>
</tr>
<tr>
<td>Specialist Care / IFR Panel Approvals</td>
<td>574,502</td>
<td>Federated</td>
</tr>
<tr>
<td>Assura Peninsula Rheumatology</td>
<td>567,046</td>
<td>Consortia</td>
</tr>
<tr>
<td>Assura Peninsula Physiotherapy</td>
<td>356,000</td>
<td>Consortia</td>
</tr>
<tr>
<td>Assura Peninsula Audiology</td>
<td>352,964</td>
<td>Consortia</td>
</tr>
<tr>
<td>AQP Radiology</td>
<td>302,342</td>
<td>Consortia</td>
</tr>
<tr>
<td>Assura Peninsula ENT</td>
<td>280,475</td>
<td>Consortia</td>
</tr>
<tr>
<td>Dementia Projects</td>
<td>244,752</td>
<td>Federated</td>
</tr>
<tr>
<td>Primary Care Advice Link - Advocacy in Wirral</td>
<td>234,200</td>
<td>Federated</td>
</tr>
<tr>
<td>Claire House</td>
<td>231,057</td>
<td>Federated</td>
</tr>
<tr>
<td>Assura Peninsula Dermatology</td>
<td>228,997</td>
<td>Consortia</td>
</tr>
<tr>
<td>Family Planning Service</td>
<td>219,278</td>
<td>Federated</td>
</tr>
<tr>
<td>Sandhills</td>
<td>213,478</td>
<td>Federated</td>
</tr>
<tr>
<td>Hospital at Home (WBC)</td>
<td>177,040</td>
<td>Federated</td>
</tr>
<tr>
<td>AQP Audiology</td>
<td>159,383</td>
<td>Consortia</td>
</tr>
<tr>
<td>End of Life - St John's Hospice</td>
<td>155,886</td>
<td>Federated</td>
</tr>
<tr>
<td>Joint Finance</td>
<td>151,764</td>
<td>Federated</td>
</tr>
<tr>
<td>Parenting &amp; Prevention</td>
<td>150,000</td>
<td>Federated</td>
</tr>
<tr>
<td>Spire Liverpool</td>
<td>145,251</td>
<td>Consortia</td>
</tr>
<tr>
<td>PCMH - WHCC</td>
<td>136,859</td>
<td>Consortia</td>
</tr>
<tr>
<td>Stroke Association</td>
<td>133,164</td>
<td>Federated</td>
</tr>
<tr>
<td>Service Description</td>
<td>Cost</td>
<td>Commission Type</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------</td>
<td>-----------------</td>
</tr>
<tr>
<td>3rd Sector</td>
<td>130,715</td>
<td>Federated</td>
</tr>
<tr>
<td>Marie Curie</td>
<td>129,598</td>
<td>Federated</td>
</tr>
<tr>
<td>Locally Commissioned Services - Minor Surgery (Bebington)</td>
<td>118,430</td>
<td>Consortia</td>
</tr>
<tr>
<td>End of Life - Bereavement</td>
<td>101,112</td>
<td>Federated</td>
</tr>
<tr>
<td>Bridgewater</td>
<td>91,750</td>
<td>Federated</td>
</tr>
<tr>
<td>Assura Peninsula Podiatry</td>
<td>85,851</td>
<td>Consortia</td>
</tr>
<tr>
<td>Assura Peninsula Ophthalmology</td>
<td>75,977</td>
<td>Consortia</td>
</tr>
<tr>
<td>Race Equality (Wirral Change)</td>
<td>53,000</td>
<td>Federated</td>
</tr>
<tr>
<td>Lantern</td>
<td>45,000</td>
<td>Federated</td>
</tr>
<tr>
<td>Wirral Holistic Care</td>
<td>42,997</td>
<td>Federated</td>
</tr>
<tr>
<td>Extended Choice Network</td>
<td>33,351</td>
<td>Consortia</td>
</tr>
<tr>
<td>Locally Commissioned Services - Minor Surgery (Wallasey)</td>
<td>27,252</td>
<td>Consortia</td>
</tr>
<tr>
<td>RNID</td>
<td>24,031</td>
<td>Federated</td>
</tr>
<tr>
<td>ARK</td>
<td>16,888</td>
<td>Federated</td>
</tr>
<tr>
<td>Homeopathy</td>
<td>15,134</td>
<td>Federated</td>
</tr>
<tr>
<td>Wirral Soc Blind &amp; Partially Sighted</td>
<td>10,000</td>
<td>Federated</td>
</tr>
<tr>
<td><strong>Total Non- NHS Contracts</strong></td>
<td><strong>17,403,433</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescribing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Prescribing - Practice level</td>
<td>48,626,538</td>
<td>Consortia</td>
</tr>
<tr>
<td>Primary Care Prescribing - Federated level (Amber, Centrally charged etc)</td>
<td>8,232,192</td>
<td>Federated</td>
</tr>
<tr>
<td><strong>Total Prescribing</strong></td>
<td><strong>56,858,730</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Commissioned Out of Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing Healthcare/ Joint Funded Packages of Care</td>
<td>15,952,270</td>
<td>Federated</td>
</tr>
<tr>
<td>Continuing Healthcare/ Fully Funded Packages of Care</td>
<td>9,975,162</td>
<td>Federated</td>
</tr>
<tr>
<td>Funded Registered Nursing Care</td>
<td>4,968,934</td>
<td>Federated</td>
</tr>
<tr>
<td>Children with Special /Safeguarding Needs</td>
<td>1,928,329</td>
<td>Federated</td>
</tr>
<tr>
<td>Primary Care Advice Link - CAB</td>
<td>528,123</td>
<td>Federated</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>519,953</td>
<td>Federated</td>
</tr>
<tr>
<td>Continuing Healthcare/ Fully Funded Packages of Care Personal Health</td>
<td>404,947</td>
<td>Federated</td>
</tr>
<tr>
<td>CAMHS</td>
<td>178,740</td>
<td>Federated</td>
</tr>
<tr>
<td>Care In The Community</td>
<td>74,964</td>
<td>Federated</td>
</tr>
<tr>
<td>Continuing Healthcare/ Joint Funded Packages of Care Personal Health</td>
<td>5,119</td>
<td>Federated</td>
</tr>
<tr>
<td><strong>Total Commissioned Out of Hospital</strong></td>
<td><strong>34,536,541</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Intermediate, Social Care &amp; Reablement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3,707,145</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Commissioning Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LES Budgets</td>
<td>3,375,889</td>
<td>Federated</td>
</tr>
<tr>
<td>Service Development &amp; Commissioning Fund</td>
<td>1,489,711</td>
<td>Consortia</td>
</tr>
<tr>
<td>Phlebotomy</td>
<td>27,361</td>
<td>Federated</td>
</tr>
<tr>
<td><strong>Total Other Commissioning Expenditure</strong></td>
<td><strong>4,892,961</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Reserves</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6,813,042</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>455,739,998</strong></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B – Summary of CCG Expenditure 2014-15

**CCG Total Expenditure 2014-15**

- **55%** Acute
- **12%** Ambulance and Other
- **11%** Commissioned Out of Hospital
- **8%** Community
- **1%** Mental Health
- **8%** Other
- **2%** Prescribing
- **2%** Reserves

**Federated / Consortia split £**

<table>
<thead>
<tr>
<th>Consortia</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Contracts</td>
<td>320,499,907</td>
</tr>
<tr>
<td>Non NHS Contracts</td>
<td>12,584,131</td>
</tr>
<tr>
<td>Prescribing</td>
<td>48,626,538</td>
</tr>
<tr>
<td>Other Commissioning Expenditure</td>
<td>1,489,711</td>
</tr>
<tr>
<td><strong>Total Consortia</strong></td>
<td><strong>383,200,287</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Federated</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Contracts</td>
<td>11,028,239</td>
</tr>
<tr>
<td>Non NHS Contracts</td>
<td>4,819,302</td>
</tr>
<tr>
<td>Prescribing</td>
<td>8,232,192</td>
</tr>
<tr>
<td>Commissioned Out of Hospital</td>
<td>34,536,541</td>
</tr>
<tr>
<td>Intermediate, Social Care and Reablement</td>
<td>3,707,145</td>
</tr>
<tr>
<td>Other Commissioning Expenditure</td>
<td>3,403,250</td>
</tr>
<tr>
<td>CCG Reserves</td>
<td>6,813,042</td>
</tr>
<tr>
<td><strong>Total Federated</strong></td>
<td><strong>72,539,711</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Contracts</td>
<td>331,528,146</td>
</tr>
<tr>
<td>Non NHS Contracts</td>
<td>17,403,433</td>
</tr>
<tr>
<td>Prescribing</td>
<td>56,858,730</td>
</tr>
<tr>
<td>Commissioned Out of Hospital</td>
<td>34,536,541</td>
</tr>
<tr>
<td>Intermediate, Social Care and Reablement</td>
<td>3,707,145</td>
</tr>
<tr>
<td>Other Commissioning Expenditure</td>
<td>4,892,961</td>
</tr>
<tr>
<td>CCG Reserves</td>
<td>6,813,042</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>455,739,998</strong></td>
</tr>
</tbody>
</table>
## Appendix C - Fair Share / Direct Apportionment Splits

Wirral Clinical Commissioning Group - 14/15 Budgets by

<table>
<thead>
<tr>
<th></th>
<th>Wirral Health Commissioning Consortium</th>
<th>Wirral GP Commissioning Consortium</th>
<th>Wirral Alliance</th>
<th>Total Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual Budget</td>
<td>Annual Budget</td>
<td>Annual Budget</td>
<td>Annual Budget</td>
</tr>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td></td>
<td>a) NHS Contracts - Section 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aintree University Hospitals NHS Foundation Trust</td>
<td>1,210,637</td>
<td>955,584</td>
<td>310,026</td>
<td>2,476,247</td>
</tr>
<tr>
<td>Alder Hey Childrens NHS Foundation Trust</td>
<td>937,927</td>
<td>740,328</td>
<td>240,189</td>
<td>1,918,444</td>
</tr>
<tr>
<td>Betsi Cadwaladr University Health Board</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Central Manchester University Hospitals NHS Foundation Trust</td>
<td>90,996</td>
<td>71,817</td>
<td>23,300</td>
<td>186,103</td>
</tr>
<tr>
<td>Cheshire &amp; Wirral Partnership NHS Foundation Trust</td>
<td>15,742,724</td>
<td>12,426,093</td>
<td>4,031,477</td>
<td>32,200,294</td>
</tr>
<tr>
<td>Clatterbridge Cancer Centre NHS Foundation Trust</td>
<td>94,563</td>
<td>74,641</td>
<td>24,216</td>
<td>193,420</td>
</tr>
<tr>
<td>Countess of Chester NHS Foundation Trust</td>
<td>960,012</td>
<td>757,759</td>
<td>245,845</td>
<td>1,963,616</td>
</tr>
<tr>
<td>Liverpool Health NHS Trust</td>
<td>22,846</td>
<td>18,033</td>
<td>5,851</td>
<td>46,730</td>
</tr>
<tr>
<td>Liverpool Heart &amp; Chest NHS Foundation Trust</td>
<td>625,725</td>
<td>493,899</td>
<td>160,239</td>
<td>2,278,859</td>
</tr>
<tr>
<td>Liverpool Womens NHS Foundation Trust</td>
<td>1,111,199</td>
<td>877,095</td>
<td>284,561</td>
<td>2,272,855</td>
</tr>
<tr>
<td>Merseycare NHS Trust</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MH NCAs (Various Providers)</td>
<td>54,243</td>
<td>42,815</td>
<td>13,891</td>
<td>110,949</td>
</tr>
<tr>
<td>Non Contracted Activity (various providers)</td>
<td>1,088,387</td>
<td>859,089</td>
<td>278,120</td>
<td>2,226,195</td>
</tr>
<tr>
<td>Royal Liverpool &amp; Broadgreen University Hospitals NHS Trust</td>
<td>3,093,560</td>
<td>2,441,819</td>
<td>792,215</td>
<td>6,327,592</td>
</tr>
<tr>
<td>Salford Royal NHS Foundation Trust</td>
<td>43,802</td>
<td>34,574</td>
<td>11,217</td>
<td>89,592</td>
</tr>
<tr>
<td>South Staffordshire and Shropshire Healthcare NHS Foundation Trust</td>
<td>1,492,127</td>
<td></td>
<td></td>
<td>1,492,127</td>
</tr>
<tr>
<td>St Helens &amp; Knowsley NHS Trust</td>
<td>267,241</td>
<td>210,939</td>
<td>68,436</td>
<td>546,616</td>
</tr>
<tr>
<td>University Hospital of South Manchester NHS Foundation Trust</td>
<td>106,990</td>
<td>84,450</td>
<td>27,399</td>
<td>218,839</td>
</tr>
<tr>
<td>Warrington &amp; Halton Hospitals NHS Foundation Trust</td>
<td>38,789</td>
<td>30,617</td>
<td>9,304</td>
<td>78,300</td>
</tr>
<tr>
<td>Wirral Community NHS Trust</td>
<td>22,161,591</td>
<td>17,492,653</td>
<td>5,675,253</td>
<td>45,329,496</td>
</tr>
<tr>
<td>Wirral University Teaching Hospital NHS Foundation Trust</td>
<td>108,291,350</td>
<td>85,476,850</td>
<td>27,311,800</td>
<td>221,060,000</td>
</tr>
<tr>
<td>Wrightington, Wigan and Leigh NHS Foundation Trust</td>
<td>20,333</td>
<td>16,050</td>
<td>4,207</td>
<td>41,590</td>
</tr>
<tr>
<td>b) Non- NHS Contracts - Section 4</td>
<td>4,869,442</td>
<td>5,923,516</td>
<td>1,791,174</td>
<td>12,584,131</td>
</tr>
<tr>
<td>AGP Physio</td>
<td>5,261</td>
<td>840,361</td>
<td></td>
<td>850,622</td>
</tr>
<tr>
<td>AGP Radiology</td>
<td>147,815</td>
<td>116,674</td>
<td>37,853</td>
<td>302,342</td>
</tr>
<tr>
<td>AGP Audiology</td>
<td>77,922</td>
<td>61,506</td>
<td>15,910</td>
<td>154,338</td>
</tr>
<tr>
<td>Assura Peninsula Rheumatology</td>
<td>277,229</td>
<td>218,823</td>
<td>70,394</td>
<td>567,446</td>
</tr>
<tr>
<td>Assura Peninsula Audiology</td>
<td>172,584</td>
<td>136,209</td>
<td>36,375</td>
<td>345,164</td>
</tr>
<tr>
<td>Assura Peninsula Dermatology</td>
<td>111,957</td>
<td>88,370</td>
<td>23,587</td>
<td>223,914</td>
</tr>
<tr>
<td>Assura Peninsula ENT</td>
<td>137,124</td>
<td>108,235</td>
<td>35,115</td>
<td>280,475</td>
</tr>
<tr>
<td>Assura Peninsula Ophthalmology</td>
<td>37,145</td>
<td>29,320</td>
<td>9,512</td>
<td>75,977</td>
</tr>
<tr>
<td>Assura Peninsula Physiotherapy</td>
<td>10,961</td>
<td>344,559</td>
<td>480</td>
<td>356,000</td>
</tr>
<tr>
<td>Assura Peninsula Podiatry</td>
<td>41,973</td>
<td>33,130</td>
<td>10,143</td>
<td>85,246</td>
</tr>
<tr>
<td>Extended Choice Network</td>
<td>18,395</td>
<td>12,870</td>
<td>5,925</td>
<td>37,190</td>
</tr>
<tr>
<td>Locally Commissioned Services - Minor Surgery (Bebington)</td>
<td>57,900</td>
<td>45,702</td>
<td>14,297</td>
<td>118,400</td>
</tr>
<tr>
<td>Locally Commissioned Services - Minor Surgery (Wallasey)</td>
<td>13,324</td>
<td>10,517</td>
<td>3,412</td>
<td>27,252</td>
</tr>
<tr>
<td>One to One Midwifery</td>
<td>649,830</td>
<td>512,926</td>
<td>166,914</td>
<td>1,329,668</td>
</tr>
<tr>
<td>PCMH - WACCG</td>
<td></td>
<td>582,904</td>
<td>582,904</td>
<td></td>
</tr>
<tr>
<td>PCMH - WGPCC</td>
<td></td>
<td>1,015,864</td>
<td>1,015,864</td>
<td></td>
</tr>
<tr>
<td>PCMH - WHCC</td>
<td>136,899</td>
<td></td>
<td>136,899</td>
<td></td>
</tr>
<tr>
<td>Spa Medica</td>
<td>530,266</td>
<td>418,551</td>
<td>135,793</td>
<td>1,084,611</td>
</tr>
<tr>
<td>Spire - Murrayfield</td>
<td>2,373,993</td>
<td>1,873,847</td>
<td>607,146</td>
<td>4,855,784</td>
</tr>
<tr>
<td>Spire Liverpool</td>
<td>71,013</td>
<td>56,052</td>
<td>15,961</td>
<td>143,026</td>
</tr>
<tr>
<td>c) Prescribing - Section 5</td>
<td>23,848,361</td>
<td>18,697,172</td>
<td>6,041,106</td>
<td>48,626,538</td>
</tr>
<tr>
<td>f) Other Commissioning Expenditure - Section 6</td>
<td>584,352</td>
<td>695,758</td>
<td>209,601</td>
<td>1,489,711</td>
</tr>
<tr>
<td>Senice Development &amp; Commissioning Fund</td>
<td>584,352</td>
<td>695,758</td>
<td>209,601</td>
<td>1,489,711</td>
</tr>
<tr>
<td>Total Programme Budget 14/15</td>
<td>186,757,185</td>
<td>148,421,548</td>
<td>48,021,554</td>
<td>383,200,287</td>
</tr>
</tbody>
</table>
**Draft 2 & 5 Year Plan Update**

<table>
<thead>
<tr>
<th>Agenda Item:</th>
<th>2.2</th>
<th>Reference:</th>
<th>GB14-15/0014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report to:</td>
<td>Governing Body</td>
<td>Meeting Date:</td>
<td>3rd June 2014</td>
</tr>
<tr>
<td>Lead Officer:</td>
<td>Abhi Mantgani, Chief Clinical Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributors:</td>
<td>Mark Bakewell, Chief Financial Officer, Wayne Greenwood, GE Healthcare Finnamore</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Governance:**
- Link to Commissioning Strategy: Develop Commissioning Strategy and objectives for Organisation, including Outcomes Framework Indicators
- Link to current governing body Objectives: To achieve financial control total with sound financial management.

**Summary:**
This report updates the CCG on draft strategic planning process.

**Recommendation:**
- To Approve
- To Note
- Comments

**Next Steps:** Finalise Draft strategic plan prior to submission

---

*This section is an assessment of the impact of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.*

**What are the implications for the following (please state if not applicable):**

<table>
<thead>
<tr>
<th>Category</th>
<th>Implication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>The plan includes the headline financial planning assumptions for the CCG for the next 5 years</td>
</tr>
<tr>
<td>Value For Money</td>
<td>All expenditure plans are subject to an ongoing value for money review</td>
</tr>
<tr>
<td>Risk</td>
<td>Work is still being undertaken to assess risks of expenditure plans</td>
</tr>
<tr>
<td>Legal</td>
<td>The plan includes delivery of the CCG’s Statutory Duties</td>
</tr>
<tr>
<td>Workforce</td>
<td>The financial plan includes budgeted “running costs” expenditure and is reflective of the respective workforce implications in these areas.</td>
</tr>
<tr>
<td>Equality &amp; Human Rights</td>
<td>Financial Plans will consider as appropriate the equality impact assessment for proposals within the budgeted expenditure</td>
</tr>
<tr>
<td>Patient and Public Involvement (PPI)</td>
<td>Budgets include funding to ensure continued involvement of patients and public in CCG decisions.</td>
</tr>
<tr>
<td>Partnership</td>
<td>The CCG works with a number of NHS Trusts and the Local Authority on a</td>
</tr>
</tbody>
</table>
Working number of its commissioning budgets.

Performance Indicators The plan reflects the planned achievement of statutory financial duties.

Do you agree that this document can be published on the website? (If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions)

This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path ie. other papers that are directly related to the current paper under discussion.

Private Business

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

If a report is deemed to be for private business, please note that the tick in the box, indicating whether it can be published on the website, must be changed to a x.

If you require any additional information please contact the Lead Director/Officer.
2 & 5 Year Plan update

Summary

This report on the development of the CCGs strategic planning provides a brief update on:

1. An independent review of the planning documentation by GE Healthcare Finnamore (GEHCF)
2. Summary of the findings from the review
3. The plan for taking the recommendations forward

1. Planning review by GEHCF

GEHCF were invited at the end of April to provide a rapid evaluation of the CCGs 2 and 5 year planning documentation, using their experience of supporting a number of CCGs nationally to structure and write their responses.

The objective of the review was to provide a summary set of observations and recommendations intended to strengthen Wirral CCGs medium and long term planning submission.

Plans were reviewed against NHS guidelines as well as general good practice in planning and delivery. Staff were engaged as part of the review process and findings were fed back to the team as a group.

2. Summary of findings

Based on the brief review conducted, there were a number of substantive recommendations:

- The strategic vision is fairly well described and spans the guidance requirements. It would be significantly enhanced if the narrative emphasised the compelling case for change right across the local health and social care economy
- The major strategic components appear ‘bottom up’ in nature – they would benefit from being scaled and aligned top down to help steer effort into the areas that will contribute to the strategy the most
- The financial story behind the strategy does not yet fully articulate the route to sustainability for the system. This can be more firmly underpinned by tighter definition of activity changes and associated benefits at work-stream and project level
- Project plans are developing at a level. The required maturity would be prompted by the use of outcome based planning approaches, and the testing and risk adjusting of plans using constructive criteria.
- The coherency and progress of the transformation programme would be enhanced by having a clear and agreed framework of governance and performance tracking, appropriate to the level of complexity and risk being managed
- Enablers have been identified at a high level – to ensure that they align and support delivery it is recommended that they are treated as major programme elements and resourced and controlled as key part of the overall programme

In addition it was recommended that the CCGs programme structure should align more closely with the overall Vision 2018 strategy for the system, and that work-streams across both could be streamlined and re-organised to be more coherent individually and as a whole.
3. Plan for taking recommendations forward

In meeting NHS England’s date for response the approach being taken is to front load the key aspects that will enhance and underpin the CCG’s submission, such that content is developed at an appropriate level within the first four weeks (i.e. by June 6), allowing two weeks for further review, feedback and refinement.

The key focus of the recommendations is to ensure that the financial imperative is embedded within the CCG/ Vision 2018’s programmes in such a way that it is clear how delivery of these will lead to sustainability for the system in 18/19.

A draft plan was developed to communicate and manage delivery –

Progress to date includes:

- Reshaping of the scope and alignment of key programmes
- Development of proposals for revised Vision 2018/ CCG governance of programmes
- Storyboarding and redrafting of the case for change/ high level finance section
- Review of other CCGs planning document format and structures (to be proposed and agreed)
- Financial assumptions and change trajectories modeling begun

Next steps to focus upon

- Completion of the first draft of financial trajectories
- Process for engagement and approval amongst stakeholders to be drafted and agreed
- Programmes of work to be given targets for financial and associated activity improvements

It should be noted that development of detailed planning for sustainability will extend beyond the date for submission, which will articulate the plan at a high level and the process being put in place to finalise and approve a single plan across the local health and social care system.

Abhi Mantgani
Chief Clinical Officer
Your partner in a healthier future for all
FOREWORD – April 2014

We are very pleased to introduce the Annual Report for the year 2013/14, a year which has been very challenging, not only for Clinical Commissioning Groups, but for the NHS as a whole.

When NHS Wirral Clinical Commissioning Group (the CCG) became a statutory body on 1st April 2013, it had been through a rigorous ‘authorisation’ process which assessed its fitness for purpose to carry out its duties. Since its inception, the CCG has fully embraced its statutory duties, strengthening its governance arrangements to ensure commissioned services are based on transparent decision making processes and in partnership with local stakeholders. It has also developed and strengthened its engagement processes, ensuring patients and clinicians are at the heart of everything we do.

As a new statutory organisation, it is important to recognise that we could not have achieved this rapid transformation without the loyalty and dedication of all our staff who work together tirelessly to ensure that our local people and visitors receive the best health care possible.

Once again, we would like to take this opportunity to thank everyone in our Clinical Commissioning Group for their commitment and hard work.

Dr Phil Jennings
Chair

Dr Abhi Mantgani
Chief Clinical Officer (Accountable Officer)
FOREWORD - Updated May 2014

Whilst this report mainly relates to the 2013/14 financial year, it is important that it also reflects the current and future performance of the CCG.

In May 2014, NHS England raised some concerns with regards to the leadership of the CCG, primarily in relation to the roles of the Chair and Chief Clinical Officer.

As a result, NHS Wirral CCG’s Governing Body has voluntarily asked NHS England to support it in the delivery of its duties and functions specifically the leadership arrangements within NHS Wirral CCG. Whilst this review is being undertaken, the Chair and Chief Clinical Officer have agreed voluntarily to step aside.

At the time of writing this report, NHS England are defining the scope of the review and it is envisaged that this will be concluded within 4-6 weeks.

Jonathan Develing

Interim Accountable Officer
## Contents

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>2</td>
</tr>
<tr>
<td>Chair and Chief Clinical Officer (Accountable Officer)</td>
<td></td>
</tr>
<tr>
<td>Foreword – Updated May 2014</td>
<td>3</td>
</tr>
<tr>
<td>1) Introduction to NHS Wirral Clinical Commissioning Group</td>
<td>6</td>
</tr>
<tr>
<td>Background</td>
<td>7</td>
</tr>
<tr>
<td>2) Member Practices introduction</td>
<td>10</td>
</tr>
<tr>
<td>3) Strategic Report 2013-14 Financial Year</td>
<td>12</td>
</tr>
<tr>
<td>3.1) Key Strategic Developments</td>
<td>12</td>
</tr>
<tr>
<td>3.2) Performance Indicators</td>
<td>18</td>
</tr>
<tr>
<td>3.3) Financial Performance</td>
<td>21</td>
</tr>
<tr>
<td>3.4) Sustainability Report</td>
<td>26</td>
</tr>
<tr>
<td>3.5) Human Resources</td>
<td>27</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td></td>
</tr>
<tr>
<td>Sickness Absence</td>
<td></td>
</tr>
<tr>
<td>Staff Well Being &amp; Engagement</td>
<td></td>
</tr>
<tr>
<td>3.6) Information Governance</td>
<td>31</td>
</tr>
<tr>
<td>3.7) Governance, Communications &amp; Patient / Public Engagement</td>
<td>32</td>
</tr>
<tr>
<td>3.8) Emergency Planning, Response and Resilience</td>
<td>34</td>
</tr>
<tr>
<td>3.9) Managing Risks, Investigating Events and Learning from the Experience of Patients</td>
<td>39</td>
</tr>
<tr>
<td>4) Members Report</td>
<td>40</td>
</tr>
<tr>
<td>5) Remuneration Report &amp; Information</td>
<td>44</td>
</tr>
<tr>
<td>6) Statement of Accountable Officers Responsibility</td>
<td>51</td>
</tr>
<tr>
<td>7) Annual Governance Statement</td>
<td>53</td>
</tr>
<tr>
<td>Appendix 1 – Board membership including profiles of members (Including Governing Body member profiles)</td>
<td>73</td>
</tr>
<tr>
<td>Appendix 2 – Register of interests</td>
<td>79</td>
</tr>
</tbody>
</table>
PUBLICATION ARRANGEMENTS

The Annual Report and a full copy of the Annual Accounts will be published on the Department of Health website.

Paper copies and summary versions of (and alternative formats of) the Annual Report will also be available on request to members of the public free of charge through the Corporate Support Department.

If you would like a paper copy please contact:

Paul Edwards, Head of Corporate Affairs pauledwards4@nhs.net
Or
Laura Wentworth, Corporate Support Officer l.wentworth@nhs.net 0151 651 0011

Electronic copies are also available on the CCG’s website: https://www.wirralccg.nhs.uk/
INTRODUCTION - A REVIEW OF THE NATURE, OBJECTIVES AND STRATEGIES OF
NHS WIRRAL CLINICAL COMMISSIONING GROUP

NHS Wirral Clinical Commissioning Group (CCG) services people registered with 58 general
practices listed within the CCG area and this area is coterminous with by Wirral Borough Council
which included a resident population of 318,000 (figure correct as at January 2014).

Our organisational aspiration is to be

“Your partner in a healthier future for all”

Our vision is to

“improve health and reduce disease by working with patients, public and partners, tackling health
inequalities and helping people to take care of themselves”

This vision is underpinned by our values, which are:

• Caring, fair and responsible.
• Safe and trusted.
• Person-centred

Our strategic objectives are:

• to Prevent people from dying prematurely
• to Enhance the quality of life for people with long term conditions
• to Help people to recover from episodes of ill health or following injury
• to Ensure people have a positive experience of care
• to Ensure people are treated and cared for in a safe environment and protected from
  avoidable harm

Our aims are to work with our patients, the public in Wirral and our stakeholders to:

• Improve the health of all Wirral citizens.
• Target inequalities in health experiences and outcomes amongst sections of our population
• Deliver needs based healthcare of the highest quality to all our resident population.
• Promote maximum self-care by involving and including our patients in all decisions made
  about them.
• To reduce waste and inefficiency and duplication within the patient journey and between
  partners
• To be a high performance, high reputation organisation with ambition

The CCG is a membership organisation and each of the 58 GP Practices on Wirral is signed up to
the CCG constitution which outlines the key duties and structures of the organisation.

The GP practices engage through a consortia structure, whereby three groups (consortia as listed
below) of GP practices work together, but report into a single Governing Body structure which sets
out the overall plans for commissioning and has the ultimate responsibility for delivering on our
duties.

• Wirral Health Commissioning Consortium
• Wirral GP Commissioning Consortium
• Wirral Alliance Commissioning Consortium
Background

Clinical Commissioning Group Authorisation

NHS Wirral Clinical Commissioning group was formally constituted on 1st April 2013 following a rigorous authorisation process carried out in 2012/13.

On 1st April 2013, the CCG had 7 ‘conditions’ resulting from the authorisation process, and these were related to providing additional evidence around planning and governance. The areas where additional evidence was required were to show that the:

- CCG had a clear and credible integrated plan, which included an operating plan for 2012-13, draft commissioning intentions for 2013-14 and a high-level strategic plan until 2014-15;
- CCG had detailed financial plan that delivered financial balance, set out how it will manage within its management allowance, and any other requirements set by the NHS Commissioning Board, now NHS England, and is integrated with the commissioning plan;
- QIPP (Quality, Innovation, Productivity & Prevention) was integrated within all plans. Clear explanation of any changes to existing QIPP plans;
- Governance arrangements were in place to identify and manage different types of risk, including key risks to delivery of QIPP;
- CCG had the standard financial management arrangements in place;
- CCG had plans in place for formally procuring any commissioning support services, to ensure that between 2013-16 it puts in place the arrangements to go through a compliant procurement process; and
- CCG can demonstrate that it had assessed the skills possessed by governing body members and had a plan to build governing body competencies/skills where required.

Once this additional evidence was provided (including the CCGs associated Commissioning, QIPP and Organisational Development Plan) the conditions were removed and the CCG became fully authorised in the early part of the financial year.
Joint Strategic Needs Assessment (JSNA)

Wirral’s Joint Strategic Needs Assessment highlights a number of significant challenges to the Health and Social Care Economy in respect of its resident population. Some of the key population features are provided below

Further information regarding the Joint Strategic Needs Assessment is available on our website: https://www.wirralccg.nhs.uk/About%20Us/

Wirral is a borough of contrast and diversity in both its physical characteristics and social demographics. There are both rural areas and townships and urban and industrialised areas in a compact peninsula of 60 square miles. The Borough has a wealth of parks and countryside and over 20 miles of coastline.

Health Inequalities

Wirral has a diverse population that is characterised by social demographic extremes ranging from some of the most affluent electoral wards in the country to some of the most deprived. The impact of this demography on health outcomes is significant resulting in life expectancy in the most deprived areas of the borough being up to 20 years less than for those residing in the affluent areas.

Wirral CCG is striving to reduce these significant inequalities and aspires to eliminate them entirely in the future. Achievement of this ambitious aim will need a multi-faceted approach due to the complex nature of the issues and a number of strategies are already being employed, examples of which include:

- Robust Joint Strategic Needs Assessment (JSNA) used to inform service development and joint commissioning
- Health and Wellbeing Board strategy in place and being implemented across the Wirral health and social care economy
- Enhanced services in primary care aimed at the early identification and treatment of disease
- Collaborative working with Wirral Local Authority (in particular Public Health and the Department of Adult Social Services) in a number of areas relating to reducing inequalities, including the re-procurement of drug and alcohol services and the ‘Healthy Child Programme’, development of a co-produced plan for the Better Care Fund and regular strategic joint commissioning meetings
- Commissioning of health workers to proactively target specific groups that have difficulty accessing health services
- Impact assessment of all CCG commissioning to ensure equitable service provision in order to prevent further widening of the inequality gap

Demographics

Wirral has a relatively high older population and a relatively low proportion of people in their twenties and thirties compared to England and Wales as a whole. The older population (aged 65 years and above) are expected to increase at the fastest rate (than any other age group) over the next decade; between 2011 and 2021 and it is estimated that this population group will have increased by 17.4% during this period.

Wirral has the largest gap in disability free life expectancy of any authority in England for males and females
Dementia is a key and worsening problem for Wirral with an estimated 4,443 people over 65 living with dementia in 2011. This is projected to rise to almost 5,300 within the next 8 years.

**Social Factors**

The Index of Multiple Deprivation (IMD) places 30 of Wirral’s Lower Super Output Areas (LSOAs) in the lowest 5% in England and 23 (LSOA) in the 3% most deprived nationally. The Employment domain of the IMD 2010 also indicates that Wirral performs poorly and is further indication of the scale of the challenge faced in Wirral and the need for a focused and coordinated approach to tackling worklessness and economic inactivity.

The most deprived areas have much higher emergency hospital admission rates than the rest of Wirral.

Lifestyle behaviours such as smoking and drinking too much alcohol, as well as obesity, contribute to health inequalities, and these behaviours are all more prevalent in Wirral's most deprived areas.

Wirral has a variety of residents at polar extremes of the income spectrum, indicating that the differential between people on very low and very high incomes is quite pronounced in Wirral.

Alcohol is a significant problem for children and young people on Wirral. Death rates from digestive diseases mainly caused by alcohol are increasing very rapidly in the most deprived areas.

Birkenhead, Tranmere, Bidston, Seacombe and Rock Ferry have between 50% and 70% of older people living in deprivation.
2. MEMBER PRACTICES’ INTRODUCTION

NHS Wirral CCG has a strong culture of engagement with its practices and this has been integral to the development of the organisation. The CCG’s plans and duties are delivered through, and in consultation with, Member Practices through its consortia.

The 58 practices on the Wirral work together in three ‘consortia’ within a federated model as part of the delivery model of the organisation.

The three consortia (Wirral GP Commissioning Consortium, Wirral Health Commissioning Consortium and Wirral Alliance Commissioning Consortium) are all committees of the Governing Body and hence are part of the Governance reporting structure; this results in a clear line of accountability and regular reporting to the Governing Body on their role in delivering statutory duties in areas such as engagement, choice, innovation and quality in primary care.

To strengthen the concept of a membership based, clinically led organisation, GPs form the majority of the Governing Body membership and 7 are directly elected by the consortia. In addition, both the Chair and Accountable Officer are practising local GPs. It is the view of member practices, and the consortia they work within, that the GP representation on the Governing Body and the consortia model is an effective way of ensuring practices are aligned and engaged with the CCG planning processes.

Each Consortium has its own clinical engagement structure, through which it informs member practices of strategic developments, and engaged on the development on strategic priorities and underpinning work streams, as well as local Consortia plans that will impact directly on, and require input from, individual Member Practices.

For instance, Wirral GP Commissioning Consortium has engaged with its Member Practices through its bi-monthly forum meeting, to which GPs and Practice Manager representatives are invited. Feedback received through this group has affected changes that have informed the Strategic Plan, for instance, improvements to Primary Care Mental Health services, and increased choice for community services such as physiotherapy and podiatry.

For example, in relation to the Strategic Planning process and service developments local consortia plans and innovations must link to those overarching CCG plans and show a demonstrable contribution. This is achieved through the development of services using the Joint Strategic Needs Assessment (JSNA) to highlight specific areas of need. GPs and patients alike are then involved directly with the development of the service to ensure engagement at the earliest opportunity. Patients and clinicians are then also involved in the evaluation of service outcomes so that decisions to continue or discontinue services are based on robust evidence. During 2013-14 examples where this process has been utilised includes the development of local schemes to address admission prevention, tele health and facilitated discharge.

Clinicians are also central to the CCG’s service redesign agenda and the subsequent development of efficient and effective patient pathways. Clinicians from all consortia play a significant role within the organisations Clinical Strategy Group and the respective QIPP (Quality, Innovation, Productivity, Prevention) workstream which alongside stakeholders from across the health and social care economy look to find improved solutions to the challenges faced by the CCG.

Clinicians are involved in a number of tiers of the organisational governance including as an example the Serious Incident Review Group which is attended and supported by local GPs. This group reviews all serious incidents and never event (defined by the National Patient Safety Agency (NPSA) as; a serious or largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers) and informs our Quality, Performance and Finance Committee and through Quality and Contract meetings influences the quality agenda and focus of our providers.
One of the successful outcomes within the financial year was the identification of the need for prioritisation with regards to improvements in Eating and Drinking and Pressure Ulcers. The identification of this led specifically to a Board to Board between our CCG and local Trust to discuss their action plans and agree vision; there has now been significant improvements.

The federated consortia approach is subject to bi-annual evaluation which ensures the on-going effectiveness of these arrangements and the CCG is currently working with the North West Leadership Academy to assess the Governing Body against the ‘Framework of Excellence in Clinical Commissioning’. The findings of this assessment will result in a development programme for the Governing Body.

Dr Pete Naylor, Assistant Clinical Chair, Wirral CCG

On behalf of the practices of Wirral
3. STRATEGIC REPORT

This strategic report provides an analysis of the key strategic developments and associated performance of the CCG’s business during the 2013-14 financial year. For the details relating to licence conditions and their subsequent removal, please see the ‘Background’ section of this report.

3.1) KEY STRATEGIC DEVELOPMENTS

Vision 2018

The CCG has established the Vision 2018 Programme Board to oversee the strategic vision for the Wirral with the Health & Social Care Economy requiring significant transformation over the next 5 financial years in order to meet the financial challenges faced. The Vision Board includes representation from the key partners in the local economy with the members consisting of lead executives and clinicians from each of the respective organisations, ensuring high level commitment to the required programme of work.

The Vision 2018 group was established in August 2013, since then the programme has set the strategic context for vision, developed a programme structure with 9 work-streams. In the same spirit, the work-streams that sit below the Vision 2018 Programme Board are made up of members from the different Wirral organisations that have ensured a real sense of joint working across the economy and pursuit of the overall goal of a high quality but sustainable health and social care economy.

Initial proposals for the new models of care have been developed and are currently being reviewed to identify how they align with the priorities of the Vision 2018 programme. Integral to the development of the proposals for integrated, primary and secondary care is the views of staff and Wirral residents, there have been initial events to gather insights along with an online survey. The findings from the engagement so far are being embedded in the development of the new models of care. At the heart of the vision is the concept of Integrated Care, the integration programme was established in 2012 and includes the development of integrated care coordination teams, this work along with the additional focus on primary and secondary care it has significant potential to radically reshape health and care systems on the Wirral.

The transformed vision for delivery is for care to be built around the needs of the patient population, providing support for patients to look after their own health and wellbeing, whilst improving access to appropriate services as required.

It is envisaged that this will comprise a system of wider integrated primary and community based services, supported by a smaller but more specialised acute care setting. Services delivered within the community will include specialised care that was previously provided within a hospital setting.

Wirral CCG is committed to incorporating the concept of “Hospitals without Walls” in developing an integrated care model. The hospital setting will be supported to develop a higher level of speciality and technology to support more complex conditions with the opportunity to develop into a specialist hub across the region for particular specialities as appropriate.

The economy’s vision will ensure that commissioning of health and social care will be provided on an integrated basis ensuring the best alignment of physical and mental health care services.

The Wirral Vision in 2018/19 will be based on the creation of a sustainable and high quality health and social care economy built around the following key characteristics.

Wider primary care, provided at scale

Our vision is one of primary care communities, where the majority of healthcare – whether that is routine or unplanned care, is delivered outside of hospital and specialist settings, close to people’s
homes. Communities will be built around GP Practices and will see healthcare and social care professionals working together to prevent ill health, provide fast and responsive access to advice and treatment for medical conditions, and supporting those with long term conditions and complex needs to manage their condition and have greater independence.

Primary Care teams will play a key role in navigating and co-ordinating the journey of patients through the system, working alongside community staff such as nurses and therapists, and specialists such as consultants, along with mental health practitioners and social workers, and other organisations such as pharmacies, opticians, and the voluntary sector, to provide care and support that is tailored to the individual, and not to the organisations that provide it. By working together we will keep people healthy and happy in their own homes and communities for as long as possible, so that going to hospital or being admitted to a care home is something that is the exception and not the norm.

If we are to deliver the transformational change of ‘wider primary care, delivered at scale’, with GP Practices placed at the heart of this primary care system, then we will need to facilitate an environment where there is much greater co-operation between services, with general practices working together and alongside a range of other health, social care and voluntary sector organisations to jointly own and deliver these outcomes.

We will continue to strive to reduce health inequality, and there will be a core level of services available to all Wirral patients. However, we will work with Public Health to take into account the needs of patients in each of the Wirral constituencies, to make sure that we put the right services in place where they are really needed.

We cannot achieve this vision alone; we will need the help of our Wirral public to take responsibility for their own health, for that of their friends and family, and in understanding that the way the people of Wirral access services may have to change significantly. We hope that we will explain clearly why we need to change, why the challenge is so great, but also why this is a real opportunity, through our primary care communities, to really work together for a healthier future for Wirral.

Integrated care

A modern model of integrated care will be achieved by systematically integrating both services and pathways, horizontally and vertically across organisational boundaries, providing tailored care for patients. For horizontal integration this will mean a single team approach to care across health and social services so that duplication is reduced and care is coordinated in a more effective fashion. For vertical integration this will mean primary, community and hospital services working together to ensure patient journeys are seamless across organisational boundaries.

Access to the highest quality urgent and emergency care

By integrating care vertically this will ensure that the full spectrum of primary and secondary care services are mapped so that patients access appropriate unplanned care at the right time in the right environment. For example by creating a variety of primary care and community centres to deal with lower end conditions this should ensure adequate capacity for major conditions that are required to be seen in a hospital setting.

For such services to work effectively all members of the health community need to ensure that users of the services are aware of the services that are available and the need to promote self-care

A step-change in the productivity of elective care

To ensure people are seen by the right person at the right time, by the right clinician in the most appropriate setting with appropriate referral. This will be supported using robust referral pathways which include triage/advice and minimises need for face to face consultation. It will also include access to specialist services only when appropriate and within the community where possible.
There will be a drive to reduce duplication and maximise efficiency by developing referral protocols and guidelines. In a transformational approach, Wirral CCG will seek to move all appropriate activity from a hospital setting and into community hubs across Wirral.

Pathways will support education and upskilling and support the delivery of procedures and treatment interventions previously carried out by specialists in a secondary care setting.

**Specialised services concentrated in centres of excellence**

Specialised services, which tend to be high in cost and often only provided in specialised centres are constantly developing and changing; new specialised services are introduced whilst other services become commonplace and cease to be specialised. The Specialised Commissioning Team which is based in the Cheshire Warrington and Wirral Area Team (NHS England) commissions specialised services on behalf of the CCG.

The CCG works closely with the team to ensure that the views of the patients are taken into account when commissioning these services and any quality issues relating to the services are raised at the Quality Surveillance Group meetings.

The CCG also work closely with commissioners of specialised services and neighbouring CCGs where there maybe potential for commissioning at scale: this might be in areas where there is low volume of activity in tandem with high cost per procedure and high degree of clinical specialism.

This will need to be in line with NICE Improving Outcomes guidance, sensitive to local need and citizen engagement.

**Ensuring that Wirral ‘citizens’ are fully included in all aspects of service design and change and that patients are fully empowered in their own care.**

The CCG upholds the NHS 2012 white paper “No decision about me without me”. The CCG has recently produced a refreshed Experience, Engagement and Communication strategy which includes 7 objectives of how the CCG intends to engage with its local population. This includes a combination of specific engagement events with clinicians and residents as well as routine engagement via established patient groups.

In addition the CCG is developing its presence on social media to enable members of the public to interact and comment more rapidly on CCG business.

The CCG will be engaging with the public and local workforce throughout the development of Vision 2018 to ensure that the strategy is built upon the needs of our population.

A significant number of people with long term conditions want to remain as independent as possible and live as healthily as they can. Their feedback suggested that they need more information, online and face-to-face. "Puffell" is a free, Internet-based portal which allows people to create a Personal Health Account and to track goals and engage with services where appropriate. This links with Wirral Well.org to direct people to existing services as they seek to self-support. For those people not online VCAW offer a face to face and printable option. At every opportunity people are empowered to self-care and make responsible decisions regarding their lifestyle choices.

**Partnerships**

During 2013/14, NHS Wirral CCG has significantly strengthened its relationships with its local economy partners.

To begin, the CCG has established a Joint Commissioning Strategy Group with the intention of bringing together the key commissioners on the Wirral to ensure and promote cohesive, whole
system commissioning that is mindful of both health and social care (and is in part underpinned by a formal Section 256 agreement with regards to joint working between health and social care)

Representation on this group includes leaders from the CCG, Adult Social Services, Children and Young People's Services and Public Health.

The CCG continues to work proactively to ensure it discharges its duties effectively in relation to aspects of public involvement and consultation, and actively works with the people of Wirral in shaping the services it commissions. The CCG works hard to develop engagement programmes with hard to reach communities and to ensure that their respective health needs are addressed in commissioning plans and priorities.

The CCG works with a wide of variety of stakeholders including Voluntary and Community Action Wirral (VCAW) to engage with a wide range of voluntary, community and faith organisations working in Wirral. This ensures the voice of communities is heard and has been used in the shaping of the CCG’s mission and values.

**Better Care Fund**

The development of Better Care Fund has been undertaken with a real sense of partnership between the CCG and the Local Authority, with a lead manager from each organisation working closely together at every step and ensuing engagement with all key partners throughout the process and has been one of the real successes of the clinical commissioning groups first year of operation.

This Joint Commissioning Strategy Group has also overseen the delivery of the Better Care Fund (BCF) and has developed a risk sharing agreement so that there is real sense of joint ownership of the BCF moving forward.

**Health and Wellbeing Board**

The Chief Clinical Officer and Chair of the CCG are both members of the Health and Wellbeing Board and have attended the quarterly meetings throughout 2013/14 which were chaired by the Leader of the Council. The Health and Wellbeing Board is a statutory committee of Wirral Council which was set up in line with the Health and Social Care Act 2012. The Health and Wellbeing Board has a core membership but also operates a wider constituency to ‘promise’ the health and wellbeing in Wirral.

The member organisations of the Health and Wellbeing Board, which includes Wirral CCG, are committed to working together at every level to improve the quality of life and wellbeing of the residents of Wirral.

Members of the committee agree to work together actively to achieve the vision and mission of the Wirral Health and Wellbeing Board on the basis of the following values, which are reflected in Board members behaviours and decision making framework:

- Putting local people first in everything we do, putting the needs of local people and communities before organisational boundaries
- Valuing excellence and professionalism wherever it is found
- Mutual trust and respect – valuing each person as an individual, taking what other have to say seriously
- Being honest about our point of view and what we can and cannot do
- Creative and innovative solutions to problems
- Removal of barriers to equality of access and opportunity

The Health and Social Care Act 2012 outlined these general principles but allowed flexibility for local authorities and partner organisations, including the CCG, to operate their health and wellbeing board structure in a way to best suit the local needs of the population.
NHS Wirral Clinical Commissioning Group have worked closely with the Local Authority to both contribute to and developed a joint Health and Wellbeing Strategy in line with section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007.

Financial Performance

The CCG has faced significant financial pressures during 2013/14, with increased levels of healthcare activity being provided for its resident population, however the CCG has achieved its financial requirements in line with NHS England Business Planning rules with regards to minimum surplus (1%) and delivery of respective cash and invoice payment targets.

A key part of the Vision 2018 programme and based on the early modelling of available financial resources and demand for services over the next 5 years suggests a sustained period of significant challenge across the health and social care economy particularly given the ageing demographics, increased demand for services, new drugs and technologies.

Given these levels of financial challenge, this means more than ever working in a collaborative approach with our provider organisations and other stakeholders, to ensure the optimal use of the resources available to the Clinical Commissioning Group and continue to work with our partners to address the challenges faced by the health and social care economy.

Service Developments

Throughout 2013/14, the CCG has pursued a robust process of clinically led service redesign to ensure services are of the highest quality for patients, in tandem with close contract monitoring of existing contracts to ensure delivery is in line with local and national targets. The CCG has a number of clinically led Quality Innovation Productivity Prevention (QIPP) teams, multidisciplinary groups that look at developing the most effective pathways of care for patients.

Key developments here have included:

- The CCG has been working closely with the department of adult social services to develop a new system of step up/step down care to replace previous services such as intermediate care which have been commissioned and funded separately. The new system is jointly funded and commissioned and provides a single pathway into services from the hospital and from the community. The new service also has the support of a dedicated multidisciplinary team across health and social care, to provide more dedicated support to patients to help them return to independence. The new service also incorporates the reablement service which supports people in their own homes rather than in a hospital or care home bed.

- The CCG has been working with Wirral University Teaching Hospital and Cheshire and Wirral Partnership Trust to develop a new dedicated mental health assessment unit in acute care on the Arrowe Park Hospital site which was implemented in December 2013. This provides a dedicated purpose designed unit for patients attending acute care with mental health problems with the support of a team of appropriately trained staff to support. This will allow the patient journey to be significantly improved both in terms of quality, privacy and dignity.

- The development of plans to delivery services, jointly commissioned with the local authority, to deliver a more integrated form of care for people on Wirral with Learning Disabilities. The focus of this will encourage less reliance on inpatient beds.

- With regards to Planned Care, the CCG has worked with local providers and other key stakeholders to redesign pathways that improve the patient journey. This may be by eliminating unnecessary steps, supporting care closer to home and or appropriate referral to right clinician, right place at the right time. Some key achievements have seen the implementation of GP direct to list for inguinal hernias, trial without catheter in the community,
rapid access chest pain clinic for low and medium risk in the community heart centre, pathways for appropriate referral for raised liver function including community work up, hyperemesis management in the community and community glaucoma follow-up.

- The Integrated Model of Care in Wirral has been established as a Care Co-ordination model, drawing together a range of agencies to help adults with health or social care problems to manage their own care. The Integration Work Stream of the Vision 2018 Programme is leading on the implementation of this model, and progress so far has led to the aligning of professionals into eight Integrated Care Co-ordination Teams meeting in locations across the Wirral three times a week with the aim of co-ordinating care plans on those adults’ behalf, working with the integrated discharge team to enable timely and effective discharge for patients with complex needs.

- Adopting a care co-ordination approach to integration is about distributing the collective resources of the health and social care economy, including the voluntary, community and faith sector, in the most effective way to ensure people are supported to manage their own health and well-being. This has meant transforming the way in which people are currently cared for and helping individuals take responsibility for their own care. The Integrated Teams are local so they are close to patients, close to the resources available to support patients, and can be accessed quickly. This means providing the right care, at the right time and in the right place. The Integrated teams are aligned closely to local clusters of GPs, reflecting the community role in both delivering care closer to people’s homes, and harnessing the resources required to support local communities.
3.2) CCG PERFORMANCE INDICATORS

CCG Assurance Framework

All CCG’s are assessed on a quarterly basis by Area teams of NHS England against a set of domains / indicators based on a standardised framework.

Results for each of the domains are shown in the table below for all available quarters

<table>
<thead>
<tr>
<th>Domains</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Amber/Green</td>
<td>Amber/Green</td>
<td>Assured</td>
</tr>
<tr>
<td>Constitution</td>
<td>Green</td>
<td>Amber/Red</td>
<td>Assured</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Green</td>
<td>Green</td>
<td>Assured</td>
</tr>
<tr>
<td>Finance</td>
<td>Green</td>
<td>Green</td>
<td>Assured</td>
</tr>
</tbody>
</table>

*the unpublished provisional Q3 assessment against the “new domains”, is awaiting moderation from the regional and national teams.

NHS Constitution

Over the past year, the CCG has developed processes and systems in order to track the progress of its service providers (e.g. local hospitals, community services) against a number of national outcomes indicators, and ensures that patients’ rights within the NHS Constitution are maintained.

Additionally, the CCG has set other local priorities against which providers' progress is monitored in line with the evidence from its Joint Strategic Needs Assessment and Commissioning Outcomes Indicators.

Progress against these indicators is presented on a monthly basis to the CCG’s Quality Performance and Finance Committee.

Wirral CCG also has local objectives, some of which overlap with national outcomes and some of which include indicators specific to the economy. Within these, a number of indicators are used to monitor progress of the following:

- Emergency readmissions within 30 days of discharge from hospital
- Number of People attending A&E with alcohol related conditions
- Enhancing quality of life for people with dementia

The NHS Constitution gives patients specific rights, and these include:

- The right to begin treatment within 18 weeks of a GP referral (or within 62 days if the referral is for cancer)
- The right to be seen at A&E within 4 hours of arrival;
- In urgent cases, the right to an ambulance within 19 minutes of 999 call;
- Where an operation is cancelled at the last minute for non-clinical reasons, the right to an operation within 28 days of the cancellation.
What we have achieved in 2013/14 against these standards: (based on most recent intelligence)

<table>
<thead>
<tr>
<th>NHS Constitution Measures</th>
<th>Period</th>
<th>Target</th>
<th>YTD Performance</th>
<th>YTD RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referral To Treatment waiting times for non-urgent consultant-led treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%</td>
<td>Feb-14</td>
<td>90%</td>
<td>94.1%</td>
<td>Green</td>
</tr>
<tr>
<td>Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%</td>
<td>Feb-14</td>
<td>95%</td>
<td>97.2%</td>
<td>Green</td>
</tr>
<tr>
<td>Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%</td>
<td>Feb-14</td>
<td>92%</td>
<td>94.2%</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Diagnostic test waiting times</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%</td>
<td>Feb-14</td>
<td>99%</td>
<td>99.2%</td>
<td>Green</td>
</tr>
<tr>
<td><strong>A&amp;E waits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department – 95%</td>
<td>Feb-14</td>
<td>95%</td>
<td>95.0%</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Cancer waits – 2 week wait</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%</td>
<td>Feb-14</td>
<td>93%</td>
<td>96.4%</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Cancer waits – 31 days</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%</td>
<td>Feb-14</td>
<td>96%</td>
<td>98.6%</td>
<td>Green</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%</td>
<td>Feb-14</td>
<td>94%</td>
<td>97.8%</td>
<td>Green</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%</td>
<td>Feb-14</td>
<td>98%</td>
<td>99.4%</td>
<td>Green</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%</td>
<td>Feb-14</td>
<td>94%</td>
<td>97.6%</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Cancer waits – 62 days</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%</td>
<td>Feb-14</td>
<td>85%</td>
<td>85.1%</td>
<td>Green</td>
</tr>
<tr>
<td>Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%</td>
<td>Feb-14</td>
<td>90%</td>
<td>96%</td>
<td>Green</td>
</tr>
<tr>
<td>Maximum 62-day wait for first definitive treatment following a consultant’s decision to upgrade the priority of the patient (all cancers) – no operational standard set</td>
<td>Feb-14</td>
<td></td>
<td>81.6%</td>
<td></td>
</tr>
<tr>
<td><strong>Category A ambulance calls</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1)</td>
<td>R1 Feb 14</td>
<td>75%</td>
<td>78.3%</td>
<td>Green</td>
</tr>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 2)</td>
<td>R2 Feb 14</td>
<td>75%</td>
<td>78.1%</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Category C ambulance calls</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category C calls resulting in an emergency response arriving at the scene within 19 minutes 95%</td>
<td>Feb-14</td>
<td>95%</td>
<td>96.4%</td>
<td>Green</td>
</tr>
<tr>
<td><strong>b) NHS Constitution support measures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mixed Sex Accommodation Breaches</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimise breaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cancelled Operations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Q3 Eng Average</td>
<td>93</td>
<td>85</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Mental health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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%</td>
<td>Q3 2013/14</td>
<td>95%</td>
<td>97.4%</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Referral To Treatment waiting times for non-urgent consultant-led treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zero tolerance of over 52 week waiters</td>
<td>Feb-14</td>
<td>0</td>
<td>1</td>
<td>Red</td>
</tr>
<tr>
<td><strong>A&amp;E waits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No waits from decision to admit to admission (trolley waits) over 12 hours</td>
<td>we 2/3/14</td>
<td>0</td>
<td>0</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Cancelled Operations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No urgent operation to be cancelled for a 2nd time</td>
<td>Feb-14</td>
<td>0</td>
<td>0</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Ambulance Handovers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All handovers between ambulance and A &amp; E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Handover within 15 mins (WUTH only)</td>
<td>Feb-14</td>
<td>100%</td>
<td>97.0%</td>
<td>Red</td>
</tr>
<tr>
<td>Ambulance Turnaround within 30 mins (WUTH only)</td>
<td>Feb-14</td>
<td>95%</td>
<td>73.0%</td>
<td>Red</td>
</tr>
</tbody>
</table>
During 2013/14, the CCG has strengthened the team responsible for quality to ensure that the quality agenda across Wirral is high priority and patients receive the best possible care and treatment possible.

Clinical Quality Review Meetings

As part of the contractual process, quality review meetings are held with each acute, community and mental health provider organisation. In 2013/14 this has included hospices and independent providers. These are contracting meetings that focus on quality providing an opportunity to review areas for improvement and good practice and monitor any improvement activities.

These meetings provide a robust mechanism where commissioners and providers can work together to identify and strive to meet standards that will serve to deliver services and improve quality. Relationships have been established to support local accountability and response to local needs and requirements.

Quality Performance and Finance Committee

This sub-committee of the CCG Governing Body provides members with assurance in relation to the systems and processes that have been put in place with regard to quality within the organisation. This includes regular reports on complaints, serious incidents and never events to identify trends and themes across commissioned services. In addition to reviewing inspection reports from independent bodies e.g. Care Quality Commission. Further information relating to this committee can be found within Section 7; Annual Governance Statement.

Quality Surveillance Group (QSGs)

A network of Quality Surveillance Groups have been established across the country to bring together different parts of health and care economies locally and in each region of England to routinely share information and intelligence to protect the quality of care patients receive. Over the past year, Wirral CCG has played an active role in the Cheshire, Warrington and Wirral Quality Surveillance Group which is held monthly.

Across the local health economy still has challenges to meet to improve the quality of patients care.

These are to:

- Eliminate Mixed Sex Accommodation
- Reduce levels of harm in the event of serious incidents
- Reduce Healthcare Acquired Infections (HCAI’s)
- Prevent Pressure Ulcers

Infection Prevention and Control

Wirral CCG remains strongly committed to reducing Healthcare Associated Infections (HCAI).

Prevention of infection is a fundamental aspect of patient care and is at the heart of patient safety. Infection prevention and control practice has traditionally been seen as the prerogative of hospital staff, however, the ever shorter hospital stay and increasing proportion of healthcare provided in the community has led to greater infection control in the various community settings.

Infection prevention and control has increased in significance and prominence, which shows no signs of diminishing. This is supported by the CQC’s focus on infection prevention standards as a key essential standard for registration for healthcare providers and the on-going inspections against the Code of Practice for the prevention and control of HCAI.
3.3) FINANCIAL PERFORMANCE

The financial statements included within this annual report demonstrate a successful year for the Clinical Commissioning Group (CCG) and has delivered all of its statutory financial duties, as outlined below:

- **Revenue Resource Limit**

  The CCG has a statutory duty to contain its revenue expenditure within its notified revenue resource limit.

  The CCG received a revenue resource limit of £467.159 (million) for the 2013-14 financial year and achieved an under spend of £4.731 (million) against this resource (in line with NHS England Business Planning Requirements of a minimum 1% surplus)

- **Capital Resource Limit**

  The CCG has a statutory duty to contain any capital expenditure within its notified capital resource limit.

  The CCG had no capital resource available during 2013/14

- **Cash Limit**

  The CCG must ensure that it does not exceed its approved level of cash available within the financial year.

  This target was achieved, with the CCG maximising its cash use by ending the financial year with a minimal cash balance of £21k (which was below the target set by NHS England for CCG’s to hold a maximum £250k cash balance)

  The 2013-14 financial statements (year end accounts) have been prepared under a direction as issued by the NHS Commissioning Board under the National Health Service Act 2006 and in accordance with appropriate accounting standards.

  **Financial Resources**

  Overall, NHS Wirral Clinical Commissioning Group received a resource allocation of £467.159 (million) for the 2013/14 financial year which was made of £7.997 (million) for running costs (based on £25 per head using ONS population figures of 319,895) and £459.162 (million) for programme expenditure.

  A planned surplus figure of £6.575m (Circa 1.43%) was agreed with NHS England at the start of the financial year.

  NHS Wirral Clinical Commissioning Group spent £455.958 (million) on programme expenditure for Wirral residents during 2013/14 and spent £6.470 (million) on running costs.

  The resulting performance was that the CCG did not achieve its planned surplus figure of £6.575m but did achieve its minimum 1% surplus in line with NHS England Business Rules for clinical commissioning groups with a surplus of £4.731 (million).

  This movement in performance was agreed with NHS England during Quarter 4 of 2013/14 financial year and was predominantly due to increased activity across a number of expenditure areas but predominantly its main secondary care provider, Wirral University Teaching Hospitals NHS Foundation Trust.
<table>
<thead>
<tr>
<th></th>
<th>2013/14 Resource Allocation £ million</th>
<th>2013/14 Actual Expenditure £ million</th>
<th>Variance £ million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme</td>
<td>459,162</td>
<td>455,957</td>
<td>(3,205)</td>
</tr>
<tr>
<td>Running Costs</td>
<td>7,997</td>
<td>6,471</td>
<td>(1,526)</td>
</tr>
<tr>
<td>Total</td>
<td>467,159</td>
<td>462,428</td>
<td>(4,731)</td>
</tr>
</tbody>
</table>

NHS Wirral Clinical Commissioning Group spent its resources as follows:

<table>
<thead>
<tr>
<th></th>
<th>Planned Expenditure £ million</th>
<th>Actual Expenditure £ million</th>
<th>Variance £ million</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Contracts</td>
<td>324,125</td>
<td>330,607</td>
<td>6,482</td>
</tr>
<tr>
<td>Non NHS Contracts</td>
<td>14,680</td>
<td>16,857</td>
<td>2,177</td>
</tr>
<tr>
<td>Prescribing</td>
<td>55,498</td>
<td>56,247</td>
<td>749</td>
</tr>
<tr>
<td>Commissioned out of Hospital</td>
<td>33,437</td>
<td>34,005</td>
<td>568</td>
</tr>
<tr>
<td>Intermediate Care</td>
<td>3,307</td>
<td>3,027</td>
<td>(280)</td>
</tr>
<tr>
<td>Other</td>
<td>22,608</td>
<td>15,214</td>
<td>(7,394)</td>
</tr>
<tr>
<td>Total Programme Expenditure</td>
<td>453,655</td>
<td>455,957</td>
<td>2,302</td>
</tr>
<tr>
<td>Running Costs</td>
<td>6,928</td>
<td>6,471</td>
<td>(457)</td>
</tr>
<tr>
<td>Planned Surplus</td>
<td>6,575</td>
<td>0</td>
<td>(6,575)</td>
</tr>
<tr>
<td>Overall Performance</td>
<td>467,159</td>
<td>462,428</td>
<td>(4,731)</td>
</tr>
</tbody>
</table>

An analysis of 2013/14 expenditure shows that the majority of the CCG expenditure relates to services commissioned with NHS Providers (72%), with prescribing expenditure (12%) and commissioned out of hospital care (for example Continuing Healthcare, Fully / Joint Funded packages of care) (8%) resulting in 92% of overall resources being utilised in these areas. The remaining 8% is expenditure with non-nhs providers (4%) and other commissioning expenditure which includes non-recurrent expenditure as identified in original financial plans and in support of Local Enhanced Services.
NHS Contracts

2013/14 Expenditure with NHS provider organisations is as per below

- Wirral University Teaching Hospital NHS Foundation Trust (WUTH) for acute services - £219.7m
- Wirral Community NHS Trust (CT) for community services - £46.4m
- Cheshire and Wirral Partnership NHS Foundation Trust (CWP) for mental health and learning disability services - £32.9m
- North West Ambulance Service NHS Trust (NWAS) £11.3m
- Non-Wirral 'Acute' / 'Secondary Care' Providers (NON-WIRRAL) - £19.4m
- Non-Contracted Activity (NCA) - £2.5m

The biggest driver for performance variance against planned levels was the contractual performance with Wirral University Teaching Hospital NHS Foundation Trust (WUTH). There has been a significant increase in activity with this provider over the last 2 financial years, partly due to increased demand for services from the resident population, partly due to the case-mix of activity being performed at the provider and also due to direction of travel and objectives of the provider organisational strategy.

Wirral University Teaching Hospitals NHS Foundation Trust

Performance against planned contract value at the end of the financial year was an over performance of £5.5m which was split as per below.

<table>
<thead>
<tr>
<th>Planned Care</th>
<th>Contract Plan</th>
<th>Full Year Expenditure</th>
<th>Variance from Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective and Day Case</td>
<td>£43,772,693</td>
<td>£46,192,598</td>
<td>£2,419,905</td>
</tr>
<tr>
<td>Outpatient Attendances</td>
<td>£22,958,784</td>
<td>£23,727,047</td>
<td>£768,263</td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>£5,243,896</td>
<td>£6,635,092</td>
<td>£1,391,196</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unplanned Care</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and Emergency</td>
<td>£8,360,411</td>
<td>£8,954,038</td>
<td>£593,626</td>
</tr>
<tr>
<td>Non-Elective</td>
<td>£70,602,030</td>
<td>£70,770,621</td>
<td>£168,590</td>
</tr>
<tr>
<td>Other</td>
<td>2013-14</td>
<td>2014-15</td>
<td>Variance</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------</td>
<td>---------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Maternity</td>
<td>£5,446,861</td>
<td>£5,037,378</td>
<td>(£409,483)</td>
</tr>
<tr>
<td>Diagnostic Imaging</td>
<td>£2,509,513</td>
<td>£2,109,813</td>
<td>(£399,700)</td>
</tr>
<tr>
<td>Non-Pbr</td>
<td>£48,442,215</td>
<td>£49,884,961</td>
<td>£1,442,746</td>
</tr>
<tr>
<td>CQUIN</td>
<td>£5,183,380</td>
<td>£5,239,339</td>
<td>£55,959</td>
</tr>
<tr>
<td>Other</td>
<td>£1,200,000</td>
<td>£1,200,000</td>
<td>£0</td>
</tr>
<tr>
<td>Total</td>
<td>£213,719,785</td>
<td>£219,750,888</td>
<td>£6,031,103</td>
</tr>
</tbody>
</table>

The performance position against non-elective points of delivery was partially offset in year with the application of block ‘caps and collars’ approach contract.

The CCG’s ability to deliver its planned control total and compliance with NHS England’s Business Rules (minimum 1% surplus) are significantly impacted upon by the performance against planned levels through this material area of CCG expenditure.

Given future financial challenges as identified through the two and five year financial planning assessment (particularly in 2015/16 with the impact of changing financial flows as a result of the implementation of Better Care Fund) it is imperative that the Wirral health and Social Care economy work in a collaborative and effective manner to address increased levels of expenditure and ensure effective use of the resources available to it.

Non-NHS Contracts

In respect of Non-NHS providers, 2013/14 Expenditure is as per below:

- Spire Murrayfield - £5.1m
- Assura – Peninsula Health - £2.2m
- St Johns Hospice - £1.7m
- One 2 One Midwives - £1.0m
- Spa Medica - £0.9m

The biggest driver for performance variance against planned levels of non-nhs provider expenditure was the contractual performance with Spire Murrayfield with an additional £1.7m of activity performed above plan, this was again predominantly in ‘Elective’ points of delivery based on referrals into the provider.

In line with financial risks associated with growth within NHS contracts, similarly there has been a significant increase in the levels of expenditure across a range of other contracts without necessarily a reduction in other areas. The CCG will need to continue to identify potential alternatives where appropriate to ensure value for money but will also need to ensure that demand is managed in an appropriate manner in order to meet the competing resources given the diminishing resources that are available.

Prescribing

Monitoring and future planning of trajectories for prescribing expenditure remains one of the key areas for the CCG given the material level of expenditure and potential impact of delivery of the overall financial position.

The 2013-14 financial year has been one of considerable movement within the year in respect of prescribing patterns and overall expenditure. The expenditure position at the end of the financial year was an over spend against planned levels of activity by £749k and was based upon increased volumes and cost growth.
The impact and availability of new technologies and prescribed drugs continues to be a material risk to the Clinical Commissioning group and further work is required with the Medicines Management Support from the Cheshire and Merseyside Commissioning Support Unit in order to assess the potential financial risks associated with this.

Commissioned Out Of Hospital

Expenditure relating to Commissioned Out of Hospital care consists in the main of Continuing Healthcare and Fully funded / Jointly funded packages of healthcare with partners in Adult Social Services

Expenditure within category continues to be a significant growth area of expenditure for the clinical commissioning group and has increased over the last few financial years on a like for like basis.

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing Healthcare, Fully &amp; Jointly Funded Packages of Care</td>
<td>18,984,569</td>
<td>22,865,662</td>
<td>25,786,464</td>
</tr>
<tr>
<td>Funded Registered Nursing Care</td>
<td>5,255,024</td>
<td>4,844,847</td>
<td>4,864,974</td>
</tr>
</tbody>
</table>

Other Expenditure Areas

The CCG held a contingency reserve of £4m as part of its agreed financial plan in respect of any potential variances against planned levels of activity. Given the above pressures regarding NHS and Non-NHS contracts, Prescribing and Commissioned Out of Hospital the contingency has been fully utilised and slippage against planned commitments within both recurrent and non-recurrent budgeted expenditure has enabled the delivery of the financial position as included above.

Compliance with Better Payment Practice Code

The Better Payment Practice Code requires the clinical commissioning group to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms.

Details of compliance with the code are given in the notes to the financial statements. In addition to the statutory duties, all NHS organisations were required to make payments to their creditors within 30 days (unless other terms have been agreed). The target is for CCGs to pay 95% of invoices within this timescale.

During 2013/14 the CCG achieved this target. For non NHS invoices 98.39% were paid in terms of number and 98.77% in terms of value.

For NHS invoices, actual invoices paid within 30 days were 98.80% in terms of number and 99.94% in terms of value.
The CCG signed up to the Prompt Payment Code, whereby the CCG undertook to: -

On the 6th March 2014 the clinical commissioning group became an approved signatory of The Prompt Payment Code. This initiative was devised by the government with The Institute of Credit Management (ICM) to tackle the crucial issue of late payment and to help small businesses. Suppliers can have confidence in any company that signs up to the code that they will be paid within clearly defined terms, and that there is a proper process for dealing with any payments that are in dispute.

Approved signatories undertake to:

- Pay suppliers on time;
- Give clear guidance to suppliers; and
- Encourage good practice

Further information on the code can be found at www.Promptpaymentcode.org.uk

International Financial Reporting Standards (IFRS)

The Accounts were prepared based on International Financial Reporting Standards (see accounting policy note within financial statements).

Losses and Special Payments

The CCG had no losses and special payments to report for 2013/14. Should any occur, as part of its risk management processes, the CCG followed up all thefts of equipment and damage to buildings, and endeavours to minimise such incidents in the future.

Accounting policies

There were no changes to accounting policies used during the financial year.

3.4) SUSTAINABILITY REPORT

NHS Wirral CCG takes its responsibilities to the environment very seriously. It undertakes a range of measures that are mindful of the future environment and these include:

- Recycling paper and plastics regularly
- Operating the majority of business from a single site that reduces usage of cars
- Encouraging car sharing when attending off-site meetings
- Purchasing new, more efficient and environmentally friendly printers
- Promoting back to back printing where paper copies are required (for example, Governing Body papers for members of the public)
- Using tablet computers for staff who frequently attend meetings, reducing the need for hard paper copies
- Storing scanned documents electronically where legally appropriate

NHS Wirral CCG’s Headquarters are currently located in Old Market House, Birkenhead and is based on a rental lease agreement with NHS Property Services.

NHS Property Services is not required to provide narrative or data in relation to property occupation for use in Clinical Commissioning Group Annual Reports 2013/14. It is anticipated that the company will provide this information for Annual Reports in 2014/15.
Moving forward, the CCG has established a work-stream as part of the Vision 2018 Programme that will oversee the estate in the Wirral economy to ensure it is fit for purpose, environmentally friendly and in the right places for patients. Furthermore, by promoting self-care for patients it is envisaged that the need for physical stock will be reduced and this should have a positive impact on the environmental footprint.

3.5) HUMAN RESOURCES

Equality & Diversity

Wirral CCG has an Equality and Diversity Policy which was approved by the Staff Partnership Forum on 12th December 2013.

The Equality Objectives Plan lays out clear work streams that support the CCG to meet and pay due regards across its key functions to meet their exacting Public Sector Equality Duty to:

- Eliminate discrimination
- Advance Equality of Opportunity
- Foster good community relationships

NHS Wirral CCG highlighted in the Equality and Diversity Strategy that:

- In addition to service delivery it is vital that our CCG and our healthcare providers have excellent employment practice and go beyond the statutory requirements.
- We know that an organisation that values the different backgrounds of its employees attracts the most talented people and has higher levels of productivity. We are committed to achieving these outcomes.

The CCG seeks to develop positive practice to promote opportunity in employment by attracting and appointing the most suitable candidate for each of its vacancies.

A Recruitment and Selection policy has been developed and this will be available in May 2014 following approval, this states that the CCG will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the following protected characteristics as outlined in the Equality Act (2010): age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership or any other personal characteristic.

Promoting diversity embodies the principles of fair treatment for all and will as a result improve recruitment and retention. The CCG values the diversity of its workforce and aims to ensure that all staff understand this commitment and adhere to the standards.

The CCG produced key Equality Objectives and an Equality and Diversity Strategy to progress the equality agenda. The Objectives were a specific requirement stipulated by the Equality Act 2010 and were informed through the NHS Equality Delivery Systems (EDS) Self-Assessment.

The Strategy highlighted the key mechanisms required to enable progress to be made throughout the year against the objectives as follows:

Objective 1: To make fair and transparent commissioning decisions

- Meetings took place to develop a process in order to embed Equality analysis into business planning / options appraisal and committee reporting structures
- Cheshire and Merseyside Commissioning Support Unit (CMCSU) provided skills and knowledge to the CCG team and leadership
• Systems were implemented to ensure intelligence of patient barriers and gaps which were reflected and addressed in priority setting and planning
• Objective plan was aligned with the Equality and Diversity strategy Plan
• EDS stretch targets were set for 2014/15

Objective 2: To improve access and outcomes for patients and communities who experience disadvantage

• The CCG developed an Equality Analysis (EA) process whereby they can assess the equality implications, such as the risk of discrimination and disadvantage. EAs enable organisations to eliminate or mitigate the risks when commissioning its services or developing key policy or strategy. They also require commissioners to utilise evidence (quantitative and qualitative) and instruct CCGs to provide a ‘level playing field’ in relation to access and outcomes for the population they serve.
• Training and improving the skills and knowledge of Health Watch took place in August 2013 and February 2014 and will form part of an on-going process. Health Watch will play a key assurance role in future monitoring of providers around EDS.

Objective 3: To improve the equality performance of our providers through robust procurement and monitoring practice

• The Equality contract quality requirements were reviewed to ensure contract mechanisms have robust measures that test Provider compliance and enable a more joined up approach to tackling barriers to access that certain protected groups face.

Objective 4: To empower and engage our workforce

• Relevant HR Policies were reviewed.

In relation to disabled employment and equal opportunities, the Equality and Diversity policy and other relevant HR policies were approved at the Cheshire and Merseyside Commissioning Support Unit Staff Partnership Forum, held together with the CCG, in December 2013.

Wirral Clinical Commissioning Group undertook a Diversity survey in conjunction with NHS England in July 2013 and the national findings are available on the website in line with our specific duty to publish equality information.

https://www.wirralccg.nhs.uk/About%20Us/equality-and-diversity.htm

Sickness absence

A revised and harmonised Attendance Management Policy was approved by the Staff Partnership Forum on 13th June 2013 which aims to ensure that the CCG has a robust policy and procedure for supporting its staff with attendance issues and to ensure that these are managed in a fair and equitable way.

The CCG proactively managed both short –term and long-term sickness absence in line with this policy, with sickness absence being monitored on a monthly basis and reported on a monthly basis to the Quality, Performance & Finance Committee – a sub-committee of the Governing Body.

Wirral CCG’s sickness absence levels stood at 0.20% at the end of December 2013. The rolling absence for the period of 1st April 2013 to 31st December 2013 was 0.79%.

Over the year there have been 59 wte days of absence. The headcount at the end of December was 44 therefore the average sick days per employee is 1.34. The figures disclosed are based on Department of Health calendar year figures reported.
Involving our staff - Employee Consultation (Staff Well Being and Engagement)

Wirral CCG recognises that our staff are our greatest asset, as it is through our staff we are able to achieve the fundamental positive outcomes in clinical commissioning required as part of the organisation’s corporate strategy and objectives. In support of this we actively encouraged and promoted staff involvement at all levels within the organisation.

Staff Forum

In order to support staff involvement and engagement a Staff Forum was established in 2013 to which all staff are encouraged to attend on a monthly basis. The purpose of the forum is to provide an opportunity for the CCG Chair and other colleagues to brief staff about any relevant developments, allow staff to network, share ideas of best practice and also suggest initiatives to improve operations throughout the organisation.

Staff Partnership Forum

Our CCG acknowledges that the effective and productive conduct of employee relations benefits significantly from a recognised forum within which all stakeholders play an active role in partnership working. In support of this the CCG agreed to actively participate in the Cheshire & Merseyside Staff Partnership Forum which aims to identify and facilitate the workforce and employment aspects of the NHS locally in developing arrangements to implement required changes which may affect the workforce.

The Staff Partnership Forum is the main body for actively engaging, consulting and negotiating with key staff side stakeholders. The committee is authorised to agree, revise and review policies and procedures which may relate to changes in employment legislation and regulation or terms and conditions of employment affecting staff covered by the national Agenda for Change Terms and Conditions.

Any policies approved by the Staff Partnership Forum during this period were subsequently noted by the Staff Forum and Governing Body meetings.

Personal Development Reviews

The CCG has adopted an annual appraisal system for all of its employees in order to manage the performance and development of its staff. Our Remuneration Committee’s minutes state that the current organisation’s objectives and appraisal system are the method by which performance and achievement of corporate objectives would be measured.

Communications Mechanisms

We have kept our staff well informed through staff briefings and an e-bulletin, in addition to events on specific topics, emails, and our website, all of which encourage feedback. In addition to this we also included a staff support section designed to copy with change, managing the transition and relieving stress including appropriate sign posting to external services such as occupational health and staff counselling services.

Staff Support

During the year the CCG continued to remain fully committed to the health and positive wellbeing of its employees and understood that the health and wellbeing of the workforce was crucial to the delivery of the improvements in patient care envisaged in the NHS Constitution. All staff have access to a comprehensive Occupational Health Service including support for Visual Unit Display (VDU) users and confidential counselling services.
Appendix 1 provides a breakdown of the Governing Body members of the CCG.

There were no other Senior Managers on Grade VSM.

Gender Profile

At the end of March 2014 Wirral CCG had 42 female staff which equates to 71.2% of the workforce and of these 36 were full time and 6 were part time. There were also 17 male staff which equates to 28.8% of the workforce and of these 7 were full time and 10 were part time. The table below includes the gender analysis in further details:

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Full Time</th>
<th>Part Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>42</td>
<td>17</td>
<td>36</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>61.0%</td>
<td>10.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>71.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>11.9%</td>
<td>16.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>28.8%</td>
<td></td>
</tr>
</tbody>
</table>

A further gender analysis of Governing Body members can be found within Appendix 1 of this report.

Disabled employees

The Clinical Commissioning Group (CCG) is committed to equality of opportunity for all employees and is committed to employment practices, policies and procedures which ensure that no employee, or potential employee received favourable treatment on the grounds of gender, race, colour, ethnic or national origin, sexual orientation, marital status, religion or belief, age, trade union membership, disability, offending background, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or any other personal characteristic as outlined in the Equality Act (2010) and any other status covered by the Human Rights Act (1998). Diversity will be viewed positively and, in recognising that everyone is different, the unique contribution that each individual’s experience, knowledge and skills can make is valued equally.

The promotion of equality and diversity is actively pursued through policies and ensure that employees receive fair, equitable and consistent treatment and ensures that employees, and potential employees, are not subject to direct or indirect discrimination.

It is a condition of employment that all employees respect and act in accordance with the Equality and Diversity Policy. Failure to do so will result in the disciplinary procedure being instigated, which could result in dismissal.
3.6) INFORMATION GOVERNANCE

As technological advances multiply, so do people’s concerns about the safety of their personal data and Information Governance was addressed at the highest level within Wirral Clinical Commissioning Group last year. All staff completed their mandatory Information Governance training and the Clinical Commissioning Group gained Level 2 status. Privacy Impact Assessments and were carried out before introducing a new project or changing a service involving person-identifiable information and an Information Asset Register and Data Flow mapping exercise were carried out.

We continued to develop and agree Information Sharing Protocols, working in partnership with health, social care, other statutory bodies, commercial healthcare bodies and the voluntary sector.

The work undertaken by the Clinical Commissioning Group during 2013/14 as part of the information governance assurance programme, together with the annual compliance against the Information Governance Toolkit, achieved improved scores year on year, which demonstrated good performance in this area.

<table>
<thead>
<tr>
<th>Category</th>
<th>Nature of Incident</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises</td>
<td>0</td>
</tr>
<tr>
<td>II</td>
<td>Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises</td>
<td>0</td>
</tr>
<tr>
<td>III</td>
<td>Insecure disposal of inadequately protected electronic equipment, devices or paper documents</td>
<td>0</td>
</tr>
<tr>
<td>IV</td>
<td>Unauthorised disclosure</td>
<td>0</td>
</tr>
<tr>
<td>V</td>
<td>Other</td>
<td>0</td>
</tr>
</tbody>
</table>

There were no Information Governance related incidents reported to the Information Commissioners during 2013/14.
3.7) GOVERNANCE, COMMUNICATIONS & ENGAGEMENT

Maintaining strong governance is vital to Wirral CCG. The CCG is dedicated to the on-going development of governance and delivering high standards of care to the people of Wirral. This is why Wirral organisations have been working collaboratively to ensure it delivers against several key performance measures judged – nationally and locally. These measures cover all aspects of healthcare, including patient safety, clinical effectiveness and cost effectiveness. The CCG is assessed against many of these measures, and will be uses them as part of its Performance framework to ensure high standards of care continue to be delivered across the economy.

NHS Wirral CCG has employed a number of methods of engagement in order to encourage participation of local citizens. These have included public events, where, for example, local citizens attended a ‘Vision’ event to hear about, discuss and inform the CCG’s long term plans and the development of the Better Care Fund.

As well as taking part in active discussions, citizens and stakeholders were encouraged to record their thoughts and comments on the day and there is also a questionnaire available on the CCG website so people can continue to express their thoughts and opinions which will, in turn, inform the planning process. The insights gathered from the engagement events are recorded and provided in a ‘you said we did’ format on the CCG website to provide transparency.

An Experience, Engagement and Communications Strategy and Policy has been developed which was approved at the February Governing Body meeting. A copy of this can be found within the policies section of our website: www.wirralccg.nhs.uk/About%20Us/our-policies.htm

Each of the three Consortia (groups of practices working together) within Wirral CCG has an active Patient Council that brings together representatives from Practice Patient Participation Groups and the wider population, who have driven the development of services that now play a key part in future CCG strategy, such as the community Minor Injury and Illness Services. Each of the Consortia has also developed virtual means of engaging with its population, for instance via websites and virtual e-mail groups.

Wirral CCG has invested in an Experience Led Commissioning programme to support our patient engagement processes. The process ensures patients, carers and staff are consulted at the earliest opportunity to allow patient feedback, thoughts and perspectives to be central to all service redesign projects. We have recently completed a Stroke Prevention project with an open question of how do we improve people’s experience of stroke prevention in Wirral. There were no expectations as to what patients would tell us or what we would implement as a result of the project. This is an approach we are keen to continue to ensure patients are truly at the heart of the decision making.

In addition to this project, we use the principles of the process to run numerous focus group sessions for specific project areas (Cancer Survivorship, Anticoagulation, Vision 2018): this is an approach we plan to continue throughout coming years to ensure all our projects are patient centred. Our focus groups also include discussions around supporting patients to manage their conditions and self-care to ensure that we are including the support mechanisms within our service redesign to empower patients to manage their own care as and when appropriate. In addition to focus groups we also conduct numerous patient surveys and questionnaires and our projects are presented to our CCG patient groups for their feedback and input.

In Wirral we are committed to expanding our attendance for focus groups to all patients to ensure authentic citizen participation. When designing and implementing CCG communication and engagement activities, the diversity of the population served, the need for equality and the potential barriers to communication and involvement some people face will be taken into account. We advertise events through numerous mechanisms; these include CCG patient groups, GP Practice Patient Participation Groups, VCAW (Voluntary & Community Action Wirral), Health Watch Wirral, GP practice TV screens, Wirral Multicultural society and subject specific voluntary organisations.
For example, we recruited some patients for our stroke prevention project via the Stroke Association and AF Association and similarly recruited patients for an Ophthalmology event via Macular Disease Society.

For topics where focus group attendance may be difficult we have made a conscious effort to travel to the patients we need to speak to. For example, during a project on children’s A&E, because our target audience was parents with young children, we attended Children’s A&E, playgroups, nurseries, and women’s groups including domestic violence groups and breastfeeding groups.

Our aim is to consult with patients throughout a specific project ensuring patients are involved in the planning processes but also as projects progress it is important to keep patient views and priorities central to every project. Friends and Family Test (FFT) data and complaints information are regularly discussed and monitored at the CCG’s Quality and Performance Committee. For FFT in particular, there is a regular Quality and Clinical Risk Meeting with the local acute provider where themes and issues are discussed and resolved. Any areas where there is a recurrent issue would inform both the contracting and planning processes.

The CCG works collaboratively with the Strategic Cancer Network as part of a partnership working approach to plan and use best evidence for quality care and outcomes for patients. The learning and teaching dovetails into the CCG Cancer QIPP group to ensure specialised services are connected to our work programmes enabling us to facilitate research such as increased cancer awareness and early detection project.

Communication and engagement for integration is key to driving greater transparency by working collaboratively with key stakeholders including provider organisations, Health Watch and VCAW to deliver the desired outcomes. This engagement has been a key principle for the integration work stream here on Wirral.

A number of workshops have been held with both staff and public and regular meetings of the patient/carer engagement domain and their contribution has been used to shape the design of the Integrated Care Co-ordination Teams (ICCTs). This ensures that their valuable contribution has supported real decision making regarding the care coordinator model and the one number to contact that has been recommended by those engaging. In addition the integration work stream encourages clinicians and professionals from the provider organisations to participate in design via the systems design group which combines service re-design and IT infrastructure to develop a shared record and care planning. This supports the overall aim to bring about transformation from a ‘bottom-up’, practical approach that reflects the views of all those involved in as transparent a way as possible to deliver our integration programme.

In addition, the CCG is using social media such as Facebook and Twitter to continue to encourage participation and an on-going series of events is planned throughout the coming year around the broader strategic vision alongside Local Authority colleagues and local providers. This is alongside utilising communication and engagement channels such as Patient Councils, Patient Participation Groups to share messages and encourage feedback.

Finally, when undertaking service redesign initiatives, the CCG will continue to involve patients in the shaping of local services and ensure that, where appropriate, a formal consultation process is undertaken. This ensures that such developments are transparent in their development and embrace both citizen and clinical perspectives.

**Leadership**

Whilst this report mainly relates to the 2013/14 financial year, it is important that it also reflects the current and future performance of the CCG.

In May 2014, NHS England raised some concerns with regards to the leadership of the CCG, primarily in relation to the roles of the Chair and Chief Clinical Officer.
As a result, NHS Wirral CCG’s Governing Body has voluntarily asked NHS England to support it in the delivery of its duties and functions specifically the leadership arrangements within NHS Wirral CCG. Whilst this review is being undertaken, the Chair and Chief Clinical Officer have agreed voluntarily to step aside.

At the time of writing this report, NHS England are defining the scope of the review and it is envisaged that this will be concluded within 4-6 weeks.

3.8) EMERGENCY PLANNING, RESPONSE AND RESILIENCE

NHS Wirral Clinical Commissioning Group commissioned Cheshire & Merseyside Commissioning Support Unit to undertake various elements of work relating to emergency planning, response and resilience (EPRR).

The Clinical Commissioning Group’s EPRR responsibility consisted of one distinct role:

(a) the statutory duties as per the *Category 2 Responders* under the Civil Contingencies Act (2004), and those responsibilities for Clinical Commissioning Groups as outlined in *The NHS Emergency Planning Guidance 2005* and its supporting guidance;

NHS Wirral Clinical Commissioning Group is also responsible for maintaining an effective response to emergencies / adviser incidents and as such the Head of Corporate Affairs maintained an on call rota, for members of the Senior Management / on call team.

Guidance was also issued setting out the EPRR roles for all Clinical Commissioning Groups from April 2013. Key documents included:

(a) *Health Emergency Preparedness, Resilience and Response from April 2013: Summary of the principle roles of health sector organisations* (Department of Health, July 2012);
(b) *Transitional Assurance Process for EPRR* (NHS Commissioning Board, October 2012);
(c) *The role of ‘Accountable Emergency Officers’ for EPPR* (NHS Commissioning Board, December 2012);
(d) *Command and Control Framework for the NHS during significant incidents and emergencies* (NHS Commissioning Board, January 2013);
(e) *Business Continuity Management Framework* (NHS Commissioning Board, January 2013);
(f) *Core Standards for EPRR* (NHS Commissioning Board, January 2013).

This guidance focuses on planning for emergencies/ major incidents and the ability of the NHS to respond to such incidents (i.e. for those incidents that only affect the NHS and those which affect all multi-agency partners). Selected tasks include:

(a) training those senior managers who will be members of on call rotas to a national core standard (which is provided by NHS England and Cheshire & Merseyside Commissioning Support Unit);
(b) establishing new on call rotas to strategically manage the response of the NHS;
(c) development of plans including Business Continuity Plan which also included a validation exercise of this plan

These three areas have been complied with and the CCG now has a Business Continuity Plan in place that has been tested with staff and a robust on call rota. In addition, on-call staff have attended training courses including
• Strategic Management in a Crisis
• Introduction to Integrated Emergency Management
• Public Health England Multi Agency Outbreak Control Plan – Exercise
• Business Continuity Validation Exercise

Cheshire and Merseyside Commissioning Support Unit Emergency Planning Response and Resilience Team have provided Wirral CCG representation at the following groups:

• Cheshire Local Health Resilience Partnership
• Cheshire Local Health Resilience Forum Practitioners Group
• Cheshire Local Health Resilience Forum Pandemic Flu Group
• Cheshire Local Health Resilience Partnership Risk Working Group
• Cheshire Resilience Forum Management Group
• Cheshire Resilience Forum ad hoc sub groups
• Merseyside Resilience Forum Capabilities Group
• Merseyside Resilience Forum Risks and Hazards Group
• Merseyside Resilience Forum Training and Exercising group

An Annual Report has also been produced to outline the work of the EPRR team which will be reviewed at the May 2014 Governing Body meeting. Objectives for further work for the CCG will be set following discussions with the Head of Corporate Affairs and Corporate Support Officer as to the CCG’s requirements for next year.

I certify that the 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 Business Continuity major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

Name: Jonathan Develing

Role: Interim Accountable Officer

Signature: .................................................................
Date: .................................................................
3.9) MANAGING RISKS, INVESTIGATING EVENTS AND LEARNING FROM THE EXPERIENCE OF PATIENTS

Patient Experience

Gaining the views of patients regarding the quality of services that have been commissioned on their behalf is of paramount importance to the CCG. Each of the three consortia within the CCG has established strong patient councils / forums. These groups are made up of representatives from each of the practices in the consortia and they express patient’s views regarding the quality of services. Over the past year, this has led to the CCG commissioning services differently following feedback.

The CCG has also held a successful patient / engagement event to gain views on the development of the CCG strategic vision (Vision 2018). The comments and opinions from patients and the public have enabled the health and social care economy shape the future of health services. One of the strengths of clinical commissioning is that the CCG is able to receive contemporaneous feedback via the GP members. This vital intelligence if used to assess the quality of care of providers and to address issues to ensure quality is maintained.

Patient enquiries

The Patient Advice and Liaison Service provided by Wired is commissioned by Wirral CCG to support patients with concerns relating to General Practice, Dentistry, Ophthalmology and Pharmacy. The purpose of the service is to provide on the spot help whenever possible, with the power to negotiate immediate or speedy resolution (within 48 hours) of problems. In some cases the PALS service will refer patients to independent advice and advocacy support from local and national sources, including Health Watch.

Complaints

Ensuring good handling of complaints is one way in which CCG’s can help to improve quality of care for patients and learning from complaints enables organisations to continually improve the services they provide and the experience for all patients. Wirral CCG ensures that complaints are managed in accordance with the strategic goals and objectives and sure that all complaints are managed promptly and efficiently, in line with the Health Act 2009 and NHS Constitution. It also ensures that they are adequately investigated and that complainants are treated with dignity and respect.

Wire CCG has outsourced the process and management of all formal complaints to the Customer Solutions Centre within Cheshire & Merseyside Commissioning Support Unit (CSU), though the CCG remains responsible and accountable for the outcome of each complaint.

An internal process has been agreed with the CSU and a local procedure has been agreed with NHS England, to ensure that complaints are processed within a timely manner.

Patients’ verbal comments, concerns, complaints and compliments are received via the CCG public facing website and are also sent direct to the CSU.

Lessons learnt from complaints are an important tool to assist quality and responsiveness. Where appropriate, lessons learnt from complaints are reported on a monthly basis to the Quality, Performance & Finance Committee, which is a sub-committee of the Governing Body.

In 2013/14 the CCG received 41 formal complaints. It is through patient feedback that we were able to learn from complaints to monitor and improve services where required, to ensure we met the needs of our patients in the future. As Commissioners of local Health Services we monitored the complaints received for trends and took appropriate action to reduce the risk of identified trends happening again.
Knowing when patients have had a good experience is as important as knowing when things have not gone well. A record of compliments was kept by our Patient Advice & Liaison Service and feedback was given to the service in question.

The Patient Advice and Liaison Service (PALS) for Wirral CCG is provided by Wired; a voluntary sector organisation.

This service provides an informal way for patients to raise any concerns with their healthcare. The PALS team work on the patients behalf by liaising with healthcare staff, listening to concerns and providing information and advice. In 2013/14 there were 621 contacts made with the PALS team.

**Serious Incidents**

Making services safe for patients is fundamental to the provision of high-quality care and it is essential that providers of healthcare have good systems in place for staff to report when patients have, or could have been harmed. Open and honest reporting demonstrates a commitment to patients and their safety and is a mark of “high reliability”. The focus on reporting should be on analysing the root cause of the incidents because serious incidents yield important lessons about changing process to reduce risk. It is only through active learning and service improvement from serious incidents that the benefits of experience are actually realised.

The definition of a serious incident is any unexpected incident, which has caused serious harm, or with the potential to cause serious harm, and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS of commissioned service. A Never Event is defined by the National Patient Safety Agency (NPSA) as; a serious or largely preventable patient safety incident that should not occur if the available preventable measures have been implemented by healthcare providers.

Wirral CCG are responsible for ensuring that when a serious incident or never event occurs, that there are measures and mechanisms in place for safeguarding patients and also to understand and review investigation of why the event occurred. The CCG work together with provider organisations to ensure that measures are put in place to prevent similar incidents reoccurring.

The performance monitoring of serious incidents and/or never events is undertaken by Cheshire & Merseyside Commissioning Support Unit, however Wirral CCG remains responsible and held accountable for ensuring that provider organisations undertake a thorough root cause analysis (RCA) investigation to identify the root causes and also review the lessons learned identified, within the 45 working day timescale.

A Serious Incident Review group (Quality Committee) has been established within the CCG to review all RCA reports and action plans, and also provides monthly update reports to the Quality, Performance & Finance Committee; a sub-committee of the Governing Body. Each incidents and report is scrutinised by the group members which is made up of clinicians and managers. This group also enables Wirral CCG to monitor and ensure that all serious incidents and/or never events are managed appropriately and within a timely manner, whilst also ensuring that root causes and lessons learned are shared across organisations with a view to prevent similar incidents occurring again.

There were 116 serious incidents reported in 2013/14, 3 of which were never events reported in 2013/14 which were investigated fully and appropriate action taken, and reviewed via the Serious Incident management process by the Quality, Performance & Finance Committee.
The chart below details the number of serious incidents provided within the period of 1st April 2013 – 31st March 2014, which is split by each reporting provider organisation.

![Incidents Reported to SteIS for the period 1st April 2013 to 31st March 2014](image)

**Pressure Sores**

Pressure sores are the highest reported serious incident across Wirral. Pressure sore formation is an indicator of the quality of care that has been received by a patient. The reduction of pressure sores has been a priority for within 2013/14 and the CCG have worked with all local provider organisations to gain improvements in this area. The performance is monitored through the CCG’s Quality, Performance and Finance Committee, which is a sub-committee of the Governing Body.

Monitoring and closure of all pressure ulcer incidents have improved. Reporting has stayed consistent at WUTH between 1 & 3 per month since May 13. WCT have seen an increase in reporting in February and March 14 due to a change in policy. All incidents identified by the Community Trust will be reported on to SteIS and reviewed within 21 days as to where the pressure ulcer was acquired. The change in process is to encourage an improvement of patient safety across the whole of the Wirral community using SteIS as a reporting mechanism to trigger pressure ulcers quickly and efficiently.
I certify that the clinical commissioning group has complied with the statutory duties laid down in the NHS Act 2006 (as amended by the Health & Social Care Act 2012).

Name: Jonathan Develing

Role: Interim Accountable Officer

Signature: …………………………………………………………………

Date: ………………………………………………………………………
4) MEMBERS REPORT

Clinical Commissioning Group & Governing Body

This report is written from the perspective of the Governing Body and that body has prepared this report. Wirral has formed one Clinical Commissioning Group and each GP Practice on Wirral is a member of the Clinical Commissioning Group.

Each practice is also a member of a local consortium of which there are three; Wirral GP Commissioning Consortium, Wirral Alliance Commissioning Consortium and Wirral Health Commissioning Consortium

<table>
<thead>
<tr>
<th>Wirral GP Commissioning Consortium</th>
<th>Wirral Health Commissioning Consortium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackheath Surgery</td>
<td>Allport Surgery</td>
</tr>
<tr>
<td>Cavendish Medical Centre</td>
<td>Eastham Group Practice</td>
</tr>
<tr>
<td>Church Road Medical Practice</td>
<td>Claughton Medical Centre</td>
</tr>
<tr>
<td>Commonfield Road Surgery</td>
<td>Victoria Park Practice</td>
</tr>
<tr>
<td>Devaney Medical Centre</td>
<td>Greenway Surgery</td>
</tr>
<tr>
<td>Hamilton Medical Centre</td>
<td>Fender Way Health Centre</td>
</tr>
<tr>
<td>Holmlands Medical Centre</td>
<td>Heswall and Pensby Group Practice</td>
</tr>
<tr>
<td>Hoylake Road Surgery</td>
<td>West Wirral Group Practice</td>
</tr>
<tr>
<td>Kings Lane Medical Practice</td>
<td>Silverdale Medical Centre</td>
</tr>
<tr>
<td>Miriam Medical Centre</td>
<td>Hoylake &amp; Meols Surgery</td>
</tr>
<tr>
<td>Earlston Medical Centre</td>
<td>Marine Lake Medical Practice</td>
</tr>
<tr>
<td>Moreton Cross Group Practice</td>
<td>Greasby Medical Centre</td>
</tr>
<tr>
<td>Moreton Medical Centre</td>
<td>All Day Health Centre</td>
</tr>
<tr>
<td>Parkfield Medical Centre (Dr Raymond and Partners)</td>
<td>Egremont Medical Centre</td>
</tr>
<tr>
<td>Parkfield Medical Centre (Dr Hawthornthwaite and Partners)</td>
<td>Central Park Surgery</td>
</tr>
<tr>
<td>Prenton Medical Centre</td>
<td>Liscard Group Practice</td>
</tr>
<tr>
<td>TG Medical Centre</td>
<td>Somerville Medical Centre</td>
</tr>
<tr>
<td>Teehey Medical Centre</td>
<td>Leasowe Primary Care Centre</td>
</tr>
<tr>
<td>Townfield Health Centre</td>
<td>Wallasey Village Surgery</td>
</tr>
<tr>
<td>Upton Group Practice</td>
<td>Grove Medical centre</td>
</tr>
<tr>
<td>Villa Medical Centre</td>
<td>Grove Road Surgery</td>
</tr>
<tr>
<td>Vittoria Medical Centre (Dr Edwards and Partners)</td>
<td>St George’s Medical Centre</td>
</tr>
<tr>
<td>Vittoria Medical Centre (Dr Murty and Partner)</td>
<td>Field Road Surgery</td>
</tr>
<tr>
<td>Whetstone Medical Centre</td>
<td>Manor Health Centre</td>
</tr>
<tr>
<td>Woodchurch Medical Centre</td>
<td></td>
</tr>
</tbody>
</table>

Wirral Alliance Commissioning Consortium

Heatherlands Medical Centre
The Orchard Surgery
Riverside Surgery
Gladstone Medical Centre
Civic Medical Centre
St Hilary Group Practice
The Spital Group Practice

Further details of our GP member practices can also be found on our public facing website: [https://www.wirralccg.nhs.uk/About%20Us/our-practices.htm](https://www.wirralccg.nhs.uk/About%20Us/our-practices.htm)
We ask the consortia to undertake a significant amount of the commissioning work with their own patients and practices. This arrangement recognises that the health priorities in one part of Wirral are not necessarily the same as in another.

We also believe that the smaller consortium groups can be more responsive to their members and the public and in areas where a single approach across the Wirral is more effective we ask the Governing Body to do this work.

The Governing Body are also responsible for preparing an Annual Governance Statement which sets out how the Governing Body discharged its responsibilities. This Statement is provided within section 7 of this report and also provides details of members of other committees.

The Governing Body comprises:

- Chair, Dr Phil Jennings
- Chief Clinical Officer, Dr Abhi Mantgani
- Interim Accountable Officer, Jonathan Develing
- Chief Financial Officer, Mark Bakewell
- Wirral GP Commissioning Consortium Chief Officer, Christine Campbell*
- Wirral GP Commissioning Consortium GP Chair, Dr John Oates
- Wirral GP Commissioning Consortium GP Executive, Dr Akhtar Ali
- Wirral GP Commissioning Consortium Urgent Care GP Executive, Dr Hannah McKay
- Wirral Health Commissioning Consortium Chief Officer, Andrew Cooper*
- Wirral Health Commissioning Consortium GP Chair, Dr Pete Naylor
- Wirral Health Commissioning Consortium GP Executive, Dr Sue Wells
- Wirral Alliance Commissioning Consortium, Iain Stewart*
- Wirral Alliance Commissioning Consortium GP Chair, Dr Mark Green
- Secondary Care Doctor, Dr Andrew Smethurst
- GP Executive, Dr David Hywel-Jones
- Head of Quality & Performance (Corporate Nurse), Lorna Quigley
- Head of Corporate Affairs, Paul Edwards*
- Lay Member (Audit & Governance), James Kay
- Lay Member (Patient Champion), Simon Wagener
- Director of Public Health, Fiona Johnstone*
- Director of Social Services, Graham Hodkinson*

* Members are non-voting members

The Governing Body membership differs from predecessor organisations in that there is significantly higher proportion of GPs. This reflects the fact that, as a membership organisation of general practices, front line clinicians are integral to the commissioning decisions of the CCG. In addition, a secondary care clinician is present to represent a wider clinical view and the attendance of the Director of Public Health and Director of Adult Social Services promotes partnership working with Wirral Local Authority.

A register of declared Interests by members of the governing body can be found in Appendix 2.

Full details of remuneration of Governing Body Members are provided within section 5.

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 them self aware of any relevant audit information and to establish that the clinical commissioning group’s audit is aware of that information.

This will be confirmed either through attendance at relevant Governing Body meeting or in writing.

Audit

NHS Wirral Clinical Commissioning group held Audit Committee’s throughout the financial year. The committee regularly reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control, ensuring that it operated across the whole of the Clinical Commissioning Group’s activities and supported the organisation’s goals.

Audit arrangements

Internal audit services were provided by Mersey Internal Audit Agency (MIAA) at a cost of £38,400. As part of the agreed Internal Audit Plan for 2013-14, MIAA have conducted a review of the Core Financial systems and control arrangements in place across NHS Wirral Clinical Commissioning Group’s (CCG) activity.

The CCG’s external audit was conducted by Grant Thornton UK LLP. The cost of the duties performed during the 2013/14 financial year was £109,800. Grant Thornton field work included a review of the CCG’s control environment, understanding of financial systems and a review of internal audit reports on core financial systems.

Audit Committee

As part of an integrated committee structure, the Audit Committee is pivotal in advising the Governing Body on the effectiveness of the system of internal control. Any significant internal control issues would be reported to the Governing Body via the Audit Committee. The Audit Committee is informed by the reports on the Clinical Commissioning group’s systems and processed prepared by both internal and external auditors.

The Audit Committee provides assurances to the Governing Body on matters of:

• Integrated Governance, Risk Management and Internal Control
• Financial reporting
• Internal Audit
• External Audit
• Counter Fraud

The Audit Committee comprises of:

• Lay Member (Audit & Governance) – Chair of the Committee
• Chief Financial Officer
• Lay Member (Patient Champion)
• Head of Corporate Affairs
• Consortium Chief Officers (X3)
• Mersey Internal Audit Agency Manager
• External Audit Manager (Grant Thornton)
• Local Counter Fraud Specialist (Cheshire & Merseyside Commissioning Support Unit)
• Lay Advisors (X3)

* The CCG has recruited 3 additional audit lay members to deepen its skills base and audit independence.
The Chief Clinical Officer, as Accountable Officer, is also invited to attend and discuss at least annually with the Committee the process for assurance that supports the Statement on Internal Control. The Chief Clinical Officer attends when the committee considers the draft internal audit plan and the annual accounts and is also invited as deemed appropriate.

Other Governing Body members and other senior CCG managers may be invited to attend, particularly when the Committee is discussions areas of risk or operations that are the responsibility of that member.

Each individual who is a member of the Audit Committee 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 them self aware of any relevant audit information and to establish that the clinical commissioning group’s audit is aware of that information.

Political and Charitable Contributions

There were no political or charitable contributions made by the CCG during the 2013/14 financial year.

Cost Allocation & Setting of Charges for Information

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

Principles for Remedy

Our CCG encourages a positive, open and honest approach to receiving and responding to complaints. Complaints provide a valuable feedback about patients’ experiences.

Complaints made to the CCG are handled by the Cheshire & Merseyside Commissioning Support Unit (CSU) in accordance with the Complaints (England) Regulations 2009, The NHS Constitution and principles published by the Health Service Ombudsman (Getting it right; being customer focused; being open and accountable; acting fairly and proportionately; putting things right; and seeking continuous improvement). This supports us to ensure the good handling of complaints to improve the quality of services for patients. There have been significant challenges with regards to how the CSU has managed complaints on behalf of the CCG during 2013-14. The CCG has acted on this and has asked that a rectification plan be put in place to improve the management process for our population.

The CCG handles complaints about services that we commission, on behalf of our population, from providers or about the exercise of any of our functions. We also investigate more complex complaints where one or more organisations are involved, including NHS England or other service providers or commissioners. Ensuring all complaints are handled with the patient/complainant at the centre of the response and coordinating the provision of a single response is a priority for us.

Governance processes have been established by the CCG to ensure the sign off and learning from complaints is built into both the CCG and CSU complaints handling processes. Every complaint is entered into a repository alongside MP letters and incidents to enable the monitoring of trends and patterns in complaints and concerns raised by patients and healthcare professionals. This helps us to detect systemic problems early by highlighting areas for improvement and development. This information is reported to the CCG’s Quality, Performance & Finance Committee on a monthly basis and a quarterly aggregated report is also provided, who analyse the information and consider any
action required, driving improvements to the quality of services commissioned by the CCG and sharing lessons learned. The Chief Officer of the CCG personally signs off the CCGs response to every complaint that we receive.

A total of 41 complaints were received during 2013/14, further information relating to this can be found on page 35 of this report.

Name: Jonathan Develing

Role: Interim Accountable Officer

Signature: .................................................................

Date: .................................................................
5) REMUNERATION REPORT

During the 2013-14 financial year, the Remuneration Committees of NHS Wirral Clinical Commissioning Group has made recommendations to the Governing Body on remuneration, terms of service and contracts of employment for the Chief Clinical Officer, Chair and Chief Finance Officer to ensure they are fairly rewarded for their individual contribution to the organisation based on the available guidance to the CCG.

Additionally, the Remuneration Committee made recommendations to the Governing Body on the remuneration, allowances and terms of service of other designated CCG posts in order to ensure they are fairly rewarded for their individual contribution to the organisation. It also advised on and oversaw appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

Composition & Membership of the Committee

The remuneration committee provides advice to the Governing Body on such remuneration includes all aspects of salary, provisions for other benefits including pensions and cars as well as arrangements for termination of employment and other contractual terms.

This Committee met 3 times in 2013/14 and provided minutes and assurance to the Governing Body.

Further details relating to the attendance and frequency at meetings can be found in the Annual Governance Statement (section 7) of this report.

A breakdown of individual attendance at the committee is detailed below:

<table>
<thead>
<tr>
<th>Member</th>
<th>Meeting Date</th>
<th>18th April 2013</th>
<th>16th October 2013</th>
<th>18th December 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>James Kay (Chair)</td>
<td>Attended</td>
<td>Attended</td>
<td>Attended</td>
<td></td>
</tr>
<tr>
<td>Dr Phil Jennings</td>
<td>Attended</td>
<td>Attended</td>
<td>Attended</td>
<td></td>
</tr>
<tr>
<td>Dr Andrew Smethurst</td>
<td>Attended</td>
<td>Attended</td>
<td>Apologies</td>
<td></td>
</tr>
<tr>
<td>Simon Wagener</td>
<td>Apologies</td>
<td>Attended</td>
<td>Attended</td>
<td></td>
</tr>
</tbody>
</table>

The Committee is chaired by the Lay Member, James Kay, (who leads on Governance and Audit) and its membership comprises of two Lay Members, Simon Wagener and Andrew Smethurst, and the Chair of the Governing Body, Dr Phil Jennings.

Independent HR advice and guidance is provided by Paul Arnold, Head of Human Resources from Cheshire & Merseyside Commissioning Support Unit. Advice is on legislative employee matters and benchmarking of NHS salaries. The role is part of a wider contractual agreement for Commissioning Support Services. The Commissioning Support Unit and Remuneration Committee have been satisfied with the advice and guidance provided by the individual.

The committee is established in accordance with NHS Wirral CCG’s Constitution, standing orders and Scheme of delegation.
Policy on Remuneration of Senior Managers.

The majority of CCG staff are paid based on national Agenda for Change terms and conditions and this includes Senior Managers with the following exceptions. For other appointments such as Chief Clinical Officer, Chair, Chief Financial Officer and GP Leads; salaries and are based on regional ‘HAY’ group guidance. For these staff who are not on Agenda for Change local agreements have been reached based on independent HR advice as cited above in relation to terms and conditions.

Senior Managers Performance Related Pay

The CCG does not operate a system of Performance Related Pay.

Policy on Senior Managers Contracts

The majority of CCG staff hold contracts based on national Agenda for Change terms and conditions and notice periods and termination payments are in line with those national terms and conditions. All senior managers in this category are permanent employees of the CCG. For other appointments such as Chief Clinical Officer, Chair, Chief Financial Officer and GP Leads, local agreements have been reached based on independent HR advice as cited above in relation to terms and conditions.

Payment to Past Managers

No awards have been made to past senior managers.
Salaries and Allowances

Salaries & Allowances for Senior Employees of Wirral CCG (from 1st April 2013 to 31st March 2014)

Salaries & Allowances for Senior Employees of Wirral CCG from 01/04/13 – 31/03/14 – Please see below for further detail regarding this.

Applicable Governing Body members may receive taxable benefits from the Clinical Commissioning Group’s lease car scheme as part of their remuneration.

<table>
<thead>
<tr>
<th>Name &amp; Title</th>
<th>Salary &amp; Fees (bands of £5,000)</th>
<th>Taxable Benefits (Rounded to the nearest £00)</th>
<th>Annual Performance Related Bonuses (bands of £5,000)</th>
<th>Long-term Performance Related Bonuses (bands of £5,000)</th>
<th>All Pension Related Benefits (bands of £2,500)</th>
<th>Total (bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jennings Philip - Chair</td>
<td>105 - 110</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>110 - 115</td>
</tr>
<tr>
<td>Mantgani Abhi - Chief Accountable Officer</td>
<td>105 - 110</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>110 - 115</td>
</tr>
<tr>
<td>Bakewell Mark - Chief Financial Officer</td>
<td>90 - 95</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>90 - 95</td>
</tr>
<tr>
<td>Quigley Lorna - Head of Quality and Performance</td>
<td>65 - 70</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>65 - 70</td>
</tr>
<tr>
<td>Edwards Paul - Head of Corporate Affairs</td>
<td>60 - 65</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60 - 65</td>
</tr>
<tr>
<td>Campbell Christine - Consortia Chief Officer</td>
<td>55 - 60</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>55 - 60</td>
</tr>
<tr>
<td>Stewart Iain Consortia - Chief Officer</td>
<td>60 - 65</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60 - 65</td>
</tr>
<tr>
<td>Cooper Andrew Consortia - Chief Officer</td>
<td>60 - 65</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60 - 65</td>
</tr>
<tr>
<td>Naylor Peter - Consortia Chair</td>
<td>70 - 75</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>70 - 75</td>
</tr>
<tr>
<td>Green Mark - Consortia Chair</td>
<td>30 - 35</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>30 - 35</td>
</tr>
<tr>
<td>Oates John - Consortia Chair</td>
<td>50 - 55</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>50 - 55</td>
</tr>
<tr>
<td>Wells Sue - GP Representative</td>
<td>5 - 10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Jones David - GP Representative</td>
<td>5 - 10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Ali Akhtar - GP Representative</td>
<td>5 - 10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5 - 10</td>
</tr>
<tr>
<td>McKay Hannah - GP Representative</td>
<td>0 - 5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 - 5</td>
</tr>
<tr>
<td>Srivastava P - GP Representative</td>
<td>0 - 5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 - 5</td>
</tr>
<tr>
<td>Kay James - Lay Member</td>
<td>10 - 15</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Wagener Simon - Lay Member</td>
<td>5 - 10</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5 - 10</td>
</tr>
</tbody>
</table>
Pension Benefits

All employees have access to and are entitled to join the NHS Pension Scheme which provides pensions on a final salary basis. Further details are provided in the Annual Accounts under section 4.5.

There are no CCG employees who have stakeholder pensions in place of being a member of the NHS pension scheme.

Pension benefits for Senior Employees at NHS Wirral Clinical Commissioning Group 2013/14:

<table>
<thead>
<tr>
<th>Name</th>
<th>Real increase (decrease) in pension at 60 (bands of £2,500)</th>
<th>Real increase (decrease) in pension lump sum at 60 (bands of £2,500)</th>
<th>Total accrued pension at 60 as 31/03/2014 (bands of £5,000)</th>
<th>Lump sum at 60 to accrued pension at 31/03/14 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value as at 31/03/2014</th>
<th>Cash Equivalent Transfer Value as at 31/03/2014</th>
<th>Real increase (decrease) in Cash Equivalent Transfer Value</th>
<th>Employer's contribution to partnership working</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jennings Philip - Chair</td>
<td>7.5 - 10</td>
<td>25 - 27.5</td>
<td>10 - 15</td>
<td>35 - 40</td>
<td>177,319</td>
<td>301,395</td>
<td>120,175</td>
<td>0</td>
</tr>
<tr>
<td>Mantgani Abhi - Chief Accountable Officer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bakewell Mark - Chief Financial Officer</td>
<td>2.5 - 5</td>
<td>12.5 - 15</td>
<td>5 - 10</td>
<td>20 - 25</td>
<td>96,552</td>
<td>156,494</td>
<td>57,818</td>
<td>0</td>
</tr>
<tr>
<td>Quigley Lorna - Head of Quality and</td>
<td>0 - 2.5</td>
<td>5 - 7.5</td>
<td>15 - 20</td>
<td>55 - 60</td>
<td>312,518</td>
<td>357,777</td>
<td>38,284</td>
<td>0</td>
</tr>
<tr>
<td>Performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edwards Paul - Head of Corporate Affairs</td>
<td>(2.5 - 0)</td>
<td>(2.5 - 0)</td>
<td>15 - 20</td>
<td>45 - 50</td>
<td>216,929</td>
<td>225,041</td>
<td>3,340</td>
<td>0</td>
</tr>
<tr>
<td>Campbell Christine - Consortia Chief Officer</td>
<td>0 - 2.5</td>
<td>2.5 - 5</td>
<td>0 - 5</td>
<td>5 - 10</td>
<td>31,971</td>
<td>48,582</td>
<td>15,608</td>
<td>0</td>
</tr>
<tr>
<td>Stewart Iain Consortia - Chief Officer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooper Andrew Consortia - Chief Officer</td>
<td>0 - 2.5</td>
<td>2.5 - 5</td>
<td>10 - 15</td>
<td>30 - 35</td>
<td>136,939</td>
<td>156,592</td>
<td>16,641</td>
<td>0</td>
</tr>
<tr>
<td>Naylor Peter - Consortia Chair</td>
<td>2.5 - 5</td>
<td>12.5 - 15</td>
<td>5 - 10</td>
<td>25 - 30</td>
<td>134,575</td>
<td>210,546</td>
<td>73,011</td>
<td>0</td>
</tr>
<tr>
<td>Green Mark - Consortia Chair</td>
<td>5 - 7.5</td>
<td>17.5 - 20</td>
<td>0 - 5</td>
<td>0 - 5</td>
<td>26,317</td>
<td>122,954</td>
<td>96,058</td>
<td>0</td>
</tr>
<tr>
<td>Oates John - Consortia Chair</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Dr Mantgani, Dr Oates and Iain Stewart are not currently members of the NHS Pension Scheme

(Source: NHS Pensions Agency)
Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Pay Multiples

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

The banded remuneration of the highest paid members of the Governing Body in Wirral CCG in the financial year 2013-14 was £112,613. This was 3.52 times the median remuneration of the workforce, which was £32,017.

In 2013-14, no employees received remuneration in excess of the highest-paid members of the Governing Body. Remuneration ranged from £112,613 to £16,271.

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

Off Payroll Engagements

The CCG has no off payroll engagements for the financial year.

Governing Body Member Profiles

Further information relating to the profiles of Governing Body members can be found within Appendix 1 of this report.

Severance payments

There were no severance payments or loss of office during 2013/14.

Staff Pay Awards

In line with National Agenda for Change agreements, all staff on pay bands 1 – 4 received a 1% increase during 2013/14.

Pension Liabilities

Note 4.5 to the accounts details the accounting for pension liabilities, covered by the provisions of the NHS Pension Scheme. Details of pension benefits of CCG senior managers are shown in the remuneration report, which is included as an appendix to this document.
There are no CCG employees who have stakeholder pensions in place of being a member of the NHS pension scheme.

Name: Jonathan Develing

Role: Interim Accountable Officer

Signature: ……………………………………………………………

Date: …………………………………………………………………
6) 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 appointed Dr Abhi Mantgani to be the Accountable Officer / Chief Clinical Officer of the Clinical Commissioning Group.

As of May 2014, Jonathan Develing (Regional Director of Operations and Delivery – NHS England North) is acting as Interim Accountable Officer whilst a capacity and capabilities review is being undertaken by NHS England. The large majority of this report has been written by Dr Abhi Mantgani and reflects the achievements registered under his leadership and that of his colleagues in the CCG Senior Management team. However, as the current incumbent the responsibility is mine to sign this document.

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.
Name: Jonathan Develing

Role: Interim Accountable Officer

Signature: .................................................................

Date: .................................................................
NHS WIRRAL CLINICAL COMMISSIONING GROUP

Governance Statement for 2013/14

Introduction

NHS Wirral Clinical Commissioning Group (CCG) was licensed from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

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

As at 1st April, the CCG was licensed with 7 ‘conditions’ resulting from the authorisation process, and these were related to providing additional evidence around planning and governance. The areas were additional evidence was required were to show that the:

- CCG had a clear and credible integrated plan, which included an operating plan for 2012-13, draft commissioning intentions for 2013-14 and a high-level strategic plan until 2014-15;
- CCG had detailed financial plan that delivered financial balance, set out how it will manage within its management allowance, and any other requirements set by the NHS Commissioning Board, now NHS England, and is integrated with the commissioning plan;
- QIPP was integrated within all plans. Clear explanation of any changes to existing QIPP plans;
- Governance arrangements were in place to identify and manage different types of risk, including key risks to delivery of QIPP;
- CCG had the standard financial management arrangements in place;
- CCG had plans in place for formally procuring any commissioning support services, to ensure that between 2013-16 it puts in place the arrangements to go through a compliant procurement process; and
- CCG can demonstrate that it had assessed the skills possessed by governing body members and had a plan to build governing body competencies/skills where required.

Once this additional evidence was provided (including the CCGs associated Commissioning, QIPP and Organisational Development Plan) the conditions were removed and the CCG became fully authorised in the early part of the financial year.

In its first year of existence as a statutory organisation, NHS Wirral Clinical Commissioning Group (CCG) has developed considerably in its approach to, and delivery of, corporate governance. Initially guided by national guidance and the authorisation process, the committee structure of the CCG has now become a firm reality that is integral to the success of the organisation.

The statutory committees that were established at the inception of the CCG (Audit, Remuneration and Quality, Performance & Finance Committee) are now running smoothly, with each having a dedicated work-plan that links to the organisation’s objectives and a ‘Corporate Support Officer’ who quality assures papers and ensures agendas link to key reporting deadlines. This also links to the development and implementation of ‘Corporate Calendar’ that maps the CCG’s statutory duties and how each committee and the Governing Body contribute to the delivery of its legal duties.

As a member organisation that is founded on clinical leadership and opinion, the CCG has strengthened its committee structure by the formation of additional committees that promote clinical engagement. Firstly the Clinical Strategy Group is the vehicle by which clinicians from a variety of sectors come together to review best practice and shape patient care and pathways. Secondly, the
Governing Body also has three ‘consortia’ as committees and these are groups of GP practices working together to promote innovation, lead on patient engagement and manage a large proportion of commissioning budgets.

It is a positive sign that two recent Internal Audit Reports (‘Committee Effectiveness’ and ‘Membership Arrangements’) both gave ‘Significant Assurance’, a signal that the additional committees that have been established are contributing to the CCG’s governance approach. Having said that, there are still a number of areas where the CCG recognises that there is further work to be done to further refine and improve in these areas. These include ensuring that all committees develop a similarly robust approach to developing an annual work plan and reviewing their own effectiveness and member skill mix. Moreover, the CCG needs to ensure that sufficient time is given to the Governing Body’s role in strategic oversight and that the balance of agendas is reflective of that.

Given the potential for conflict of interests that can arise from a GP led organisation, the CCG has also established an ‘Approvals Committee’ that is a committee comprised of non-GP members to ensure probity in decisions that may materially affect General Practice. It is thought that this approach is uncommon in CCG’s and contributed to an ethos of transparency in decision making, as the minutes of the meeting, along with all other committee minutes are made available to the public via the CCG’s website and form part of Governing Body business, a meeting which is held in public.

In summary, I believe that the CCG has progressed considerable in its organisational development, but I also recognise that the organisation needs to continually review its own effectiveness in relation to its governance arrangements so that decisions are always clear, transparent and in line with the principles of the NHS Constitution.

**Scope of Responsibility**

As Accountable Officer, I have responsibility for leading this review of our governance systems and processes and for maintaining a sound system of internal control that supports the achievement of the Clinical Commissioning Group’s (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 the CCG Accountable Officer Appointment Letter.

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

Wirral CCG commits to continue to improve health & reduce disease by working with patients, public and partners, tackling health inequalities and helping people to take care of themselves. Every GP Practice on Wirral is a member of the CCG and each practice is also a member of the local consortium of which there are 3;

- Wirral GP Commissioning Consortium
- Wirral Health Commissioning Consortium
- Wirral Alliance Commissioning Consortium

The 3 consortia work together under a single Governing Body which sets the overall plans for commissioning and has the ultimate responsibility for delivering our duties.

To fulfil my role as Accountable Officer, I have:

- continued to review and realign the responsibilities of the Chief Officers of Consortia’s, Chief Financial Officer, GP Chairs and Heads of Service.
b) chaired a weekly Operational Group meeting that, although not a formal committee of the Governing Body, provides an opportunity for clinicians and senior managers to oversee the transformational and corporate agenda facing the CCG

c) with Governing Body members, overseen the introduction of a Quality, Performance and Finance Committee to provide greater assurance to the Governing Body

d) refined the Integrated Performance Report and in particular the key elements to be scrutinised by the Governing Body and Quality, Performance & Finance Committee, in order to seek assurance. The assurance process describes how assurance is contained within the Risk Management Strategy & Policy.

In addition to the Risk Management Strategy & Policy, I have considered the wider objectives of the CCG which requires effective partnership working across the wider health economy and beyond.

I have processes in place to ensure that I and / or my senior management team has good working arrangements with our partner organisations which include:

a) representation on the Local Safeguarding Boards for Children and Adults

b) regular meetings and between the CCG and

   i. Clinical Commissioning Groups in our area,
   ii. Wirral University Teaching Hospital NHS Foundation Trust
   iii. Cheshire & Wirral Partnership NHS Foundation Trust
   iv. Wirral Community NHS Trust
   v. Cheshire & Merseyside Commissioning Support Unit
   vi. NHS England
   vii. GP Providers
   viii. Local Authority
   ix. Healthwatch

c) attendance at the local Chairs and Chief Executives’ Forum and regular meetings with Chief Executives and senior managers from:

   i. Wirral University Teaching Hospital NHS Foundation Trust
   ii. NHS England
   iii. Cheshire & Wirral Partnership NHS Foundation Trust
   iv. Cheshire & Merseyside Commissioning Support Unit
   v. Wirral Community NHS Trust
   vi. Local Authority

**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.

**The CCG Governance Framework**

The National Health Service Act 2006 (as amended) at paragraph 14L(2)(b) states: *The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.*
The CCG’s governance framework provides assurance from service areas to the Governing Body through its embedded committee structure, which is described below.

**Governing Body**

The Governing Body has met formally on a monthly basis, using an annual work programme process to help it plan its agenda and communication to the senior management team and the CCG’s committees, sub-committees and groups of the assurance it requires throughout the year.

The Governing Body retains authority to approve key strategic documents, business plans and financial plans on behalf of the CCG.

The Governing Body comprises of

- Chair
- Chief Clinical Officer
- Chief Financial Officer
- Consortium GP Chairs (x3)
- Consortium GP Executives (x4)
- Consortium Chief Officers (x3) *
- Secondary Care Doctor
- Head of Quality & Performance (Corporate Nurse)
- Head of Corporate Affairs *
- Lay Member (Audit and Governance)
- Lay Member (Patient Champion)
- Director of Public Health*
- Director of Social Services*

* Members are non-voting members

At an overall level, responsibility for governance is held by the Governing Body. The Governing Body is accountable for ensuring that the right culture, systems and procedures are in place to enable appropriate governance, including establishing committees of the Committee as required. The Governing Body has retained responsibility for its Scheme of Reservation and Delegation and through this, and approving the terms of reference for Board reporting committees, maintain overall responsibility for the statutory functions of the CCG and has clarified the information it requires to be assured that all functions are appropriately discharged.

The Governing Body has had regular and structured informal sessions, held alongside main Governing Body, meetings in areas such as the assurance framework and corporate risk register.

Committee Structure – The formal committees of the Governing Body have been designed to provide assurance on delivery of the CCG’s strategic aims and objectives. An outline of the CCG’s committee structure can be found below.

**Audit Committee**

The Audit Committee has met on a quarterly basis and has an annual work programme. Formal minutes were produced and an action log maintained of open and closed actions. Its formal minutes were provided to the Governing Body Committee.

This Committee is chaired by the Lay Member (who leads on governance and audit). It makes arrangements for its meetings to be regularly attended by the Chief Financial Officer, Lay Advisors, other members of the senior management team and the CCG’s internal (Mersey Internal Audit Agency) and external auditors (Grant Thornton Auditors).
Its role is to review, on behalf of the Governing Body:

- the effectiveness of the processes in place to manage and oversee the systems necessary for integrated governance, risk management, internal control (i.e. financial management).
- to ensure it is satisfied that the same level of scrutiny and independent audit over controls and assurances is applied to the risks to all strategic objectives, be they clinical, financial or operational.

As part of an integrated committee structure, the Audit Committee is pivotal in advising the Governing Body on the effectiveness of the system of internal control. Any significant internal control issues would be reported to the Governing Body via the Audit Committee. The Audit Committee is informed by reports on the CCG’s systems and processes prepared by both internal and external auditors.

- During 2013/14 reports received by the committee included:
  - Assurance Framework and Corporate Risk Register reports
  - Business of other committees and review of their inter relationships
  - Counter Fraud reports
  - External audit progress report
  - Financial related reports including agreement of final accounts timetable and plan
  - Information Governance update reports
  - Clinical audit progress reports

Remuneration Committee

This Committee met 3 times in 2013/14 and provided minutes and assurance to the Governing Body.

The Committee is chaired by the Lay Member (who leads on governance and audit) and its membership comprises of two Lay Advisors, Governing Body Registered Nurse and the Chair of the Governing Body. Its role is to oversee and agree the remuneration and Terms of Service of the Chief Clinical Officer, the Chair, Consortia Chairs and the Chief Financial Officer, together with any staff employed by the CCG whose terms of service are not covered by national agreements. It provides advice to the Governing Body on a range of employment issues for all staff i.e. pensions, car schemes and termination of employment. The committee is established in accordance with NHS Wirral CCG’s Constitution, standing orders and Scheme of delegation.

Quality, Performance & Finance Committee

During 2013/14 this Committee met monthly, had an annual work programme, produced formal minutes and maintained an action log of open and closed actions. Its formal minutes were provided to the Governing Body.

This Committee is chaired by the Chair of the CCG and its membership comprises of:

- Chair
- Chief Clinical Officer
- Chief Financial Officer
- Head of Quality & Performance
- Chief Officers – Consortia
- Lay Member (Patient Champion)
- Lay Member (Audit & Governance)
- Corporate Support Officers (x2)
This Committee provides the Board with assurance that the committee monitors the financial, quality, contractual and commissioning performance of the CCG against its relevant objective’s and targets to assure the governance body of overall compliance with its statutory & regulatory obligations.

During 2013/14 reports received by the committee included:

- Financial and Activity Information
- Performance against Targets / Objectives
- Contract Monitoring meetings
- Patient experience including complaints, PALs enquiries, MP letters, FOI requests
- Workforce matters relating to sickness / turnover / disciplinary

Its role also includes:

- To report to the Governing Body on quality, governance, performance monitoring, financial and workforce issues and establish appropriate links with other committees
- Receive assurance that the CCG meets all its relevant obligations with regards to the quality of commissioned services including patient experience and infection control
- Review the CCG annual finance plan for incorporation with the operational plan
- Oversee and review the performance of all contracts and service level agreements commissioned by the CCG
- Review the outcomes and action plans as associated with all serious incidents to ensure learning is shared across the CCG and its commissioned services
- Receive regular information governance reports and toolkit compliance updates
- Receive assurance that the relevant standards in relation to safeguarding children and adults are being complied with and that the risks associated with those identified and controlled
- Receive assurance that relevant standards are in place relating to equality and human rights
- Receive regular reports on areas of risk via the risk management process (risk register) and assurance framework process
- Review all exception reports relating to the quality of the patient experience including Freedom of Information requests, complaints and PALS enquiries

Approvals Committee

During 2013/14 this committee met 5 times, had an annual work programme, produced formal minutes and maintained an action log of open and closed actions. Its formal minutes were provided to the Governing Body together with an assurance report.

This Committee is chaired by the Lay Member (who leads on governance and audit) and its membership comprises of Lay Member (Patient Champion), Chief Financial Officer, Head of Quality & Performance (Corporate Nurse), Consortia Chief Officers and Director of Public Health. This Committee provides the Governing Body with assurance that national and local standards are being met.

The Approvals membership has been strengthened by the addition of 2 of the Lay Advisors from the Audit Committee as a way of deepening its skills base and independence.

Its role also includes scrutinising and approving with or without conditions and/or reject commissioning decisions where a potential conflict of interest has been identified for the GP membership of the CCG Governing Body or Consortia Boards. This provides assurance that the CCG are able to demonstrate to its stakeholders that all of its commissioning decisions are made selflessly, fairly, transparently and with independent scrutiny.
During 2013/14 reports received by the committee include:

- Admissions Prevention Service – GP Visiting
- Wirral Locally Enhanced Services
- Wirral Prescribing Incentive Scheme
- Practice Commissioning and Audit
- Conflicts of Interest Policy
- Wirral GP Commissioning Consortium Care Home Scheme
- Demand Management Pilot
- mHealth COPD Support Service
- Care Home Support Service
- Practice Invest to Save Proposals
- Managing High Quality Referrals in GP Practice
- Wirral Health Commissioning Consortium Paediatric Asthma Education Programme
- Primary Care Extended Access

Wirral Health Commissioning Consortia (WHCC) Executive Board

The WHCC Executive Board Committee works under delegated authority from the Wirral CCG Governing Body. It is therefore bound by the principles outlined in the CCG Constitution and functions in accordance with the Wirral CCG Scheme of Reservation & Delegation (SORD).

The responsibilities delegated to the WHCC Executive Board from the CCG Governing Body includes the following:

- Secondary Care
- PBR/cost per case tertiary
- Prescribing
- Community Services
- Clinical Engagement
- Patient Engagement
- Primary Care Local Enhanced Services
- Training and Development
- Consortium Workforce and Operating Costs
- Consortium Investments and Service Developments
- Deployment of local incentive schemes to manage freed-up resources
- Primary Care Mental Health
- Primary Care End of Life Care
- Primary Care Cancer Care

The WHCC Executive Board Committee takes corporate responsibility for all consortium activities. All members of the committee have the responsibility to ensure that constituent practices are informed and engaged about consortium and CCG developments and plans. WHCC Executive Board meetings are held in public on a monthly basis.

The WHCC Executive Board Committee comprises the following members:

Voting members
- Chair
- Chief Officer
- GP Executive Members (X5)
- Practice Manager Representative
Members in Attendance

- WHCC Finance Lead
- WHCC Executive Assistant

The Chair, Chief Officer and 2 of the 5 elected GP Executive Members sit as members of the NHS Wirral CCG Governing Body to ensure effective 2-way communications between the Governing Body and its sub-committee. The remaining 3 GP Executive Board members undertake roles as leads for clusters of WHCC GP Practices. This promotes strong communication links between the member practices, the WHCC Executive Board and ultimately the Wirral CCG Governing Body itself.

WHCC’s work programme is based on the non-recurrent resource allocated to it by the Governing Body and is set in line with Wirral CCG’s strategic objectives. The Consortium has a Business Development Committee which utilises the expertise of its clinical and patient members to develop locally commissioned services to meet the needs of its population as identified in the Joint Strategic Needs Assessment (JSNA).

Patient involvement is further strengthened through the WHCC Patient Forum which directly involved representatives from member practices in the commissioning activities of the consortium; commitment to meaningful patient involvement is further exemplified through the full voting membership status of the patient members of the Executive Board.

The Consortium has commissioned a number of innovative schemes including services to reduce unnecessary admission to hospital such as the A2H service and the peer review of referrals, up skilling and education programmes in areas such as dermatology, MSK, COPD and diabetes, telehealth and telecare schemes, as well as more general schemes such as improving general practice proactive support for individuals in care homes.

All of this investment is monitored and reviewed through the WHCC Executive Board structure described above with learning’s shared across the consortia and CCG informally, through the CCG Operations Group, and formally through the standing agenda item relating to consortia on the Governing Body Board agenda.

Wirral Alliance Commissioning Consortia (WACC) Executive Board

The WACC Executive Board Committee works under delegated authority from the Wirral CCG Governing Body. It is therefore bound by the principles outlined in the CCG Constitution and functions in accordance with the Wirral CCG Scheme of Reservation & Delegation (SORD).

The responsibilities delegated to the WACC Executive Board from the CCG Governing Body include the following:

- Secondary Care
- PBR/cost per case tertiary
- Prescribing
- Community Services
- Clinical Engagement
- Patient Engagement
- Primary Care Local Enhanced Services
- Training and Development
- Consortium Workforce and Operating Costs
• Consortium Investments and Service Developments
• Deployment of local incentive schemes to manage freed-up resources
• Primary Care Mental Health
• Primary Care End of Life Care
• Primary Care Cancer Care

The WACC Executive Board Committee takes corporate responsibility for all consortium activities. All members of the committee have the responsibility to ensure that constituent practices are informed and engaged about consortium and CCG developments and plans. WACC Executive Board meetings are held in public on a monthly basis.

The WACC Executive Board Committee comprises the following members:

Voting members
• Chair
• Chief Officer
• GP Executive Members (X6)
• Practice Manager Representative
• Practice Nurse Representative
• Chair Patient Group

Members in Attendance
• WACC Finance Link
• WACC Business Intelligence Link
• Public Health Wirral Link
• WACC Executive Assistant

The Chair and Chief Officer sit as members of the NHS Wirral CCG Governing Body to ensure effective 2-way communications between the Governing Body and its sub-committee. This promotes strong communication links between the member practices, the WACC Executive Board and ultimately the Wirral CCG Governing Body itself.

WACC’s work programme is based on the non-recurrent resource allocated to it by the Governing Body and is set in line with Wirral CCG’s strategic objectives. The Consortium has a Clinical Working Group to review and recommend to WACC Executive Board on its clinical commissioning work areas, to develop locally commissioned services to meet the needs of its population as identified in the Joint Strategic Needs Assessment (JSNA).

Patient involvement is sought through the WACC Patient Engagement Group which directly involved representatives from all member practices in the commissioning activities of the consortium; commitment to meaningful patient involvement is further exemplified through the full voting membership status of the patient member of the Executive Board.

The Consortium has commissioned a number of innovative schemes including services to reduce unnecessary admission to hospital such as the A2H service; COPD Specialist Nurse service; Diabetes Specialist Nurse service; Mental Health support service to patients with long-term conditions; Care Home Assessment & Review Service (CHARS) now being adopted by Wirral Adult Social Services as part of contractual requirements with Care Homes on Wirral as well as more general schemes such as Osteopathy, Acupuncture, Joint Injection service and Healthcare Assistants for long-term conditions based within member practices.

All of this investment is monitored and reviewed through the WACC Executive Board structure described above with learning shared across all consortia and CCG informally, through the CCG Operations Group, and formally through the standing agenda item relating to consortia on the Governing Body Board agenda.
Wirral GP Commissioning Consortia (WGPCC) Executive Board

The Consortia Executive Boards have continued to discharge the responsibilities delegated by the Governing Body to the Consortia, namely:

- Secondary Care
- PBR/cost per case tertiary
- Prescribing
- Community Services
- Clinical Engagement
- Patient Engagement
- Primary Care Local Enhanced Services
- Training and Development
- Consortium Workforce and Operating Costs
- Consortium Investments and Service Developments
- Deployment of local incentive schemes to manage freed-up resources
- Primary Care Mental Health
- Primary Care End of Life Care
- Primary Care Cancer Care

The WGPCC Executive Board comprises the following members:

- Chair
- Chief Officer
- Executive GP (x6)
- Lay representative (x2)
- Practice Manager representative
- The Consortium Finance lead also attends as a co-opted member

The Board has met in public on a monthly basis throughout the year, and monitors the performance of the Consortium against its delegated budget, its patient engagement priorities, and also against its agreed commissioning plan.

The WGPCC Executive Board members have been elected by the WGPCC member practices and represent the interests of the practice members. Any key decisions relating to the composition of the Consortium or relating to practice membership must be ratified by the WGPCC Practices Members Forum, which comprises membership from each of the Consortium Member Practices.

WGPCC discharges its responsibilities relating to patient engagement through its Patient Council structure; the Patient Council has met on a bi-monthly basis and provides a forum for patient representatives from each of the Member practices to come together to support the Consortium in its commissioning decisions, and represent the views of the WGPCC registered patient population. The Patient Council feeds into a Patient Council Executive Board, which is a subcommittee of the WGPCC Executive Board, and ensures effective two-way communication between the clinical leaders and patient representatives.

Practice member engagement has been further supported through the two other key meetings within the WGPCC structure – the GP Forum and Practice Manager Forum. These groups have met on a six-weekly basis and have continued to provide a forum for clinical engagement and practice manager support.

Attendance at Governing Body and Committees
As Accountable Officer, I am assured that both the Governing Body and its Sub-Committees have reviewed their performance and effectiveness during 2013/14, through self-assessment and annual reports.

<table>
<thead>
<tr>
<th>Board/Committee</th>
<th>Average Attendance of Members %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governing Body Committee</td>
<td>82%</td>
</tr>
<tr>
<td>Audit Committee</td>
<td>91%</td>
</tr>
<tr>
<td>Remuneration Committee</td>
<td>91%</td>
</tr>
<tr>
<td>Quality, Performance &amp; Finance Committee</td>
<td>69%</td>
</tr>
<tr>
<td>Approvals Committee</td>
<td>74%</td>
</tr>
<tr>
<td>Wirral Health Commissioning Consortia Board</td>
<td>85%</td>
</tr>
<tr>
<td>Wirral Alliance Commissioning Consortia Board</td>
<td>75%</td>
</tr>
<tr>
<td>Wirral GP Commissioning Consortia Board</td>
<td>74%</td>
</tr>
</tbody>
</table>

The above committee structure supports the CCG’s approach to Integrated Governance which is defined as ‘systems, processes and behaviours by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations’. The CCG is committed to ensuring its continued high performance through robust systems and processes. The CCG works continuously to deliver high quality safe care and to minimise risk and improve quality at all levels and across all services in the organisation.

A breakdown of individual attendance at the Remuneration Committee is detailed below, as per the Remuneration Report:

<table>
<thead>
<tr>
<th>Member</th>
<th>Meeting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18&lt;sup&gt;th&lt;/sup&gt; April 2013</td>
</tr>
<tr>
<td>James Kay (Chair)</td>
<td>Attended</td>
</tr>
<tr>
<td>Dr Phil Jennings</td>
<td>Attended</td>
</tr>
<tr>
<td>Dr Andrew Smethurst</td>
<td>Attended</td>
</tr>
<tr>
<td>Simon Wagener</td>
<td>Apologies</td>
</tr>
</tbody>
</table>
The CCG Risk Management Framework

As Accountable Officer, I have overall responsibility for risk management within the CCG and this is discharged through agreed delegation to the Senior Management team which is documented within the CCG’s Risk Management Strategy & Policy and identified below:

<table>
<thead>
<tr>
<th>Lead Officer</th>
<th>Risk Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Financial Officer, Mark Bakewell</td>
<td>Financial Information Governance Senior Information Risk Owner</td>
</tr>
<tr>
<td>Head of Corporate Affairs, Paul Edwards</td>
<td>Complaints, MP letters and Litigation Business Continuity Communications and Engagement Freedom of Information Requests</td>
</tr>
<tr>
<td>Head of Quality &amp; Performance (Executive Nurse), Lorna Quigley</td>
<td>Safeguarding Clinical and Non Clinical Risk Management Health, Safety and Fire Clinical Effectiveness Quality</td>
</tr>
<tr>
<td>Chief Officer – Wirral Alliance Commissioning Consortium – Iain Stewart</td>
<td>Contract lead for Personal Health Budgets and Continuing Healthcare Engagement with patients registered with practices within the consortium</td>
</tr>
<tr>
<td>Chief Officer – Wirral Health Commissioning Consortium – Andrew Cooper</td>
<td>Contract lead for Wirral Community NHS Trust Engagement with patients registered with practices within the consortium</td>
</tr>
<tr>
<td>Chief Officer – Wirral GP Commissioning Consortium – Christine Campbell</td>
<td>Contract lead for Cheshire &amp; Wirral Partnership NHS Foundation Trust Engagement with patients registered with practices within the consortium</td>
</tr>
<tr>
<td>Dr Bennett Quinn</td>
<td>Caldicott Guardian</td>
</tr>
<tr>
<td>Head of Contracting – Rob Nolan</td>
<td>Procurement Emergency Preparedness</td>
</tr>
</tbody>
</table>

The Governing Body reviews and approves its Risk Management Strategy & Policy every two years and the Strategy was reviewed and approved in July 2013.

The key elements of the Risk Management Strategy & Policy include the Governing Body’s commitment to risk management and a statement that identifies the support for employees in providing services that are safe for patients and recognises that risk management is everyone’s business.

The following elements are included:

- the corporate and strategic context for risk management
- the organisational arrangements and responsibilities
- the risk management accountability reporting structure
- the stages of the risk management process
- description of the corporate risk register
- risk matrix

Where risks are identified they are assessed and scored and then entered as part of the Assurance Framework (where there is a risk to the strategic aims of the CCG) or the Corporate Risk Register (which captures other organisational risks). The two are interlinked, whereby significant risks
identified via the Corporate Risk Register are brought to the attention of the Governing Body and may be added to the Assurance Framework. In the case of the Corporate Risk Register and the Assurance Framework, key controls are identified, together with action plans which aim to reduce and manage any identified risks. Any gaps in assurance or control also result in an action plan. This is further explored in the following section.

There is a systematic process for the identification of risk throughout the organisation which is then documented in operational risk registers/corporate risk register/assurance framework. The risk registers are reviewed monthly to ensure risks are being managed effectively in accordance with the Risk Management Strategy & Policy, and are reviewed at the Quality, Performance & Finance Committee and Governing Body.

The risk evaluation model is based on a grading of impact and likelihood. Risks are then scored against impact and likelihood and either managed locally or raised to the strategic corporate risk register/assurance framework, which is reviewed and monitored by the Quality, Performance & Finance Committee and Governing Body. This is maintained by the Head of Corporate Affairs.

The Governing Body receive the assurance framework quarterly and corporate risk register monthly to discuss the strategic and principal risks and controls in place to mitigate the risk. The Governing Body also receive integrated performance reports which provide data in respect of financial, clinical and national targets and objectives. Any areas of risk are then highlighted through the use of a Red, Amber and Green (RAG) rating system.

The following gives guidance as to the actions taken based on the risk assessment and outlines who has authority to act.

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Authority to Act</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Very Low and Low</strong></td>
<td>To be escalated and appropriate actions to be taken by Corporate Support Officers and Service Redesign Managers.</td>
</tr>
<tr>
<td><strong>Moderate risks</strong></td>
<td>To be escalated and appropriate actions to be taken by Commissioning Managers and Senior Finance Managers.</td>
</tr>
<tr>
<td><strong>High risks</strong></td>
<td>To be escalated and appropriate actions to be taken by members of the Governing Body.</td>
</tr>
</tbody>
</table>

The CCG is currently looking at the option of implementing an integrated risk management system which will be used for the reporting of all primary care related incidents from GP’s.

**The CCG Internal Control Framework**

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

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

The CCG’s Audit Committee is provided with detail of the CCG’s approach to internal control via the Risk Management Strategy and Policy that is approved at Governing Body. This ensures the audit committee can take a view on the quality and effectiveness of these processes. It is deemed that, given that the nature of the audit committee is to provide an assurance on CCG systems and processes, this is a sufficient process to ensure internal control processes are robust and of appropriate quality.
Information Governance

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

Information governance risks are assessed using the Information Governance Toolkit. The CCG has a Senior Information Risk Owner (Chief Financial Officer) who reviews all data protection issues in partnership with the Senior Governance Manager, Cheshire & Merseyside Commissioning Support Unit.

The CCG’s Information Governance status is reviewed and monitored by the Quality, Performance & Finance Committee and the Governing Body. This has supported the CCG’s self-assessment of achieving level two against the each of the Information Governance Toolkit requirements. During 2013/14 the CCG achieved 85% compliance against the statutory & mandatory training requirements.

The CCG has not had any lapses in data security for 2013/14, and nothing has been reported to the Information Commissioner.

<table>
<thead>
<tr>
<th>Category</th>
<th>Nature of Incident</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises</td>
<td>0</td>
</tr>
<tr>
<td>II</td>
<td>Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises</td>
<td>0</td>
</tr>
<tr>
<td>III</td>
<td>Insecure disposal of inadequately protected electronic equipment, devices or paper documents</td>
<td>0</td>
</tr>
<tr>
<td>IV</td>
<td>Unauthorised disclosure</td>
<td>0</td>
</tr>
<tr>
<td>V</td>
<td>Other</td>
<td>0</td>
</tr>
</tbody>
</table>

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have established processes and procedures in line with the information governance toolkit.

As above, we have ensured all staff undertake information governance training and have implemented a staff information governance handbook and a specific page on our Intranet to ensure staff are aware of their information governance roles and responsibilities.

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

Pension Obligations

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

**Equality, Diversity & Human Rights Obligations**

Control measures are in place to ensure that all the CCG’s obligations under equality, diversity and human rights legislation are complied with and in line with the CCG’s Equality & Diversity Strategy 2013-2015.

**Sustainable Development Obligations**

The CCG is required to report its progress in delivering against sustainable development indicators.

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

We will ensure the CCG complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

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

**Risk Assessment in relation to Governance, Risk Management & Internal Control**

The Governing Body has overall responsibility for the management of risk which it discharges through the Accountable Officer and members of the Governing Body and senior management team. The management of risk is an integral component of the CCG’s governance committee structure. The risk management systems and processes allow the CCG to deliver a multi-disciplinary approach to risk management. This is underpinned by a clear accountability governance structure.

In addition, the CCG continually re-assesses risk, and identifies and responds to new risks, through, for example, incident reporting, complaints data, claims, risk assessments. The CCG also reviews recommendations from internal and external data, reports and inquiries into other local provider organisations and national guidance to ensure the CCG encompass lessons learnt.

The CCG complies with Local Counter Fraud and Security Management Services Directives, via the Cheshire & Merseyside Commissioning Support Unit.

The CCG reviewed its standing orders, financial instructions and scheme of delegation (corporate governance framework) in March 2013.

To support achievement of the organisational objectives, and in order to fulfil its responsibilities, the Board has developed a management system which allows decisions to be taken in a structured and equitable way. The Risk Management Strategy & Policy is a key component within that management system.

The CCG’s Assurance Framework sets out the strategic and principal risks which could impact on the delivery of the organisations objectives. The strategic risks which have been identified in 2013/14 have included areas such as:

a) The local health economy fails to work together and becomes fragmented

**Summary of key controls / systems the CCG has in place to manage the risk:**

- Joint Strategic Needs Assessment (JSNA) has been developed and refreshed
• Health and Wellbeing Board in place
• Membership of Governing Body includes Public Health, Local Authority & Lay member representation
• Integrated planning processes have been established
• Joint Strategic Commissioning Group established
• Vision 2018 Programme Board formed – a group made up of senior leaders from Health and Social Care Commissioners and Providers

b) Reducing financial resource available across health and social care

**Summary of key controls / systems the CCG has in place to manage the risk:**

• Quality Innovation Productivity Prevention (QIPP) strategy & plans
• Department Adult Social Care (DASS) membership on the CCG Governing Body
• Health and Wellbeing Board
• Quality, Performance & Finance Committee monitoring
• Integrated planning processes
• Joint Strategic Commissioning Group established
• Vision 2018 programme plan

c) CCG fails to understands peoples health experiences due to lack of engagement

**Summary of key controls / systems the CCG has in place to manage the risk:**

• CCG Communications & Engagement Plan
• Consortia patient councils
• Patient Advice & Liaison Service provided by Wired
• Complaints management and monitoring
• Funding for BME workers
• Website feedback mechanisms including CCG contact email address
• Quality, Performance & Finance Committee reporting
• Patient Engagement reports to CCG Governing Body
• Triangulation as part of the Communications, Engagement & Experience group
• Relationship with the Care Quality Commission
• Quality Surveillance Group

d) Raising demand and reducing capacity in a constrained financial environment

**Summary of key controls / systems the CCG has in place to manage the risk:**

• CCG Strategic Plan
• Quality Innovation Productivity Prevention Plan with measurable outcomes targets
• Quality, Performance & Finance Committee monitoring
• Clinical Strategy Group monitoring
• Clinical Leads for Quality Innovation Productivity Prevention work streams
• Indicators of success / failure in demand management and action plans as required.

e) Failure to be proactive with opinion makers

**Summary of key controls / systems the CCG has in place to manage the risk:**

• CCG Communications & Engagement Plan
• Regular communications with local politicians as Councillors, MPs plus regular and open communications with the local media
• Staff and community newsletters from CCG and from Consortia
• Regular briefings of encouragement to the voluntary, community and faith sectors
• Healthwatch and other local community representatives through area forums
• Patient Engagement reports to the CCG Governing Body
• Triangulation as part of Communications, Engagement & Experience Group
• Communications & Engagement staff now in place
• Vision 2018 programme

In the early part of the 2013/14 financial year, there were felt to be a small number of gaps in assurance or control and such areas resulted in an action plans to address the gaps. For example, there was felt to be a lack of sufficient assurance on the CCG’s engagement approach. This led the a number of actions that included the development of a revised Communications and Engagement Strategy, recruitment of staff to support CCG engagement and implementing the recommendations from Mersey Internal Audit Agency’s report on Engagement. As a result, this gap was removed and a similar process was adopted for other gaps in control and assurance.

Review of the Economy, Efficiency and Effectiveness of the Use of Resources

The CCG has a Quality, Performance and Finance Committee which meets monthly and regularly assesses the effective use of resources. It does this by reviewing performance and financial data to ensure this is closely scrutinised by internal staff and lay members. In addition the CCG receives an opinion from the Head of Internal Audit on use of resources and value for money, together additional views via an External Audit opinion.

Review of the Effectiveness of Governance, Risk Management and Internal Control

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

Capacity to Handle Risk

The Quality, Performance and Finance Committee reviews the Corporate Risk Register at every monthly meeting. This includes reviewing action plans to resolve and mitigate risks, adjusting risk scores and learning lessons that can be applied elsewhere. High level risks are reported to the Governing Body and the Risk Register and the Assurance Framework are led by the Head of Corporate Affairs who works with the Governing Body to ensure risks are fully understood and mitigated against. Internally, the CCG promotes a ‘no blame’, open culture where staff are encouraged to report risks and learn from good practice.

Review of Effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the 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. My review is also informed by comments made by the external auditors in their management letter and other reports.

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and risk / governance / quality committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an on-going process designed to:

a) identify and prioritise the risks to the achievement of the policies, aims and objectives of Wirral CCG, and

b) evaluate the likelihood of those risks being realised the impact should they be realised, and to manage them efficiently, effectively and economically

My review is informed in a number of ways. The Head of Internal Audit (Mersey Internal Audit Agency) provides me with an opinion on the overall arrangements for gaining assurance and on the controls reviewed as part of the internal audit work. Further assurance has been received in relation to the Assurance Framework; Board reporting and Risk Management systems and other internal audit reports undertaken.

My review is informed by the Governing Body members and Senior Management Team within the organisation that have responsibility for the development and maintenance of the system of internal control, provide me with assurance. The corporate risk register/assurance framework itself provides me with assurance that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by debate and reports at the Governing Body meetings, Audit Committee, reports from the Quality, Performance & Finance Committee, the Approvals committee, Remuneration committee and from the Consortia Board meetings.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control, by receiving and reviewing detail within the meeting minutes of key groups which promote risk management.

I am aware of the role of the Governing Body in providing active leadership to the CCG within a framework of prudent and effective controls that enable risk to be assessed and managed. I am also aware of the committees other groups and individuals which promote risk management. Details of these committees and their function are outlined above.

Additionally my review has taken account of the following:

Internal Audit – who provide reports to the Audit Committee and full reports to the Chief Financial Officer, Head of Corporate Affairs and Head of Quality & Performance and other Senior Managers as appropriate. Regular meetings are also held between the Chief Financial Officer, Head of Corporate Affairs, Corporate Support Officer and Audit Manager, Mersey Internal Audit Agency.

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

The CCG has had one internal audit reviews during 2013/14 which reported limited assurance; Commissioning Support Unit Contract Management. This highlighted 1 high level recommendation and 3 medium level recommendations which are due for completion by the end of June 2014 and work is currently being undertaken to address the recommendations and actions.

Internal Audit has assigned significant assurance to the following reviews undertaken within 2013/14:

- QIPP / CIP review
- Financial Systems Key Controls
- Partnership Arrangements / Better Care Fund
• Information Governance

The CCG has established a management tracking system for all audit review recommendations and agreed actions, which is monitored on a monthly basis by the Corporate Support Officer and presented to the Audit Committee meetings.

The CCG has received reports from the external auditor and has adopted recommendations made in the reports to improve services and performance.

My review confirms that NHS Wirral Clinical Commissioning Group has a sound system of internal control that supports the achievement of its policies, aims and objectives. The Governing Body is committed to continuous improvement and enhancement of the systems of internal control.

Data Quality

Information to be included

Business Critical Models

Within the CCG 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.

Data Security

We have submitted an excellent level of compliance with the information governance toolkit and have achieving level two against the each of the Information Governance Toolkit requirements.

Discharge of Statutory Functions

During establishment, the arrangements put in place by the CCG and explained within the Corporate Governance Framework were developed with extensive expert external legal input, to ensure compliance with all relevant legislation. That legal advice also informed the matter reserved for Membership Body and Governing Body decision and the scheme of delegation.

In light of the Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated 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 Senior Manager. All consortia have confirmed that their structure provides the necessary capability and capacity to undertake all of the CCG’s statutory duties.

Update on Governance Statement (28th May 2014)

As you will have noticed in the update to the foreword of this annual report, the leadership of NHS Wirral CCG is the subject of a capacity and capabilities review primarily focussing on the roles of the Chair and Chief Clinical Officer (Accountable Officer). This review followed an Extraordinary Governing Body meeting held on 27th May 2014 which acknowledged that the Governing Body could not give assurance to NHS England that it could carry out fully its duties and functions whilst subject to such a capability review. As a result of this decision the Governing Body asked for and was given support from NHS England on a voluntary basis. Support provided by NHS England includes my
appointment as Interim Accountable Officer, during the temporary absence of Dr Mantgani and Dr Jennings.

End Note

As Interim Accountable Officer I recognise that there are significant challenges in delivering locally based services in the coming years. Like many CCG’s there are demographic, economic and qualitative challenges which will need to be reflected within the strategic intentions of the organisation over the next 5 year period. The CCG is working closely with partners across the system to support the delivery of our Plans.

I have listed the significant risks that face the organisation earlier within the Governance Statement and these are underpinned by action plans.

In the preparation of this document I would like to express my personal thanks to the senior management of the CCG and the CCG governing body in demonstrating the maturity of the organisation in seeking the support of NHS England

Name: Jonathan Develing

Role: Interim Accountable Officer

Signature: ………………………………………………………………

Date: …………………………………………………………………
## APPENDIX 1

### BOARD MEMBERS

Current Governing Body Members and Period of Office

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Start Date with Wirral Clinical Commissioning Group</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Phil Jennings</td>
<td>Chair</td>
<td>01/04/2013</td>
<td>Male</td>
</tr>
<tr>
<td>Dr Abhi Mantgani</td>
<td>Chief Clinical Officer</td>
<td>01/04/2013</td>
<td>Male</td>
</tr>
<tr>
<td>Jonathan Develing</td>
<td>Interim Accountable Officer</td>
<td>28/05/2014</td>
<td>Male</td>
</tr>
<tr>
<td>Mark Bakewell</td>
<td>Chief Financial Officer</td>
<td>01/04/2013</td>
<td>Male</td>
</tr>
<tr>
<td>Christine Campbell*</td>
<td>Consortium Chief Officer - Wirral GP Commissioning Consortium</td>
<td>01/04/2013</td>
<td>Female</td>
</tr>
<tr>
<td>Dr John Oates</td>
<td>Consortium GP Chair – Wirral GP Commissioning Consortium</td>
<td>01/04/2013</td>
<td>Male</td>
</tr>
<tr>
<td>Dr Akhtar Ali</td>
<td>Consortium GP Executive – Wirral GP Commissioning Consortium</td>
<td>01/04/2013</td>
<td>Male</td>
</tr>
<tr>
<td>Dr Hannah McKay</td>
<td>Consortium GP Executive – Wirral GP Commissioning Consortium</td>
<td>01/04/2013</td>
<td>Female</td>
</tr>
<tr>
<td>Andrew Cooper*</td>
<td>Consortium Chief Officer - Wirral Health Commissioning Consortium</td>
<td>01/04/2013</td>
<td>Male</td>
</tr>
<tr>
<td>Dr Pete Naylor</td>
<td>Consortium GP Chair – Wirral Health Commissioning Consortium</td>
<td>01/04/2013</td>
<td>Male</td>
</tr>
<tr>
<td>Dr Sue Wells</td>
<td>Consortium GP Executive, Wirral Health Commissioning Consortium</td>
<td>01/04/2013</td>
<td>Female</td>
</tr>
<tr>
<td>Iain Stewart*</td>
<td>Consortium Chief Officer – Wirral Alliance Commissioning Consortium</td>
<td>01/04/2013</td>
<td>Male</td>
</tr>
<tr>
<td>Dr Mark Green</td>
<td>Consortium GP Chair – Wirral Alliance Commissioning Consortium</td>
<td>01/04/2013</td>
<td>Male</td>
</tr>
<tr>
<td>Dr Andrew Smethurst</td>
<td>Secondary Care Doctor</td>
<td>01/04/2013</td>
<td>Male</td>
</tr>
<tr>
<td>Dr David Hywel-Jones</td>
<td>GP Executive</td>
<td>01/04/2013</td>
<td>Male</td>
</tr>
<tr>
<td>Lorna Quigley</td>
<td>Head of Quality &amp; Performance (Corporate Nurse)</td>
<td>01/04/2013</td>
<td>Female</td>
</tr>
<tr>
<td>Paul Edwards*</td>
<td>Head of Corporate Affairs</td>
<td>01/05/2013</td>
<td>Male</td>
</tr>
<tr>
<td>James Kay</td>
<td>Lay Member (Audit &amp; Governance)</td>
<td>01/04/2013</td>
<td>Male</td>
</tr>
<tr>
<td>Simon Wagener</td>
<td>Lay Member (Patient Champion)</td>
<td>01/04/2013</td>
<td>Male</td>
</tr>
<tr>
<td>Fiona Johnstone*</td>
<td>Director of Public Health (Local Authority)</td>
<td>01/04/2013</td>
<td>Female</td>
</tr>
<tr>
<td>Graham Hodkinson*</td>
<td>Director of Social Services (Local Authority)</td>
<td>01/04/2013</td>
<td>Male</td>
</tr>
</tbody>
</table>
Summary Profile of each Governing Body member:

Dr Phil Jennings, Chair

Dr Jennings was born and brought up in the North East of England and has been living in Wirral since 2002. Phil is a graduate of Newcastle University Medical School and began his medical career working in the North East as a Cardiology trainee. After moving to Merseyside, Phil became a GP principal at a West Wirral Group Practice in 2004 and retains his clinical role. Phil became more involved with commissioning and, most crucially, worked for NHS Wirral Primary Care Trust as a Professional Executive Committee member before leading Wirral Clinical Commissioning Group through to its successful authorisation in 2013. Phil’s major current roles include:

- Chairman, Wirral Clinical Commissioning Group
- GP Principal, West Wirral Group Practice

Dr Abhi Mantgani, Chief Clinical Officer

Dr Abhi Mantgani graduated with MBBS from University of Mysore in India. He obtained the qualification of LRCP LRCS LRCPS from Scotland and is a fellow of the Royal College of General Practitioners. He has worked in Ireland and in UK since 1978 and has been a GP in Wirral since 1986. He is the Senior Executive partner of Miriam Primary Care Group that provides a number of primary care services at Miriam Medical Centre in Birkenhead and Earlston Medical Centre in Wallasey. Since 1999, Abhi has had a number of lead management roles in Wirral PCT as the Joint Medical Director and Chair of the Professional Executive Committee. He has led on a number of service redesign initiatives including Cardiovascular, Diabetes, Renal, Diagnostics and IT. He was the Responsible Officer for Appraisal and ensured NHS Wirral achieved 100% uptake for 10 years. His current major roles include

- Chief Clinical Officer (Accountable Officer) for Wirral CCG
- Senior Executive Partner Miriam Primary Care Group

Jonathan Develing, Interim Accountable Officer

Jonathan Develing is currently the Interim Accountable Officer at NHS Wirral Clinical Commissioning Group further to his role of the Regional Director of Operations and Delivery for NHS England. Jonathan’s previous roles have included Director of Commissioning for North Cheshire, Director of Specialised Commissioning for Cheshire and Merseyside and Chief Officer for North of England Specialised Commissioning Group.

Mark Bakewell, Chief Financial Officer

Mark Bakewell is the Chief Financial Officer for NHS Wirral Clinical Commissioning Group (CCG), and has been a member if the Chartered Institute of Global Management Accounts (CGMA) since 2004 and has worked within the NHS since 2000, within a variety of roles across commissioning and provider organisations. Marks role as a member of the Governing Body of the CCG is to provide professional expertise on finance with specific responsibility for financial strategy, financial manager and financial governance of the Clinical Commissioning Group, whilst contributing to the development of a Commissioning Strategy and providing financial leadership to the process of clinical redesign.

Christine Campbell, Consortium Chief Officer - Wirral GP Commissioning Consortium

Christine commenced her NHS career with Wirral Primary Care Trust over 8 years ago.
During this time she has undertaken various roles within primary care contracting, building a sound knowledge of the GP contract, Quality & Outcomes Framework and enhanced services, and also an understanding of the landscape and priorities of the practices that she has supported.
Christine became Deputy Chief Officer for Wirral GP Commissioning Consortium in December 2010 during the transition to GP commissioning, and is now Chief Officer with responsibility for commissioning services on behalf of 26 GP Practices and around 126,000 patients.
Christine is also the Clinical Commissioning Group senior lead for Wirral mental health and learning disability services.

Dr John Oates, Consortium GP Chair – Wirral GP Commissioning Consortium

Dr John Oates went to Medical School in Dundee before returning to Wirral to complete his training as a G.P. He entered the General Practice in 1985 in Bootle before joining his current practice in New Ferry in 1989. He has been a Member of the Royal College General Practitioners since 1986. John was lead GP for Wirral Out of Hours from 2000 to 2013. He has been involved in Practice Based Commissioning since 2006 and has been Chair of Wirral G.P. Commissioning Consortium since 2010.
John has also been a Governor at a Wirral Secondary School for 10 years. He continues to practice as a G.P. three days per week.

Dr Akhtar Ali, Consortium GP Executive – Wirral GP Commissioning Consortium

Dr Ali has been a practicing GP principal since 1989 and has lived and worked on the Wirral since 1991. His wife worked in Arrowe Park Hospital as an orthoptist in the eye department till her retirement last year.
Akhtar is a senior partner in a four doctor family practice in Moreton and has gained experience in general surgery, general medicine, anaesthetics, neurology, neurosurgery, geriatric medicine, paediatrics, gynaecology and obstetrics, ENT surgery and general practice.
Dr Ali is a GP executive member of the Wirral CCG Governing body and GP board member of Wirral GP Commissioning Consortium.

Dr Hannah McKay, Urgent Care Lead GP – Wirral GP Commissioning Consortium

Dr Hannah McKay was born in Liverpool in the old Liverpool Women's hospital but spent the first 18 years of her life living on Wirral. Having attended The University of Birmingham and she worked in a variety of hospital roles across many areas of the country as well as overseas and started her career in General Practice in 2006.
Hannah returned to Wirral in the Autumn of 2007 for family reasons and became a partner at Morton Medical Centre in early 2009. She uses her previously hospital experience to help inform her in her role as Urgent Care need and remains mindful of the needs of the 5 generations of her family that live in Wirral and what their needs will be in the future.

Andrew Cooper, Consortium Chief Officer - Wirral Health Commissioning Consortium

Andrew has worked within the NHS since 1994 when he commenced his nurse training, achieving a first class Bachelor of Nursing degree in 1998 from the University of Liverpool. He has subsequently worked in a number of nursing roles in Liverpool and Wirral, initially as a Staff Nurse and then as a Charge Nurse / Team Leader.
Andrew moved away from clinical nursing to focus on training and development through a Professional Development Nurse role in 2004; he has since held a number of management roles including managing Health Visiting and District Nursing services in Wirral. He has continued to undertake professional development to support these roles, obtaining post-graduate qualifications in management, leadership and quality improvement. Latterly, Andrew was Head of Wallasey locality within Wirral PCT and became Chief Officer for Wirral Health Commissioning Consortium during the NHS reforms in 2011/2012.
Andrew’s current role is responsible for commissioning services for a population of approximately 165,000 patients and involves engaging with the 24 member practices that form Wirral Health Commissioning Consortium. He is also Wirral CCG’s senior contract lead for the Wirral Community Trust contract.

Andrew is currently undertaking a Health Executive Masters in Business Administration (MBA) at Keele University which he hopes to complete in 2015.

Dr Pete Naylor, Consortium GP Chair – Wirral Health Commissioning Consortium

Dr Naylor is a graduate of Sheffield University and moved to Wirral in 1999 to undertake his General Practice training. He has remained at St George’s Medical Centre in Wallasey where he is a partner continuing regular clinical practice. He has been involved in health care management for many years having previously been a Professional Executive Committee Member for Wirral Primary Care Trust. He has been acting as Clinical Lead for the Wirral University Teaching Hospital Contract and supports the Quality agenda which includes Chairing the Serious Incident Review Group. He currently also works as a GP Standing Committee Member for the Diagnostics section of the National Institute for Health and Care Excellence (NICE.). Pete’s major roles include:

- Assistant Clinical Chair, Wirral Clinical Commissioning Group
- Chair, Wirral Health Commissioning Consortium.

Dr Sue Wells, Consortium GP Executive, Wirral Health Commissioning Consortium

Dr Wells started life in the Midlands, graduated from Cambridge University in 1982 and progressed by completion of Vocational Training for General Practice in Chester.

Susan is married with 2 children and moved to Wirral in 1987 to become a GP principal in a GP Practices in West Kirby, where she now continues to work.

In her earlier years as a GP, Susan was involved with activities for the Royal College of General Practitioners in Mersey Faculty and nationally over 9 years. She then developed an interest in educations as a GP Trainer which is still on-going at present.

Susan was elected to the Board of Wirral Health Commissioning Consortium in 2011 and is a Wirral Health Commissioning Consortium GP Executive on the Clinical Commissioning Group Governing Body.

Iain Stewart, Consortium Chief Officer – Wirral Alliance Commissioning Consortium

Iain joined the NHS in 1996 after 15 years in financial services and started working on Wirral in 1999. He gained an honours degree in Technology Management at Liverpool John Moores University in 1998 and has worked with General Practices on Wirral across the full range of NHS policies and initiatives. In 2008 he took a secondment opportunity to help set up Wallasey Health Alliance –a not-for-profit LLP – to focus upon commissioning of NHS patient services. In its first full financial year the Alliance achieved budget efficiencies of over £500,000 which enabled reinvestment into local patient services and was an excellent platform for building knowledge and experience in NHS commissioning which he contributes to the now established NHS Wirral Clinical Commissioning Group and the Wirral Alliance Consortium.

Iain has the following Lead roles on behalf of the CCG: Commissioning of services for Military Veterans and Commissioning of services from the Community, Charity and Faith sector.

Dr Mark Green, Consortium GP Chair – Wirral Alliance Commissioning Consortium

Dr Green is the Chair of Wirral Alliance Commissioning Consortium and a GP partner at St Hilary Group Practice in Wallasey. He is a CCG Governing Body member and also the named GP for Adult Safeguarding as well as the GP Lead for Community Services commissioning.
Dr Andrew Smethurst, Secondary Care Doctor

Dr Smethurst did his Radiology training in Liverpool and has been a Consultant Radiologist at Aintree University Hospital since 1995. Andy's previous roles include Clinical Director for Radiology, Chair of Aintree Medical Staff Committee, Member of Council for the Royal College of Radiologists and Chair of the Radiology Speciality Training and Education Committee. Andy's major current roles include:
- Hospital Doctor on Wirral Clinical Commissioning Group’s Governing Body.
- Cheshire and Merseyside Regional Chairman for the Royal College of Radiologists.
- Consultant Radiologist Aintree University Hospital.

Dr David Hywel-Jones, GP Executive

David was born and brought up in Wrexham, North Wales, attending a Welsh Speaking Secondary School. He attended Liverpool University from 1982-1987, trained on the Wirral and in Liverpool before accepting a partnership at Pensby and Heswall Group practice in 1992. David later became the Senior Partner in April 2013.

Lorna Quigley, Head of Quality & Performance (Corporate Nurse)

Lorna commenced her NHS career 28 years ago whilst training as a Nurse at Walton and Fazakerley Hospitals. Lorna then went on to various other roles within the voluntary sector and NHS within general management, acute hospital trusts, primary care trust and now Wirral Clinical Commissioning Group. Lorna's previous roles have included Assistant Director of Service Development, Lead Nurse and other performance related roles. Lorna's current role at the CCG is Head of Quality and Performance and this involves monitoring activity, performance and quality of services that are commissioned by the CCG against agreed standards, responsibility as Executive Lead for Safeguarding Children and Vulnerable Adults and is also the lead for infection, prevention and control.

Paul Edwards, Head of Corporate Affairs

Paul has worked in the NHS since 1993 in variety of roles, including management positions in Business Development, Primary Care Contacting, Commissioning and clinical services provision. He holds an Honours degree, post graduate qualifications in Health Economics and a Masters in Business Administration. Paul's current role as 'Head of Corporate Affairs' involves leading on all aspects of corporate governance and ensuring that the CCG's business is undertaken to the highest standards of probity and according to statutory and regulatory requirements.

James Kay, Lay Member (Audit & Governance)

James Kay moved to Wirral in 1989 with his private sector company Healthwise to establish the UK’s National Drugs, AIDs and Alcohol Helplines within a new base in Liverpool. James has held various senior management positions in public, private and third sector organisations over the last thirty years. He joined Wirral Primary Care Trust as a Non-Executive Director in 2006 and became the Chairman of the Trust in 2010, until it was abolished as part of the government’s health service reforms. James is currently the Chair of Wirral Clinical Commissioning Groups Audit Committee, Approvals Committee and Remuneration Committee. James is also a Chartered Director, a Fellow of the Chartered Management Institute and of the Institute of Directors.
Simon Wagener, Lay Member (Patient Champion)

Simon’s experience of the care system began when he became the sole care provider for his father following the latter’s major stroke in 1992. This role was to last for 10 years and made him aware of the vital importance of care provision in delivering a good quality of life. Since then he has worked with local voluntary organisations, including WIRED, and completed his NVQ4 in Advice & Guidance in 2007. In 2010 he founded the Carers’ Union, of which he has been Secretary and Chair. Other roles have included:
Co-chair of Wirral Carers Association
Carer rep on the Health & Well Being Overview Scrutiny Committee
Public Governor of Cheshire & Wirral NHS Foundation Trust
He took up the role of Lay Member for Public & Patient Involvement for Wirral CCG in October 2012.

Fiona Johnstone, Director of Public Health (Local Authority)

Fiona Johnstone has been a Director of Public Health since May 2002, coming to post in Wirral at the end of September 2010.
She is responsible for monitoring and improving the health status of local people, advising on strategies to reduce inequalities, identifying health needs, developing programmes to reduce risk and the provision of public health evidence and expertise to support commissioning of services.

She has a particular interest in health inequalities, having conducted one of the first equity audits in the country, as well as considerable experience of working in primary care and Local Authority settings, as well as in the academic sector.

Fiona has worked jointly between the local authority and the NHS on Wirral since September 2010. NHS Reform means that she is now jointly appointed by the local authority and Public Health England.

Graham Hodkinson, Director of Social Services (Local Authority)

Graham was born and educated in Wirral. He moved away in 1990 to pursue a career in Social Work. He moved back to Wirral with his family in 2012 to take on the role of Director of Adult Social Services. He has considerable experience of working at the interface between health and social care in both acute and community focussed services.

Graham has been leading the Transformation of social care and the integration workstream of Vision 2018.
## Register of Interests – Year: 2014/15 (May 2014)

<table>
<thead>
<tr>
<th>Name</th>
<th>Nature of Interest</th>
<th>Details of Relevant Organisation</th>
<th>Effective Date – Commencement of interest</th>
<th>Length of appointment (where applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Akhtar Ali GP Executive</td>
<td>- Senior GP Partner</td>
<td>- Hoylake Road Medical Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mark Bakewell Chief Financial Officer</td>
<td>- Relationship with Chief Officer (Wirral GP Commissioning Consortium)</td>
<td>- Wirral Clinical Commissioning Group – Wirral GP Commissioning Consortium</td>
<td>January 2014</td>
<td></td>
</tr>
<tr>
<td>Christine Campbell Chief Officer (WGPCC)</td>
<td>- Mother is employed as Orthodontic Nurse</td>
<td>- Wirral Hospitals NHS Foundation Trust</td>
<td>April 2012</td>
<td>January 2014</td>
</tr>
<tr>
<td></td>
<td>- Relationship with Chief Financial Officer</td>
<td>- Wirral Clinical Commissioning Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Andrew Cooper Chief Officer (WHCC)</td>
<td>- Wife employee</td>
<td>- Cheshire &amp; Wirral Partnership NHS Foundation Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Parent Governor</td>
<td>- Thingwall Primary School</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Member</td>
<td>- Royden Revolve Rotary Club</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jonathan Develing</td>
<td>- Wife employee</td>
<td>- School Nurse – Wirral University Teaching Hospital NHS Foundation</td>
<td>May 2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Mentor</td>
<td>- Director of ‘Broadcare’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Affiliations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>---------------------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paul Edwards</td>
<td>Head of Corporate Affairs</td>
<td>• Nil return</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Mark Green</td>
<td>Chair (WACC)</td>
<td>• GP Partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graham Hodkinson</td>
<td>Director of Social Services</td>
<td>• St Hilary Brow Group Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr David Hywel-Jones</td>
<td>GP Partner</td>
<td>• Heswall GP Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Wirral Council</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Philip Jennings</td>
<td>Chair</td>
<td>• Heswall &amp; Pensby Group Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Alder Hey Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fiona Johnstone</td>
<td>Director of Public Health</td>
<td>• West Wirral Group Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Somerville Group Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Wirral Community Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>James Kay</td>
<td>Lay Member (Audit &amp; Governance)</td>
<td>• Wirral Council</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vintage Radio Station</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• August 2013</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Dr Abhi Mantgani  
Chief Clinical Officer | • Senior Executive Partner  
• Director  
• Director  
• Senior Partner  
• Member  
• Member | • Miriam Primary Care Group (Miriam & Earlston).  
• Mantgani, Hill & Potts LLP – owns and manages the lease at 1 Earlston Road and the financial management of non-pms work of Miriam Primary Care Group.  
• Laird Associates Ltd – this manages the lease at Seabank Medical Centre old premises, terminating in December 2013.  
• Miriam Medical Centre & Seabank Medical Centre are members of the Peninsula Health LLP and the practices have signed any potential profits to be transferred to the Patient Trust set up to use the resources for patient services. Miriam Primary Care Group has not benefitted from any profits from its membership of Peninsula Health LLP and all profits less taxation provision have been transferred to Peninsula Patient Trust.  
• Prenton Golf Club.  
• Birkenhead Medical Society. | • April 2012  
• April 2012  
• April 2012  
• April 2012  
• 1997 |
| Dr Hannah McKay | • GP practice within Peninsula Group which brings me no financial gain.  
• Member | • Peninsula Group Practice  
• Clinical Strategy Group and Local Medical Committee (no conflict anticipated). |
| Dr Pete Naylor Chair (WHCC) | • Occupational work for the University of Manchester (currently unpaid).  
• Isolated advisory work in a diabetic agent for Bristol-Myers Squibb and Astra Zeneca (27/02/2012).  
• Advisory work under the Chairmanship of Mike Farrar with Astra Zeneca regarding future partnership working with the pharmaceutical industry.  
• Partner  
• Occasional advisory work relating to prescribing for: 'Lead Physician' and 'Gillian Kenny Associates'.  
• National Institute for Health & Care Excellence Standing Group on Diagnostics Advisory Committee.  
• Spouse employed | • ICE Creates | • October 2012  
• St George's Medical Centre. Supplies a local minor surgery service. A Community Ophthalmology Service is also run from the practice under the title 'Wirral Vision'. |
| **Dr John Oates**  
| **Chair (WGPCC)** | **• GP Partner**  
| | • My GP practice, in conjunction with other Wirral Practices is a provider of the Admissions Prevention Service and hosts a Minor Injuries Service for Wirral GPCC.  
| | • My practice hosts audiology, Primary Care Mental Health & physio-therapy for NHS providers.  
| | • My wife is a self-employed counsellor.  
| | • My practice is a member of the Peninsula Health LLP, a provider of services to Wirral CCG.  
| | • Member  
| | **• Wirral Practice (Dr Hawthornthwaites & Partners, New Ferry).**  
| | • Working for Peninsula Health LLP, a provider of Primary Care Mental Health Services to Wirral GPCC.  
| | • British Royal Medical Association, Royal College of General Practitioners and School Governor at St Anselm's College, Birkenhead.  
| **Lorna Quigley**  
| **Head of Quality & Performance** | **• Undertake mentoring of staff on an ad hoc basis.**  
| | • Husband employed.  
| | **• Pharmaceutical industry**  
| | • University Hospital, Aintree  
| | • 2011  
| | • 1985 |
| **Dr Andrew Smethurst (Secondary Care Doctor)** | **• Radiological private practice**  
**• Full-time Consultant Radiologist**  
**• Wife is a Wirral GP**  
**• There are a number of GP’s on the Governing Body who I have known for years (some are friends).**  
**• Member**  
**• Current Regional Chairman** | **• Based at Aintree University Hospital**  
**• Based at Aintree University Hospital**  
**• Marine Lake Medical Practice, West Kirby**  
**• Royal College of Radiologists and British Medical Association.**  
**• Royal College of Radiologists.** |
| **Iain Stewart**  
**Chief Officer (WACC)** | **• CCG Stakeholder Governor**  
**• Spouse is Head of Contracting & Bid Management** | **• Cheshire & Wirral Partnership NHS Foundation Trust**  
**• Wirral University Hospitals NHS Foundation Trust** |
| **Simon Wagener**  
**Lay Member (Patient Champion)** | **• Nil return** |  |
| Dr Sue Wells  
GP Executive (WHCC) | • GP Partner  
• Senior Medical Officer  
• Practice covers intermediate care beds at Hoylake Cottage Hospital  
• Member | • Marine Lake Medical Practice  
• West Kirby Residential School  
• BMA and Fellow RCGP |
NHS Wirral Clinical Commissioning Group

This year: 2013-14
This year ended: 31 March 2014
This year commencing: 1 April 2013
The Primary Statements:

- Statement of Comprehensive Net Expenditure for the year ended 31st March 2014 (SOCNE) 3
- Statement of Financial Position as at 31st March 2014 4
- Statement of Changes in Taxpayers' Equity for the year ended 31st March 2014 (SOCITE) 5
- Statement of Cash Flows for the year ended 31st March 2014 6

Notes to the Accounts

1. Accounting policies 7 - 19
2. Other operating revenue 20
3. Revenue 20
4. Employee benefits and staff numbers 20 - 23
5. Operating expenses 24
6. Better payment practice code 25
7. Income generation activities 25
8. Investment revenue 25
9. Other gains and losses 25
10. Finance costs 25
11. Net gain/(loss) on transfer by absorption 25
12. Operating leases 26
13. Property, plant and equipment 26
14. Intangible non-current assets 26
15. Investment property 26
16. Inventories 26
17. Trade and other receivables 27
18. Other financial assets 27
19. Other current assets 27
20. Cash and cash equivalents 27
21. Non-current assets held for sale 28
22. Analysis of impairments and reversals 28
23. Trade and other payables 28
24. Other financial liabilities 28
25. Other liabilities 28
26. Borrowings 28
27. Private finance initiative, LIFT and other service concession arrangements 28
28. Finance lease obligations 28
29. Finance lease receivables 28
30. Provisions 29
31. Contingencies 29
32. Commitments 29
33. Financial instruments 29 - 30
34. Operating segments 30
35. Pooled budgets 31
36. NHS Lift investments 31
37. Intra-government and other balances 31
38. Related party transactions 32
39. Events after the end of the reporting period 33
40. Losses and special payments 33
41. Third party assets 33
42. Financial performance targets 33
43. Impact of IFRS 33
44. Analysis of charitable reserves 33
## NHS Wirral Clinical Commissioning Group - Annual Accounts 2013-14

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

<table>
<thead>
<tr>
<th>Note</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administration Costs and Programme Expenditure</strong></td>
<td></td>
</tr>
<tr>
<td>Gross employee benefits</td>
<td>4</td>
</tr>
<tr>
<td>Other costs</td>
<td>5</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>2</td>
</tr>
<tr>
<td><strong>Net operating costs before interest</strong></td>
<td></td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>2</td>
</tr>
<tr>
<td>Other (gains)/losses</td>
<td>9</td>
</tr>
<tr>
<td>Finance costs</td>
<td>10</td>
</tr>
<tr>
<td><strong>Net operating costs for the financial year</strong></td>
<td></td>
</tr>
<tr>
<td>Net (gain)/loss on transfers by absorption</td>
<td></td>
</tr>
<tr>
<td><strong>Net operating costs for the financial year including absorption transfers</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Of which:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Administration Costs</strong></td>
<td></td>
</tr>
<tr>
<td>Gross employee benefits</td>
<td>4</td>
</tr>
<tr>
<td>Other costs</td>
<td>5</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>2</td>
</tr>
<tr>
<td><strong>Net administration costs before interest</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Programme Expenditure</strong></td>
<td></td>
</tr>
<tr>
<td>Gross employee benefits</td>
<td>4</td>
</tr>
<tr>
<td>Other costs</td>
<td>5</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>2</td>
</tr>
<tr>
<td><strong>Net programme expenditure before interest</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Other Comprehensive Net Expenditure</strong></td>
<td>2013-14 £000</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of property, plant &amp; equipment</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of intangibles</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of financial assets</td>
<td>-</td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on available for sale financial assets</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on assets held for sale</td>
<td>-</td>
</tr>
<tr>
<td>Net actuarial gain/(loss) on pension schemes</td>
<td>-</td>
</tr>
<tr>
<td>Share of (profit)/loss of associates and joint ventures</td>
<td>-</td>
</tr>
<tr>
<td><strong>Reclassification Adjustments</strong></td>
<td></td>
</tr>
<tr>
<td>On disposal of available for sale financial assets</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total comprehensive net expenditure for the year</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Statement of Financial Position as at

31 March 2014

<table>
<thead>
<tr>
<th>Note</th>
<th>£000</th>
</tr>
</thead>
</table>

**Non-current assets:**
- Property, plant and equipment 13  
- Intangible assets 14  
- Investment property 15  
- Trade and other receivables 17  
- Other financial assets 18  
**Total non-current assets**

**Current assets:**
- Inventories 16  
- Trade and other receivables 17 3,578  
- Other financial assets 18  
- Other current assets 19  
- Cash and cash equivalents 20 21  
**Total current assets** 3,599  

**Total assets** 3,599

**Current liabilities**
- Trade and other payables 23 (26,698)  
- Other financial liabilities 24  
- Other liabilities 25  
- Borrowings 26  
- Provisions 30  
**Total current liabilities** (26,698)

**Total Assets less Current Liabilities** (23,098)

**Non-current liabilities**
- Trade and other payables 23  
- Other financial liabilities 24  
- Other liabilities 25  
- Borrowings 26  
- Provisions 30  
**Total non-current liabilities**

**Total Assets Employed** (23,098)

**Financed by Taxpayers' Equity**  
- General fund SOCITE (23,098)  
- Revaluation reserve  
- Other reserves  
- Charitable Reserves 44  
**Total taxpayers' equity:** (23,098)

The notes on pages 5 to 33 form part of this statement.

The financial statements on pages 1 to 4 were approved by the Governing Body on 3rd June 2014 and signed on its behalf by:

Jon Develing Interim Accountable Officer
### Statement of Changes In Taxpayers Equity for the year ended 31 March 2014

<table>
<thead>
<tr>
<th>Note</th>
<th>General fund</th>
<th>Revaluation reserve</th>
<th>Other reserves</th>
<th>Total reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Changes in taxpayers’ equity for 2013-14</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance at 1 April 2013</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfer of assets and liabilities from closed NHS Bodies as a result of the 1 April 2013 transition</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfer between reserves in respect of assets transferred from closed NHS bodies</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Adjusted CCG balance at 1 April 2013</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Changes in CCG taxpayers’ equity for 2013-14</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>SOCNE (462,427)</td>
<td>-</td>
<td>-</td>
<td>(462,427)</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of property, plant and equipment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of intangible assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of financial assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total revaluations against revaluation reserve</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net gain (loss) on available for sale financial assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net gain (loss) on revaluation of assets held for sale</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net actuarial gain (loss) on pensions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Release of reserves to the Statement of Comprehensive Net Expenditure</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Reclassification adjustment on disposal of available for sale financial</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers by absorption to (from) other bodies</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfer between reserves in respect of assets transferred under absorption</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Reserves eliminated on dissolution</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net Recognised CCG Expenditure for the Financial Year</strong></td>
<td>(462,427)</td>
<td>-</td>
<td>-</td>
<td>(462,427)</td>
</tr>
<tr>
<td>Net funding</td>
<td>439,329</td>
<td>-</td>
<td>-</td>
<td>439,329</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2014</strong></td>
<td>(23,098)</td>
<td>-</td>
<td>-</td>
<td>(23,098)</td>
</tr>
<tr>
<td>Note</td>
<td>£000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>SOCNE (462,427)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other gains (losses) on foreign exchange</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donated assets received credited to revenue but non-cash</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government granted assets received credited to revenue but non-cash</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest paid</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Release of PFI deferred credit</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Increase)/decrease in inventories</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in trade &amp; other receivables</td>
<td>17 (3,578)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Increase)/decrease in other current assets</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in trade &amp; other payables</td>
<td>23 26,698</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase/(decrease) in other current liabilities</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in provisions</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net Cash Outflow from Operating Activities</strong></td>
<td>(439,308)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Cash Flows from Investing Activities** |        |
| Interest received | - |
| (Payments) for property, plant and equipment | - |
| (Payments) for intangible assets | - |
| (Payments) for investments with the Department of Health | - |
| (Payments) for other financial assets | - |
| (Payments) for financial assets (LIFT) | - |
| Proceeds from disposal of assets held for sale: property, plant and equipment | - |
| Proceeds from disposal of assets held for sale: intangible assets | - |
| Proceeds from disposal of investments with the Department of Health | - |
| Proceeds from disposal of other financial assets | - |
| Proceeds from disposal of financial assets (LIFT) | - |
| Loans made in respect of LIFT | - |
| Loans repaid in respect of LIFT | - |
| Rental revenue | - |
| **Net Cash Inflow (Outflow) from Investing Activities** | - |

| **Net Cash Outflow before Financing** | (439,308) |

| **Cash Flows from Financing Activities** |        |
| Net funding received | SOCITE 439,329 |
| Other loans received | - |
| Other loans repaid | - |
| Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT | - |
| Capital grants and other capital receipts | - |
| Capital receipts surrendered | - |
| **Net Cash Inflow from Financing Activities** | 439,329 |

| **Net Increase in Cash & Cash Equivalents** | 20 21 |

| **Cash & Cash Equivalents at the Beginning of the Financial Year** | - |
| Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies | - |
| **Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year** | 21 |
Notes to the financial statements

1 Accounting Policies

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

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

The CCG’s original draft accounts included £13.056 income and expenditure relating to a transactional service for Isle of Man Patients that is administered by Cheshire and Merseyside Commissioning Support Unit using NHS Wirral Clinical Commissioning Group’s ledger. Following discussions with our auditors and NHS England we have concluded that the original accounting treatment was mistaken as the CCG has no responsibility for the Isle of Man transactions. Suitable amendments have been made to the CCG’s account to correct this matter. There is a nil impact to the Clinical Commissioning Group as revenue matches costs incurred. The transactions are now shown net in the Statement of Net Expenditure and balances are excluded from the Statement of Financial Position.

The accounting arrangements for balances transferred from predecessor PCTs (“legacy” balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The impact of the legacy balances accounted for by the CCG is disclosed in note 11 to these financial statements. The CCG’s arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 30.

1.1 Going Concern

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

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 Charitable Funds

From 2013-14, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies’ own returns is removed. Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities’ accounts. NHS Wirral Commissioning Group does not hold any charitable funds.

1.6 Pooled Budgets

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

If the clinical commissioning group is in a “jointly controlled operation”, the clinical commissioning group recognises:
- The assets the clinical commissioning group controls;
- The liabilities the clinical commissioning group incurs;
- The expenses the clinical commissioning group incurs; and,
- The clinical commissioning group’s share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a “jointly controlled assets” arrangement, in addition to the above, the clinical commissioning group recognises:
- The 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.

NHS Wirral Commissioning Group does not have any pooled budget arrangements.
Notes to the financial statements

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 Critical Judgements in Applying Accounting Policies

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

1.7.2 Key Sources of Estimation Uncertainty

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

- Primary Care practice prescribing information is received by the clinical commissioning group approximately 6 weeks following the end of each reporting period. Management have estimated the year-end prescribing expenditure (approx. £9m) based on an analysis of the forecast provided by the Prescription Pricing Division of the NHS Business Services Authority and the Clinical Commissioning Groups internal model. This forecast is based on 11 months actual prescribing data. Analysis of previous year’s data would suggest that there is no reason for this forecast to be materially different to actual year-end prescribing results.

1.8 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The main source of funding for the Clinical Commissioning Group is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the General Fund of the Clinical Commissioning Group. Parliamentary funding is recognised in the financial period in which the cash is received.

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.
Notes to the financial statements

1.9 Employee Benefits

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

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

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

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

1.10 Other Expenses

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

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

1.11 Property, Plant & Equipment

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

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

1.11.2 Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

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

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

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

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

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

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

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

1.11.3 Subsequent Expenditure

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

1.12 Intangible Assets

1.12.1 Recognition

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

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

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

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
Notes to the financial statements

- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 Measurement

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

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

1.13 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated. Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

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

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

1.14 **Donated Assets**

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

1.15 **Government Grants**

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

1.16 **Non-current Assets Held For Sale**

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

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses. The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

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

1.17 **Leases**

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

1.17.1 **The Clinical Commissioning Group as Lessee**

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

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

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

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

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

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

1.18 Private Finance Initiative Transactions

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

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract ‘lifecycle replacement’.

1.18.1 Services Received

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

1.18.2 PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the clinical commissioning group’s approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 PFI Liability

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

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

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

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

1.18.4 Lifecycle Replacement

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

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

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a ‘free’ asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.18.5 Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the clinical commissioning group’s Statement of Financial Position.

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

1.19 Inventories

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

1.20 Cash & Cash Equivalents

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

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

1.21 Provisions

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

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

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

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

The NHS Litigation Authority operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group. As at 31st March 2014, there were no claims outstanding for NHS Wirral Clinical Commissioning Group.

1.23 Non-clinical Risk Pooling

The clinical commissioning group participates in the Liabilities to Third Parties Scheme. This is a risk pooling scheme 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 contribution, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.24 Carbon Reduction Commitment Scheme

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

1.25 Contingencies

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

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

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

1.26 Financial Assets

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

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

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.
1.26.1  **Financial Assets at Fair Value Through Profit and Loss**

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

1.26.2  **Held to Maturity Assets**

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.26.3  **Available For Sale Financial Assets**

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

1.26.4  **Loans & Receivables**

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

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

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

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

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

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

1.27  **Financial Liabilities**

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

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

1.27.1  **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.
Notes to the financial statements

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

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

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

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

1.30 Third Party Assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

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

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

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

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

1.33 Associates

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

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

1.34 Joint Ventures

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

1.35 Joint Operations

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

1.36 Research & Development

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

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

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2013-14</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other revenue</td>
<td>457</td>
<td>42</td>
<td>415</td>
</tr>
<tr>
<td><strong>Total other operating revenue</strong></td>
<td><strong>525</strong></td>
<td><strong>43</strong></td>
<td><strong>482</strong></td>
</tr>
</tbody>
</table>

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.

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

3 Revenue

The clinical commissioning group did not receive any revenue from the rendering of services or sale of goods during the period.

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2013-14</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
</tr>
<tr>
<td>From rendering of services</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>From sale of goods</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>525</strong></td>
<td><strong>43</strong></td>
<td><strong>482</strong></td>
</tr>
</tbody>
</table>

4 Employee benefits and staff numbers

4.1.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2013-14</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>2,203</td>
<td>2,043</td>
<td>160</td>
</tr>
<tr>
<td>Social security costs</td>
<td>168</td>
<td>168</td>
<td>-</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>215</td>
<td>215</td>
<td>-</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td><strong>2,585</strong></td>
<td><strong>2,425</strong></td>
<td><strong>160</strong></td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td><strong>2,585</strong></td>
<td><strong>2,425</strong></td>
<td><strong>160</strong></td>
</tr>
</tbody>
</table>

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.
4.5 Pension costs

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

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

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

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

4.5.1 Full actuarial (funding) valuation

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

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

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

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

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.
Statement of responsibilities of auditors and of audited bodies

Local NHS bodies

March 2014
The Audit Commission’s role is to protect the public purse.

We do this by appointing auditors to a range of local public bodies in England. We set the standards we expect auditors to meet and oversee their work. Our aim is to secure high-quality audits at the best price possible.

We use information from auditors and published data to provide authoritative, evidence-based analysis. This helps local public services to learn from one another and manage the financial challenges they face.

We also compare data across the public sector to identify where services could be open to abuse and help organisations fight fraud.
Introduction

1 The Audit Commission (the Commission) is responsible for appointing auditors and determining their terms of appointment, as well as for preparing a Code of Audit Practice (the Code), which prescribes the way in which auditors are to carry out their functions. The Commission has prepared a Code for the audits of local government bodies and a Code for the audit of local NHS bodies. From time to time, the Commission issues guidance to auditors under section 3(8) of the Audit Commission Act 1998 (the Act) and Paragraph 7(3) of Schedule 1 to the Act. This statement sets out guidance on general responsibilities relevant to audits of NHS bodies and so supports the Code. A separate statement has been prepared for the audit of local government bodies.

2 This statement serves as the formal terms of engagement between the Audit Commission’s appointed auditors and NHS bodies. It summarises where the different responsibilities of auditors and of the audited body begin and end, and what is to be expected of the audited body in certain areas. Throughout this statement, the term ‘audited body’ covers both the directors and senior officers of the body.

3 The responsibilities of auditors are derived from statute (principally the Audit Commission Act 1998) and from the Code. Nothing in this statement is intended to limit or extend those responsibilities. In particular, audited bodies should note that because auditors must not prejudice their independence of the audited body, the role of the appointed auditor does not include providing financial or legal advice or consultancy to the audited body.

4 Auditors may wish to refer to this statement in audit planning documents, annual audit letters, reports and other audit outputs.

Introduction to responsibilities

5 Those responsible for the conduct of public business and for spending public money are accountable for ensuring that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

6 In discharging this accountability, public bodies are responsible for putting in place proper arrangements for the governance of their affairs and the stewardship of the resources at their disposal. They are also required to report on their arrangements in their annual published governance statement.

7 It is the responsibility of the audited body to ensure that proper arrangements are in place, but certain individuals have specific responsibilities. NHS trusts have a unitary board, consisting of a non-executive chairman, non-executive directors and executive directors.

8 Clinical commissioning groups (CCGs) have governing bodies consisting of a chief finance officer, a registered nurse, a secondary care specialist and at least 2 lay members. The chairman and non-executive directors (or in the case of CCGs, the governing body chair and non-executive members) are responsible for monitoring the executive management of the body. In addition, there is a requirement for an audit committee, which contributes independently to the NHS bodies’ overall process for ensuring that an effective internal control and risk management system is maintained. The accountable officer (who is also the chief executive at NHS trusts) is responsible to the CCG members or trust board for the day-to-day management of the organisation and is also responsible to the Department of Health for the proper stewardship of public money and assets.
9 In carrying out their work auditors will:
• plan and manage the audits in a timely, professional and efficient manner;
• plan to complete work within agreed deadlines;
• maintain close liaison with the audited body; and
• provide appropriate and adequate resources and assign responsibilities to staff with the relevant expertise and experience.

10 In meeting their responsibilities, auditors obtain representations from management, both orally and in writing, on specific aspects of the audit.

11 The following paragraphs summarise the specific responsibilities of auditors and of audited bodies in relation to the responsibilities of auditors described in the Code.

Responsibilities in relation to the financial statements

12 The financial statements, which comprise the published accounts of the audited body, are an essential means by which it accounts for its stewardship of the resources at its disposal and its financial performance in the use of those resources. It is the responsibility of the audited body to:
• put in place, and review the effectiveness of its system of internal control, including arrangements to ensure the regularity and lawfulness of transactions;i
• maintain proper accounting records; and
• prepare financial statements that give a true and fair view of the financial position of the body and its expenditure and income and that are in accordance with applicable laws, regulations and accounting policies.

13 The audited body is also responsible for preparing and publishing with its financial statements a governance statement and an annual report, incorporating a remuneration report.ii Audited bodies may also prepare and publish summarised financial statements and are required to prepare summarisation schedules and submit these to the Department of Health to enable it to produce accounts for the whole of the National Health Service.

14 In preparing their financial statements, audited bodies are responsible for:
• preparing realistic plans that include clear targets and achievable timetables for the production of the financial statements;
• assigning responsibilities clearly to staff with the appropriate expertise and experience;
• providing necessary resources to enable delivery of the plan;
• maintaining adequate documentation in support of the financial statements and, at the start of the audit, providing a complete set of working papers that provide an adequate explanation of the entries in those financial statements;
• ensuring that senior management monitors, supervises and reviews work to meet agreed standards and deadlines; and
• ensuring that a senior individual at top management level personally reviews and approves the financial statements before presentation to the auditor.

i The Trust Development Authority (TDA) issues guidance that sets out how accountable officers in NHS trusts review the system of internal control. NHS England issues the equivalent guidance to Clinical Commissioning Groups (CCGs).

ii Chapter 1 of the Manual for Accounts requires health bodies to publish a governance statement with the annual accounts. Chapters 2 and 6 of NHS England’s Annual Reporting Guidance sets out the requirements for the form and content of CCG governance statements.
15 If draft financial statements and working papers of appropriate quality are not available at the agreed start date of the audit, the auditor is unable to meet the planned audit timetable and the start date of the audit will be delayed. The audit fee is calculated on the basis that the draft financial statements, and detailed working papers, are provided to an agreed timetable and are of an acceptable standard. If information is not provided to this timetable, or is provided to an unacceptable standard, the auditor will incur additional costs in carrying out any extra work that is necessary. The Commission will charge an additional fee if the additional work is substantial.

16 In carrying out their responsibilities in relation to the financial statements, auditors will have regard to the concept of materiality.

17 Subject to the concept of materiality, auditors provide reasonable assurance that the financial statements:
   • are free from material misstatement, whether caused by fraud or other irregularity or error;
   • comply with statutory and other applicable requirements; and
   • comply with all relevant requirements for accounting presentation and disclosure.

18 Subject to the concept of materiality, auditors of CCGs also provide reasonable assurance on the regularity of expenditure and income. In carrying out an audit, auditors do not perform detailed tests of all transactions. Therefore the audit process should not be relied upon to disclose all unlawful transactions or events that may have occurred or might occur.

19 Auditors plan and perform their audit on the basis of their assessment of risk. Auditors examine selected transactions and balances on a test basis and assess the significant estimates and judgements made by the audited body in preparing the statements.

20 Auditors evaluate significant financial systems, and the associated internal financial controls, for the purpose of giving their opinion on the financial statements. However, they do not provide assurance to audited bodies on the operational effectiveness of specific systems and controls or their wider system of internal control. Where auditors identify any weaknesses in such systems and controls, they draw them to the attention of the audited body, but they cannot be expected to identify all weaknesses that may exist.

21 Auditors review whether the governance statement has been presented in accordance with relevant requirements and report if it does not meet these requirements or if it is misleading or inconsistent with other information the auditor is aware of. In doing so, auditors take into account the knowledge of the audited body gained through their work in relation to the financial statements and through their work in relation to the body’s arrangements for securing economy, efficiency and effectiveness in the use of its resources. They also have regard to the work of other regulators, to the extent that it is relevant to auditors’ responsibilities. Auditors are not required to consider whether the statement on internal control covers all risks and controls, and auditors are not required to express a formal opinion on the effectiveness of the audited body’s corporate governance procedures or risk and control procedures.

22 Auditors also review for consistency other information that is published by the audited body alongside the financial statements, such as an annual report. If auditors have concerns about the consistency of any such information they will report them to those charged with governance.

23 At the conclusion of the audit of the accounts, auditors give their opinion on the financial statements, including:
• whether they give a true and fair view of the financial position of the audited body and its expenditure and income for the year in question;
• whether they have been prepared properly in accordance with relevant legislation and applicable accounting standards;
• for CCGs, on the regularity of their expenditure and income; and
• whether the part of the remuneration report to be audited has been properly prepared.

Auditors also give their opinion on whether the summarisation schedules at NHS trusts (consolidation templates at CCGs) and, where prepared, summarised financial statements have been properly prepared.

Electronic publication of the financial statements

Where the audited body wishes to publish its financial statements electronically, it is responsible for ensuring that the publication presents accurately the financial statements and the auditor’s report on those financial statements. This responsibility also applies to the presentation of any financial information published in respect of prior periods.

Similarly, where the audited body wishes to distribute electronic copies of the financial statements, and the auditor’s report on those financial statements, to its stakeholders, it is responsible for ensuring that these are presented accurately.

The auditor’s report on the financial statements should not be reproduced or referred to electronically without the auditor’s prior written agreement. This enables the auditor to review the process by which the financial statements to be published electronically are derived from the financial information contained in the manually signed financial statements, check that the proposed electronic version is identical in content with the manually signed financial statements and check that the conversion of the manually signed financial statements into an electronic format has not distorted the overall presentation of the financial information.

The examination of the controls over the electronic publication of audited financial statements is beyond the scope of auditors’ responsibilities in relation to the financial statements the auditor cannot be held responsible for changes made to audited information after the initial publication of the financial statements and the auditor’s report.

Responsibilities in relation to arrangements for securing economy, efficiency and effectiveness in the use of resources

It is the responsibility of the audited body to put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, and to ensure proper stewardship and governance, and regularly to review the adequacy and effectiveness of them. Such corporate performance management and financial management arrangements form a key part of the system of internal control and comprise the arrangements for:
• planning finances effectively to deliver strategic priorities and secure sound financial health;
• having a sound understanding of costs and performance and achieving efficiencies in activities;
• reliable and timely financial reporting that meets the needs of internal users, stakeholders and local people;
commissioning and procuring quality services and supplies that are tailored to local needs and deliver sustainable outcomes and value for money;

producing relevant and reliable data and information to support decision making and manage performance;

promoting and demonstrating the principles and values of good governance;

managing risks and maintaining a sound system of internal control;

making effective use of natural resources;

managing assets effectively to help it deliver strategic priorities and service needs; and

planning, organising and developing the workforce effectively to support the achievement of strategic priorities.

The audited body is responsible for reporting on these arrangements as part of its annual governance statement.

Auditors have a responsibility to satisfy themselves that the audited body has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. In doing so they are required to have regard to criteria specified by the Audit Commission. In meeting this responsibility auditors review and, where appropriate, examine evidence that is relevant to the audited body’s corporate performance management and financial management arrangements.

In planning this work, auditors consider and assess the significant risks of giving a wrong conclusion on the audited body’s arrangements for securing economy, efficiency and effectiveness. The auditor’s assessment of what is significant is a matter of professional judgement and includes consideration of both the quantitative and qualitative aspects of the item or subject matter in question. Auditors discuss their assessment of these risks with the audited body.

When assessing risk auditors consider:

- the relevance and significance of the potential business risks faced by all bodies of a particular type. These are the significant operational and financial risks to the achievement of the audited body’s statutory functions and objectives, which apply to the audited body and are relevant to auditors’ responsibilities under the Code;

- other business risks that apply specifically to individual audited bodies;

- the audited body’s own assessment of the risks it faces; and

- the arrangements put in place by the body to manage and address its risks.

In assessing risks auditors have regard to:

- evidence gained from previous audit work, including the response of the audited body to previous audit work;

- the work of other statutory inspectorates; and

- any other relevant improvement needs.

In reviewing the audited body’s arrangements for securing economy, efficiency and effectiveness in the use of resources, it is not part of auditors’ functions to question the merits of the policies of the audited body, but auditors may examine the arrangements by which policy decisions are reached and consider the effects of the implementation of policy. It is the responsibility of the audited body to decide whether and how to implement any recommendations.

The criteria referred to is published on the Commission’s website.
made by auditors and, in making any recommendations, auditors must avoid giving any perception that they have any role in the decision-making arrangements of the audited body.

35 Auditors do not provide assurance to audited bodies on the operational effectiveness of specific aspects of their arrangements. Neither can they be relied on to have identified every weakness or every opportunity for improvement. Audited bodies should consider auditors’ conclusions and recommendations in their broader operational or other relevant context.

36 In reviewing audited bodies’ arrangements for producing relevant and reliable data and information to support decision making and manage performance, auditors may review the data supporting specific performance information. Audited bodies are responsible for applying appropriate data quality standards, collecting data that is fit for purpose and, where appropriate, conforms to prescribed definitions. Audited bodies are also responsible for satisfying themselves that performance information is reliable and accurate.

37 Where auditors identify significant misstatements or errors in specific performance information or the underlying data, they draw them to the attention of the audited body, but they do not provide assurance to audited bodies on the accuracy or reliability of performance information or the underlying data.

38 Audit work in relation to the audited body’s arrangements to ensure it promotes and demonstrates the principles and values of good governance and does not remove the possibility that breaches of proper standards of financial conduct, or fraud and corruption, have occurred and remained undetected. Neither is it auditors’ responsibility to prevent or detect breaches of proper standards of financial conduct, or fraud and corruption, although they are alert to the possibility and act promptly if grounds for suspicion come to their notice.

39 At the conclusion of the audit auditors report their value for money conclusion on:

- the audited body’s arrangements for securing economy, efficiency and effectiveness in its use of resources; and
- whether significant matters have come to their attention, which prevent them from concluding that the audited body has put in place proper arrangements.

Specific powers and duties of auditors

40 Auditors have specific powers and duties under the Audit Commission Act 1998 (the Act) in relation to matters of legality.

41 Auditors must:

- consider whether to issue a public interest report concerning any matter that comes to the auditor’s attention during the course of the audit, which they judge should be considered by the audited body or brought to public attention (section 8 of the Act); and
- refer a matter to the Secretary of State as soon as they have reason to believe that an audited body has made, or is about to make, decisions involving potentially unlawful expenditure or has taken, or is about to take, potentially unlawful action likely to cause a loss or deficiency (section 19 of the Act).

42 Fees arising in connection with auditors’ exercise of these powers and duties, including costs relating to the appointment of legal or other advisers to the auditors, are borne by the audited body.
Reporting the results of audit work

43 Auditors provide:

- audit planning documents;
- oral and/or written reports or memoranda to officers and, where appropriate, directors on the results of, or matters arising from, specific aspects of auditors’ work;
- a report to those charged with governance, normally submitted to the audit committee, summarising the work of the auditor;
- an audit report, including the auditor’s opinion on the financial statements and a conclusion on whether the audited body has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources;
- a certificate that the audit of the accounts has been completed in accordance with statutory requirements; and
- an annual audit letter addressed to the audited body, which is based on the report to those charged with governance.

44 Audit reports are addressed to officers or directors of the audited body, as appropriate. Auditors do not have responsibilities to officers or directors in their individual capacities or to third parties that choose to place reliance upon the reports from auditors.

45 In addition, the following outputs, the need for which may arise at any point during the audit process, are issued where appropriate:

- a report under section 8 of the Act;
- a referral to the Secretary of State under section 19 of the Act; and
- information to be reported to the Commission in a specified format to enable it to carry out any of its functions or to assist other bodies, such as the Care Quality Commission and the National Audit Office, in carrying out their functions.

46 When considering the action to be taken on audit reports, audited bodies should bear in mind the scope of the audit and responsibilities of auditors, as set out in the Code and as further explained in this statement. Matters raised by auditors are drawn from those that come to their attention during the audit. The audit cannot be relied upon to detect all errors, weaknesses or opportunities for improvements in management arrangements that might exist. Audited bodies should assess auditors’ conclusions and recommendations for their wider implications before deciding whether to accept or implement them.

Ad hoc requests for auditors’ views

47 There may be occasions when audited bodies seek the views of auditors on the legality, accounting treatment or value for money of a transaction before embarking upon it. In such cases, auditors are as helpful as possible, but are precluded from giving a definite view in any case because auditors:

- must not prejudice their independence by being involved in the decision-making processes of the audited body;
- are not financial or legal advisers to the audited body; and
- may not act in any way that might restrict their ability to exercise the special powers conferred upon them by statute.
48 In response to such requests, auditors can offer only an indication as to whether anything in the information available to them at the time of forming a view could cause them to consider exercising the specific powers conferred upon them by statute. Any response from auditors should not be taken as suggesting that the proposed transaction or course of action will be exempt from challenge in future, whether by auditors or others entitled to raise objection to it. It is the responsibility of the audited body to decide whether to embark on any transaction.

Audit of charitable funds

49 This section is relevant to those charities to which the Audit Commission appoints auditors under s43A of the Charities Act 1993.

50 Trustees of charitable funds subject to audit have a duty to prepare financial statements for each financial year which give a true and fair view of:

- the state of the charity’s affairs at the end of the financial year; and
- the incoming resources and the application of those resources by the charity for that period.

51 Trustees must ensure that the financial statements are prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities.

52 It is the duty of the auditor to report to the trustees whether the financial statements give a true and fair view and whether they have been prepared in accordance with the Charities Act 1993 and the Charity (Accounts and Reports) Regulations 2008.

53 Auditors are also required to report immediately to the Charity Commissioners any matter which they have reasonable cause to believe is, or is likely to be, of material significance to the Commissioners’ functions under s8 (general power to institute inquiries) or s18 (power to act for protection of charities) of the 1993 Act. Such matters may relate not only to the activities or affairs of the charity, but also to any institution or body corporate which is connected with the charity.

54 The audit fee is calculated on the basis that detailed working papers, and other specified information, are provided to an agreed timetable. Where audited bodies do not meet agreed timetables and/or provide poor documentation such that additional audit work is necessary, or the audit is delayed, the Commission will charge a higher fee to recover the additional costs incurred.

Grant claims and returns – certification

55 Auditors may be required by the Commission to carry out work to support certification of grants or returns. Auditors carry out this work on an agency basis on behalf of the Commission. A separate statement of responsibilities of grant-paying bodies, authorities, the Audit Commission and appointed auditors covering this work can be found at www.audit-commission.gov.uk

---

i S43A of the Charities Act 1993 prescribes that all English NHS charities shall be subject to an independent examination or audit by a person appointed by the Audit Commission. Charities with a gross income exceeding thresholds set out in section 43(1) of the 1993 Act must be subject to an audit. For all other charities, the Commission can elect whether they should be subject to audit or independent examination. The Commission has decided that all charities not required to have an audit shall be subject to independent examination, unless the trustees elect for an audit. The auditor or examiner appointed must then follow the procedures required under s43(7)(b) of the Charities Act. Where an independent examination is carried out, the responsibilities of the examiner are more limited.
Access to information, data security and confidentiality

56 Auditors have wide-ranging rights of access to documents and information in relation to the audit. Such rights apply not only to documents and information held by the audited body and its directors and staff, including documents held in electronic form, but also to the audited body’s partners and contractors, whether in the public, private or third sectors. Auditors may also require a person holding or accountable for any relevant document to give them such information and explanation as they consider necessary.

57 There are restrictions on the disclosure of information obtained in the course of the audit, subject only to specific exemptions. The Freedom of Information Act 2000 does not apply to the Commission’s appointed auditors, as they have not been designated as public authorities for the purposes of that legislation, although they are subject to the Environmental Information Regulations 2004. Audited bodies wishing to disclose information obtained from an auditor, which is subject to a statutory restriction on its disclosure, must seek the auditor’s consent to that disclosure.

58 Auditors protect the integrity of data relating to audited bodies and individuals either received or obtained during the audit. They ensure that data is held securely and that all reasonable steps are taken to ensure compliance with statutory and other requirements relating to the collection, holding and disclosure of information.
The Audit Findings
for NHS Wirral Clinical Commissioning Group

Year ended 31 March 2014
28 May 2014 – draft for discussion with Governing Body 3 June 2014

Robin Baker
Engagement Lead
T 0161 214 6399
E robin.j.baker@uk.gt.com

Liz Temple-Murray
Manager
T 0161 214 6370
E liz.m.temple-murray@uk.gt.com

Gordon Haworth
Executive
T 0161 214 6385
E gordon.haworth@uk.gt.com
The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed primarily for the purpose of expressing our opinion on the financial statements. Our audit is not designed to test all internal controls or identify all areas of control weakness. However, where, as part of our testing, we identify any control weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose defalcations or other irregularities, or to include all possible improvements in internal control that a more extensive special examination might identify.

We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Executive summary</td>
<td>4</td>
</tr>
<tr>
<td>2. Audit findings</td>
<td>8</td>
</tr>
<tr>
<td>3. Value for Money</td>
<td>19</td>
</tr>
<tr>
<td>4. Fees, non audit services and independence</td>
<td>22</td>
</tr>
<tr>
<td>5. Communication of audit matters</td>
<td>24</td>
</tr>
</tbody>
</table>

**Appendices**

A  Audit opinion
Section 1: Executive summary

01. Executive summary
02. Audit findings
03. Value for Money
04. Fees, non audit services and independence
05. Communication of audit matters
Executive summary

Purpose of this report
This report highlights the key issues affecting the results of Wirral Clinical Commissioning Group (the CCG) and the preparation of the CCG’s financial statements for the year ended 31 March 2014. It is also used to report our audit findings to management and those charged with governance in accordance with the requirements of International Standard on Auditing (UK & Ireland) 260.

Under the Audit Commission’s Code of Audit Practice (the Code) we are required to report whether, in our opinion, the CCG’s financial statements present a true and fair view of the financial position. We are also required to reach a formal conclusion on whether the CCG has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources (the Value for Money conclusion).

Introduction
In the conduct of our audit we have not had to alter or change our planned approach, which we communicated to the Audit Committee in our Audit Plan in March 2014. As we noted in the Audit Plan, the CCG’s principal challenges in this first year of existence were to establish the new commissioning framework ensuring that it had well developed commissioning and contract monitoring arrangements in place which addressed the local healthcare priorities within the financial targets.

At the time of drafting this report (28 May 2014) we have completed a significant amount of our planned audit work. There are still some tests that need to be completed. In particular:
• finalising our testing of primary and secondary healthcare costs;
• review of related party transactions;
• obtaining and reviewing the management letter of representation;
• obtaining and reviewing the service auditor’s report on the Cheshire and Merseyside Commissioning Support Unit;
• finalising work on the VfM conclusion;

• review of the final version of the Annual Report including the Governance Statement and Remuneration Report and the amendments to the financial statements;
• updating our post balance sheet events review, to the date of signing the opinion;
• work on whole of government accounts.

We received the pre-audit Annual Report, financial statements and accompanying working papers on the 23 April at the commencement of our work, in accordance with the national deadline.

Key audit and financial reporting issues

Financial statements opinion

As at 28 May, and subject to the completion of the outstanding work described above, we expect to issue an unqualified opinion on the CCG’s financial statements. Our audit has identified a material error of £13.056m in the financial statements in respect of income and payments on behalf of the Isle of Man Government that the Chief Finance Officer has agreed to amend. The Chief Finance Officer has declined to amend for the £0.483m assets being held by the CCG for the Isle of Man. The Chief Finance Officer has also amended the accounts for the disclosure changes identified during the audit. These are primarily to improve the presentation of the accounts. Therefore, we anticipate being able to issue an unqualified audit opinion by the Department of Health deadline of midday on 6 June 2014.

The CCG’s pre-audit Annual Report and accounts were produced to a satisfactory standard. The finance team worked hard to ensure that the supporting evidence to support figures in the accounts was available to audit on a timely basis.

Further details are set out in section 2 of this report.
Executive summary

Regularity opinion
As well as an opinion on the accounts, we are required to give a regularity opinion on whether expenditure has been incurred ‘as intended by Parliament’. Failure to meet statutory financial targets automatically results in a qualified regularity opinion.

We are pleased to report that, based on our review of the CCG’s expenditure and following the amendment to the accounts, we expect to issue an unqualified regularity opinion.

Remuneration report
We are also required to issue an opinion on the remuneration report and to confirm that it has been properly prepared in accordance with the guidance. At the time of drafting this report we are still in the process of completing our review and testing of the amounts included within the Remuneration Report.

Value for money (VfM)
We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are also required to report any matters that prevent us being satisfied that the audited body has put in place such arrangements. As we described in our Audit Plan the Audit Commission has directed us to undertake a tailored approach to value for money this year, recognising that CCGs are new organisations whose arrangements are developing.

At the time of drafting this report we have completed the bulk of our work in this area but are still reviewing some aspects of the CCG’s arrangements to secure economy, efficiency and effectiveness in its use of resource. As such we are unable to conclude at this time.

Our work so far on Value for Money is set out in section 3 of this report. We will provide an update on the consideration of these matters to the Governing Body meeting on 3 June 2014.

Agreement of Balances and Whole of Government Accounts (WGA)
Our work on the agreement of balances exercise undertaken by NHS England is currently underway.

Controls
Roles and responsibilities
The CCG’s management is responsible for the identification, assessment, management and monitoring of risk, and for developing, operating and monitoring the system of internal control. Our audit is not designed to test all internal controls or identify all areas of control weakness. However, where, as part of our testing, we identify any control weaknesses, we report these to the CCG.

Our work to date has not identified any significant control weaknesses which we wish to highlight for your attention. Further details are provided within section 2 of this report.
The way forward
Matters arising from the financial statements audit and our review of the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources have been discussed with the Chief Finance Officer. We also discussed and presented our report to the Audit Committee at its meeting on the 28 May 2014. We ask the Governing Body to note the contents of this report and will update members on 3 June 2014.

Acknowledgement
We would like to take this opportunity to record our appreciation for the assistance provided by the finance team and other staff during our audit.

Grant Thornton UK LLP
28 May 2014
Section 2: Audit findings

01. Executive summary
02. Audit findings
03. Value for Money
04. Fees, non audit services and independence
05. Communication of audit matters
Audit findings against significant risks

"Significant risks often relate to significant non-routine transactions and judgmental matters. Non-routine transactions are transactions that are unusual, either due to size or nature, and that therefore occur infrequently. Judgmental matters may include the development of accounting estimates for which there is significant measurement uncertainty" (ISA 315).

In this section we detail our response to the significant risks of material misstatement which we identified in the Audit Plan. As we noted in our plan, there are two presumed significant risks which are applicable to all audits under auditing standards.

<table>
<thead>
<tr>
<th>Risks identified in our audit plan</th>
<th>Work completed</th>
<th>Assurance gained and issues arising</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improper revenue recognition</td>
<td>The CCG's main source of funding is its allocation from NHS England. This is known as its Revenue Resource Limit (RRL). An independent confirmation of the RRL has been obtained centrally from NHS England on behalf of all CCG auditors, and has been provided to us by the Audit Commission. We anticipated that other operating income would not be significant and planned to rebut the risk of fraud. Excluding the £13.056m Isle of Man transaction, the risk of revenue recognition fraud on the remaining £0.354m is low and can be rebutted. As part of our audit work we have completed; • review and testing of revenue recognition policies; • testing of material revenue streams; and • review of unusual significant transactions.</td>
<td>Our audit work identified £13.056m improperly recognised in the accounts. The income is received from the Isle of Man Government in respect of their arrangement with the CSU who provide financial services for payments to provider trusts in England. The CSU is purely using the CCGs ledger for the transactions. Revenue matches costs and so there is a nil overall impact on the financial position. However following the discussions with a number of stakeholders it has been determined that the accounting treatment is incorrect and the Chief Finance Officer has agreed to amend. More detail is at the 'Adjusted misstatements' table below. The revenue resource limit obtained of £467,159k agrees to the figure disclosed in the notes to the accounts.</td>
</tr>
<tr>
<td>2. Management override of controls</td>
<td>As part of our audit work we have completed; • review of entity controls; • review of accounting estimates, judgements and decisions made by management; • testing of journals entries; and • review of accounting estimates, judgements and decisions made by management.</td>
<td>Our audit work has not identified any evidence of management override of controls. In particular the findings of our review of journal controls and testing of journal entries has not identified any significant issues. We set out later in this section of the report our work and findings on key accounting estimates and judgements.</td>
</tr>
</tbody>
</table>
Audit findings against other risks

In this section we detail our response to the other risks of material misstatement which we identified in the Audit Plan. Recommendations, together with management responses are attached at appendix A.

<table>
<thead>
<tr>
<th>Transaction cycle</th>
<th>Description of risk</th>
<th>Work completed</th>
<th>Assurance gained &amp; issues arising</th>
</tr>
</thead>
</table>
| **Secondary Care Commissioning** | Contract costs not accounted for properly. Activity variation adjustments to expenditures not correct. | We have undertaken the following work in relation to this risk:  
• Documentation and identification of the process and key controls in the CCG's secondary healthcare commissioning cycle.  
• Walked through a sample item to confirm our understanding.  
• Sample tested to ensure expenditure and accruals are in accordance with the contract and the provider statements.  
• Reviewed agreement of balances and ensured the year end position reflects the agreements.  
• Reviewed variations to contracts at year end have been appropriately authorised  
• Considered the service auditor's report in respect of relevant controls operated by SBS. | At the time of drafting our report our audit work has not identified any significant issues in relation to the risks identified.  
The agreement of balances exercise undertaken by NHS England is currently underway.  
The service auditor's report in respect of controls operated by SBS does not require us to draw any issues to your attention.  
Difficulty was experienced in obtaining all required information to support our testing of major secondary healthcare contracts. In particular, contract information had to be drawn from disparate sources and it was not always possible to see contract values, contract signatures and contract terms within the same consolidated document. This appears to reflect the nature of the contracting process itself, and the split of responsibilities between CCG and CSU. As noted above, we are satisfied that we have now gained sufficient evidence from our testing that our audit work has not identified any significant issues. |
| **Secondary Care Commissioning** | Invoiced non-contract costs not accounted for properly | We have undertaken the following work in relation to this risk:  
• Documentation and identification of the process and key controls in the CCG's secondary healthcare commissioning cycle.  
• Walked through a sample item to confirm our understanding.  
• Carried out substantive testing of invoices to ensure activity has occurred, value is correct and accounted for in the correct accounting period. | At the time of drafting our report our audit work has not identified any significant issues in relation to the risks identified. |
# Accounting policies, Estimates & Judgements

In this section we report on our consideration of accounting policies, in particular revenue recognition policies, and key estimates and judgements made and included with the CCG’s financial statements.

<table>
<thead>
<tr>
<th>Accounting area</th>
<th>Summary of policy</th>
<th>Comments</th>
<th>Assessment</th>
</tr>
</thead>
</table>
| Revenue recognition              | • The CCG has adopted the standard revenue recognition policies for the NHS as set out in the manual for accounts.  
• The policies for revenue recognition are set out in section 1.8 of the CCG’s accounting policies. | • The CCG’s revenue recognition policies are in accordance with the requirements of the Annual Reporting Guidance except for the arrangement with the Isle of Man Government. The Chief Finance Officer has agreed to amend accounting entries and the relevant notes. | 🟤         |
| Judgements and estimates         | • Key estimates and judgements include  
  – Prescribing expenditure.  
  – Provisions in particular for continuing health care. | • The CCG’s accounting policies and judgements are reasonable and appropriately disclosed.  
• Our work on Prescribing expenditure is underway. We are expecting independent confirmation from the NHS Business Services Authority (BSA) to provide further evidence on the reasonableness of the accrual.  
• NHS England has recommended that the accounting policies should disclose that NHS England is accounting for certain continuing healthcare liabilities on behalf of the CCG. The disclosure in section 1 of the accounting policies in the CCG’s accounts needs to be amended to provide details of the disclosure. | 🟢         |
| Other accounting policies        | • The CCG has adopted the standard accounting policies for the NHS as set out in the manual for accounts. | • Policies not applicable to the CCG have not been deleted e.g. donated assets and foreign exchange. Although this is not in line with the Manual for Accounts the NHSE Annual Reporting Guidance encourages CCGs not to edit. | 🟢         |
# Misclassifications & disclosure changes

The table below provides details of misclassification and disclosure changes identified during the audit which have been made in the final set of financial statements.

<table>
<thead>
<tr>
<th>Adjustment type</th>
<th>Value £'000</th>
<th>Account balance</th>
<th>Impact on the financial statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Disclosure</td>
<td>n/a</td>
<td>Note 42</td>
<td>Financial Performance Targets: Revenue resource used on specified matters has been disclosed as the value of programme expenditure. The CCG has no specified matters by definition, and the disclosure should read zero. The target and performance figures for the surplus should be included in the note. CCGs are awaiting further guidance from NHSE regarding the duty of 'Expenditure not to exceed income'.</td>
</tr>
<tr>
<td>2 Classification</td>
<td>46</td>
<td>Note 5</td>
<td>Internal audit fees of £38k have been incorrectly classified as 'other auditor's remuneration' which should only record additional fees charged by Grant Thornton. This has been re-analysed against general supplies &amp; services.</td>
</tr>
<tr>
<td>3 Disclosure</td>
<td>n/a</td>
<td>Note 1.7.2</td>
<td>Accounting policies identify the prescribing accrual as a key estimate but do not disclose the value of the estimate made, as required by the MfA 4.8 and IAS 1</td>
</tr>
<tr>
<td>4 Disclosure</td>
<td>n/a</td>
<td>Note 1.1</td>
<td>The accounting policy on 'Going Concern' has reference to the issue of a s19 report (implying that there has been an identified breach of financial duty). Note 42 confirms that all statutory targets were met.</td>
</tr>
<tr>
<td>5 Disclosure</td>
<td>n/a</td>
<td>Note 4.3</td>
<td>The CCG has just received the sickness absence figures and can now include them in the note. However, the CCG is querying the DH figures as they are not consistent with the CCG/CSU HR figures. If the CCG decides to use the DH figures the note needs to disclose that they are only for a period of 9 months.</td>
</tr>
<tr>
<td>6 Disclosure</td>
<td>n/a</td>
<td>n/a</td>
<td>A number of rounding differences were identified in the financial statements which have been highlighted in the consistency statement.</td>
</tr>
</tbody>
</table>
## Misclassifications & disclosure changes (continued)

The table below provides details of misclassification and disclosure changes identified during the audit which have been made in the final set of financial statements.

<table>
<thead>
<tr>
<th>Adjustment type</th>
<th>Value</th>
<th>Account balance</th>
<th>Impact on the financial statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Classification</td>
<td>n/a</td>
<td>Governance Statement in the Annual Report</td>
<td>The Governance Statement does not make explicit reference to compliance with the UK Corporate Governance Code and this is not in line with the ARG template. NHSE has recommended to the CCG that it revises the Governance Statement to include this explicit reference in line with the ARG. Bodies that choose voluntarily to adopt the UK Corporate Governance Code are subject to a much longer audit report in accordance with ISA 700 (revised). In its response to the consultation on the ARG NHSE clearly indicates that it does not intend that CCGs report voluntary compliance with the UK corporate governance code thereby triggering the long form audit report. We recommend the CCG includes a more appropriate form of words that will not.</td>
</tr>
<tr>
<td>8 Disclosure</td>
<td>n/a</td>
<td>Remuneration Report in the Annual Report</td>
<td>Some inaccuracy noted in the salary bandings at Appendix 5. The Chair and Chief Accountable Officer bandings, disclosed as 110-115k should read 105-110k. Head of Corporate affairs banding, disclosed as 65-70k should be 60-65k. J Oates banding, disclosed as 65-70k, should be 50-55k. P Naylor banding, disclosed as 80-85k, should be 70-75k.</td>
</tr>
<tr>
<td>9 Disclosure</td>
<td>n/a</td>
<td>Remuneration Report in the Annual Report</td>
<td>The banding requirements at Appendix 6 (Pension benefits) have not been universally adhered to. The total accrued pension and lump sum at 60 as at 31/03/13 have been disclosed in bands of £2.5k rather than the prescribed bands of £5k.</td>
</tr>
<tr>
<td>10 Disclosure</td>
<td>n/a</td>
<td>Remuneration Report in the Annual Report</td>
<td>Not all information provided by NHSPA has been reflected at Appendix 6 (Pension Benefits) due to the timing of available information. The information for Chief Officer M Green was originally omitted from the table.</td>
</tr>
<tr>
<td>11 Disclosure</td>
<td>n/a</td>
<td>Remuneration Report in the Annual Report</td>
<td>Calculation of Median Pay Multiple: The client had incorrectly calculated the median salary in calculating the value of the multiple. As a result, the disclosed value of 3.16 should read 3.52.</td>
</tr>
</tbody>
</table>
Adjusted misstatements

A number of adjustments to the draft accounts have been identified during the audit process. We are required to report all misstatements to those charged with governance, whether or not the accounts have been adjusted by management. The table below summarises the adjustments arising from the audit which have been processed by management.

**Impact of adjusted misstatements**

All adjusted misstatements are set out in detail below along with the impact on the key statements and the reported surplus.

<table>
<thead>
<tr>
<th>Detail</th>
<th>Statement of Comprehensive Net Expenditure £'000</th>
<th>Statement of Financial Position £'000</th>
<th>Impact on surplus £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Wirral CCG's pre audit Statement of Comprehensive Net Expenditure (SoCNE) shows £13.41m 'Other operating revenue' and at note 3 this is broken down to show that £13.056m relates to a transactional service for Isle of Man Patients that is administered by Cheshire and Merseyside Commissioning Support Unit using NHS Wirral Clinical Commissioning Group’s ledger. There is an equal charge to expenditure that is highlighted in note 5 which means that there is a nil impact to the Clinical Commissioning Group as revenue matches costs incurred. The transactions are in respect of around 60 providers in England that the Isle of Man Government commissions healthcare from. NHS Wirral CCG’s ledger has been used to record the transactions and our view is that this is not the appropriate accounting treatment. The Chief Finance Officer has agreed amend the accounts in respect of the income and expenditure element but not for the balances included within the Statement of Financial Position (see unadjusted error page 16). Going forward the CCG should consider whether it continues using its ledger for transactions under this arrangement.</td>
<td>0</td>
<td>Not adjusted – see page 16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>However, the CCG has agreed end of year balances on both income/expenditure and receivables/payables with the 60 providers that the Isle of Man commissions healthcare from. Amending for the error will result in a mismatch of income and expenditure balances at the consolidation level. The CCG has agreed with NHSE that it will clearly explain the reasons for this. We will report accordingly to the NAO as part of our work on WGA.</td>
</tr>
</tbody>
</table>
A number of adjustments to the draft accounts have been identified during the audit process. We are required to report all misstatements to those charged with governance, whether or not the accounts have been adjusted by management. The table below summarises the adjustments arising from the audit which have been processed by management.

**Impact of adjusted misstatements**

All adjusted misstatements are set out in detail below along with the impact on the key statements and the reported surplus.

### Table: Adjusted misstatements (continued)

<table>
<thead>
<tr>
<th>Detail</th>
<th>Statement of Comprehensive Net Expenditure £'000</th>
<th>Statement of Financial Position £'000</th>
<th>Impact on surplus £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Note 5 - Operating expenses: External audit fees are understated by £11k. The audit fee of £99k in note 5 to the accounts should be £110k (calculated as the original fee of £99k plus VAT of 20% less the Audit Commission rebate of £9k. The rebate had previously been recognised as revenue as opposed to net of expenditure. The VAT of £19k is the overall impact on the SoCNE and the CCGs surplus position. The fee is also disclosed on an incorrect line.</td>
<td>19</td>
<td>19</td>
<td></td>
</tr>
</tbody>
</table>

**Overall impact**

|                                                                 | 19 | 19 | 19 |
Audit findings

Unadjusted misstatements

The table below provides details of adjustments identified during the audit but which have not been made within the final set of financial statements. The Audit Committee is required to approve management’s proposed treatment of all items recorded within the table below:

<table>
<thead>
<tr>
<th>Detail</th>
<th>Statement of Comprehensive Net Expenditure £’000</th>
<th>Statement of Financial Position £’000</th>
<th>Chief Finance Officer’s reason for not adjusting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>483</td>
<td>Whilst the treatment / adjustment of the Isle of Man (CCG / CSU) ‘net’ accounting principle has been agreed in line with the Manual For Accounts, the unintended consequence of this relates to the treatment of current assets (trade and other receivables) within the CCG’s Statement of Financial Position for the 2013-14 financial year. The same ‘net’ treatment methodology is unable to be applied within the financial statements and would also have a consequential impact upon the wider cash management principles within NHS system. The CCG does not operate separate cash allocations for CCG / (IOM/CSU) hosting issues in terms of its target balance of holding a cash balance of less than £250k at the end of the financial years). Outstanding Payment as at the end of the financial year has subsequently been received by the CCG in April 2014 and is no longer an outstanding receivable item.</td>
</tr>
</tbody>
</table>

In the Statement of Financial Position (SoFP) and at note 23 ‘trade and other receivables’ is under stated by £483k. At note 34 the arrangement is represented as an operating segment, showing that £483k of liabilities in the SoFP are in respect of the Isle of Man – this is incorrect as they are assets. Our view is that these assets should not be recognised in the CCG’s SoFP nor shown as an operating segment and the accounts should be adjusted accordingly.

Overall impact 0 483
Internal controls

The purpose of an audit is to express an opinion on the financial statements.

Our audit included consideration of internal controls relevant to the preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control. Any matters reported here are limited to those deficiencies that we have identified during the course of our audit and that we have concluded are of sufficient importance to merit being reported to you in accordance with auditing standards.

At this stage we have not had sight of the service auditor's report on the Cheshire and Merseyside Commissioning Support Unit. As the CCG uses the CSU to provide financial services we will need to review the service auditor's report to highlight any significant issues for your attention.

As part of our planned programme of work, our information system specialist team undertook a high level review of the general IT control environment at the CCG. This was undertaken as part of the review of the internal controls system. We are pleased to report that no significant issues arose from our work. We identified a small number of areas where the CCG's existing IT arrangements can be developed and have reported these to management.

Our audit of journals has identified a number of control deficiencies that whilst not significant merit your attention:

- the national system allows users to self-authorise journals rather than incorporating a supervisory check;
- the CCG was not able to provide supporting information for one of the journals that we tested;
- general ledger authority limits were not consistent with policies;
- senior financial reporting personnel have the ability to make journal entries.

The CCG should discuss controls with the CSU to ensure that they are robust and that supporting information is retained.
Other communication requirements

We set out below details of other matters which we, as auditors, are required by auditing standards to communicate to those charged with governance.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Matters in relation to fraud</td>
<td>We have previously discussed the risk of fraud with management and the Audit Committee. We have not been made aware of any incidents in the period and no other issues have been identified during the course of our audit procedures.</td>
</tr>
<tr>
<td>2. Matters in relation to related parties</td>
<td>Management appear to have adopted a reasonable approach to identifying and disclosing transactions with related parties in the CCG's accounts. Our detailed review is still in progress.</td>
</tr>
<tr>
<td>3. Matters in relation to laws and regulations</td>
<td>We are not aware of any significant incidences of non-compliance with relevant laws and regulations.</td>
</tr>
<tr>
<td>4. Written representations</td>
<td>A letter of representation will be requested from the CCG.</td>
</tr>
<tr>
<td>5. Disclosures</td>
<td>Our review found no material omissions in the financial statements. The Chief Finance Officer has amended the accounts for the disclosure changes identified during the audit. These are primarily to improve the presentation of the accounts and to take into account on-going guidance from the NHSE.</td>
</tr>
<tr>
<td>6. Going Concern</td>
<td>We have considered management's assessment that it is appropriate to prepare the CCG's accounts on a going concern basis. Our work has identified no significant issues in relation to going concern.</td>
</tr>
</tbody>
</table>
Section 3: Value for Money

01. Executive summary
02. Audit findings
03. Value for Money
04. Fees, non audit services and independence
05. Communication of audit matters
Value for Money

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

In recognition that CCGs are new organisations, the Audit Commission has not specified reporting criteria for the VfM conclusion at CCGs for 2013/14. We will give our VfM conclusion on the basis of:
• reviewing the CCG's annual governance statement
• reviewing the results of the work of relevant regulatory bodies or inspectorates (including NHS England reviews) to consider whether there is any impact on our responsibilities
• undertaking other local risk based work as required, or any work mandated by the Audit Commission, including a review of the arrangements for the Better Care Fund.

In order to identify whether any local work is required, we carried out a risk assessment against the following key themes identified in the Audit Commission’s guidance:
• leadership
• commissioning
• financial planning and management
• data quality
• external relationships.

Key findings
Our work on the VfM conclusion is still in progress. The main matters to note from our VfM conclusion work to date are:

Leadership
• NHS Wirral CCG was authorised to become a statutory body on 1st April 2013 with seven conditions. Once additional evidence was provided (including the CCG’s associated Commissioning, QIPP and Organisational Development Plan) the conditions were removed and the CCG became fully authorised in the early part of the financial year. The CCG has reviewed and updated its Constitution and scheme of reservation and delegation and recruited lay members to provide specific skills and expertise. The CCG has set out its strategic direction which has been agreed at the Governing Body and with the Membership. It has clear processes for internal control and compliance is reported to appropriate committees including the Audit Committee. The Assurance Framework is well established and review of evidence is completed on an on-going basis. Financial and performance reports are considered on a regular basis by the Performance and Finance Committee and Governing Body.

Commissioning
• The CCG is working with the Director of Public Health and the Health and Wellbeing Board of Wirral Council to further develop the Joint Strategic Needs Assessment, the Better Care Fund plan and the Health & Wellbeing Strategy 2013-2016 for Wirral. The CCG has developed its commissioning plan, two year operational plan and the five year strategic plan taking into account available resources and identifying the savings that will need to be made. Performance against contract providers shows a year end over performance of around £8.5m as at the end of March, mainly due to over performance at Wirral University Teaching Hospitals NHS Foundation Trust (WUTH). This over performance was funded mainly from reserves. The Quality, Performance & Finance Committee and Governing Body receive regular contract performance information.
Value for Money

Financial planning and management
- Wirral CCG has submitted its five year financial plan which proposes setting surplus budgets for the next five years but recognises the challenges of meeting savings targets over the period. The CCG achieved its QIPP target of £3m in 2013/14 and is planning to find £18.5m savings in 2014/15. The bulk of the QIPP savings were achieved from the provider efficiencies built into tariffs. Effective financial management arrangements are in place.

Data Quality
- The CCG’s systems have developed to provide support for monitoring clinical performance, quality and finance. The CCG has submitted its completed assessment for Information Governance toolkit with significant assurance for Level 2 self-assessment.

External relationships
- The CCG works with partners through membership of key groups and involvement in the development of and consultation on plans as noted above. In addition to membership of the Wirral Council Health and Wellbeing Board the CCG contributes to other key groups including local community and voluntary groups. The CCG has regular meetings with providers, monthly meetings and quarterly check point meetings with NHSE and monthly SLA meetings with the CSU.

Better Care Fund
- As part of our VfM work we considered the work carried out by the CCG in partnership with Wirral Council and others to agree and develop the Wirral Better Care Fund (BCF) Plan. Previously known as the Integration Transformation Fund, the BCF was established to ensure a transformation in integrated health and social care through a single pooled budget to support health and social care services to work more closely together in local areas.
- The national conditions have been considered and addressed. The plan was jointly agreed and the CCG and partners achieved the timescale and assurance requirements set by NHS England. The plan includes protection for social care services and 7 day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends. The plan also supports better data sharing between health and social care and a joint approach to assessments and care planning to ensure that where funding is used for integrated packages of care, there is an accountable professional. The CCG needs to ensure that providers are involved to agree the consequential impact of changes in the acute sector.

Overall VfM conclusion
Our work is still in progress and we will give our overall VfM conclusion when it is complete.
Section 4: Fees, non audit services and independence
Fees, non audit services and independence

We confirm below our final fees charged for the audit and confirm there were no fees for the provision of non audit services.

<table>
<thead>
<tr>
<th>Fees</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG audit</td>
<td>£99,000</td>
</tr>
<tr>
<td>Total audit fees (excluding VAT)</td>
<td>£99,000</td>
</tr>
</tbody>
</table>

In March 2014 the Audit Commission approved a rebate in the planned fee of £9k.

The audit fee of £99k in note 5 to the accounts should be £110k (calculated as the original fee of £99k plus VAT of 20% less the Audit Commission rebate of £9k).

Other auditor's remuneration in note 5 to the accounts shows charges of £38k in respect of internal audit services but these have not been provided by Grant Thornton.

Fees for other services

<table>
<thead>
<tr>
<th>Service</th>
<th>Fees £</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Nil</td>
</tr>
</tbody>
</table>

Independence and ethics

We confirm that there are no significant facts or matters that impact on our independence as auditors that we are required or wish to draw to your attention. We have complied with the Auditing Practices Board's Ethical Standards and therefore we confirm that we are independent and are able to express an objective opinion on the financial statements.

We confirm that we have implemented policies and procedures to meet the requirements of the Auditing Practices Board's Ethical Standards.
Section 5: Communication of audit matters
Communication of audit matters to those charged with governance

International Standards on Auditing (ISA) 260, as well as other ISAs, prescribe matters which we are required to communicate with those charged with governance, and which we set out in the table opposite.

The Audit Plan outlined our audit strategy and plan to deliver the audit, while this Audit Findings report presents the key issues and other matters arising from the audit, together with an explanation as to how these have been resolved.

Respective responsibilities

The Audit Findings Report has been prepared in the context of the Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission (www.audit-commission.gov.uk).

We have been appointed as the CCG's independent external auditors by the Audit Commission, the body responsible for appointing external auditors to local public bodies in England. As external auditors, we have a broad remit covering finance and governance matters.

Our annual work programme is set in accordance with the Code of Audit Practice ('the Code') issued by the Audit Commission and includes nationally prescribed and locally determined work. Our work considers the CCG's key risks when reaching our conclusions under the Code.

It is the responsibility of the CCG to ensure that proper arrangements are in place for the conduct of its business, and that public money is safeguarded and properly accounted for. We have considered how the CCG is fulfilling these responsibilities.

Our communication plan

<table>
<thead>
<tr>
<th>Our communication plan</th>
<th>Audit Plan</th>
<th>Audit Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respective responsibilities of auditor and management/those charged with governance</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>(updated April 2014 - attached)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overview of the planned scope and timing of the audit. Form, timing and expected</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>general content of communications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Views about the qualitative aspects of the entity's accounting and financial</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>reporting practices, significant matters and issues arising during the audit and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>written representations that have been sought</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirmation of independence and objectivity</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>A statement that we have complied with relevant ethical requirements regarding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>independence, relationships and other matters which might be thought to bear on</td>
<td></td>
<td></td>
</tr>
<tr>
<td>independence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Details of non-audit work performed by Grant Thornton UK LLP and network firms,</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>together with fees charged</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Details of safeguards applied to threats to independence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Material weaknesses in internal control identified during the audit</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Identification or suspicion of fraud involving management and/or others which results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in material misstatement of the financial statements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with laws and regulations</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Expected unmodified auditor's report</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Uncorrected misstatements</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Significant matters arising in connection with related parties</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Significant matters in relation to going concern</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>
Appendices
Appendix A: Audit opinion

We anticipate we will provide the CCG with an unqualified audit opinion. An illustration of our audit report is shown below.
## Consortium Update Reports
### Governing Body June 2014

<table>
<thead>
<tr>
<th>Agenda Item:</th>
<th>Reference:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report to:</td>
<td>NHS Wirral CCG Governing Body</td>
</tr>
<tr>
<td></td>
<td>Meeting Date: 3rd June 2014</td>
</tr>
</tbody>
</table>

**Lead Officer:** Andrew Cooper, Chief Officer, Wirral Health Commissioning Consortium  
Dr Pete Naylor, Chair – Wirral Health Commissioning Consortium

**Contributors:**

**Governance:**
- Link to Commissioning Strategy
- Link to current governing body Objectives

**Summary:**
Each Consortium has been asked to prepare a report on a quarterly basis detailing how it has contributed to key CCG priorities, including:
- patient engagement
- contribution to QIPP (Quality, Innovation, Productivity and Prevention)
- GP Practice education and training

This will demonstrate to patients, stakeholders and the public the range of innovative activities taking place at a Consortium level, and the contribution made to the overall CCG Strategic plan and priorities through the Consortia and their member practices.

This report describes activities undertaken by Wirral Health Commissioning Consortium since the last submission in January 2014.

**Recommendation:**
- To Approve
- To Note

**Next Steps:**
The Consortia will prepare this report and submit to the Governing Body on a quarterly basis.
This section is an assessment of the **impact** of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.

<table>
<thead>
<tr>
<th>What are the implications for the following (please state if not applicable):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial</strong></td>
<td>The report highlights the way in which the Consortia have contributed towards the QIPP requirement.</td>
</tr>
<tr>
<td><strong>Value For Money</strong></td>
<td>When developing any scheme or investment plan, each Consortium will need to demonstrate value for money.</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td>In addition to reports submitted to the Governing Body, the Consortia meet on a weekly basis regarding any engagement or service development activities, to reduce the risk of duplication, and to highlight any risks to the Consortia or organisation as early as possible.</td>
</tr>
<tr>
<td><strong>Legal</strong></td>
<td>Each Consortium will work closely with the Commissioning Support Unit when developing any proposals to ensure that they are compliant with their legal obligations, for instance in relation to procurement, or decommissioning any service.</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td>The Consortia have described how they have supported the primary care workforce to deliver the CCG agenda through education and training.</td>
</tr>
<tr>
<td><strong>Equality &amp; Human Rights</strong></td>
<td>Each Consortium will be expected to demonstrate that any commissioning and engagement work undertaken is in line with Equality and Human Rights requirements, and many of the projects undertaken by the Consortia aim specifically to target and reduce health inequalities.</td>
</tr>
<tr>
<td><strong>Patient and Public Involvement (PPI)</strong></td>
<td>The Consortia outline the patient and public engagement activities that they have undertaken.</td>
</tr>
<tr>
<td><strong>Partnership Working</strong></td>
<td>The service redesign and innovation projects undertaken by the Consortia are the product of partnership working with a range of stakeholders, including primary and secondary care clinicians, patients and the public.</td>
</tr>
<tr>
<td><strong>Performance Indicators</strong></td>
<td>Performance Indicators will be developed by the Consortia in relation to specific schemes, so that their impact and merit in future investment may be evaluated.</td>
</tr>
</tbody>
</table>

Do you agree that this document can be published on the website? (If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions)  

[✓]
This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path ie. other papers that are directly related to the current paper under discussion.

<table>
<thead>
<tr>
<th>Report Name</th>
<th>Reference</th>
<th>Submitted to</th>
<th>Date</th>
<th>Brief Summary of Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHCC Consortium Report – Quarter 1</td>
<td>GB 13-14/027</td>
<td>Governing Body</td>
<td>August 2013</td>
<td>Noted</td>
</tr>
<tr>
<td>WHCC Consortium Report – Quarter 2</td>
<td>GB 13-14/039</td>
<td>Governing Body</td>
<td>October 2013</td>
<td>Noted</td>
</tr>
</tbody>
</table>

**Private Business**

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

If a report is deemed to be for private business, please note that the tick in the box, indicating whether it can be published on the website, must be changed to a x.

If you require any additional information please contact the Lead Director/Officer.
Consortium Name: WIRRAL HEALTH COMMISSIONING CONSORTIUM (WHCC)

Since Quarter 3, WHCC patients have been involved in the following commissioning activity:

- Involvement in the regional review of Procedures of Low Clinical Priority
- Involvement in the end of year reviews for consortium schemes
- Involvement in the Vision 2018 programme including discussion regarding workstreams and feedback regarding logos and straplines
- Contribution to the Wirral Clinical Commissioning Group (CCG) Vision 2018 engagement events
- Involvement in discussions relating to Joint Strategic Needs Assessment (JSNA) and priorities for WHCC

In addition, WHCC has also been involved with the following engagement activity:

- Lead General Practitioner (GP) for communication and the Patient Forum Chair have developed and agreed content for the patient section of the WHCC website
- Collation of responses from WHCC patient questionnaire – results as per annual report presented at May Governing Body
| **Promoting Choice** | WHCC undertakes a rolling programme of practice visits. Patient engagement and involvement is a standing agenda item and each practice is requested to outline how they are engaging with their patient population. Since quarter 3, WHCC has launched its high quality referral scheme which primarily promotes GP peer review of all potential referrals. The purpose of the scheme is to ascertain that the suggested intervention provides the most appropriate patient pathway or whether there is an alternative option that the patient could be offered to promote choice. During the final quarter of 2013/2014 through the contract negotiation process, it was agreed that WHCC would come in line with the other consortia and offer choice of provider for podiatry and physiotherapy services (through the Any Qualified Provider (AQP) route). In addition, WHCC has also launched its diabetes intermediate service. This offers an alternative for patients requiring diabetes care and includes a service for individuals that are unable to leave their home, a face-to-face intermediate service and an advice service for professionals. |
| **Promoting Innovation** | The scheme to improve identification of Chronic Obstructive Pulmonary Disease (COPD) exacerbations using telehealth monitoring has been launched with the 5 initial pilot practices. The scheme aims to identify whether telehealth inhaler devices can be used to predict exacerbation of COPD in a timelier manner than traditional methods. The scheme has received positive feedback from both Patient Forum and GP practices and will be rolled out to all 24 WHCC practices following the initial pilot phase. |
| **Contribution to QIPP** | WHCC invested additional resources into the Commissioning Support Unit (CSU) Medicines Management team to focus on medicines QIPP. This scheme has now been evaluated and it has been identified that it has: |
- Efficiently implemented additional medication change projects across all WHCC practices, realising sustained efficiencies (as identified in the Medicines Management QIPP Plan) that are additional to those delivered by the Commissioning Support Unit Medicines Management team.
- Facilitated earlier implementation of projects in WHCC practices, increasing the in-year efficiencies realised.
- Promoted local formulary choices and influenced change in prescribing practice.
- Increased the practice-based Medicines Management support time that WHCC practices have had.

Whilst the project achieved a ‘break even’ position, it is anticipated that the changes in practice will have a longer-term impact and will also have supported the consortium to achieve cost growth of 0.9% below the national average in prescribing.

WHCC has continued to promote involvement of its member practices in the CCG QIPP groups and as a result has increased the number of WHCC GPs involved. In addition, a WHCC GP Executive has been assigned to each QIPP area and the content of the minutes of all QIPP teams are reviewed at the WHCC Executive Board meeting to further promote involvement and understanding.

<table>
<thead>
<tr>
<th>Contribution to Strategic Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order to ensure effective member practice involvement and promote coherence with consortium activity and the CCG Strategic Plan, the draft plan has been shared with all member practices. The protected time assigned each month for practice clusters to work together was utilised to focus on reviewing the draft plan and providing feedback. This feedback will be collated and fed in to the planning process.</td>
</tr>
</tbody>
</table>

Reducing Inequalities – The scheme to offer bespoke smoking cessation advice to individuals with long-term conditions has now been rolled out to the second cohort of practices. The scheme will be evaluated at the end of the pilot phase and will be rolled out to the rest of the consortium if the evaluation demonstrates success.
Care Closer to Home – As mentioned previously, WHCC has implemented a comprehensive community-based diabetes service that offers an intermediate service, specialist advice and visits for patients unable to leave their home.

Care Closer to Home – a scheme to fit intrauterine devices for women that suffer with heavy menstrual bleeding has been launched. This is delivered via 3 WHCC practices on behalf of the consortium.

Care Closer to Home / Urgent Care – the WHCC care home scheme continues to undertake the following:

- Review all newly admitted patients to care home regarding medication and any immediate problems within 7 days of admission
- Review patients about whom staff have concerns within 7 days
- Encourage use of end of life care planning
- Review any resident discharged from hospital in the last 7 days
- Review any resident who has accessed A&E in the last 7 days
- Review any resident who has had contact with the practice in the last 7 days
- Work closely with community geriatrician to support identified residents

A final evaluation of the scheme will be undertaken in June; however, the learning to date is already feeding in to the development of services for the over-75s to be delivered on a pan-Wirral basis.

Quality in Primary Care

WHCC undertakes a rolling programme of practice visits to all member practices. These visits incorporate the review of practice-level information, allowing the consortium to not only review quality at a practice level but also to compare practices and highlight outlying areas which may identify cause for concern from a quality perspective.

During the last quarter of 2013/2014, the practice visit agenda was reviewed and the visits were re-badged as a ‘Listening and Quality Visit’. The rationale for this re-focus was to clearly demonstrate that the purpose of the visit was to promote effective 2-way communication and learn and share good practice thus working towards improving
the quality and efficiency of primary care.

In addition, there are identified links with the NHS England area team to ensure intelligence is shared where appropriate in order to establish a ‘whole picture’ approach if concerns are highlighted.

At the end of Quarter 4, all 24 member practices had been visited.

<table>
<thead>
<tr>
<th>Education and Clinical Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Since Q3, the following education has been delivered for WHCC practices:</td>
</tr>
<tr>
<td>- Continuation of the Practice Nurse development programme including:</td>
</tr>
<tr>
<td>- Dermatology training for Practice nurses</td>
</tr>
<tr>
<td>- Diabetes</td>
</tr>
<tr>
<td>- Heart Failure</td>
</tr>
<tr>
<td>- Sexual health update</td>
</tr>
<tr>
<td>- Smoking cessation update</td>
</tr>
<tr>
<td>- Drug and alcohol services update</td>
</tr>
<tr>
<td>- Training session on abnormal Liver Function Tests (LFTs)</td>
</tr>
<tr>
<td>- Multidisciplinary diabetes education programme</td>
</tr>
<tr>
<td>- Paediatric asthma training and mentorship</td>
</tr>
<tr>
<td>- Business skills training for Practice Managers</td>
</tr>
<tr>
<td>- Cytology update for GPs and Nurses</td>
</tr>
<tr>
<td>- Chaperone training</td>
</tr>
<tr>
<td>- Basic life support training offered to all practices</td>
</tr>
<tr>
<td>- ‘Creating a business culture’ training for Practice Managers</td>
</tr>
<tr>
<td>- Ear care training for Practice Nurses</td>
</tr>
<tr>
<td>- Travel health training for Practice Nurses</td>
</tr>
<tr>
<td>- Podiatry update for Practice Nurses</td>
</tr>
<tr>
<td>- Chest examination skills training for Practice Nurses</td>
</tr>
</tbody>
</table>
WHCC has also continued to focus heavily on improving engagement and communication with its member practices. This is exemplified in the following ways:

- Ongoing development of the WHCC website for practices and patients alike
- Ongoing (at least weekly) review and updates to the WHCC Directory of Services (on the WHCC website)
- Continuation of the weekly ‘GEMS’ – short bullet points of pertinent information sent out every Friday to WHCC practices
- Publication of a monthly consortium update with distribution to all GPs and the opportunity to discuss any issue during ‘consortium question-time’ at the GP Members’ meeting

These efforts have continued and now have an even greater emphasis for the consortium following the recent feedback from GP practices relating to concerns over engagement regarding potential changes to primary care delivery.

<table>
<thead>
<tr>
<th>Additional Comments and Information</th>
</tr>
</thead>
</table>

From a commissioning budget perspective, the consortium remained in an overspend position at the end of the financial year. However, from a positive perspective, GP referrals to Wirral University Teaching Hospital remained within acceptable tolerances with A&E attendances noted to be 3% under expected activity levels.

In addition, the WHCC board is fully aware of the current financial pressures, particularly in relation to CCG running costs. The Board utilised one of its pre-planned meetings to review the existing WHCC Executive Board and subcommittee structures. The result of this process was a rationalisation of the current structure which has significantly reduced the number of WHCC Executive Board subcommittees and total number of meetings held.

A reduction in running costs has been achieved by not recruiting to a vacant GP Executive post and not continuing to have a separate consortium training lead. However, WHCC remains strongly committed to communication and engagement with its members, their practice staff and patients so the GP Members’ meeting, Practice Managers’ Forum, Practice Nurses’ Forum and Patients’ Forum have not been affected and will continue on a monthly basis as at present. Nor will the focus on education and up-skilling be affected by not having a dedicated training lead as one of the existing WHCC GP Executives will now have ‘training lead’ as part of their portfolio.
<table>
<thead>
<tr>
<th>Agenda Item:</th>
<th>5.1</th>
<th>Reference:</th>
<th>GB14-15/017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report to:</td>
<td>Governing Body</td>
<td>Meeting Date:</td>
<td>03.06.2014</td>
</tr>
<tr>
<td>Lead Officer:</td>
<td>Paul Edwards, Head of Corporate Affairs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributors:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance:</td>
<td>Link to Commissioning Strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Link to current governing body Objectives</td>
<td>The Corporate Calendar illustrates the key statutory and corporate duties of the Governing Body</td>
<td></td>
</tr>
<tr>
<td>Summary:</td>
<td>The Corporate Calendar maps out the annual cycle of Governing Body business. It shows a clear reporting schedule and timeframes for specific reports related to the business and duties of the CCG. This in turn should provide assurance that key duties are being complied with and how the source of those specific assurances. These are usually from specified reports from identified Lead Officers, or reports and minutes from sub-committees of the Governing Body.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation:</td>
<td>To Approve</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>To Note</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next Steps:</td>
<td>Ensure Governing Body business is in line with the Corporate Calendar</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This section is an assessment of the **impact** of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.

<table>
<thead>
<tr>
<th>What are the implications for the following (please state if not applicable):</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial</strong></td>
</tr>
<tr>
<td>The Corporate Calendar highlights the requirement for Financial Performance reports at each Governing Body meeting via the Integrated Finance and Performance Report</td>
</tr>
<tr>
<td><strong>Value For Money</strong></td>
</tr>
<tr>
<td>N/A</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
</tr>
<tr>
<td>The Corporate Calendar highlights the requirement for the CCG Assurance Framework to be presented to the Governing Body on a quarterly basis. This is in addition to the Risk Register which in presented at each Governing Body.</td>
</tr>
<tr>
<td><strong>Legal</strong></td>
</tr>
<tr>
<td>The Corporate Calendar highlights the statutory duties required of CCGs and how they are dealt with via the Governing Body.</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
</tr>
<tr>
<td>The Corporate Calendar highlights the requirement for Workforce Reports at quarterly intervals at the Governing Body.</td>
</tr>
<tr>
<td><strong>Equality &amp; Human Rights</strong></td>
</tr>
<tr>
<td>The Corporate Calendar highlights the requirement for Equality Reports at defined intervals at the Governing Body.</td>
</tr>
<tr>
<td><strong>Patient and Public Involvement (PPI)</strong></td>
</tr>
<tr>
<td>The Corporate Calendar highlights the requirement for demonstrating engagement in its commissioning activities and this is now incorporated into the Consortia reports which highlight patient and public involvement.</td>
</tr>
<tr>
<td><strong>Partnership Working</strong></td>
</tr>
<tr>
<td>The Corporate Calendar highlights the requirement for Performance reports at each Governing Body meeting via the Integrated Finance and Performance Report</td>
</tr>
</tbody>
</table>

Do you agree that this document can be published on the website?  
(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions)

This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path ie. other papers that are directly related to the current paper under discussion.
### Private Business

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

If a report is deemed to be for private business, please note that the tick in the box, indicating whether it can be published on the website, must be changed to a x.

If you require any additional information please contact the Lead Director/Officer.
## Governing Body Corporate Calendar 2014/15

<table>
<thead>
<tr>
<th>Duties and Responsibilities</th>
<th>Assurance Source/Lead Officer</th>
<th>Papers/Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of JSNA</td>
<td>Planning Cycle/Commissioning Intentions</td>
<td>Planning Cycle/Commissioning Intentions</td>
</tr>
<tr>
<td>Secure Public Involvement</td>
<td>Consortia Patient Groups/Governing Body meeting in public/specific Consultation exercises</td>
<td>Consortia Reports/Reports on specific consultations</td>
</tr>
<tr>
<td>NHS Constitution</td>
<td>QPF/Head of Performance and Quality</td>
<td>Integrated Finance and Performance Report</td>
</tr>
<tr>
<td>Effective Efficient Services</td>
<td>QPF Groups/Clinical Strategy Group/Head of Quality and Performance</td>
<td>QPF Minutes</td>
</tr>
<tr>
<td>Continuous Improvement</td>
<td>QPF</td>
<td>QPF Minutes</td>
</tr>
<tr>
<td>Primary Care Quality</td>
<td>Consortia</td>
<td>Consortia Reports</td>
</tr>
<tr>
<td>Secure</td>
<td></td>
<td>Consortia Minutes</td>
</tr>
<tr>
<td>Reduce Inequalities</td>
<td>Strategic Plan/Commissioning Plans</td>
<td>Strategic Plan-update paper</td>
</tr>
<tr>
<td>Involving Pts/Carers</td>
<td>Consortia</td>
<td>Consortia Minutes</td>
</tr>
<tr>
<td>Finance</td>
<td>Chief Financial Officer</td>
<td>Integrated Finance and Performance Report</td>
</tr>
<tr>
<td>Performance</td>
<td></td>
<td>Integrated Finance and Performance Report</td>
</tr>
<tr>
<td>Information Governance</td>
<td>QPF/Audit Committee</td>
<td>QPF Minutes</td>
</tr>
<tr>
<td>Workforce/Human Resources</td>
<td>Head of Corporate Affairs</td>
<td>Workforce Reports via QPF</td>
</tr>
<tr>
<td>Constitutional Terms of Review</td>
<td>Head of Corporate Affairs</td>
<td>Constitutional Review paper</td>
</tr>
<tr>
<td>Emergency Preparedness and Resilience (EPRR)</td>
<td>Head of Corporate Affairs</td>
<td>EPRR paper</td>
</tr>
<tr>
<td>SLA/Committed</td>
<td>Minutes/SLA Committee Minutes</td>
<td>Minutes/SLA Committee Minutes</td>
</tr>
<tr>
<td>Audit Committee Annual Report</td>
<td>Audit Committee Chair/Lead Manager</td>
<td>Audit Committee Annual Report</td>
</tr>
<tr>
<td>Remuneration Committee Annual Report</td>
<td>Remuneration Committee Chair/Lead Manager</td>
<td>Remuneration Committee Annual Report</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>Head of Corporate Affairs</td>
<td>Assurance Framework</td>
</tr>
<tr>
<td>Strategic Plan Progress</td>
<td>Commissioning Managers</td>
<td>Strategic Plan-update paper</td>
</tr>
<tr>
<td>Public Sector Equality Duty</td>
<td>Head of Quality and Performance</td>
<td>Equality Duty paper</td>
</tr>
<tr>
<td>Annual Governance Statement</td>
<td>Head of Corporate Affairs</td>
<td>Annual Governance Statement</td>
</tr>
<tr>
<td>Annual Report</td>
<td>Head of Corporate Affairs/Chief Financial Officer</td>
<td>Annual Report</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>Head of Quality and Performance</td>
<td>Safeguarding update paper</td>
</tr>
<tr>
<td>Quality Premium</td>
<td>QPF</td>
<td>QPF Minutes</td>
</tr>
<tr>
<td>Risk Register</td>
<td>QPF</td>
<td>QPF Minutes</td>
</tr>
<tr>
<td>Commissioning Support Unit Service Level Agreement</td>
<td>Head of Quality and Performance</td>
<td>CSU SLA Performance report</td>
</tr>
</tbody>
</table>

**Key**

- **QPF**: Quality, Performance and Finance Committee
- **CSG**: Clinical Strategy Group
- **QIPP**: Quality, Innovation, Productivity and Prevention
- **JSNA**: Joint Strategic Needs Assessment
**Duties and Responsibilities**
- Annual Governance Statement
- Audit Committee Annual Report
- Research
- Secure Public Involvement
- Primary Care Quality
- Involving Pts/Carers
- Choices
- Innovation
- Education
- Quality Premium
- Risk Register
- NHS Constitution
- Continuous Improvement
- Quality
- Performance
- Information Governance
- Effective Efficient Services
- Remuneration Committee Annual Report
- Emergency Preparedness and Resilience
- Reduce Inequalities
- Use of JSNA
- Finance
- Final Accounts
- Policy Renewal/adoptions
- Workforce/HR
- Assurance Framework
- Constitutional/Terms of Reference Review
- Annual Report
- Public Sector Equality Duty
- Safeguarding
- Commissioning Support Unit SLA
- Strategic Plan Progress
<table>
<thead>
<tr>
<th>Assurance Source/Lead Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Committee</td>
</tr>
<tr>
<td>Audit Committee</td>
</tr>
<tr>
<td>Clinical Strategy Group/Research Network</td>
</tr>
<tr>
<td>Consortia</td>
</tr>
<tr>
<td>Consortia</td>
</tr>
<tr>
<td>Consortia</td>
</tr>
<tr>
<td>Consortia</td>
</tr>
<tr>
<td>Consortia/Consortia/Clinical Strategy Group</td>
</tr>
<tr>
<td>Consortia/Head of Corporate Affairs</td>
</tr>
<tr>
<td>Quality and Performance Committee</td>
</tr>
<tr>
<td>Quality and Performance Committee</td>
</tr>
<tr>
<td>Quality and Performance Committee</td>
</tr>
<tr>
<td>Quality and Performance Committee</td>
</tr>
<tr>
<td>Quality and Performance Committee</td>
</tr>
<tr>
<td>Quality and Performance Committee</td>
</tr>
<tr>
<td>Quality and Performance Committee/Audit</td>
</tr>
<tr>
<td>Committee/Audit Committee</td>
</tr>
<tr>
<td>Quality and Performance Committee/Consortia</td>
</tr>
<tr>
<td>Audit Committee</td>
</tr>
<tr>
<td>Audit Committee</td>
</tr>
<tr>
<td>Senior Resilience Manager, Commissioning</td>
</tr>
<tr>
<td>Support Unit</td>
</tr>
<tr>
<td>Strategic Plan/Commissioning Plans</td>
</tr>
<tr>
<td>Annual Status Review/Commissioning Intentions</td>
</tr>
<tr>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>Head of Corporate Affairs</td>
</tr>
<tr>
<td>Head of Corporate Affairs</td>
</tr>
<tr>
<td>Head of Corporate Affairs</td>
</tr>
<tr>
<td>Head of Corporate Affairs/Head of Corporate</td>
</tr>
<tr>
<td>Affairs/Head of Corporate Affairs/Chief</td>
</tr>
<tr>
<td>Financial Officer</td>
</tr>
<tr>
<td>Head of Corporate Affairs/Head of Corporate</td>
</tr>
<tr>
<td>Affairs/Head of Corporate Affairs/Chief</td>
</tr>
<tr>
<td>Financial Officer</td>
</tr>
<tr>
<td>Head of Quality and Performance</td>
</tr>
<tr>
<td>Head of Quality and Performance</td>
</tr>
<tr>
<td>Head of Quality and Performance</td>
</tr>
<tr>
<td>Commissioning Managers</td>
</tr>
<tr>
<td>Papers/Reports</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Annual Governance Statement</td>
</tr>
<tr>
<td>Remuneration Committee Annual Report</td>
</tr>
<tr>
<td>Clinical Strategy Group Minutes</td>
</tr>
<tr>
<td>Consortia Reports/Reports on specific consultations</td>
</tr>
<tr>
<td>Consortia Reports</td>
</tr>
<tr>
<td>Consortia Reports/Congress Group Minutes</td>
</tr>
<tr>
<td>Organisational Development update paper/Consortia Reports</td>
</tr>
<tr>
<td>Quality and Performance Committee Minutes</td>
</tr>
<tr>
<td>Risk Register</td>
</tr>
<tr>
<td>Integrated Finance and Performance Report</td>
</tr>
<tr>
<td>Quality and Performance Committee Minutes</td>
</tr>
<tr>
<td>Quality and Performance Committee Minutes</td>
</tr>
<tr>
<td>Integrated Finance and Performance Report</td>
</tr>
<tr>
<td>Quality and Performance/Audit Committee Minutes</td>
</tr>
<tr>
<td>Quality and Performance/Clinical Strategy Committee Minutes</td>
</tr>
<tr>
<td>Assurance Framework</td>
</tr>
<tr>
<td>Emergency Preparedness and Resilience paper</td>
</tr>
<tr>
<td>Strategic Plan update paper</td>
</tr>
<tr>
<td>Annual Status Review/Commissioning Intentions</td>
</tr>
<tr>
<td>Integrated Finance and Performance Report</td>
</tr>
<tr>
<td>Final Accounts paper</td>
</tr>
<tr>
<td>Policies as required</td>
</tr>
<tr>
<td>Workforce Reports</td>
</tr>
<tr>
<td>Assurance Framework</td>
</tr>
<tr>
<td>Constitutional Review paper</td>
</tr>
<tr>
<td>Annual Report</td>
</tr>
<tr>
<td>Equality Duty paper</td>
</tr>
<tr>
<td>Safeguarding update paper</td>
</tr>
<tr>
<td>CSU SLA Performance report</td>
</tr>
<tr>
<td>Strategic Plan update paper</td>
</tr>
</tbody>
</table>
WIRRAL HEALTH COMMISSIONING CONSORTIUM
EXECUTIVE COMMITTEE
Minutes of Meeting

Wednesday 16\textsuperscript{th} April 2014
Albert Lodge - Victoria Central Health Centre

Present:

- Dr Peter Naylor (Chair)  Chair
- Andrew Cooper    Chief Officer
- Dr Sue Wells    GP Executive Lead
- Dr David Jones    GP Executive Lead
- Dr Sian Stokes    GP Executive Lead
- Dr Paula Cowan    GP Executive Lead
- Debbie Platt    Practice Nurse Representative
- Barbara Dunton    Operations Manager
- Diane Moon    Practice Manager Representative
- Brian Knight    Patient Forum Chair
- Dr Paula Cowan    Practice Nurse Representative
- Debbie Platt    Operations Manager
- Diane Moon    Practice Manager Representative
- Brian Knight    Patient Forum Chair
- Louise Morris    Senior Finance Accountant

In Attendance:

- Pauline Bolt    Commissioning Support Manager
- Grace Price – Jones    Executive Assistant

<table>
<thead>
<tr>
<th>Ref No</th>
<th>Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHCC/EB/13-14/0169</td>
<td>1.1 Apologies for Absence</td>
</tr>
<tr>
<td></td>
<td>Dr Sue Wells informed the Executive Committee that she will be Chairing the beginning of the meeting at Dr Peter Naylor and Andrew Cooper will be arriving late.</td>
</tr>
<tr>
<td>WHCC/EB/13-14/0170</td>
<td>1.2 Declarations of Interest</td>
</tr>
<tr>
<td></td>
<td>All the GPs declared a declaration of interest in the service review updates under agenda item 2.2.</td>
</tr>
<tr>
<td>WHCC/EB/13-14/0171</td>
<td>1.3 Public Comments/Questions</td>
</tr>
<tr>
<td></td>
<td>There were no members of the public in attendance at the meeting.</td>
</tr>
<tr>
<td>WHCC/EB/13-14/0172</td>
<td>1.4 Minutes and Action Points of the previous meeting</td>
</tr>
<tr>
<td></td>
<td>The minutes of the previous meeting were agreed as a true account of the last meeting.</td>
</tr>
<tr>
<td></td>
<td>Matters Arising</td>
</tr>
<tr>
<td></td>
<td>No matters arising were discussed.</td>
</tr>
</tbody>
</table>
### Action Points

Action point 2.1 - *Query with Executive Practice Manager Representative whether a guide on using the text messaging service can be created* – The system provided with EMIS was discussed, it is free and works well, however, it is not as advanced. EMIS does have an audit trail of text messages sent out to patients. There was a discussion in regards to a new contract which allows the patient to access the appointment system electronically.

Action point 2.1 - *Investigate whether Vision has a function to send out text messages to patients* – it was explored and Vision does have a text messaging function.

It was agreed that the action point will remain on the list for further discussion at the next meeting after discussion with Iplato.

All other action points were completed.

### 2.1 Alcohol Service Update

Gary Rickwood was introduced to the committee. The importance of alcohol services on Wirral was discussed and the figures relating to alcohol dependence on Wirral were also considered.

The committee requested an update on the alcohol strategy. The strategy has three areas that are being targeted:

- Identification, prevention, treatment and recovery
- Crime disorder and communities
- Young people, families and carers

Wirral figures are against the trend for the North West. In 2007/2008 Wirral was the 6th highest area within the country. In 2011/2012 Wirral had dropped to 36th.

There are reductions in the number of A&E attendances for alcohol related illness at Wirral University Teaching Hospital.

The committee had very positive feedback on the alcohol workers.

There was a discussion about the service currently being re-tendered. There are six bids from providers to provide the service.

It was agreed that the role of Primary Care could be strengthened as GPs see solutions every day. There was discussion about shared care.

Public health is keen to have more Primary Care involvement and that if there is anything being developed that requires input from Primary Care Public Health will contact the CCG.

### 2.2 Service Review Updates

#### Care Home Support Service

An overview of the Care Home Support service was given to the committee. The GPs providing the service have written a report that outlines some of the limitations that have
<table>
<thead>
<tr>
<th>Ref No</th>
<th>Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHCC/EB/</td>
<td>been found since the service began. Each of the reports has been discussed by the members. The GPs have created guides for the care home staff to help them manage patients. The guides are going to be distributed to practices. The GPs providing the service did some UK research and produced a report for noting by the Executive Committee. The GPs looked at a number of different models of care. There was a discussion about some of the models suggested may overlap with the new Direct Enhanced Service. There is currently a Wirral wide review being undertaken. The Executive Committee requested that thanks are passed onto the GPs for the review. <strong>Telehealth</strong> From the evaluation the equipment does help patients by giving them confidence. It was found that a number of the patients do find it easier to use; however, the uptake for the service needs to be improved.</td>
</tr>
<tr>
<td>13-14/0175</td>
<td><strong>2.2 Practice Scheme Evaluations</strong> Some of the evaluations have still not been received from practices. The evaluations that do not include the key outcomes have been sent back to practices for further information. Numbers of the referrals into the several counselling schemes that were funded have been requested from the practices as it is queried what impact would be on the IAPT service. This is going back to Business Development Committee for further discussion.</td>
</tr>
<tr>
<td>WHCC/EB/</td>
<td><strong>3.1 Finance Update</strong> The Finance Lead presented the Finance Report for Month 11 which was noted by the Board. The consortium overall position was reported as £4.8m overspent which is an adverse movement from the previous month. There is an overspend of £3.8m on NHS Contracts, primarily at Wirral University Teaching Hospital of £3.5m, there is an overspend at Wirral Community NHS Trust of £176k. Non – NHS Contracts are overspent by £513k, mainly at Spire Murrayfield. Prescribing overspend is a £710k as at February, despite an overall negative cost growth being reported. The consortium shows a potential forecast overspend of £6.01m. There was a query as to whether referrals are now coded and charged for patients that have cancelled their appointments. One board member highlighted that a patient that they knew had cancelled was still on the outpatient appointment list. It was clarified that GP referral rates have not changed significantly and some referrals seemed to be charged differently.</td>
</tr>
<tr>
<td>13-14/0176</td>
<td></td>
</tr>
<tr>
<td>Ref No</td>
<td>Minute</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>WHCC/EB/13-14/0177</td>
<td><strong>3.2 Items for Risk Log</strong>&lt;br&gt;No items were identified for the risk log.</td>
</tr>
<tr>
<td>WHCC/EB/13-14/0178</td>
<td><strong>3.3 Risk Register</strong>&lt;br&gt;The committee agreed that the risk register will be reviewed at the next meeting due to the year end.</td>
</tr>
<tr>
<td>WHCC/EB/13-14/0179</td>
<td><strong>4.1 Subgroup Minutes for Noting</strong>&lt;br&gt;The minutes from the subcommittees were noted by the Board.&lt;br&gt;It was agreed that Clinical Strategy Group to move to Private Business as it is a closed meeting.&lt;br&gt;On the Patient Forum minutes it was requested that the sentence stating the ‘Anger of seeing GPSI’ was revised.</td>
</tr>
<tr>
<td>WHCC/EB/13-14/0180</td>
<td><strong>5. Summary of Actions</strong>&lt;br&gt;Please refer to action points attached.</td>
</tr>
<tr>
<td>WHCC/EB/13-14/0181</td>
<td><strong>6. Summary of Financial Approvals</strong>&lt;br&gt;The summary was noted by the committee.</td>
</tr>
<tr>
<td>WHCC/EB/13-14/0182</td>
<td><strong>7. Any Other Business</strong>&lt;br&gt;A number of members of the committee attended a Datix demonstration. The tool is going to be Wirral wide and will be used to record soft intelligence for significant events within services from the patients that they may not want to address as a complaint. The tool was very clear to use and was flexible enough to be localised, the general consensus of those attending was very positive in terms of its potential benefits for Wirral practices.</td>
</tr>
</tbody>
</table>

**Date and Time of Next Meeting**

The date and time of the next meeting is Wednesday 14th May 2014, 1.00pm at Albert Lodge, Victoria Central Health Centre.

Please send any further apologies to Grace Price-Jones on g.price-jones@nhs.net
Minutes of the WGPCC Executive Board meeting – 11 March 2014

Present:

Dr Akhtar Ali (AA) GP Lead
Penny Angill (PA) Practice Manager Member
Christine Campbell (CC) Chief Officer
Dr Simon Delaney (SD) GP Lead
Dr Maria Earl (ME) GP Lead
Dr Hannah McKay (HM) GP Lead
Louise Morris (LM) Consortia Finance Lead
Dr John Oates (JO) Chair
Eddy Shallcross (ES) Patient Council Chair

In attendance:

Anita Fletcher (AF) WGPCC Administrator
Paul McGovern (PM) Commissioning Support Manager
Jennifer Shaw (JS) Commissioning & Engagement Support Manager

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td>WGPCC/EB/13-14/061</td>
<td>1.1 Apologies for absence</td>
</tr>
<tr>
<td></td>
<td>Apologies were received from Sam Saminaden.</td>
</tr>
<tr>
<td></td>
<td>1.2 Declarations of interest</td>
</tr>
<tr>
<td></td>
<td>JO and ME declared interest in item 3.2 as their practices are involved in delivering this scheme. It was agreed that both would leave the room when this item was discussed and ES would chair this item.</td>
</tr>
<tr>
<td></td>
<td>1.3 Public Comments/Questions</td>
</tr>
<tr>
<td></td>
<td>There were no members of the public present.</td>
</tr>
<tr>
<td></td>
<td>1.4 Minutes and Action Points of the last meeting</td>
</tr>
<tr>
<td></td>
<td>The minutes were agreed to be a true record of the meeting.</td>
</tr>
</tbody>
</table>

**Matters Arising**

**Financial Budget 2013/14** – PbR activity to be split between ‘GP’ and ‘other’ referrals – Members were advised that work has been undertaken on this and shared by the Chief Finance Officer. GP referral figures and Consultant to Consultant figures on a monthly basis were highlighted for all Divisions and members were informed that this would be a challenge going forward.

**WGPCC Executive Board Election Process 2014** – An update was given to members regarding the three GP member posts which are due to expire at the end of March 2014. The
### Minutes of the WGPCC Executive Board meeting – 11 March 2014

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>three successful candidates are Dr Alam, Dr Ali and Dr Lee; all three were congratulated on their success. Members were informed that these posts might need to run for only one year to bring them in line with the other GP tenure at the end of March 2015. Running costs could be reduced next year which might impact on the number of Board members from April 2015. Members were advised that all Divisions have been asked to look at expenditure here.</td>
</tr>
<tr>
<td></td>
<td>A query was made as to how this decision was made in relating to the Terms of Reference and the Constitution. After discussion it was clarified to the Board that no decision had been made. The intention was to highlight to the Board that financial constraints may dictate in the future a review of membership. If this were the case a proposal would come to the Board.</td>
</tr>
<tr>
<td></td>
<td>Following the recent election of Board members it was again time to appoint the 2 WGPCC members for the WCCG Governing Body. The current members are the Chair, Dr Ali and Dr McKay who had agreed to fulfil the role until the end March 2014 following Dr Srivastava’s resignation. GP Board members were invited to put their names forward. It was agreed that the same procedure would be followed that applied previously. If there were more than 2 applicants the Board would take a vote. Action: CC to contact GP Board members regarding the WGPCC representatives on the CCG Governing Body.</td>
</tr>
</tbody>
</table>

**Action Points**

**Minutes and Action Points: Financial Budget 2013/14** – Action complete – ES liaised with Sheena Hennell regarding the number of physiotherapy sessions Consortia patients have. LM agreed to circulate this information to Executive Board members. A further query was raised from this as to the maximum number of appointments a patient can have; LM will look into this and update at the next Executive Board meeting.  
**Primary Care Mental Health Referral Guidelines** – Action complete – This is an agenda item at this meeting.  
**Practice Managers Update** – Action complete – CRB checks information has been shared with all WGPCC Practice Managers.  

1.5 Minutes for Noting

The minutes from the Patient Council Executive Board meeting, held on the 10th December 2013, were queried as they did not appear to be the ratified minutes from that meeting. The correct version would be included with papers for the May Executive Board. The minutes from the Governing Body meeting, held on 4th February 2014, were noted.  

1.6 Complaints, Compliments and Patient Feedback

Executive Board members were advised that feedback from practices regarding the new Admissions Prevention service had been received. It was felt that the approach from the service did not appear to be as good. The service had been made aware of this and the feedback had been acted upon. Any further issues should be flagged with CC.  

2.1 Feedback on the Future Provision of Primary Care Mental Health (PCMH)

Executive Board Members were advised that in February 2014 on online survey had been issued to Practice Members requesting their views on the future profile of Primary Care Mental Health Services via an online survey. The services will be procured during 2014/15 for commencement of the new service in April 2015.
The survey was presented to the GPs on 14th February 2014 with a closing response date of 24th February 2014. During this time, 18 responses were received; although this was not great in numbers some good feedback had been received. Full details of the questions and the results are set out in the Board paper.

From the results received 33% would like to see one service provider across Wirral for all types and steps in therapy. Regarding the way in which these services should be funded the results were quite close in answers. There was an overwhelming response for the Primary Care Mental Health budget to be managed by the Consortium.

In summary, the survey responses indicate that members would like:
- The consortium to manage the funding for PCMH
- Cost by appointment, closely followed by block contract
- A choice of providers, but with each provider able to deliver all steps, closely followed by one provider across Wirral

Board members were disappointed that only 18 responses had been received. Board Members were asked if they were happy to go with these results or reissue the survey again to practices. It was felt that the responses had been received from practices rather than individual GP responses. The poor response was very surprising as GPs usually have a strong view on this subject.

Following further discussion, the suggestion was made to take the survey back to practices with new questions based on the answers received and also ask if the response being submitted is on behalf of a practice or an individual one. Members were reminded that all Primary Care Mental Health contracts will come to an end on 31st March 2015 with a view to the new service being offered from 1st April 2015.

Board members were in agreement for the survey to be resubmitted, based on the suggestions outlined above.

**Action:** JS to resubmit the online survey for views on the Primary Care Mental Health service, and check if practices feel the results accurately represent their views.

---

**3.1 Admission Prevention and Facilitated Discharge Review and Evaluation 2013/14**

Members were informed that a budget allocation for the Consortium has not yet been received and therefore the Board is asked for a decision in principle.

The document is an evaluation report for the Admission Prevention & Facilitated Discharge Service delivered by Miriam Primary Care Group for 2013/14. The report assesses progress and development of the service over the year and takes account of the potential role of the service as part of the new Integrated Care Co-ordination service model for 2014/15.

Members were advised that key points to note are the change in provider and break in service of approximately six weeks; the service is now provided by Miriam Medical Centre; it has stayed within budget and met targets.

The new contract value for 2013/14 was set at £170,000 and in the first eight months (June 2013-January 2014) the service has seen 382 patients and is on target to exceed the 500 target set for the previous service.

With regards to savings, figures within the report estimate the highest and lowest potential savings delivered by the service based on throughput activity up to the end of Month 8 in
Ref No. 2013/14. The estimated savings formula has been adjusted to take into account patients in the following categories: admitted, no input required, patient declined support, and onward referral, which all account for approximately 20% of activity.

A serious case review had taken place due to an at-risk patient and members were advised that the outcome of this review has found positive practice by the service, but has highlighted six recommendations for improvement. Meetings have taken place to ensure these service recommendations are put in place.

The future direction of the Admission Prevention and Facilitated Discharge Service will need to be considered in the context of ‘Caring Together – My Voice, My Choice My Life’ the new strategy and plan to deliver seamless health and social care through Integrated Care Coordination Teams within eight localised clusters across Wirral.

One of the key support mechanisms to the successful delivery of the Admission Prevention and Facilitated Discharge Service has been direct access to financial resource in order to spot purchase placements in nursing and residential homes or domiciliary care packages.

The risks to Wirral GP Commissioning Consortium of not continuing the service were highlighted and conclusions discussed.

The paper recommends:

- Wirral GP Commissioning Consortium Executive Board supports the continuation of the current contract for the Admission Prevention and Facilitated Discharge Service for 2014-15 via resources available within the Better Care Fund budgets.

- The Service Specification is reviewed and incorporates the recommended change to Practice resulting from the recent Serious Case Review and takes a view on nursing and clinical support to patients, rather than predominately arranging care interventions.

- The Service acts as the main gateway for all member GP Practices to refer patients at risk of hospital admission or in need of discharge support, to be assessed for relevant health, therapy, and social care interventions

- The Service would work within the new MDT structure, with revised and consistent eligibility criteria to replace the Social Care Fund that will support the future fast access to care interventions for preventing hospital admissions and enabling timely discharges from wards.

- Future decisions on the commissioning, provision, and ownership of the service by the Consortium are taken in the context of the Caring Together and Vision 2018 strategies.

Members were advised that it is being proposed that the Better Care Fund will cover the cost of the service. The Social Care Fund is no longer available, and so care packages will be funded through Social Services as appropriate.

For the outcome figures, there has been a significant jump in the numbers of patients in January 2014 due to extra resources for winter pressures. Members were advised that this has continued into February and March and could go into April, which demonstrates the positive impact of the service.

With regards to a serious case review, it needs to be made clear that a first follow up must be undertaken within two working days by a health care professional to identify if there are concerns that the bed and home placement is not suitable to meet the patient’s health, social...
and emotional care needs, so potential problems can be addressed at an early stage.

The Executive Board members were happy to support all recommendations set out in the paper.

### 3.2 Minor Injury and Illness Service Evaluation 2013-14

Due to interest being declared in this item, JO and ME left the room while this item was discussed; the item was chaired by ES.

Members were informed that the paper provides an evaluation of the four existing sites for 2013/14, and seeks to inform the decision of the Executive Board when considering commissioning arrangements for the forthcoming financial year.

Attendance at all four sites has continued to grow, and 30% of patients for the sites at Birkenhead Medical Building and Parkfield Medical Centre come from the wider Wirral footprint. Patient feedback has been excellent, and very few people have required onward signposting to secondary care.

The risks if the Consortium did not continue to commission the Minor Injury and Illness service were highlighted.

Whilst in ideal circumstances the preferred option would be continue supporting and expanding the development of local based Minor Injury & Illness Services, there are both the recommendations of the Urgent Care Review and the future financial resource challenges of the wider health and public sector economies to consider. Therefore the following are some possible options for consideration:

- To continue funding all four centres on the current financial resource and available service hours;
- To close one or more of the existing sites and use the freed up resource to expand the hours of the remaining services.

The service continues to meet an increasing demand and is well used both locally and from patients across the wider Wirral footprint and continues to meet performance targets. The Minor Injury and Illness service model has been recognised nationally, through shortlisting for Health Service Journal and British Medical Journal awards, as one that is innovative and in line with national thinking around urgent care. Furthermore, the model is directly aligned with the draft Primary Care Strategy for Wirral and the notion of a hub and spoke primary care community model.

Based on the positive impact of the service, the established pattern of use at the original two sites, and considering the risks outlined above, this paper recommends Wirral GP Commissioning Consortium Executive Board continues to fund Miriam Primary Care Group to the contract value of £403k to deliver Minor Injury & Illness Services for 2014-15 on the same model developed throughout 2013-14 at both Birkenhead Medical Building and Parkfield Medical Centre. This would be possible through the recurrent resources allocated to the Consortium for 2014/15. Given that the availability of non-recurrent resource is not yet known, it is recommended that the Consortium does not commit to continue with both new pilot projects, but instead considers funding either Holmlands or Moreton, or an alternative model should any non-recurrent resources become available. A further £200k is required for Moreton Health Clinic to provide the same service model at the Chadwick Street venue and for Miriam to continue delivering services at Holmlands Medical Centre (based on 2013/14 costs of £100k per site).

The Consortium will need to review the focus of the service in order to ensure the appropriate
skill mix, and that it is used appropriately.

Discussion took place among Board members and a query was raised as to how many people are seen at Moreton and Holmlands who are registered with these practices; members were advised that this information is available if required. It was requested that this data is made available in relation to all four sites before a decision could be made.

Members were advised that a decision on this would need to be taken before the next Executive Board meeting in May 2014. Further figures would therefore be shared with members and email discussion would take place as necessary. It was therefore agreed that a decision on the services would be put on hold until data for all four sites is obtained.

Given that current contracts expire before April 2014, it was agreed that the contracts for all four sites would be extended until the end of May 2014 to give sufficient time for the Board to make a decision.

**Action:** PMc to notify providers of this outcome, provide Board members with the additional data as requested, and a further paper is to be brought to the Board meeting in May.

### 3.3 WGPCC Expenditure Priorities 2014/15

CC explained that the Consortium has been allocated a recurrent, non-recurrent and running cost budget for 2013/14. Whilst full detail of available budgets is not yet available, it is likely that there will be a reduction in the level of resources allocated to the Consortium in 2014/15. The paper therefore proposes investment options based on existing schemes in 2013/14 and existing structures, and priorities for the Consortium and CCG.

Members were advised that running costs per head for 2013/14 are set at £4.80 but will reduce for 2014/15 to £4.50 per head and will reduce further in 2015/16 to £4.00. Changes have already been made within the Consortium which fit comfortably within budget. Members were informed that the Consortium is not proposing any significant changes for next year but it may need to consider clinical engagement costs in the future.

Commissioning budgets for 2014/15 have not yet been allocated to Consortia. However, early indications are that, whilst the recurrent service development budget will be available, there may only be limited access to non-recurrent funding. The commissioning priorities set out in the paper were highlighted and members were advised that there is unlikely to be any non-recurrent budget for 2014/15. As an Executive Board, we need look at what is absolutely required and what the Consortium could do without next year.

The Consortium has been advised that the Admissions Prevention service will be funded through the Better Care Fund. Furthermore, providers of primary care mental health will be expected to, and have agreed to, see patients aged over 16 as part of their core contract from 1st April 2014. The Cancer audits were a one-off piece of work, as were the patient engagement investments.

Given that there is unlikely to be sufficient resource to fund all remaining schemes / initiatives, the Board is asked to consider prioritising investment in each of the schemes set out in the paper. Work is on-going to develop a Wirral-wide model for care home reviews and therefore consideration must be given to the value of continuing with a standalone service as a Consortium. With regards to the practice training and bursary budgets, it is felt this would be detrimental to practices if this was taken away as upskilling of practice staff is key to the primary care strategy. Board members may also want to consider having slippage for Primary Care Mental Health, should referrals continue above predicted levels.
It was agreed that members would give a view on each scheme line by line as to whether they should continue, can be stopped or more detail is required before a decision can be made. Schemes and outcomes are shown below:

- Practice-based ECG service - continue
- Practice Training Budget - continue
- Bursary scheme - continue
- Backfill for PLT events - continue
- Translation and Interpreting – continue
- Community Gynaecology service – continue as key to Consortium QIPP contribution
- Community Minor Surgery service – continue as key to Consortium QIPP contribution
- Patient Engagement Local Enhanced Service – stop (national engagement scheme will continue and it was felt that this scheme had incentivised one-off activities)
- DNA campaign - stop
- Patient Council recruitment campaign – ‘Your GP Needs You’ – stop – no need for future investment
- Care Home review scheme – stop as Wirral-wide initiatives will be implemented
- ‘Top-up’ for Primary Care Mental Health service provider to see patients aged 16 – 17 – stop as this will become part of core contracts for Mental Health
- Primary Care Mental Health – potential for contingency if resources remain
- Minor Injury and illness services (1 / 5th with recurrent budget) – will be in line with outcome of Board decision
- Admissions Prevention and Discharge Facilitation scheme – stop as funded through Better Care Fund
- Practice cancer audits – accounted for through running costs
- Falls Pick up service – need to understand if this will be funded centrally by CCG
- Teledermatology - continue
- Telehealth for COPD and Heart Failure Service - need to understand if this will be funded centrally by CCG
- COPD support leaflets - continue

Members were advised that it is hoped budgets will be available in time for the next Executive Board meeting on 13th May 2014.

---

4.1 Financial Budget 2013/14

LM presented the financial position for WGPCC as the end of January (Month 10) and advised that the year to date position for the Consortium is an over-spend of £683k, a favourable movement of £179k on the previous month, with over performance against commissioning expenditure of £804k offset by underperformance against running costs of £121k. Full detail is provided within the paper.

The performance position in relation to NHS contracts at month 10 shows an overspend of £48k, previous month £344k overspend. Contract performance against the WUTH contract is an overspend of £506k as at January. The Wirral-wide position is £3.5m overspent at month 10).

At month 10, Non-NHS Contracts are overspent by £1.35m. An adverse movement of £160k. Over performance in the main shows against Spire Murrayfield £419k, AQP services £979k. (Physio services £399k, Rheumatology £173k, plus other pressures against Dermatology, Radiology and ENT) and Independent Midwifery £58k.
For data quality issues referred to in previous months, the non PBR activity for WUTH will only be reported on after the end of each quarter.

With regards to non-recurrent investment, plans are in place to utilise all 2% headroom allocated to the Consortia and this is currently being reviewed with CC.

**Action:** LM to distribute Month 10 financial information to all WGPCC Practices.

Consistency in figures from the previous minutes was queried; LM agreed to check the data on this.

The Executive Board noted the financial position for WGPCC as at the end of January 2014.

### 4.2 Patient Council and Engagement Update

Members were informed that the next meeting of the Wirral GPCC Patient Council is due to be held on 25th March 2014; items for the agenda include:

- Vision 2018
- Presentation by Hilda Yarker from the Commissioning Support Unit on procedures of low clinical priority
- Patient Council Terms of Reference
- Minor Injuries and Illness services

The Terms of Reference are currently being drawn up with JS, ES and Elisabeth Hodgson, a Patient Council Executive Group member.

The main issues for discussion in the January meeting of the Patient Council included:

- A presentation from Fiona Johnstone, Director of Public Health on the Social Isolation Annual report of the Director of Public Health for Wirral.
- Discussion and presentation of the Fracture Neck of Femur pathway and update was provided
- Patient Council Terms of Reference, including draft template
- Vision 2018 update
- Future patient engagement events, including into the Vision 2018 event on 12th February

Members were advised that the Virtual Patient Council is now up and running.

One area that is concerning patients at present is care.data due to the lack of information available on this subject; members were informed that the launch of care.data has been delayed.

### 4.3 Practice Managers’ Update

**Practice Managers’ Forum** – Executive Board members were advised that the next Practice Managers’ Forum would be taking place on Thursday 13th March 2014.

**Primary Care Extended Access Scheme** – PA informed members that she had attended a well debated meeting in Wallasey regarding this subject. Executive Board members were informed that Wirral GPCC has offered to meet with Member Practices to discuss the scheme further if they require.
<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.4 Items for Risk Register</td>
<td>There were no new items to be included on the risk register.</td>
</tr>
<tr>
<td>WGPCC/EB/13-14/065</td>
<td>5. Any Other Business</td>
</tr>
<tr>
<td></td>
<td>There was no further business discussed.</td>
</tr>
<tr>
<td>WGPCC/EB/13-14/066</td>
<td>6. Private Business</td>
</tr>
<tr>
<td></td>
<td>There was no private business discussed.</td>
</tr>
<tr>
<td></td>
<td>7. Date and Time of Next Meeting</td>
</tr>
<tr>
<td></td>
<td>The date and time of the next meeting is Tuesday 13th May 2014, 6.30pm in the Nightingale Room, Old Market House, Birkenhead.</td>
</tr>
<tr>
<td></td>
<td>Please send any apologies to Anita Fletcher on <a href="mailto:anitafletcher@nhs.net">anitafletcher@nhs.net</a></td>
</tr>
</tbody>
</table>

The meeting finished at 8.45pm
Audit Committee Meeting

Thursday 3rd April 2014
9.30am – 11.30am, Room 539, Old Market House

Present:

James Kay (JK)                  Audit Committee Chair
Mark Bakewell (MB)              Chief Financial Officer
Anne-Marie Harrop (AMH)        Audit Manager, Mersey Internal Audit Agency
Liz Temple-Murray (LTM)         Manager - Grant Thornton
Sylvia Cheater (SC)            Audit Lay Member
Tracey Fisher (TF)              Audit Lay Member
Paul Edwards (PE)               Head of Corporate Affairs
Simon Wagener (SW)              Lay Member
Laura Wentworth (LW)           Corporate Support Officer
Gordon Haworth (GH)            Executive Assurance- Grant Thornton
Bernard Halley (BH)            Audit Lay Member
Joy Hammond (JH)               Head of Fraud and Probity Services
Lin Elliott (LE)               Audit Manager – Mersey Internal Audit Agency

In Attendance:

Chelsea Worthington (CW)       Administrative Assistant (minutes)
Andrew Cooper (AC)             Wirral Health Commissioning Consortium Chief Officer
Iain Stewart (IS)              Wirral Alliance Commissioning Consortium Chief Officer
Lorna Quigley (LQ)             Head of Quality and Performance
Dr Abhi Mantgani (AM)          Chief Clinical Officer

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Agenda Items</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC14-15/01</td>
<td>PRELIMINARY BUSINESS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Welcome to New Audit Member</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AMH introduced LE to the group as the new Internal Audit Manager who will be attending future meetings on behalf of MIAA, in place of AMH. The group noted that LE will attend all future audit meetings and thanked AMH for all of the work from MIAA to date.</td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td><strong>Apologies:</strong> Robin Baker – Grant Thornton&lt;br&gt;Christine Campbell – Wirral GP Commissioning Consortium Chief Officer</td>
<td></td>
</tr>
</tbody>
</table>
1.2 **Declarations of Interest:**

No declarations of interest were made.

1.3 **Minutes of Previous Meeting/Action points of previous meeting held on 13th November 2013**

**Action Points:**
- Action 32 – LQ to provide an update regarding this.
- Action 48 - to be closed and removed from list.
- Action 51 – On-going at present.
- Action 52- to be closed and removed from list.
- Action 53- PE to resend the assurance framework with the descriptions of the acronyms to Lay Members.
- Action 54- to be closed and removed from list.
- Action 55 – MB advised that he is currently in discussions with ICT regarding contradiction of system policies and screensavers – On-going at present.
- Action 56 – to be closed and removed from list.
- Action 57- to be closed and removed from list.
- Action 58 – to be closed and removed from list.
- Action 59 – to be closed and removed from list.
- Action 60 – to be closed and removed from list.

SW raised a point on page 6 of the previous minutes regarding the attendance of Bennett Quinn to the Quality Performance and Finance meetings. It was agreed that the wording should be amended to highlight that Bennett Quinn will be invited to the Quality Performance & Finance Committees as per the work plan of the meeting.

The minutes of the previous meeting held on 30th January 2014 were agreed as a true and accurate record subject to the change to the wording as noted above.

It was noted that the actions tracker should be updated to reflect items completed or amended.

1.4 **Matters Arising:**

BH noted that there is an error with regards to the open date on the Action tracker in the Audit papers and the A3 copy each member received at the meeting. LW advised that there had been a formatting issue and that the correct version is the document circulated within the agenda of the meeting.

PE explained to the committee the importance of receiving feedback on the revised consortia TORs as part of the NHS England update cycle for constitution amendments. The TORs will be presented at May’s Governing Body meeting then be sent to NHS England for approval. PE requested for any comments regarding the revised terms of reference to be sent to him by close of play on 9th April.

The group agreed there were no other matters arising.
ITEMS FOR DISCUSSION

2.13 Counter Fraud Update

It was agreed to take the Counter Fraud item as first agenda item in order to release JH from the rest of the meeting.

JH presented the Counter Fraud work plan to the group. The work plan is a generic plan and as yet no guidance has been received from NHS Protect therefore this document has been collated to show in generic terms what will be covered.

There are currently 10 areas to make sure that the CCG are compliant:
1. Prepare and implement annual anti-fraud plan
2. Attend NHS protect meetings
3. Provide training and presentations to staff including bribery act awareness
4. To meet with key personnel including senior managers and the C.F.O on a regular basis
5. Ensure appropriate dissemination of fraud alerts
6. Review a selection of CCG policies
7. Attend each audit committee meeting and provide a written and verbal update
8. Investigate any allegations of fraud or bribery in an appropriate and diligent manner, ensuring the CFO is kept abreast of any developments.
9. Prepare an annual report detailing the work undertaken
10. Liaise closely with the appropriate external bodies including NHS England

JH presented the Fraud update paper to the group and provided an update to the committee on the on-going case of a patient.

2.1 Audit Workplan

MB presented the Audit Work plan to the group and it was noted that all due items from the plan are included within the agenda of the meeting. It was noted that the current work plan is only valid until May 2014 and therefore the group will need to work together with MB to collate the work plan for the next 12 month period.

LTM advised that under the section external audit on the work plan the audit committee will receive the external auditors report to those charged with governance at the next meeting scheduled for the 28th May therefore the work plan will need to be updated to reflect this.

MB/JK
<table>
<thead>
<tr>
<th>2.2</th>
<th>AMH advised that the MIAA annual internal audit report and work plan should be on the work plan for April and not May – MB to amend the work plan accordingly.</th>
<th>MB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Final Accounts Timetable</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MB presented the final accounts timetable to group members and the group agreed that it is helpful for the document to contain such high level of detail.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MB explained that the purpose of bringing the timetable to the committee was to provide the relevant assurance that there is a plan in place.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on current information, the CCG are on track and well placed against the timetable. MB highlighted that he is very pleased with the support from the CSU finance team in year end preparations.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LTM agreed that bringing this document to the committee is very helpful and this shows that there is a firm plan in place for the CCG.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BH noted that the top corner of the document refers to Warrington CCG. MB explained that this is a standard document which has been received by all CCG’s from the CSU and this will be amended for Wirral.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Action – MB to liaise with CSU re references to Warrington CCG within the document to be amended to Wirral CCG.</strong></td>
<td>MB</td>
</tr>
<tr>
<td>2.3</td>
<td><strong>Review of losses and payments</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MB advised that there have been no losses and payments to date. The group noted that it is a statutory requirement for this item to be included on each Audit Committee agenda.</td>
<td></td>
</tr>
<tr>
<td>2.4</td>
<td><strong>Assurance Framework opinion</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LE presented the Assurance framework review report to the group and explained that this review is undertaken by MIAA annually. LE concluded that the CCG have established a very good assurance framework which has been designed to meet the requirements and is a good system for monitoring internal control to manage risks within the CCG. PE advised that the CCG will continually review the action plan linked to this.</td>
<td></td>
</tr>
<tr>
<td>2.5</td>
<td><strong>Audit Committee Progress Reports</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AMH presented the Audit Committee progress report and explained that the purpose of this is to provide an update to the Audit Committee regarding assurances, key issues and progress against the Internal Audit Plan for 2013/14. AMH advised that the report details the findings, recommendations and agreed actions. The group noted that all the work completed is on a residual work plan for last year, which is linked to the Audit Tracker document.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AMH advised group members that there was limited assurance across all CCG’s in Cheshire &amp; Merseyside with regards to the KPIs within the CSU.</td>
<td></td>
</tr>
</tbody>
</table>
Contract Management Audit therefore this is not just an issue for Wirral CCG.

AMH explained that the CCG statutory duties section within the document is more of a gap analysis review and that MIAA have no concerns regarding this.

PE highlighted that this is a really helpful exercise as it is good for the CCG to be aware of where any gaps are.

AMH advised that the plan is complete and an events brochure will be sent out to all members following this meeting.

**Action – AMH to send audit committee members a copy of the events brochure**

### 2.6 Director of Internal Audit Opinion /Annual report 13/14

LE presented the Director of Internal Audit Opinion and Annual Report for 13/14 and advised group members that the Audits Opinion is in accordance with the Public Sector Internal Audit Standards. The Director of Internal Audit is required to provide an annual opinion which is based upon work performed and overall adequacy and effectiveness of the organisation.

The overall opinion is that of Significant Assurance, the definition of which is that there is a generally sound system of internal control designed to meet the organisations objectives, and that controls are generally being applied consistently. However there were some weaknesses in the design / inconsistent application of controls which could put the achievement of particular objective at risk.

### 2.7 Draft Internal Audit Plan 14/15

AMH presented the Draft Internal Audit Plan 14/15 to group members. The plan describes how MIAA will deliver the CCG’s internal audit services within 14/15. The plan is based on local risk assessment and details how MIAA’s work aligns the CCGs strategic risk assessment. AMH explained that the document has previously been shared with the CCG. It was agreed to move stakeholder engagement and duty of candour to be brought forward as a priority.

It was agreed that the inclusion of prescribing incentives within the plan will be kept under review.

The confirmed fee’s for 14/15 are £38,800 for internal audit.

The group members agreed to sign off and approve this plan based on the above changes.

### 2.9 IG Report

MB presented the IG report to the group and explained that this is the same
report which has been previously reviewed at the March Quality, Performance & Finance Committee. MB highlighted that the CCG has achieved level 2 compliance for the financial year and that the CCG now need to assess its standing and requirements for next financial year.

### 2.8 Information Governance Assurance Review

MB presented the MIAA IG toolkit audit review to the group in support of the previous update regarding level 2 compliance.

### 2.10 Review External Audit Progress and Reports

LTM presented the Audit Progress Report. LTM explained that the CCG are on track with the current guidance however there are a few key issues which include: going concern assumption, accounting for legacy transactions and balance, closing the gap for essential changes in Mental Health and Accounts workshop planed for CCGs.

LTM apologised for the cancellation of the arranged Liverpool workshop. LTM advised that she is happy to go through seminar feedback with group members if they feel necessary.

The group discussed the possibility of holding an additional meeting once a draft set of CCG accounts had been completed (due 23rd April), in order to discuss in more detail any relevant issues and enable further understanding of the year end requirements

CW to arrange meeting between Audit Lay Members and External Audit team

### 2.11 Audit Plan 2013/14

LTM presented the audit plan of 2013/14 to the group and explained how it supports the CCG in understanding its business and challenges for the organisation.

BH queried whether the External Auditor team use the Internal Auditors resources to review. LTM identified that elements of prior audit work are taken into consideration however given difference in methodologies, testing and documentation requirements it was not always feasible to do so.

Committee to note the two significant risks identified within the report regarding fraudulent transactions and the management over ride of controls.

### 2.12 2014/15 fees

LTM explained that the fees for 13/14 were £99,000 with a £9,000 service charge refunded for being a CCG for the first year.

The confirmed fee’s for 14/15 are £90,000 for external audit.

LTM explained that a summary of all Grant Thornton’s Fees are available online.
### 2.14 Review Clinical Audit Process

LQ joined the meeting

LQ provided an update to the group regarding quality and safety issues and to provide assurance regarding aspects of clinical commissioning. LQ advised that there is a Cheshire, Warrington & Wirral Quality Surveillance Group which is attended by the CCG. This looks at systems and processes as a cluster of CCGs and is an opportunity for intelligence to be shared across the patch.

LQ continued that the CCG have built on the work which has been completed previously, together with confident systems in place to spot issues quickly and ensure that learning is shared to prevent incidents from occurring again.

CCG continues to develop appropriate systems and processes to enhance quality aspect of its commissioning duties.

### 2.15 Plan How To Discharge Audit Committee Duties

PE provided a verbal update to the group on how the audit committee’s duties are discharged. The group noted that the Audit Committee is being strengthened through the membership of the new Audit Lay Members.

MB advised that the results from the survey monkey regarding the committee survey will be brought to the next audit meeting which is scheduled to take place on the 28th May.

AMH suggested for a member of MIAA to come in and deliver a presentation on committee effectiveness at a meeting later on in the year. The group agreed that this would be helpful to receive for members. It was agreed that this would be booked in for a meeting in the 3rd quarter of the year.

**Action** - CW to arrange meeting

### 2.16 Audit Tracker

MB presented the audit tracker document to the group and each of the ongoing actions were noted.

MB advised that himself, LW and AMH have been through the tracker in a pre-meet prior to this group.

SW explained that he is attending the Wirral Alliance Commissioning Consortium AGM on 15th April and will then provide feedback re their progress against the on-going audit to the next Audit Committee.

**Action** – SW to feedback on WACC update to the May Audit Committee.

### 2.17 Annual Report/ Governance Statement

PE presented the draft Annual Report/ Governance Statement to the group. PE explained that the CCG are still currently working off the draft NHS
England guidance document for both this and the Annual Report. PE requested for any further comments regarding this document to be passed to him at the earliest opportunity.

**Action – PE to send draft copy of report to LTM**

**2.18 Receive Other Sources of Assurance**

PE provided a verbal update on the other sources of assurance building on prior discussions and explained that the updated version will be presented to the next Audit Committee in May.

**2.19 Grant Thornton Letter To Management**

MB presented the Letters to Management from Grant Thornton and thanked everyone for their contribution. It was noted that the questions and answers from the CCG went to a previous Governing Body meeting where it was approved.

MB explained that the CCG are currently in the process of responding to Grant Thornton.

JK thanked the new Lay Members for their feedback in response to this.

**2.20 Chairs Report**

PE discussed with group the requirement of each sub committee to prepare a report to the governing body on its activities and its linkage with Annual Report / Annual Governance Statement

PE proposed that the Audit Committee report is to be used as a template and circulated to other sub committee leads as a pro-forma for completion.

**ITEMS FOR INFORMATION**

**3.1** No further items were received or noted.

**ANY OTHER BUSINESS**

**4.1** The group welcomed the Accountable Officer Dr Abhi Mantgani, to discuss some suggested amendments to the CCG’s Approvals Committee membership and activity.

Given the growing agenda and requirement for transparency it would be
helpful for the Approvals Committee to be strengthened with new lay members.

JK advised that he has already had some discussions with the Executive about this and will be developing some proposals to strengthen the Approvals Committee which can go forward to the May Governing Body meeting.

**Action** JK to work with CCG officers on a proposal to enhance the Approvals Committee membership.

AM sought the view of the Audit Committee on a further matter.

A number of GP incentive schemes have been implemented after Approvals Committee sign off. It is now timely to review the implementation of these schemes.

AM suggested that this work would best be done by an independent review undertaken by an external body. This would strengthen our governance processes given the potential for a conflict of interest if the work were to be led by a CCG Officer / GP.

Members agreed and authorized the Chair to take this matter forward towards commissioning such an external review in discussions with the Chief Financial Officer and Head of Corporate Affairs.

**Action** JK to meet with MB and PE to plan the outlines of an external review of incentive schemes authorised over the last 12 months by the Approvals Committee.

---

**DATE AND TIME OF NEXT MEETING**

The next meeting will be held on:

**28th May 2014, 10am -12pm, Room 539, Old Market House.**

Please forward apologies / agenda papers to chelsea.worthington@nhs.net
## Risk Scoring Matrix

<table>
<thead>
<tr>
<th>Level</th>
<th>Descriptor</th>
<th>Examples</th>
<th>Frequency/Occurrence</th>
<th>Consequence Likelihood</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rare</td>
<td>Difficult to believe that this will ever happen again</td>
<td>Annually</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Unlikely</td>
<td>Do not expect it to happen/happen again but it may</td>
<td>Bi-annually</td>
<td></td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>Possible</td>
<td>It is possible that it may occur/reoccur</td>
<td>Monthly</td>
<td></td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>4</td>
<td>Likely</td>
<td>It is likely to occur/reoccur but is not a persistent issue</td>
<td>Weekly</td>
<td></td>
<td>4</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>5</td>
<td>Almost Certain</td>
<td>Will almost certainly occur/reoccur and could be a persistent issue</td>
<td>Daily</td>
<td></td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Risk ID</td>
<td>Date added</td>
<td>Source</td>
<td>Division</td>
<td>Risk Description</td>
<td>Organisational Objectives (reference to stakeholder)</td>
<td>Impact</td>
<td>Likelihood</td>
<td>Previous Score</td>
<td>Key Control Established (reference to evidence)</td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
<td>--------</td>
<td>----------</td>
<td>------------------</td>
<td>-----------------------------------------------------</td>
<td>--------</td>
<td>------------</td>
<td>---------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>12-13 A</td>
<td>12-13 Financial Year</td>
<td>Senior Body</td>
<td>Goals</td>
<td>12-13</td>
<td>4 3</td>
<td>12.00</td>
<td>Contract Monitoring</td>
<td>CSU Performance</td>
<td>Business Intelligence</td>
</tr>
<tr>
<td>12-13 B</td>
<td>12-13 Financial Year</td>
<td>Senior Body</td>
<td>Goals</td>
<td>12-13</td>
<td>4 3</td>
<td>12.00</td>
<td>Contract Monitoring</td>
<td>CSU Performance</td>
<td>Business Intelligence</td>
</tr>
<tr>
<td>13-14 A</td>
<td>12-13 Financial Year</td>
<td>Senior Body</td>
<td>Goals</td>
<td>12-13</td>
<td>4 3</td>
<td>12.00</td>
<td>Contact Monitoring</td>
<td>CSU Performance</td>
<td>Business Intelligence</td>
</tr>
<tr>
<td>13-14 B</td>
<td>12-13 Financial Year</td>
<td>Senior Body</td>
<td>Goals</td>
<td>12-13</td>
<td>4 3</td>
<td>12.00</td>
<td>Contact Monitoring</td>
<td>CSU Performance</td>
<td>Business Intelligence</td>
</tr>
<tr>
<td>13-14 C</td>
<td>12-13 Financial Year</td>
<td>Senior Body</td>
<td>Goals</td>
<td>12-13</td>
<td>4 3</td>
<td>12.00</td>
<td>Contact Monitoring</td>
<td>CSU Performance</td>
<td>Business Intelligence</td>
</tr>
</tbody>
</table>

**Note:** The table provides a structured view of risks, their descriptions, likelihood, impact, controls, and the next review date. Each risk is associated with specific stakeholders and actions plans. The table is designed to facilitate a clear understanding of the risk management process.
**Risk Register Process**

**Before QPF Meeting**
E-mail to be sent to QPF members to request any new risks.
Risk added to Register by TB.

**At QPF Meeting:**
New Risks and corresponding action plan to be considered for inclusion - either keep or decision escalated to risk owner.
Current risks to be reviewed in line with action plan progression.

**After QPF Meeting**
TB to update Monitoring column with decisions made at group.
TB to amend residual risk rating in line with actions.

**At Governing Body**
Review new and escalated risks
Agree to include or de-escalate risks

**After Governing Body**
TB to update Monitoring column with decisions made at group.
TB to amend residual risk rating in line with actions.
Add removed risks to the Removed risks Tab.
Save and copy for next review.