NHS
South Sefton
Clinical Commissioning Group

Annual Report and Accounts

2017 - 2018

Staying **local**
& together

Contents

Performance overview

Introduction

Welcome to our Annual Report and Accounts 2017-2018. This document is a guide to the work we have done over the last year, setting out our key achievements and the challenges we have faced along the way.

You will find information about how we are working to improve the quality of the services we commission whilst also improving our financial position. We have made good progress against some challenging budgetary targets and this work will continue over the coming period.

We have also continued to further develop the health services our residents have access to and a good example of this is our new and dedicated transgender services that we co-designed with patients and medical professionals.

In addition, our medicines management team have continued to progress innovative schemes such as our repeat prescription ordering service and Care at the Chemist. This work has delivered real benefits in patient safety, whilst also achieving significant cost savings. You can read more about these programmes later on in this report.

2018 marks the 70th anniversary of the NHS and so we have chosen to nominate a 'community partner of the year' in recognition of the enormous contributions of the third sector to the health of the local population in South Sefton. Our staff chose to nominate Sefton Council for Voluntary Services (CVS) and we would like to place on record our thanks to them and all of the other voluntary, community and faith organisations who do so much important work for local people.

This report also details examples of the engagement work that we have carried out over the last twelve months and continue to do so, ensuring the health service meets the needs of residents in south Sefton.

There is no doubt that we continue to face significant financial pressures. However, we have achieved significant efficiencies over the last year and will continue to embrace the responsibility of ensuring that our services are sustainable.

Dr Craig Gillespie

Acting chair

Fiona Taylor

Chief officer

Our journey in 2017-2018

We have made some good progress as we journeyed through 2017-2018 during an increasingly demanding period for the NHS nationally and locally. More than ever, our focus has been on commissioning the most efficient and effective services possible through our quality, innovation, productivity and prevention programme (QIPP). We achieved some good quality improvements that our patients are benefiting from during the year, whilst at the same time ensuring we are spending all the money we have for healthcare wisely.

Here is a roadmap of some of the significant achievements and challenges from our journey in 2017-2018 that you will read more about later in this report.

April 2017

- We set an ambitious savings target of around £8.5million to improve quality and efficiency of the services we commission against a total budget of nearly £245 million

May 2017

- We celebrate Sefton's #nurseheroes in a week long campaign recognising their tireless work and dedication, using social media to share their stories, also highlighting the rewards of a career in nursing

June 2017

- Mersey Care NHS Foundation Trust takes over the running of the majority of community services, like blood testing and district nursing following a transaction process informed by residents views
- A review of our commissioning policy begins, with residents asked for views about an initial batch of 18 policies for specific treatments, updated to bring them in line with the latest medical evidence. In total over 100 policies will be reviewed during the year long process to ensure we commission the most effective procedures and treatments
- A 'you said we did' focused Big Chat 8 drew residents to hear about how we've been using their views from previous events to inform our services and plans. Attendees were also asked for views about our latest plans for more effective and efficient services

July 2017

- We maintain our annual performance rating of 'requires improvement', reflecting our hard work amidst a challenging environment
- New report called 'Working Together for a Healthier Community' highlights the impact of our investment in the voluntary, community and faith sector (VCF), through grants from CCGs in Sefton totalling £2.5million over three years to improve local health and wellbeing. You can view the report on our website
- Our repeat prescription ordering pilot is rolled out to all Sefton GP practices after an initial pilot proved successful - improving safety and saving over £220,000 in its first three months

September 2017

- ‘30 Days of Sefton in Mind’ involved partners across the borough promoting good mental health and wellbeing and the support that is available locally to achieve it. It used social media to share case studies and contacts
- High ratings for GPs achieved in latest patient survey, with most practices scoring above the national average in many categories

October 2017

- NHS England’s annual CCG performance process rates us as ‘requires improvement’ for a second consecutive year, meaning we have maintained our position during an increasingly challenging period through our good work
- Together with Sefton Council we encouraged eligible residents to get protected against the effects of influenza as part of the annual flu vaccination campaign
- Our Integrated Community Reablement and Assessment Service (ICRAS) with Sefton Council, providing more appropriate care for some of our most vulnerable patients launches on 1 October, representing significant progress in joining up health and social care

November 2017

- Residents encouraged to ‘take control and self care for life’, in a week long campaign using video and other media focusing on options available to looking after their health

December 2017

- CHIP, our Care Home Innovation Programme, is highly commended in the telehealth category of the Health Business Awards 2017
- Our year round Examine Your Options campaign reminds people during the busy festive period that A&E departments are for life threatening conditions and to consider other options for minor ailments such as self care and expert pharmacy advice

January 2018

- Our finance team is reaccredited at level two in the Finance Skill Development North West ‘Towards Excellence’ programme
- National Better Care Fund leaders visit Sefton to see first hand the good early practice and results of our new our new ICRAS programme, to share learning more widely

February 2018

- ‘Good’ rating announced for local diabetes care in the national performance of better health in England 2016-2017 assessments

March 2018

- Repeat prescription ordering pilot shortlisted in Health Service Journal Value Awards 2018
- We achieve nearly £3 million quality savings against our target, which is over 1% of our annual budget

Who we are and what we do

We are NHS South Sefton Clinical Commissioning Group (CCG) and we have been responsible for planning and buying – or 'commissioning' – nearly all local health services since 1 April 2013. In 2017-2018 we had a budget of £245 million to spend on commissioning the following health services for our 154,732 south Sefton residents[1]:

- Community based services, such as district nursing and blood testing
- Hospital care, including routine operations, outpatient clinics, maternity and accident and emergency services
- GP out of hours services, giving people access to a doctor when their surgery is closed in the evenings, weekends and bank holidays
- Nearly all mental health services

Our CCG is a membership organisation made up of doctors, nurses, lay representatives and other health professionals, representing all 30 doctor's surgeries in south Sefton. We support practices to be actively involved in the work of the CCG. Much of this work is carried out in 'localities', covering four geographical areas, so practices can really focus on addressing the health needs of their individual communities (see page 30). Our four localities are Bootle, Crosby, Maghull, Seaforth and Litherland. A Governing Body of elected GPs, practice staff, lay representatives and other professionals makes decisions about our CCG on behalf of the wider membership.

Whilst we support people's right to choose where they are treated and who provides their care[2], the majority of the services we commissioned in 2017-2018 were commissioned from the following providers:

- Aintree University Hospital NHS Foundation Trust – where the majority of our residents receive any general hospital care they may need
- Mersey Care NHS Foundation Trust – providing community services from 1 June 2017 in addition to many of the mental health services we commission
- North West Ambulance Service NHS Trust – providers of patient transport services as well as its network of emergency response vehicles
- Other NHS organisations – including Southport and Ormskirk Hospital NHS Trust, Royal Liverpool and Broadgreen University Hospitals NHS Trust, Liverpool Women's NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust, The Walton Centre and Liverpool Heart and Chest Hospital NHS Foundation Trust
- Community and voluntary sector organisations – like Sefton Carers Centre and the Alzheimer's Society
- Independent and private sector providers – including Go To Doc that is led by doctors and provides our GP out of hours service
- Midlands and Lancashire Commissioning Support Unit – which provides many of our administrative and operational functions like procurement and human resources

[1] Source: NHS England - 2016-17 to 2020-21 Allocations, 2015 Unweighted ONS population estimate uplifted by ONS resident population growth at Local Authority level for 2017-2018 allocations https://www.england.nhs.uk/publication/nhs-england-allocations-2016-17-to-2020-21-overall-weighted-populations-for-core-ccg-allocations/

[2] NHS Constitution https://www.gov.uk/government/publications/the-nhs-constitution-for-england

So we can make the right commissioning decisions for our patients' needs, we continually review and monitor local services to make sure they meet the standards and quality we expect. Alongside this, we routinely assess all the information and medical evidence we have about current health and health services in south Sefton, to inform what more we need to do.

Our strategic approach to commissioning services is set out in our strategy for transformation, called Shaping Sefton. A number of other CCG and partnership plans, strategies and targets inform our work too. This includes the Joint Strategic Needs Assessment (JSNA) and Sefton's Health and Wellbeing Strategy, both developed by Sefton Council working together with us. We also have a joint strategy for integration with the council called 'Making it Happen'[3].

Our plans also have to meet a number of nationally set standards and requirements like the NHS Outcomes Framework[4], Five Year Forward View[5], GP Forward View[6], Improvement and Assessment Framework for CCGs[7] and the NHS Constitution[8], which also sets out the legal rights of our patients' and staff and what is expected from them in return – so we can all get the best from the NHS and the resources it has at its disposal.

Our residents also play an important role in helping us to shape our work and oversee services, and we involve them in our work in a number of different ways – from routinely gaining their views and experiences, to inviting representatives to join some of our most important groups and committees.

You will read more about all these different aspects of our work throughout this report and you will also find a range of further information on our website www.southseftonccg.nhs.uk

[3] Find all of these on Sefton Council website - https://www.sefton.gov.uk/17872
[4] NHS Outcomes Framework indicators - https://www.england.nhs.uk/about/equality/equality-hub/nhs-outcome-framework-health-inequalities-indicators/
[5] 5YFV - https://www.england.nhs.uk/five-year-forward-view/
[6] GPFV - https://www.england.nhs.uk/gp/gpfv/
[7] Improvement and Assessment Framework - https://www.england.nhs.uk/commissioning/ccg-assess/
[8] NHS Constitution - https://www.gov.uk/government/publications/the-nhs-constitution-for-england

Our local challenges

The NHS is facing the most challenging period in its history. Funding constraints, increasing demand for services and workforce issues are all contributory factors. The picture is no different here in south Sefton.

So, like many other CCGs across the country much of our work during 2017-2018 focused on ensuring continued quality of services amidst these mounting pressures.

Additionally, there are a number of distinct environmental and social factors that we must take account of when we are planning and commissioning health services for south Sefton.

These include the following:

- Our population is made up of a significantly higher proportion of older residents with an estimated 19.0% of the population over the age of 65 compared to 17.3% aged over 65 nationally. This is expected to grow to more than 38,300 in the next 10 years
- Whilst our residents aged 85 years and over is smaller in number than other age groups, we expect this to rise significantly from an estimated 4,500 in 2018 to an estimated 5,800 by 2027 - an increase of 27%
- South Sefton has significantly higher levels of deprivation and child poverty with almost 33% of the population are considered to live in the most deprived 10% of neighbourhoods in the country

Overall, health in south Sefton is getting better. However, unacceptable inequalities in health persist in different parts of the borough and these present clear areas for improvement:

- Within our most deprived communities, average life expectancy is 11 years less than people living in the more affluent parts of the area
- Levels of long term health conditions are much higher than the national average - particularly heart disease, respiratory disease, kidney disease, mental health conditions and obesity
- Levels of early deaths from heart disease have reduced over the last decade as smoking rates have reduced and our patients are better educated about risks to their health and the importance of leading a healthy lifestyle but we know there is still more to do to improve this

You can read more about the operational and financial challenges we have faced in 2017-2018 on pages 12-23, whilst further information about local health and wellbeing is available from Sefton's JSNA[9].

[9] Sefton JSNA - https://www.sefton.gov.uk/17872

Our strategy for health and care

Given all the pressures and challenges we are faced with, it is clear the NHS needs to work differently if it is to remain efficient, effective and sustainable for the future.

Together with NHS Southport and Formby CCG, we have set out a shared vision as part of our Shaping Sefton transformation programme that proposes change and responds to the challenges we face locally.

We call this vision 'community centred health and care' - where services work better together, are more responsive to people's needs and are provided as close to people's homes as possible.

Shaping Sefton is consistent with the thinking set out in the national 5 Year Forward View (5YFV) that suggests new models of care to transform and futureproof NHS services.

Shaping Sefton is also about preventing ill health and supporting greater wellbeing amongst our residents. So, it is closely linked to our work with Sefton Council through the Health and Wellbeing Board that you will read about in the next section of this report.

We have continued to make progress towards this vision in 2017-2018 against Shaping Sefton's three overarching areas of priority, informed by all the information and views we have collected over time. These priority areas are:

- Primary care
- Urgent care
- Care for the most vulnerable

At the end of 2017-2018 we set up a new Sefton Health and Care Transformation Board, bringing us together with our partners from across the borough to make quicker progress in line with Shaping Sefton.

Beyond Sefton, we are working even more closely and systematically with partners in the Cheshire & Merseyside Health and Care Partnership[10] to better understand where bigger system changes might improve care for our local residents.

Importantly, by joining together with a wide range of partners to commission services we aim to achieve more for our residents. This is particularly important in this financially challenging time for all public sector organisations, so we look to pool our resources and coordinate our efforts whenever we can to ensure services across health and social care remain sustainable.

[10] https://www.england.nhs.uk/systemchange/view-stps/cheshire-and-merseyside/

Delivering our strategy in partnership

You will read below about some of our most important organisational partners that we are involving in our work. These organisations are responsible for different aspects of local health and care services, which are described below. They share our vision for more joined up and sustainable health and care services that better meet the health needs of our residents.

NHS England

Together with NHS England, we work to ensure health services for south Sefton residents meet national and local standards. Whilst NHS England is the lead commissioner for primary care services, we were awarded 'joint commissioning' status from 1 April 2017. It means we are able to develop primary care in line with our vision for all future healthcare through our system wide Shaping Sefton programme. Locally, the Cheshire and Merseyside Area Team oversees standards and holds the contracts for GP surgeries, dentists, pharmacists and opticians, as well as some screening and immunisation programmes. Other local teams commission some additional services our residents may need from time to time, such as specialist, prison and armed forces healthcare.

Sefton Health and Wellbeing Board

This partnership board steers much of the work we do together with Sefton Council. Our chair and chief officer are core members of this committee, which brings us together with others who have a lead responsibility for health and social care in the borough. This includes local councillors, council officers, NHS providers, NHS England, representatives of the community voluntary and faith sector and Healthwatch Sefton.

Together, we have devised a Sefton wide strategy for health and wellbeing. This was based on our Joint Strategic Needs Assessment (JSNA) that brings together all the information we have about current services, to highlight where we need to do more in the future. This is particularly important as we continue to work together on addressing the inequalities in health that exist in different parts of the borough. Our 5 year strategy for improvement, called 'Health in Sefton – 2014-2019'[11] explains more about our joint role in developing the Health and Wellbeing Strategy and you will find examples of our joint work in this report.

Sefton Council

We work closely with our council commissioning colleagues across many areas including social care, mental health and children's services. Our jointly agreed 'Making it Happen' strategy describes our commitment and work towards further integration, which we believe will have great benefits for our residents by making their health and social care more seamless and effective. A well established Integrated Commissioning Group takes a lead on delivering this strategy, making significant progress this year through our Intermediate Care and Reablement Service (see page 34). This group is also looking at where we can further pool our resources towards achieving better outcomes for our patients. This is part of our work around the Better Care Fund programme[12].

[11] https://www.southseftonccg.nhs.uk/media/1156/summary_5_year_strategy_september_2014.pdf
[12] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

The council is responsible for promoting and protecting good health across Sefton. It works closely with the national body, Public Health England to do this in partnership with NHS England and ourselves. This helps to steer our work to reduce health inequalities in line with the aims of our joint health and wellbeing strategy.

The local authority also holds us to account through its overview and scrutiny functions. Our chief officer is a regular attendee of the Overview and Scrutiny Committee (OSC) for Adult Social Care and Health to update councillors of key work programmes and our chief nurse is a regular attendee of the OSC for Children and Young People.

Other clinical commissioning groups

We work with neighbouring clinical commissioning groups to plan and buy services when there is a benefit for south Sefton residents, or where services are provided across a wider geographical area, like hospital care. We share a management team with neighbouring NHS Southport and Formby CCG as well as employing staff dedicated solely to do our work. This means we are able to maintain efficient running costs and share good practice where it offers benefits to our local residents. It also helps us to work more effectively with Sefton Council and the Health and Wellbeing Board on borough wide programmes and initiatives. This is particularly important when we are addressing the variations in health that exist in different parts of Sefton, so that no one community is disadvantaged and improvements are experienced by all.

Provider organisations

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

Healthwatch Sefton

Healthwatch Sefton gathers and represents the views of people living in the borough. Due to its independence, Healthwatch can challenge those who provide services but it can also work in partnership with us and other statutory bodies to improve frontline health and social care. The chair of Healthwatch Sefton is a co-opted member of our Governing Body. The organisation also has representation on some of our other committees and working groups, including our Engagement and Patient Experience Group.

Performance analysis

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

There are also a number of documents that set out targets for different areas of our work. This includes the pledges contained in the NHS Constitution, the NHS Outcomes Framework, Better Care Fund and the Improvement and Assessment Framework.

The work you will read about throughout this report has all contributed to our performance for 2017-2018.

Detailed information about our performance during the year, including any significant issues or achievements can be found in our integrated performance reports, which are published on our website[13] in addition to being presented to our Governing Body.

[13] View integrated performance reports here - https://www.southseftonccg.nhs.uk/what-we-do/how-well-our-services-perform/

How we performed

Improvement and assessment framework

For a second consecutive year we were rated as 'requires improvement' in the annual improvement and assessment framework (IAF) process carried out by NHS England against 61 performance indicators.

Overall, our rating highlighted progress and ongoing challenges, whilst continuing to reflect the increasingly testing environment the organisation is operating in. Maintaining the rating of 'requires improvement' during such a difficult year reflects the hard work we have carried out and the improvements we have made. The assessment is based on performance data for 2016-2017 and areas cited as strengths or good practice include the following:

- Performance at or above the level required for the majority of NHS Constitution standards
- Significant assurance received on all internal audits including quality, stakeholder engagement and financial management, which show we have a good 'control environment' in place
- Proper arrangements in all significant respects to ensure we delivered value for money in our use of resources
- Our openness in relation to our financial position
- Recognition of our strong oversight of our budgetary challenges provided by our Governing Body and committee structure

You can read more about the IAF process on NHS England's website[14] and see a breakdown of our full results on the My NHS website[15]. The 2017-18 year-end assessment for the CCG will be available on the My NHS website from July 2018[16]. More about our results can also be found in our monthly integrated performance reports[17].

Better Care Fund performance

Sefton Health and Wellbeing Board submitted our Better Care Fund (BCF)[18] programme plan in September 2017. It sets out areas of work between Sefton Council and ourselves including funding contributions, scheme level spending plans and national metrics. We were also required to confirm draft Delayed Transfers of Care (DTOC) trajectories and submit a first quarterly monitoring return on the use of the improved BCF (iBCF) funding. Quarterly performance monitoring returns are submitted to NHS England on behalf of the Sefton Health and Wellbeing Board. Throughout the year we have reported meeting all national BCF conditions. Our Integrated Reablement and Assessment Service (ICRAS) scheme, launched in October 2017 is making significant progress in supporting hospital discharges as well as avoiding unnecessary hospital admission. Progress against our BCF plan is reported in our monthly integrated performance report.

[14] NHS England IAF framework - https://www.england.nhs.uk/commissioning/ccg-assess/
[15] My NHS - https://www.nhs.uk/service-search/Performance/Search
[16] MyNHS website - https://www.nhs.uk/service-search/performance/search
[17] View integrated performance reports here - https://www.southseftonccg.nhs.uk/what-we-do/how-well-our-services-perform/
[18] About the Better Care Fund https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

The following table shows overall performance for April 2017 – February 2018, with much relating to the work of our providers. Where providers fall short of expectations, we work with them to support improvement and this sometimes includes contractual measures to ensure our services meet the best possible standards.

NHS Constitution Indicators	CCG	Main Provider
A&E 4 Hour Waits (All Types)		Aintree*
Cancer 2 Week GP Referral		Aintree
RTT 18 Week Incomplete Pathway		Aintree
Other Key Targets	**CCG**	**Main Provider**
A&E 4 Hour Waits (Type 1)		Aintree
Cancer 14 Day Breast Symptom		Aintree
Cancer 31 Day First Treatment		Aintree
Cancer 31 Day Subsequent - Drug		Aintree
Cancer 31 Day Subsequent - Surgery		Aintree
Cancer 31 Day Subsequent - Radiotherapy		Aintree
Cancer 62 Day Standard		Aintree
Cancer 62 Day Screening		Aintree
Cancer 62 Day Consultant Upgrade		Aintree
Children & Young people eating disorders routine ref - 4 weeks		
Children & Young people eating disorders urgent ref- 1 week		
CPA Patients discharged and followed up in 7 days		
Dementia Diagnosis Rate		
Diagnostic Test Waiting Time		Aintree
Early Intervention in Psychosis (EIP)		
HCAI - C.Diff		Aintree
HCAI - MRSA		Aintree
HCAI - E Coli		
IAPT Access - Roll Out		
IAPT - Recovery Rate		
Mixed Sex Accommodation		Aintree
NHS E-Referral Service Utilisation		
Personal Health Budgets		
RTT 18 Week Incomplete Pathway		Aintree
RTT 52+ week waiters		Aintree
Stroke 90% time on stroke unit		Aintree
Stroke who experience TIA		Aintree
Wheelchairs - Children waiting less than 18 weeks		
Ambulance - Category One**		
Ambulance - Category Two**		
Ambulance - Category Three**		
Ambulance - Category Four**		

**Aintree University Hospital NHS Foundation Trust*

***No ambulance data is unavailable at present due to new indicators being developed.*

What we are doing to address performance

Accident and emergency services

Again this year has seen failure of the national accident and emergency (A&E) target of 95% of patients waiting no longer than four hours. Performance against this measure has been a significant challenge nationally, not just in Sefton. We are working with all partners through the North Mersey A&E Delivery Board, which brings us together with providers and other commissioners from across health and social care to improve performance against this target. Aintree University Hospital NHS Foundation Trust has revised its Cheshire & Merseyside 5 Year Forward View trajectory for A&E in 2017-2018. It failed the 93.3% February plan agreed with NHS Improvement, recording performance of 83.9% (for all A&E department types). This represents a 1.69% decrease compared to January 2018.

Ambulance services

North West Ambulance Service (NWAS) went live with its new Ambulance Response Programme (ARP) in August 2017. ARP has redesigned the way ambulance teams work. It focuses on ensuring patients get rapid care for life-changing conditions such as stroke from the point of pick up, rather than simply 'stopping the clock' and stabilising patients until they are handed over to hospital emergency teams. Performance under the new ARP regime has been significantly challenging for NWAS and to date, it has been disappointing and below expectations. Regrettably the benefits offered by ARP, of getting the right resources to patients in a timely and efficient manner first time, have not yet been sustainably delivered or met across the North West. NWAS was asked to draw up a comprehensive recovery plan and performance improvement trajectory and has implemented a series of actions to improve performance. Unfortunately, NWAS has noted that the scale of changes required to manage the transition from the former operational performance monitoring systems to the new system has been more significant than expected. As a result, it is only recently that county and CCG level performance data has become available. Therefore, the CCG expects to be in a better position to fully interpret the new ambulance performance data once it has become more routinely available.

Cancer

We achieved all cancer measures as at quarter 3 apart from the two week breast symptom target, which recorded 92.86% slightly under the 93% plan. Although Aintree University Hospital NHS Foundation Trust failed three of the nine measures in quarter 3, these included 31 day subsequent (surgery), 62 day screening and 62 day consultant upgrade. Non achievement in these areas is synonymous with individual patients choosing to wait longer for personal reasons – for example, planned holidays - and complex pathways involving a number of specialist organisations providing care and treatment across a patient journey. We are working with these NHS England commissioned services to address these challenges.

Dementia

We achieved the ambition of 66.7% in dementia diagnosis rates from August to November 2017. Unfortunately we are now under the target and are reporting 63.2% in February 2018. Work is continuing with practices to improve diagnosis opportunities to help recover and achieve the ambition rate, including dedicated web-based resources supporting practices

through the process of case finding patients with dementia. As well as a planned data cleansing exercise at the practices, a pilot is being carried out to develop a multidisciplinary, multiagency approach to the management of people living well with Alzheimer's disease.

Diagnostic test waiting times

For the whole of 2017-2018, Aintree University Hospital NHS Foundation Trust experienced difficulties in meeting this target due to capacity pressures in some test areas. This remains a challenge to the trust and action plans are in place. The trust has indicated that it hopes to be back on track by March 2018, meeting the target of less than 1% of patients having its diagnostic tests within six weeks. February saw a big improvement, recording 1.1% very close to the under 1% plan.

Healthcare associated infections

We are achieving the target for the healthcare associated infection (HCAI), C.difficile for 2017-2018 as at February 2018 but recorded one case of MRSA in June 2017 going over the zero tolerance target. For each case of C.difficile and MRSA, we hold a clinically led 'post infection review' and this identifies any critical points and contributory factors. Lessons learnt and recommendations for improvement are delivered at both practice and CCG level through learning events in order to try and mitigate the risk of harm to patients.

Improving Access to Psychological Therapies

Whilst we did not meet national access and recovery rates for Improving Access to Psychological Therapies (IAPT) in year, we did see an improving trend. The year end projected 'access rate' is 14.4% which is an improvement on the 13.5%, which was achieved in 2016-2017. The 6 and 18 weeks waiting time targets were achieved all year. We are working with the provider to make improvements towards meeting the national targets and for recovery the provider is looking to improve case management and also identifying patients who have not recovered to allow for targeted supervision. For access rates, the provider is hoping to recruit to full capacity, target under referring GP practices and improve referrals from general healthcare and people with long term conditions. The provider is also working closely with GP practices to encourage an increase in referrals, which would have a positive impact on access rates. In addition, people can now self-refer to this service and the number of venues where IAPT is delivered has increased.

Mixed sex accommodation

After recording nine mixed sex accommodation breaches last year, for 2017-2018 there were no breaches at all at Aintree University Hospital NHS Foundation Trust, with the ongoing work with all agencies showing an improvement on previous year.

NHS e-referral service usage

The NHS e-Referral Service combines electronic booking with a choice of place, date and time for first hospital or clinic appointments. The national NHS ambition is that e-referral utilisation coverage should be 80% by end of quarter 2 in 2017-2018 and 100% by end of quarter 2 in 2018-2019.The latest February 2018 data shows we are not achieving the target and are recording 24%. Work with practices to improve rates is ongoing.

Referral to treatment

From December 2017 we have fallen below the 92% referral to treatment (RTT) threshold for patients on an incomplete pathway waiting no more than 18 weeks from referral, recording 90.3% in February. The declining performance at the Royal Liverpool Broadgreen Hospital is having an adverse impact on our performance. Aintree University Hospital NHS Foundation Trust also failed this standard, recording 90.6% in February 2018. Significant pressure on the hospital bed base was experienced through December and January, contributing to the cancellation of routine elective cases to accommodate medical outlying patients, along with the cancellation of a number of outpatient clinics to release resources to support wards.

Stroke

This year we fell below the national stroke target of 80% for patients spending 90% of their time on a stroke unit every month apart from September 2017. We did however achieve the 60% target for transient ischaemic attack (TIA) consistently every month so far in 2017-2018. We continued to work with partners across North Mersey during 2017-2018, including the clinically led Stroke Network to consider that will suggest a strategic vison for stroke provision across the full pathway of services. It is hoped that this vision will provide the platform to develop a strategic plan to improve service delivery in line with the required standards and outcomes we expect for our patients.

Personal Health Budgets

Personal health budgets (PHBs) provide an amount of money to eligible residents to support their identified health and wellbeing needs, which are planned and agreed between the person and their local NHS team. We are under plan for personal health budgets as at quarter 3. We continue to look for potential ways to increase the number of PHBs and collaborative work continues with other CCGs. Our quality team has supported the review of the current PHB processes to be more streamlined, which is providing positive results. We have also been successful in applying for support from NHS England which will enable us to improve how we deliver PHB services for wheelchair users and children and young people.

Financial performance

In recent years the impact of the funding challenges in the NHS and the wider public sector has been increasingly felt by the CCG. Cost pressures can be attributed to population growth, inflation and the increased proportion of older people living longer and with increasingly complex care needs. This means we need to deliver more from every pound we spend.

Locally, the commitment is not to reduce core services, so we must transform them. All healthcare partners have a duty to ensure that local care meets the needs of the population, providing high quality and sustainable services within the money we have allocated from government for healthcare

To help towards this improvement in efficiency together with our local partners we are committed to integrating services to reduce duplication and improve them for people. As our Shaping Sefton plans to integrate health and care gathers pace and become firmly embedded, we expect patient experience and outcomes to further improve leading to reductions in demand on some services. Our approach to commissioning will look to ensure that we prioritise effective and efficient care for our population as we seek to use our resources in the best possible way.

Clinical commissioning groups have a duty to operate within their available resources and this is described in our CCG constitution. It is also required as part of NHS England 'business rules', which also require us to deliver a year end surplus of 1% of our total annual financial allocation. We delivered financial surpluses in the first four years of operation. The financial position has worsened 2017-2018 and at the end of the financial year we are reporting a £2.99 million deficit.

	2013/14		2014/15		2015/16		2016/17		2017/18	
	Allocation £'M	Expenditure £'M	Allocation £'M	Expenditure £'M	Allocation £'M	Expenditure £'M	Allocation £'M	Expenditure £'M	Allocation £'M	Expenditure £'M
Programme	222.47	220.34	227.28	224.91	239.42	237.06	241.05	243.70	241.57	246.36
Running Cost Allowance	3.68	3.50	4.06	3.58	3.30	3.26	3.27	2.86	3.22	2.93
TOTAL	226.15	223.84	231.34	228.49	242.72	240.32	244.32	246.56	244.79	249.29
Surplus/ (Deficit) before application of NHS England reserves		**2.31**		**2.85**		**2.40**		**-2.24**		**-4.50**
Adjust for:										
Risk reserve - (1% 2016/17 - 0.5% 2017/18)								**2.34**		1.21
Category M drug rebate										0.30
Surplus/ (Deficit) for the year		**2.31**		**2.85**		**2.40**		**0.10**		**-2.99**

We also have a number of financial duties under the NHS Act 2006 (as amended). Performance against these duties is described in the table below:

Summary Financial Performance 2017-18	Duty Achieved
Expenditure not to exceed income	×
Capital resource use does not exceed the amount specified in Directions	Not Applicable
Revenue resource use does not exceed the anout specified in Directions	×
Capital resource on specified matter(s) does not exceed the amount specified in Directions	Not Applicable
Revenue Administration resource use does not exceed the amount specified in Directions	✓

During March 2018 our external auditors, Grant Thornton UK LLP, issued a referral to the Secretary of State as stipulated under section 30 of the Local Audit and Accountability Act 2014. This referral was made because we planned to exceed our notified allocation as at 31 March 2018.

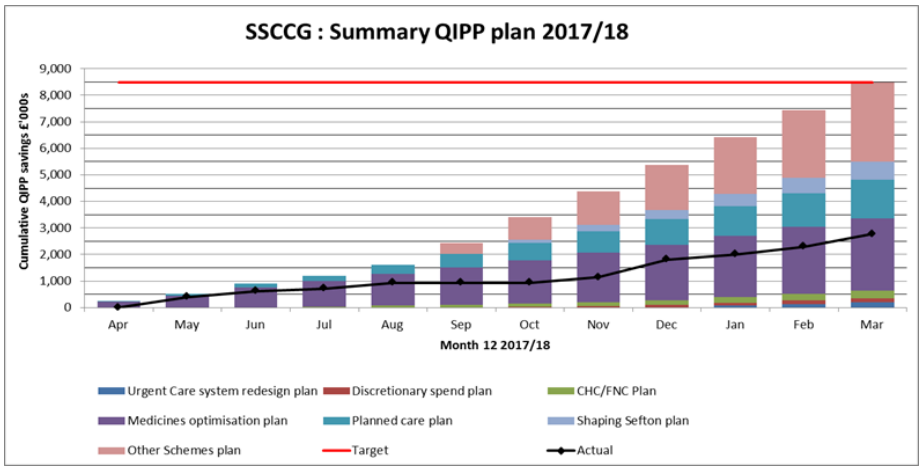
NHS South Sefton CCG is required to assess and satisfy itself that it is appropriate to prepare financial statements on a 'going concern' basis for at least 12 months from the date of the accounts. We have made an assessment of factors affecting the CCG and we have concluded that:

- Healthcare services will continue to be provided for the residents of south Sefton for the indefinite future
- We have appropriate management capacity and capability to implement our CCG long term financial strategy
- We have a robust risk management strategy and processes in place

Our Governing Body agreed to a financial plan reflecting a break even position. However, during the financial year a number of cost pressures emerged, specifically over performance within acute provider contracts (NHS and non NHS) and costs of continuing healthcare packages.

Our 2017-2018 financial position was also dependent on us delivering a challenging Quality, Innovation, Productivity and Prevention (QIPP) programme to meet planned savings of £8.48 million. We delivered 33% of this in year, which equates to £2.77million.

As set out in the 2017-2018 NHS planning guidance, CCGs were required to hold a 0.5% reserve uncommitted from the start of the year. This was intended to be held as a contingency to mitigate financial risks in the wider NHS system. NHS England has confirmed that this funding is not required centrally and therefore the reserve has been offset against our CCG cost pressures from the current financial year. The position has also been improved by the return to the CCG of around £300k by NHS England in relation to price reductions for certain types of drugs known as Category M drugs.



We have developed a long term financial strategy to ensure we get the best possible health and care services for our population within the funding available. Our QIPP plans are central to ensuring we deliver value for money for our residents, at the same time contributing to improvement of our financial position.

Our QIPP plan includes schemes categorised under the following headings:

- Elective care pathways -- Elective care is planned care. Areas we have looked at include first outpatient appointments (e.g., with a hospital consultant), admissions (eg, for a day case operation such as cataract surgery, or an in-patient admission for a procedure requiring one or more nights in hospital), follow up appointments and outpatient procedures
- Medicines optimisation - Schemes under this heading aim to ensure that medicines provide the greatest possible benefit to people by encouraging medicines reconciliation, medication review and the use of patient decision aids. Some of these are described on page 40
- Continuing healthcare and funded nursing care - Continuing healthcare (CHC) is a package of care arranged and funded by the NHS for individuals not in hospital and assessed as having a 'primary health need'. NHS funded nursing care is provided by a registered nurse for people who live in a care home. Find out more on page 26
- Non elective opportunities - Non elective care is unplanned care which could be an emergency or urgent intervention. Reducing avoidable emergency admissions improves the quality of life for people with long term and acute conditions for patients and their families as well as reducing pressures on financial resources
- Discretionary expenditure - All other areas of expenditure under our control, like day to day running costs of the CCG.

In the autumn of 2016, we worked with other CCGs and providers in North Merseyside to develop 'Acting as One' arrangements in support of wider sustainable and transformation plans, promoting financial stability and mitigating risks right across the local health economy.

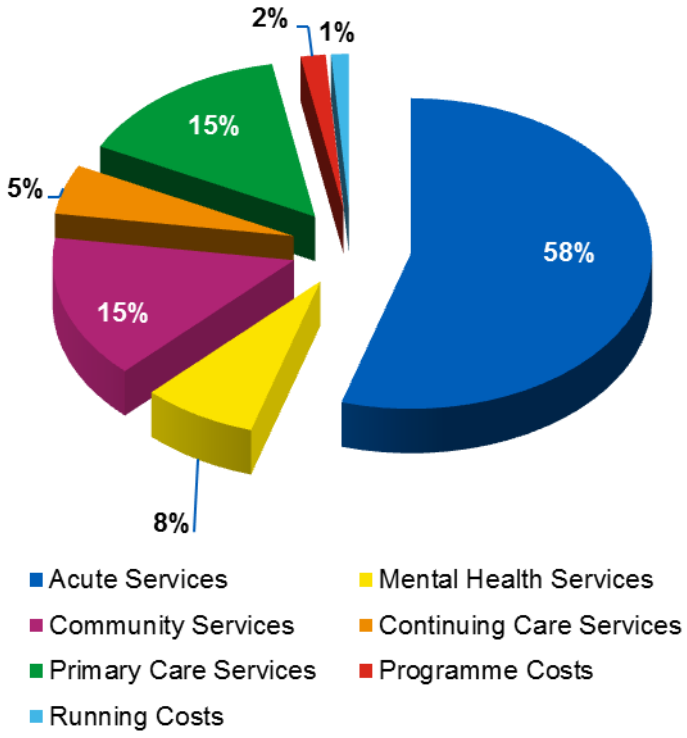
All partners in 'Acting as One' agreed a set of principles for contracting over the two year period 2017-2019. Our expenditure would have increased by £0.73 million had it not been part of the Acting as One arrangements with local providers. The arrangement has therefore helped reduce the financial risk we faced in 2017-2018.

We will continue to contract outside of the “Acting as One” arrangements with other providers. Financial performance will continue to be rigorously monitored for emerging issues and financial risks.

Our CCG finance team is a key enabler in supporting business transformation. There is a strong focus on development and training to ensure the team remains ‘fit for purpose’. During the year the finance team has continued to ensure that the services it provides are of the highest standard. During the year the team was successful in retaining the Finance Skills Development North West - Towards Excellence - Level 2 Accreditation. Work is ongoing to submit evidence to reach the highest level available (Level 3) during the 2018-2019 financial year.

Analysis of funding and expenditure

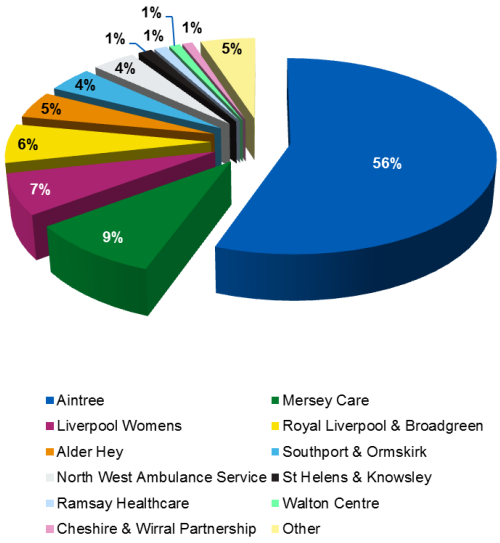
During 2017-2018 we received £244.79m of parliamentary revenue funding. A breakdown of this funding and how it was used is reported in the table below:



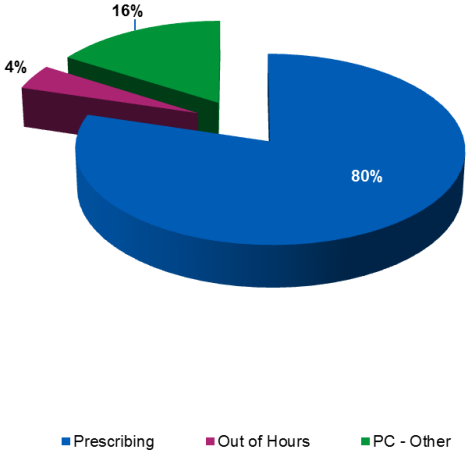
Area	Total Costs (£000s)
Acute Services	135,385
Mental Health Services	19,083
Community Services	37,111
Continuing Care Services	12,817
Primary Care Services	36,311
Programme Costs	4,148
Running Costs	2,931

Our main areas of spend were as follows:

Secondary healthcare – this represents the cost of contracts with hospitals to provide services for our population. This includes accident and emergency, mental illness, general and acute services. Secondary healthcare costs are shown by provider in the following table.



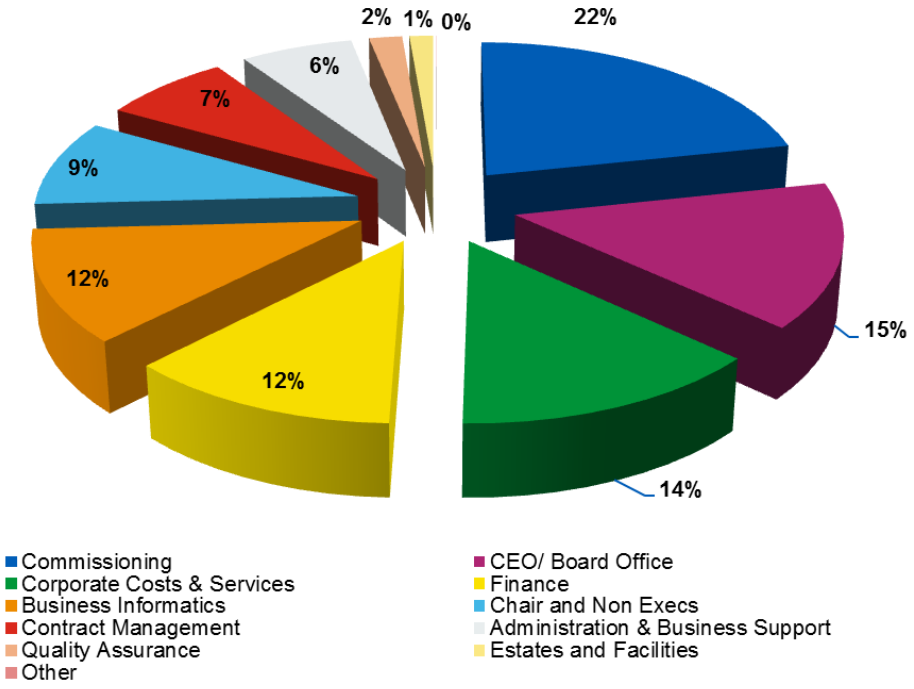
Primary care costs – the majority of this area of spend relates to the costs of drugs prescribed by GPs. Also included are some other services commissioned by GPs and primary care contractors for example, out of hours services.



CHC – this relates to the costs of services provided in a community setting for example, district nursing, physiotherapy and community clinics. It also includes long term packages of care for people at home, in nursing homes and residential care.

Programme costs – this category of spend mainly refers to non-acute services such as reablement and other mental health services.

Running costs – these are the costs associated with supporting the process of commissioning the healthcare services we provide.



Better payment practice code

We are committed to dealing fairly and professionally with all of our supplier partners. One way that we do this is by working to the Better Payment Practice Code. It means meeting the target to pay all non-NHS trade creditors within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

	2017-18		2016-17	
	Number %	Value %	Number %	Value %
NHS Payables	97.2	99.9	96.0	99.9
Non NHS Payables	95.9	97.0	96.4	91.1

Monitoring and ensuring quality

Our Joint Quality Committee with NHS Southport and Formby CCG is responsible for monitoring and overseeing performance against national requirements, such as those in the NHS Constitution, along with local quality standards including patient safety and patient experience, as well as health and safety.

To do this, the committee receives and assesses a wide range of data and information from the organisations we commission services from, as well as from within the CCG. We have developed a data dashboard bringing together reports and information from the services we commission, so we can more easily take action to promote safe and effective care from all providers. Detail of any quality issues arising during the year can be found in our integrated performance reports[19] and Governing Body papers[20], all available from our website.

Managing and responding to risks

Our Joint Quality Committee provides the Governing Body with assurance that there are structures, systems and processes in place to identify and manage any significant risks that we may face. We continue to identify and manage risks through the corporate risk register which is presented to the Joint Quality Committee ahead of the Governing Body. This helps us to ensure that local health services meet the highest possible standards of quality and patient safety. It also supports us in meeting our statutory duties as well as helping us to plan for a healthcare system which is robust and capable of dealing with unplanned events. Here are some of the main risks we identified during 2017-2018:

- The risk that financial pressure on the health and social care system may cause delays and quality of care for patients
- The sustainability of local GP services due to workforce pressures
- The risk of not learning across the system from serious incidents.
- The financial risk of not delivering our savings targets and making best use of our resources

You can read more about how we manage risks in our governance statement (pages 57-79).

Our Quality Strategy

Every patient and person that we support can and should expect high quality care. The CCG revised its quality strategy in 2017 to ensure it continues to reference national guidance such as 'Leading Change, Adding Value'[21] on how we commission services and ensure the safety, the efficacy and the overall experience of care of patients. The strategy provides guidance on how services should be provided reliably to every patient, every time. There are six fundamental values at the core of our strategy - care, compassion, competence, communication, courage and commitment, known as the 6Cs.

[19] Integrated performance reports - https://www.southseftonccg.nhs.uk/what-we-do/how-well-our-services-perform/
[20] Governing Body papers - https://www.southseftonccg.nhs.uk/about-us/governing-body/governing-body-meetings/
[21] Leading Change, Adding Value - https://www.england.nhs.uk/leadingchange/about/

Staff development

We are committed to providing professional development opportunities for our staff. Two members of the quality team took up secondment opportunities with local provider trusts in 2017-2018, allowing them to learn from new experiences whilst assisting the provider in terms of additional resource.

Supporting primary care professionals

Our quality team has instigated a number of initiatives in 2017-2018 to support the delivery of primary care across Sefton. These included:

- Two diabetes workshops commissioned to provide an update for nurses working in primary care to improve their management skills for patients with diabetes
- Commissioned a travel health foundation course for 40 practice nurses to enable them to offer travel health advice and vaccinations in primary care
- Commissioned a travel health update for those already providing a travel health service
- Monthly protected learning time events with a clinical topic pertinent to nurses and healthcare assistants working in primary care
- Quarterly protected learning time events for over 180 GPs and nurses on clinical themes to support primary care working
- Attended the General Practice Nursing collaborative to support the wider developments of the General Practice Forward View into primary care
- Supported the Enhanced Training Practice in the development of student nurse placements in primary care

Working to reduce the risk of heart attacks and strokes

Tackling high blood pressure has been identified as a public health priority in Cheshire and Merseyside. Over the last twelve months, we have been working to facilitate improvements in the management of hypertension in primary care by working with partners such as the General Practice Nursing (GPN) collaborative and the Champs Public Health collaborative. The team has gained funding from the GPN collaborative to support the development of blood pressure champions to continue the work and education plans of British Heart Foundation. We also organised for nurses and healthcare assistants in primary care across Sefton to attend an education programme provided by British Heart Foundation and courses for practice nurses on motivational interviewing to improve consultations and the best way to support self-care in their patients. In addition, we have facilitated a best practice template to enable better management of the condition. We have submitted details of the work we have been doing to the National Institute for Health and Care Excellence (NICE) and hope to gain accreditation for the hypertension quality standard.

Quality in hospital based care

Our quality team has been supporting the delivery of acute care. In 2017-2018, we established and continue to support a weekly multi-agency discharge event (MADE) on the Aintree University Hospital NHS Foundation Trust site. In addition we supported a MADE event at Southport and Ormskirk Hospital NHS Trust in January 2018. This work enables better communication between partners and facilitates the discharge of patients from hospital to improve capacity on site. We have also continued our work with the North Mersey A&E Delivery Board and their respective A&E delivery board sub groups. In addition, members of

our senior leadership team continued to support acute organisations on-site during periods of significant system pressure.

Learning Disabilities Mortality Review

The quality team established and systems and processes to support the national Learning Disabilities Mortality Review Programme (LeDeR) and are looking to support the increase of LeDeR reviewers across health and social care in Sefton.

Court of Protection

There have been a number of cases which have been supported through the Court of Protection, working closely with our commissioning support unit, Sefton Council and legal colleagues. The assistant chief nurse is the 'local area contact' and a member of the NHS England Cheshire and Merseyside LeDeR Steering Group.

Improving Continuing Healthcare

Continuing Healthcare (CHC) is the name given to packages of ongoing care, arranged and funded solely by the NHS, where patients aged over 18 have a primary health care need as a result of a disability, accident or illness. We have continued our work on improvements to systems and decision making processes, as well as reviewing the most appropriate place of assessment for CHC eligibility for patients. We have also been working with colleagues at Sefton Council to review processes where responsibility for an individual's needs crosses both health and social care.

Tackling serious incidents

Our serious incident process has been reviewed, resulting in a new terms of reference and standard operating procedure, which have been approved at our Joint Quality Committee. In addition, we will be working with Mersey Internal Audit Agency to test our processes and provide us with further assurance.

Special Educational Needs and Disability Services

We worked with NHS Southport and Formby CCG and Sefton Council to submit a written statement of action in July 2017 that responded to an earlier borough wide inspection of special educational needs and disability services (SEND). The action plan within the statement has been agreed by the Office for Standards in Education (Ofstead) and the Care Quality Commission (CQC). Monitoring meetings have taken place with the Department for Education and NHS England, and feedback has reflected the positive progress being made against the action plan. A Health SEND Strategic Group, established with other commissioner and provider partners, has been meeting regularly in 2017-2018. This group is supporting ownership of the SEND agenda across the health system, to drive improvements as detailed in the written statement of action. You can find a copy of the written statement of action on our website[22].

[22] Written statement of action - https://www.southseftonccg.nhs.uk/what-we-do/how-well-our-services-perform/annual-assurance-and-other-assessments/

Sefton focus for safeguarding

We made a decision to bring our safeguarding team back in-house and withdrew from the hosted arrangement managed by NHS Halton CCG. These changes took effect on 1st March 2018. The designated nurse safeguarding children was transferred to us from NHS Halton CCG. In addition, there were two vacant posts for the designated nurse children in care and designated safeguarding adult. Both positions have now been recruited and should be in post by 1 July 2018. The assistant chief nurse is providing cover in the meantime to ensure there are no gaps in adult safeguarding.

Screening and immunisation

Our quality team works with Public Health England's screening and immunisation and cervical screening teams to support their ongoing programmes of work.

Commissioning for quality and innovation

The Commissioning for Quality and Innovation (CQUIN) process was reviewed and has been developed to offer robust assurance that providers are achieving their required targets and submitting the relevant evidence. This more robust system has helped to identify improvements in quality of care for patients.

Being prepared for emergencies

We have a role to play in supporting the management of emergencies such as major incidents, or natural events like flooding and pandemic flu. Our duties are set out in the Civil Contingencies Act 2004, which names CCGs as 'Category 2' responders. This means we are required to share information and cooperate with other agencies in planning for and responding to emergencies should they happen. Like Category 1 responders, such as the police, fire service and Sefton Council, we must also produce plans to help us to assess risk and ensure that arrangements are in place for informing and warning the public should this be necessary.

The NHS Core Standards for Emergency Planning, Response and Resilience further requires us to ensure that our service providers have plans in place to respond to and recover from emergencies. We gain operational support in meeting our duties from our Commissioning Support Unit through its Emergency Planning, Response and Resilience Team.

Here are some of the ways we met our duties in 2017-2018:

- NHS England's EPRR Core Standards 2017-18 set out the minimum requirements which NHS organisations and providers of NHS funded care must meet to demonstrate their ability to respond to emergencies and be able to continue providing safe patient care. We achieved a 'substantial' rating
- Our Governing Body lay representative Graham Morris holds the EPRR portfolio as part of his responsibilities. He is a regular and active member of our Governing Body and his attendance can be found on page 52
- We work with CCGs and service providers across Merseyside to ensure the healthcare system can respond to incidents night and day – we have a 24/7 on call system, so service providers and other agencies can contact us round the clock in the event of emergencies
- We have developed business continuity and incident response plans - as well as making sure our own plans are robust, we monitor the plans of our service providers
- Our staff take part in regular training sessions and exercises – so we have the skills and experience to deal with unexpected incidents

Other work to improve quality and performance

Below are some other examples of our work during the year to ensure the quality and performance of the services we commission remains sustainable into the future.

You will see that all of these schemes have links and interdependencies between our three Shaping Sefton strategic priority areas of primary care, urgent care and care for the most vulnerable.

Primary care

Whilst NHS England holds the contracts for primary care, we have joint commissioning status for the services provided in the 30 practices that make up our CCG.

In addition, we are always working to improve the quality of primary care. One of the ways we do this is through our local quality contract (LQC), which our member practices can choose to sign up to and that we further developed in 2017-2018. There are a number of schemes that make up the contract including work to understand current skill mix and workforce across the CCG, a prescribing quality scheme and a transformation scheme which has allowed practices the opportunity to trial and introduce new ways of working.

Below are some other examples of what we are doing to support quality in primary care.

Strengthening GP localities

We made good progress across our four GP practice localities - Bootle, Crosby, Maghull and Seaforth and Litherland – in 2017-2018. We appointed a new dedicated locality manager and devised a plan for the year to focus discussions and work in each of these geographical forums. A particularly positive project was looking at the top five high intensity users to general practice. This was a new initiative that saw the introduction of mini 'multi disciplinary team' style sessions, providing a forum for peers to look at how they might better support some of their most vulnerable patients. This was very well received by localities and work they are looking to continue this year. This also prompted the greater use of the Aristotle data system by practices, so their learning can be shared across localities to look at more effective ways of working in the future.

We have also been working with the Department of Work and Pensions (DWP) around the introduction of Universal Credit. This has been of particular importance to our more deprived areas in south Sefton and has provided practices with the correct information in order to signpost patients appropriately. We are also running a couple of pilot sites in the Bootle and Thornton area where the DWP plans to hold 'satellite sessions' to assist claimants in accessing appropriate services and support where appropriate.

In 2018-2019, we will start working through our newly updated locality profiles which will include looking at disease prevalence and how we can develop projects to fall in line with CCG targets on particular areas of disease. A further element will also include workforce profiles for future succession planning.

Making Every Contact Count

Following a project carried out last year in Bootle locality, we have been working with Living Well Sefton to roll out Making Every Contact Count (MECC) training across all our member practices. MECC supports GP practice staff to have opportunistic health chats with patients to encourage improved wellbeing. MECC also prepares staff for active patient signposting training, which forms part of the GPFV as described earlier. This has been an invaluable piece of work to encourage patients to make healthier lifestyle choices and provide staff with the tools and confidence to deliver effective health chats.

As a result of this work, Living Well Sefton has been running a further pilot in Bootle, where Living Well Mentors spend time in practices, so doctors can refer patients directly the team for one-to-one support and advice. As well as successfully addressing patients' lifestyle and wellbeing issues, this has freed up GP time in participating practices. Our ambition is to roll this scheme out across south Sefton.

General Practice Forward View

Published in April 2016, the General Practice Forward View (GPFV)[23] sets out a framework of support for primary care so it remains sustainable for the future. Locally, we have carried out a great deal of work in 2017–2018 around the GPFV.

As part of our (LQC), all practices have undertaken at least one of the 'high impact actions' to support them in releasing time to provide more care. To supplement this work a series of six action learning sets has been offered, where practices have been able to come together to work on their high impact action projects, such as active signposting, and productive workflows.

Practice reception and clerical teams have been offered training around active signposting with around 140 staff across the whole of Sefton having received this training to date. There are plans to build on this training in 2018-2019 once outcomes are shared. In addition to this, we have had some successes around practice manager development. A number of local practice managers have been successful in securing places on the General Practice Improvement Leaders course, a six day programme designed around quality improvement. We have had a number of successful applications under the Practice Manager Development Fund, which has seen those managers receive national funding for training courses to develop and add to their management skills.

Following discussion and engagement in 2017-2018, approximately 25% of our practices have applied to undertake the Productive General Practice Quick Start programme. This is a practice led series of workshops that forms part of the Releasing Time for Care element of GPFV, and builds on the work already completed by practices in relation to this element.

Finally, we have been successful in rolling out some new technology to practices as part of the GPFV. This includes a new patient information screen system for waiting rooms, as well as funding laptops for practices to enable mobile working for clinicians. Funding has now also been received for online consultations and plans are underway to roll this out to practices starting from 2018-2019.

[23] GPFV - https://www.england.nhs.uk/gp/gpfv/

Urgent care

In the past year there has been significant focus on how we can support our local residents to understand the range of options available to help them to best manage their health care needs. This is important to ensure that services are accessed appropriately and we make the best use of the resources available in our local community.

We continue to raise awareness using a number of methods including our Examine Your Options campaign of services that can provide our residents with the best advice when they are unwell such as NHS Choices website, or by calling NHS 111. In addition, we carried out a lot of work to remind people of the importance of their high street chemist in providing expert advice on minor illnesses and ailments to support people in self-care.

Examine Your Options importantly reminds people that A&E and 999 services are for life-threatening and serious conditions and have reviewed the systems we have in place to enable people to be seen in the right place which meets their needs. An example of this is the Clinical Assessment Service which works in conjunction with NHS 111.

Sefton Clinical Assessment Service

Sefton Clinical Assessment Service (CAS) offers an additional and alternative course of assessment and treatment for those patients calling NHS 111 who urgently need review from a doctor but who do not need A&E care. The service is part of the North West Clinical Assessment Service and initially operated during the out of hours period. It is a collaboration between NHS111, North West Ambulance Service NHS Trust (NWAS) and Go To Doc Healthcare. Sefton was in the second wave of North West CCGs rolling out this service in June 2017. It was initially trialled for three months before being reviewed. In January 2018 we extended the service to include in-hours, achieving 24 hour coverage for our residents. This is how the service works in Sefton:

- Appropriate patients are identified by NHS 111 during their initial telephone assessment and referred to Go To Doc
- A GP will call patients back within 60 minutes of their original call to NHS111
- If it is urgent the patient will receive a call back from a GP within 20 minutes

Sefton CAS enhances the ability to provide high quality and safe care, and will mean that more services will work together to benefit the patient.

Acute Visiting Scheme

Our Acute Visiting Scheme (AVS) continues to be successful in providing support for residents within south Sefton care homes. It aims to reduce unnecessary hospital admissions and to increase support for GP practices in managing their vulnerable care home patients. AVS is managed by our out of hours provider, Go To Doc. It operates in normal working hours and enables GP practices to refer their acutely unwell care home patients to the service. This is a valuable service in helping to avoid unnecessary hospital admissions and we will continue work with our various providers using the wide range of skills and clinical expertise of our health care professionals to develop further initiatives which help to support people within the community and maintain care closer to home.

Emergency Care Improvement Programme

This work programme has continued in the past year with Aintree University Hospital NHS Foundation Trust and Royal Liverpool University Hospital working in collaboration with the CCG and NHS Improvement. The programme focuses on the quality, safety and patient flow within our emergency and urgent care services. It looks to improve the emergency care four hour waiting standard and overall patient experience. This includes a review of patient experience for pre hospital care, in hospital experience and organising a careful, safe and timely discharge. This work is being carried out in collaboration with our hospitals, the council's social services, community care services and local GPs. Key areas of work have been the rollout of the SAFER patient flow bundle developing processes for senior review, assessment and decision making in conjunction with discharge planning to provide support where required. Our focus is in ensuring that patients do not have delays in receiving the care they require both within the hospital setting but also on discharge to the community. To support this goal, multi-agency discharge events are held on a weekly basis with input from partner organisations to bring together the local health and social care system to challenge and improve patient flow, delays and simplify discharge processes. We have seen significant pressures on our acute services over the winter period highlighting the need for this ongoing review and service improvement programme; along with also working with our local residents to ensure that services are accessed appropriately to meet their needs. Further information on this work can be obtained here: https://improvement.nhs.uk/improvement-hub/emergency-care

Community services

Community services have a big role to play in our work to transform and futureproof urgent care for our residents. As we have set out in our Shaping Sefton strategy, good progress has been made during 2017-2018 in providing more appropriate, joined up care as close to people's homes as possible.

New providers for community health services

From 1 June 2017, Mersey Care NHS Foundation Trust and North West Boroughs Healthcare NHS Foundation Trust (previously 5 Boroughs Partnership) became the new providers of community services across south Sefton. These services include blood testing, community matrons, district nursing, treatment rooms, foot care, intermediate care, adult diabetes and adult dietetics, IV therapy and community respiratory care. Our new provider builds on previous work to improve health and wellbeing of our residents, following the transfer of these services from Liverpool Community Health NHS Trust. Whilst Mersey Care delivers the majority of these adult services, North West Boroughs Healthcare provides Litherland Walk-in Centre, blood testing and, in conjunction with Sefton Council, community equipment. This is in addition to the borough's children's community health services which transferred to North West Boroughs Healthcare in April. Work has begun to look at how we can improve and develop these services to better meet the needs of our residents and in line with our Shaping Sefton programme to provide more care closer to home. This is particularly important given ongoing pressures on our acute services but with the potential to support aspects of this care within community settings. Mersey Care is working closely with other organisations such as Aintree University Hospital NHS Foundation Trust and Sefton Council with the aim of delivering seamless care arrangements from hospital to community.

An example of this is the involvement in the Integrated Community Reablement and Assessment Service (ICRAS) within south Sefton.

ICRAS

This service went live at the start of October 2017. It was created by the merger of a number of community teams across health and social care, as follows: urgent care, community intermediate care, discharge planning, therapies, Ward 35 intermediate care and hospital-based social workers. ICRAS has two main functions. Firstly, it delivers 'step-up' services, where people receive their care in more appropriate settings rather than being admitted to hospital. Secondly, its 'step-down' care better supports some of our more vulnerable patients transition from hospital to home. ICRAS is suitable for patients who have been recently clinically assessed and are at imminent risk of hospital admission without support, but who can wait a maximum of 2 hours for assessment. Initial review of ICRAS indicates that the services are being successful in supporting more people in their own homes and avoiding the need for hospital admission. The service also works closely with Aintree University Hospital NHS Foundation Trust to enable people to be discharged safely to the community with the support they need e.g. social care, nursing or therapy. We will continue to develop the range of services which can be incorporated within the ICRAS model in the coming year.

Care for the most vulnerable

There have been some really exciting and innovative developments in this wide and varied work programme during 2017-2018 as you will read below.

Care Home Innovation Programme

Known as CHIP, our care home innovation programme is one of the first schemes of its kind to offer care homes and their residents such a comprehensive package of support. Now in its second year, CHIP has continued to make good progress in 2017-2018. It demonstrated a 25% reduction in all ambulance conveyances compared to the 12 months prior to its launch. There are several elements to CHIP. Dedicated care home matrons are the foundation to the program. 24/7 televideo allows care home staff to access nursing advice and support using a secure video link. The CHIP team also includes a community geriatrician, pharmacist, speech therapist, dietician and community psychiatric nurse. Key to its success has been the carer training programme, care planning and bi-monthly quality improvement collaborative meetings - providing a range of training and support to help staff better care for their residents.

Virtual Ward – proactive care

Our proactive care programme has continued and is now in its fifth year. It is aimed at those with long term conditions, particularly older patients, helping them to stay as well as possible, for as long as possible through a package of preventative care provided in their own home, or close to their home. They are offered proactive 12 week intensive support to improve their health and wellbeing which is delivered by a wide range of health and social care professionals who coordinate and tailor support based on each patient's individual needs. The programme focuses on patients who are at most risk of being admitted to hospital and works to prevent the health of these patients from deteriorating, which can otherwise result in them needing urgent or emergency care. Doctors and other healthcare professionals identify patients who will benefit from the wide range of care available and refer them to their locality pro-active care team. Initiatives such as ICRAS and the Virtual Ward are important enablers in allowing people to remain at home but with their care needs addressed and avoiding the need for a hospital admission. We will continue to focus on the development of similar schemes in the next year to support our local community.

Supporting the sustainability of our care homes

Our quality team has been working on the development of a care home dashboard with the support of our business intelligence team. It is anticipated this piece of work will progress, once the designated safeguarding adult manager is in post. A provider failure policy has been developed and agreed between Sefton Council and ourselves. The policy sets out roles and responsibilities for Sefton Council and the CCG to work in a co-ordinated way to support the safe transfer of residents to an alternative placement. The policy specifies that the alternative placement must be one where their individual health needs can be met and, where possible that they, their family and/or advocate have been involved in that decision. The policy is due to be submitted for approval at the Joint Quality Committee in April and subsequently the Integrated Commissioning Group.

Preventing diabetes

We were successful in being chosen to deliver the first wave of the new National Diabetes Prevention Programme (NDPP), which was launched in 2016. Currently 14 GP practices are actively referring their patients and 205 patients have been signed-up to the programme, which is being held in local community venues. The aim of the scheme is to prevent those at risk of type 2 diabetes from developing the condition. As well as the human cost, type 2 diabetes treatment currently accounts for around nine percent of the annual NHS budget. Nationally, this equates to around £8.8 billion each year. Those referred to NDPP receive tailored, personalised help to reduce their risk of type 2 diabetes. This includes education on healthy eating and lifestyle and help to lose weight and bespoke physical exercise programmes, which together have been proven to reduce the risk of developing the disease.

Trans Health Sefton

Shortfalls in the national transgender pathway resulted in difficulties for patients in terms of access and outcomes. This compounded existing health inequalities experienced by transgender, bi-sexual and intersex people, leading to inadequate care standards and significant risks to patients' health and wellbeing. In response, we have co-produced an innovative primary care pathway and training programme, with patients, providers and professionals at the heart of its development. A new clinic is now operational and this is already improving access locally. Health inequalities have been reduced and there has been an improvement in patient experience, safety and wellbeing.

Macmillan cancer recovery package

We have continued to work with Macmillan in 2017-2018 to put in place the 'Recovery Package' for people with a cancer diagnosis, which has four main elements:

- Holistic needs assessment
- Care planning
- Treatment summary
- Cancer care review

These elements form part of an overall support and self-management package for people affected by cancer. This includes physical activity as part of a healthy lifestyle, managing consequences of treatment, information, financial and work support .The Recovery Package is recognised in the NHS England Five Year Forward View and the Cancer Taskforce Strategy which outlines a commitment to ensuring that 'every person with cancer has access to the elements of the Recovery Package by 2020'. The roll out of these interventions will better support and improve the quality of life of people living with and beyond cancer. We have supported a two year community Macmillan pilot working with Aintree University Hospital NHS Foundation Trust and Sefton CVS to undertake holistic needs assessments and care planning from May 2017. This will be for people with a new diagnosis of cancer and those at end of treatment in a community setting near to their home and will make excellent use of community assets.

Commissioning the most effective treatments

We commissioned Midlands and Lancashire Commissioning Support Unit to develop and deliver a robust prior approval process for procedures of limited clinical value (PLCV). This process relates to request by providers to fund treatments where there is little clinical evidence of their effectiveness for the majority of patients, based on criteria contained in the likes of NICE Guidelines, our local commissioning policy, or contracted activity for a cohort of patients. Providers are instructed to seek funding approval prior to treatment for all PLCV. This ensures each case is assessed against clinical evidence of what may work for that patient, ensuring the best medical outcomes and greater efficiency.

Woodlands Hospice

Woodlands Hospice provides a variety of services with the aim of delivering care in the patients Preferred Place of Care (PPC). We work with Woodlands Hospice to support patients with serious illnesses, so they can achieve the best possible quality of life at each new stage. Woodlands Hospice help to do this in the Hospice and at Home its in-patient unit, and its Wellbeing and Support Centre.

Mental health

We believe in a far more proactive and preventative approach to mental health so as to reduce the long term impact of mental health conditions and dementia. We also believe that improving mental health is just as important as improving physical health and each condition should not be treated in isolation but in a co-ordinated approach which can more effectively deal with the challenges of our ageing population, unacceptable inequalities in health and wide variations in the quality of and access to these services.

Improving Access to Psychological Therapies

Access Sefton is the local service that our residents can contact directly or via a health professional for a wider range of psychological therapies for common mental health problems such as anxiety and depression. To enable greater access, the service in 2017-2018 has developed group working in addition to the one to one counselling that is offered. Recognising the links that exist between physical and mental health conditions, Access Sefton is developing further links with a range of local health professionals so that people with long term conditions can be offered help as part of their overall care. In 2017-2018 nearly 3,500 people accessed the service in south Sefton. Read about the performance of Access Sefton on page 38.

Reducing mental health out of area acute admissions

Our main mental health provider Mersey Care NHS Foundation Trust has made significant progress in reducing admissions to out of area inpatient services thereby enabling people to be treated locally closer to their families and carers.

Dementia Strategy

Dementia has been identified as one of our strategic priorities. We are committed to working with partners to implement identified local priorities and our vision is to enable people with dementia to receive appropriate and accurate diagnosis, and to receive the right information and support to make informed decisions and to be able to plan ahead to meet needs and avoid crisis wherever possible. Our role in delivering better outcomes for people with dementia and carers includes commissioning appropriate and timely services that support patients and their carers to live well with dementia. We are working with the Cheshire and Merseyside Dementia Network to explore further opportunities to improve services across the dementia pathway, and implement improvements in line with the Prime Ministers Challenge on Dementia 2020. We continue to support the development of Dementia Friendly Communities and will work collaboratively with the Sefton Dementia Action Alliance to embed best practice in commissioned services as well as public services to enable people with dementia and their carers to gain a positive experience when accessing shops and services across Sefton.

Early intervention psychosis

The investment made in 2016-2017 is enabling our early intervention psychosis service to achieve the two week waiting time standard. Early intervention services provided by dedicated teams are highly effective in improving peoples' outcomes and reducing future demand on mental health services.

Improving hospital liaison

In September 2017, a resourced 24/7 mental health liaison was established in Aintree University Hospital NHS Foundation Trust. This has greatly enhanced the previous service and is enabling people with mental health conditions, or dementia in a hospital setting to have their needs addressed in a more timely manner.

Child and adolescent mental health

During 2017-2018 the Sefton Local Transformation Plan (LTP) for Children and Young People's Mental Health continued to drive change and improvement around Child and Adolescent Mental Health Services (CAMHS). We have continued to collaborate with our local partners including Public Health and the VCF sector and we remain committed to moving towards the 'THRIVE'[24] model.

During 2017-2018 Venus, a local VCF organisation, has been funded to pilot a community emotional health and wellbeing hub, increasing the availability of evidenced based support in the community and during extended hours. This is being mainstreamed during 2018-2019. Sefton CVS has been funded to trial and develop new support in schools including working with children moving from primary to secondary school, peer mentoring and offering subsidised counselling support to schools. This will be evaluated in 2018-2019.

Sefton has a compliant specialist community eating disorder service, jointly developed with NHS Liverpool CCG, which has seen significant growth in referrals during the year with 93% of urgent cases being seen within one week.

Sefton continues to have a strong children and young people IAPT programme, with a further nine local trainees from different agencies taking up training places during the year.

We have match funded the development of increased out of hours crisis support including an advice line and assessments for young people admitted with a mental health issue via A&E.

[24] THRIVE - http://www.implementingthrive.org/about-us/the-thrive-framework/

Medicines management

Unused prescription medicines cost the NHS in Sefton an estimated £2 million a year. In addition, patient safety can be compromised by having large volumes of medication in the home without supervision.

Our approach to medicines management is system wide and has allowed us to deliver real improvements to patient safety and care, whilst also identifying significant cost efficiencies. Over the last financial year, the CCG employed medicines management team, consisting of pharmacists and technicians, has delivered over 9,000 engagements with south Sefton patients. You can see a breakdown of that activity below:

Patient reviews via GP practice work	Care Homes	Visiting patients in their own homes	Total
8794	**228**	**364**	**9386**

Repeat prescription ordering scheme

Our repeat prescription ordering scheme (RPOS) has been running since May 2016. Initial findings look very promising in South Sefton with an estimated 1.23% reduction in the number of items prescribed and an estimated £379k in money saved. The scheme has also identified patients who were not ordering their prescription medicines, thus highlighting potential concordance issues. This has enabled reviews to be undertaken to support such patients. There is ongoing work with patient groups to understand the needs of specific patients around medicines ordering and concordance and how to support them. RPOS has been shortlisted for an award at the national HSJ Value Awards 2018.

Care at the Chemist

Our Care at the Chemist (CATC) has been in service for a number of years. CATC is a quick and easy way to get advice and treatment for a wide range of everyday illnesses and ailments. Pharmacists ordinarily and routinely provide health advice to their customers regardless of Care at the Chemist but the scheme additionally ensures residents have access to a range of medicines for minor illnesses for which they might otherwise consider a trip to the doctor. Medicines are free for anyone who does not pay for their prescriptions, so long as the person provides their proof of exemption. People who do pay are charged the current prescription charge. If the medicine costs less to buy over the counter than the prescription charge, the person will pay the lower rate. At the beginning of 2017-2018, we reviewed CATC, which recommended a reduction in the costs associated with running the service. Consequently, there was a reduction in the number of pharmacies who participated in the service. However, 17 pharmacies across Sefton did continue to provide CATC and, as of 1 April 2018, this number has now risen to 20. A list of participating pharmacies and more information is available on our website[25].

[25] Care at the Chemist - https://www.southseftonccg.nhs.uk/your-health-and-services/care-at-the-chemist/

Medicines review pilot for high risk patients

Adverse Drug Events (ADE) account for approximately one fifth of hospital readmissions and up to half of those may be preventable. In order to reduce this, our medicines management team and Aintree University Hospital NHS Foundation Trust pharmacy team set up a domiciliary medicines reconciliation and medicines review service for high risk groups of patients recently discharged from the hospital. The project established a system to review patient's medicines once they had been discharged from hospital and improve adherence by educating patients on the medicines they have been prescribed. Patients were also given lifestyle advice along with information about their medical condition and disease management.

An evaluation of the project found that:

- 87.5% of patients received lifestyle advice, information regarding their medical condition or some other form of education regarding disease management
- 81% of patients self-reported improvements in medicines adherence

Discussions with Aintree University Hospital NHS Foundation Trust and other providers are ongoing as to how the pilot could be rolled out in other areas. The service has been shortlisted for an award at the HSJ Patient Safety Awards 2018.

Involving our residents

We believe that involving south Sefton residents in our work is fundamental to achieving better health and wellbeing. Our patients know the quality of existing health services from first hand experience, and the view of local people can help us to determine what more we need to do to achieve our aims.

National guidance and duties[26] shape our work and also support us in involving people effectively in what we do. In addition our structures and process reflect how we embed involvement in our daily work.

- We have a lay representative dedicated to patient and public involvement on our Governing Body, where our most important work is debated and approved
- We hold bi-monthly Governing Body meetings in public, where residents are invited to hear members discussing and making decisions about our work. Ahead of the start of these formal meetings, there is an opportunity for people to meet some of the doctors and other professionals who make up the committee. They are also welcome to ask any questions or queries they have during this session
- Our organisation works across four geographical GP practice localities. These are well established forums, chaired by doctors and where our member practices participate in and influence our work. Practices also use these forums to feedback service and patient experience issues for action. Quarterly wider group meetings provide a further forum for practices to get involved in CCG business
- We have a Joint Quality Committee with NHS Southport and Formby CCG and overseeing patient experience is one of its main areas of responsibility. The committee provides our Governing Body with direct assurance of the experience our patients receive from the services we commission, taking action when this falls below what we expect
- Our Engagement and Patient Experience Group (EPEG) reports to our Governing Body via our Joint Quality Committee. It is a Sefton wide group and is jointly chaired by our lay member for patient and public involvement and their counterpart from NHS Southport and Formby CCG. It includes representation from Healthwatch Sefton, Sefton Council, Sefton CVS - there to represent the borough's vibrant voluntary, community and faith sector - Sefton Carers Centre and Sefton Young Advisers
- By working together, EPEG helps us maximise the opportunities we have to engage across the different sectors in Sefton in a coordinated way. EPEG gives expert advice about how and where to go to engage and consult our residents. This includes tapping in to the forums and networks that our partners manage, run and have access to
- All the information we gather from our engagement and consultation activities is scrutinised by EPEG, in addition to the patient experience data that is reported to us by our providers, such as Friends and Family Test results. All this data informs our work by helping us to gauge how effective the services we commission are and where we can improve them. It also helps us to spot early any emerging trends and issues, so we can take quicker action via the Joint Quality Committee

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

- We design and carry out specific involvement exercises for different aspects of our work, particularly when we are planning changes to a service now or in the future, including pre and post equality impact assessments. These exercises often use differing methods to encourage people to get involved, aiming to be as tailored and appropriate as possible for the different groups of residents we need to speak with. We design them with and report their results to EPEG
- Whenever appropriate, we invite patient, public or carer representatives to get directly involved in our day to day commissioning work, such as taking part in procurement processes, or joining our working groups to enable services and programmes to be 'co-produced'. In 2017-2018 we took a co-production approach to reviewing our complaints policy
- Our regular public Big Chat events where we bring people together to discuss our work, ask for their views about our plans and feedback how we have used their comments and experiences so far We hold 'Big Chat style' annual general meetings to make these sessions as meaningful and useful as possible for our residents
- Many GP practices in south Sefton have patient groups. These enable patients to have greater participation in their local NHS
- We routinely report all our involvement activities in line with our legal duties in a number of different ways – from including information on our website to updating people at our public events
- Many of our organisation's wider governance arrangements play an important role in our ladder of assurance for patient and public involvement. Processes and systems are embedded in some of our most important committees such as our Corporate Governance Committee and our strategies, policies and protocols

How we involved people in 2017-2018

There are a number of different ways that we involve local people in our work and use their views to shape how it progresses. This could be tapping into our local voluntary, community and faith networks, or carrying out more focused work with specific communities and groups of people affected by our work. More examples of how we involved people, including feedback reports and information about how we used views can be found on our website[27], in addition to these below.

Big Chat 8

We held this Big Chat in the early evening after residents asked us to look at different timings for these events, so as many people as possible could attend. The event began with an update of our work and plans and was followed by a presentation from our new community services provider Mersey Care NHS Foundation Trust. This introductory session explained more about community services and how the new provider plans to capture local people's feedback on these services. This was followed by a 'you said, we did' item which focused on the feedback and outcomes from some of our recent discussions with people about proposed changes to some of the medicines schemes, including the repeat prescription ordering system, Care at the Chemist and the prescribing of gluten free foods. The feedback had raised particular concerns about the potential impact of some of these changes on vulnerable patients and their ability to access these services, and we explained what work we were doing to address this. We also talked to people about our ongoing financial challenges and people discussed how we

[27] https://www.southseftonccg.nhs.uk/get-involved/

might better use our limited NHS resources which generated several suggestions, many of which centred around the further development of integrated local health and social care services.

Big Chat 9 meets Annual Review

As in previous years, we combined our Big Chat 9 event with our annual review, or annual general meeting. After an overview of our performance and achievements in 2016-2017, the afternoon focused on the options available to people to manage their own health and wellbeing, including table discussions about how people 'Examine their Options' when they are unwell and what factors they consider when choosing which health service to use. For example, understanding when people would consider visiting a local chemist for advice instead of making a GP appointment. People told us that they weren't always sure which service to choose and that people often needed more information and guidance to help with this. So, we will look at how we can improve information to support their choices in the year ahead. We also held an interactive 'self care' session which highlighted the '5 ways to Wellbeing' and we talked to people about 'Personal Health Budgets' and how these can enable patients to choose the right health care and support for them.

Orthopaedics and ENT services in Liverpool

We worked closely with NHS Liverpool CCG, Healthwatch Sefton and CVS partners to ensure that local residents were able to give their views on the proposals for the future of orthopaedic and ear, nose and throat services in Liverpool. The review of these services is being led by Liverpool CCG working closely with the three hospital trusts which provide care and treatment for many Sefton residents. As well as residents having the opportunity to learn more online and complete a survey, during the consultation process, NHS Liverpool CCG visited a number of different groups and forums to talk about these proposals and gather people's views. This feedback has contributed to the overall review of these proposals and the final outcome, which is expected in the near future.

Review of local health policies

Working in partnership with six other local CCGs, we started a review of over 100 policies for 'Procedures of Lower Clinical Priority' (PLCP) which we regularly review to reflect the most recent medical knowledge. The first two batches of policies were reviewed in 2017-18 which included treatments such as hair removal, breast reduction and back pain procedures. As some of the proposed updates involved changes for patients, people were invited to share their views and we attended several events to raise awareness of the review and to encourage people to get involved. The feedback we received was considered alongside other evidence, and helped us decide whether to adopt all the changes, some of which were excluded such as the increase in the minimum age of breast surgery. The policy review is currently ongoing and we will be inviting feedback on the last phase later in 2018.

National consultations

Throughout the year, we have supported and promoted several national consultations, encouraging local residents and stakeholders to get involved and share their views. These included the following consultations:

- Gender identity services for adults
- Medicines which should not routinely be prescribed
- Children and young people's mental health services
- Over the counter medicines

Further information on these consultations can be found on our website. For a number of these consultations, we contributed a CCG response highlighting the feedback and key themes from any local engagement with residents. For example, we spoke to local people about the prescribing of 'over the counter' medicines which we collated and shared with NHS England so this could be included in the feedback for the national consultation.

Work with Sefton Young Advisors

Through our work with Sefton Young Advisors (YAs), we are looking at ways to increase opportunities for local young people to get involved in their local NHS. Sefton YAs are part of Sefton Council for Voluntary Services and provide advice and support to local organisations on how to better involve young people in their work. During the year we have been working closely with the YAs to develop a health themed event which is scheduled for later in 2018 and which will invite local schools, colleges and youth groups to discuss local health services. We also supported an Every Child Matters health event to raise awareness of diabetes and the risks, particularly highlighting the increase in the number of Type 2 diabetes cases in younger age groups. The feedback from these discussions identified gaps in local diabetes preventative services for young people, and also services to support diabetic young people. This feedback has been shared with NHS England and will contribute to the ongoing development of the national diabetes prevention strategy.

Working with other groups

To keep our partners and public informed of our work, we regularly attend our partners meetings and events. For example, we regularly attend Sefton's Health and Social Care Forum to update members on our plans and any changes to services. We also attend local older people's forums such as Sefton Opera's 'Keep Well, Keep Warm' and Sefton Council's Senior Road User's events to speak to residents about how they can better manage their medicines and to raise awareness of the various ways of getting health advice.

GP services

We have been working with NHS England to develop plans for our local GP surgeries. Together with NHS England we help commission local GP services and as part of local GP developments, we have been supporting NHS England to involve patients about how some of these services might be delivered differently. This included supporting the consultation on the future of Hightown GP practice involving a series of public events to talk to patients and local residents about the options and to hear their views on these. The comments and feedback from these events and discussions helped NHS England and the CCG to understand that patients wanted the practice to remain open and to continue to provide GP services to the local population. Following the consultation, NHS England led a process to appoint a new GP services provider to run the practice and although initially unsuccessful, a new provider was eventually found who will take over management of the practice in June 2018. The news was welcomed by patients and local residents, as this followed concerns that the practice might have to close if a new provider could not be found.

Developing our involvement approach

We understand the importance of continually evaluating what we do and learning from feedback how we can more effectively involve local residents in our work. To help us develop and improve how we do this, we invited residents and partners to complete a survey to tell us what they thought. This included questions about our Big Chat events, how we work with partners and community groups and the methods we use to gather views, such as online surveys. The feedback shared also helped us update our communications and engagement strategy which was reviewed in 2017- 2018.

What people told us:

- Our Big Chat events are informative and a helpful way of sharing views on some of the ideas and plans for developing local health services, but these large scale events aren't for everyone
- Develop our work with partners and community groups, using their events and networks to involve more local residents, particularly those from minority groups
- Continue with our various methods of keeping local people involved and informed, but with a particular focus on face to face contact, newsletters, local media and online/social media options.

In addition to what residents told us about how well we involve them, there were two important external assessments of our performance in 2017-2018 that reflected our good work and which are also helping us to shape our future approach. Firstly, our systems and work to engage stakeholders was independently assessed by Merseyside Internal Audit Agency (MIAA). We received a 'significant assurance' rating and it highlighted some areas for development, notably the introduction of a new e-bulletin for stakeholders that we plan to introduce in 2018-2019. Secondly, NHS England carried out a desktop review of how well we met new patient participation indicators that will be part of the CCG improvement and assessment framework. We achieved a 'good' or green rating.

Our plans for the year ahead

This feedback has been very important in helping us plan and develop our engagement activities for the coming year. We have been meeting with local CVS partners and Healthwatch Sefton to discuss how we can work more closely together, particularly on specific engagement projects and events. As this plan takes shape, we are also refreshing and updating our lists of partner and community group contacts. This will enable us to continue to reach and involve a broad and diverse cross section of the local population and to identify where we might have gaps. We are always keen to expand our work with local partners and organisations, for example, in 2017 -2018 we developed a closer working relationship with the 'Veterans in Sefton' programme and One Vision Housing, and we intend to build on this approach. To support and embed these developments, we are also planning a new quarterly stakeholder engagement bulletin which will keep our residents and partners up to date with local and national involvement opportunities and news. You will find our updated communications and engagement strategy for 2018-2020 on our website[28].

[28] Visit our publications library - https://www.southseftonccg.nhs.uk/get-informed/publications/

Equality and diversity

We want to ensure that we commission services fairly, so that no community or group is left behind in the changes that we make to health services as we work towards the vision and challenges set out in NHS England's Five Year Forward View.

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

You can read a full account of how we respond to our duties in our full equality and diversity annual report, which we publish on our website. It sets out how we pay 'due regard' to our public sector equality duty, which we consider daily as we make commissioning decisions on behalf of the population we serve.

Our duties

We are required to prepare and publish equality objectives to meet our specific duty as outlined in the Equality Act 2010. Our 4 year objectives plan is specific and measurable, and it is aimed at tackling a diverse range of barriers faced by people who share protected characteristics in relation to health services we commission and support.

Our equality objectives are:

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

Equality delivery systems 2

To help us set our equality objectives and improve access and outcomes for people who face barriers we have implemented our equality delivery systems (EDS) 2 toolkit. Information about EDS 2 is contained within our full annual equality and diversity report 2017, which was recently approved by our Governing Body. We have improved our performance and seven outcomes have now moved from developing status to achieving status. During 2018 we will be working collaboratively with all other Merseyside CCGs and a number of provider NHS Trusts on implementing EDS 2.

Provider performance

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

Key areas of focus include:

- Accessible information standards
- Carrying out reasonable adjustments
- Working with providers to improve how they pay ‘due regard’ to their Public Sector Equality Duty
- Collaborative working on EDS 2

Our staff

We have duties to meet under the Equality Act 2010 in relation to workforce and organisational development. We take positive steps to ensure that our policies deal with equality implications around recruitment and selection, pay and benefits, flexible working hours, training and development, policies around managing employees and protecting employees from harassment, victimisation and discrimination. It is mandatory for all our staff to complete equality training and, in addition, we have a workforce equality plan, which has contributed to us paying due regard to our Workforce Race Equality Standard.

Working towards a sustainable NHS

As an NHS organisation and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of the rising cost of natural resources.

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

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

Policies

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

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

As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

Sustainability

The second annual review of the progress and prospects in sustainable development for the health and care system was published in February 2018 by the Sustainable Development Unit (SDU). It shows that the SDU work across the system has delivered financial savings from reducing the energy, water and waste bill of the NHS. This has demonstrated in year cost savings in excess of £90m and carbon savings of 330,000 cubic tonnes, avoiding over £13m in care and treatment costs since last year. This is based on the NHS Estates Returns Information Collection date (ERIC) from NHS providers.

Partnerships

We recognise that as a commissioning organisation rather than a provider of services, most of our carbon footprint derives from commissioning health and care services. As a commissioning and contracting organisation, we will need effective contract mechanisms to deliver our ambitions for sustainable healthcare delivery.

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a CCG, evidence of this commitment will need to be provided in part through contracting mechanisms.

Our direct resources used through transport, travel and electricity are negligible compared to the resources used through the services we commission, predominantly through our main providers. Our priority therefore is to work in partnership with our main providers to improve their performance and to minimise the harm and maximise the positive gain that can be made to health from the way our providers operate. For commissioned services here is the sustainability comparator for our providers:

Organisation Name	SDMP	On track for 34% reduction	GCC	Healthy travel plan	Adaptation	SD reporting score
Aintree University Hospital NHS Foundation Trust	Yes	Yes	Yes	Yes	No	Excellent
Liverpool Community Health NHS Trust	Yes	No	No	No	No	Poor
Mersey Care NHS Foundation Trust	Yes	Yes	No	No	No	Good
Southport and Ormskirk Hospital NHS Trust	Yes	No	No	Yes	No	Minimum
Royal Liverpool and Broadgreen University Hospitals NHS Trust	Yes	No	Yes	Yes	Yes	Excellent
Alder Hey Children's NHS Foundation Trust	Yes	No	No	Yes	Yes	Good

This information has been taken from the February 2018 organisational summaries as collated by the Sustainable Development Unit. More information on these measures is available here: http://www.sduhealth.org.uk/policy-strategy/reporting/organisational-summaries.aspx

Workforce operations

We have a small workforce and a small headquarters, so we are a relatively low carbon emitting organisation. We lease our office in Southport from NHS Property Services, and we will work with them to provide all the required information about carbon emissions in future years.

As a responsible employer, we encourage our employees to use public transport and the location of our offices in Bootle and Southport is within a short walking distance of main train and bus routes. In addition to this, we offer our employees the opportunity to purchase a bike through the national cycle scheme where the employee can pay through a salary deduction over 12 month period. We also offer a salary sacrifice scheme for low emission cars for employees to consider minimising their impact on the environment.

Accountability report

Our organisational structure helps us to work effectively and commission the best healthcare possible, spending our share of NHS funding wisely. This section gives you more information about our Governing Body, member practices and staff. It also details the composition and roles of our most important committees.

Corporate governance report

Members report

Governing Body membership

The table below shows the people who made up our Governing Body in 2017-2018, their roles and the committees they were a part of.

Name	Role	Governing Body	Audit Committee	Finance and Resources Committee	Remuneration Committee	Joint Quality Committee (Established September 2016)	Approvals Committee	Joint QIPP Committee	Clinical QIPP Advisory	Joint Commissioning Committee
Dr Craig Gillespie	Clinical Vice Chair, GP	Yes						Yes	Yes	Yes
Dr Andrew Mimnagh	Clinical Chair	Chair				Yes		Yes	Yes	
Graham Morris	Vice Chair & Lay Member – Governance and Audit	Yes	Chair	Chair	Chair		Chair	Yes		Yes
Lin Bennett	Practice Manager	Yes (up until 31.1.2018)	Yes (1.9.17 – 31.1.18)	Yes (up until 31.1.2018)		Yes (up until 31.1.2018)				
Fiona Taylor	Chief Officer	Yes		Ex officio member		Ex officio member	Yes	Yes	Ex officio member	
Debbie Fagan	Chief Nurse	Yes		Yes		Yes	Yes	Yes	Yes	

Dr Dan McDowell	Secondary Care Doctor	Yes (up until 31.12.2017)	Yes (until 31.12.17)		Yes	Yes	Yes	Yes	Yes	
Martin McDowell	Chief Finance Officer	Yes		Yes		Yes	Yes	Yes		
Dr John Wray	GP Clinical Director	Yes		Yes					Yes	
Dr Ricky Sinha	GP Clinical Director	Yes			Yes					
Dr Sunil Sapre	GP Clinical Director	Yes		Yes					Yes	
Graham Bayliss	Lay member – Patient and Public Engagement	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes
Dr Peter Chamberlain	GP Clinical Director	Yes				Yes				
Dr Gina Halstead	GP Clinical Director	Yes				Chair				
Dr Jeff Simmonds	Secondary Care Doctor	Yes (from 1.1.18)	Yes (from 1.1.18)							

Conflicts of interest

We have a managing conflicts of interest and gifts and hospitality policy that can be found on our website[29]. To accompany the policy we have a formal register of interests and a register of hospitality and gifts, all of which can be found on our website. All formal meeting agendas commence with a 'declaration of interest' and the chair of the meeting will address any declarations made in accordance with the policy and record any such matters and actions in the formal meeting minutes

Personal data related incidents

Our Joint Quality Committee ensures that any information we hold about our patients' care is held securely and in line with data protection legislation and wider information governance requirements. We report any personal data breaches to the Information Commissioner's Office (ICO). We also report breaches in our information governance annual report that we publish on our website. When breaches do occur, we work hard to strengthen our systems, and our staff carry out regular training to ensure their work complies with national standards and regulations. In 2017-2018 we were responsible for reporting a breach of personal data to the ICO carried out by one of our providers, Midlands and Lancashire CSU. Following swift action, mitigations and a thorough review of processes we are assured the provider has responded thoroughly and appropriately.

Members' declaration

Each member knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and has taken 'all the steps that he or she ought to have taken to make himself/herself aware of any such information and to establish that the auditors are aware of it'.

Modern Slavery Act

We fully support the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2018 is published on our website[30].

[29] Find links to these documents here - https://www.southseftonccg.nhs.uk/about-us/our-constitution/
[30] Find our statement here - https://www.southseftonccg.nhs.uk/get-informed/modern-slavery-and-human-trafficking/

Statement of accountable officer's responsibilities

The National Health Service Act 2006 (as amended) states that each clinical commissioning group shall have an accountable officer and that officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Fiona Taylor to be the accountable officer of NHS South Sefton.

The responsibilities of an accountable officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include 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)
- For safeguarding the clinical commissioning group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- The relevant responsibilities of accounting officers under Managing Public Money
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended))
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG 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 CCG 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 Group Accounting Manual 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 Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements
- Prepare the financial statements on a going concern basis

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter, with the exception of meeting the financial duties under Sections 223H (1) and 223I (3) of the National Health Service Act 2006 (as amended). This is because the CCG expenditure in 2017/18 exceeded its income.

I also confirm that:

- As far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as accountable officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information
- That the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable

Fiona Taylor

Accountable officer

25 May 2018

Governance statement

Introduction and context

NHS South Sefton Clinical Commissioning Group (CCG) is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

Scope of responsibility

As accountable officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

The CCG is a clinically led membership organisation made up of general practices. Member practices are responsible for determining the governing arrangements for the organisation which are set out its constitution.

The constitution has been developed to reflect and support the objectives and values defined by the CCG and to ensure that all business functions discharged by the CCG are discharged in an open and transparent manner. It has been developed with the member practices and localities.

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

The Governing Body comprises a diverse range of skills from executive and lay members and there is a clear division of responsibility between running the Governing Body and running the operational elements of the CCG's business. The chair is responsible for the leadership of the Governing Body and ensures that directors have had access to relevant information to assist

them in the delivery of their duties. The lay members have actively provided scrutiny and challenge at Governing Body and sub-committee level.

Each committee comprises membership and representation from appropriate officers and lay members with sufficient experience and knowledge to support the committees in discharging their duties.

Governing Body meetings have been well attended by members of the senior leadership team and lay members during the year ensuring that the Governing Body has been able to make fully informed decisions to support and deliver the strategic objectives.

Strategic objectives
To focus on the identification of QIPP schemes and the implementation and delivery of these to achieve the CCG QIPP target.
To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the "Forward View", underpinned by transformation through the agreed strategic blueprints and programmes as part of the North Mersey LDS.
To ensure that the CCG maintains and manages performance and quality across the mandated constitutional measures.
To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complementary primary care quality contract.
To advance integration of in-hospital and community services in support of the CCG locality model of care.
To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

The Governing Body is assured of its effectiveness in terms of performance management through the regular corporate performance reports on finance, QIPP, quality and key performance indicators as set out in national guidance.

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

Practice name and address	
15 Sefton Road	15 Sefton Road, Litherland, Liverpool , Merseyside, L21 9HA
Aintree Road Medical Centre	1B Aintree Road, Bootle, Liverpool, L20 9DL
Blundellsands Surgery	1 Warren Road, Blundellsands, Liverpool, L23 6TZ
Bootle Village Surgery	204 Stanley Road, Bootle, L20 3EW
Bridge Road Medical Centre	66-88 Bridge Road, Litherland, Liverpool, L21 6PH
Concept House Surgery	17 Merton Road, Bootle, Merseyside, L20 3BG
Crosby Village Surgery (Interim provider – UC24)	3 Little Crosby Road, L23 2TE
Crossways Practice (Interim provider – UC24)	168 Liverpool Road, Crosby, L23 0QW
Eastview Surgery	81-83 Crosby Road North, Waterloo, L22 4QD
Ford Medical Practice	91-93 Gorsey Lane, Litherland, Liverpool, L21 0DF
Glovers Lane Surgery	Glovers Lane, Netherton, L30 5TA
High Pastures Surgery	138 Liverpool Road North, Maghull, L31 2HW
Hightown – (interim Provider Ashurst Health Ltd)	St Georges Road, L38 3RY
Kingsway Surgery	30 Kingsway, Waterloo, L22 0QW
Litherland Practice – (Interim provider – UC24)	Hatton Hill Road, Litherland, Liverpool, Merseyside, L21 9JN
Liverpool Rd Medical Practice	133 Liverpool Road, Crosby, Liverpool, Merseyside, L23 5TE
Maghull Health Centre (Dr. Sapre)	Maghull Family Health Centre, Maghull, L31 0DJ
Maghull Health Centre	Maghull Health Centre, Maghull, L31 0DJ
Maghull Practice (Interim Provider – UC24)	Maghull Health Centre, Maghull, L31 0DJ
Moore Street Medical Centre	77 Moore Street, Bootle, Liverpool, L20 4SE
NethertonSurgery – (Interim provider – UC24)	Netherton Health Centre, Magdalen Square, Bootle, Merseyside, L30 5SP

North Park Health Centre	290 Knowsley Road, Bootle, Merseyside, Liverpool, L20 5DQ
Orrell Park Medical Centre	Trinity Church, Orrell Lane, Liverpool, L9 8BU
Park Street Surgery	Park Street, Bootle, Liverpool, L20 3DF
Parkhaven SSP Health Limited (Dr Maaserani Is Interim Provider)	Parkhaven Trust, Liverpool Road South, L31 3RY
Rawson Road Medical Centre	136-138 Rawson Rd, Liverpool, L21 1HP
Seaforth SSP Health Ltd (Dr Maaserani Is Interim Provider)	20 Seaforth Road, Liverpool, Merseyside, L21 3TA
Sefton Road Surgery	129 Sefton Road, Litherland, Liverpool, Merseyside, L21 9HG
The Strand Medical Centre	272 Marsh Lane, Bootle, L20 5BW
Thornton - SSP Health Limited (Formby Village Is Interim Provider)	Bretlands Road, Thornton, L23 1TQ
Westway Medical Centre	Westway Medical Centre, Maghull, L31 0DJ

To ensure the CCG continues to be well led and effective, during the year the CCG continued to develop its leadership capability, bringing in new clinical leadership as well as continuing to secure dedicated time for development. There has been substantial involvement by the CCG in the work of the Cheshire & Merseyside Health and Care Partnership and progress made towards shared decision making models, all of which will lead to sustained improvements in services both at scale and for our population.

The CCG is able to demonstrate excellent leadership in terms of quality and finance and proactively seeks to engage the public in its work and use patient feedback to inform the way forward. The outputs of our audits confirm that there are robust governance and accountability arrangements in place and that these are appropriately refreshed to support the new operating environment across Cheshire and Merseyside. The CCG has submitted a “green” self-assessment.

In May 2017, the Governing Body received the consolidated outputs of its self-assessment of its effectiveness that examined behaviours and processes in respect of strategy, managing the business, managing relationships, financial stewardship, risk and control frameworks, skills, responsiveness to events, management of meetings and planning for the future (succession planning). The results were positive and an action plan was develop for areas that require strengthening to meet the challenges the CCG faced for 2017-2018. The Governing Body is also assured of its effectiveness via the provider performance reports and compliance with

constitutional standards. Further assurances on effectiveness are also provided as part of NHSE IAF quarterly and annual assessment processes.

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

Joint Quality Committee

The committee is established in accordance with the Legislative Reform (Clinical Commissioning Group) Order 2014 and the associated enabling provisions of set out in Section 23.4 of NHS South Sefton CCG Constitution and Section 6.6 of NHS Southport and Formby CCG Constitution.

The main functions of the committee are:

- To monitor standards and provide assurance on the quality of commissioned services, by the CCG to ensure that local and national standards are met
- To promote a culture of continuous improvement and innovation with respect to safety, clinical effectiveness and patient experience

The committee's key responsibilities are to:

- Ensure all decision making is consistent with the CCGs' QIPP priorities
- Approve arrangements including supporting policies to minimise clinical risk, maximise patient safety and secure continuous improvement in quality and patient outcomes
- Approve the arrangements for handling complaints
- Approve the CCGs' arrangements for engaging patients and their carers in decisions concerning their healthcare
- Approve arrangements for supporting NHS England in discharging its responsibilities to secure continuous improvement in the quality of general medical services in conjunction with the CCG and NHSE Joint Commissioning Committees
- Approve and monitor the arrangements in respect of Safeguarding (children and adults)
- Monitor the quality of commissioned services, compliance with Controlled Drugs Regulations 2013

The committee comprises the chief nurse and quality officer, lay members, clinicians and other CCG officers to ensure that the committee is appropriately skilled and resourced to deliver its objectives.

Joint Quality Committee has been well attended by all CCG officers, lay members and clinicians throughout the year so there has been robust scrutiny and challenge at all times. This has enabled the Joint Quality Committee to provide robust assurances to the respective Governing Body and to inform the Governing Body of key risk areas.

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

In respect of 2017-2018, key items of note were:

- Provider performance
- Quality surveillance

- Corporate risk registers
- Safeguarding assurance
- Chief nurse business update
- Serious incident report

Audit Committee

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

In September 2017 the CCG Governing Body in conjunction with NHS Southport and Formby CCG Governing Body agreed to support the proposals for the respective Audit Committees to meet as "committees in common" as a more efficient and effective way of supporting the statutory business of the CCGs. That arrangement came into effect during October 2017.

A "committees in common" arrangement enables the two committees to meet at the same time in the same place with a shared agenda, however both committees must remain quorate at all times to ensure compliance with the CCGs' constitutions.

It therefore follows that the CCG has not created a "new" committee, but the meeting arrangements in terms of time, place and venue have been changed. The functions, accountabilities and responsibilities remain unchanged.

The principal functions of the committee are as follows:

- To support the establishment of an effective system of integrated governance, risk management and internal control, across the whole of the CCGs' activities to support the delivery of the CCG's objectives
- To review and approve the arrangements for discharging the CCGs' statutory financial duties
- To review and approve arrangements for the CCGs' standards of Business Conduct including conflicts of interest, the register of interests and codes of conduct
- To ensure that the organisation has policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and to approve such policies

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

- Lay member (governance) (chair) and conflict of interest guardian
- Lay member (patient experience & engagement)
- Practice manager Governing Body member
- Secondary care doctor

The Audit Committee chair or vice chair and one other member are necessary for quorum purposes. In addition to the committee members, officers from the CCG are also asked to attend the committee as required. This always includes senior representation from finance.

In carrying out the above work, the committee primarily utilises the work of internal audit, external audit and other assurance functions as required.

A number of representatives from external organisations have attended to provide expert opinion and support:

- Audit Manager - MIAA
- Anti-Fraud Specialist - MIAA
- Audit Directors - Grant Thornton (2017-18)
- Audit Managers - Grant Thornton (2017-18)
- Audit Directors - KPMG (2016-17)
- Audit Managers - KPMG (2016-17)

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

Internal audit

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

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

Internal audit, together with CCG management, prepared a plan of work that was approved by the Audit Committee and progress against that plan has been monitored throughout the year.

During 2017-2018, MIAA has reviewed the operations of the CCG. No major issues have been identified. Reports have been provided for all completed reviews and in all cases action plans have been agreed. Actions have or will be implemented and progress against action plans is regularly monitored.Significant assurance has been provided for all areas reviewed in 2017-2018. This means that there were no areas reported by MIAA where weaknesses in control, or consistent non- compliance with key controls could have resulted in failure to achieve the review objective.

External audit

Role - The objectives of the external auditors are to review and report on the CCG's financial statements and on its Annual Governance Statement (AGS).

Anti-fraud specialist

Role - The CCG is committed to taking all necessary steps to counter fraud, bribery and corruption. To meet its objectives, it has adopted the four-stage approach developed by the NHS Counter Fraud Authority (CFA).

The NHS CFA unified approach to tackling all crime against the NHS (Tackling Crime against the NHS: A Strategic Approach') is delivered across four key operational areas:

- To ensure that the organisation's strategic governance arrangements have embedded anti-crime measures across all levels
- To inform and involve NHS staff and the public through raising awareness of crime risks against the NHS, and publicising those risks and effects of crime
- Prevent and deter individuals who may be tempted to commit crime against the NHS and ensure that opportunities for crime to occur are minimised
- To detect and investigate crime and hold to account those individuals who have committed crimes by prosecuting and seeking redress

The anti-fraud specialist, together with CCG management, prepared a plan of work that was approved by the Audit Committee and progress against that plan continues to be monitored throughout the year. The Audit Committee approved an updated anti-fraud, bribery and corruption policy at its January 2018 meeting.

Regular items for review

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

- Losses and special payments
- Outstanding debts
- Financial policies and procedures
- Tender waivers
- Declarations of interest
- Self-assessment of the committee's effectiveness
- Information Governance Toolkit
- Risk registers reviews

In respect of 2017-2018, key items of note are:

- Annual Governance Statement 2016/17;
- Annual Accounts 2016/17 approved;
- Annual report 2016/17 approved, and

- ISA 260 2016/17 – an "except for" qualified opinion on regularity from the external auditors, KPMG. The CCG reported a deficit in its financial statements for the year ending 31 March 2017, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraph 223I of Section 27 of the Health and Social Care Act 2012.

Remuneration Committee

The committee ensures compliance with statutory requirements and undertook reviews of very senior managers' remuneration to comply with the requirements set out in the NHS Codes of Conduct and Accountability and the Higgs report. The committee reviews and agrees appraisal and remuneration of CCG officers.

In September 2017 the CCG Governing Body in conjunction with NHS Southport and Formby CCG Governing Body agreed to support the proposals for the respective Remuneration Committees to meet as "committees in common" as a more efficient and effective way of supporting the statutory business of the CCGs. That arrangement came into effect during October 2017.

A "committees in common" arrangement enables the two committees to meet at the same time in the same place with a shared agenda, however both committees must remain quorate at all times to ensure compliance with the CCGs' constitutions. It therefore follows that the CCG has not created a "new" committee, but the meeting arrangements in terms of time, place and venue have been changed.

In October 2017 the CCG undertook a review of the role and remit of the committee to ensure that it was discharging its responsibilities in accordance with relevant regulations and guidance. The outputs of that review were reported to the Governing Body in November with a recommendation that the terms of reference and scheme of delegation were amended to more accurately reflect the fact that remuneration for the chief officer and chief finance officer was a matter reserved to the Governing Body. The recommendations were approved and implemented in November 2017.

During the year, the committee has agreed the following:

- Pay uplift for staff on Agenda for Change Terms & Conditions and doctors and dentists – April 2017
- Annual very senior manager (VSM) salary review
- Very senior manager (VSM) redundancy arrangements
- Retire and return applications

Finance and Resource Committee

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

In respect of 2017-2018, key items of note within the year are:

- Approval of financial strategy and plans
- Approval of CCG operational budgets
- Review and discussion of monthly financial reports
- QIPP plan updates
- Workforce reports
- Prescribing updates

Joint QIPP Committee

The principal function of the committee is to monitor progress on the implementation and benefit realisation of the CCGs QIPP plans, providing assurances to the Governing Body that the CCG is on track to achieve its QIPP targets.

Clinical QIPP Advisory Group

This group is responsible for providing clinical advice in respect of the development of all QIPP schemes and makes recommendations to the Joint QIPP Committee. The group is not decision making, but advisory in its capacity.

Joint Commissioning Committee

The committee is a joint committee of NHSE and the CCG, with the primary purpose of jointly commissioning primary medical services for the people of south Sefton. This committee is established as a sub-committee of the Governing Body.

The role of the Joint Commissioning Committee is to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act except those relating to individual GP performance management, which have been reserved to NHS England.

Governing Body Members - Committee Attendance 2017-18

Member	Governing Body	Approvals Committee (includes one extra called at late notice)	Audit Committee	Joint Quality Committee	Remuneration Committee	Joint QIPP Committee	Finance and Resource Committee	Joint Commissioning Committee
Fiona Taylor 5.	5 of 6	1 of 2		2 of 10		3 of 10	3 of 9	
Martin McDowell	5 of 6	2 of 2		5 of 10		9 of 10	9 of 9	
Debbie Fagan	5 of 6	2 of 2		10 of 10		6 of 10	7 of 9	
Andy Mimnagh	4 of 6			0 of 10		6 of 10		
Craig Gillespie 6.	6 of 6					1 of 10		6 of 6
Graham Morris	6 of 6	1 of 2	5 of 5		2 of 2	7 of 10	7 of 9	1 of 6
Gina Halstead* 1.	2 of 6			5 of 10				
Pete Chamberlain	6 of 6							
Dan McDowell 2.	2 of 6		4 of 4	1 of 10	2 of 2			
Sunil Sapre	5 of 6						8 of 9	
Ricky Sinha	1 of 6							
John Wray	1 of 6						1 of 9	
Graham Bayliss	6 of 6	2 of 2	4 of 5	5 of 10	2 of 2	2 of 10	7 of 9	5 of 6
Lin Bennett 3.	4 of 6		1 of 2	1 of 10			3 of 9	
Matthew Aston	4 of 6							
Jeff Simmonds 4.	1 of 6		1 of 1	2 of 10		6 of 10		

*Clinical Lead for Quality

1. Joined part way through year; January 2018
2. Left part way through year: December 2017
3. Left part way through year: beginning of February 2018
4. Joined part way through year; January 2018
5. Ex-officio member of the Quality Committee and the Finance and Resource Committee
6. As acting chair part way through the year – December 2017 (CCG Chair or acting Chair is required to be a substantive member of the Joint QIPP Committee)

UK corporate governance code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice. This Governance Statement is intended to demonstrate the clinical commissioning group's continued aspirations to comply with the principles set out in this code.

Up to the date of this statement the CCG has continued to work towards full compliance with the code.

Discharge of statutory functions

In light of recommendations of the 1983 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Risk management arrangement and effectiveness

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

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives
- Prevent and deter risks from arising by ensuring there is sufficient resource and capacity to support the CCGs strategy and objectives
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically

Capacity to handle risk

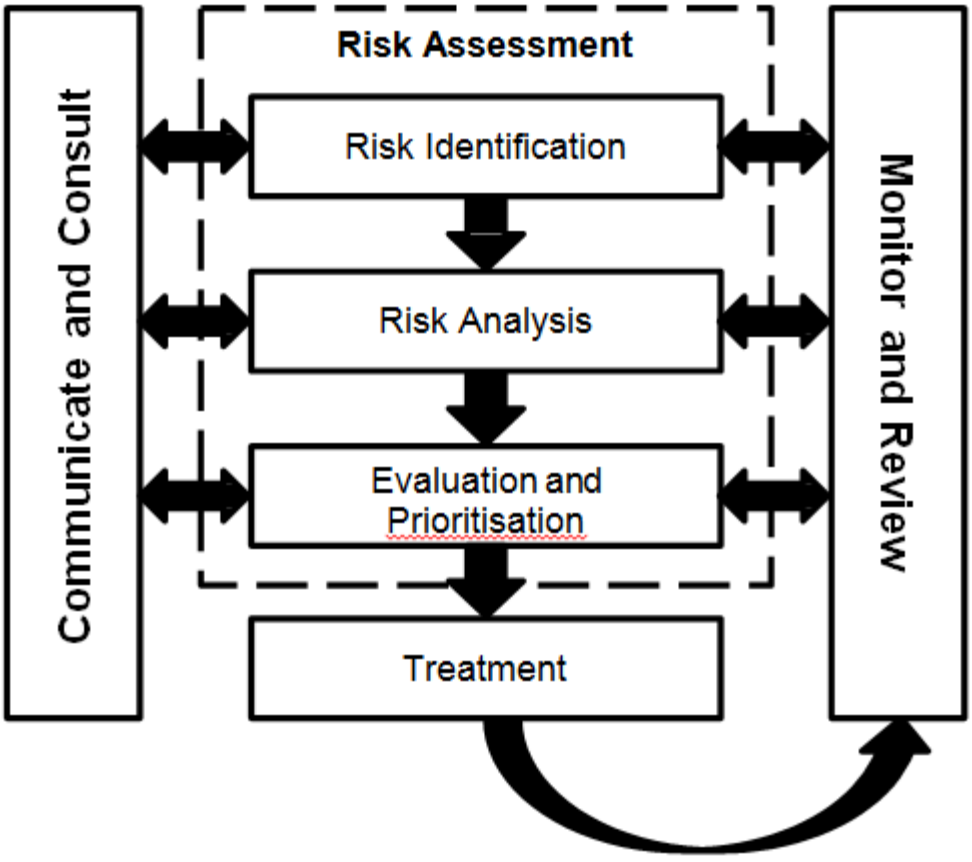
The Governing Body has developed and approved the corporate objectives, and the evaluation of the risks to achieving these objectives are set out in the Governing Body assurance framework which is regularly reviewed and scrutinised by the Leadership Team, Corporate Governance Support Group, Audit Committee and the Governing Body. The Governing Body assurance framework is a key document the purpose of which is to provide the Governing Body with 'reasonable' assurance that internal systems are functioning effectively. It is a high level document that is used to inform and give assurance to the Governing Body that the risks to achieving key objectives are recognised and that controls are in place or being developed to manage these risks.

The senior management team has responsibility for ensuring that all objectives are appropriately resourced to secure delivery and to mitigate risks to delivery arising.

To ensure that there are effective controls in place to deter and prevent fraud the CCG has appointed an anti-fraud specialist (AFS), the service is provided by Mersey Internal Audit Agency (MIAA). The AFS undertakes an approved programme of work with the CCG ensuring that there are appropriate controls and mechanisms in place.

Risk management framework

The CCG has adopted the risk management framework described in the NHS Executives Controls Assurance risk management standard. This draws on the main components of risk strategy, that is risk identification, risk analysis, evaluation and prioritisation and risk treatment.



Risk assessment

Risks are rated, and controls that will address these risks are identified, gaps in control or assurance are noted and action plans to close gaps summarised and updated. Potential and actual sources of assurance are identified and the latter are also rated for the level of assurance provided. A summary of the assurance levels for all assurance framework entries is updated each quarter and accompanies the full document. The corporate risk register provides the Governing Body with a summary of the principal risks facing the organisation, with a summary of the actions needed and being taken to reduce these risks to an acceptable level. The information contained in the corporate risk register should be sufficient to allow the Governing Body to be involved in prioritising and managing major risks. The risks described in

the corporate risk register will be more wide-ranging than those in the Governing Body assurance framework, covering a number of domains.

Where risks to achieving organisational objectives are identified in the corporate risk register these are added to the Governing Body assurance framework; and where gaps in control are identified in the Governing Body assurance framework, these risks are added to the corporate risk register. The two documents thus work together to provide the Governing Body with assurance and action plans on risk management in the organisation. The corporate risk register is updated and presented for review and scrutiny at the same time as the Governing Body assurance framework.

The CCG commissions a range of training programmes which include specific mandatory training for particular staff groups which aims to minimise the risks inherent in their daily work. Information governance, counter fraud, fire, health and safety, equality and diversity and safeguarding training are mandatory training requirements for all staff.

To ensure that there is a mechanism for public stakeholders to assist in the management of risks that impact on the public, the CCG has established an Engagement and Patient Experience Group (EPEG). This group reviews proposals for service change ensuring compliance with the Public Sector Equality Duty and other relevant laws before progressing further with consultation.

The CCG also consults with the Overview and Scrutiny Committee on any proposals potentially impacting on the public so that there is holistic and system wide assessment and mitigation of risks.

Other sources of assurance internal control framework

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

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

Annual audit of conflicts of interest management

The statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published an audit framework.

The internal audit plan includes an element of time to facilitate the annual review of conflicts of interest management.

Data quality

Data services (DSCRO) are commissioned through Arden & Gem CSU who process and quality assures that data that is received from providers and works with the CCG to challenge providers if inconsistencies are identified. DSCROs are regional processing centres for NHS Digital who are granted powers by the Health and Social Care Act 2012 to lawfully process patient identifiable information.

Midlands and Lancashire CSU is commissioned to provide the CCG with inter alia, performance reports, contract monitoring reports, quality dashboards and other activity and performance data.

The CCG's business intelligence team also assess the quality of the data provided and ensure that concerns are addressed through the provider information sub group meetings.

These processes provide assurances that the quality of the data upon which the membership and Governing Body rely is robust.

Information Governance

All key information assets have been identified by the asset owners on an information asset register. The data security and confidentiality risks to each asset have been identified and control implemented to mitigate risks.

The risks to the physical information assets are minimal, and pose no significant information governance concern for the CCG.

All inbound and outbound flows of data have been identified through a data flow mapping tool. All data flows are being transferred appropriately.

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

We place high importance on ensuring that there are robust information governance systems and processes in place to help protect personal and corporate information. We have established an information governance management framework and have developed information governance policies and procedures in line with the Information Governance Toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information handbook which contains information to ensure staff awareness of their roles and responsibilities.

The chief finance officer is the CCG's senior information risk owner (SIRO) and the chief nurse and quality officer is the CCG's Caldicott Guardian.

There are processes in place for incident reporting and the investigation of serious incidents. Information risk assessment and management procedures are in place and we continue to strive towards fully embedding a risk culture throughout the organisation against identified risks.

Business critical models

Officers of the CCG have reviewed the Macpherson report to consider the implications for the CCG. A report was provided to Audit Committee in April 2018 which provided assurance on CCG processes in place for business critical models. Similarly, the CCG's internal auditors have also undertaken a review of management accounting procedures during 2017-2018 which included estimation techniques. No significant concerns were reported in respect of the control environment operating in this area. Our business critical models and processes have been identified as risk assurance and risk management, financial and resources control, contracting and procurement processes, policy planning, forecasting and commissioning of health services, quality assurance processes, business management and corporate processes and governance arrangements.

Third party assurances

The CCG has delegated arrangements in place with providers external to the CCG for some services. Where the CCG relies on third party providers, assurance is requested to seek assurance on the effectiveness of controls and processes in place. This usually takes the form of service auditor reports.

Pensions obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations. Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Equality, diversity and human rights obligations

Control measures are in place to ensure that the clinical commissioning group complies with the required public sector equality duty set out in the Equality Act 2010.

Sustainable developments obligations

The CCG will develop plans to assess risks, enhance performance and reduce its impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning. As accountable officer I will ensure the clinical commissioning group complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012. Further details of how the CCG meets these obligations are contained in the 'working sustainably' section of the report.

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

NHS South Sefton CCG has a risk management strategy. The following key elements are contained within the strategy:

- Aims and objectives
- Roles, responsibilities and accountability
- The risk management process – risk identification, risk assessment, risk treatment, monitoring and review, risk prevention
- Risk grading – criteria
- Training and support

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

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

Key risks identified during 207-2018 are:

- Non- achievement of the CCG's financial duties due to significant cost pressures and underperformance against planned QIPP targets
- Pressures in urgent care

Overall the CCG is vigilant to the potential risks to the CCG operating licence and maintains a system of strong internal control and risk management. However no organisation can be complacent and the CCG recognises this and has taken steps during the year in a number of key areas to ensure that compliance with the operating licence is maintained and protected.

Effective governance arrangements – as highlighted above the CCG keeps under constant review the governance structures and committees that support the Governing Body in the discharge of its role and responsibilities.

Performance information – during the year the integrated performance report which is presented formally to the Governing Body has been subject to regular review, refinement and further strengthening so as to fully meet the needs and requirements of the Governing Body and provide them with assurance as to compliance with the CCG's licence and statutory duties.

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

The CCG seeks to gain best value through all of its contracting and procurement processes. The CCG has approved a scheme of delegation, prime financial policies and a schedule of financial limits that ensures there are proper controls in respect of expenditure.

The agreed limits for quotation and tendering are detailed in those policies and staff are required to properly assess bids for services in accordance with the policies.

The CCG buys procurement expertise and support from the Midlands and Lancashire CSU and this service is delivered by appropriately trained and accredited individuals.

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

The Governing Body is informed by its committees on the economic, efficient and effective use of resources and in particular by the Audit Committee and the Finance and Resources Committee that oversees and directs the use of the CCG resources. In doing so Governing Body members benefit from the experience and skills of a strong and competent senior management team, who work within a strong framework of performance management. The 2017-18 year end results for the quality of leadership indicator (part of the IAF see page 13) will be available from July 2018 on the MyNHS website[31].

Through the CCG's Joint QIPP Committee programmes of work and service redesign and transformational programmes are all clinically led by Governing Body members who are supported by project leads and a project management infrastructure.

All significant investment decisions are subject to a rigorous assessment and prioritisation process that is applied in such a way as to determine the relative effectiveness of the proposal, including the impact upon key strategic outcomes and objectives. Use is also made of data and support from our public health colleagues in the local authority.

Delegation of functions

The CCG had delegated arrangements in place with providers external to the CCG for the following:

- St Helens and Knowsley NHS Trust – payroll processing
- NHS Shared Business Services – provision of transactional finance services
- Midlands and Lancashire Commissioning Support Unit –aspects of Continuing Healthcare (CHC), Individual Funding Requests (IFR) and Funded Nursing Care (FNC) reviews, Business Intelligence, Human Resources and Organisational Development, Medicines Management, Risk Management Corporate Governance and compliance
- Informatics Merseyside that provides our information technology services and support

During 2017-2018 any identified risks associated with delegated arrangements have been monitored through the CCG's governance and risk management processes. The CCG has

[31] MyNHS website - https://www.nhs.uk/service-search/performance/search

monitored risks associated with these activities through periodic evaluation of relevant key performance indicators, regular attendance at local user groups and close partnership working.

Counter fraud arrangements

The CCG complies with the NHS Counter Fraud Authority Standards for Commissioners: Fraud, Bribery and Corruption as found at the following link https://cfa.nhs.uk/counter-fraud-standard

An accredited anti-fraud specialist is contracted via Mersey Internal Audit Agency to provide counter fraud services. The chief finance officer is the CCG executive Governing Body member. The anti-fraud specialist attends Audit Committee meetings, providing formal updates of progress against the annual counter fraud plan and programme of activities. The CCG performs a self-assessment of the NHS Counter Fraud Authority for Commissioners, the results of which are reported to Audit Committee.

Head of internal audit opinion

The purpose of the Director of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This opinion will assist the Governing Body in the completion of its Annual Governance Statement (AGS), along with considerations or organisational performance, regulatory compliance, the wider operating environment and health and social care transformation.

This opinion is provided in the context that the Clinical Commissioning Group like other organisations across the NHS is facing a number of challenging issues and wider organisational factors.

Roles and Responsibilities

The whole Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievements of policies, aims and objectives
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process
- the conduct and results of the review of the effectiveness of the system of internal control, including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising

The organisation's Assurance Framework should bring together all of the evidence required to support the AGS requirements.

In accordance with Public Sector Internal Audit Standards, the Director of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control).

This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which can provide assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Governing Body takes into account in making its AGS.

Executive summary

My opinion is set out as follows:

- Basis for the opinion
- Overall opinion
- Commentary

Basis for the Opinion

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes.
2. An assessment of the range of individual assurances arising from risk based internal audit assignments that have been reported throughout the period. The assessment takes account of the relative materiality of systems reviewed and management's progress in addressing control weaknesses identified.
3. An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

My opinion is one source of assurance that the organisation has in providing its AGS other third party assurances should also be considered. In addition the organisation should take account of other independent assurances that are considered relevant.

The Director of Audit's overall opinion for the period 1 April 2017 to 31 March 2018 is:

Substantial Assurance can be given that there is an adequate system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Commentary

The overall opinion is underpinned by the work conducted through the risk based internal audit plan, including core financial systems, risk assessed quality and safety reviews and governance processes.

This opinion is provided in the context that the Clinical Commissioning Group like other organisations across the NHS is facing a number of challenging issues and wider organisational factors.

Financial position	The CCG is facing challenging issues in respect of financial performance and is expecting to report a deficit position for 2017/18. The Governing Body has taken action to continually review the financial position of the Trust and regular updates are provided at Governing Body meetings
QIPP	The savings target for 2017/18 was £8.48m and the CCG is anticipating that this will not be fully achieved. The successful delivery of cost saving plans will be a key focus for the Governing Body throughout 2018/19. Going forward the CCG is likely to face stronger financial challenges.
CCG Annual Assessment	The CCG has been rated as Requires Improvement by NHS England in its annual assessment of performance against key performance indicators.
Senior management Changes	Senior management within the CCG has remained stable during 2017/18
Provider Performance	The CCG has continued to regularly report providers' performance against a range of targets. The CCG's primary provider: Aintree University Hospital NHS Foundation Trust has generally met cancer targets but has been challenged in year on referral to treatment and A&E waiting times. Primary Care performance is also regularly reported. The CCG needs to continue to work with providers to ensure required performance improvements are achieved.
Partnership	The CCG is part of the Cheshire and Merseyside Health and Care Partnership, working to deliver transformation across the health and social care system.

In providing this opinion I can confirm continued compliance with the definition of internal audit (as set out in your Internal Audit Charter), code of ethics and professional standards. I also confirm organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

Tim Crowley
Director of Audit, MIAA
March 2018

Internal Audit Reports issued in 2017-18

Audit Title	Level of Assurance Given
Financial Reporting	High
CSU Contract Management	High
Financial Systems Controls	Significant
Governing Body Reporting	Significant
Continuing Healthcare (CHC)	Significant
Information Governance (IG) Toolkit	Significant

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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports. Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principle objectives have been reviewed.

I have been advised on the implications of the result of this review by the Governing Body, the Audit Committee, Joint Quality Committee and the Finance and Resources Committee. If appropriate a plan to address weaknesses and ensure continuous improvement of systems will be put in place.

The Governing Body received the minutes of all committees including the Audit Committee, Joint Quality Committee, Finance and Resources Committee, and Joint QIPP Committee. The Joint Quality Committee approves relevant policies following review and assessment by the Corporate Governance Support Group and the Audit Committee monitors action plans arising from internal audit reviews.

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

Conclusion

No significant internal control issues have been identified. This is confirmed by the head of internal audit opinion and also by the internal reviews that have provided the CCG with substantial assurance on the arrangements in place. The report of the head of internal audit is attached to this governance statement.

Fiona Taylor

Accountable officer

25 May 2018

Remuneration report

Introduction

Section 234B and Schedule 7A of The Companies Act, as interpreted for the public sector in the General Accounting Manual, requires NHS bodies to prepare a remuneration report containing information about directors' remuneration. The report is prepared in respect of the senior managers of the NHS body. Senior managers are defined as 'those persons in senior positions having authority or responsibility for directing or controlling major activities of the NHS body. This means those who influence the decisions of the clinical commissioning group as a whole, rather than the decisions of individual directorates or departments'. For the purposes of this report, this includes the CCG's Governing Body members.

Remuneration Committee

The terms of reference for the Remuneration Committee are approved by the Governing Body and contained within the CCG Constitution. The Constitution also sets out membership of the Remuneration Committee and is available on the CCG website.

The CCG Remuneration Committee membership is made up of Governing Body members from NHS Southport and Formby CCG and NHS South Sefton CCG. The committee is a joint Remuneration Committee due to the shared management relationship between the two CCGs.

Name	Title	April 2017	September 2017
NHS South Sefton CCG			
Graham Morris	Chair and Governing Body Lay Member	✓	✓
Graham Bayliss	Governing Body Lay Member	✓	✓
Dan McDowell*	Secondary Care Doctor and Lay Member	✓	✓
NHS Southport and Formby CCG			
Helen Nichols	Chair and Govening Body Lay Member	✓	✓
Gill Brown	Governing Body Lay Member	✓	✓

* Tenure ceased in December 2017

Policy on remuneration of senior managers

Since the creation of CCGs there has been no mandated guidance on a standardised approach to senior manager remuneration for clinical commissioning groups and as such the CCG continues to use the report commissioned by the Hay Group to provide guidance on the appropriate level of remuneration for Governing Body members and senior executives.

NHS England's Guidance (Remuneration guidance for chief officers (where the senior manager also undertakes the accountable officer role) and chief finance officers) continues to be used as a reference for the remuneration of the chief officer and chief finance officer roles within the CCG.

Both NHS England and the Hay Group guidance reviewed the pay and employment conditions of other employees in order to determine the framework for senior manager's remuneration. The terms and conditions of service for all NHS staff, except very senior managers (VSMs) are nationally agreed by the NHS Staff Council. These terms and conditions include, pay and allowances; terms of employment such as leave and hours of working; the process for ensuring effective employee relations; and regulations with regard to equality and diversity.

The performance of all senior managers is measured and assessed using our personal development review process, based on organisational and individual objectives, which is also extended to all employees throughout the organisation.

During 2017-2018 Mersey Internal Audit Agency (MIAA) performed a benchmarking review across Cheshire and Merseyside on clinical commissioner remuneration arrangements. The review was not intended to provide an assurance opinion but to identify opportunities for CCGs to adopt good practice from other CCGs in the area. These areas will be considered as appropriate by the CCG in 2018-2019.

Pensions

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

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, i.e. an 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 is taken as equal to the contributions payable to the scheme for the accounting period. Further information with regard to pension benefits can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/nhs-pensions

In respect of 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.

The accounting policy relating to pension costs is described in the Notes 1.8 and 4.5 to the Financial Statements and pension liabilities existing at 31 March 2018 are disclosed within the Statement of Financial Position under other payables.

Under the Pensions Act 2008, every employer in the UK must put certain staff into a pension scheme and contribute towards it. This is known as 'automatic enrolment'. The CCG staging

date for auto-enrolment was 1 July 2017. The CCG has completed work in 2017-2018 with the outsourced payroll provider to ensure compliance with all legal duties.

Policy on senior manager's service contracts

All members of staff, with the exception of the chief finance officer, chief officer and specific Governing Body members are covered by Agenda for Change contracts of employment with contractual entitlements in line with the national NHS Terms and Conditions of Service as negotiated by the NHS Staff Council.

Contracts for all other roles are compliant with both UK and EU legislation and approved by the CCG's Remuneration Committee. Any future amendments to these contracts or the remuneration associated with them are the responsibility of the Remuneration Committee to review on an annual basis.

The CCG does not have any very senior managers paid in excess of £150,000 per annum.

Senior manager remuneration **subject to audit**

The table below sets out the salaries and allowances we have paid, or that are payable to our senior managers in 2017-2018.

Name	Title	Salary & Fees	Taxable Benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonuses	All Pension Related Benefits	Total	Total 2016/17
		(bands of £5,000)	(Rounded to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)
Taylor FL	Chief Officer	60 - 65	200	0	0	15 - 17.5	75 - 80	70 - 75
McDowell M	Chief Finance Officer / Deputy Chief Officer	50 - 55	2,300	0	0	15 - 17.5	65 - 70	65 - 70
Fagan DC	Chief Nurse	40 - 45	0	0	0	35 - 37.5	80 - 85	60 - 65
Mimnagh A	Chair	55 - 60	0	0	0	0	55 - 60	40 - 45
Gillespie C	Clinical Vice Chair & GP Clinical Director	15 - 20	0	0	0	0	15 - 20	15 - 20.
Wray J **	GP Clinical Director	30 - 35	0	0	0	0	30 - 35	20 - 25
Sinha R	GP Clinical Director	15 - 20	0	0	0	0	15 - 20	15 - 20.
Chamberlain PJ **	GP Clinical Director	15 - 20	0	0	0	0	15 - 20	70 - 75
Sapre S	GP Clinical Director	15 - 20	0	0	0	0	15 - 20	15 - 20.
Halstead G **	GP Clinical Director	10 - 15	0	0	0	0	10 - 15	20 - 25
Simmonds J #	Secondary Care Doctor	0 - 5	0	0	0	0	0 - 5	0
McDowell D *	Secondary Care Doctor	15 - 20	0	0	0	0	15 - 20	20-25
Morris GL	Vice Chair & Lay member - Governance	10 - 15	0	0	0	0	10 - 15	10-15
Bayliss G	Lay Member, Engagement and Patient Experience	5 - 10	0	0	0	0	5 - 10	5-10
Bennett L *	Practice Manager	0 - 5	0	0	0	0	0 - 5	0 - 5

** These members vacated the post within the financial year.*

*** Total paid in 2016/17 and 2017/18 includes payments for additional clinical roles and duties performed by members.*

 # Tenure began January 2018

Payments reflect the role in carrying out Governing Body duties. In addition, payments were made to the individuals highlighted to reflect the additional clinical roles and duties performed by GP Governing Body members. These payments are also disclosed in the related party transactions as part of the annual accounts.

We have a joint management arrangement with neighbouring NHS Southport and Formby CCG. The chief officer (Fiona Taylor), chief finance officer (Martin McDowell) and chief nurse (Debbie Fagan) receive remuneration for undertaking these roles for both CCGs.

Their total banded remuneration from these roles is:

- Fiona Taylor £125,000 to £130,000 and £30,000 to £32,500 all pension related benefits
- Martin McDowell £100,000 to £105,000 and £30,000 to £32,500 all pension related benefits
- Debbie Fagan £85,000 to £90,000 and £72,500 to £75,000 all pension related benefits

The total remuneration of the chief officer and chief finance officer includes a 20% supplement on their basic salary paid in accordance with NHS England guidance and agreed by our Remuneration Committees to recognise the joint roles that they undertake, as officers covering two CCGs. They hold the same positions with NHS Southport and Formby CCG.

Name	Title	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2018	Lump sum at age 60 related to accrued pension at 31 March 2018	Cash equivalent transfer value at 1 April 2017	Cash equivalent transfer value at 1 April 2018	Real increase in cash equivalent transfer value	Employers contribution to partnership pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£'000	£'000	£'000	£'000
McDowell M	Chief Finance Officer / Deputy Chief Officer	0 - 2.5	0 - 2.5	30 - 35	75 - 80	447	501	50	0
Taylor FL	Chief Officer	0 - 2.5	2.5 - 5	55 - 60	170 - 175	1,055	1,161	94	0
Fagan DC	Chief Nurse	2.5 - 5	5 - 7.5	30 - 35	85 - 90	439	529	85	0

Table above subject to audit

The information in the table above for our chief officer (Fiona Taylor), chief finance officer (Martin McDowell) and chief nurse (Debbie Fagan) relates to their total pension benefits arising from their joint management roles in NHS Southport and Formby CCG and NHS South Sefton CCG.

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

Cash Equivalent Transfer Values

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

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

During 2017-2018 the CCG has not made any payments for loss of office.

Payments to past members

During 2017-2018 the CCG has not made any payments to any past senior managers.

Pay multiples **subject to audit**

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/ Member in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director/ member in NHS South Sefton CCG in the financial year 2017-18 was £62,500 (2016-17: £62,500). This was 3.14 times (2016-17: 2.70) the median remuneration of the workforce, which was £19,923 (2016-17: £23,169).

In 2017-2018, no employees (2016-17: 0) received remuneration in excess of the highest paid director/ member. Remuneration ranged from £0 to £5,000 (2016-17, £5,000 to £10,000) to £60,000 to £65,000 (2016-17, £60,000 to £65,000).

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

The pay multiple calculation has been amended to reflect the overall charge to the organisation rather than the shared cost with NHS Southport and Formby CCG due to the joint management arrangements in place; this is in line with the Group Accounting Manual 2017-2018.

Staff report

Our staff and members are our greatest asset. To ensure we remain an effective and innovative organisation into the future, we must continually support our members and staff to grow and develop their knowledge and skills in line with the latest developments in healthcare and technologies. Our refreshed organisational development plan highlights five priority areas for actions that we have been progressing over the last twelve months. These are:

1. Integrated care in localities
2. Commissioning capacity and capability
3. Programme management approach for delivery of QIPP and transformation
4. System leadership, team and talent management
5. Public engagement and partnership working for transformation

Here are some examples of how we have developed this work to support our membership and workforce:

Our Governing Body

Our Governing Body participates in a development session every other month which provides an opportunity for reflection on national and local developments to inform our strategy and how it is delivered. Governing Body members have also been able to access a range of personal development opportunities, with some members participating in national development programmes or network events with other CCGs.

Our members

Our member practices are supported to carry out their commissioning responsibilities in a number of different ways.

- Continuing professional development sessions are regularly organised for clinical staff and these are called Protected Learning Time (PLT) events. The CCG also supports monthly “in-house” sessions, which enables all GP practices to hold individual educational and practice training events
- Regular meetings in localities enable key issues relating to local services to be raised and discussed, so that the Governing Body and lead commissioners are kept informed in order to influence commissioning decisions
- Our nurse facilitators support the development and access to education, training and mentoring for practice nurses and healthcare assistants and the CCG became one of the first in the county to host student nurse placements
- We hold quarterly membership meetings where practices come together to discuss wider CCG work and initiatives to improve patient care
- A weekly e-bulletin provides members with updates on CCG work, along with relevant national publications and development opportunities
- An intranet site provides a wide range of information designed to support our members, which we are continuing to update in based on member’s feedback

Staff numbers and costs subject to audit

At the end of March 2018 we employed 117 people (68 whole time equivalents) to help us carry out our work. This includes commissioning and medicines management professionals, doctors, nurses and administration and support staff. The majority of our staff work jointly with NHS Southport and Formby CCG through our shared management team arrangements.

	Permanent Employees £'000	Other Employees £'000	Total £'000
Salaries & Wages	2,018	33	2,051
Social Security Costs	496		496
Employer Contributions to NHS Pension Scheme	609		609
Total	**3,122**	**33**	**3,156**

	Permanent	Other	Total
Administration and estates staff	32	4	36
Medical and dental staff	8	-	8
Nursing, midwifery and health visiting staff	3	-	3
Scientific, therapeutic and technical staff	21	-	21
TOTAL	64	4	68

Staff composition

	Governing body	Very Senior Managers	Other employees	Total
Male	10	0	15	25
Female	3	0	42	43
Total	**13**	**0**	**57**	**68**

There were no very senior managers (according to the definition within the Group Accounting Manual) who were not member of the CCG Governing Body.

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

- We are committed to being a fair and equal employer and our workplace policies are in line with all relevant equality, diversity and human rights legislation to ensure none of our staff are disadvantaged by our working, training or recruiting processes. More information on equality and diversity can be found on page 47

- We meet regularly to discuss business and performance, and to share ideas and innovation. During 2017-2018, we once again held our annual CCG Away Day which encompassed a staff awards ceremony, providing a great opportunity to celebrate some great individual and team achievements
- We ensure our staff have the resources and development opportunities to help them carry out their day to day work, including support to complete essential core training requirements, holding annual personal development reviews, promoting and providing staff support and occupational health services focusing on health and wellbeing, as well as ensuring easy access to information through our intranet
- Following a successful grant application to the North West Leadership Academy we have begun to refresh our approach to personal development planning, ensuring staff know how to lead an excellent development conversation and can facilitate access to a range of flexible opportunities to help staff develop
- We have launched a new dedicated monthly e-bulletin as a result of staff views gained through a review of our existing communications channels
- In 2017-18 we participated in the national NHS Staff Survey, which once again reported very pleasing results with the vast majority of responses demonstrating higher scores that the national average. Lessons learned continue to inform our organisational development planning

Sickness absence rates

Rates of sickness absence in our organisation are low. Our annual rolling sickness absence at the end of March 2018 was 4.83%. We have policies in place that set out how we manage and support staff through periods of illness or other types of leave.

Disabled employees

We ensure our disabled staff are treated equally, without discrimination and shown due regard. More information can be found on page 47.

The Trade Union (Facility Time Publication Requirements) Regulations 2017

Under regulations that came into force on 1 April 2017, certain public sector organisations are required to report information in relation to Trade Union activities and the cost of any facility time in connection with these activities.

The CCG had no relevant union officials during the year ended 31 March 2018 and consequently the CCG can confirm

- There were no employees who were relevant union officials
- The percentage time spent on facility time was nil
- The percentage of the paybill spent on facility time was nil
- No hours were spent on paid Trade Union activities by relevant officials in the period

Staff Partnership Forum

We acknowledge 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, we have a recognition agreement with trade unions and staff side representatives and 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 forum is authorised to agree, revise and review policies and procedures which may relate to changes in employment legislation and regulation and the terms and conditions of employment affecting our staff covered by the national Agenda for Change Terms and Conditions.

Any policies approved by the Staff Partnership Forum during this period were subsequently ratified by the Finance & Resource Committee or Joint Quality Committee which are both sub-committees of the Governing Body.

Expenditure on consultancy

During 2017-2018 the CCG spent around £86.7k on consultancy services. The majority of this was incurred on consultancy services to develop the CCG's Transformation Plan.

Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2018, for more than £245 per day and that last longer than six months:

The number that have existed:	Number
• For less than one year at the time of reporting	0
• For between one and two years at the time of reporting	0
• For between two and three years at the time of reporting	0
• For between three and four years at the time of reporting	0
• For four or more years at the time of reporting	3
Total number of existing engagements as of 31 March 2018	3

All existing off payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

New off-payroll engagements

For all new off-payroll engagements between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Number of the above which include contractual clauses giving the clinical commissioning group the right to request assurance in relation to Income Tax and National Insurance obligations	0
Of which, the number:	
• Assessed as caught by IR35	0
• Assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency/ assurance purposes during the year	10
Number of engagements that saw a change to IR 35 status following the consistency review	5

Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed “board members, and/or senior officials with significant financial responsibility”, during the financial year. This figure should include both off-payroll and on-payroll engagements.	15

Exit packages, including special (non-contractual) payments

Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 – £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

There were no redundancy or exit costs for NHS South Sefton CCG during 2017-2018

Analysis of other departures

	Agreements Number	Total Value of agreements £'000
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval**	-	-
TOTAL	**0**	**0**

There were no costs of other departures for NHS South Sefton CCG during 2017-2018.

Signed:

Fiona Taylor

Accountable officer

25 May 2018

Parliamentary accountability and audit report

NHS South Sefton CCG is not required to produce a parliamentary accountability and audit report. Disclosures on remote contingent liabilities, losses and special payments, gifts and fees and charges are included as notes in the financial statements of this report on page 97 to 100. An audit certificate and report is also included in this Annual Report at page 93.

Independent auditor's report to the members of the Governing Body of NHS South Sefton Clinical Commissioning Group

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of NHS South Sefton Clinical Commissioning Group (the 'CCG') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012.

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the CCG's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of our work including that gained through work in relation to the CCG's

arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012 ; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Qualified opinion on regularity required by the Code of Audit Practice

In our opinion, except for the effects of the matters described in the Basis for qualified opinion on regularity section of our report, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

The CCG reported a deficit of £2.99 million against its total in year revenue resource limit in its financial statements for the year ended 31 March 2018, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraph 223I of Section 27 of the Health and Social Care Act 2012, to ensure that its revenue resource use in a financial year does not exceed the amount specified by direction of the NHS Commissioning Board. This deficit also resulted in a breach of the CCG's duty under the National Health Service Act 2006, as amended by paragraph 223H of Section 27 of the Health and Social Care Act 2012, to ensure that its expenditure in a financial year does not exceed its income.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the CCG, or an officer of the CCG, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was

about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we have made a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 9 March 2018 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to NHS South Sefton CCG's planned breach of its revenue resource limit for the year ended 31 March 2018.

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 55 to 56, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the CCG lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the CCG.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Report on other legal and regulatory requirements – Conclusion on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matter described in the basis for qualified conclusion section of our report we are satisfied that, in all significant respects NHS South Sefton CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

Our review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matter:

The CCG reported a deficit of £2.99 million in its financial statements for the year ended 31 March 2018 which was a £2.99 million overspend against its original budget of break–even, agreed with NHS England.
The CCG has set a budget to achieve a £1 million surplus in 2018/19, however there are significant risks to the CCG achieving the savings required to deliver the 2018/19 budget.

This matter identifies weaknesses in the CCG's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures. This matters is evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibilities for the review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3) (c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of NHS South Sefton CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Robin Baker

Robin Baker
Director
for and on behalf of Grant Thornton UK LLP

Royal Liver Building
Liverpool
L3 1PS

25 May 2018

Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2018

	Note	2017-18 £000	2016-17 £000
Income from sales of goods and services	2	**(897)**	(2,092)
Other operating income	2	**(216)**	(205)
Total operating income		**(1,113)**	**(2,297)**
Staff costs	4	**3,156**	3,554
Purchase of goods and services	5	**245,197**	242,684
Depreciation and impairment charges	5	**14**	14
Provision expense	5	**200**	-
Other operating expenditure	5	**332**	265
Total operating expenditure		**248,899**	**246,517**
Net operating expenditure		**247,786**	**244,220**
Total comprehensive net expenditure for the year ended 31 March 2018		**247,786**	**244,220**

Statement of Financial Position as at 31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets:			
Property, plant and equipment	8	**115**	**14**
Total non- current assets		**115**	**14**
Current assets:			
Trade and other receivables	9	**1,938**	**1,817**
Cash and cash equivalents	10	**105**	**139**
Total current assets		**2,043**	**1,956**
Total assets		**2,158**	**1,970**
Current liabilities:			
Trade and other payables	11	**(13,900)**	**(11,850)**
Provisions	12	(**200)**	**-**
Total current liabilities		**(14,100)**	**(11,850)**
Total Liabilities Employed		**(11,942)**	**(9,879)**
Financed by Taxpayers' Equity			
General fund		**(11,942)**	**(9,879)**
Total taxpayers' equity:		**(11,942)**	**(9,879)**

The notes on pages 101 to 137 form part of this statement.

The financial statements on pages 97 to 100 were approved by the Governing Body on 24 May 2018 and signed on its behalf by:

Fiona Taylor
Chief Accountable Officer
25 May 2018

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2018

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Changes in taxpayers' equity for 2017-18				
Balance at 1 April 2017	(9,879)	-	-	**(9,879)**
Changes in NHS South Sefton CCG taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(247,786)	-	-	**(247,786)**
Net Recognised CCG Expenditure for the Financial Year	(247,786)	-	-	**(247,786)**
Net funding	245,723	-	-	**245,723**
Balance at 31 March 2018	**(11,942)**	**-**	**-**	**(11,942)**

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Changes in taxpayers' equity for 2016-17				
Balance at 1 April 2016	(15,280)	-	-	**(15,280)**
Changes in NHS South Sefton CCG taxpayers' equity for 2016-17				
Net operating costs for the financial year	(244,220)	-	-	**(244,220)**
Net Recognised CCG Expenditure for the Financial Year	(244,220)			**(244,220)**
Net funding	249,621	-	-	249,621
Balance at 31 March 2017	**(9,879)**	**-**	**-**	**(9,879)**

Statement of Cash Flows for the Year Ended 31 March 2018

	Note	2017-18 £000	2016-17 £000
Cash Flows from Operating Activities			
Net operating costs for the financial year	5	(247,786)	(244,220)
Depreciation and amortisation	5	14	14
(Increase)/decrease in trade & other receivables	9	(121)	162
Increase/(decrease) in trade & other payables	11	2,051	(5,293)
Provisions utilised	12	-	(262)
Increase/(decrease) in provisions	12	200	-
Net Cash Outflow from Operating Activities		(245,642)	(249,599)
Cash Flows from Investing Activities			
(Payments) for property plant and equipment		(115)	-
Net Cash Outflow before Financing		(245,757)	(249,599)
Cash Flows from Financing Activities			
Net funding received		245,723	249,621
Net Cash Inflow (Outflow) from Financing Activities		245,723	249,621
Net Increase (Decrease) in Cash & Cash Equivalents	10	(34)	22
Cash & Cash Equivalents at the Beginning of the Financial Year		139	117
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		105	139

The notes on pages 101 to 137 form part of this statement.

Notes to the Financial Statements

1. Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2017-18 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual 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 Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014)

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

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

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

1.5 Pooled Budgets

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

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

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

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

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

1.6 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.6.1 Critical Judgements in Applying Accounting Policies

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

- Accruals - Included within the financial statements to the extent that the CCG recognises an obligation at the 31 March 2018 for which it had not been invoiced. Estimates of accruals are undertaken by management based on the information available at the end of the financial year, together with past experience, and
- Provisions – Recognised when the CCG 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.

1.6.2 Key Sources of Estimation Uncertainty

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

- Activity is accounted for in the financial year it takes place, and not necessarily when cash

payments are made or received. The Clinical Commissioning Group has a robust process for identifying that activities have taken place and for identifying the appropriate accounting period. Therefore the degree of estimation uncertainty is considered to be low;

- The prescribing accrual for the final month of the year is based upon forecasted figures provided by the Business Services Authority and estimates undertaken by management based on information available at the end of the financial year, together with past experience, and
- Individual Packages of Care primarily fall into the areas of Continuing Healthcare (CHC) and Funded Nursing Care (FNC). Monthly financial information from DPS is one month in arrears, and so estimates are required to establish an expected monthly charge and year-end forecast. The estimates are therefore a reflection of DPS data and local knowledge.

1.7 Revenue

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

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

1.8 Employee Benefits

1.8.1 Short-term Employee Benefits

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

1.8.2 Retirement Benefit Costs

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

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

1.9 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods and services have been received. They are measured at the fair value of the consideration payable. Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.10 Property Plant & Equipment

1.10.1 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;
- 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;
- 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, and
- Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.10.2 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 valuation.

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 – depreciation 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 current value in existing use.

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.

1.10.3 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.

1.11 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated. Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

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

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

1.12 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.

1.12.3 The Clinical Commissioning Group as Lessee

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

clinical commissioning group's surplus/deficit.

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

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

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

1.12.4 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.

1.13 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.

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

1.14 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 2.42%
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85%
- Timing of cash flows (over 10 years): Minus 1.56%

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.

1.15 Clinical Negligence Costs

The NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

1.16 Non-clinical Risk Pooling

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

1.17 Continuing Healthcare Risk Pooling

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

1.18 Contingencies

A contingent liability is a possible obligation that arise from past events and whose existence will be confirmed only be 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.

1.19 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.

1.19.1 Financial Assets at Fair Value Through Profit & 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.

1.19.2 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.

1.19.3 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.

1.19.4 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.

1.20 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.

1.21 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.

1.22 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).

1.23 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.

1.24 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.

1.25 Accounting Standards that have been issued but have not yet been adopted

The DHSC Group accounting manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to FREM adoption and early adoption is not therefore permitted, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018);
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH group bodies);
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018);
- IFRS 16: Leases (application 1 January 2019);
- IFRS 17 Insurance Contracts (application from 1 January 2021);
- IFRIC 22 Foreign Currency Transactions and Advance Consideration (application from 1 January 2018), and
- IFRIC 23 Uncertainty over Income Tax Treatments (application from 1 January 2019).

The application of the Standards as revised would not have a material impact on the accounts for 2017-18, were they applied in that year.

2. Other Operating Revenue

	2017-18 Total £000	2017-18 Admin £000	2017-18 Programme £000	2016-17 Total £000
Prescription fees and charges	130	-	130	139
Education, training and research	10	-	10	13
Charitable and other contributions revenue expenditure: non-NHS	20	-	20	64
Non-patient care services to other bodies	887	217	670	2,080
Other revenue	66	-	66	1
Total other operating revenue	**1,113**	**217**	**896**	**2,297**

Non-patient care services to other bodies include income derived from public health services.

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

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

3. Revenue

	2017-18 Total £000	2017-18 Admin £000	2017-18 Programme £000	2016-17 Total £000
From rendering of services	**1,113**	217	896	2,297
Total other operating revenue	**1,113**	**217**	**896**	2,297

Revenue is totally from the supply of services. The Clinical Commissioning Group receives no revenue from the sale of goods.

4. Employee Benefits & Staff Numbers

4.1 Employee benefits

4.1.1Employee benefits expenditure

	2017-18 Total	Permanent Employees	Other Other	2016-17 Total
	£000	£000	£000	£000
Salaries and wages	**2,051**	2,018	33	**2,441**
Social security costs	**496**	496	-	**499**
Employer contributions to NHS pension scheme	**609**	609	-	**614**
Other pension costs	**-**	-	-	-
Other post employment benefits	**-**	-	-	-
Other employment benefits	**-**	-	-	-
Termination Benefits	**-**	-	-	-
Gross employee benefits expenditure	**3,156**	**3,122**	**33**	**3,554**
Less recoveries in respect of employee benefits	**-**	-	-	-
Total - Net admin employee benefits including capitalised costs	**3,156**	3,122	33	**3,554**
Less: Employee costs capitalised	**-**	-	-	-
Net employee benefits excluding capitalised costs	**3,156**	3,122	33	**3,554**

Please see pages 80 to 85 of the annual report for further information on staff costs

4.2 Average number of people employed

	2017-18			2016-17
	Permanent Employees	Other	Total	Total
	Number	Number	Number	Number
Total CCG (WTE)	64	4	68	74
Of the above:				
Number of whole time equivalent people engaged on capital projects	-	-	-	-

Please see pages 80 to 85 of the annual report for further information on staff costs

4.3 Staff sickness absence and ill health retirements

Please see pages 80 to 85 of the annual report for staff sickness reported.

4.4 Exit packages agreed in the financial year

	2017-18		2017-18		2017-18	
	Compulsory redundancies		Other agreed departures		Total	
	Number	£'000	Number	£'000	Number	£'000
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	-	-	-	-	-	-

4.5 Severance Payments

	2016-17 Compulsory redundancies		2016-17 Other agreed departures		2016-17 Total	
	Number	£000	Number	£000	Number	£000
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	1	38	1	38
£100,001 to £150,000	-	-	1	76	1	76
£150,001 to £200,000	-	-	1	122	1	122
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**3**	**236**	**3**	**236**

	2017-18 Departures where special payments have been made		2016-17 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	1	38,026
£50,001 to £100,000			1	75,894
£100,001 to £150,000			1	121,596
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**3**	**235,516**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or full in the previous period.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where the CCG has agreed early retirements, the additional costs are met by NHS Entities and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement

costs are met by the NHS Pension Scheme and are not included in the tables. The Clinical Commissioning Group had no ill health retirements in 2017-18 (2016-17: Nil).

4.6 Pension costs

Past and present employees are covered by the provisions of the two NHS Pensions Schemes. Details of the benefits payable and the rules of the schemes under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded, defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently he Government's Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2018, is based on valuation data as at 31 March 2016, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations and the discount rate prescribed by HM Treasury have also been used.

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) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can be obtained from the Stationery Office.

b) 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 actuary report (taking into account their recent demographic experience), and to

recommend contribution rates by employees and employers.

The latest published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate representatives as deemed appropriate.

For 2017-18, employers' contributions of £609k were payable to the NHS Pensions Scheme (2016-17: £614k) at the rate of 14.38% of pensionable pay (2016/17 14.3%). The scheme's actuary reviews employers' contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS pension line of note 4.1.1.

5. Operating Expenses

	2017/18 Total £000	2017/18 Admin £000	2017/18 Programme £000	2016/17 Total £000
Gross employee benefits				
employee benefits excluding governing body members	**2,951**	1,826	1,125	3,354
Executive governing body members	**205**	205	-	200
Total gross employee benefits	**3,156**	**2,031**	**1,125**	**3,554**
Other Costs				
Services from other CCGs and NHS England	**576**	249	327	1,892
Services from foundation trusts	**150,390**	23	150,367	126,905
Services from other NHS trusts	**28,424**	-	28,424	49,594
Sustainability Transformation Fund	**-**	-	-	-
Services from Other WGA bodies	**-**	-	-	4
Purchase of healthcare from non-NHS bodies	**28,332**	-	28,332	27,762
Purchase of social care	**-**	-	-	-
Chair and Non Executive Members	**211**	211	-	178
Supplies and services – clinical	**417**	-	417	700
Supplies and services – general	**512**	96	416	9
Consultancy services	**87**	82	5	171
Establishment	**2,549**	109	2,440	2,749
Premises	**529**	211	318	630
Depreciation	**14**	-	14	14
Audit fees **	**46**	46	-	49
Other non statutory audit expenditure				
· Internal audit services *	**32**	32	-	36
· Other services	**-**	-	-	-
General Dental services and personal dental services	**-**	-	-	-
Prescribing costs	**28,923**	-	28,923	29,186
Pharmaceutical services	**-**	-	-	-
General Ophthalmic services	**10**	-	10	5
GPMS/APMS and PCTMS	**3,923**	-	3,923	2,302
Other professional fees	**330**	-	330	389
Legal fees	**32**	32	-	-
Grants to Other bodies	**-**	-	-	-
Education and training	**85**	26	59	71
Provisions	**200**	-	200	
CHC Risk Pool contributions	**-**	-	-	230
Non cash apprenticeship training grants	**-**	-	-	-
Other expenditure	**121**	-	121	87
Total other costs	**245,743**	1,117	244,626	242,963
Total operating expenses	**248,899** -	3,148 -	245,751 -	**246,517**

* Internal Audit services during the year were provided by Mersey Internal Audit Agency (MIAA)

**In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, where a CCG contract with its auditors provides for a limitation of the auditor's liability, the principal terms of this limitation must be disclosed. The contract for the provision of external audit services is held by Grant Thornton UK LLP. This limitation has been confirmed as £2 million. The external audit fees include Value Added Tax (VAT).

6. Better Payment Practice Code

6.1 Measure of compliance

	2017-18 Number	2017-18 £000	2016-17 Number	2016-17 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices paid in the Year	4,810	37,554	6,953	36,902
Total Non-NHS Trade Invoices paid within Target	4,613	36,420	6,699	33,632
Percentage of Non-NHS Trade Invoices paid within target	**95.90%**	**96.98%**	96.35%	91.14%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,222	182,156	2,036	183,242
Total NHS Trade Invoices Paid within Target	2,160	182,030	1,955	183,193
Percentage of NHS Trade Invoices paid within target	**97.21%**	**99.93%**	96.02%	99.97%

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 Better Payment Practice Code sets out target compliance of 95%.

7. Operating Leases

7.1 As lessee

The Clinical Commissioning Group has arrangements in place with NHS Property Services and Community Health Partnerships for the use of property assets. Although no formal contracts are in place the substance of the transactions involved convey the right of the Clinical Commissioning Group to use the property assets. In accordance with IAS 17 and the Group Accounting Manual 2017-18 payments are required to be disclosed as operating lease payments. Payments made in 2017-18 are shown below:

7.1.1 Payments recognised as an expense

	Land £000	Buildings £000	Other £000	2017-18 Total £000	2016-17 Total £000
Payments recognised as an expense					
Minimum lease payments	**-**	**473**	**1**	**474**	**522**
Contingent rents	**-**	**-**	**-**	**-**	**-**
Sub-lease payments	**-**	**-**	**-**	**-**	**-**
Total	**-**	**473**	**1**	**474**	**522**

7.1.2 Future minimum lease payments

While our arrangements with Community Health Partnerships Ltd and NHS Property Services Ltd fall within the definition of operating leases, the rental charge for the remainder of the current lease, has not yet been agreed. Consequently, this note does not include future minimum lease payments for these arrangements.

8. Property, Plant & Equipment

	Plant & Machinery £000	Information Technology £000	Total £000
Cost or valuation at 1 April 2017	74	57	**131**
Additions	-	115	115
Disposals	-	-	-
Cost or valuation at 31 March 2018	**74**	**172**	**246**
Depreciation at 1 April 2017	**60**	**57**	**117**
Charged during year	14	-	14
Depreciation at 31 March 2018	**74**	**57**	**131**
Net book value at 31 March 2018	-	115	115
Purchased	-	115	115
Donated	-	-	-
Total at 31 March 2018	-	115	115

The information technology additions have not been depreciated in 2017/18 in line with note 1.10 above as the CCG have not yet consumed the economic benefit or service potential of the assets.

8.1.1 Economic lives

	Minimum Life (years)	Maximum Life (years)
Plant & Machinery	1	3
Information technology	1	3

9. Trade & Other Receivables

	Current 2017-18 £000	Current 2016-17 £000
NHS receivables: Revenue	1,618	849
NHS accrued income	(3)	368
Non-NHS and other WGA receivables: Revenue	252	300
Non-NHS prepayments	24	239
Non-NHS accrued income	0	5
VAT	0	16
Other	47	39
Total	**1,938**	**1,817**

There were no non–current receivables in 2017-18 (2016-17: nil)

There were no prepaid pension contributions included in 2017-18 (2017-18: nil)

9.1 Receivables past their due date but not impaired

	2017-18 £000	2016/17 £000
By up to three months	814	131
By three to six months	459	1
By more than six months	506	75
Total	**1,779**	**207**

10. Cash & Cash Equivalents

	2017-18 £000	2016-17 £000
Balance at 1 April 2017	139	117
Net change in year	(34)	22
Balance at 31 March 2018	105	139
Made up of:		
Cash with the Government Banking Service	105	139
Cash with Commercial banks		-
Cash in hand		-
Current investments		-
Cash and cash equivalents as in statement of financial position	105	139
Bank overdraft: Government Banking Service		-
Bank overdraft: Commercial banks		-
Total bank overdrafts		-
Balance at 31 March 2018	105	139
Patients' money held by the clinical commissioning group, not included above	-	-

11. Trade & Other Payables

	Current 2017-18 £000	Current 2016-17 £000
NHS payables: revenue	2,111	259
NHS accruals	497	528
NHS deferred income	191	-
Non-NHS and other WGA payables: revenue	2,633	2,284
Non-NHS and other WGA accruals	7,567	8,112
Social security costs	76	76
VAT	7	-
Tax	66	66
Other payables	752	525
Total	**13,900**	**11,850**

There were no non–current payables in 2017-18 (2016-17: nil)

12. Provisions

	Current 2017-18 £000	Current 2016-17 £000
Other	**200**	**-**
Total	**-**	**-**

There were no non-current provisions in 2017/18 (2016/17: nil).

	Other £000	Total £000
Balance at 1 April 2017	-	-
Arising during the year	200	200
Utilised during the year	-	-
Reversed unused	-	
Unwinding of discount	-	-
Change in discount rate	-	-
Transfer (to) from other public sector body	-	-
Balance at 31 March 2018	**200**	**200**

Expected timing of cash flows:

Within one year	200	200
Between one and five years	-	-
After five years	-	-
Balance at 31 March 2018	**200**	**200**

13. Contingencies

The Clinical Commissioning Group has assessed the likelihood and impact of contingent assets and liabilities as at 31 March 2018. The likelihood is assessed as remote and the impact would not be material.

14. Clinical Negligence Costs

The value of provisions carried in the books of the NHS Litigation Authority in regard to CNST claims as at 31 March 2018 was nil (2016-17:nil).

15. Financial Instruments

15.1 Financial risk management

International Financial Reporting Standard 7: Financial Instrument: Disclosure requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

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

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

15.1.1 Currency risk

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

15.1.2 Interest rate risk

The Clinical Commissioning Group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Clinical Commissioning Group has no borrowings and therefore has no exposure to interest rate fluctuations.

15.1.3 Credit risk

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

15.1.4 Liquidity risk

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

15.2 Financial assets

	At 'fair value through profit and loss' 2017-18 £000	Loans and Receivables 2017-18 £000	Available for Sale 2017-18 £000	Total 2017-18 £000
Receivables:				
· NHS	-	1,615	-	1,615
· Non-NHS	-	252	-	252
Cash at bank and in hand	-	105	-	105
Other financial assets	-	47	-	47
Total at 31 March 2018	**-**	**2,019**	**-**	**2,019**

	At 'fair value through profit and loss' 2016-17 £000	Loans and Receivables 2016-17 £000	Available for Sale 2016-17 £000	Total 2016-17 £000
Receivables:				
· NHS	-	1,218	-	1,218
· Non-NHS	-	305	-	305
Cash at bank and in hand	-	139	-	139
Other financial assets	-	39	-	39
Total at 31 March 2017	-	**1,701**	**-**	**1,701**

15.3 Financial liabilities

	At 'fair value through profit and loss'	Other	Total
	2017-18 £000	2017-18 £000	2017-18 £000
Payables:			
· NHS	-	2,608	2,608
· Non-NHS	-	10,953	10,953
Total at 31 March 2018	**-**	**13,561**	**13,561**

	At 'fair value through profit and loss'	Other	Total
	2016-17 £000	2016-17 £000	2016-17 £000
Payables:			
· NHS	-	787	787
· Non-NHS	-	10,921	10,921
Total at 31 March 2017	-	**11,707**	**11,707**

15.4 Maturity of Financial Liabilities

	Payable to DH £'000	Payable to Other bodies £'000	Total £'000
In one year or less	10,953	2,608	13,561
In more than one year but not more than two years			
In more than two years but not more than five years			
In more than five years			
Total at 31 March 2018	10,953	2,608	13,561

16. Operating Segments

The Clinical Commissioning Group has only one segment: Commissioning of Healthcare Services. All internally generated reports to the CCG Governing Body are based on one operating segment.

	Gross expenditure £000	Income £000	Net expenditure £000	Total assets £000	Total liabilities £000	Net liabilities £000
Commissioning of Healthcare Services	248,899	(1,113)	247,786	2,158	(14,100)	(11,942)
Total	**248,899**	**(1,113)**	**247,786**	**2,158**	**(14,100)**	**(11,942)**

17. Pooled Budgets

The Clinical Commissioning Group share of the income and expenditure handled by the pooled budget in relation to the Better Care Fund in the financial year were:

	2017-18 £000	2016-17 £000
Better Care Fund		
Income	(14,063)	**(13,814)**
Expenditure	14,063	**13,814**
Total	-	-

The Better Care Fund (BCF) came into operation on 1 April 2015, with £3.46 billion of NHS England's funding to CCGs ring-fenced for the establishment of the fund. To administer the fund, CCGs were required to establish joint arrangements with local authorities to operate a pooled budget to deliver more integrated health and social care.

NHS South Sefton CCG is party to a Better Care Fund pooled budget arrangement with NHS Southport & Formby CCG and Sefton Metropolitan Borough Council – the total fund value is £35.48m, Southport & Formby CCGs share of this fund is £14.06m.

The Better Care Fund arrangement encompasses the following:

- Self-Care, Wellbeing and prevention
- Integrated Care at locality level building on Virtual Ward and Care Closer to Home initiatives
- Intermediate Care and Re-ablement.

The income and expenditure detailed in the table above, is analysed within note 5 Operating Expenses.

18. Related Party Transactions

Organisation	Payments to related Party	Receipts from Related Party	Amount owed to Related Party	Amount due from Related Party
Ford Medical Practice	195	-	-	-
Bridge Road Medical Centre	188	-	-	-
The Blundellsands Surgery	416	-	-	-
DF Consultancy	29	-	-	-
Exacta Medico Legal Ltd	5	-	-	-
Vitty & Partners	307	-	-	-
Strand Medical Centre	217	-	6	-
Equality & Diversity Development Services	44	-	-	-
Ashurst Medical Centre	43	-	-	-
Maghull Health Centre	38	-	-	-
S2S Health Ltd	272	-	-	-
Alternative Futures Group	35	-	-	-
GSK Pharmaceutical	-	-	-	62

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

- NHS England (including commissioning support units);
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies, mainly Sefton Council.

19. Events after the Reporting Period

As at the balance sheet date the CCG were awaiting an outcome from an expert determination process. This related to a number of disputed charges from Southport and Ormskirk Hospital NHS Trust. The CCG were notified of the decision on 19th April 2018. A provision has been included in the accounts in relation to this matter.

20. Losses & Special Payments

The total number of losses and special payments cases, and their total value, was as follows:

Losses

	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £000	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £000
Administrative write-offs	3	44	-	-
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Book Keeping Losses	-	-	-	-
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total	3	44	-	-

Special Payments

	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £000	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £000
Compensation payments	-	-	3	236
Extra contractual Payments	-	-	-	-
Ex gratia payments	-	-	-	-
Extra statutory extra regulatory payments	-	-	-	-
Special severance payments	-	-	-	-
Total	-	-	3	236

21. Financial Performance Duties

Clinical Commissioning Groups have a number of financial duties under the National Health Service Act 2006 (as amended). The Clinical Commissioning groups performance against those duties was as follows:

NHS Act Section	Duty	2017-18 Target £'M	2017-18 Performance £'M	2016-17 Target £'M	2016-17 Performance £'M
223H (1)	Expenditure not to exceed income	£245.7	£248.8	£246.6	£246.5
223I (2)	Capital resource use does not exceed the amount specified in Directions	115	115	0	0
223I (3)	Revenue resource use does not exceed the amount specified in Directions	£244.8	£247.8	£244.3	£244.2
223J (1)	Capital resource use on specified matter (s) does not exceed the amount specified in Directions	0	0	0	0
223J (2)	Revenue resource use on specified matter (s) does not exceed the amount specified in Directions	0	0	0	0
223J (3)	Revenue administration resource use does not exceed the amount specified in Directions	£3.248	£2.931	£3.270	£2.863

At the end of the 2017-2018 financial year, the CCG reported a £2.99 million deficit.

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