NHS
South Sefton
Clinical Commissioning Group

Annual Report and Annual Accounts 2016-2017

NHS South Sefton Clinical Commissioning Group

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Performance report

Performance overview

Welcome to our Annual Report and Accounts. It sets out our progress, achievements and challenges from 2016-2017 and we hope you find it both a useful and interesting overview of our work.

You will read about some of our most important strategies and programmes – like Shaping Sefton, which looks to transform health and social care services, so they are better joined up, more responsive, sustainable and effective for the benefit of our patients.

You will also find out about how well the services we commission performed during the year and what we are doing to improve them further. We made good progress amidst ever tightening financial constraints across the NHS, and whilst we are pleased with this, we know there is more to do.

Now in our fourth year, our work and our relationships with some of our most important partners are maturing and recognition of the strength of our leadership across the wider health and social care system increasing. This is reflected in the national attention we have gained for our work this year including our award winning Care Home Innovation Programme (CHIP), medicines management and workforce initiatives.

Importantly, we have been looking at how we can strengthen our work with our local communities to ensure services are the best they can be, and we would like to thank all those who have shared their views and experiences over the past year. Later in the report you will find examples of where we are using people's feedback to inform how we develop future healthcare. We have learned a great deal from our residents, particularly about how we begin to make some difficult choices.

We have worked hard over the past year to address the increasingly challenging financial landscape we are working in. Whilst the reasons for this are complex, there are a number of distinct local factors that we have had to take account of including:

- the increasing demand for healthcare
- the increasing cost of healthcare
- a significantly higher number of older more frail residents who have more complex health needs
- new responsibilities transferred from other commissioners that we must pay for from our existing budget

Whilst the CCG received 2.4% more money this year, the increase was much less than the Merseyside (2.9%) and national (3.4%) average. Coupled with increased local pressures and inflation rates, the CCG saw no real terms growth in budget allocation.

Set against this backdrop we have had a difficult task in ensuring south Sefton residents continue to experience high quality, essential healthcare when they need it the most. However, we have responded positively to these factors, making good progress against our targets. To

do this we have put new systems and programmes in place, so we can be sure that the services we commission offer the most efficient and effective care and treatments. You will read more about this work later in the report.

Finally, we know there are great challenges ahead for the NHS and we will continue to work hard to meet our duties over the coming 12 months towards improving health and wellbeing of local people.

Dr Andrew Mimnagh
Chair

Fiona Taylor
Chief officer

Interview with chief officer Fiona Taylor

Fiona Taylor was appointed as chief officer of NHS South Sefton CCG in 2012. As she reached 35 years of service in the NHS this year we thought we'd like to know a bit more about her experiences during this time and of being a leader and a role model to others.

When did you join the NHS?

I joined in 1982 at the age of 17 as a student nurse in Salford and qualified in 1985 as a registered general nurse.

How did you get to the position you're in now in Sefton?

Working in Salford, I then trained as a midwife and health visitor. Following this I went on to be the paediatric liaison health visitor and redesigned the service.

In 1992 I became a manager and in 1999 a deputy director of nursing, quickly becoming the director of nursing in Mancunian Community Health Trust. I later joined Bradford City Teaching Primary Care Trust (PCT) in 2001.

Since then, I've worked at director level and held a variety of roles, including acting chief executive of Bradford City Teaching PCT. In 2012 I was appointed chief officer of the two CCG's in Sefton, NHS South Sefton CCG and NHS Southport and Formby CCG so I have been in this role for five years now.

What do you like most about working in the NHS?

I like the fact that the work that we do has the potential to greatly improve people's lives which is really rewarding and I know other people that I work with feel as passionately as I do.

What have you been most proud of at the CCG this year?

I have to say the team of talented people I work with, as amidst such a challenging year they have really pulled together and I am extremely proud of the work they have done.

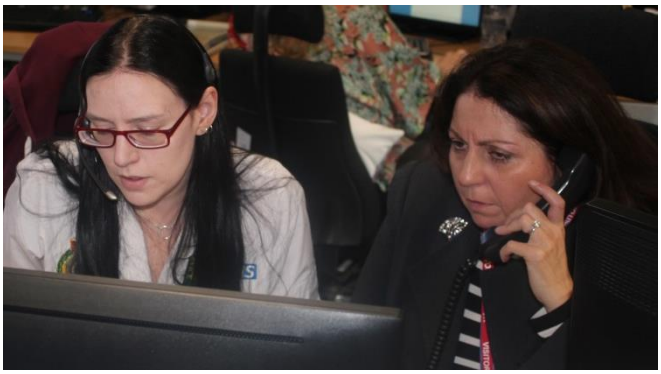
I am also proud of the relationships we have built on this year with our key partners across health and social care. These connections enable us to do the best for our residents.

What has been the biggest challenge in 2016-2017?

For us and many other CCGs and NHS organisations across the country it has been a challenge working in an environment with ever increasing financial constraints. As required, we have tried to make the right decisions for our patients and we hope that they think the same. Our repeat prescription pilot and raising awareness of medicine waste has also had a huge impact on savings for the NHS this year.

What is one of your most memorable experiences of working in the NHS?

There are so many highlights from over the years but most recently I have to say I really enjoyed doing my shift with the North West Ambulance Service (NWAS). It is so important for me to go and see the services that we are responsible for commissioning and it was amazing to see the hard work the team put in on a day to day basis.



I also spent some time at the call centre which made me realise how important this part of the NWAS service is. The people answering those calls have a difficult role giving patients the right advice and also trying to keep the caller calm. They are such an amazing team.

Obviously, being a midwife is a role that is difficult to compare with any other. Having the opportunity to bring babies into the world and seeing the joy on the parent's faces was invaluable. I loved every minute.

In my current role at the CCG, I have to say I love working with the team there, they are all so committed in everything they do. I find as chief officer it is the most challenging role I have undertaken, however it is a privilege to work with such a fantastic team who serve the people of Sefton and give something back to their local community.

What do you do in your spare time?

I have recently joined St Ann's Hospice as a Trustee. This is something I've wanted to do for a while and I would like to do all I can to help and support them.

Final thoughts?

Just to say, that it has undoubtedly been a difficult year and we have had to make some tough decisions but we have always remained focused on the outcome for our patients and their needs. I am grateful to our public, for all their challenge and support in helping us shape services in Sefton.

About us

We are NHS South Sefton Clinical Commissioning Group (CCG) and we are responsible for planning and buying – or 'commissioning' – nearly all local health services for our residents.

The Health and Social Care Act sets out our full statutory duties. This came into effect on 1 April 2013, when we formally became responsible for local healthcare commissioning.

Made up of doctors, nurses, lay representatives and other health professionals, we are a membership organisation bringing together all 30 doctor's surgeries in south Sefton. A legal 'constitution' sets out how our member practices work together as part of our CCG.

We have a governing body of elected GPs, practice staff, lay representatives and other professionals who accountable for our organisation who make decisions about our work on behalf of the wider membership.

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.

Our four localities are Bootle, Crosby, Maghull, Seaforth and Litherland.

Collectively, the range of services we are responsible for includes:

- Community based services – e.g. district nursing and blood testing;
- Hospital care – including routine operations, outpatient clinics, maternity services and accident and emergency care;
- GP out of hours services – ensuring people have access to a doctor when their surgery is closed in the evenings, weekends and bank holidays; and
- Mental health services –commissioning mental health services.

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.

Our residents also play an important role in helping us to shape our plans 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 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

What we do

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

In 2016-2017 we had a budget of £244.2million to spend on commissioning health services for 154,859[1] south Sefton residents. You can see a breakdown of how we spent the money allocated to us for local health services on page 15. The majority of our budget, around 65%, is spent on hospital based services. Whilst we support people's right to choose where they are treated and who provides their care[2], the majority of the services we commissioned in 2016-2017 were from Aintree University Hospital NHS Foundation Trust and Liverpool Community Health NHS Trust. Our other main service providers include:

- Mersey Care NHS Foundation Trust – the leading mental health trust across Merseyside
- North West Ambulance Service NHS Trust –providers of patient transport services as well as its network of emergency response vehicles
- 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

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 plans also have to meet a number of nationally set standards and requirements like the NHS Outcomes Framework[3], the Five Year Forward View[4], Improvement and Assurance Framework for CCGs[5] and the NHS Constitution[6], 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.

[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 2016/17 allocations https://www.england.nhs.uk/wp-content/uploads/2016/04/j-overall-weighted-populations.xlsx

[2] Choice of place of treatment is one of the rights included in the NHS Constitution

[3] NHS Outcomes Framework - http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/

[4] Five Year Forward View - http://www.england.nhs.uk/ourwork/futurenhs/

[5] Assurance Framework - https://www.england.nhs.uk/commissioning/ccg-auth/

[6] NHS Constitution - http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

Who we work with

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

NHS England

Together with NHS England, we work to ensure health services for south Sefton residents meet national and local standards. This was the second year that we had greater involvement' in primary care co-commissioning through NHS England's new arrangements giving CCGs more say about the future of these services. This arrangement is helping us 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 you may need, including specialist, prison and armed forces healthcare.

Sefton Council

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.

At the end of 2016 – 2017 we strengthened our work with Sefton's Public Health team through a new jointly approved partnership agreement. We are both core members of Sefton Health and Wellbeing Board and our memorandum of understanding will steer our work to reduce health inequalities in line with the aims of our joint health and wellbeing strategy. We also share some joint commissioning posts with the local authority including those for some aspects of mental health and children's services.

As well as working together with the council through the Health and Wellbeing Board, the local authority also hold 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 issues and progress.

Sefton Health and Wellbeing Board

Much of the work we do with Sefton Council happens through the Health and Wellbeing Board. Our chair and chief officer are core members of this committee bringing us together with others who have a lead responsibility for health and social care in the borough, including 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 social care services. This was based on our Joint Strategic Needs Assessment (JSNA), which brings together all the information we have about current services, to highlight where we need to do more in the future.

This year we agreed the ‘Making it Happen’ strategy which describes how we will better integrate health and social care services so care for our patients is more seamless and effective. We have established an integrated commissioning group, tasked with delivering this strategy and part of its role will be to look at how we can best spend the portion of existing NHS money being set aside for the Better Care Fund to achieve our vision and meet our shared targets. You can read more about the Better Care Fund and Making it Happen on page 13.

You can find out how, together with the council, we developed our Joint Strategic Needs Assessment and resulting Health and Wellbeing Strategy by reading previous annual reports, where you can also read how these exercises then informed our Shaping Sefton strategy. www.southseftonccg.nhs.uk/get-informed/publications

Other clinical commissioning groups

We work with neighbouring clinical commissioning groups including NHS Liverpool CCG 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. We have begun to work more closely with NHS Liverpool CCG on joining up our transformational programmes - Shaping Sefton and Healthy Liverpool – which are coming together through the North Mersey Local Delivery System (LDS).

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.

About south Sefton

There are a number of distinct environmental and social factors that we must take account of when we are planning health services for south Sefton – an area stretching from Bootle in the south, Hightown in the north and Melling and Lydiate in the east – including:

- Our population is made up of a significantly higher proportion of older residents with an estimated 20.4% of the population over the age of 65 compared to 18.1% 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 4,400 in 2017 to an estimated 5,700 by 2027 - an increase of 23%
- South Sefton has significantly higher levels of deprivation and child poverty with almost 32% of the population are considered to live in the most deprived 10% of neighborhoods in the country

Overall, health in south Sefton is getting better, but there are 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

Shaping Sefton

We want all health and care services to work better together – or to be more joined up – with as many as possible provided in our local communities, so it is easier for you to get the right support and treatment first time, to help you live a healthy life and improve your wellbeing.

We call this vision **community centred health and care** – where services are wrapped around our patients and our GP practice localities, with hospitals concentrating on specialist care for our most poorly patients.

We are working towards this vision through our Shaping Sefton programme.

Shaping Sefton looks right across health and care organisations in the borough to determine how they might work better together as a more united system, working closely with partners like Sefton Council and service providers.

Underpinning Shaping Sefton is our five year strategy and our blueprint for transforming healthcare, which we have developed jointly with NHS Southport and Formby CCG.

Community centred health and care brings together eight priority health and transformational programmes, wrapped around our GP practices and their patients:

care for older and more frail people | primary care | community services | urgent care | mental health | cardiovascular disease | respiratory disease | intermediate care

Our Shaping Sefton programme has been further developed in 2016-2017, through the creation of a Sustainability and Transformation Plan (STP)[7] for Cheshire and Merseyside, which is now called the Cheshire and Merseyside Five Year Forward View (5YFV). This has seen us linking more closely with other CCGs, Sefton Council and NHS service provider organisations in the region to develop the 5YFV plan. The Cheshire and Merseyside STP is the second largest in England, covering a population of 2.5 million, 12 CCGs, 20 providers and nine local authorities.

STPs set out a new approach in the NHS to ensure that services are planned by place rather than around individual organisations and institutions.

[7]Sustainability and Transformation Planning - https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/

Whilst our STP sets out how we will work collectively across the region on those services that affect all our patients, here in south Sefton we still produce a local operational plan each year, which focuses on those aspects of healthcare that really affect our residents and in line with **Shaping Sefton**.

Local Delivery System
Our Cheshire and Merseyside STP is broken down into three local delivery systems (LDS) that better reflect where our patients go to receive care and treatment. They are:

- North Mersey
- The Alliance (mid Mersey)
- Cheshire and Wirral

We are members of the North Mersey LDS, which covers NHS organisations in Sefton and Liverpool. Through the North Mersey LDS, we are bringing together our established transformation programmes of Shaping Sefton and Healthy Liverpool, so we can do more together to improve care across a bigger area.

You will find a copy of the Cheshire and Merseyside STP on our website[8], where you can read more about our plans for the North Mersey LDS area.

Better Care Fund
The CCGs are required to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) with Sefton Council for 2017-18 and 2018-19, via the Sefton Health and Wellbeing Board. You can read more about this on page 9.

We have continued to work very closely with Sefton Council since our establishment in April 2013. As partners within the Health and Wellbeing Board, we have worked together with local people, communities and partners such as Healthwatch Sefton to develop a shared vision.

Together we are Sefton – a great place to be!
We will work as one Sefton for the benefit of local people, businesses and visitors

Underpinning the Health and Wellbeing Vision is the promise that in commissioning and delivering services, the different partners, stakeholders and organisations in Sefton will work together to seek to improve the health and wellbeing of everyone, with the resources available.

During 2016-2017 the Sefton Health and Wellbeing Board has worked on a joint integration strategy with the local authority called ‘Making It Happen’. The vision of which is to deliver personalised coordinated care with the aim to move towards full integrated health and social care services by 2020.

[8] http://www.southseftonccg.nhs.uk/get-informed/latest-news/sustainability-and-transformation- plan-published/

Demand for healthcare has never been so great and our patients' conditions are becoming more and more complex. This comes at a time when resources across the NHS, like other public bodies, are challenged. So, we believe that all partners involved in providing health and social care need to work more effectively together, so we can continue to provide quality services into the future.

In addition, we believe this approach will also help us to more effectively address the biggest issues that affect our residents' health, which are often linked to wider social issues like their lifestyle, or the area of south Sefton that they live in (page 11).

What this means for you

As well as those core services that we routinely commission, we have developed a number of schemes and programmes towards our vision for community centred health and care. These really focus on the specific health needs of our residents.

Here are some examples of our work across our 'blueprint' priority areas in 2016-2017:

Care for older and more frail people

CHIP – our Care Home Innovation Programme

CHIP, one of the first schemes of its kind to offer care homes and their residents such a comprehensive package of support, has now been running for two years. It has demonstrated a 25% reduction in all ambulance conveyances compared to the 12 months prior to 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 program, care planning and bi-monthly quality improvement collaborative meetings - providing a range of training and support to help staff better care for their residents.

The CHIP team won an award in February 2017 for Best System Improvement at the North West Coast awards. The CHIP model is now influencing similar programs across Cheshire and Merseyside.

Dr Pete Chamberlain and Dr Debbie Harvey collect the award

We have several case studies and thank you letters in from care homes involved in the programme in Sefton. Here are some examples:

"Thank you to the CHIP team for adding in the use of televideo and to Airedale for arranging three services in one particular case. We had a paramedic, ambulance crew and a GP in attendance within a short space of time. Well done Orrell Grange staff too, 90% of our staff are now confident and competent with using televideo through training and practice organised by the CCG."

Manager at Orrell Grange nursing home in Bootle

"I have benefitted from the telehealth programme and feel more comfortable speaking to doctors this way as it was easy to explain my symptoms. I do think that for me it has prevented the need for further healthcare as I've stopped getting regular infections now.

"I have found it very useful to be able to speak to professionals like this as the nursing staff at the home aren't fully trained doctors so I am very thankful to have expert advice over telehealth."

Patient at Afton Lodge care home

Care home medicines project

For the fourth year in a row we offered annual medication reviews to care home residents. Through more regular monitoring of patients' medicines we can ensure they are taking the most appropriate ones for their condition at the right time. In 2016-2017 we reviewed more than 400 patients, the scheme helped prevent people from needing hospital treatment over 20 occasions. In excess of £18,000 was also saved through better and more effective prescribing.

In addition, pharmacists also provide advice to nursing home staff around the safe management of medicines, and act as a bridge between nursing homes, primary care and hospitals – all with the aim of improving the treatment and experience for this vulnerable group of patients.

Acute frailty unit

Many of our older patients who are taken to hospital for an urgent health problem often have to wait a long time before seeing the specialist medical staff who can support them back home, where they will often make a better recovery. To address this, Aintree University Hospitals NHS Foundation Trust has set up an acute frailty unit to support specialist assessment and care planning in a dedicated unit away from the Accident and Emergency Department. Adopting a multidisciplinary approach, the unit supports rapid reablement of patients with wraparound services to support care in the home setting rather than patients requiring admission to a hospital bed.

Building on this approach, we are working with Liverpool CCG and Knowsley CCG to commission a common integrated frailty pathway that incorporates community, hospital and social care from home to hospital and home again.

Primary care and quality

Quality in primary care

Whilst we do not hold the contracts for GP practices, which is the responsibility of our partners at NHS England, we are involved in the commissioning of our 30 GP practices and have responsibility for the quality of GP services.

We are always working to improve the quality of primary care. To do this, we have further developed our local quality contract, which our member practices can choose to sign up to. There are a number of schemes that make up the contract, including one to increase access. During 2016-2017 this resulted in an additional 125 appointments per week being made available to patients.

Care Quality Commission (CQC) ratings

In 2016-17, 21 out of 26 (80%) of our GP practices were inspected by the Care Quality Commission (CQC). These were rated overall as 'good'. 13 of the 26 were rated 'good' in each of the following specific categories; safe, effective, caring, responsive and well-led.

The CCG work with NHSE where there is a requirement following a CQC inspection for an action plan to address issues highlighted.

Access to primary medical care

The CCG has focused on access to primary care medical services to ensure that patients with conditions that can be well managed in primary care receive the treatment they need from General Practice. Practices remain open to patients throughout the day (Monday to Friday), except when the practice has their monthly half day training session. There has also been an opportunity for practices to offer extended access to their registered patients.

Frail elderly

There has been a focus on patients aged 70 and over with the aim of identifying frial patients through proactive reviews. This has enabled practices to develop frailty registers, and generate individualised community care plans for patients. Patients keep a copy of their care plan which can then be shared with other health professionals that may become involved in their care, for example a district nurse, a GP working out of hours who may not know them, or the ambulance service.

Identification and care planning at end of life

The importance of identifying patients who may be in their last year of life has been recognised in order to provide an opportunity for care planning to discuss patient preference with regard to treatment options, where treatment is delivered and to ensure, as far as possible, that the patient ultimately dies in their preferred place of care.

Awards

The CCG nursing team was shortlisted for a Health Service Journal (HSJ) award in the workforce category for its healthcare apprenticeship scheme in primary care.

The team was also shortlisted in the student placement of the year category in the Student Nursing Times Award for the work they undertook to facilitate student nurse placements. We were the first CCG in the country to be formally accredited as a hub and spoke placement.

The deputy chief nurse also received a 'Silver Award' from the Innovation Agency for being an 'innovation scout'.

Leading Change, Adding Value

In May 2016 the quality team facilitated a visit from the NHS England central nursing team to promote 'Leading Change, Adding Value'[9] and to showcase the work we had undertaken with Midlands and Lancashire Commissioning Support Unit using a benchmarking tool in relation to Continuing Health Care and Funded Nursing Care.

Workforce development

Our practice nurse leads have supported the redesign of the Practice Nurse Foundation course with John Moores University, the next cohort is planned and nurses new to practice will be able to apply shortly.

The General Practice Forward View plans are taking shape and work is ongoing to support the development of new roles and improve the skills of the workforce in primary care. Our local enhanced training practice is co-ordinating the placements available to health care professionals and supporting the mentoring of the staff to give them an experience of primary care nursing and medical care.

The practice nurse leads also liaise with our higher education institutions to shape the development of continuing professional development courses available to health professionals.

[9] https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-framework.pdf

They meet regularly with Public Health England to support the Immunisation and Cervical screening programme boards and feed back to the practices, promoting and monitoring the screening programmes.

The practice nurse leads at the CCG provide advice for practice managers recruiting nursing staff and support their training needs analysis.

Training for staff

We have been working across the Cheshire and Merseyside Public Health Collaborative (ChaMPs) to improve high blood pressure management across the CCGs. This was identified by Public Health as a population risk in the area.

As a result of this we provided bespoke education to GPs, practice nurses and health care assistants about improving hypertension management in primary care, and we are working with the British Heart Foundation to develop a “good practice” template to support better care and management of the disease. We are also promoting improvements to lifestyle in order to reduce the risks from heart attacks and strokes for patients.

Making Every Contact Count

We did a lot of work in 2016-17 to train administration and reception staff at all seven practices in the Bootle locality so they can carry out opportunistic health chats with patients about ways to improve their lifestyles as practice staff are generally the first point of contact for anyone wanting help for a health problem. Across south Sefton these staff speak with hundreds of people every day. This work has now been taken over by Living Well Sefton who will continue to roll out the training.

Our Bootle locality is harnessing the potential of its reception staff to ‘Make Every Contact Count’ (MECC) in helping people to make healthier lifestyle choices.

Communityservices

New community services providers

Community services is the collective name for a range of care and treatments that are often provided from health centres, clinics and sometimes in patients own homes.

In south Sefton they are provided by Liverpool Community Health NHS Trust (LCH) and include blood testing, community matrons, district nursing, Litherland Walk-in Centre, treatment rooms, leg and foot care, intermediate care, adult diabetes and adult dietetics. LCH also provides a small number of these services, like Intravenous (IV) therapy and community respiratory care to Southport and Formby residents.

During 2016-2017, we worked closely with LCH and NHS Southport and Formby CCG as part of an NHS Improvement (NHSI) process to find a new provider for these services. As part of this transaction process bids were evaluated from possible new NHS providers to determine which

would be capable of delivering our CCG joint Shaping Sefton vision of community centred health and care. In November 2016, NHSI announced Mersey Care NHS Foundation Trust as the preferred provider for the majority of our south Sefton community services and further work is taking place through 2017-2018 to progress this.

Virtual Ward – proactive care

Our proactive care programme 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.

Now in its fourth year, 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.

There are four pro-active care teams; one for each of our GP practice localities and each team consists of a virtual ward co-coordinator, community matron, district nurse, medicines management pharmacist, physiotherapist, occupational therapist and a community health and wellbeing trainer.

Each locality team holds fortnightly Virtual 'ward rounds', commonly known as a multi-disciplinary team (MDT) meeting. Decisions and information from these meetings is then communicated directly to the patient's registered GP, updating their clinical notes. This MDT approach reproduces the strengths of a hospital ward in the community by using a multi-disciplinary team approach in healthcare provision. In linking these healthcare professional teams, we hope to increase the inter-professional knowledge and reduce the delay in the coordination of care.

You can see a video on just one example of how proactive care works here:
Sharon's Story - https://www.youtube.com/watch?v=6YaoYZ9W4P8

Urgent care

Community urgent care team

Now in its third year, the team provides a rapid response to patients who need urgent healthcare but who do not need to go to hospital. For patients, this means more appropriate care, often in their own home. Being admitted to hospital can be distressing for some patients and may also not provide people with the most effective care for their condition.

The team works alongside community intermediate care to continue to monitor and manage patients in their own home whenever possible The urgent care team also work closely with GP practices, ambulance crews, hospitals, the proactive Virtual Ward team and other community based services to identify, assess care for and monitor patients. During 2016-2017 the service widened the scope of the team to include chronic obstructive pulmonary disease (COPD), intravenous cellulitis treatments, heart failure deterioration and specialist palliative care, so it provides a more comprehensive care.

Following the transition of services to the new community provider in summer 2017 the CCG will continue to proactively work with providers to develop services which meet the needs of Sefton residents.

GP streaming

GP streaming is a scheme based within the Aintree University Hospital Accident and Emergency Department (AED) which enables deflection of appropriate patients to a GP rather than AED. Aimed at relieving pressures upon Accident and Emergency Departments GP Streaming operates between 19:00 – 23:00 Monday to Friday and between 10:00 – 22:00 Saturday and Sunday.

In terms of future service provision, the system has been mandated to provide a GP streaming service adjacent to each accident and emergency department where departments are not co-located with either an Urgent Care Centre or Walk in Centre. We are working closely with our providers to ensure that robust streaming models are in place seven days each week to support a “see and treat” model by a GP between the hours of 08:00 and 23:00 each day. The future streaming service will also include, in addition to one or more GP’s, a clinical nurse, health care assistant and administrative support to assess and treat patients in the “primary care setting” on the acute hospital site or divert patients to the most appropriate service to manage their condition. Services must be live by October 2017.

Acute Visiting Scheme and Alternative to Transfer

The Acute Visiting Scheme (AVS) and Alternative to Transfer Scheme (AT) were launched in January 2015 with the aim of reducing the number of unnecessary ambulance conveyances to hospital and increasing the capacity of GP practices.

Both schemes are managed by our out of hours provider Go To Doc, working together with the North West Ambulance Service (NWAS). In normal working hours, GP practices can refer their acutely unwell care home patients to the Acute Visiting Scheme

(AVS) who will carry out a home visit, reducing the risk of patients being admitted to hospital and increasing the capacity of GP practices. The ATT service operates 24 hour a day, seeing Go To Doc working with NWAS to divert patients to more appropriate care instead of A&E whenever possible. This could be the community urgent care team, or by carrying out a home visit. This is greatly beneficial for our most frail patients and at the same time has helped to reduce pressure in general practices at this busy time for primary care.

From February 2016 to January 2017 the ATT scheme accepted 1,099 referrals and managed 878 (92%) without onward referral, and subsequent ambulance conveyance, to the Accident and Emergency Department and therefore achieved care closer to the patients home.

Emergency care improvement programme

As part of an emergency care improvement programme, Aintree University Hospitals NHS Foundation Trust and Royal Liverpool University Hospital have been working in collaboration with the CCG and NHSI to improve the quality, safety and patient flow within our emergency and urgent care services. The aim is 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 acute hospital trusts, Sefton social services, community care services and local GPs.

Further information on this work can be obtained here:
https://improvement.nhs.uk/improvement-hub/emergency-care/

Mental health

Improving Access to Psychological Therapies (IAPT)

Access Sefton is the local service that gives people across the borough greater access to a wider range of psychological therapies. Residents can now contact the service directly, rather than being referred to Access Sefton by their GP.

Recognising the links that exist between physical and mental health conditions, Access Sefton is connecting with a range of local health professionals so that people with long term conditions can be offered help as part of their overall care.

Access Sefton has also been making strong links with our voluntary, community and faith sector (VCF) and have organised for residents in the borough to access therapy services in a number of locations nearer to their place of residence, grouping people in different localities together.

In 2016-17 over 3,000 people accessed the service in south Sefton.

Dementia strategy

Building on our commitment to improving services that enable people living with dementia, their carers and family to live well with dementia and other long term conditions we have continued to work closely with our member GP practices to improve local dementia diagnosis rates for 2016-17.

Our vision is to enable people with memory difficulties (cognitive impairment) to receive a timely, appropriate and accurate diagnosis, followed up by the right information and support to make informed decisions about their health and care. Post diagnostic support is also vital and despite the pressures on funding we continue to find ways of assisting people with dementia to live well with their conditions.

We are also committed to supporting the development of dementia friendly communities. The national clinical director for dementia at NHS England, Dr Alistair Burns visited the CCG in May 2016 to train our members of staff who are now 'Dementia Friends' along with over 100 GP practice reception staff.

Along with other key organisations we have signed up to the National Dementia Action Alliance and actively promote the continued growth of the Sefton Dementia Action Alliance.

Child and adolescent mental health

In 2016-17 the Sefton Local Transformation Plan (LTP) for Children and Young People's Mental Health has driven change and improvement around Child and Adolescent Mental Health Services (CAMHS). In addition, a new Joint Children and Young People Emotional Health and Wellbeing Strategy was agreed during the year, which the LTP will underpin. The LTP has seen extra new investment of £890k being channelled into supporting the emotional health and wellbeing of Sefton children and young people.

Priority during the year has been given to reducing local waiting times, which have significantly improved both in terms of how long it would take to be seen if referred today and the number of people waiting.

The LTP has also seen a large amount of collaborative work being led by the local voluntary, community and faith sector (VCF) looking at new ways of working. Sefton continues to have a strong Children and Young People Improving Access to Psychological Therapies programme with a further 10 local trainees from different agencies taking up places on training in 2016-17. Sefton has a compliant Specialist Community Eating Disorder service (jointly developed with Liverpool CCG).

Early intervention psychosis

In April 2016 we committed additional investment in early intervention psychosis services which has enabled a wider suite of interventions to be offered to those people aged 14 to 65 and ensure that the two week waiting time standard is achieved. 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

Since April 2016 we have been working with Mersey Care NHS Foundation Trust to enhance the level of mental health liaison in Aintree University Hospitals NHS Foundation Trust. People with urgent and emergency mental health needs should expect high quality 24/7 care in the same way we would expect for physical health care and we are planning to further enhance this provision in 2017-18.

Cardiovascular disease

Diabetes prevention

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 just under nine percent of the annual NHS budget. Nationally, this equates to around £8.8 billion each year.

Those referred onto NDPP will get tailored, personalised help to reduce their risk of type 2 diabetes including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes, all of which together have been proven to reduce the risk of developing the disease.

CCG staff with the provider, Living Well Taking Control and some of its patients

One patient said: **"**The programme has made a lot of difference to my life. I'm cooking from scratch again and teaching my granddaughter to cook, I don't comfort eat anymore and am thinking about what I eat before I do. Overall I'm feeling more positive about my life and would recommend the programme to anyone who might be at risk of diabetes and needs support getting back on track."

Acute kidney injury

We are continuing to work with the Cheshire and Merseyside Acute Kidney Injury Group and looking at ways to reduce avoidable harm and death for people with acute kidney injury. The National Think Kidneys Acute Kidney Programme completed its objectives set out in its three year plan at the end of February 2017 but the work is still ongoing as is the work undertaken locally. A care bundle and other resources are being developed and implemented to assist primary care in delivering care before patients require emergency treatment and there is more to be done to improve care for patients when they are in hospital.

Respiratorydisease

One Vision Housing

In order to bring health and housing together we have been working more this year with One Vision Housing, a registered provider of Social Housing, with approximately 13,000 homes across Sefton, Liverpool and Wirral.

With the help of Mersey Internal Audit Agency (MIAA) we organised an event for customers of One Vision to attend a Breathe Well course with Sefton CVS and Liverpool Community Health. This saw a group of residents from the Bootle locality come together and learn skills and techniques to assist with breathing conditions such as COPD. The team are working on a plan is to roll the course out to other localities.

Respiratory and case finding project

We commissioned a CCG wide practice education and mentorship programme aimed at upskilling the entire practice (nurses, HCAs and GPs) workforce in assessment and management of asthma and chronic obstructive pulmonary disease (COPD).

The training was opened up to the wider respiratory workforce including community matrons and community respiratory teams. Training was also delivered to our medicines management team. To date the 25 of our 30 GP practices in south Sefton have benefitted from the following:

- Five training days
- All nurses on the project signed up and participated in a computer based learning programme which is accredited by Royal College of GPs (RCGPs). The course was also opened up to GPs who were interested in the training
- Mentorship clinics have been delivered at each practice
- Top three practices also had case finding clinics delivered

The findings from the three case finding clinics identified a number of patient care issues which led to funding being secured to deliver up to seven case finding clinics across the area. A number of additional nurses were recruited to deliver the clinics which were all delivered by October 2016. Ongoing training will be offered and rolled out to all of the GP practices and this will be completed by July 2017.

Improving quality and reducing waste

We have worked hard over the past year to ensure the services we commission are as efficient and effective as can be. We set ourselves a savings target of £10.38m during the year and we have made good progress against this. In fact, we delivered amongst the highest levels of savings amongst CCGs in Cheshire and Merseyside, ensuring as much of our money as possible is directed on quality care and treatments for our patients. This work was overseen by our new clinical quality innovation, productivity and prevention committee, which you can read about on page 43, and below are some examples of what this means for patients.

Only order what you need

We continued to raise awareness on medicines waste throughout the year whenever we had the opportunity. This included spreading the message at events and forums organised by a wide range of partners including Sefton Partnership for Older Citizens (SPOC), Sefton OPERA, Macmillan, Sefton Council and Sefton CVS.

We encourage residents to help save vital NHS resources by not over ordering repeat prescriptions. It is estimated that wasted medicines cost the two CCGs in Sefton around £2 million pounds per year, which could otherwise have been spent on frontline care. In addition, around half the population does not take medicines as prescribed. The campaign also highlighted the importance of taking medicines as directed to ensure they are as effective as possible.

Our head of medicines management and her team were shortlisted for several awards last year due to the work they have done in Sefton to raise awareness.

Changes to our cataract policy

We introduced a new and easier way of accessing treatment for cataracts in 2016-17. Rather than being referred by your GP practice to hospital for assessment, people now have their initial appointment at a more convenient, local high street optician.

Patients are then only referred to a hospital of their choice by their optometrist when they are ready for cataract surgery. This change in the process results in shortened hospital outpatient waiting times.

There are six optometrist practices in south Sefton who are currently able to offer this service and others are currently undergoing training and accreditation.

Since the new policy was introduced, over 120 patients have used the service.

Repeat prescription ordering pilot

In September 2016 we launched the repeat prescription ordering pilot in 19 GP practices across Sefton. Due to its success with estimated quarterly savings of just over £104,000 in south Sefton in the first three months, a further 13 GP practices signed up in March 2017 to be involved.

Janet Faye, Susanne Lynch and Jenny Johnston promote the pilot

The pilot means that patients at the GP practices involved can only order their repeat prescriptions through their GP practice. They can no longer order at their pharmacies. To help with this the CCG has been promoting GP online services and encouraging patients to sign up to use this service.

For more information please visit: http://www.southseftonccg.nhs.uk/get-involved/current-exercises/pilot-scheme-for-ordering-repeat-medicines/

Care at the Chemist

Pharmacists ordinarily and routinely provide health advice to their customers. The Care at the Chemist 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.

Anyone who joins Care at the Chemist can be assessed by an expert pharmacist, who will advise them about how to treat their condition. This includes supplying people with any medicines they might need, which are free for anyone who does not pay for prescriptions and costing no more than a prescription charge for everyone else.

Contracts with pharmacies that choose to run the scheme are being revised for the next financial year (2017-18). It means from 1 April 2017 the scheme will be offered in fewer pharmacies.

Other examples of our work

Improving care for cancer patients

With Cancer Research UK and Macmillan we are looking at how we can support earlier cancer diagnosis and improve outcomes for our patients. As more patients are successfully treated for their cancer we need to support them to better live with and beyond cancer.

Macmillan cancer recovery package

We have been working in partnership with Macmillan to implement 'The Recovery Package' for people with a cancer diagnosis which has four main interventions:

- 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 commissioned a two year community Macmillan pilot working with Aintree University Hospital 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.

This links directly into the living with and beyond cancer agenda supporting individuals to ensure that they are leading as healthy and active a life as possible; more people than ever before are living with and beyond a cancer diagnosis. The impact of cancer does not suddenly stop when the treatment is over

In partnership with Aintree University Hospital Trust and Sefton Council we hosted our first community Health and Wellbeing Event at The Meadows, Maghull to increase supportive community networks for those affected by cancer.

Within the last twelve months public consultation took place to canvass opinion about community Macmillan Information Hubs and have set up two hubs as pilot projects. They are situated at Maghull Health Centre and Bootle Council One Stop Shop, here residents can drop

in to ask about cancer where free, confidential information and support is offered to those worried or affected by cancer.

Care for people at the end of their lives

In south Sefton between January 2016 and December 2016, 46% of deaths took place in people's usual place of residence. This compares to 52% of deaths in hospital and 2% elsewhere showing an increase on the number of people being cared for and dying in their usual place of residence in 2015. We commission a number of services for patients and their carers to be supported in the final stages of life in their usual place of residence.

Children's services

Following the NHSI led transaction process relating to Sefton's outgoing community provider, Liverpool Community Health (LCH), children and young people community health Services will be transferred to Alder Hey from April 2017. This is in line with Sefton's ongoing commitment to further integrating such services.

VCF fund

Working in partnership with Sefton Council for Voluntary Service (CVS), organisations were asked to submit bids for one off funding to support specific initiatives.

Schemes include:

- Children and young people; with a focus on reducing obesity, emotional wellbeing and transitions
- Older people; supporting people with dementia, social isolation and loneliness
- Adult mental health; helping people overcome issues such as anxiety, low self-esteem, lack of confidence and stress

We recognise the valuable role these groups play in achieving better health and wellbeing for our residents.

A total of 52 different groups and organisations received grants to deliver projects which have benefitted 2,881 children and young people, 3,291 older people and 3,443 adults.

Although this funding has now come to an end, the grant funding has been instrumental in encouraging more partnership working to create better pathways and services for people needing more informal services provided by the sector and helps assist in reducing demand on the hard-pressed frontline services of the NHS.

A full report from Sefton CVS will soon be available documenting the wide variety of projects that took place to improve the health and wellbeing of our citizens.

We continue to work closely with a number of Voluntary Community and Faith organisations via core contracting and commission a range of services for the benefit of Sefton residents.

"I'm more confident. I'll talk more and, in class, I'm not as shy as I used to be, so I answer more in class and get more involved."

A member of Parenting 2000

An 87-year-old widower from the Crosby area became a regular at the **Age Concern** Wednesday club when he entertained the others by playing the piano.

He said: "This keeps me going and makes me feel important. The meals were delicious, the company is excellent and the activities are superb."

Strand by Me

Strand by Me is a health and community shop being run by Sefton CVS and supported by the CCG. It has been open 18 months now and each week a different organisation sets out its stall at Strand by Me, from the Stroke Association to local NHS sexual health services. Residents can simply pop in to the shop, based on the lower floor of the Bootle's Strand Shopping Centre, to find out about a wide range of services and support available locally.

As a venue the shop has been hired by 89 organisations this year, engaging with almost 6,000 individuals in a range of opportunities since it opened, from traditional health clinics to more holistic wellbeing services.

Monitoring for 2016-17 indicates that mental health issues are the most commonly cited reason for seeking support at Strand by Me, 41% of people using the shop express concern about their mental health. In response, we have developed strong links with Mersey Care, Ambition Sefton and Access Sefton, all of whom now provide regular drop-in and one to one sessions at Strand by Me.

The shop has established strong relationships in the Sefton community and is utilised by community groups such as Breathe Easy, a self-care group set up from a previous CCG programme, the Strands Residents Association and the National Diabetes Prevention Programme group.

The shop's most popular session is a health and wellbeing session run by the May Logan centre which now runs twice a week. Each session delivers an average of 16 health checks which result, on average with two referrals to each of the following: smoking cessation

courses, diet and exercise opportunities and to GP's for further investigation.

One member of the public who has used the shop said: "*I was skeptical at first as it was very busy but only took a few moments out for relaxation and it was amazing thank you so much it was beautiful and staff were fantastic".* (Parenting 2000 event)."

To find out more about Strand by Me, as well as what's on and what's coming up, join the Facebook group at www.facebook.com/StrandByMeShop

Veterans in Sefton
(Formerly the Sefton Veterans project)

Veterans in Sefton provides a comprehensive information, advice and guidance service for all members of Sefton's Armed Forces Community including veterans, serving personnel and their families.

The group charity is run by former armed forces personnel who have developed a fully holistic and cohesive support service. They can offer help with health and wellbeing, social activities, community integration and volunteering opportunities.

The CCG funds Veterans in Sefton through Sefton CVS and more recently the project has received funding from The Royal British Legion. It has also been established with the assistance of the CCG and Sefton CVS as an individual charity.

"I needed someone to understand me. I needed help, just didn't know who to ask or how to ask. Every time I mentioned being in the armed forces to a doctor he just wanted to give me tablets. I needed someone to talk to.

"I am now an alcohol free responsible father to my 3 kids who can walk like a man again. I still have wobbles sometimes but knowing they are there to help is a huge safety net for me."
Terry, aged 44

Communicating better health

Using digital to get the message across

We know that an increasing number of our residents routinely use digital technologies like computers, smartphones and tablets to communicate in their daily lives. Younger residents have told us they particularly prefer these methods of communication. So, we have been looking at ways to improve our digital communications. For the second year in a row, we worked with Liverpool John Moores University to offer a 12 month digital communications and engagement internship. This has helped us to further strengthen our digital communications strategy and increase our presence on social media.

During the year, we began using video to promote our work and to raise awareness of health and wellbeing issues amongst our residents. We launched a new You Tube channel to store our library of short videos, which inform people about any changes and to promote the services that we commission. You can see our films by searching NHS South Sefton CCG on www.youtube.com. This new development complements our existing website and twitter channel @NHSSSCCG, which have both gone from strength to strength this year. We hope to work further with Sefton Young Advisers during 2017-2018 to further boost our digital communications.

Sharing news with partners

We've established good links with our partners that help us to systematically share our news and important health messages. This helps us to reach more residents than we could do on our own.

NHS Informatics Merseyside

We work in partnership with Informatics Merseyside, an NHS shared service delivering Information Management and Technology (IMT) services to partner organisations and customers across the region. Hosted by Mersey Care NHS Foundation Trust, Informatics Merseyside works closely with us to ensure technology and innovation is used effectively as an enabler to better health and care. Fiona Taylor, our chief officer, is the chair of Informatics Merseyside's Partnership Board. This is a collective forum, attended by other partner CIOs and executives, for collaborating on the design, development and delivery of shared health informatics services. A range of IT services and support are provided to help drive efficiency and support new models of care, the detail for which is specified within our service level agreement (SLA) with Informatics Merseyside, which is reviewed on annual basis.

Digital care and innovation

As the beating heart of our health service, our doctors, nurses and wider health care professionals rely on having access to timely and accurate information in order to make informed decisions about care delivery. To support this and achieve the ambitions of NHS England's Five Year Forward View and Personalised Health and Care 2020, care providers across Merseyside have signed up to a vision to 'act as one' with the ultimate aim of transforming care through information sharing and the greater use of digital technology and

innovation. The approach for achieving this vision is outlined within Merseyside Local Digital Roadmap.

Merseyside local digital roadmap

Merseyside stands out as a leader in digital care and innovation, with clinically led programmes held in high regard both nationally and internationally and ground-breaking results in information sharing, assistive technology and analytics, helping to deliver evidenced based patient outcomes and improved quality of care.

As a region, there is a long established culture of clinical and managerial partnership, with digital leaders regularly spending time with their clinical partners to understand the challenges facing frontline care delivery and the ways technology can best support this.

The Merseyside Local Digital Roadmap exploits the foundations laid over years of collaboration with other local commissioners, providers and authorities, with the aim of supporting better health and care for the people of Merseyside by maximising the benefits of digital technology and innovation. This roadmap outlines three shared ambitions:

1. To create a connected health and social care economy where all care providers are able to work seamlessly together through interoperable systems
2. To digitally empower individuals to take more control over their own health and wellbeing
3. To exploit the digital revolution through the innovative use of emerging technologies

Through a seismic change in the use of digital technology and innovation, we will support the delivery of these ambitions in order to transform the way health and social care services are delivered. To date, some significant progress has been made, with a number of key achievements including:

- The signing of a single Information Sharing Framework and Information Sharing Agreement across all North Mersey healthcare providers
- The launch of a community cardiology hub, allowing GP practices to refer a patient to cardiology triage
- The ability to electronically discharge from all Trusts providing clinical services to Sefton practices
- The implementation of the Electronic Prescription Service in 90% of GP practices across Sefton, with the remainder to be complete by June 2017
- The rollout of the Summary Care Record across community pharmacies in Sefton, supporting treatment decisions through timely and efficient access to information
- The migration of all Sefton GP practices onto a shared IT domain, helping to improve efficiency and provide a more robust IT infrastructure

Further information about the Merseyside Digital Roadmap, including economy-wide achievements, plans and governance arrangements can be found by visiting: http://www.ilinksmersey.nhs.uk

Examine Your Options

This striking visual campaign supports our wider work to deal with the additional demands on NHS services over the busy winter months, as well as encouraging patients' good use of health services year round. Examine Your Options raises awareness of the range of healthcare available to residents when they are ill. It particularly focuses on pharmacy, GP out of hours and self care. This year, the campaign included newspaper advertisements promoting holiday opening times over Christmas, New Year and Easter. It could also be seen on the outside of buses, with posters inside targeting passengers over these holiday periods. Supporting information materials were also distributed to a wide range of local organisations and at events. You can Examine Your Options by visiting our website www.southseftonccg.nhs.uk and visiting the 'your health and services' section.

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 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 new for 2016-2017 the Improvement and Assessment Framework.

The work you have been reading about so far contributed to our performance for 2016-2017. Detailed information can be found in our integrated performance reports, which are published on our website in addition to being presented to our governing body at each of its public meetings[10].

How well we perform

NHS England carries out ongoing assurance assessments of CCGs against a nationally set framework that focuses on how well we perform in key areas. The assessment includes holding regular assurance meetings with CCGs and scrutinising key performance data. Much of this data relates to the performance of the provider organisations – like hospitals and community services - that CCGs commission services from.

In 2016-2017, NHS England published results for our performance during the previous year. We were rated ***good*** in four out of the five areas of our work and received an overall rating of ***requires improvement***, reflecting the increasing financial challenges that the local NHS is facing.

You can see a breakdown of our results for 2015-2016 below:

1. Well led organisation – *good*
2. Delegated functions – *good*
3. Performance – *good*
4. Finance – *good*
5. Planning – *requires improvement*

Areas of strength and good practice include meeting financial duties, achieving referral to treatment waiting times and not exceeding targets for cases of the hospital acquired infection, C Difficile during the year.

Areas of challenge focused on the demanding financial challenges facing the CCG in the year ahead and whilst NHS England commissions primary care, a struggling workforce was cited in the CCG's results due to some GPs retiring and the area having lower levels of doctors per head of population when compared to the national average. .

[10] All our integrated performance reports and governing body papers can be found on our website www.southseftonccg.nhs.uk

The 2016-17 year-end assessment for the CCG will be available on www.nhs.uk/service-search/Performance/Search from July 2017.

In 2016-2017 NHS England changed its assurance framework, calling it the CCG Improvement and Assessment Framework (IAF) covering 60 indicators, and now publishes our performance results quarterly on My NHS[11].

An IAF dashboard is released quarterly identifying areas of declining performance, or performance indicators which sit in the lowest 20% of CCGs nationally. The CCG has developed a framework to assign its leadership team, clinical and managerial leads to every indicator. The purpose of this is to assign responsibility to improving performance for each indicator to a named lead. The IAF dashboard is also included in the integrated performance report presented to governing body monthly for review and assurance.

The latest performance dashboard (Quarter 3 release) shows that we are performing well in the following areas:

- Maternity
- Child health
- Diabetes
- Personal health budgets
- Patients with long term conditions who feel supported to manage their conditions
- Quality of life for carers
- Cancer
- Some mental health measures
- Primary care
- Quality of CCG leadership

There is scope for improvement in some other areas such as: falls, electronic referrals, inequalities in hospital admissions, Improving Access to Psychological Therapies (IAPT), some mental health measures relating to crisis services, dementia diagnosis and care planning, A&E performance, primary care access, and financial performance.

The indicators identified as requiring improvement are all either existing measures reported through the integrated performance report to our governing body, meaning actions are already in train and are monitored for improvement on a monthly basis or form part of our Operational Plans for 2017-19. These metrics will be added to the integrated performance report for 2017/18 onwards to ensure performance and any necessary mitigating actions are monitored.

CCGs are also measured in six clinical priority areas: cancer, diabetes, mental health, dementia, maternity and learning disabilities. NHS England delivered their latest assessment of our performance in September 2016. Whilst we are rated as 'Performing Well' for diabetes, the other areas are rated as 'Needs improvement'. We monitor these areas locally and can demonstrate improvement in cancer, mental health and some areas of maternity.

Finally, NHS England assesses CCGs on their quality of leadership, and these are also published on

[11] https://www.nhs.uk/Service-Search/performance/search

My NHS. They are based on four key lines of enquiry to determine how robustly the leaders of a CCG are performing their role. These are: staff engagement, progress against the workforce race equality standard, effectiveness of working relationships in the local system and compliance with probity and corporate governance. The latest available results (Quarter 2 2016/17) rate NHS South Sefton CCG as 'Green'. The year end results for the quality of leadership Indicator will be available from July 2017 at www.nhs.uk/service-search/scorecard/results/1175

Better Care Fund performance

A Better Care Fund Plan for 201617 was agreed between the CCG and Local Authority and submitted to the national Better Care Support Team in July 2016. Joint work between July and October 2016 further developed these plans for implementation in a document called "Making it Happen", our joint Strategy for Integration.

Every quarter we submit a performance report to NHS England to describe progress in different areas of our Better Care Fund including financial performance and performance on outcomes:

- Unplanned admissions to hospital for patients in the Sefton Health and Wellbeing Board area are lower than the number of admissions we planned, which is positive
- Whilst delayed transfers of care in the Sefton Health and Wellbeing Board area are above plan, these delays are going up nationally, whilst in Sefton delays are still below the national average rate of increase
- We have a local goal to identify the number of people in the Sefton Health and Wellbeing Board area diagnosed with dementia. Whilst the increase in those being diagnosed is not as high as we have planned, we are diagnosing more patients with dementia which goes some way to ensuring they receive the care and support they need to live well with dementia
- Our local measure of patient experience, as measured by the proportion of patients reporting their overall satisfaction with GP services is "Very Good" or "Good" is on track at 85.4% for patients in the Sefton Health and Wellbeing Board area

How well our providers perform

On the next pages you will see an overview of performance during the year. Nearly all of the measures shown are based on the performance of the organisations we commission services from. 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.

The table below shows overall performance for April 2016 – March 2017

NHS Constitution Indicators	CCG	Main Provider
A&E 4 Hour Waits (All Types)		Aintree
Ambulance Category A Calls (Red 1)		NWAS
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
Ambulance Category A Calls (Red 2)		NWAS
Ambulance Category 19 transportation		NWAS
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
Diagnostic Test Waiting Time		Aintree
Early Intervention in Psychosis (EIP)		
HCAI - C.Difficile		Aintree
HCAI - MRSA		Aintree
IAPT Access - Roll Out		
IAPT - Recovery Rate		
Mixed Sex Accommodation		Aintree
RTT 18 Week Incomplete Pathway		Aintree
RTT 52+ week waiters		Aintree
Stroke 90% time on stroke unit		Aintree
Stroke who experience TIA		Aintree
NHS E-Referral Service Utilisation		

Key

Met or exceeded

Did not meet

Within 5% of target

No target/new indicator

Working to improve performance

An audit of our processes and the framework for managing performance across the organisation was reviewed by the Merseyside Internal Audit Agency in 2016. This resulted in a "high assurance" rating, the highest possible level of assurance.

- A&E – this year has seen a failure to meet the national 4 hour A&E target of 95%. Performance against this measure has been a challenge in 2016/17 nationally too, with pressure to admit more patients to hospital impacting on performance. A plan has been put in place, redesigning all pathways taking account of previous advice from NHS England's Emergency Care Intensive Support Team. We are working with all partners through the A&E Delivery Board to improve performance against this target. Aintree revised their Cheshire & Merseyside 5 year Forward View trajectory and achieved 86.4% in February against a plan of 80%.
- Ambulance – there has been a significant dip in performance around national ambulance targets, with the CCG and NWAS failing for most of the year. We are working with all partners to improve performance against these targets. The provider actions for improvement include:
    - An agreed workforce plan and establishment of a performance development plan to be monitored twice a week;
    - Senior Manager, Trust Board and NHS Improvement (NHSI) focus on performance through the introduction of weekly telephone conferences with commissioners to focus on performance; and
    - A remedial performance plan was introduced in January 2017 to focus on performance improvement.
- Cancer – we achieved all cancer measures as at quarter 3 (April – December year to date 2016). Although in February Aintree fell under the 85% for the 62 day standard whereby 85% of patients should begin their first definitive treatment following urgent GP referral within 62 days. Also the CCG fell under the local target of 85% for 62 day wait for first treatment following referral from an NHS cancer screening service. Analysis of non achievement in these areas is due to 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.
- Diagnostic test waiting times – the CCG and Aintree hospital failed the diagnostic target in March 2017 (whereby no more than 1% of patients should wait more than 6 weeks for a diagnostic test). At Aintree, endoscopy has experienced continued pressure during March which resulted in the undertaking of additional activity in order to meet the trusts 2 week wait suspected cancer standard, and this has impacted the ability to deliver the non-urgent 6 week standard. Aintree hospital has an action plan, which includes undertaking additional endoscopy activity, undertaking a service review and weekly reviews of capacity and demand.
- HCAI – we achieved the target for C.difficile for 2016/17, but recorded two cases of MRSA going over the zero tolerance target. For each case of C.Difficile and MRSA the CCG holds a 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.

- IAPT – whilst we will not meet national access and recovery rates for IAPT in year, we did see an improving trend.
    - 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;
    - The provider is looking to improve case management including identifying patients who haven't recovered to allow for targeted supervision;
    - In respect of access rates the provider is hoping to recruit to full capacity; and
    - Action will be taken to target under referring GP practices; improve referrals from general healthcare for people with long term conditions.
- Mixed sex accommodation (MSA) – there have been a few MSA breaches in 2016/17, February saw the CCG have 1 breach, year to date there have been a total of 9. Work is on-going with all agencies to minimise the number of delayed transfers of care and to free up acute beds as soon as possible, this will continue to be closely monitored.
- Stroke - Aintree failed the 80% target for patients spending 90% of their time on a stroke unit; recording 56.1%. This is a considerable drop from the previous month when the trust recorded 80.6%. Nurse and therapy recruitment has followed business case approval for hyper acute stroke beds (hyper acute patients are patients presenting at hospital within 6 hours of a stroke). Cross checks of IT systems and discussion of late referrals to the stroke team has taken place with the acute and emergency care teams to ensure lessons are learned and delays prevented.

Monitoring and ensuring quality

Our joint quality committee is responsible for monitoring and overseeing performance against national requirements, such as those in the NHS Constitution[12], 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.

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 2016-2017:

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

You can read more about how we manage risks in our governance report on page 62.

Our quality strategy

Every patient and person that we support can and should expect high quality care. In 2016-17 the quality strategy underpinned how we commission services to ensure they are amongst the safest and most effective in the NHS. The strategy provided 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. We have commenced the review of this strategy following the publication of 'Leading Change, Adding Value' and plans are in place to finalise the updated strategy in 2017-18.

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

Promoting and using research to improve care

We understand that commissioning the best possible care for our residents, means that we must also be an organisation that promotes research and innovation and uses research evidence in designing and planning services. Our research strategy was revised and approved in 2016-17 and sets out how the CCG supports research and provides assurance on the type of research carried out across the CCG. The research agenda is led by the deputy chief nurse.

We continue to support our member GP practices that are keen to get involved in research within primary care as well as working with local higher education Institutions in meeting our research strategy for healthcare and preventive services. The CCG is also a member of the Collaboration for Leadership in Applied Health Research and Care North West Coast with a focus on addressing health inequalities across a number of research themes.

Improving continuing healthcare

During 2016-17 our quality team has had a continued focus on work to improve systems and the decision making processes for continuing healthcare (CHC) assessments. CHC is the name given to packages of ongoing care, which are arranged and funded solely by the NHS, and where patients aged over 18 have a primary health nee', as a result of disability, accident or illness. We continue to ensure that appropriate health support is commissioned for our most vulnerable patients, underpinned by the specialist skills and knowledge to enable effective decision making about each patient's eligibility. We are working with our commissioning support unit and we continue to work closely with Sefton Council where responsibility for an individual's needs crosses both health and social care as a priority area for integration. The CCG facilitated a visit from the NHSE national nursing team in order to spend a day with the team and see at first hand the work we have undertaken to support our improvement work in this area.

Personal health budgets (PHB)

PHBs provide an amount of money to eligible individuals to support their identified health and wellbeing needs, which are planned and agreed between the person and their local NHS team. The quality team has undertaken a number of consultation and engagement events to the wider constituency as part of awareness raising, with the support of Sefton CVS and Sefton Carers Centre. Awareness raising sessions have also been offered and provided to our community NHS providers.

Our new policy[13] has been in place from April 2016, and supports us in delivering our duty to ensure that eligible patients have the right to request a PHB if they choose. Throughout 2016-17 work has continued to be undertaken to further improve our local systems and processes and look at how we can promote the uptake of PHBs for those who are eligible.

[13] http://www.southseftonccg.nhs.uk/media/1473/ssccg-personal-health-budget-policy-and-procedures.pdf

Transforming care for people with learning disabilities

We have continued to contribute to Transforming Care plans, working with other CCGs through a North Mersey 'hub' and feeding into the wider Cheshire and Mersey area to improve services for people with learning disabilities and autism who display behaviour that challenges, including those with a mental health condition.

Quality in care homes

We have been working closely with the Care Quality Commission (CQC) around its inspection programme of local care homes. Where a closure of a care home has taken place, we have worked collaboratively with Local Authority partners and supported the safe transfer of those residents.

Our quality team supports the clinical quality standards within nursing homes and has provided education of care home staff in monitoring and assessing patients. In addition, we have worked in partnership with Local Authority and NHS England colleagues to roll out the 'React to Red' programme which looks at the prevention of pressure ulcers for residents of residential and care homes across Sefton.

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 and mitigate risks.

Managing information about you

The joint quality committee also ensures that any information we hold about your care is held securely and in line with data protection legislation and wider information governance requirements. There were no recorded data breaches in 2016-2017. If breaches do occur, we work hard to strengthen our systems, and our staff carry out regular training to ensure their work complies with national standards and regulations.

Safeguarding

The CCG safeguarding service continues to support children's and adult's safeguarding assurance of health services across the CCG. The safeguarding service continues to performance monitor and quality assure commissioned services for safeguarding and report to the CCG joint quality committee. A number of safeguarding policies have been revised in 2016-17 including the CCG's afeguarding Training Policy. The service has supported a number of inspections in 2016-17 including the Ofsted Single Inspection Framework and Special Educational Needs and Disability (SEND) inspection.

Briefings to both joint quality committee and governing body on national reviews, guidance and the planned merger of the Safeguarding Adult Boards have been delivered. Monitoring of training compliance to ensure CCG and governing body staff maintain their competency in safeguarding was carried out throughout the year.

The safeguarding service also took part in multi-agency audits to support the Local Safeguarding Children's Board oversight of the local health economy. The named GP for safeguarding children has worked with constituent GP practices in supporting of information sharing with the Multi Agency Safeguarding Hub (MASH) to promote children's safeguarding.

Acting on our patients' experiences

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

- We require our service providers to supply information about what patients think about the quality and safety of their healthcare through their own patient experience surveys as well as the national Friends and Family Test;
- We have a borough wide cross sector Engagement and Patient Experience Group (EPEG) jointly with NHS Southport and Formby CCG – this group reports to the joint quality committee and gathers patient experience information from Healthwatch Sefton and other independent sources including the voluntary, community and faith sector, and you can read more on page 47;
- We have developed a 'data dashboard' for EPEG to oversee 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; and
- Our complaints policy and process – these reflect the national guidance, 'Principles for Remedy'[14] and help us to identify trends and spot warning signs of any emerging problems. Our patient experience team, part of the commissioning support unit, provides help to people with any queries or concerns they have about their health or their treatment. The team also collects complaints, queries and concerns, and reports them to EPEG and our joint quality committee

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

[14] https://www.ombudsman.org.uk/sites/default/files/page/Principles%20for%20Remedy.pdf

Involving you

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.

Involving you in our daily business

We have a number of statutory responsibilities[15] to make sure good, two way engagement and involvement is part of our daily business and our organisational structures reflect our commitment to this:

- The chair of Healthwatch Sefton, the local champion for patients, is a co-opted member of our governing body
- We have a named governing body lay member lead for public engagement and involvement
- Our Engagement and Patient Experience Group (EPEG) reports to our joint quality committee. It is jointly chaired by our governing body lead and their counterpart from NHS Southport and Formby CCG. It includes representation from Healthwatch Sefton, Sefton Council and Sefton CVS which represents the voluntary, community and faith sector. This year, we extended the membership to include representation from Sefton Carers Centre and Sefton Young Advisors as we work more closely with these groups
- By working together, EPEG helps us to maximise the opportunities we have to engage across the different sectors in Sefton and provides expert advice about how and where to go to engage people. It collects the information we gather from all our engagement activities and patient experience feedback to inform our work, and to help us to gauge how effective our services are and where we can improve them
- Whenever it is appropriate, we invite patient, public or carer representatives to get directly involved in our day to day work and in 2016-2017 this included assessing procurement bids and steering group membership for our dermatology, respiratory and virtual ward programmes
- A number of GP practices in south Sefton have patient groups. We offer support to practices to help set up or develop their own group. These groups enable patients to have their say about services at their practice and hear about our wider work
- We hold regular public Big Chat events where we bring people together to discuss our work, ask for their views about our plans and feedback how we have used people's comments and experiences so far

[15] 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

- 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. This included helping with the review of local maternity and neonatal services led by NHS Liverpool CCG, the development of local GP services such as Hightown Village Surgery, and feedback from patients on how to improve the ordering of repeat medicines
- Our governing body and annual general meetings are open to all residents and provide further opportunities for people to hear more about our work, ask questions and find out about other ways they can get involved. We publish all papers on our website for public scrutiny
- We have developed digital communication channels so that local people can more easily share their views and experiences, this includes Twitter and the 'make a comment' section of our website
- We are now in the final stages of developing our engagement and patient experience feedback system which brings together all the comments and feedback we receive from local people. This makes it easier for us to identify any issues with a service and highlights when a service is performing well

Your involvement in 2016-2017

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.

Here are some examples from the year and you will find more on our website.

Big Chat 6

In response to a request from residents for an evening event, our Big Chat 6 event in June 2016 was held in the early evening. After an update of our work and plans, the event focused on some of the opportunities for change and asked people about some of the ideas and schemes that were being considered to help improve services and to save money. Some of these ideas included ways of reducing the costs of wasted medicines, how technology in healthcare could improve services and some ideas for helping to make primary care more efficient.

The feedback from the medicines waste discussions were particularly useful in helping us to develop our plans for a repeat prescription ordering pilot which was trailed in several practices later in the year.

Big Chat 7 meets Annual Review

As in previous years, we combined our Big Chat 7 event in September 2016 with our annual review, or AGM. The afternoon focused on the financial challenges that the NHS faces and built upon the feedback we received earlier in the year from Big Chat 6. After an overview of our performance and achievements in 2015-16, the event focused on several medicine and prescription schemes which we were thinking of changing to save money. We also asked people 'to balance the books' and to suggest ways that we could do this.

The feedback from the discussions have helped us to evaluate some of our schemes in greater detail and as a result we have now changed how we deliver the 'Care at the Chemist' scheme and successfully rolled out the repeat prescription ordering pilot to more GP practices.

Community services review

To support a wider review of these services, we carried out a programme of activities to capture people's views during the early part of 2016. This included going out to speak to a range of people and also running an online survey to enable a much wider group of residents to share their experiences. We used this feedback to learn more about which services worked well and where improvements could be made.

The results informed the NHSI led transaction process to find a new, preferred NHS provider for these services. The views we collected will continue to help shape these services into the future, towards meeting our Shaping Sefton vision for community centred health and care. You can read more about the NHSI led transaction process on page 19.

Repeat prescription ordering pilot

With the support of our partners and their networks, we planned and attended a range of activities and events to tell people about the pilot and to hear their views and experiences of the scheme. In particular, our community pharmacists focused on talking to those vulnerable patients who might need help ordering their medicines in the new way, to make sure any additional support was put in place. In addition, we ran an online survey to capture the views of a much wider group of residents, and we also worked with local chemists and GP staff so that they could also help support people in using the new system.

Work with Sefton Young Advisors

Through our work with Sefton Young Advisors, we are looking at ways to increase opportunities for local young people to get involved in their local NHS. Sefton Young Advisors 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. The Young Advisors ran an Engagement and Patient Experience Group (EPEG) event where they talked about the best ways of engaging with young people and how GP services could be made more young person friendly. We also attended a local Health and Wellbeing event for local schools and involved young people in a quiz about the different health care options and when to use these.

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' 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.

Maternity and neonatal services

We worked with Healthwatch Sefton to ensure our local residents were able to give their views about the future of maternity and neonatal services at Liverpool Women's NHS Foundation Trust. The review of these services is being led by NHS Liverpool CCG working closely with the hospital trust, which provides care and treatment for many Sefton residents each year.

Healthwatch Sefton arranged some tea and toast events on our behalf to speak to local women about their experiences of these city centre based services and to discuss ideas for developing these services to ensure their sustainability into the future. The feedback received at these events has contributed to the ongoing review of these services at Liverpool Women's NHS Foundation Trust.

GP services

We have been working with NHS England to develop future plans for some of 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 local public events that were held about the relocation of the Maghull Parkhaven GP Practice and talking to patient participation group members about the future of Hightown GP practice. The comments and feedback from these events and discussions helped NHS England and the CCG to understand the concerns of local people and contributed to developments and planning of further local engagement events.

Equality and diversity

Promoting equality is at the heart of everything we do. We want to ensure that we commission services fairly, so that no community or group is left behind in the changes that we make to health services as we work towards the vision set out in our 5 year strategy and 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 our 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[16], 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 objectives plan has been significantly revised in light or our equality delivery systems 2 assessment in 2016-17. Our 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 we undertook an innovative approach to our equality delivery systems (EDS) 2 toolkit and assessment, which involved extensive engagement with national, regional and local organisations that represent the interests of people who share protected characteristics. Information about EDS 2 is contained within our full annual equality and diversity report. The CCG has improved its performance and six outcomes have now moved from developing status to achieving status.

[16] http://www.southseftonccg.nhs.uk/get-informed/equality-and-diversity/

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.

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 meeting the Workforce Race Equality Standard.

Working sustainably

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

Modelled carbon footprint

The latest report on the NHS carbon footprint was published in January 2016 and is based on 2015 data. It shows that the NHS carbon footprint in England is 22.8 million tonnes of carbon dioxide equivalents (MtCO2e). Between 2007 and 2015 the carbon footprint has reduced by 11%

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. 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 Hospitals NHS Foundation Trust	✓	✓	×	✓	×	Excellent
Liverpool Community Health NHS Trust	✓	×	✓	×	×	Minimum
Mersey Care NHS Foundation Trust	✓	✓	×	×	×	Data Not Available
Southport & Ormskirk Hospital NHS Trust	✓	×	×	✓	×	Poor
Royal Liverpool and Broadgreen University Hospitals NHS Trust	✓	✓	✓	✓	✓	Excellent
Alder Hey Childrens NHS Foundation Trust	✓	✓	×	✓	✓	Good

This information has been taken from the December 2016 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 Bootle 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, our Bootle office location 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.

Financial performance

The funding challenges in the NHS are well documented and all healthcare partners have a responsibility to play their part to ensure local healthcare is high quality and sustainable. Locally the aim is not to reduce core services, so we must transform them.

The NHS must deal with cost pressures brought about by inflation, population growth and the increased proportion of older people living longer and with complex care needs. This means we need to deliver more from every pound we spend. To help towards this improvement in efficiency, NHS South Sefton CCG and our local partners are committed to integrating services to reduce duplication and improve them for people. We are confident that as plans to integrate services gather pace and become firmly embedded locally that patient experience and outcomes will 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 and services for our population as we seek to utilise our resources in the best possible way.

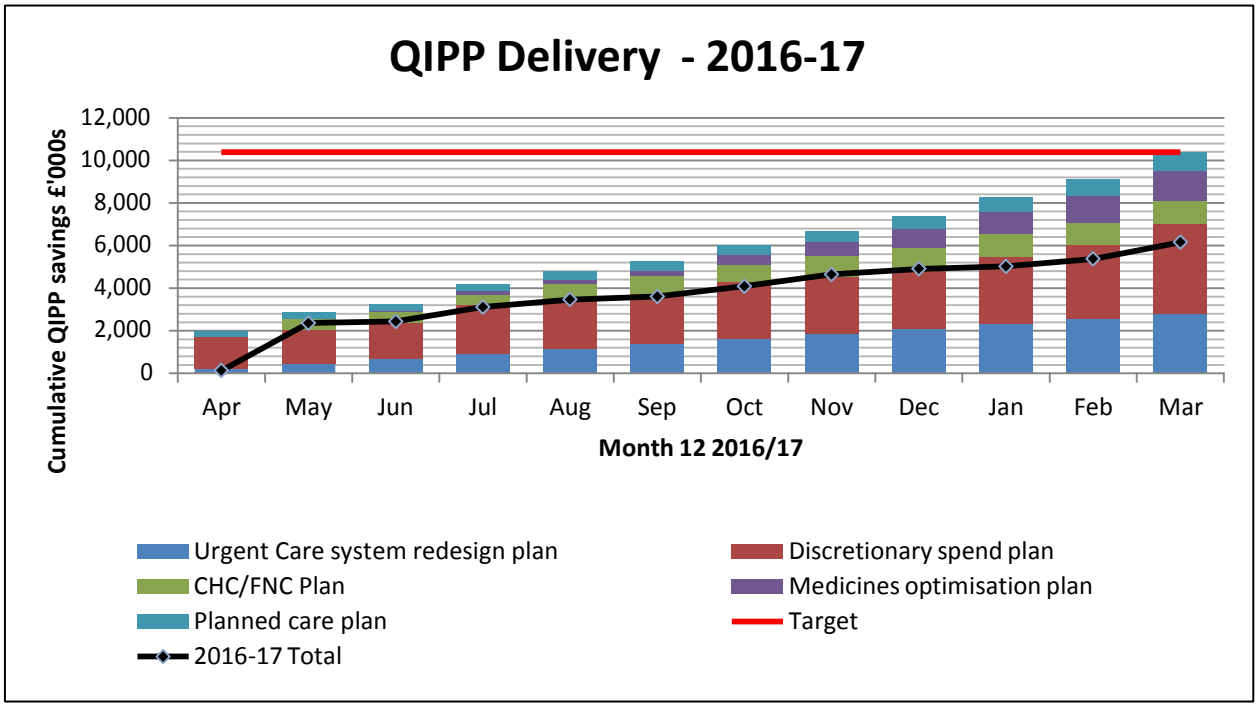
NHS Clinical Commissioning Groups have a number of financial duties under the NHS Act 2006 (as amended). During 2016-17 South Sefton CCG has:

Summary Financial Performance 2016-17	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 amount specified in Directions	✓
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	Not Applicable
Revenue resource use 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	✓

NHS South Sefton CCG has delivered a financial surplus each year since 2013. However, our financial situation has worsened in 2016-17 and we recorded a reduced surplus of £0.10m at the end of the current financial year against a planned surplus of £2.45m.

	2013/14		2014/15		2015/16		2016/17	
	Allocation £'M	Expenditure £'M	Allocation £'M	Expenditure £'M	Allocation £'M	Expenditure £'M	Allocation £'M	Expenditure £'M
Programme	222.47	223.84	227.28	224.91	239.42	237.06	241.05	241.36
Running Cost Allowance	3.68	3.50	4.06	3.58	3.30	3.26	3.27	2.86
TOTAL	226.15	223.84	231.34	228.49	242.72	240.32	244.32	244.22
Surplus/ (Deficit) for the year		**2.31**		**2.85**		**2.40**		**0.10**

During the year a number of financial pressures emerged – specifically over performance within acute provider contracts (NHS and non NHS) as well as the mandated national increase in costs for Funded Nursing Care. Our 2016-17 financial plan was dependent on the delivery of a challenging Quality, Innovation, Productivity and Prevention (QIPP) programme to deliver planned savings of £10.38million, the CCG delivered 59% of this in year - £6.12million. The CCG delivered QIPP savings of 2.6% of planned expenditure compared against Cheshire & Mersey region average delivery of 2.2% in 2016-17.



NHS South Sefton CCG has 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 pivotal to ensure that we deliver value for money for our population, at the same time contributing to improvement of the financial position.

The QIPP plan includes schemes categorised under the following headings:

- **Elective care pathways** - elective care is planned care. Examples include first outpatient appointments (e.g. with a hospital consultant), admissions (e.g. 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.
- **Continuing Healthcare/ Funded Nursing Care –** NHS continuing healthcare 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 care provided by a registered nurse for people who live in a care home.
- **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 CCG control.

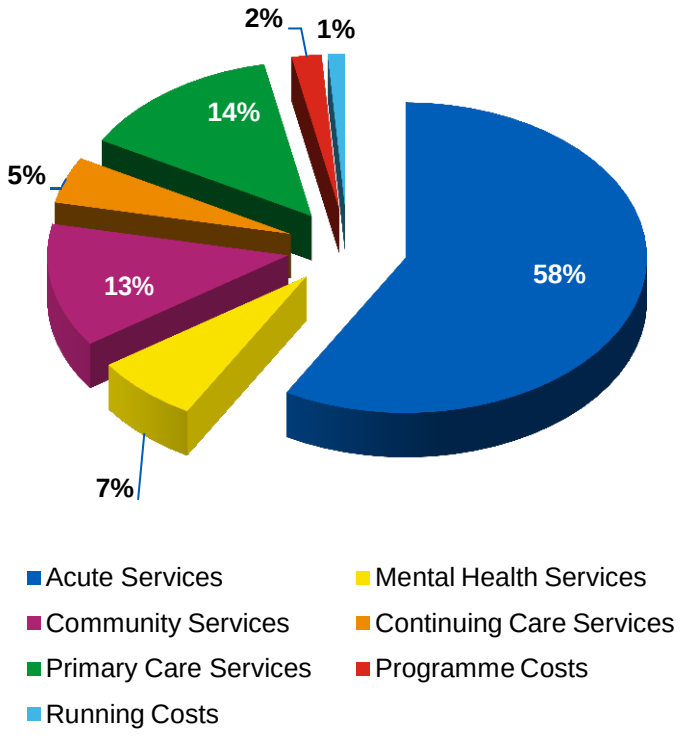
During 2016-17 the CCG has continued work with local health economy colleagues as part of the North Mersey Local Delivery System (LDS) to develop robust Sustainability and Transformation plans (STP) as required by NHS England. These plans outline collaborative high level requirements to ensure that health and social care economies live within their allocated resources over the next four years. The CCG have also worked with North Mersey LDS colleagues (CCGs and Providers) to develop “Acting as One” arrangements in support of STP plans and to promote financial stability across the local health economy.

The “Acting as One “partners have agreed a set of principles for contracting for the financial years 2017-18 and 2018-19. The arrangement supports the delivery of the North Mersey LDS plans for system transformation and aims to provide financial stability to support this agenda and to mitigate financial risk. Financial performance will continue to be rigorously monitored for emerging issues and financial risks.

The finance team is a key enabler to support business transformation. There is a strong focus on development and training to ensure the team remain “fit for purpose”. During the year the finance team has continued to ensure that the services provided by the team are of the highest standard. The team was awarded the Finance Skills Development North West - Towards Excellence - Level 2 Accreditation in September 2014 and is planning to submit evidence to reach the highest level available (Level3) during the 2017-18 financial year.

Analysis of Funding and Expenditure

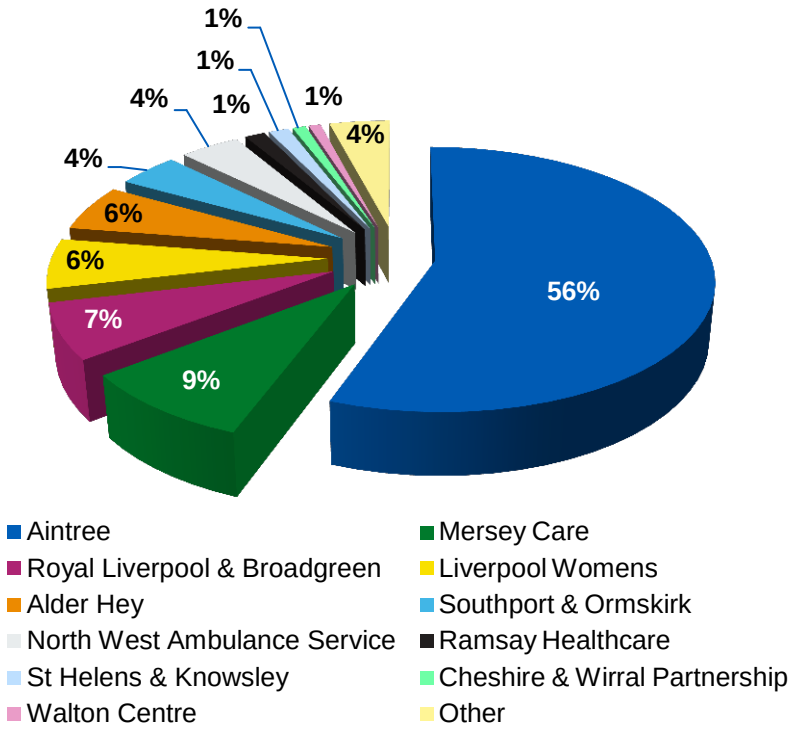
During 2016-17 the CCG received £244.32m of parliamentary revenue funding. A breakdown of this funding and how it was utilised is reported in the table below:



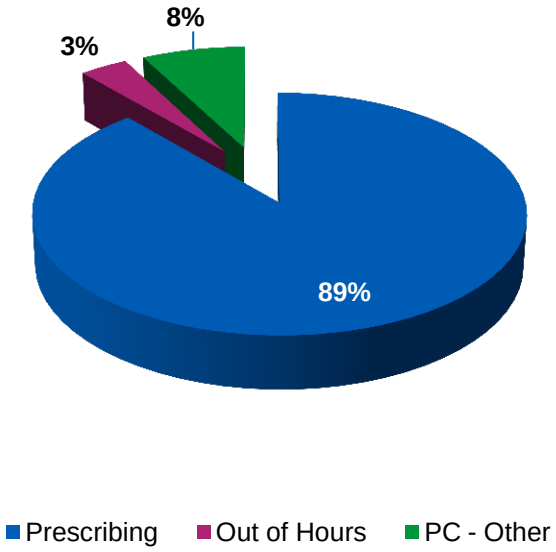
Area	Total Costs (£000s)
Acute Services	142,231
Mental Health Services	17,354
Community Services	31,534
Continuing Care Services	11,891
Primary Care Services	33,470
Programme Costs	4,892

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:



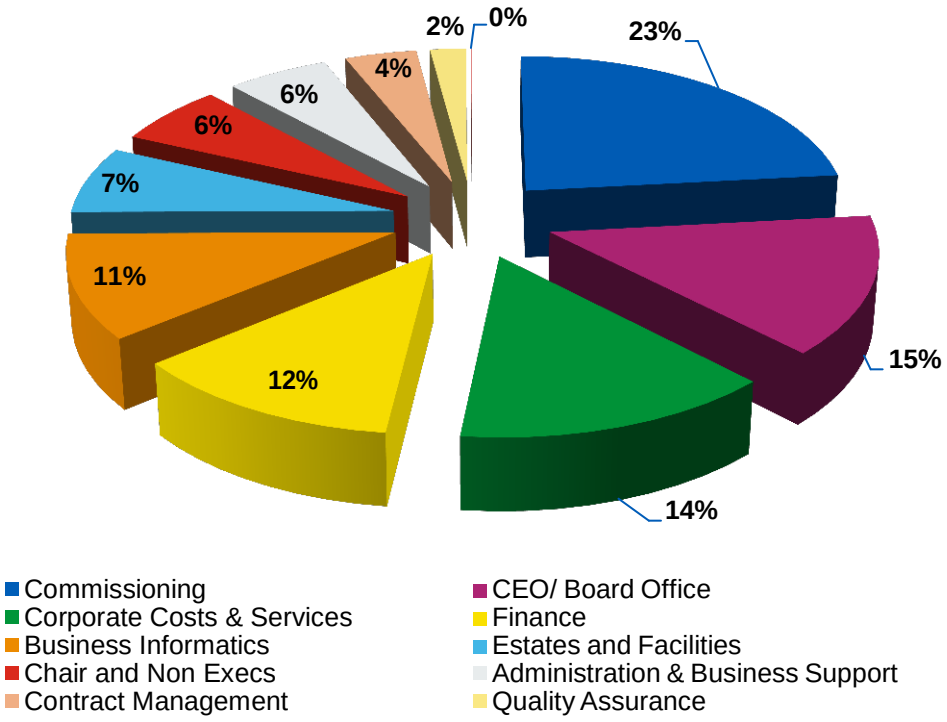
Primary care costs – the majority of this area of spend relates to the costs of drugs prescribed by GPs. Also included are some other services commissioned by GPs and primary care contractors for example, out of hours services.



Community Healthcare – 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.

Other 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

	2016-17		2015-16	
	Number %	Value %	Number %	Value %
NHS Payables	96.0	99.9	90.6	99.9
Non NHS Payables	96.4	91.1	91.6	92.6

Accountability report

Corporate governance 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.

Members report

Governing body membership

The table below shows the people who made up our governing body in 2016-2017, their roles and the committees[13] they were a part of.

Name	Role	Governing Body	Audit Committee	Finance and Resources Committee	Remuneration Committee	Quality Committee (Dis-established September 2016	Joint Quality Committee (Established September 2016)	Approvals Committee	Joint QIPP Committee	Joint Commissioning Committee
Dr Craig Gillespie	Clinical Vice Chair, GP	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	
Lin Bennett	Practice Manager	Yes		Yes			Yes			

Name	Role	Governing Body	Audit Committee	Finance and Resources Committee	Remuneration Committee	Quality Committee (Dis-established September 2016)	Joint Quality Committee (Established September 2016)	Approvals Committee	Joint QIPP Committee	Joint Commissioning Committee
Fiona Taylor	Chief Officer	Yes		Ex officio member		Ex officio member		Yes	Yes	
Debbie Fagan	Chief Nurse	Yes		Yes		Yes	Yes	Yes	Yes	
Dr Dan McDowell	Secondary Care Doctor	Yes	Yes		Yes	Yes	Yes	Yes	Yes	
Martin McDowell	Chief Finance Officer	Yes		Yes		Yes	Yes	Yes	Yes	
Dr John Wray	GP Clinical Director	Yes		Yes						
Dr Ricky Sinha	GP Clinical Director	Yes			Ye					
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	Yes
Dr Peter Chamberlain	GP Clinical Director	Yes				Yes	Yes		Yes	
Dr Gina Halstead	GP Clinical Director					Chair	Chair			

[13] More details about conflicts of interest can be found on page 64.

Conflicts of interest

The CCG has a Managing Conflicts of Interest and Gifts and Hospitality Policy in operation; a copy of this is available from the CCG website. To accompany the policy the CCG has in place a formal register of interests, an up to date copy of this can be found in the CCG website at:

http://www.southseftonccg.nhs.uk/about-us/our-constitution/ In addition to the declarations of interest the CCG also maintains a register of hospitality and gifts. 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

Managing information securely

The 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 did not report any data breaches to the Office of the Information Commissioner in 2016- 2017. If breaches do occur, we work hard to strengthen our systems, and our staff carry out regular training to ensure their work complies with national standards and regulations.

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.

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 Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the 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; and,

- Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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 2017

Governance Statement

Introduction and context

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

The clinical commissioning group'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 clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money*. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group 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 clinical commissioning group is a clinically led membership organisation made up of general practices. The member practices of the CCG are responsible for determining the governing arrangements for the organisation which are set out its constitution[17].

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

[17] NHS South Sefton CCG Constitution January

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. In June 2016 NHSE issued guidance in respect of Conflicts of Interest and Gifts and Hospitality and recommended that CCGs appoint an additional lay member for governance. The CCG resolved not to appoint an additional lay member but instead agreed that the lay member for governance would provide governance support across both NHS South Sefton CCG and NHS Southport and Formby CCG. This reciprocal arrangement was agreed by the governing bodies of both organisations at their public meetings in September 2016 and the arrangement is reflected in their respective constitutions.

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 (Quality, Improvement, Productivity & Prevention) 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.
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
42 Kingsway	42 Kingsway, Waterloo, L22 4RQ
Aintree Road Medical Centre	1B Aintree Road, Bootle, Liverpool, L20 9DL
Azalea Surgery	20 Kingsway, Waterloo, L22 4RQ
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 - SSP Health Limited (Dr Maaserani Is Interim Provider)	3 Little Crosby Road, L23 2TE
Crossways SSP Health Ltd (Dr Maaserani Is Interim Provider)	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 - SSP Health Limited (Formby Village Surgery Is Interim Provider)	St Georges Road, L38 3RY
Kingsway Surgery	30 Kingsway, Waterloo, L22 0QW
Litherland - SSP Health Limited (Dr Maaserani Is Interim Provider)	Hatton Hill Road, Litherland, Liverpool, Merseyside, L21 9JN
Liverpool Rd Medical Practice	133 Liverpool Road, Crosby, Liverpool, Merseyside, L23 5TE
Maghull Health Centre	Maghull Family Health Centre, Maghull, L31 0DJ
Maghull Health Centre	Maghull Health Centre, Maghull, L31 0DJ
Moore Street Medical Centre	77 Moore Street, Bootle, Liverpool, L20 4SE
Netherton - SSP Health Limited	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

During February and March 2017, the governing body undertook a 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 is being developed for areas that require strengthening to meet the new challenges the CCG faces for 2017/18. 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.

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The governing body is supported by a sub-committee structure comprising the committees listed below.

Quality Committee and Joint Quality Committee

The substantive quality committee was disestablished in July 2016 and a new joint committee was formed. The joint quality committee is established as a joint committee of NHS South Sefton CCG and NHS Southport and Formby CCG. The committee is established in

accordance with the Legislative Reform (Clinical Commissioning Group) Order 2014[18] and the associated enabling provisions of set out in Section 23.4 of NHS South Sefton CCG Constitution[19] and Section 6.6 of NHS Southport and Formby CCG Constitution[20].

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 CCG's arrangements for engaging patients and their carers in decisions concerning their healthcare
- approve the arrangements for handling complaints
- 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 joint 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.

The Quality Committee and Joint Quality Committee have been well attended by all CCG officers, lay members and clinicians throughout Q1, 2 and 3 so that there has been robust scrutiny and challenge at all times. This has enabled the quality committee and joint quality committee to provide robust assurances to the 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 2016-17, key items of note were:

- Provider rerformance
- Quality surveillance
- Corporate risk registers
- Safeguarding assurance

[18] Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292808/Legislative_Reform__Clinical_Commissioning_Groups___Order_2014-revised_dr....pdf

[19] *Ibid* at page 29

[20] *Ibid* at page 17

- Chief nurse business update
- Serious incident reporting
- Community services transition

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.

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 CCG's activities to support the delivery of the CCG's objectives
- To review and approve the arrangements for discharging the CCG's statutory financial duties
- To review and approve arrangements for the CCG's 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)
- 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
- Local Counter Fraud Officers - MIAA
- Audit Directors - KPMG
- Audit Managers - KPMG

The audit committee supports the governing body by critically reviewing governance and assurance processes on which the governing body places reliance. The work of the audit committee is not to manage the process of populating the Assurance Framework or to become involved in the operational development of risk management processes, either at an overall

level or for individual risks; these are the responsibility of the governing body supported by line management. The role of the audit committee is to satisfy itself that these operational 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 2016-17 Mersey Internal Audit Agency (MIAA) have 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 2016-17. 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 Statement on Internal Control.

Counter 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 Protect:

- **Strategic Governance** – this section sets out the standard in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organization
- **Inform and Involve** – this section is set out the requirement in relation to raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of crime against the NHS

- **Prevent and Deter** – this section sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS and ensure that opportunities for crime are minimized
- **Hold to Account** – this section sets out the requirement in relation to detecting crime and investigating crime. Prosecuting those who have committed crime and seeking redress.

The Local Counter 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.

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

In respect of 2016-17, key items of note are:

- Annual Governance Statement approved for 2015-16
- Annual Accounts approved for 2015-16
- Annual report approved for 2015-16
- ISA 260 – unqualified audit report from the external auditors, KPMG, for 2015-16

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.[21] The committee reviews and agrees appraisal and remuneration of CCG officers.

During the year, the committee has agreed adoption of agenda for change terms and conditions, considered pay for Very Senior Managers (VSM) and reviewed redundancy benefits. The Committee has also been advised on areas to be implemented across the CCG in response to legislation for example, the requirements of HMRC around IR35 in relation to the employment of contractors and pensions auto-enrolment.

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

Finance and resources Sub Committee

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

In respect of 2016-17, key items of note within the year are:

- Approval of financial strategy
- Approval of CCG operational budgets
- Review and discussion of monthly financial reports

Joint QIPP committee

The substantive QIPP Committee was disestablished in July 2016 and a new joint committee was formed. The joint Committee is established as a joint committee of NHS South Sefton CCG and NHS Southport and Formby CCG. The committee is established in accordance with the Legislative Reform (Clinical Commissioning Group) Order 2014[22] and the associated enabling provisions of set out in Section 23.4 of NHS South Sefton CCG Constitution[23] and Section 6.6 of NHS Southport and Formby CCG Constitution[24].

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 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.

[22] Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292808/Legislative_Reform__Clinical_Commissioning_Groups___Order_2014-revised_dr....pdf

[23] *Ibid* at page 29

[24] *Ibid* at page 17

Committee Attendance 2016-17

Member	Governing Body	Audit Committee	Finance & Resources	Remuneration Committee	Quality Committee	Joint Quality Committee	Approvals Committee	Joint QIPP Committee	Joint Commissioning Committee	Clinical QIPP Group
Fiona Taylor	6 of 6				2 of 2		2 of 4			3 of 6
Martin McDowell	6 of 6		7 of 9		2 of 2	4 of 9	4 of 4			5 of 6
Debbie Fagan	6 of 6		6 of 9		2 of 2	9 of 9	3 of 4			5 of 6
Andy Mimnagh	6 of 6				2 of 2	7 of 9		7 of 11		2 of 6
Craig Gillespie	6 of 6							7 of 11	7 of 7	3 of 6
Graham Morris	6 of 6	5 of 5	9 of 9	2 of 2			4 of 4	10 of 11	1 of 7	
Gina Halstead*					2 of 2	6 of 9				
Pete Chamberlain	6 of 6				2 of 2	3 of 9		5 of 11		1 of 6
Dan McDowell	6 of 6	4 of 5		2 of 2	2 of 2	3 of 9	4 of 4	9 of 11		4 of 6
Sunil Sapre	6 of 6		5 of 9					3 of 11		2 of 6
Ricky Sinha	6 of 6			2 of 2						1 of 6
John Wray	6 of 6									
Graham Bayliss	6 of 6	3 of 5	7 of 9	2 of 2	2 of 2	6 of 9	3 of 4	5 of 11	5 of 7	
Lin Bennett	6 of 6		7 of 9		1 of 2	2 of 9				

***Clinical Lead for Quality**

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 ed

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

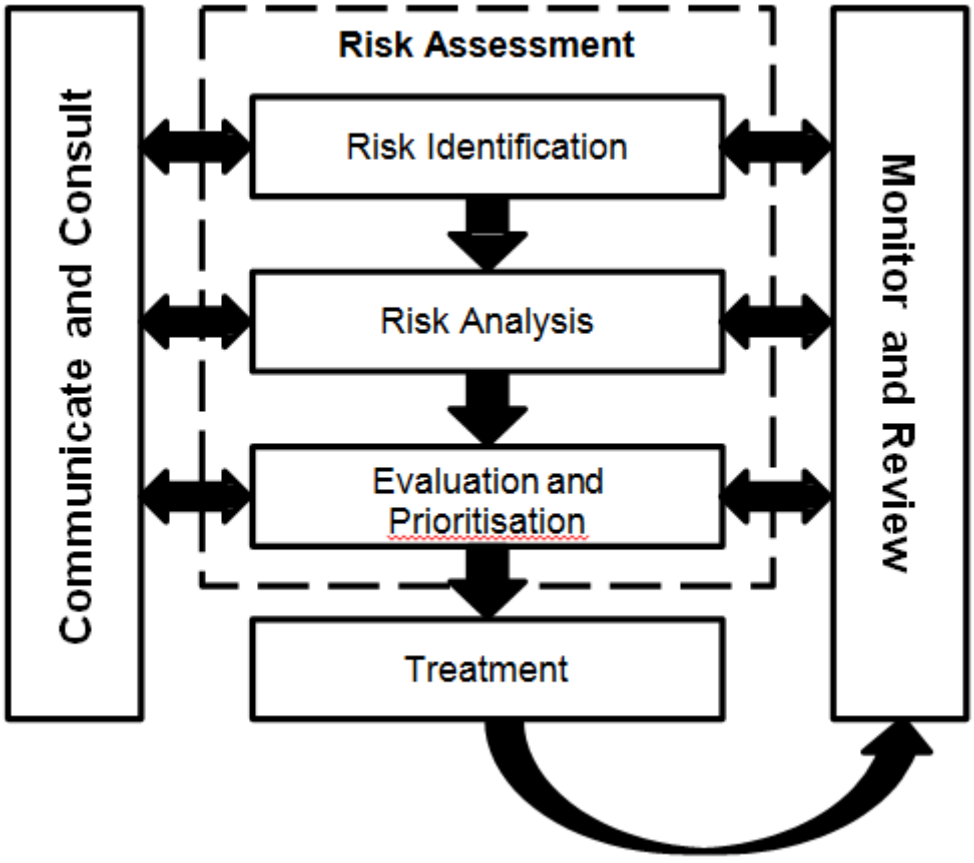
The governing body has developed the corporate objectives, and the evaluation of the risks to achieving these objectives are set out in the governing body Assurance Framework which is regularly reviewed and scrutinised by the senior management team, Corporate Governance Support Group, audit committee and the governing body. The governing body Assurance Framework is a key document whose purpose is to provide the governing body with 'reasonable' assurance that internal systems are functioning effectively. It is a high level document that is used to inform and give assurance to the governing body that the risks to achieving key objectives are recognised and that controls are in place or being developed to manage these risks.

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 a Counter Fraud Specialist (CFS), the service is provided by Mersey Internal Audit Agency (MIAA). The CFS 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 Experience and Public Engagement 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 revised 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 a template 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 processes 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 The Health and Social Care Information Centre (HSCIC) 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 CCGs 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 January 2017 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 2016-17 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.

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

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

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

Key risks identified during 2016-17 are:

- Pressures in the urgent care system and within community services including primary care make delivery against national targets increasingly challenging
- Non- achievement of the CCGs financial duties due to significant cost pressures and underperformance against planned QIPP targets

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 Commissioning Support Unit 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.

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
- 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
- NHS Halton CCG – hosted service for safeguarding arrangements

During 2016-17 any identified risks associated with delegated arrangements have been monitored through the CCG's governance and risk management processes. The CCG has 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 Protect Standards for Commissioners: Fraud, Bribery and Corruption.

An accredited Counter 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 Counter 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 Protect Standards for Commissioners, the results of which are reported to audit committee.

In July 2016 a NHS Protect inspection was conducted and management responded to all issues raised.

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.

Basis for the opinion:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes
- 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
- An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented

The Director of Audit's overall opinion for the period 1 April 2016 to 31 March 2017 is:

Significant Assurance *can be given that there is a generally sound system of internal control to meet the organisation's objectives, and that controls are generally being applied consistently.*

Commentary

This opinion is provided in the context that the Clinical Commissioning Group like other organisations across the NHS is facing some challenging issues in respect of financial performance. The Clinical Commissioning Group's financial plan has been rated as Amber by NHS England and the Clinical Commissioning Group and has taken action to improve its the financial position. Regular updates on financial performance are provided at governing body meetings. The successful delivery of cost saving plans will be a key focus for the governing body throughout 2017/18 and beyond.

Senior management within the Clinical Commissioning Group has remained stable. NHS England has rated the quality of leadership at the Clinical Commissioning Group as Green.

Operationally the Clinical Commissioning Group has continued to regularly report providers' performance against a range of targets. The Clinical Commissioning Group's primary provider Aintree University Hospital NHS Foundation Trust has 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 Clinical Commissioning Group needs to continue to work with providers to ensure required performance improvements are achieved.

NHS South Sefton CCG is a member of Cheshire & Merseyside STP and is part of the North Mersey Local Delivery System (LDS). A set of priorities has been identified for the LDS that align to the CCG's own strategic plans, known as Shaping Sefton. NHS South Sefton is working with other partners within the LDS, including NHS Southport & Formby CCG and NHS Liverpool CCG, whose transformational programmes are closely aligned.

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 2017

Internal audit reports issued in 2016-17

Audit Title	Level of Assurance Given
Risk Management	Significant
Co- Commissioning	Significant
Assurance on Quality of Services Commissioned	Significant
Financial Systems Controls	Significant
Provider Contract Management	Significant
Stakeholder Engagement	Significant
Better Care Fund	Significant
Quality, Innovation Productivity and Prevention (QIPP)	Significant
Information Governance 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 is 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 Director 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 Director of Internal Audit Opinion and also by the internal reviews that have provided the CCG with significant assurance on the arrangements in place.

Fiona Taylor

Accountable Officer

May 2017

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's 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 listed below. It met twice during the year (April 2016 and March 2017). At the April 2016 meeting the committee made the decision that in future there would be a joint remuneration committee with neighbouring Southport and Formby CCG due to the shared management relationship between the two CCGs. This resolution was endorsed by the governing body in October 2016.

Name	Title	April 2016 South Sefton CCG	March 2017 Joint Committee with Southport & Formby CCG
Graham Morris	Chair and governing body Lay Member	✓	✓
Graham Bayliss	governing body Lay Member	✓	✓
Dan McDowell	Secondary Care Doctor and governing body Lay Member	✓	✓
Dr Ritesh Sinha	GP and governing body Member	✓	×

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.

*** Subject to audit**

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 which is also extended to all employees throughout the organisation.

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.nhsba.nhs.uk/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 2017 are disclosed within the Statement of Financial Position under other payables.

The law on workplace pensions has changed. 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 is 1 July 2017. The CCG is currently working 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 £142,500 per annum.

Senior manager remuneration

The table below sets out the salaries and allowances we have paid, or that are payable to our senior managers in 2016-2017.

Name	Title	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	2016-17 Total	2015-16 Total
		(bands of £5,000)	(Rounded to the nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)
		£'000	£'00	£'000	£'000	£'000	£'000	£'000
Taylor FL	Chief Officer	60 - 65	23	0	0	7.5 - 10	70 - 75	65-70
McDowell M	Chief Finance Officer / Deputy Chief Officer	50 - 55	23	0	0	10 – 12.5	65 - 70	55 - 60
Fagan DC	Chief Nurse	40 - 45	0	0	0	17.5 - 20	60 - 65	50 - 55
Mimnagh A	Chair	40 - 45	0	0	0	0	40 -45	15 - 20
Gillespie C	Clinical Vice Chair & GP Clinical Director	15 - 20	0	0	0	0	15 - 20	15 - 20
Wray J*	GP Clinical Director	15 - 20	0	0	0	0	15 - 20	15 - 20
Sinha R*	GP Clinical Director	15 - 20	0	0	0	0	15 - 20	10 - 15
Chamberlain PJ***	GP Clinical Director	70 - 75	0	0	0	0	70 - 75	85 - 90
Shaw C**	GP Clinical Director	0 - 0	0	0	0	0	0 - 0	10 - 15

Name	Title	Salary & Fees	Taxable Benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonuses	All Pension Related Benefits	2016-17 Total	2015-16 Total
Thomas P**	GP Clinical Director	0 - 0	0	0	0	0	0 - 0	5 - 10
Sapre S*	GP Clinical Director	15 - 20	0	0	0	0	15 - 20	0 - 0
McDowell D	Secondary Care Clinician	20 - 25	0	0	0	0	20 - 25	20 - 25
Morris GL	Vice Chair & Lay member - Governance	10 - 15	0	0	0	0	10 - 15	10 - 15
Driver RJ**	Lay Member, Engagement and Patient Experience	0 - 0	0	0	0	0	0 - 0	5 - 10
Bayliss G	Lay Member, Engagement and Patient Experience	5 - 10	0	0	0	0	5 - 10	0 - 0
McGibbon S**	Practice Manager	0 - 0	0	0	0	0	0 - 0	0 - 5
Mulvey T**	Practice Manager	0 - 0	0	0	0	0	0 - 0	0 - 5
Bennett L	Practice Manager	0 - 5	0	0	0	0	0 - 5	0 - 0

** Payments reflect the role in carrying out GB duties only. Additional payments are made to reflect the additional clinical roles and duties performed by GP GB members and those payments are disclosed in the related party transactions as part of the annual accounts.*
*** These members vacated the post within the financial year and have been included for reference to prior year figures.*
**** £17k of payment identified above relates to GB duties only.*

Taxable benefits included within the table above relate to a contractual car allowance.

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

- Fiona Taylor £125,000 to £130,000 and £17,500 to £20,000 all pension related benefits
- Martin McDowell £100,000 to £105,000 and £22,500 to £25,000 all pension related benefits
- Debbie Fagan £80,000 to £85,000 and £37,500 to 40,000 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.

Pension benefits

Name	Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2017 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2017 (bands of £5,000)	Cash equivalent transfer value at 1 April 2016 £000	Cash equivalent transfer value at 1 April 2017 £000	Real increase in cash equivalent transfer value £000	Employers contribution to partnership pension £000
McDowell M	Chief Finance Officer / Deputy Chief Officer	0 - 2.5	0 – 2.5	25 - 30	75 - 80	417	447	30	0
Taylor FL	Chief Officer	0 - 2.5	2.5 - 5	55 - 60	165 - 170	997	1,055	59	0
Fagan DC	Chief Nurse	0 - 2.5	2.5 – 5	25 - 30	75 - 80	406	439	34	0

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 Southport & Formby CCG and 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 pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

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

Compensation on early retirement or for loss of office

During 2016-17 the CCG has not made any payments for loss of office to any past senior managers.

Payments to past members

During 2016-17 the CCG has not made any payments to any past senior managers.

Pay multiples

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

The banded remuneration of the highest paid member of the governing body in NHS South Sefton CCG in the financial year 2016-17 was £60,000 to £65,000 (2015-16: £80,000 to £85,000).

This was 2.73 times (2015-16: 3.5) the median remuneration of the workforce, which was £23,169 (2015-16: £22,940).

In 2016-2017, no employees (2015-16: 0) received remuneration in excess of the highest

paid member of the governing body. Banded Remuneration ranged from £5,000 to £10,000 (2015-16, £5,000 to £10,000) to £60,000 to £65,000 (2015-16, £80,000 to £85,000).

The highest paid member of the governing body changed between the years 2015-16 and 2016-17 therefore resulting in a change in the median ratio

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 part time employees as full time equivalents. The total pay has also been updated to reflect the overall charge to the organisation rather than the shared cost with NHS Southport & Formby CCG due to the joint management arrangements in place; this is in line with the Group Accounting Manual 2016-17.

Staff report

Our staff and members are our greatest asset. To ensure we remain to be 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 organisational development plan highlights five priority areas for actions that we have been progressing over the last twelve months. These are:-

1. Locality development
2. Commissioning capacity and capability
3. Programme management approach and transformation
4. Leadership, team and talent management
5. Public engagement and partnership working

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 country 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 based on member’s feedback

Staff numbers and costs

At the end of March 2017 we employed 112 people (74 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 & Formby CCG through our shared management team arrangements. We also have a small number of joint appointments with Sefton Council.

	Permanent Employees £'000	Other Employees £'000	Total £'000
Salaries & Wages	2,304	138	2,442
Social Security	499	0	499
Employer Contributions to NHS Pension Scheme	614	0	614
Total	**3,417**	**138**	**3,554**

Staff composition

	Governing Body	Very Senior Managers	Other employees	Total
Male	10	0	24	35
Female	3	0	73	77
Total	**13**	**0**	**97**	**112**

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
- We meet regularly to discuss business and performance, and to share ideas and innovation. During 2016-17, 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 2016-17 we participated in the national NHS Staff Survey, which 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 2017 was 4.86%. 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 52.

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 Quality Committee which are both sub- committees of the governing body.

Expenditure on consultancy

During 2016-17 the CCG spent £171,446 on consultancy services. The majority of this was incurred on consultancy services to develop the CCG's transformation plan.

Existing off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2017, for more than £220 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	0
Total number of existing engagements as of 31 March 2017	0

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 2016 and 31 March 2017, for more than £220 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 2016 and 31 March 2017	5
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
Number for whom assurance has been requested	5
Of which, the number:	
For whom assurance has been received	1
• For whom assurance has not been received*	4
• That have been terminated as a result of assurance not being received	0

*Where assurance has not been received, the individual left the organisation prior to assurance being sought.

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 2016 and 31 March 2017:

	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.	13

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	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	1	38,026	0	0	0	0
£50,001 - £100,000	0	0	1	75,894	0	0	0	0
£100,001 - £150,000	0	0	1	121,596	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**	**3**	**235,516**	**0**	**0**	**0**	**0**

Redundancy and other departure cost have been paid in accordance with the provisions of NHS Pension Scheme. Exit costs in this note are accounted for in full in the year of departure. Where South Sefton CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Analysis of other departures

	Agreements Number	Total Value of agreements £'000
Voluntary redundancies including early retirement contractual costs	**3**	**236**
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	**3**	**236**

As a single exit package can be made up of several components each of which will be counted separately in this note, the total number above will not necessarily match the total numbers in the notes to the accounts which will be the number of individuals.

Fiona Taylor

Accountable Officer

May 2017

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 105. An audit certificate and report is also included in this Annual Report at page 102.

Independent auditor's report to the members of the governing body of NHS South Sefton CCG

We have audited the financial statements of NHS South Sefton CCG for the year ended 31 March 2017 on pages 105 to 143 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

This report is made solely to the Members of the governing body of NHS South Sefton 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, as a body, 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 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.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on page 65, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view and is also responsible for the regularity of expenditure and income. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General under the Local Audit and Accountability Act 2014 ('the Code of Audit Practice').

As explained in the Annual Governance Statement the Accountable officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. We are required under Section 21(1)(c) 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. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer, and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

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 2016, as to whether 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 2017.

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2017 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

Opinion on regularity

In our opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with guidance issued by the NHS Commissioning Board;
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has 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 issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014; or

- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in respect of the above responsibilities.

Certificate

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

Robert Jones
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
1 St Peter's Square,
Manchester
M2 3AE

30 May 2017

Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2017

	Note	2016-17 £000	2015-16 £000
Income from sales of goods and services	2	(2,092)	(595)
Other operating income	2	(205)	(115)
Total operating income		**(2,297)**	**(710)**
Staff costs	4	3,554	3,115
Purchase of goods and services	5	242,684	234,018
Depreciation and impairment charges	5	14	15
Provision expense	5	-	(152)
Other operating expenditure	5	265	737
Total operating expenditure		**246,517**	**237,732**
Net operating expenditure		**244,220**	**237,022**
Total comprehensive net expenditure for the year ended 31 March 2017		**244,220**	**237,022**

Statement of Financial Position as at 31 March 2017

	Note	31 March 2017 £000	31 March 2016 £000
Non-current assets:			
Property, plant and equipment	8	14	28
Total non- current assets		**14**	**28**
Current assets:			
Trade and other receivables	9	1,817	1,979
Cash and cash equivalents	10	139	117
Total current assets		**1,956**	**2,096**
Total assets		**1,970**	**2,125**
Current liabilities:			
Trade and other payables	11	(11,850)	(17,143)
Provisions	12	-	(262)
Total current liabilities		**(11,850)**	**(17,405)**
Total Liabilities Employed		**(9,879)**	**(15,280)**
Financed by Taxpayers' Equity			
General fund		**(9,879)**	(15,280)
Total taxpayers' equity:		**(9,879)**	**(15,280)**

The notes on pages 109 to 143 form part of this statement.

The financial statements on pages 105 to 108 were approved by the governing body on 24 May 2017 and signed on its behalf by:

Fiona Taylor
Accountable Officer
25 May 2017

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2017

	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 Southport & Formby CCG taxpayers' equity for 2016-17				
Net operating expenditure 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)**

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Changes in taxpayers' equity for 2015-16				
Balance at 1 April 2015	(16,259)			**(16,259)**
Changes in Southport & Formby CCG taxpayers' equity for 2015-16				
Net operating costs for the financial year	(237,022)			**(237,022)**
Net Recognised CCG Expenditure for the Financial Year	(237,022)			**(237,022)**
Net funding	238,001			238,001
Balance at 31 March 2016	**(15,280)**			**(15,280)**

Statement of Cash Flows for the Year Ended 31 March 2017

	Note	2016-17 £000	2015-16 £000
Cash Flows from Operating Activities			
Net operating costs for the financial year	5	(244,220)	(237,022)
Depreciation and amortisation	5	14	15
(Increase)/decrease in trade & other receivables	9	162	(461)
Increase/(decrease) in trade & other payables	11	(5,293)	(425)
Provisions utilised	12	(262)	-
Increase/(decrease) in provisions	12	-	(152)
Net Cash Inflow (Outflow) from Operating Activities		(249,599)	(238,046)
Net Cash Inflow (Outflow) before Financing		(249,599)	(238,046)
Cash Flows from Financing Activities			
Net funding received		249,621	238,001
Net Cash Inflow (Outflow) from Financing Activities		249,621	238,001
Net Increase (Decrease) in Cash & Cash Equivalents	10	22	(45)
Cash & Cash Equivalents at the Beginning of the Financial Year		117	162
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		139	117

The notes on pages 109 to 145 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. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. 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 Accounting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

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

1.5 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, have been included in the financial statements to the extent that the CCG recognises an obligation at the 31 March 2017 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.
- 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.

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. 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 Property Plant & Equipment

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

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

1.9.2 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.

1.9.3 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.

1.10 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.

1.11 **Leases**

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

1.11.1 The Clinical Commissioning Group as Lessee

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

Operating lease payments are recognised as an expense on a straight-line basis over the

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

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

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

1.11.2 The Clinical Commissioning Group as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Clinical Commissioning Group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Clinical Commissioning Group's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.12 **Other Expenses**

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

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

1.13 **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 2.70%
- Timing of cash flows (6 to 10 years inclusive): Minus 1.95%
- Timing of cash flows (over 10 years): Minus 0.80%

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

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.15 Clinical Negligence Costs

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

1.16 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 Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.17 Continuing Healthcare Risk Pooling

In 2014-15 a risk pool scheme has been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme Clinical

Commissioning Group contribute annually to a pooled fund, which is used to settle the claims.

1.18 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.

1.18.1 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.

1.18.2 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.

1.18.3 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.

1.18.4 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. 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.

1.19 **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.

1.20 **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.

1.21 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Clinical Commissioning Group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.22 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.

1.23 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.

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2016-17, 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)

The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.

2. Other Operating Revenue

	2016-17 Total	2016-17 Admin	2016-17 Programme	2015-16 Total
	£000	£000	£000	£000
Prescription fees and charges	**139**	-	139	**31**
Education, training and research	**13**	-	13	**5**
Charitable and other contributions revenue expenditure: non-NHS	**64**	-	64	**61**
Non-patient care services to other bodies	**2,080**	317	1,762	**590**
Other revenue	1	(10)	11	**23**
Total other operating revenue	**2,297**	**308**	**1,990**	**710**

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

	2016-17 Total	2016-17 Admin	2016-17 Programme	2015-16 Total
	£000	£000	£000	£000
From rendering of services	**2,297**	308	1,990	**710**
Total other operating revenue	**2,297**	**308**	**1,990**	**710**

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

4.1.1 Employee benefits expenditure

	2016-17 Total	Permanent Employees	Other	2015-16 Total
	£000	£000	£000	£000
Salaries and wages	**2,442**	2,304	138	2,587
Social security costs	**499**	499	-	213
Employer contributions to NHS pension scheme	**614**	614	-	315
Other pension costs	**-**	-	-	-
Other post-employment benefits	**-**	-	-	-
Other employment benefits	**-**	-	-	-
Termination benefits	**-**	-	-	
Gross employee benefits expenditure	**3,554**	3,417	**138**	**3,115**
Less recoveries in respect of employee benefits	**-**	-	-	**-**
Total - Net admin employee benefits including capitalised costs	**3,554**	3,417	138	**3,115**
Less: Employee costs capitalised	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**3,554**	3,417	138	**3,115**

Please see page 95 of the annual report for further information on staff costs

4.2 Average number of people employed

	2016-17			2015-16
	Permanent Employees Number	Other Number	Total Number	Total Number
Total CCG (WTE)	72	2	74	61
Of the above:				
Number of whole time equivalent people engaged on capital projects	-	-	-	-

Please see page 95 of the annual report for further information on staff costs

4.3 Staff sickness absence and ill health retirements

Please see page 96 of the annual report for staff sickness reported.

South Sefton CCG operates a shared management function with neighbouring Southport & Formby CCG. The majority of posts detailed in table 4.3 above are joint posts with Southport & Formby CCG.

4.4 Exit packages agreed in the financial year

	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	-	-	1	38	**1**	**38**
£50,001 to £100,000	-	-	1	75	**1**	**75**
£100,001 to £150,000	-	-	1	122	**1**	**122**
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**3**	**236**	**3**	**236**

	2015-16 Compulsory redundancies		2015-16 Other agreed departures		2015-16 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	**-**	**-**	**-**	**-**	**-**	**-**

	2016-17		2015-16	
	Departures where special payments have been made		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 2016-17 (2015-16: Nil).

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

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

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

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at **www.nhsbsa.nhs.uk/pensions.**

For 2016-17, employers' contributions of £615k were payable to the NHS Pensions Scheme (2015-16: £315k) at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer 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

	2016-17 Total £000	2016-17 Admin £000	2016-17 Programme £000	2015-16 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	3,354	2,046	1,308	2,695
Executive governing body members	200	200	-	420
Total gross employee benefits	**3,554**	**2,246**	**1,308**	**3,115**
Other costs				
Services from other CCGs and NHS England	**1,892**	48	1,845	636
Services from foundation trusts	**126,905**	19	126,885	109,939
Services from other NHS trusts	**49,594**	-	49,594	60,562
Services from other WGA bodies	**4**	-	4	-
Purchase of healthcare from non-NHS bodies	**27,762**	-	27,762	26,759
Chair and lay membership body and governing body members	**178**	178	-	-
Supplies and services – clinical	**700**	-	700	620
Supplies and services – general	**9**	110	(101)	84
Consultancy services	**171**	91	80	77
Establishment	**2,749**	52	2,697	2,281
Premises	**630**	295	335	656
Depreciation	**14**	-	14	15
Audit fees	**49**	49	-	54
Other auditor's remuneration	**-**	-	-	-
· Internal audit services*	**36**	36	-	32
- Other Services	**-**	-	-	12
Prescribing costs	**29,186**	-	29,186	29,765
General ophthalmic services	**5**	-	5	3
GPMS/APMS and PCTM	**2,302**	-	2,302	2,284
Other professional fees excl. audit	**389**	30	359	301
Grants to other bodies	**-**	-	-	12
Education and training	**71**	15	56	34
Provisions	**-**	-	-	(152)
CHC Risk Pool contributions	**230**	-	230	574
Other expenditure	**87**	2	85	69
Total other costs	**242,963**	925	242,038	**234,618**
Total operating expenses	**246,517**	**3,171**	**243,347**	**237,732**

*Internal audit services during the year were provided by Mersey Internal Audit Agency.

6. Better Payment Practice Code

6.1 Measure of compliance

	2016-17 Number	2016-17 £000	2015-16 Number	2015-16 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	6,953	36,902	7,356	33,010
Total Non-NHS Trade Invoices paid within target	6,699	33,632	6,737	30,558
Percentage of Non-NHS Trade invoices paid within target	96.35%	91.14%	91.59%	92.57%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,036	183,242	1,854	175,229
Total NHS Trade Invoices Paid within target	1,955	183,193	1,679	175,005
Percentage of NHS Trade Invoices paid within target	96.02%	99.97%	90.56%	99.87%

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 2016-17 payments are required to be disclosed as operating lease payments. Payments made in 2016-17 are shown below:

7.1.1 Payments recognised as an expense

	Land £000	Buildings £000	Other £000	2016-17 Total £000	2015-16 Total £000
Payments recognised as an expense					
Minimum lease payments	-	518	4	522	554
Contingent rents	-	-	-	-	-
Sub-lease payments	-	-	-	-	-
Total	-	518	4	522	554

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 2016	74	57	**131**
Additions	-	-	-
Disposals	-	-	-
Cost or valuation at 31 March 2017	**74**	**57**	**131**
Depreciation at 1 April 2016	**46**	**57**	**103**
Charged during year	14	-	14
Depreciation at 1 April 2017	**60**	**57**	**117**
Net book value at 31 March 2017	14	-	14
Purchased	14	-	14
Donated	-	-	-
Total at 31 March 2017	14	-	14

8.1.1 Economic lives

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

9. Trade & Other Receivables

	Current 2016-17 £000	Current 2015-16 £000
NHS receivables: Revenue	849	848
NHS accrued income	368	570
Non-NHS and other WGA receivables: Revenue	300	431
Non-NHS prepayments	239	94
Non-NHS accrued income	5	11
VAT	16	12
Other	39	13
Total	**1,817**	**1,979**

There were no non–current receivables in 2016-17 (2015-16: nil)

There were no prepaid pension contributions included in 2016-17 (2015-16: nil)

9.1 Receivables past their due date but not impaired

	2016-17 £000	2015/16 £000
By up to three months	131	304
By three to six months	1	17
By more than six months	75	19
Total	**207**	**340**

£37k of the amount above has subsequently been recovered post the statement of financial date.

10. Cash & Cash Equivalents

	2016-17 £000	2015-16 £000
Balance at 1 April 2016	117	162
Net change in year	22	(45)
Balance at 31 March 2017	139	117
Made up of:		
Cash with the Government Banking Service	139	117
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	139	117
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	-	-
Balance at 31 March 2017	139	117
Patients' money held by the clinical commissioning group, not included above	-	-

11. Trade & Other Payables

	Current 2016-17 £000	Current 2015-16 £000
NHS payables: revenue	259	1,471
NHS accruals	528	2,776
Non-NHS and other WGA payables: revenue	2,284	1,763
Non-NHS and other WGA accruals	8,112	9,431
Social security costs	76	61
Tax	66	59
Other payables	525	1,581
Total	**11,850**	17,143

There were no non–current payables in 2016-17 (2015-16: nil)

Included within Other payables are outstanding pension contributions of £91k

12. Provisions

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the Clinical Commissioning Group. However, the legal liability remains with the Clinical Commissioning Group. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this Clinical Commissioning Group at 31 March 2017 is £0.3m (2015-16: £1.3m).

	Current 2016-17 £000	Current 2015-16 £000
Restructuring	-	262
Total	-	262

There were no non-current provisions in 2016/17 (2015/16: nil).

	Restructuring £000	Total £000
Balance at 1 April 2016	262	262
Arising during the year	-	-
Utilised during the year	(262)	(262)
Reversed unused	-	
Unwinding of discount	-	-
Change in discount rate	-	-
Transfer (to) from other public sector body	-	-
Balance at 31 March 2017	-	-
Expected timing of cash flows:		
Within one year	-	-
Between one and five years	-	-
After five years	-	-
Balance at 31 March 2017	-	-

13. Contingencies

The Clinical Commissioning Group has assessed that the likelihood of contingent assets and liabilities is remote as at 31 March 2017.

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 2017 was nil (2015-16: 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' 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**

	At 'fair value through profit and loss' 2015-16 £000	Loans and Receivables 2015-16 £000	Available for Sale 2015-16 £000	Total 2015-16 £000
Receivables:				
· NHS	-	1,418	-	1,418
· Non-NHS	-	442	-	442
Cash at bank and in hand	-	117	-	117
Other financial assets	-	13	-	13
Total at 31 March 2016	-	**1,990**	**-**	**1,990**

15.3 Financial liabilities

	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**

	At 'fair value through profit and loss'	Other	Total
	2015-16 £000	2015-16 £000	2015-16 £000
Payables:			
· NHS	-	4,247	4,247
· Non-NHS	-	12,775	12,775
Total at 31 March 2016	-	**17,022**	**17,022**

16. Operating Segments

The Clinical Commissioning Group has only one segment: Commissioning of Healthcare Services.

	Gross expenditure £000	Income £000	Net expenditure £000	Total assets £000	Total liabilities £000	Net liabilities £000
Commissioning of Healthcare Services	246,517	(2,297)	244,220	1,970	(11,850)	(9,879)
Total	**246,517**	**(2,297)**	**244,220**	**1,970**	**(11,850)**	**(9,879)**

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:

	2016-17 £000	2015-16 £000
Better Care Fund		
Income	(13,814)	(11,840)
Expenditure	13,814	11,840
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.

South Sefton CCG is party to a Better Care Fund pooled budget arrangement with Southport & Formby CCG and Sefton Metropolitan Borough Council – the total fund value is £26.97m, South Sefton CCGs share of this fund is £13.81m.

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

Details of related party transactions with individuals are as follows:

Organisation	Payments to related Party	Receipts from Related Party	Amount owed to Related Party	Amount due from Related Party
Ford Medical Practice	109	-	-	-
Williams & Partners	11	-	-	-
The Blundellsands Surgery	257	-	-	-
Tong & Gillespie	29	-	-	-
Hughes & Partners	120	-	-	-
North Park Health Centre	73	-	-	-
Westway Medical Centre	218	-	4	-
Dr Georgina Halstead	19	-	-	-

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 part of our work around the nationally mandated Sustainability and Transformation Plans, we are working together with NHS Southport and Formby CCG and NHS Liverpool CCG through the North Mersey Local Delivery System. Discussions are ongoing regarding bringing together our transformational programmes, Shaping Sefton and Healthy Liverpool, in order to strengthen local commissioning. In the future, this may mean organisational reconfiguration and as at the 31 March 2017 discussions are ongoing between the three organisations.

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 2016-17 Number	Total Value of Cases 2016-17 £000	Total Number of Cases 2015-16 Number	Total Value of Cases 2015-16 £000
Administrative write-offs	-	-	-	-
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Book Keeping Losses	-	-	-	-
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total				

Special Payments

	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £000	Total Number of Cases 2015-16 Number	Total Value of Cases 2015-16 £000
Compensation payments	3	236	-	-
Extra contractual Payments*	-	-	-	-
Ex gratia payments	-	-	-	-
Extra statutory extra regulatory payments	-	-	-	-
Special severance payments	-	-	-	-
Total	**3**	236	-	-

*Nine extra contractual payments were made relating to a request from NHS England to make payments to a member practices on their behalf. This has since been recovered from NHS England and therefore no payments have been included in the table above.

One payment has been made relating to a legal settlement between NHS England and a GP Practice. This has since been recovered from NHS England and therefore no payments have been included in the table above.

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 Group's performance against those duties was as follows:

NHS Act Section	Duty	2016-17 Target	2016-17 Performance	2015-16 Target	2015-16 Performance
223H (1)	Expenditure not to exceed income	£246.6m	£246.5m	£240.1m	£237.7m
223I (2)	Capital resource use does not exceed the amount specified in Directions	-	-	-	-
223I (3)	Revenue resource use does not exceed the amount specified in Directions	£244.3m	£244.2m	£239.4m	£237.0m
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	£3.270m	£2.863m	£3.296m	£3.258m