NHS
South Sefton
Clinical Commissioning Group

Annual Report and Accounts

Quarter 1 2022 – 2023

Staying **local**
& together

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About our annual report and accounts

We produce our annual report and accounts in line with national reporting requirements.

These requirements are set out in a ‘manual’ that we follow, which asks us to report information relating to our work in three main sections as follows:

- Performance report - including an overview, performance analysis and performance measures
- Accountability report - including the members report, corporate governance report, annual governance statement, remuneration and staff report
- Annual accounts

Performance overview

Introduction

We welcome you to the Q1 Annual Report and Accounts for NHS South Sefton CCG before it is disestablished by the passing of the Health and Social Care Bill and our duties transfer to a new NHS Cheshire and Merseyside Integrated Care Board on 1 July 2022.

You will read more about these changes that are designed to join up the way we work together with our partners to improve health and care services in the borough through the new Sefton Partnership, which will be part of a wider Cheshire and Merseyside Integrated Care System.

We believe these new structures will help us to better deliver our aims and ambitions that we have developed with partners, which are set out in Sefton Health and Wellbeing Strategy and our local plan for the NHS, Sefton2gether.

You will also read about our progress and challenges in early 2022, including our work and performance, which has again been heavily focused around our response to the coronavirus pandemic.

During the lifetime of the CCG, we have achieved a great deal and we are proud of the changes we have made with the aim of improving health and care for our residents. We would like to take this opportunity to thank our colleagues across health and care in Sefton for their ongoing support over the years as we enter a new phase for the NHS. We also thank our residents for the support and patience you have shown your local NHS throughout the COVID-19 pandemic and following it.

Dr Pete Chamberlain	Fiona Taylor
Chair	Chief officer

Purpose of this performance overview

The performance overview section of this report highlights our approach and achievements during Quarter 1 of the financial year 2022-2023.

It gives a snapshot of who we are, what we do, the challenges we have faced and what we have done as a result.

Our journey in Quarter 1 2022-2023

During this time period and similarly to last year, most of our work has been focused on supporting the local NHS response to COVID-19 and promoting the vaccination, whilst ensuring patients have continued and safe access to services. Below is a roadmap of some of the significant dates relating to COVID-19 and other pieces of work we have achieved in April – June 2022.

April 2022

In April we let our residents know the best way to get healthcare support over the Easter bank holiday weekend. We reminded residents to look out for signs of bowel cancer for bowel cancer awareness month and that their GP practice was here for them.

We promoted the COVID-19 vaccination for under 18s and the MMR vaccines for children too. There was a rise in the amount of scarlet fever cases across the North West so we reminded people of the symptoms to look out for.

We also promoted the new Organisation for the Review of Care and Health Applications (ORCHA) platform which is an online health app library tailored to the health needs of Sefton residents: sefton.orcha.co.uk

May 2022

In May we shared information on monkeypox and what to look out for as there were several cases in the UK and numbers were increasing.

We again, promoted alternative options for healthcare support when GP practices are closed in the run up to the Jubilee bank holiday weekend and we shared Joanne's story on how her GP practice were still there for her Dad during the pandemic, reminding others how to best access their GP practice.[1]

We also worked with Sefton Council to promote the use of the #SeftonInMind hashtag on social media during mental health awareness week (9-15 May) to encourage conversations about loneliness.

June 2022

In June we announced that our medicines management team had been shortlisted for the Improving Safety in Medicines Management Award at this year's HSJ Patient Safety Awards, recognising their outstanding contribution to healthcare.[2]

We encouraged everyone eligible to get their cervical screening test for cervical screening awareness week (20-26 June) and reminded residents how to keep cool in the heat wave. We also promoted the First Episode Rapid Early Intervention for Eating Disorders' (FREED) service which was extended into Sefton after funding was secured. The service, run by Mersey Care NHS Foundation Trust is open to 16 to 25-year-olds in the area who have had an eating disorder for three years or less.

[1] https://www.southseftonccg.nhs.uk/get-informed/latest-news/sefton-resident-thanks-gp-and-tells-others-they-are-still-here-for-you/
[2] https://www.southseftonccg.nhs.uk/get-informed/latest-news/ccgs-in-sefton-shortlisted-for-the-2022-hsj-patient-safety-awards/

Who we are and what we do

We are NHS South Sefton Clinical Commissioning Group (CCG) and we have been responsible for planning and buying – or 'commissioning' – nearly all local health services since 1 April 2013. From April – June 2022 we had a budget of £79.571 million to spend on commissioning the following health services for our 157,035 south Sefton residents:

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

Our CCG is a membership organisation made up of doctors, nurses, lay representatives and other health professionals, representing 29 doctor's surgeries in south Sefton. We support practices to be actively involved in the work of the CCG. Much of this work is carried out in 'localities', covering four geographical areas, so practices can really focus on addressing the health needs of their individual communities. Our four localities are Bootle, Crosby, Maghull and Seaforth and Litherland. In addition to working in localities our member practices continue to strengthen the work they do together through Primary Care Networks (PCNs) to provide joint services to their patients.

A Governing Body of elected GPs, practice staff, lay representatives and other professionals makes decisions for our CCG on behalf of the wider membership. Whilst we support people's right to choose where they are treated and who provides their care[3], the majority of the services we commissioned in early 2022 were commissioned from the following providers:

- Liverpool University Hospitals NHS Foundation Trust – where the majority of our residents receive any general hospital care they may need
- Mersey Care NHS Foundation Trust – providing community services in addition to many of the mental health services we commission
- North West Ambulance Service NHS Trust – providers of patient transport services as well as its network of emergency response vehicles
- Other NHS organisations – including Southport and Ormskirk Hospital NHS Trust, 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, voluntary and faith sector organisations– like Sefton Carers Centre and the Alzheimer's Society
- Independent and private sector providers – including PC24 that is led by doctors and provides our GP out of hours service
- Midlands and Lancashire Commissioning Support Unit – providing many of our administrative and operational functions like procurement and human resources.

So we can make the right commissioning decisions for our patients' needs, we continually

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

review and monitor local services to make sure they meet the standards and quality we expect.

Alongside this, we routinely assess all the information and medical evidence we have about current health and health services in south Sefton, to inform what more we need to do.

Our strategic approach to commissioning services is set out in our strategy document, Sefton2gether, the five year plan for the local NHS. A number of other CCG and partnership plans and strategies also inform our work. These include the Joint Strategic Needs Assessment (JSNA) and Sefton's Health and Wellbeing Strategy - Living Well in Sefton, produced in partnership with Sefton Council.

We co-produced Living Well in Sefton and Sefton2gether with our partners in the Health and Wellbeing Board in 2019-20. Together, our approach to developing these strategies aligns with the emphasis placed in the NHS Long Term Plan on addressing the wider factors that determine good health. Additionally, Sefton2gether explicitly references the role of NHS organisations in addressing these wider determinants through the four pillars of population health.

Our plans also have to meet a number of nationally set standards and requirements like the NHS planning and contracting guidance, the NHS Long Term Plan, Oversight Framework for CCGs and the NHS Constitution[4], 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. Details of this can be found in the performance section of the report where it is explained that performance measures were scaled down due to the pandemic.

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

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

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

Our local challenges

During 2022-2023 the NHS continues to face challenges from the on-going effects of the COVID-19 Pandemic, directly and in-directly. Demand for planned care has risen increasing waiting times, shortages in workforce, and funding constraints remain. The urgent care system is also facing continued challenges with pressures on emergency services such as increased ambulance activity, response times, and handovers. Locally in south Sefton these pressures are also being felt.

Despite these multi-factorial pressures the CCG has maintained its focus on high quality care as evidenced in the continued good performance across primary care CQC standards. A focus was also on, not only the pandemic, but also recovery from the longer-term aftereffects with much closer working across the wider Cheshire & Merseyside system enabling a pooled resource approach.

In addition to these challenges, south Sefton has several environmental and social elements that need to be factored in when planning and commissioning health services for the population.

These include the following:

- The demographic makeup of our population shows a higher proportion of residents 65 years and over, approximately 21%, compared with a national rate of closer to 19%. Populations for this age group indicate significant increases over the next 10-15 years.

- South Sefton has significantly higher levels of deprivation and child poverty with income deprivation affecting children across several Boroughs within the top 1% in the country.

Improvements in health have been made in several areas, however, there remains unacceptable inequalities across the boroughs and these present clear areas for improvement:

- Life expectancy for both males and females is lower than the national rate with healthy life rates for males significantly lower. The variation increases when looking at locality level information with an approximate six year variation between the highest and lowest areas.

- Levels of long-term health conditions are much higher than the national average especially Hypertension and Chronic Kidney Disease. Other factors such as obesity, respiratory diseases, mental health disorders and depression are higher in Sefton than nationally.

The Joint Strategic Needs Assessment (JSNA) supports the strategic development and service planning by examining health and social variations and inequalities that exist within Sefton. The information outlined in the JSNA supports commissioning plans and joint working with our health and social care partners.

You can find out more about local health and wellbeing from Sefton's JSNA[1] , Sefton's Children & Young Peoples JSNA[2], Sefton Public Health Annual Report and RightCare Health Inequalities data pack[3] for south Sefton.

[1] Sefton JSNA - https://www.sefton.gov.uk/media/1884/jsna-highlight-report-2018.pdf

[2] Sefton Children & Young Peoples JSNA - https://www.sefton.gov.uk/media/1885/children-and-young-people-overview-september_2021-final.pdf

[3] NHS Rightcare Equality and Health Inequalities pack - https://www.england.nhs.uk/wp-content/uploads/2018/12/ehircp-nw-south_sefton-ccg-dec-18.pdf

Our strategy for health, care, and wellbeing

Our CCG strategy has been guided by the NHS England Long Term Plan. Building on the 2014 original Shaping Sefton strategy and working in a partnership approach, the new five year plan Sefton2gether was launched in 2019. The plan looks at the Sefton requirements and has been developed by the NHS, Sefton Council, the voluntary, community and faith (VCF) sector and the people of Sefton. It underpins elements of the Sefton Health and Wellbeing Strategy. Our aim is to continually improve health and wellbeing for all in Sefton.

The ambitions and priorities will continue to be implemented over the next two years and importantly this plan is a 'partnership' plan for the whole of Sefton.

We are committed to working closely with partners to link up where our ambitions align. This will all be carried out under the umbrella of Sefton Health and Wellbeing Strategy and working within the finances available.

We also aim to cut delays, improve the quality of care, bring care closer to everyone's homes and reduce both A&E attendances and hospital admissions.

In line with the ambitions of the national NHS Long Term Plan, we want to refocus our efforts and increase our investment in early intervention and prevention rather than cure – this represents a significant change in the way we have prioritised our resources in the past.

We know that some of the foundations we are building on will take many years to show results. Delivering improved health outcomes can take generations but that will not stop us planning and working now to make a positive change for the future. This includes things like increasing vaccination and immunisation rates as well as identifying when we can intervene earlier to stop or reduce ill health getting worse. This will help people live longer, healthier lives and reduce the need for traditional medical services in the future. By encouraging people to live a healthier lifestyle, such as eating and drinking more healthily, taking more exercise and not smoking, we will hopefully not have to rely on health and care services as much in the future.

We also want to help address some of the structural / wider determinants of health, to see how best we can work together with partners on things like poverty, housing, education, transport, skills, and employment. This includes looking at "social value"; which describes the wider benefits achieved from delivering public services. It considers more than just people's wages and income and includes things like; wellbeing, health, inclusion and many other benefits of being employed and active in the community.

We need to prevent and reduce existing conditions which are prevalent in Sefton, like diabetes, heart disease, cancer and mental health across all ages. We are aware we need to reduce the time people wait for surgery and urgent care and provide value for money to taxpayers. We can do this by thinking more strategically about our future commissioning arrangements with all providers, including the VCF sector.

We are all committed to delivering the key aims of this strategy for Sefton and helping residents to start well, live well, age well and have a good end of life. We want to ensure that health and care across Sefton considers the entire life-course so that we can help and support across all ages, whether it be a newborn baby or someone coming towards the end of their life.

We are developing a refreshed partnership plan that will reflect our learning from the COVID-19 pandemic and help to deliver Sefton2gether. This will combine the joint actions of the CCG, Sefton Council and wider partners from the Sefton Health and Wellbeing Strategy[8] and the Children's and Young People Plan[9] to ensure consistent messaging around local strategic aims and priorities.

Our ambitions

A healthy balance

There is a 12-year difference between the life expectancy in the poorest parts of Sefton compared to the richest parts. Evidence from the COVID-19 pandemic has highlighted this gap is increasing. Our goal is to reduce the gap through targeted advice, information and support with health care when it is needed, helping people to live longer.

Great expectations

We want to make sure that people are able to live their best life by helping them choose to live longer and be healthier. We want to help everyone increase the number of years they live, free from any major health conditions.

Early intervention

If people need help, the sooner we are able to support, the better the outcomes. That's why we are promoting early intervention through our health care system, making sure that any worries people have are seen to as quickly as possible before they turn into major problems.

Prevention

Prevention and early intervention go hand in hand. This is why we are encouraging people to stay healthy and active to prevent health and wellbeing problems later on in life.

Empowering self-care

Helping people to care for themselves is very important to us. Self care and lifestyle changes such as stopping smoking, doing more exercise and eating and drinking healthily can make a big difference to everyone – from weight loss to managing existing mental health conditions. This also includes helping those people with long term conditions, e.g. diabetes or recovering from cancer to maintain as healthy a life as possible. After all, real change must come from within.

Access to high quality services

We want to make sure that everyone can access high quality services that meet required quality standards and are located where people need them most. We are constantly looking for new ways to improve and meet everyone's needs efficiently and effectively.

8 https://modgov.sefton.gov.uk/documents/s94293/Enc.%201%20for%20The%20Health%20and%20Wellbeing%20Strategy%202020-2025.pdf

9 https://www.sefton.gov.uk/media/1010/children-and-young-peoples-plan-2020-2025-final.pdf

Planning ahead

There are long-term NHS goals that we have to meet to make sure that everyone is well looked after. These goals include reducing waiting times, supporting maternity services, reducing health inequalities and tackling diabetes, improving outcomes from cancer and supporting people with mental health problems at a local level. This is more important now than ever, given that we need to restore and improve services in view of the impact of the pandemic.

Sustainability

We want our health and care system to be financially sound. We must understand how we can manage our money in a way that meets everyone's needs. We also want to be able to maintain the high quality of care available, no matter what happens politically and economically. Because of this we have to make sure that we are prepared for all circumstances and have the services in place when and where they are most effective.

Social value

We want the NHS and wider public sector to be of value to the local population. We want to create a service that is trusted, an employer who is fair and loyal and a pillar that the community can depend on. We aim to do this through constant communication and transparency about what we are doing and why. This includes the five main things which make the NHS an "Anchor Institution":

- Purchasing more locally and for social benefit
- Using buildings and spaces to support communities
- Widening access to quality work
- Working more closely with local partners
- Reducing its environmental impact

Working together

We aim to make the most of the resources we have available, both within the NHS and across our partners. We want to ensure we all focus on "whole system delivery" through working together and being as efficient as possible. The overall approach is guided by the need to address the multifaceted health issues we have within Sefton and by working differently, which mean that people are not living as long or as healthily as they could.

8 https://modgov.sefton.gov.uk/documents/s94293/Enc.%201%20for%20The%20Health%20and%20Wellbeing%20Strategy%202020-2025.pdf

10 https://www.sefton.gov.uk/media/1010/children-and-young-peoples-plan-2020-2025-final.pdf

Delivering our strategy in partnership

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

NHS England and Improvement

Together with NHS England and Improvement (NHSE/I), we work to ensure health services for south Sefton residents meet national and local standards. This has been the second year since we took on full responsibility for the commissioning of general medical services from NHSE/I, known as 'full delegation'.

During early 2022, the Cheshire and Merseyside Area Team continued to oversee standards and hold the contracts for dentists, pharmacists and opticians, as well as being responsible for some screening and immunisation programmes. Other local teams commission some additional services our residents may need from time to time, such as specialist, prison and armed forces healthcare.

Cheshire and Merseyside Health and Care Partnership

We are working closely with the Cheshire and Merseyside Health and Care Partnership[5] and the other eight Cheshire and Mersey CCGs to develop the emerging integrated care board (ICB). On 1 July 2022, the ICB will take on the NHS commissioning functions of CCGs, which will be abolished, as well as some of NHS England's commissioning functions. The ICB will be part of a wider integrated care system (ICS), bringing together NHS organisations, councils and wider partners in Cheshire and Merseyside to deliver more joined up approaches to improving health and care outcomes.

These new structures will help us to better address local challenges around population health, quality of care and the increasing financial pressures on our services. Our universal goal is to improve health and wellbeing and reduce health inequalities across Cheshire and Merseyside.

Sefton Partnership

We are working with organisations across Sefton to establish a new health and care partnership that will strengthen the way they work together for the benefit of borough residents. Sefton Partnership is focused on integrating health and care for the borough and will work as part of the wider ICS in Cheshire and Merseyside.

Sefton Partnership will bring together Sefton Council, all local NHS, voluntary, community and faith (VCF) groups and other organisations involved in improving health and care in the borough.

Sefton Health and Wellbeing Board

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

[5] https://www.cheshireandmerseysidepartnership.co.uk/

the community voluntary and faith sector and Healthwatch Sefton.

Together, we have devised a Sefton wide strategy for health and wellbeing[6]. This was based on our Joint Strategic Needs Assessment (JSNA) that brings together all the information we have about current services, to highlight where we need to do more in the future. This is particularly important as we continue to work together on addressing the inequalities in health that exist in different parts of the borough. Our 5 year strategy, Sefton2gether[7] will support the delivery of our joint Health and Wellbeing Strategy and you will find examples of our joint work elsewhere in this annual report.

Sefton Council

We work closely with our council colleagues across many areas to drive improved health and wellbeing for local people. Our work in developing the Sefton Partnership will further strengthen our approach to achieving service integration across health, council and wider services, which we believe will have great benefits for our residents by making their health and care more seamless and effective. We are also looking at where we can further pool our resources towards achieving better outcomes for our patients. This is part of our work around the Better Care Fund programme[8].

The council is responsible for promoting and protecting good health across Sefton. It works closely with the newly formed national body, the Office for Health Improvement and Disparities, to do this in partnership with NHS England and ourselves. This helps to steer our work to reduce health inequalities in line with the aims of our joint health and wellbeing strategy. The local authority also holds us to account through its overview and scrutiny functions. Our chief officer is a regular attendee of the Overview and Scrutiny Committee (OSC) for Adult Social Care and Health and the OSC for Children, Young People and Safeguarding to update councillors of key work programmes.

Other clinical commissioning groups

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

Provider organisations

The majority of services we commission are from other NHS organisations like hospital and community services trusts. In addition, we also commission some services from the voluntary, community and faith sector and private providers. We closely monitor the work of all our providers to ensure their services meet the high standards of quality we expect

[6] https://modgov.sefton.gov.uk/documents/s94293/Enc.%201%20for%20The%20Health%20and%20Wellbeing%20Strategy%202020-2025.pdf
[7] https://www.southseftonccg.nhs.uk/what-we-do/sefton2gether/
[8] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/

for our patients. We also involve our providers in planning how we might improve care in the future, and a number of these organisations are represented on some of our most important working groups.

Healthwatch Sefton

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

Performance analysis

As a statutory body we ensure all our duties are being fully managed. One way in which this is done is via performance monitoring and management of the serviced we commission. We do this through several routes - internal governance structures and processes as described elsewhere in this report, external contractual routes with providers, and regularly assessments by national regulatory bodies such as NHS England & Improvement.

There are also a number of documents that set out targets for different areas of our work. This includes the pledges contained in the NHS Constitution, the NHS Outcomes Framework, Better Care Fund and the System Oversight Framework. Aligned to this are also specific CCG plans set out in the NHS Operational Plans.

The work you will read about throughout this report has all contributed to our performance for Q1 2022-2023. Due to the continued effects of the pandemic several performance reporting indicators and processes continue to be stepped down.

Detailed information about our performance during the year, including any significant issues or achievements can be found in our integrated performance reports, which are published on our website[10] in addition to being presented to our Governing Body.

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

Performance summary

System Oversight Framework

NHS England has a legal responsibility to assess the performance of each CCG on an annual basis - the method and indicators each CCG is assessed on is outlined in the NHS System Oversight Framework (SoF) (since revised from the NHS Oversight Framework). The approach to the NHS SOF comprises a set of around 100 indicators, with metrics relating to quality, access and outcomes, preventing ill health and reducing inequalities, leadership and capability, people, and finance and use of resources. The SoF covers CCG, Provider, and ICS' organizational performance. Reporting for 2022/23 is yet to be released with previous years performance detailed in the 2021/22 annual report.

Better Care Fund performance

Sefton Health and Wellbeing Board submits our Better Care Fund (BCF)[11] programme plan which sets out areas of work between Sefton Council and ourselves including funding contributions, scheme level spending plans and national metrics. Quarterly performance monitoring returns are submitted to NHS England on behalf of the Sefton Health and Wellbeing Board.

12 About the Better Care Fund https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

NHS South Sefton CCG Summary Performance Table

The following table shows overall performance for Q1 of 2022/23, with much relating to the work of our providers. We work with Providers to support improvement, and this sometimes includes contractual measures to ensure our services meet the best possible standards.

Quarter 1 Performance Position 2022-23 - South Sefton CCG	CCG	Main Provider
A&E (All Types) (Nat Target 95%)		
A&E 12-hour breaches		
RTT (Nat Target 92%)		
Referral to Treatment Incomplete pathways 52+ Week Waiters (Zero Tolerance)		
Diagnostics (Nat Target less than 1%)		
Cancer - 2-week urgent GP Referral for suspected Cancer (Nat Target 93%)		
Cancer - 2 week wait breast symptoms (Nat Target 93%)		
Cancer - 31 day first definitive treatment (Nat Target 96%)		
Cancer - 31-day standard for subsequent treatment - Drug (Nat Target 98%)		
Cancer - 31-day standard for subsequent treatment - Surgery (Nat Target 94%)		
Cancer - 31-day standard for subsequent treatment - Radiotherapy (Nat Target 94%)		
Cancer - 62-day urgent referral to treatment waits (Nat Target 85%)		
Cancer - 62 day wait for 1st treatment following referral to screening service (Nat Target 90%)		
Ambulance Handovers 30-60 mins (Zero Tolerance)		
Ambulance Handovers 60+ mins (Zero Tolerance)		
Mixed Sex Accommodation (Zero Tolerance)		
Care Programmed Approach (CPA) follow up 7 days 2022/23 – Q1 (Target 95%)		
Early Intervention in Psychosis (EIP) 2022/23 – Q1 (Target 60%)		
IAPT Access (1.59% target monthly)		
IAPT Recovery (Target 50%)		
IAPT % 6 week waits to enter treatment (Target 75%)		
IAPT % 18 week waits to enter treatment (Target 95%)		
Dementia (Target 66.7%)		
Smoking at time of Delivery (SATOD) 2022/23 – Q1 (National ambition below 6%)		
MRSA - Zero tolerance		
C.Difficile - (measuring against last year's YTD targets CCG = 14, LUHFT = 34)		
E coli - (measuring against last year's YTD targets CCG = 33, LUHFT = 44)		
Children & Young People Mental Health Services (CYPMH) – 12 months rolling (Target 50%)		
Children and Young People with Eating Disorders - routine referrals within 4 weeks – Q1 (Target 95%)		
Children and Young People with Eating Disorders - urgent referral within one week – Q1 (Target 95%)		
Proportion of CYP new ASD referrals that started an assessment within 12 weeks Target 90%)		
Proportion of CYP new ASD referrals that completed an assessment within 30 weeks (Target 90%)		
Proportion of CYP new ADHD referrals that started an assessment within 12 weeks (Target 90%)		
Proportion of CYP new ADHD referrals that completed an assessment within 30 weeks (Target 90%)		
CAMHS - % Referral to Choice within 6 weeks (Target 92%)		
CAMHS - % Referral to Partnership within 18 weeks (Target 92%)		

(Target 90%)		
Proportion of CYP new ASD referrals that completed an assessment within 30 weeks (Target 90%)		
Proportion of CYP new ADHD referrals that started an assessment within 12 weeks (Target 90%)		
Proportion of CYP new ADHD referrals that completed an assessment within 30 weeks (Target 90%)		
CAMHS - % Referral to Choice within 6 weeks (Target 92%)		
CAMHS - % Referral to Partnership within 18 weeks (Target 92%)		

What we are doing to address performance

While the effects of the pandemic are still on-going and likely to be felt for several years restoration and recovery of elective services remains a focal point for the Sefton and the wider NHS. This is in conjunction with support and focus for services facing increased pressure such as urgent care, mental health, Children's, and other key services. We are committed to, and continue to work closely with, health and social care colleagues to improve service delivery and outcomes.

Urgent care services

Urgent care services are continuing to operate in a fluctuating pandemic system, staff absences as a result remain high and in turn further pressures in admissions and discharges are felt.

A&E activity as well as emergency admission levels have increased compared to a significant drop in 2020-2021 and are now close to or above pre-pandemic figures in some cases

In relation to A&E 4-Hour waits for all types, South Sefton and Liverpool University Hospital Foundation Trust (LUHFT) continue to report under the 95% target for Q1 22/23. South Sefton and the Trust performance is also lower than the nationally reported level of 72.11%.

New in 2022/23, Providers are required to report waits in A&E from arrival to discharge, admission or transfer. In Q1 22/23, LUHFT reported approx. 11% of patients waiting over 12hrs against a plan of 2%. No harms have been identified for the latest 12-hour breaches, resulting in no serious incidents being reported.

Calls to ambulance services have also increased significantly which in turn has reduced performance in response, handover, and turnaround times. The original target to meet all ARP (Ambulance Response Programme) standards has not been met and was severely adversely impacted upon by COVID-19 and the reason mentioned above. Performance is being addressed through a range of actions including increasing number of response vehicles available, reviewing call handling and timely dispatch of vehicles as well as ambulance handover times from A&E to release vehicles back into system.

Two of the three healthcare associated infections (HCAI) measures are failing the target levels, these are MRSA and C.Difficile. Post infection reviews take place after each case with lessons learnt and recommendations for improvement are implemented. The Infection, Prevention and Control (IPC) Programme Board is in place to focus on the reduction of gram-negative bloodstream infections and address the need for a system wide collaborative approach.

Planned care services

Local providers have continued to undertake urgent elective treatments during the COVID-19 pandemic period, and this has been clinically prioritised. There is a focus on delivering greater theatre capacity utilising on site theatres and that of the independent sector. This will include use of nationally agreed independent sector contracts following clinical assessment in terms of triage and prioritisation.

In the context of responding to the ongoing challenges presented by COVID-19, whilst also restoring services, meeting new care demands and tackling health inequalities, Elective Recovery Funds (ERF) have been made available to systems that achieve activity levels above set thresholds. In Cheshire & Mersey Hospital Cell (established to co-ordinate acute hospital planning

resulting from the COVID-19 pandemic), the delivery of activity both at Trust and system level is being assessed against agreed trajectories.

Incomplete waiting lists continue to rise, now over 23,000 patients including 3,000 patients waiting beyond 52 weeks and 42 waiting over 104 weeks. Performance for patients being seen within 18 weeks is now below 50% against a 92% target.
Diagnostic faces similar challenges with inflated waiting lists and longer waits beyond 6 weeks and 13 weeks although performance is improving. 12.3% patients are waiting over 6wks for diagnostic tests. Areas most affected are within the endoscopy modalities such as Gastroscopy, Colonoscopy, and Flexi-Sigmoidoscopy.

Recovery of elective activity and diagnostic access is being led at a regional level by Cheshire and Merseyside with input locally where needed.

Cancer services

As with planned care, cancer services continue to be affected by the global pandemic with several pathways specifically impacted due to reduced capacity in other linked areas such as diagnostic provision.

South Sefton is achieving 2 of the 9 cancer measures in June-22 and 3 of the 9 cancer measures for Q1. LUHFT are achieving 1 in Q1.

Pressures in breast and colorectal services continue to dominate underperformance across most access standards.

South Sefton and the Trust are still below for both the two week wait measures in month 3. The main reason for the breaches for both measures is inadequate outpatient capacity associated with increased demand which continues to exceed pre pandemic levels but with a sense that rates are starting to reduce.

For 2-week breast symptoms South Sefton and the Trust continue to report significantly below the 93% target, despite an increase in performance in June-22. South Sefton reported 26.67% and the Trust 33.18%

The cancer alliance continues to play a vital role in ensuring performance and recovery is organised across the Cheshire and Mersey area. Assurance is also provided by the CCGs main providers as to priority given to those most at clinical risk.

Children and young people services

In its ongoing response to the pandemic, Alder Hey Children's Hospital NHS Foundation Trust continues to focus on returning to pre-COVID levels of activity for community therapy services provision and Child and Adolescent Mental Health Services (CAMHS).

Performance has dropped throughout the year across a few services with issues faced similar to those across the whole of the NHS – increasing demand and reduced workforce.

Services that have experienced significant increased waiting times and challenges include mental health and ASD and ADHD. More information of these is included below:

Mental health services for children and young people

CAMHS performance in the first quarter of 2022/23 continued to be challenged, due to the sustained post-COVID increases in referrals and number of complex and urgent cases. In

addition, expansion of the mental health workforce and a shortage of qualified therapist continues to impact on recruitment and staffing of the service. These issues are reflected regionally and nationally.

In June 2022, against a waiting time target of 92%, Alder Hey's CAMHS was reporting a 34.1% compliance for the 6 week to assessment and 51.9% to commence treatment within 18 weeks.

The service continues to prioritise urgent cases which receive an appointment within two weeks. Those on the waiting list are regularly contacted and risk reassessed and are offered an earlier appointment if clinically indicated. The service is implementing a service improvement plan to address waiting times which is being reviewed and closely monitored by the CCG.

Third sector providers of children and young people's mental support in Sefton, Venus and Parenting 2000, continue to experience similar challenges and have been delivering open access sessions to improve and increase accessibility to mental health support. These have been funded by the additional national covid recovery mental health funding released in 2021/22.

For 2022/23, investment has been agreed and expanded by the CCG in line with Mental Health Investment Standard (MHIS), Service Development Fund (SDF) and Service Resilience (SR) allocations. This supports the aims of the NHS long term plan including:

- Expansion of children and young people's eating disorders services to improve access and waiting times
- Implementation of Mental Health Support Teams (MHSTs) in schools – Sefton has two fully implemented MHSTs which support 40 schools and a third team is coming on line in January 2023
- Availability of 24/7 crisis support and implementation of the 'home based intensive treatment team' to support young people in crisis in their own homes

ASD and ADHD services for children and young people

As with mental health services, demand for ASD and ADHD assessment and diagnostic services increased significantly following the Covid-19 pandemic.

Based on levels of demand in April 2022, the outturn for 2022/2023 was projected as exceeding commissioned capacity by 40% for ASD and 60% for ADHD.

In June 2022, performance for completion of the diagnostic pathway within 30 weeks was 51.9% for ASD and 64% for ADHD respectively. This was against Alder Hey's internal target of 90%. Notably, 100% of assessments commenced within 12 weeks, in line with NICE guidance.

In 2021/22, the CCG agreed additional non recurrent investment to the pathway to increase capacity and reduce waiting times. Ongoing demand will be monitored throughout 2022/23 and reviewed to inform investment decisions moving forward.

In the meantime, the Trust is implementing a service improvement plan which is focusing on staffing structures and operational and pathway efficiencies.

As part of its SEND improvement work and the Sefton Start Well programme, there are plans in place to develop a wider neurodevelopmental pathway to improve pre and post diagnostic support and so work towards providing an offer based on need rather than diagnosis. Currently Sefton children, young people and families with an ASD diagnosis have the opportunity to be supported by a post diagnosis programme. Whilst this is currently a pilot, there are plans to explore funding opportunities to continue with this offer.

Mental health services

Access and recovery within the Improving Access to Psychological Therapies (IAPT) service continues to under-perform, partly due to the effects of the pandemic and partly due to historic issues related to the number of patients starting treatment. It has also been noted that patients entering the IAPT service within Sefton have a higher severity which again affected recovery. Access remains below the 1.59% monthly target at less than 1% per month. Recovery has fluctuated throughout the year above and below the 50% planned value.

Demand for Eating Disorder service continues to increase and exceed capacity. COVID-19 has had a significant impact upon demand, along with the acuity and complexity of patients accessing the service.

For IAPT, Mental Health Matters fell below the national standard target. Performance is being closely monitored through regular meetings with the service. The percentage of people who moved to recovery was 60% in June-22 against the target of 50% and is now reporting above plan. For IAPT six week waits to enter treatment, this measure has now been under target for 8 months. Inherited waits continue to impact performance.

Dementia diagnosis rates remain below the 66.7% target at 60.1% and continue to be affected by the pandemic.

Both IAPT and Dementia, along with other mental health services, continue to be an area of recovery both locally and across Cheshire and Merseyside.

Graham Urwin

Graham Urwin

Chief Executive, Cheshire & Merseyside ICB

29 June 2023

Financial performance

The CCG receives funds from the government to meet the healthcare needs of the population in South Sefton and we have a duty to ensure that high quality and sustainable services are provided within the funding allocated. This is achieved by working in partnership with local health care providers and other organisations. We are firmly committed to working with our partners to transform services to improve efficiency and to ensure we prioritise effective and efficient care for our population so that we use our resources in the best possible way.

CCGs have a duty to operate within their available resources and this is described in our CCG constitution. At the start of each financial year the CCG agrees a financial plan with NHS England and Improvement and contracts with providers of services.

The CCG was disestablished on 30th June 2022 and services transferred to a new organisation; Cheshire and Merseyside Integrated Care Board (ICB). The annual report covers the period April – June 2022.

A temporary revised financial regime was implemented in 2020/2021 in response to the COVID-19 emergency The financial regime for 2022/23 begins the return to the usual financial arrangements.

CCG allocations were revised under the temporary regime but returned to the standard published allocations for 2022/23. The usual contracting guidance and processes with providers was replaced with a standardised approach across England and this remained in place for 2022/23. The CCG's statutory duty to break even for the financial year was unchanged.

The CCG was required to break even for the financial year.

The table below shows the CCG financial performance for the last five years.

At the end of June 2022, the CCG has reported a breakeven position as agreed with NHS England and Improvement.

	2018/19		2019/20		2020/21		2021/22		2022/23 (Q1)	
	Allocation £m	Expenditure £m	Allocation £m	Expenditure £m	Allocation £m	Expenditure £m	Allocation £m	Expenditure £m	Allocation £m	Expenditure £m
Programme	248.26	247.66	256.88	266.79	288.77	289.27	292.61	293.32	73.32	73.32
Programme - Delegated co-commissioning -										
General Medical Services	-	-	22.42	21.62	23.54	23.54	26.08	25.65	5.53	5.53
Running Cost Allowance	3.26	2.86	3.55	3.34	3.13	3.13	3.25	2.97	0.72	0.72
TOTAL	**251.52**	**250.52**	**282.85**	**291.75**	**312.72**	**312.72**	**321.94**	**321.940**	**79.57**	**79.57**
Surplus/ (Deficit) before application of NHS England reserves		**1**		**-9**		**0**		**0**		**0**

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

Summary Financial Performance 2021-22	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	✓

The CCG is required to assess and satisfy itself that it is appropriate to prepare financial statements on a 'going concern' basis for at least 12 months from the date of the accounts.

We have made an assessment of factors affecting the CCG and we have concluded that:

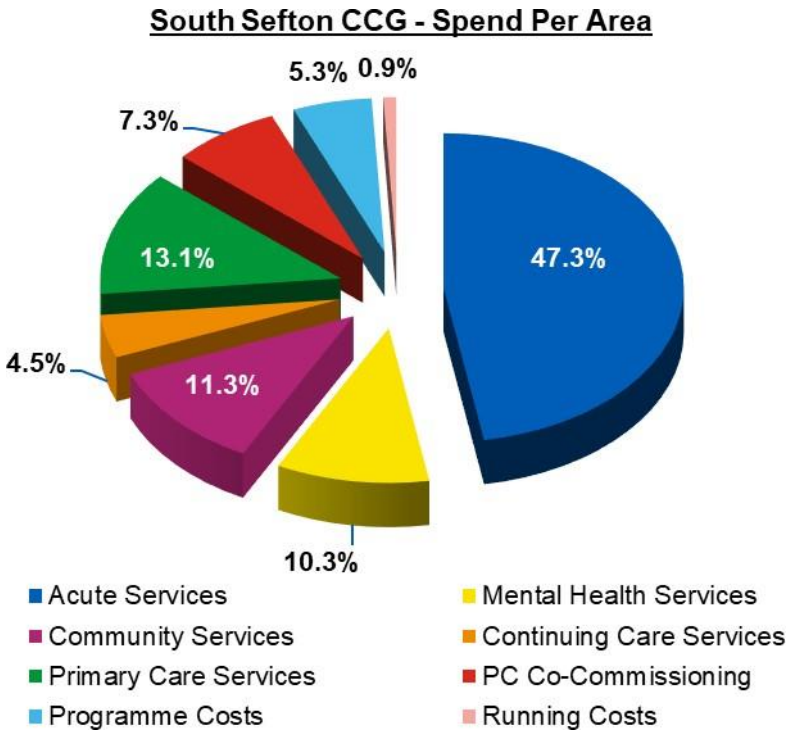
a. Healthcare services will continue to be provided for the residents of south Sefton for the indefinite future
b. We have appropriate management capacity and capability to implement our CCG long term financial strategy
c. We have a robust risk management strategy and processes in place.

The NHS planning guidance described an increased focus on working together with partner organisations across Cheshire and Merseyside on a system based approach for delivery of services and financial management across the health economy. CCGs and NHS providers within Cheshire and Merseyside have worked together to agree a system financial plan to ensure available resources are used efficiently and effectively to deliver the plan as required and meet statutory duties.

Our CCG finance team is a key enabler in supporting business transformation. There is a strong focus on continuous development and training to ensure the team remains 'fit for purpose' as business partners to the CCG and the wider local health economy. During the year the finance team has continued to ensure that the services it provides are of the highest standard. The team are active participants in the North West Skills Development Network and access the resources available through the network to continually develop skills. The team is a Future Focused Finance Accredited Employer at Level 2 and also hold the Finance Skills Development North West - Towards Excellence - Level 2 Accreditation.

Analysis of funding and expenditure

During 2022-2023 (April 22 – June 22), the CCG received £79.570 million of parliamentary revenue funding. A breakdown of this funding and how it was used is reported in the table below:



Area	Total Costs (£000s)
Acute Services	39,098
Mental Health Services	8,510
Community Services	9,336
Continuing Care Services	3,721
Primary Care Services	10,815
PC Co-Commissioning	6,063
Programme Costs	4,400
Running Costs	720

Our main areas of spend were as follows:

Acute Services (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. Other services commissioned by GPs and primary care contractors are included, for example, out of hours services and GP IT costs, along with costs relating to GP clinical leadership undertaken on behalf of the CCG.

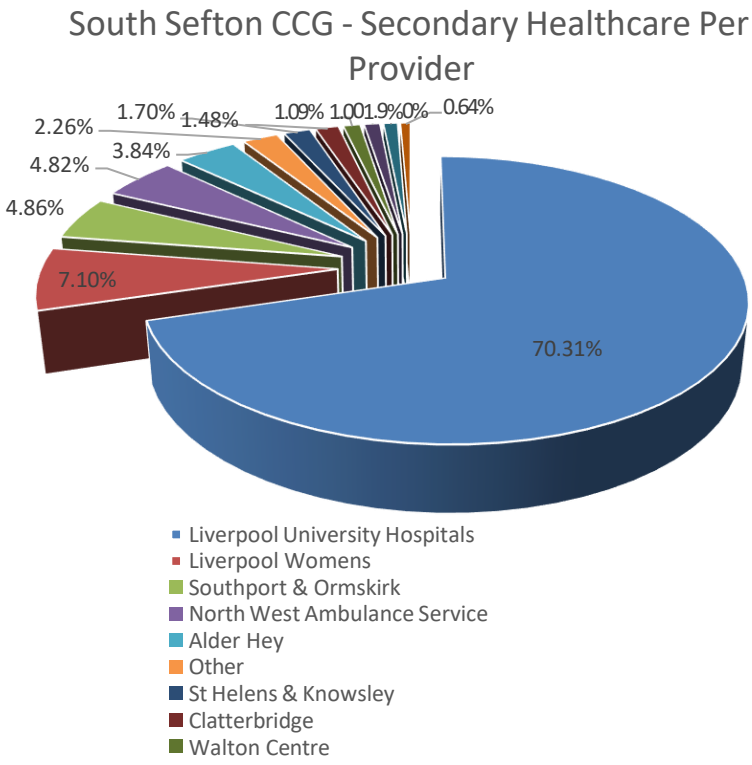
The CCG is also responsible for delegated co- commissioning of Primary Care – General Medical Services.

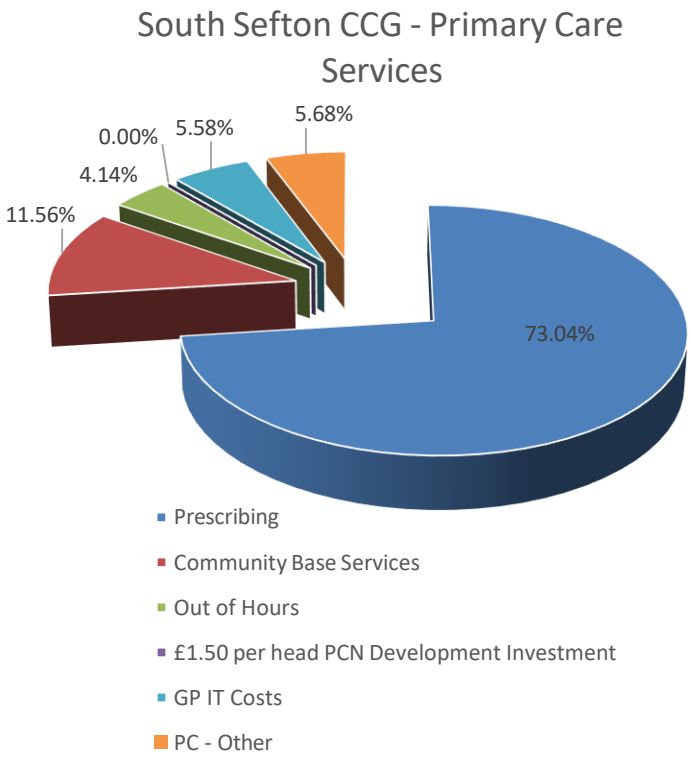
Community Services costs – this relates to the costs of services provided in a community setting for example, district nursing, physiotherapy and community clinics.

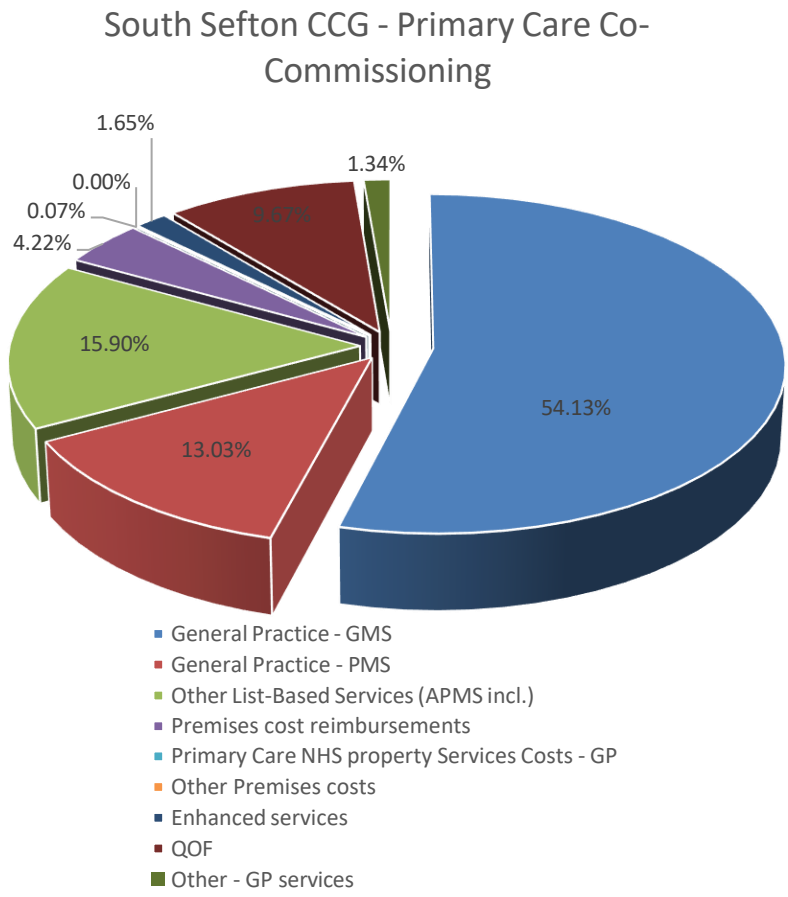
Continuing Health Care services – this is a package of care arranged and funded by the NHS for individuals not in hospital and assessed as having a 'primary health need'. It also includes long term packages of care for people at home, in nursing homes and residential care.

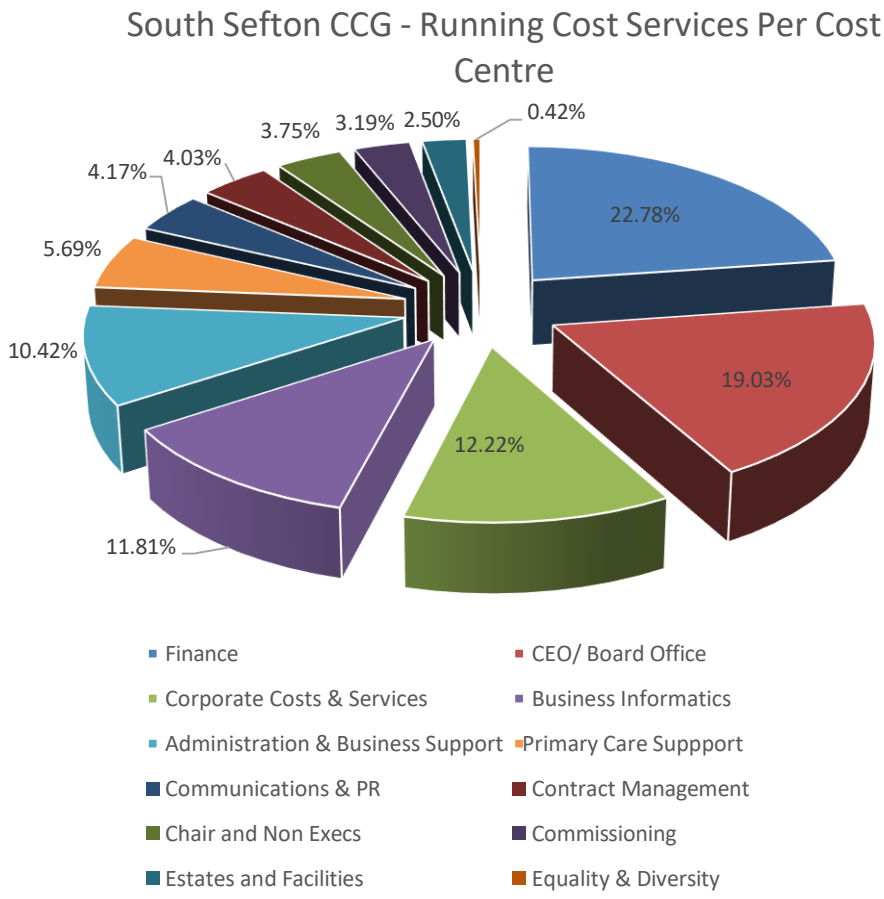
Programme costs – this category of spend mainly refers to non-acute services such as reablement and other mental health services.

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




South Sefton CCG - Primary Care Services
5.68%
5.58%
0.00%
4.14%
11.56%
73.04%
Prescribing
Community Base Services
Out of Hours
£1.50 per head PCN Development Investment
GP IT Costs
PC - Other


South Sefton CCG - Primary Care Co-Commissioning
1.65%
1.34%
0.00%
0.07%
9.67%
4.22%
15.90%
54.13%
13.03%
General Practice - GMS
General Practice - PMS
Other List-Based Services (APMS incl.)
Premises cost reimbursements
Primary Care NHS property Services Costs - GP
Other Premises costs
Enhanced services
QOF
Other - GP services



Better payment practice code

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

	2021-22		Q1 2022-23	
	Number %	Value %	Number %	Value %
Non-NHS Payables	**95.13**	**97.76**	**94.73**	**94.73**
NHS Payables	**95.14**	**99.79**	**91.60**	**99.55**

Percentages are calculated by taking the total number / value of paid invoices / credit notes and dividing this by the total number / value payable.

Monitoring and ensuring quality

The Quality team plays an important role ensuring services commissioned by the CCG are safe, effective, high quality and reflect the voice of people who access them to ensure the services meet the needs of the population.

The team works to promote a culture of openness and transparency where incidents and errors occur, and to nurture a culture of improvement across the health and social care community in Sefton. As such, the team places the needs of people at the centre of all its work to ensure that we learn from people's experiences, and we make it a priority to maintain a focus on high quality patient care and outcomes. We have robust processes and governance arrangements to provide our Governing Body with assurance relating to the quality and performance of the services we commission

As outlined in the Health and Social Care Act 2012, we have a duty to ensure improvement in the quality of our services. In order to fulfil this duty, during 2021-2022 we have ensured that the established mechanisms remain robust, to ensure that high quality and safe care is commissioned and maintained. The CCG utilises information that can be triangulated from a number of sources to monitor quality and safety of services these include; performance information, Care Quality Commission (CQC), Ofsted Sefton Healthwatch reports, incident reporting including serious incidents, safeguarding alerts and concerns, feedback from users of the services e.g. complaints, whistleblowing, Friends and Family Test. The CCG has a number of mechanisms by which it addresses the quality of services. These are listed below:

Quality Performance Group meetings and Contract Quality Review meetings

As part of the contractual process, Contract Quality Performance Group Meetings (CQPG), Contract Quality Review Meetings (CQRM) and Contract Commissioning Quality Review Meetings (CCQRM) are held with our acute, community and independent providers. The CQPG / CQRM / CCQRM meetings focus on quality, providing an opportunity to review areas for improvement and good practice and to monitor any improvement plans in relation to the requirements laid out within the NHS standard contract.

Quality is a key item within the contract meetings for the services whom South Sefton CCG are the lead commissioner; Southport and Ormskirk Hospitals NHS Trust, Renacres Hospital, DMC Health Care and iSIGHT Clinic. In addition, the CCG supports the quality agenda alongside colleagues across the Merseyside CCGs. The CCG contributes to the established Collaborative Commissioning Forums for NHS Mersey Care NHS Foundation Trust, Liverpool University Hospitals NHS Foundation Trust, Alder Hey Children's Hospital NHS Foundation Trust and Liverpool Women's NHS Foundation Trust. These are services where the lead commissioning organisation is NHS Liverpool Clinical Commissioning Group (Liverpool CCG). This allows time for a more detailed quality discussion and action setting. These meetings provide robust mechanisms where commissioners and providers work together to identify and strive to meet standards that will serve to deliver services for the population of south Sefton.

As part of the CQPG arrangements, Mersey Care NHS Foundation Trust has been placed on enhanced surveillance. This is normal process due to the merger of the trust with North West Borough's NHS Trust which took place in June 2021. A single CQPG is in place which includes both community and Mental Health services, separate contract meetings for individual CCGs.

Liverpool University Hospitals NHS Foundation Trust continues to be on enhanced surveillance following the merger of Aintree University Hospitals NHS Foundation Trust and the Royal Liverpool and Broadgreen University Hospitals NHS Foundation Trust. The CQC section 31 notice remains in place which was issued to the trust in July 2021. In addition the trust was

placed on segment level 4 of the NHS England and Improvement (NHS EI) Oversight Framework. The segmentation level indicates the scale and general nature of support the trust requires, level 4 indicating mandated intensive support. Wider system support continues to be in place via the System Improvement Board (SIB) which is led by NHS England / Improvement Cheshire and Merseyside, to support and monitor improvements.

Contract monitoring arrangements continue in their normal format as part of the restoration following the COVID-19 national legislation. However, CQPGs, CQRMs and CCQRMs have continued in a virtual format to support commissioned organisations in relation to; hospital discharges, discharge avoidance, nosocomial infections, infection and prevention control, safe staffing and patient safety.

Commissioning for Quality and Innovation

The Commissioning for Quality and Innovation (CQUINs) payments framework was set up in 2009-2010 to encourage service providers to continually improve the quality of care provided to patients and to share a transparent process with commissioners. CQUINs enable CCG commissioners to reward excellence, by linking a proportion of service providers' income to the achievement of national and local quality improvement goals.

From April 2022/23 the scheme is being reintroduced for providers that are within the scope of the Aligned Payment and Incentives (API) rules, as set out in the National Tariff.

NHS England and NHS Improvement (NHS EI) identified a small number of core clinical priority areas, where improvement is expected across 2022/23. These are short-term clinical improvements that have been selected due to their ongoing importance in the context of COVID-19 recovery. Where there is a clear need to support reductions in clinical variation between providers.

All clinical processes and methods are already being adopted nationally. Their inclusion in CQUIN is to draw attention to their benefits, and to harness the experience of existing adopters to accelerate uptake

Quality review visits

These are undertaken on an ad-hoc basis within provider organisations when the CCG has persistent or increasing quality concerns identified. These visits provide intelligence to gain assurance that there are robust measures in place within an organisation, to ensure that high quality care is in place, or identify areas where improvement is required. The reviews are conducted by a small clinical team from the CCG using a set criteria based on Care Quality Commission (CQC) standards to assess the standard of care, staffing and patient experience.

No focused quality visits took place across the CCG commissioned services during the period April 2022 – July 2022. Quality visits will be reviewed in 2022-2023.

Quality risk profile

This tool enables commissioners, regulators and providers to come together to share and review information when a serious concern about the quality of care has been raised. This process facilitates rapid collective judgements to be taken, actions agreed and a level of enhanced surveillance implemented effectively.

No Quality Risk Profile (QRP) or single item quality safety group meetings convened during the timeframe for any of the CCGs commissioned services.

Joint Quality and Performance Committee

In previous years the CCG had a Joint Quality and Performance Committee (JQPC) with NHS Southport and Formby CCG, as a sub-committee of our Governing Body. Its membership included our Governing Body Lay Member for Patient and Public Involvement. The committee provided us with assurance in relation to the quality of the systems and processes that have been established by the organisation.

The JQPC includes regular reports on complaints, serious incidents, 'never events' and safeguarding, to identify trends and themes across commissioned services. The committee also reviews inspection reports from regulatory bodies e.g, Care Quality Commission (CQC). Our cross sector Engagement and Patient Experience Group reports directly to JQPC, providing further assurance around the services we commission. You can read more about this group on page 75.

Due to expected transition from CCG to the Integrated Care System (ICS), a review has been undertaken of the CCG governance arrangements during 2021/22. JQPC was stepped down in year with the last meeting taking place in November 2021. Reports that would have been submitted to JQPC are being submitted to the CCG's Senior Leadership Team (SLT). SLT is a committee comprising members of our Governing Body, and includes membership from our lay member for Patient and Public Involvement (PPI) and lay member for governance.

Quality Surveillance Group

A network of Quality Surveillance Groups (QSGs) have been established across the country to bring together different parts of health and care systems locally and in each region of England to routinely share information and intelligence to protect the quality of care patients receive. The information includes NHS commissioned health services and independent providers including care homes. Over the past year, we have played an active role in the Merseyside and Cheshire QSG which meets on alternate months. This has included highlighting;

- NHS commissioned maternity services in relation to safe services for pregnant women and their babies. This relates to the learning and recommendations from the Ockenden Report (2020)
- The safe prescribing of anti-epileptic medication for women of child-bearing age, and the safe insertion of surgical mesh for women suffering from urinary incontinence. This relates to the Baroness Cumberledge Report – First Do No Harm (2020)
- The management of the NHS Continuing Healthcare framework in line with the statutory guidance.

The local health economy still has challenges to meet to improve the quality of patients care. These are to:

- Reduce levels of harm in the event of serious incidents, in particular 'never events'.
- Reduce Healthcare Acquired Infections (HCAI's) in particular C difficile and Gram-negative Bacterium
- Achieve the four-hour A&E standard and eliminate corridor care
- Promote patient dignity by eliminating mixed sex accommodation breaches
- Reduce the waiting times following a GP referral to treatment

- Ensuring no patient harm occurs whilst patients are waiting to be seen and or waiting for treatment.

We continue to be an active member of this group and contribute to the discussion regarding the future role and function of QSG.

Single Item Quality Surveillance Group

If quality concerns arise within a single organisation based on an outcome of a review of soft intelligence, with support from NHS England we will convene a Single Item Quality Surveillance Group (SI QSG). The aim of the meeting is:

- To gain a collective understanding of the issues
- To gain assurance that the organisation will develop a coherent, robust and sustainable plan to mitigate risks and progress improvements at pace
- To discuss and agree any offers of support from commissioners
- Consider any additional implications

No SI QSGs have taken place during April 2022 – June 2022.

Safeguarding

Our safeguarding service continues to support the CCG to discharge its statutory responsibilities to safeguard the welfare of adults and children at risk of abuse, and children in care and to ensure that the health services it commissions are also compliant in this respect. CCGs are also required to demonstrate that they have appropriate systems in place for discharging their statutory duties in terms of:

- Ensuring there is a clear line of accountability for safeguarding, properly reflected in the CCG governance arrangements, i.e. a named executive lead to take overall leadership responsibility for the organisation's safeguarding arrangements.
- Clear policies setting out the commitment, and approach, to safeguarding including safe recruitment practices and arrangements for dealing with allegations against people who work with children and adults as appropriate.
- Training staff in recognising and reporting safeguarding issues, appropriate supervision and ensuring that staffs are competent to carry out their responsibilities for safeguarding. Bespoke training sessions have been developed and delivered virtually during this period in respect of key messages for primary care and a briefing in respect of local profile of Safeguarding in Sefton to supplement e learning courses.
- Effective safeguarding partnership arrangements that set out how the statutory safeguarding partners (police, local authority and clinical commissioning group), alongside other relevant partners, will work together as Sefton Safeguarding Children partnership (SSCP)
- Appropriate arrangements to cooperate with local authorities in the operation Sefton Safeguarding Adult Board and Corporate Parenting Panel
- Employing, or securing, the expertise of Designated Doctors, Named GPs and the Designated Nurses for Safeguarding Children and for Looked After Children and the Designated Safeguarding Adult Manager.

Sefton Safeguarding Adults Board

The Sefton Safeguarding Adults Board (SSAB) has a statutory responsibility to:

- Ensure effective arrangements for information sharing
- Effective systems for responding to abuse and neglect of adults
- Support the development of a positive learning culture across partnerships for safeguarding adults to ensure that organisations are not unduly risk avers
- Undertake Safeguarding Adult Reviews where the criteria are met

New arrangements in response to the disbanding of the Merseyside Safeguarding Adults Board came into place in 2021-2022. The CCG supported the development of Sefton Safeguarding Adults Board (SSAB) and its sub-groups. In line with its statutory requirements, SSAB have a process in place to review and approved Safeguarding Adult Reviews. The CCG has continued to support these new arrangements during the period that this report covers.

Sefton Safeguarding Children Partnership

New arrangements, in response to the Children and Social Work Act 2017 and Working Together 2018, replaced Local Safeguarding Children Boards (LSCB) with new local multi-agency safeguarding partnership arrangements were introduced in Sefton in September 2019.

A further review and strengthening of the arrangements were completed in September 2021 resulting in the new Sefton Safeguarding Children Partnership and its subgroups. These new arrangements have continued throughout the period that this report covers.

Corporate Parenting Panel

In Autumn 2021, Sefton's Corporate Parenting Board was remodelled into a Corporate Parenting Panel. The rationale behind the remodelling was to make the board less formal and more interactive for young people attending, with a focus on how members, as corporate parents, can drive forward priorities for children in care. To achieve this, the membership was reduced to include a core group and working groups formed to progress the identified key priorities of:

- Health and wellbeing
- Transition and preparation for adulthood
- Safe and stable homes
- Being heard
- Raising aspirations

These new arrangements have continued throughout the period that this report covers. The Deputy Chief Nurse and the Designated Nurse Children in Care remain members of the Panel as well as the Designated Nurse chairing the health and wellbeing working group.

Sefton Safer Together

We are a statutory member of Sefton Safer Together (previously known as Sefton Safer Communities Partnership), which has a clear priority for partners in Sefton to ensure the safety of the residents in Sefton. As a partnership, organisations across the borough of Sefton to work towards reducing crime and reassuring communities. The CCG has supported the work of the

Sefton Safer Community Partnership in the learning from Domestic Homicide Reviews in highlighting best practice and learning from individual reviews.

Domestic Abuse Partnership Board

Following the enactment of the Domestic Abuse Bill in April 2021, Local Authorities were required to establish a Domestic Abuse Partnership Board. Within Sefton, the previously established Domestic Abuse Executive evolved to the new Board in September 2021.

Membership from the CCG is through the Safeguarding Service and focus since September has been on the development of a robust Domestic Abuse Needs Assessment to identify and understand the needs of domestic abuse victims and their children within Sefton.

During the period that this report covers we have continued to support system wide learning through involvement in Domestic Homicide Reviews, Child Safeguarding Practice Reviews, Safeguarding Adult Reviews, Child Death Overview Panels and Serious Incident Panels.

Oversight and monitoring of progress continues against action plans from these reviews, as well as those arising from Safeguarding Inspection Frameworks including Care Quality Commission, Joint Targeted Area Inspection and SEND.

Harm Review Process

The pandemic has resulted in the waiting times from referral to treatment time increasing, with a particular focus on restoration, recovery and patient safety. Trusts are revising the waiting lists in-line with re-prioritisation process and the Cheshire and Merseyside (C&M) Long Waiter Quality Principles. Liverpool University Hospitals NHS Trust (LUHFT) has been reviewing the longest waiting patients for each specialty with no harm being identified. The trust has also reviewed their Harm Review standard operating procedure to incorporate the C&M Long Waiters Harm Review quality principles. The CCG continued to monitor the implementation of the harm review process and seek assurance for any harms that may occur.

Adult Continuing Healthcare (CHC)

NHS Continuing Healthcare is a package of care solely funded and arranged by the NHS where the individual has been found to have a 'primary health need' as set out in the national framework for NHS Continuing Healthcare & NHS-funded Nursing Care (2018 and as updated in 2022). Such care may be provided to an individual aged 18 years and over in order to meet needs that have arisen as a result of illness, accident or disability. This is a complex area requiring a specific skill set to ensure individuals needs are appropriately assessed and reviewed. Much of our work has focussed on improving our performance in relation to the national standard of ensuring individuals are assessed and receive a decision on their eligibility for NHS Continuing Healthcare within 28 days. This has meant close working with our two main providers responsible for assessing and reviewing individuals namely Midlands & Lancashire Commissioning Support Unit and Mersey Care NHS Foundation Trust.

We have also been working closely with Sefton Council in terms of training social workers so that they can complete the first stage of the NHS Continuing Healthcare which is the checklist. The positive benefit of undertaking this training with our social care colleagues is that there is now a reduced waiting time for individuals to have a checklist completed for the first stage of the screening process for NHS Continuing Healthcare & NHS-funded Nursing Care through more staff having been trained to undertake this function. We have also improved our oversight of the processes involved and now have a designated post that carries out this function. This role supports our commitment towards continuous improvement in terms of the assessment and review service which both Midlands & Lancashire Commissioning Support Unit and Mersey Care NHS Foundation Trust deliver on our behalf.

Robust governance in regards to delivery of NHS Continuing Healthcare is exercised by the Individual Patient Activity Clinical Quality & Performance Group. Membership of this group is drawn from provider organisations and local authority with the target aims of;

- Focussing on patient and carer experience of NHS Continuing Healthcare;
- Ensuring that assessments take place at the right time and place
- To identify best practice in the delivery of NHS Continuing Healthcare services
- To aspire to the best of national standards in terms of service delivery
- To ensure we are making the best use of resources thereby offering better value for the population
- Strengthening our alignment to the NHS England programmes of work that contain an NHS Continuing Healthcare component, for example choice and personalisation, and the development of the All Age Continuing Healthcare vision

Going forward, we recognise there is still much to do in the area of NHS Continuing Healthcare for our population and we remain committed to ensuring we deliver on providing the very best NHS Continuing Healthcare service possible for those that we serve.

Special Educational Needs and Disabilities

Sefton Council has a duty to assess the Special Educational Needs and Disability, known as SEND, of children and young people and provide appropriate services. We have a duty to cooperate in the delivery of these services across our CCG area. and there is a SEND partnership and governance framework in place to support this. The CCG has continued to make improvements in these services led by the SEND Continuous Improvement Board (SENDCIB). This work has resulted in the Improvement Notice that was issued in 2016 being lifted in July 2021.

The CCG continues to convene and chair the monthly SEND health performance improvement group. Its membership comprises representatives from our quality and commissioning teams, our commissioned providers, Sefton Council, Sefton Parent Carer Forum and the voluntary, community and faith (VCF) sector. This group reviews the health performance and actions from the joint health and social care SEND improvement plan, to hold members to account on performance and outcomes. This group reports directly through to the SEND Continuous Improvement Board. The CCGs SEND health performance improvement group receives case studies as examples to share with health partners, which have also been presented to CCGs Governing Body and Joint Quality and Performance Committee in year. These case studies demonstrate the improvements to services and outcomes for children young people and their families ensuring the voice and lived experiences of children and families in south sefton are central to decision making.

The CCG continues to be represented as core membership at the Local Authority SEND Continuous Improvement Board, Senior Leadership Team and Performance Subgroup. The SEND Continuous Improvement Board continues to receive health performance data and updates as part of the SEND improvement plan. The Designated Clinical Officer continues to chair the Co-production sub group of the SENDCIB to support the involvement, engagement and co-production of service development and improvement of children and families with representatives from Sefton Parent Carer Forum.

The CCG is working collaboratively with the local authority to implement the revised improvement plan and performance dashboard, now that the improvement notice has been lifted. This is strengthened by the work of Sefton's 'Start Well Programme' and steering group, an integrated workstream with the Local Authority that has identified and agreed the improvement and development priorities for Children's and Young People's commissioned services across Sefton. This includes a number of SEND related priorities, including the development of an All Age Autism Strategy.

In addition, as part of the Transforming Care Programme there are development and improvement workstreams in progress across national, regional and the wider Cheshire and Merseyside footprint.These will also support and influence SEND developments at a local level.

Despite the ongoing impact of COVID-19 on increasing demand for a number of SEND related services, the sustained improvements and developments that led to the Improvement Notice being lifted will continue to be delivered and further developed. Notably:

- Sustained reduction in waiting times for Occupational Therapy and Dietetics .
- Successful implementation of a Sensory Occupational Therapy service in January 2022, to increase education and support to parents/carers, schools, nurseries and professionals.
- Ongoing review and improvement to the Autistic Spectrum disorder (ASD) pathway, including requirement for additional CCG investment to address increasing demand for assessment, which will be further reviewed in 2022/23. Local plans also include the development of an All Age Autism Strategy to inform wider pathway development.
- Introduction and expansion of an ASD diagnostic pilot to support parents/carers and young people. This will be reviewed in 2022/23 to inform future commissioning plans.
- Additional national and CCG investment to address increasing demand and waiting times for Children and Adolescent Mental Health Services (CAMHS). Further work continues to be undertaken to develop and expand provision in line with the Long-Term Plan, Sefton's Children and Young People's Emotional Health and Wellbeing Strategy.
- Ongoing review of quality and timeliness of initial health assessments, to ensure continued improvement.
- Improvements in the timeliness and quality of health advices, the outcomes of which contribute to the education, care and health care plans for children, including those who are looked after.
- Strengthening of the Designated Clinical Officer (DCO) for SEND arrangements, including visibility amongst health and education system partners.

There has been a direct impact on the waiting times for SEND related service, including CAMHS as a result of COVID-19 (see Children and Young People performance update, page 24). This reflects local and national pressures across these services. Recovery and improvement plans have been established and implemented as required, as part of performance and contracting arrangements.

Through the CCGs SEND, contract and Integrated Performance Review governance processes, commissioners continue to closely monitor service performance and waiting times. Working closely with NHS providers, partners and the wider system to collectively address the ongoing waiting times pressures and challenges.

Learning from Lives and Death – People with a learning disability and autistic people

The learning from deaths of people with a learning disability (LeDeR) programme was set up as a service improvement programme by NHS England. It looks at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and or people with autistic spectrum disorder, and reduce health inequalities.

Since May 2021 the program is inclusive of learning from death of people with a diagnosis of autistic spectrum disorder (ASD). People with ASD were eligible for a review from 1 January 2021. The programme requires all people with a diagnosis of a learning disability or ASD from the age of 4 years, to have a review into the circumstances of their death. With the aim of the programme:

- To identify key learning to support increased quality of care and service delivery for people with a learning disability.
- To prevent avoidable deaths of people with a learning disability or ASD

The LeDeR programme is co-ordinated by the CCG Local Area Contact (LAC) and Deputy Local Area Contact across three of the north Mersey CCGs (Liverpool CCG, South Sefton CCG, Southport and Formby CCG).

During April 2022 – June 2022 the CCG has been supporting the transfer of the management of LeDeR across to the Integrated Care Board (ICB).

Quality impact assessments

The CCG has a Quality Impact assessment (QIA) process in place to facilitate consideration of the consequences and possible impacts on quality related to commissioning decisions, business cases and any other business plans. This would include service commissioning and decommissioning services, quality innovation productivity and prevention (QIPP) schemes, service developments and improvement plans.

QIAs are undertaken as part of the development and proposal stage and are reviewed on a regular basis by the identified project lead. The impact is considered throughout the implementation stage and during the final review after the business plan has been implemented. It also allows for preventative action to be taken to mitigate against any risks identified.

The process continues to be in place during the period of this report to ensure a consistent application across all commissioning decisions. This ensures improved risk mitigation and quality monitoring across all commissioned services.

Care homes and independent care sector

During April 2022 – June 2022 the Quality and Safeguarding team, have continued to work collaboratively with Sefton Borough Council (Sefton MBC) to support:

- Quality and safeguarding concerns in care homes
- Monitoring the impact of COVID on staffing levels in care homes

We have oversight of the capacity tracker which provides live data on available beds, staff, COVID vaccination status of both staff and resident in care homes. This has allowed us in conjunction with the local authority to provide the required support to care homes if issues arise. It also permitted the health ecosystem to understand the availability of beds in care

homes, supporting discharge planning from acute services to be arranged appropriately to meet the needs of patients.

Joint working continues between the Local Authority as per the three year joint Integrated Care Home Strategy in all areas relating to care home provision of services in order to promote early intervention and defines the models of care to be provided for care home residents.

We continue to support the local authority at the care home provider engagement group which was set up in 2021 - 2022. To support care home providers to share learning and challenges. The care home providers have used this group to work in partnership across Sefton and escalate issues to aid swift resolution of issues. The joint working amongst all partners ensures continues improvement in the delivery of high quality of care for the residents of Sefton living in care homes.

Infection and Prevention Control (IPC) and Health Care Acquired infections (HCAI)

During April – June 2022 there has remained a significant focus on IPC, following the updated guidance on infection control measures required.

National guidance was published with trajectory's set for HCAI's, which includes but not limited to Methicillin-resistant staphylococcus aureus (MRSA), Gram Negative bloodstream infections (GNBSI) and Clostridium Difficile, this was shared with all commissioned organisations who report both nationally and locally the performance.

The antimicrobial resistance (AMR) Joint Oversight board remains in place with scheduled meetings are on a 6-weekly basis with approved terms of reference. An associated work plan based on the NHSE national template under development to maintain oversight of and local place-based collaboratives work plans, that are reflective of current priority areas for Cheshire and Merseyside

The North Mersey GNBSI group continues led by the CCG Programme Manager for Quality and Performance. The purpose of the group is to gain assurance that all providers, local authorities, and CCGs across the area can develop systems and processes to reduce preventable infections. The CCG in partnership with other CCG areas across Cheshire and Merseyside have submitted a bid to the national team to take place in a hydration pilot, to support research into the reduction of incidences of GNBSI. The bid was successful and the pilot will commence in Winter 2022.

Serious Incidents – reporting

The CCG continue to manage serious incident reporting in accordance with the National Serious Incident Framework and ensure this is interpreted locally. During the time period covered by this report we have continued to scrutinise all incidents at the CCG Serious Incident Review Group (SIRG) for all cases meeting serious incidents threshold. To ensure root causes are identified, actions implemented, and lessons have been learnt. The CCG quality team supports the SIRG in NHS Liverpool CCG, where serious incidents are managed from key NHS services across Sefton where NHS Liverpool CCG is the lead commissioner.

During 2021-2022, there were a series of surgical Never Events that had resulted in harm to patients that had occurred across Liverpool University Hospitals NHS Foundation Trust. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. We have been supporting the trust and Liverpool CCG in the oversight and assurance from the trust action plan, to ensure effective risk management and governance systems are in place to mitigate and prevent further occurrence.

The CCG has an identified Patient Safety Specialist, who is part of the quality team. This is a national requirement for all NHS organisations as part of the NHS patient Safety Strategy. The CCG Patient Safety Specialist will have oversight of and provide support for patient safety activities across the commissioned organisations. Part of the role will be to ensure that systems thinking, human factors and 'just culture' principles are embedded in all patient safety activity.

Screening

Our quality team continues to work collaboratively with Public Health England's screening and immunisation and cervical screening teams to support their on-going programmes of work. Cervical screening has been adversely impacted by the pandemic in terms of individuals accessing screening.

The national cervical screening target for practices is to ensure that 80% of eligible individuals participate in the screening programme.

During Q1 of 22/23 practices in NHS South Sefton CCG reached a target of 69.3%.

Now practices have returned to business as usual, it is understood that access has been an issue for patients during the Covid Pandemic and practices are working hard to ensure any screening appointments missed are followed up and appointments sent out. We also have our GP Federations offering Cervical Screening appointments within extended access hours as part of the measures to increase uptake across south Sefton.

Primary Care

The CCG has delegated authority from NHSE/I to commission primary care medical services from our GP practices. Merseyside Internal Audit Authority (MIAA) conducts internal audits CCGs with this delegated authority to provide assurance that they are discharging NHSE/I's statutory primary medical care functions effectively. In 2021, MIAA provided us with an overall assurance rating of 'Full Assurance'.

Maintaining Quality in Primary Care

2022/23 continues to see general practice adapting to support the pandemic response, whilst also administering the COVID-19 vaccination programme, the largest vaccination programme in the history of the NHS.

The pandemic has resulted in unprecedented demands on general practice, practices have remained open, providing safe patient access by careful appointment planning to minimise waiting times and maintain social distancing. General practice implemented a remote triage model, where clinicians determine the most appropriate consultation, either telephone, video or face to face. E-consult has remained available as a flexible way for patients to access their practice.

A survey was developed by the CCG and promoted by individual GP practices in order to gain patient views on access to general practice throughout the pandemic.

Acute Visiting Scheme

An acute visiting service to support the treatment of patients in their own homes has been available to patients registered with a South Sefton GP practice. Patients who contact their practice requesting a home visit will be triaged and where appropriate will be booked into the service. The service has a range of clinicians including Advanced Nurse Practitioners, Paramedics and GPs.

7-Day Access

A 7-day access service providing routine primary care in the evenings and weekends is operational from Litherland Town Hall. Patients can access this service through their GP practice. There are a range of clinicians/ services available including first contact physiotherapy.

Local Quality Contract

One of the ways we work to improve the quality of primary care is through our Local Quality Contract (LQC), which our member practices can choose to sign up to.

There are several schemes within the contract to support quality improvements, efficiencies in spend elsewhere in the health economy, and the sustainability of general practice.

Examples include the provision of phlebotomy in a primary care setting, public health interventions to promote screening and vaccination uptake, supporting patients who are carers and schemes that focus on medication management.

Learning Disabilities

In June 2022 Sefton Place were successful in securing a bid for funding a project to focus on those patients with learning disabilities who have not accessed an annual health check in the previous twelve months. Two registered nurses were recruited initially to support the planning of the programme.

Ukraine

The CCG worked collaboratively with Sefton Local Authority and voluntary and community sector organisations to support the health and wellbeing needs of individuals and families arriving in Sefton under the Ukraine Family or the Ukraine Sponsorship (Homes for Ukraine) schemes. Processes were put in place to ensure that people arriving could register with a GP practice to access services appropriate to their health needs.

Primary Care Networks

Further developments of Primary Care Networks (PCNs) have taken place encouraging collaborative working and supporting primary care at scale. There is one PCN in South Sefton, all GP practices in South Sefton are a member of the PCN.

Alongside the COVID-19 vaccination programme, the PCN has continued to run several other schemes to support patients in the local area, including utilisation of a pharmacy hub to support with medicine management in practices, and working collaboratively with our voluntary sector organisations to have social prescribing link workers across each PCN to support patients. Throughout the pandemic, PCNs have focused upon the delivery of a national PCN Direct Enhanced Service (DES), which includes a scheme to enhance the health of residents in care homes.

From April 2022 the PCN have been making preparatory arrangements for Enhanced Access. The 'Enhanced Access' model of care is a national development to offer patients access to general practice services in the evenings Monday to Friday and on a Saturday 9am to 5pm. Enhanced Access will replace the 7-Day Service in October 2022.

The PCN will continue to recruit under the Additional Roles Reimbursement Scheme (ARRS) in line with the national PCN DES guidance.

BP at Home

BP @Home is a national programme introduced into general practice as a new way of working. During the pandemic face to face consultations were restricted and this programme ensures that patients can take an active part in self-care by monitoring their Blood Pressure and sending reading back to the practice and their clinical records via digital means, text messages and digital templates. Electronic blood pressure machines are offered free to patients who have agreed to self-monitor in this way. This in turn frees up face to face appointments for those whose need is greatest, whilst ensuring that clinical staff still have oversight and can manage patients appropriately.

Cheshire and Merseyside Happy Hearts website has information about managing your blood pressure available on this link

Cheshire & Merseyside Happy Hearts | Blood Pressure (happy-hearts.co.uk)

Video consultations

Before the pandemic the primary care team were looking at embracing digital technology to help better manage patient flow and ensure equality of access to more vulnerable groups. Video Group Consultations were starting to be delivered. It was a way of seeing a certain group of patients with the same condition in a group consultation with the clinician available to offer advice and guidance about the condition. The GP can also answer any questions, discuss blood results and improve levels of control i.e., Blood Sugars for those with Diabetes or Cholesterol for those with Heart Attacks or Strokes.

This method of communication with patients is being promoted with patients and is now seen as another useful tool in improving patient care and access to health care professionals. Equipment has been provided to clinicians to support this way of working and education sessions have been made available for staff to enhance their skills.

People in the video groups have agreed to ensure everyone's confidentiality prior to each session. Feedback has been good with the groups saying they were uncertain at the beginning but found the experience to be good, finding out they are not the only person with similar problems, and the group dynamic helped to persuade people to care for themselves better. It was also time saving as they can access from home or work and saved time traveling, thereby being a more flexible way to consult.

Here is a link to more information about video group consultations, Have you heard about Video Group Clinics? - Subtitles - Bing video

Workforce Update

It is recognised that the clinical workforce is key to ensuring patients are cared for appropriately. Now the pandemic crisis is nearing an end we realise that many staff who had come out of retirement will return to retirement and many more burnt out by the experience will join them.

Primary Care are looking toward Primary Care Networks to support the growth of staff into primary care via the Additional Roles Reimbursement Scheme. But we continue to need Nurses and GPs which are by far the greatest numbers of workforce in primary care. There are several initiatives across our Sefton Place supporting the apprenticeship route into administration and Clinical roles. New Roles are becoming established in primary care, Physicians Associates, Nursing Associates, Mental Health Practitioners, Social Prescribers and Care Co-ordinators, many working across practices within their primary care network, providing specialist care to different groups of patients, housebound, care home, learning disability, and mental health, all being provided with additional support to better manage in their community and home settings.

GPs new to Primary care following their specialist education have access to a GP Fellowship programme, and Nurses too can access a GPN Preceptorship programme that supports their first year ensuring they have the necessary knowledge and skills to work in primary care. We also link with our local Universities to support placement development so that students of health professions can get a credible experience of primary care, so they consider their career path in the future being in this area.

Protected Leaning Time (PLT)

Protected Learning Time events both online and face to face. Meetings are now monthly, and the online platform has proven to be a good way of increasing access to the events, there is no travelling required and access is easy from each clinician's laptop, desktop computer or their mobile phone. Attendance has increased from our previous face to face meetings. More recently, since the height of the pandemic, patient demand has increased and clinicians are busy trying to catch up with the backlog of work, so online access is a good way to communicate new clinical guidelines and improve patient care across the Sefton Place by ensuring GPs, Nurses and Allied Health Professionals are keeping up to date.

Recent subjects have included Asthma Management, Digital Group Consultations, Lipid Guidelines in Primary Care and Safeguarding.

Patient Participation Groups (PPG)

A PPG is a group of people who meet regularly to discuss their General Practice and is usually made up of patient volunteers and practice staff. Some practices in south Sefton have found it difficult to recruit PPG members whilst some practices have been able to establish proactive PPG's.

The CCG and Healthwatch Sefton have worked together to form a patient participation steering group. This is made up of representative from residents of Sefton who may or may not be part of an existing Practice PPG. Supporting documents have been produced to help practice both recruit and maintain PPGs. The steering group have met several times with good practice being shared. The overall aim of the steering group is to promote, support and engage in patient engagement via PPGs. The CCG will continue to support practice to establish PPGs.

Digital Champion programme

Each practice in south Sefton has a nominated digital champion whose aim is to support both patients and practice staff to maximise the use of technology, to improve access to health care services. With an increase in the use of technology during the pandemic, staff have become more confident in dealing with digital software such as online consultations, text messaging, and the NHS App, amongst other online services. Digital champion training has been secured from iMerseyside to ensure staff are kept up to date with the latest in health technologies. Focused sessions are held monthly dedicated to a particular service or product where digital champions can learn and share their experiences.

An MS Teams channel has been created to enable digital champions to share learning/experiences between practices. This has also enabled swift communications to be shared around changes to digital functions. This has helped practices to keep up to date and be prepared for those changes.

In Quarter 1 April to June 2022, the number of e-consultations submitted to practices in south Sefton totaled 18,012

Patient feedback from: '*I filled in the eCconsult, in the comfort of my own home, taking time to give all relevant information required'.*

COVID-19 Vaccination Programme

GP practices, in collaboration with other GP practices in their PCN grouping continued to deliver the COVID-19 vaccination programme.

Phase 4 includes an 'evergreen offer' for patients who have never had a vaccine or a previous booster and are encouraged to take up the offer. Phase 4 is a spring booster programme for the over 75's care home and housebound residents and any age (over 5) immunosuppressed patient.

Vaccinations for school age children, 5 – 17-year old continued to be offered to complete primary courses.

The CCG continues to work closely with Cheshire & Merseyside screening and immunisations team, Sefton local authority public health department and general practice to address variations in the delivery of all vaccine programmes.

Urgent care

There have been significant pressures on our urgent care service in the past year but with many positive changes introduced to ensure that care can be provided safely and on a timely basis.

Residents that require urgent care have been continued to be encouraged to ring or go online at NHS 111 first prior to attending A&E or a walk-in centre. The Directory of Services (DoS) has been developed to increase dispositions to alternative services away from A&E where clinically appropriate. In addition, patients can be directed to the Clinical Assessment Service (CAS) for a clinical triage where the patient could be treated virtually, booked into an urgent face to face appointment or referred to a more appropriate community service.

The Litherland walk-in centre has continued to provide an urgent care service to the population of both CCGs during quarter 1, 22/23. The services that they provide include on the day review and treatment of minor ailments. In addition to this they also provide planned diagnostic services such as Xray, ECG service and diagnostic blood tests. Mersey Care NHS Foundation Trust are working to further develop pathways which will support hospital attendance avoidance and the need for admissions.

Hospital admission and discharge processes

We have been working in collaboration with the hospital and community teams to ensure that patients do not have to stay in hospital any longer than needed and that services are in place to support residents into the most appropriate place for their care. The emphasis has been on out of hospital care and effective care planning, particularly for the frail elderly population. The aim is to ensure that patients do not need to go to hospital due to avoidable conditions and that proactive management can keep individuals well for longer, meaning that they have more time spent at home with family and loved ones.

Hospital services, community services, social care and Northwest Ambulance Services have been working together to ensure that patients care needs are met at home. The aim of which is to promote independence and self-care. Examples of this include:

Integrated Community Reablement Assessment Services (ICRAS)

Our ICRAS service was created by the merger of a number of community teams across health and social care. These integrated teams are co-located and have a single point of contact to enable easy access from primary care services and secondary care services.

ICRAS has two main functions. Firstly, it delivers ‘step-up’ services, where people receive their care in more appropriate settings rather than being admitted to hospital. Secondly, its ‘step-down’ care better supports some of our more vulnerable patient’s transition from hospital to home. ICRAS is suitable for patients who have been recently clinically assessed and are at imminent risk of hospital admission without support, but who can wait a maximum of two hours for assessment.

Initial review of ICRAS indicates that the services are being successful in supporting more people in their own homes and avoiding the need for hospital admission. The service also works closely with Southport & Ormskirk Hospital NHS Trust to enable people to be discharged safely to the community with the support they need e.g. social care, nursing or therapy. The ICRAS approach continues to be an important component in supporting our residents within the local community.

Some initiatives have been developed specifically in response to the pandemic with services in place to support aspects of urgent and ongoing care for those who have suffered from COVID-19. Examples include:

COVID Oximetry @Home

This service has been rolled out across Sefton in response to the significant challenges and impact that the pandemic has had on local residents. This at-home monitoring service will be available for those with a positive COVID-19 test result or clinical diagnosis of COVID-19 and who are clinically extremely vulnerable within the last 7 days.

COVID Virtual Ward

The service was implemented across Sefton to enable patients to be discharged earlier from hospital following an admission due to COVID-19. Those patients that are stable, recovering from COVID-19 but have no reason to reside at the hospital will be discharged to the COVID Virtual Ward and be monitored by the Telehealth service with the patient self-recording their oxygen levels and a respiratory consultant reviewing regularly via a virtual ward round. Patients will be monitored up to 14 days following discharge unless clinically indicated.

Long COVID Assessment Service

Local services have been developed in every part of the country to bring together the right professionals to provide physical, cognitive and psychological assessments for those experiencing suspected post-COVID syndrome (Long COVID), so that they can be referred to the right support.

Mersey Care NHS Foundation Trust provides the Tier 3 MDT service at Place. The service is available for symptomatic patients who are more than 4-12 weeks from their COVID infection and is suitable for patients who were treated either in hospital or in the community.

The service works in partnership with Liverpool University Hospitals NHS Foundation Trust (LUHFT), Liverpool Heart and Chest Hospital, Primary Care, Third sector and our Sefton therapy and community services as well as online resources to deliver assessment, recovery and rehabilitation services to Sefton patients.

Knowledge about Long Covid and the evidence for the treatment and management of the condition are evolving and the service continues to review and refine the model of service delivery engaging with key stakeholders alongside raising awareness of the service and how it can support Sefton residents.

Community services

Community services have played an important role supporting residents within their own homes avoiding hospital admission but also supporting early discharge. This is particularly important given ongoing pressures on our acute services but with the potential to support aspects of this care within community settings.

Mersey Care Foundation Trust provide all community healthcare services across Sefton. These services include blood testing, frailty practitioners, district nursing, treatment rooms, foot care, intermediate care, respiratory services, cardiology services and adult diabetes and adult dietetics. Mersey Care Foundation Trust provides these services to our population to ensure that patients are cared for closer to home. Our providers build on previous work to improve health and wellbeing of our residents. Work has begun to look at how we can improve and develop these services to better meet the needs of our residents and in line with our Sefton2gether programme to provide more care closer to home. Examples of this include:

Integrated Care Teams (ICT)

The ICT approach has been further strengthened during 2020 and provides co-ordinated health and social care for patients who are at high risk of emergency admission to hospital – such as those with long term conditions and frail or vulnerable older people. They aim to maintain our residents in their own home and all the different members of the team meet regularly to help manage condition, maintain well-being and prevent unnecessary admission to hospital.

The team has health and social care professionals who work closely with GPs. This includes district nurses, frailty practitioners, medicines management, therapists, and a social worker. The team are able to access extra advice and help from a range of services that are appropriate for a person's care. This may include heart failure nurses, respiratory team, diabetes team and dieticians. Residents receiving support through the ICT will be referred if necessary but may not need input from all of these services.

Phlebotomy

This is a service which supports high numbers on a daily basis and which was significantly impacted at the start of the pandemic due to the need to maintain safe social distancing and ensure adherence with infection prevention control requirements. This led to long waiting times to access the service. Significant work has been undertaken in the past year to support new ways of working and to increase capacity to previous levels. We now have a booking system in place where residents can book their own appointments. There has been a need to see more people within their own homes due to housebound or shielding requirements which have placed additional pressure on the service. Where possible residents are asked to attend the clinics to make best use of resources and ensure that those who do need to be seen in their own home can be supported on a timely basis.

Virtual support

As with all our health services a mixed approach of telephone and video consultations are now being used to reduce risk of infection but also make best use of our health care teams at this time. This has proved to be a positive aspect to how people can be supported on a more timely basis. Access to clinics and care within the home remains in place where patients need to be seen face-to-face.

Mersey Care Foundation Trust continued to work closely with other organisations such as Southport and On Hospital NHS Trust, Sefton Council and the VCF sector, with the aim of delivering seamless care arrangements from hospital to community.

Supporting Mental Health

Sefton Community Voluntary Services (CVS) have been working across Sefton to support individuals who have social issues and/or multiple physical and mental health conditions that require wraparound care and support that is often not accessible from a single service.

Sefton CVS provide individuals with knowledge, skills and use coping mechanisms to enable individuals to become independent and eradicate reliance on emergency services. We have seen extremely positive feedback in relation to the quality and impact on the health and wellbeing of individuals and reduced demand on acute emergency services.

The High Intensity User service has expanded into those with Severe Mental Illness (SMI) that often use urgent care services for both physical and mental health to improve continuity of care between mental as well as physical health services and provide additional support for those people that need it most.

Ageing Well Programme

Cheshire and Merseyside Health and Care partnership have launched the Ageing Well Programme and Sefton CCGs are committed to delivering the three key elements although, urgent and community services will focus on the 2 hour Urgent Community Response and 48 hour Reablement element of the programme for the purpose of this section.

Urgent Community Response programme:

- Deliver a 2 hour urgent community response for people in crisis and at risk of hospital admission.
- Deliver a 48 hour reablement support to help avoid future crises and wraparound care to promote independence.

The Sefton UCR was implemented in April 2022 and has combined several services from health, social and the voluntary sector to transform community care and optimise people staying at home or their usual place of residence safely. In order to achieve this, Sefton have commissioned new or added additional capacity into existing services following a gap analysis of current services and informed by data from urgent and emergency care services. These services include:

- Commissioning of Progress Housing to provide a rapid lifting service across Sefton that will respond in approximately 30 minutes for uninjured falls to avoid North West Ambulance Service responding and reduce the risks associated with a long lie awaiting paramedic arrival on scene. The rapid responder will risk assess, lift the patient and onward refer to other suitable local services to improve patient outcomes.
- Expansion of the Sefton Emergency Response Vehicle (SERV) provided by North West Ambulance Service to cover the whole of Sefton. SERV specialises in patients who have suffered from an acute health event that could be caused by a frailty-related syndrome. SERV reduces the need for patients to be unnecessarily conveyed to hospital, by providing a service within the community that is centred on the needs of the local population.
- We have added to the Community Respiratory Team (CRT) to enable 7 day working to be able to respond to respiratory exacerbations 7 days, 08:00 – 20:00.
- We have increased capacity of the Intravenous Therapy (IVT) team and opened up additional pathways such as IV antibiotics and IV fluids to enable people to stay at home rather than always requiring hospital admission for these pathways.
- Commissioning of the Acute Visiting Service (AVS) as a 2 hour rapid response provided

by Go to Doc. The AVS respond to 2 hour responses that require urgent intervention for acute illnesses or infections and take direct referrals from care homes and ICRAS.

- Expansion of the Sefton Reablement Service provided by New Directions to increase reablement capacity for the 48 hour element of the UCR by promoting independence and reducing reliance on supportive services such as domiciliary care.
- Additional capacity for the High Intensity User and Discharge Support services provide by Sefton CVS to support people who have had a crisis with person-centred and wraparound care to reduce risk of future crises occurring.
- Increased capacity at the Single Point of Contact (SPC) provided by Mersey Care NHS FT to increase call handlers and triage nurses to enable easy access to the UCR service by referrers and redirect to the most suitable service.
- Collaborating with cancer services to provide an integrated oncology and urgent care response for those that are undergoing cancer treatment but may require urgent care intervention to avoid A&E attendance or hospital admission.

Care for the most vulnerable

Diabetes

Patient education is central to diabetes prevention and management. Work is ongoing to catch up on opportunities that were missed during the Covid-19 pandemic to identify people at high risk of developing type 2 diabetes and offer them the opportunity to take part in the National Diabetes Prevention Programme “Healthier You” which has now re-commenced face to face groups in community settings.

Finding Cancer Earlier

The NHS Long Term Plan sets bold ambitions over the next 6 years to advance the detection of cancer at an early stage and thereby increase survival. We continue to work collaboratively with practices and PCNs to deliver these improvements; for example, increasing participation in national cancer screening programmes, raising awareness of the signs and symptoms of different cancers, ensuring the diagnostic process is as swift as possible and promotion of new technology to detect cancer earlier

Targeted Lung Health checks

South Sefton CCG was selected to become a phase 3 pilot site for the national programme based on lung cancer mortality rates. The programme aims to detect lung cancers at an earlier and more treatable stage. People who have ever smoked as recorded in their GP records who are aged between 55 and 74 are invited for a lung check with a nurse to assess their risk of developing lung cancer based on their medical, smoking, occupational and family history. Those deemed to be at higher risk are offered a low dose CT scan at a mobile unit in the community

Results from earlier phases of the programme saw more than 70% of people who were diagnosed with a lung cancer were suitable for curative treatment. We are also seeing encouraging numbers of participants who are current smokers make the decision to access smoking cessation services and high quit rates are reported in this group.

The programme will coming to south Sefton at the end of 2022.

Faster Diagnosis

The new Faster Diagnosis Standard for cancer was implemented from December 2021. The standard sets a 28 day limit on the time it should take from referral for a suspected cancer to receive the results of all tests and investigations which will confirm or exclude a cancer diagnosis and inform the patient. We are seeing referrals for suspected caner sustained at 120% of pre-pandemic levels which places considerable pressures on diagnostic services

Support for people with cancer

Emotional wellbeing and practical support needs to be a priority following a cancer diagnosis and through treatment, recovery and beyond.

The South Sefton PCN now provides a team of specialist cancer social prescriber link-workers through Sefton CVS who can offer highly personalised support to anyone facing a cancer diagnosis.

Blood cancer services

February 2022 saw improvements in the way treatments for blood cancers are delivered. Blood cancer specialists in the haematology team at Aintree University Hospital became part of The Clatterbridge Cancer Centre NHS Foundation Trust. They will deliver a new specialist haemato-oncology service for confirmed or suspected blood cancers such as leukaemia, lymphomas and myelomas. It also means that a wider range of treatments, clinical trials and support services can be offered.

Children and Young People with Special Educational Needs and Disabilities (SEND)

This cohort of young people and their families are recognised as being amongst the most vulnerable groups in Sefton. As outlined in the Quality Section of this report (pages 36 - 37), the CCG has a duty of care to work with the Local Authority and partners to ensure that these children, young people and their families receive quality health services that meet need, are accessible and delivered in a timely manner.

In addition, children and young people with a learning disability (LD) and/or autism are prioritised through the national, regional and local Transforming Care workstreams that focus on developing and improving services for this group. A specific element is dedicated to supporting those most at risk from escalating mental health concerns and/or challenging behaviour and possible admission to an acute or mental health hospital bed. The CCG maintains and manages a register of these young people (known as the Dynamic Support Database) and works in collaboration with the Local Authority, health care providers, schools/colleges and third sector partners to ensure an MDT approach to supporting these children, young people and their families, preventing a hospital admission when possible.

Specialist Palliative Care/End of Life Care Services

We continue to support Specialist Palliative Care Services and End of Life Care. This helps to support improved patient/family experience, reduced levels of inappropriate emergency admissions and length of stay for patients in the last 12 months of life.

Woodlands Hospice Charitable Trust

Woodlands Hospice provides a variety of services with the aim of delivering specialist palliative care in the patients' Preferred Place of Care (PPC). South Sefton CCG work closely with Woodlands Hospice to support patients with life limiting illnesses, so they can achieve the best possible quality of life at each stage of their illness. Woodlands Hospice supports patients, families and carers within the Hospice setting via their 15 bedded Inpatient Unit and in their Wellbeing and Support Centre. Services within the Wellbeing and Support Centre include Multi Professional Assessment days, group therapies and outpatient clinics for all professions. Woodlands Hospice also provides services within the community including therapy outreach service, Hospice at Home Service and an End-of-Life Facilitator supporting with care homes as well as a bereavement service for families including children who have lost loved ones.

Hospice at Home Service

Hospice at Home offers additional support to patients wishing to stay at home as they approach the end of their life. The service works alongside other existing community services and offers:

- A specialist sitting service
- Accompanied transfer to home
- Crisis intervention/crisis prevention delivered by a consultant-led medical team

End of Life Care – St Joseph's Hospice

We commission and spot purchase end of life beds from St Joseph's hospice, a 29 bedded unit providing end of life care.

St Joseph's is a nurse-led service and provides ongoing support to residents and their families. Clinical activity is supported by their in-house NMP (non-medical prescriber) nurses. We support a visiting GP and a local network of specialist clinical support.

We continue to work with other providers of end-of-life care, the aim of which is to improve integration across the workforce, including but not exhaustive:

- Local Authority
- North West Ambulance Service
- Community Providers of end-of-life care
- Primary Care
- Care Homes
- Hospice's
- Out of Hours Services

Specialist Palliative care services and End of Life care are also provided via our community services – Mersey Care Community Foundation Trust.

Integrated Mersey Palliative Care Team

The Integrated Mersey Palliative Care Team (IMPaCT) service model was introduced to integrate end of life care across hospital, hospices, primary care and community pathways to improve access and coordination of care for patients across these critical services. This collaborative model has promoted best practice, supported the patients right to die in their agreed place of care, prevented the escalation of care to hospital and improved the experience of death and dying for families and loved ones.

Work is underway in conjunction with Southport and Formby CCG commissioned provider- Queenscourt hospice to deliver a consistent offer across the whole of Sefton.

Response to COVID-19

Working in partnership, Sefton Council, the CCG, Local Primary Care Networks and local NHS providers have continued to support local care homes throughout the on-going COVID-19 pandemic. This includes:-

- Regular meetings of the Care Home Strategic Partnership – where Sefton Care Homes and lead officers come together to work collaboratively on shared issues
- Enhanced Health in Care homes – support for care homes through weekly check-ins, multi-disciplinary team meetings and proactive support from a range of care professionals
- On-going delivery of the Joint Care Strategy
- Personal Protective Equipment provision
- Education and Training support
- Medicines Management, practice pharmacist proactive care and support
- Additional funding through grant provision
- PCN led vaccination in care homes
- On-going support for Learning Disability Homes.

Mental Health and Learning Disability

The CCG established a partner-wide one-year strategic review of mental health services in 2021-2022. The review brought together those who provide and commission mental health services across Sefton. The first phase focused on establishing an evidence base, with the second and final phase focusing on producing a framework that will guide partner priorities from 2022-23 onwards.

Improving Access to Psychological Services (IAPT)

To support the ongoing demand for mental health services, additional investment has been identified to increase the infrastructure in the IAPT service.

This is keeping with the NHS long term plan ambition of continued investments in mental health services.

The Crisis Café in Crosby was established in April 2022 and continues to offer out of hours support to anyone experiencing a mental health crisis. They give adults in Sefton a safe place to go as an alternative to A&E, this was achieved through working in collaboration with a number of organisations and demonstrates the huge benefits for our communities, that working in partnership can achieve.

Shortlist for LGA - Services for people with Mental Health and learning disabilities

Sefton Council with Sefton CCG was shortlisted for an LGA award for introducing a model of service **Individual service fund** (ISF) which is a hybrid of a commissioned services and a direct payment, that enables individuals to have increased choice and control over who supports them. It has been very welcomed by the people concerned with positive feedback in how they are supported.

Medicines management

Our approach to medicines management (MM) is system wide, working with our counterpart CCG in Southport and Formby, primary care networks (PCNs) and GP practices allowing us to deliver real improvements to patient safety and care, whilst also identifying significant cost efficiencies. We also work closely with our colleagues in our local hospitals and community pharmacies. The medicines management team (MMT) is made up of clinical pharmacists, pharmacy technicians, a prescribing support officer, dedicated administrative and data business intelligence support.

Medicines Management Hub

The Sefton MM hub continues to deal with medication related queries from GPs, PCNs and community pharmacies, such as: supply shortages, local formulary issues and general medicines information enquiries. The hub also carries out medicines reconciliations for patients discharged from hospital. If patients are identified as needing a more in depth medication review or support in relation to their medication, the hub is able to arrange such a review from one of the team's clinical pharmacists.

Between April 2022 and June 2022, the MM hub dealt with 1,939 medication queries from GP practices, 673 community pharmacy queries, and reconciled/reviewed 2,062 post hospital discharge summaries for patients in NHS South Sefton CCG.

Interventions made by the MM hub team contribute to improving patient care by reducing hospital discharge medication errors. Communication with patients and carers contribute to improving patient care by ensuring that the patient has the correct medication and understands how to take their medication correctly. Interactions with secondary care colleagues and community pharmacies have helped to develop relationships and promote the role of the CCG MMT as a clinical resource.

Improving Quality of Prescribing and Supporting Patients

Working with our PCNs and identifying patients via the MM hub the clinical pharmacists undertake medication reviews with patients. These can be referred to as "structured medication reviews". Between April 2022 and June 2022, the MMT completed 761 structured medication reviews for patients in South Sefton. Of the reviews completed 166 were undertaken with residents living in care homes and 595 with patients living in their own homes. The MMT also reviewed the medicines of 87 patients newly registered to a GP practice in south Sefton.

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others. From April 2022 to June 2022 the MMT reviewed and actioned 8 CAS alerts involving medicines.

Response to COVID-19

During Q1 of 2022-2023, Sefton's MMT continued to support patients in response to the COVID-19 pandemic.

Two community pharmacies in Sefton are commissioned to provide prescribers and patients with urgent access to a specified list of medicines, used for symptom management of COVID-19. The pharmacies also offer a one-hour fast-track delivery service through a request from the prescriber.

The MMT have continued to support care homes and their residents. The Homely Remedy Policy has been reviewed and updated which allows care homes to administer paracetamol and codeine linctus for patients showing symptoms suggestive of COVID-19 without delay. The team continues to review patients who live in a care home for their suitability to receive the COVID-19 homely medicines if the need arises. This is done on a home-by-home basis should they report an outbreak to us.

A community pharmacy COVID-19 medicines service is commissioned in two pharmacies in Sefton. They hold a protected stock of end-of-life drugs and supply care homes with paracetamol and codeine linctus for use as per the COVID-19 Homely Remedy Policy.

Care at the Chemist

Our minor ailment service, Care at the Chemist (CATC), has been available to our patients for a number of years. CATC supports patients to self- care by providing access to treatment and advice for a wide range of everyday illnesses and ailments from a number of local community pharmacies. Pharmacists ordinarily and routinely provide health advice to their customers regardless of CATC but the scheme additionally ensures residents have access to a range of medicines for minor illnesses for which they might otherwise consider a trip to the doctor. Following a successful pilot, from April 2022 we have commissioned an Extended Care at the Chemist service. Women between the ages of 16 and 65 years who have symptoms of an uncomplicated urinary tract infection (UTI) and who are not pregnant or breastfeeding, can now access treatment directly from participating pharmacies without the need to be seen by a GP.

Medicines supplied on CATC are free for anyone who does not pay for their prescriptions. People who do pay are charged the current prescription charge. If the medicine costs less to buy over the counter than the prescription charge, the person will pay the lower rate.

Between April 2022 - June 2022 2,341 Care at the Chemist consultations were carried out in South Sefton.

A list of participating pharmacies and more information is available on our website[14]

14 https://www.southseftonccg.nhs.uk/your-health-and-services/care-at-the-chemist/

Going digital

Our vision for the future is to be ‘digital first’ and to support our patients and professionals to embrace digital tools in order to make a real difference to care quality, efficiency and experience.

Over recent years, through investment from NHS England’s Digital First and GP IT programmes, we have been able to work with our IT delivery partner - NHS Informatics Merseyside (https://www.imerseyside.nhs.uk) and our GP practices to optimise the use of existing technologies, introduce a number of new digital patient services as well as invest in our IT infrastructure.

Whilst this investment certainly helped prepare us for the digital challenges presented by Covid-19, the impact of the pandemic rapidly accelerated our digital journey and our plans have progressed significantly in order to deliver the ‘digital first’ approach needed for the safe delivery of care during what can be aptly referred to as the greatest global health emergency in our history.

To help ensure that we continue to deliver care effectively, improve communication between our care professionals and provide services that are convenient for our patients, we will continue to work with NHS Informatics Merseyside to identify digital opportunities and to respond to the challenges of the new GP Contract and NHS Long Term Plan.

Further information about our digital progress to-date and plans for the future are outlined below.

Our digital response to COVID-19

The scale and pace of our digital adoption over the past two years has been unprecedented. Necessity has forced the NHS to adapt the way services are delivered, with people accepting that during the pandemic, remote care was the right and only option.

Whilst this has helped to create a firm foundation and confidence for our digital journey ahead, there is an appreciation that not everyone prefers accessing services remotely, with concerns of a shift towards call-centre-style medicine causing a digital divide. Whilst a careful balance needs to be found in order to meet the needs of all those accessing services and support, there is widespread acknowledgement that the digital advances made during the pandemic have delivered many benefits for general practice, most notably greater efficiency.

‘Digital-first’ primary care, where patients use digital and online tools for faster and improved access to advice, support and treatment, is an important aim of the NHS Long Term Plan. As a result of the pandemic, practices have increasingly moved towards triage systems and exploring digital opportunities for remote consultations which have not only helped improve access for patients but have also helped improve GP efficiency and all-round safety.

The move towards this ‘digital first’ approach also supports other national drivers including extended access schemes to ensure everyone has improved access to general practice services. In addition to this, the promotion of online patient services such as the NHS app and the ability to manage referral bookings online are also making it easier for patients to access information and book, check, change and cancel appointments online without help from the practice.

Digital optimisation

To ensure GP practices continue to get the most value from their clinical systems and digital tools, throughout the pandemic NHS Informatics Merseyside has been working with practices to review their processes, identify best practice and ways in which digital technology can be used to improve care quality, safety and efficiency.

This has not only involved the introduction of new digital tools and the promotion of online services but has also involved security expertise and investment in our underlying digital infrastructure.

Online consultations (e-Consult)

An online consultation service called e-Consult is now being used by all South Sefton GP practices. The service is not for booking appointments or ordering repeat prescriptions, the service patients with advice and guidance on their symptoms following the completion of a simple online form that can be accessed directly from the GP practice website. The service will be reviewed again as GP practices return to previous ways of working.

Patients who submit their symptoms will receive a response typically within one to two working days, which could include advice or the offer of an appointment if necessary. The service also offers round the clock NHS self-help information, signposting to services, and a symptom checker. In many cases, use of the service will avoid the need to make a visit to the GP practice, saving time and a journey.

In response to COVID-19, the e-Consult video consultation service was provided to all practices free of charge for a six-month period. The e-Consult service has also been integrated with the NHS App so that patients using this service could submit an online consultation directly from within the app itself.

For the period 1 April 2022 to 30 June 2022, in South Sefton, there have been 18,012 patient online consultations submitted, with an estimated total of 10,807 appointments saved in general practice.

Video consultations

All GP services across South Sefton can now offer video consultations, where patients can speak to their GP using the video camera on their smartphone, tablet or computer. This has not only helped to reduce risks surrounding the spread of infection but also helps save time by reducing the need to travel for a face-to-face appointments.

For the period 1 April 2022 to 30 June 2022, in South Sefton, there have been 163 video consultations carried out. 14% of practices in South Sefton have used this feature in the last 28 days.

Text messaging

The iPlato text messaging service has been introduced for practices across South Sefton to help improve communication with patients and support the delivery of care. In response to Covid-19, text messaging credits have been provided to support practices in sending out vital communications.

For the period 1 April 2022 to 30 June 2022, in South Sefton, there have been 367,422 SMS message fragments sent, (1 message fragment is equal to 160 characters) and 2,503 “data messages” sent (data messages are those sent directly to the MyGP app).

The Accurx solution has been in place amongst all practices since April 2020, and this gave practices access to free of charge text messaging, and video consultation. The free of charge SMS offer has been taken up by practices independently. Subsequently, additional functionality was made available to practices to allow them to send documents via SMS, and to receive photographs from patients via SMS (all of which supported remote management of patients). For the period 1 April 2022 to 30 June 2022, in South Sefton, the following activity has take place in South Sefton practices:

- 120,855 ad hoc text messages sent, of which
    - 5,821 were messages containing documents as a response to patients (for example, sending fit notes to patients)
    - 2,639 messages were received from patients with photographs attached (as part of remote monitoring, clinicians are able to ask patients to send photographs eg of dermatology conditions)

Accurx also offer some additional functionality in the form of structured questionnaire templates which can be sent to patients in order to support long term condition management and collection of key data to support management of conditions. The templates allow for responses to be automatically coded directly into the patient record thereby improving with real time data collection and making improvements to patient records, clinical and patient safety. This functionality is termed “Floreys”. There are a number of these templates which are made available free of charge, as well as a suite of additional templates which are available at cost.

From January 2022, practices were given access to the full range of Florey templates. For the period 1 April 2022 to 30 June 2022, in South Sefton, 2,985 Florey templates have been sent to patients across South Sefton.

‘Express Access’ laptops

‘Express Access’ laptops have been provided to all GP practices in order to support the safe and efficient delivery of remote care and home working.

These devices use the latest Office 365 software and operating system and provide healthcare professionals with access to the information they need from wherever they are in order to deliver timely and effective care such as accessing the EMIS Web clinical system whilst out on a home visit.

Plans are in place over the next 12 months to move to a single device approach where all clinicians and ‘mobile’ staff members will be supplied with these laptops which have the ability to be ‘docked’ in a practice as a desktop and also used in a remote environment.

Microsoft 365

Microsoft 365 is a cloud-based service that includes the latest version of Microsoft Office, as well as other useful apps, such as Microsoft Teams and OneDrive, to enable users to collaborate with colleagues, work more efficiently and create, access and share files from anywhere on any device.

Currently this service is being rolled out to GP practices across South Sefton as part of a phased approach. To date, Microsoft Teams has gone live across all GP practices providing online meeting and team collaboration services and we have launched the latest version of Microsoft Office, with plans to move to Exchange Online (cloud-based access to email and calendar services) and One Drive (cloud-based file storage) in the very near future.

Digitising Lloyd George records

NHS Informatics Merseyside is currently supporting a number of practices with the digitisation of their Lloyd George patient records. This project will see paper records securely removed from practices, scanned and uploaded directly back into the electronic patient record. During Phase One, 26 practices within South Sefton have completed this one-off process. During Phase Two, there are 3 South Sefton practices participating.

The following benefits have been reported:

- Provision of a more holistic view of a patient's history
- Convenient access to the entire record electronically enabling timely and informed care decisions
- An average of two hours per week admin time being saved

In addition to this, funding has also been secured for the roll out PDF redaction software to help practices hide sensitive information where information sharing is required for care purposes.

Digital Fax

Across South Sefton, all GP practices are live with a contractually compliant digital fax solution.

NHS App

The NHS App is available to all patients in South Sefton and provides a simple and secure way to access a range of NHS services from a smartphone or tablet. Users can:

- Check symptoms
- Find out what to do when you need help urgently
- Book and manage appointments at your GP practice
- Order repeat prescriptions
- Securely view your GP medical record
- Register to be an organ donor
- Choose how the NHS uses your data

GP practice websites

To help improve communication with patients and encourage two-way engagement, investment has been secured to provide every GP practice with a new website from NHS Informatics Merseyside. These websites can be updated by the practice quickly and easily using the Umbraco Content Management System (CMS) and integrated with existing NHS online services. The sites are hosted and supported by NHS Informatics Merseyside and are developed in accordance with the NHS design principles and latest accessibility standards. This service is also available to those wishing to move from a third-party provider.

Digital waiting rooms

The waiting room provides patients with their first impression of the GP practice. To help support practices to use this space as a tool for informing, educating and engaging patients, a programme of work has been completed to rollout the Envisage GP waiting room TV and call system, as well as an electronic check-in system.

The Envisage GP waiting room tv and call screen can be used to inform patients about the range of services offered by the practice, such as flu and baby clinics, with the check-in system helping to improve efficiency for both patients and practice staff.

In addition to this, funding has been secured to introduce a reception device at each GP practice in South Sefton, which will enable patients to access online services and support whilst in the practice. Patients will be supported by an identified Digital Health Champion from within the practice who will be responsible for supporting patients to access online services where required in order to improve digital health literacy and inclusion.

Digital Health Champions

With guidance from NHS Informatics Merseyside, Digital Health Champions will be identified at each practice and will be responsible for supporting their colleagues and patients in the use of new online health services to help improve digital literacy and support the NHS shared drive for digital inclusion.

IT security

Data and cyber security services are provided by NHS Informatics Merseyside. This service has achieved ISO27001 certification for 'the provision of informatics security consultancy, support and technical services' and has also achieved the government-backed NHS Cyber Essentials accreditation.

The IT security service has been supporting the phased rollout of Microsoft 365 and the security policies, including Multifactor Authentication requirements, to ensure that this is being managed in accordance with the Data Security and Protection Toolkit (DSPT).

Prior to Covid-19, the service had been working with practices to support the completion of the Data Security and Protection Toolkit, which is an online self-assessment tool that all organisations that have access to NHS patient data and systems must complete to provide assurance that good data security standards are being practiced and that personal information is handled correctly.

In addition to this, the service has also been supporting practices with the completion of Data Protection Impact Assessments (DPIA), which is a process designed to help systematically analyse, identify and minimise data protection risks.

Digital infrastructure

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 enable this to happen, significant investment has been made in our technical infrastructure in order to ensure that this remains fit for purpose and able to fully support the digital tools and systems in place

Wi-Fi

All GP practices across South Sefton now have access to practice and patient Wi-Fi services on a secure and resilient infrastructure.

Network bandwidth

Network bandwidth across the GP practice network has been continually upgraded to keep pace with the rapid expansion of digital tools and online services such as video consultations. Each practice has had their primary and secondary network links upgraded from 10 to 30 megabytes per second and data centre links upgraded to 1GB.

Hardware refresh

Regular IT equipment refresh programmes are progressed across our GP practices annually. The next phase of this programme will support our plans for a single device approach and will provide GP practices with large screen monitors

Digital Inclusion strategy

Digital inclusion is about ensuring the benefits of the internet and digital technologies are available and known to everyone, enabling individuals to improve their quality of life, employability, health, and wellbeing.

Access to digital services is evolving, with new and emerging technology changing how individuals access digital tools to support independence, without necessarily being aware they are digitally active. Sensor technology, smart speakers (Alexa, Google, Apple) are providing different types of interaction with assistive aids that can help people stay independent at home for longer.

We are developing a strategy with partners across Sefton to put in place support and opportunities to help those who want and can become digitally active, allowing them to maximise the potential for technology to help them live well.

Our vision is to develop:

'a place where Sefton residents and organisations understand the benefits of digital, feel safe and confident online and are supported to develop their skills and thrive in an increasingly digital world'.

Being prepared for emergencies

The past year has seen some significant changes to the commissioning environment and a change to the CCG, now becoming part of the newly formed Merseyside and Cheshire Integrated Care Board (ICB). The ICB is considered a Category 1 responder under the Civil Contingencies Act 2004 and will have additional responsibilities in leading and coordinating the health economy preparation for, response to and recovery from incidents.

Changes to the way we operate have been considered by the CCG's Corporate Governance Support Group, the Incident Management Team and the Leadership Team.

Work to manage the effective transition to Integrated Care Systems (ICS) and integrated Care Board (ICB) is ongoing.

Alongside the transition planning for ICB, NHS South Sefton CCG has continued to respond to the challenges of maintaining business as usual activities and response to and recovery from the local demands of a global pandemic. Work has been undertaken to learn lessons from management of Covid-19 alongside partners across the local health economy.

The CCG has continued to work with commissioned providers in both primary and secondary care to deliver services at the same time as managing the impacts of separation, testing and vaccination. We have continued to provide support to the local system through engagement with NHS England and by the provision of a continuously available on call service.

We are a member of and has been an active participant in the Cheshire and Mersey Local Health Resilience Partnership's Commissioning Sub-Group Forum run under the auspices of NHS England. We continue to receive advice and guidance on our business continuity activities and emergency response preparations from Midlands and Lancashire Commissioning Support Unit.

Response to winter activity saw a comprehensive 'Winter Ready' checklist produced alongside local health and social care partners and made available through the CCG website.

We have robust business continuity and emergency response plans in place. These have been reviewed as part of the transitionary arrangements for the establishment of the Integrated Care Board.

We were rated "Fully Compliant" under NHS England's annual EPRR Core Standards assessment and we sought and gained similar assurance from the secondary care providers where we are the lead commissioner.

Involving our residents

We are committed to putting the voice of patients and the public at the heart of our commissioning and we believe this 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 our residents can help us to determine what more we need to do to achieve our aims, so services are ‘patient centred’ and better focused around their local needs.

Although COVID-19 restrictions lifted slightly we made the decision not to carry out face to face activities that bring us together with residents and other partners that would normally be part of our day to day work in early 2022 to keep our residents safe.

We are now actively looking at the different ways we engage with people in the future and what will work best for them in the future using a mix of digital and face to face approaches to ensure as many of our residents as possible have the chance to get involved in our work.

We recognise there is no one size that fits all and we will continue to work closely with our partners across the borough to ensure we are reaching those who find it hardest to participate in our exercises and activities, such as ethnic minority residents and those who experience the greatest health inequalities.

Our approach to involving you

We have established structures and processes in the CCG to ensure that we embed involvement in our daily work. These illustrate how we meet our statutory obligations and they are underpinned by the following two important documents.

- Our CCG Constitution reflects our commitment and our legal duty under the National Health Service Act 2006 and Social Care Act 2012 to involve our residents in developing and commissioning health services
- Our Communications and Engagement Strategy describes our legal duty to involve in greater detail. It also outlines our principles and approach to involving our residents and the partners we work with

You will read more about our existing structures and processes in this section, along with some examples of the work we have been able to carry out during the year.

All of the groups, committees and forums mentioned in this section met virtually online during early 2022 to ensure they met COVID-19 safe guidance. In some cases the frequency and focus of these meetings were also affected by our response to the pandemic.

Our framework for involvement

You can see our framework for involvement in full on our website[9]. The examples below illustrate some of its key elements – reflecting our CCG Constitution and our Communications and Engagement Strategy – and how they have supported and provided assurance in early 2022 around our public and patient involvement work:

Our committees, groups and policies

Governing Body - a lay representative dedicated to patient and public involvement sits on our Governing Body, where our most important work is debated and approved. The chair of Healthwatch Sefton is also a member of the Governing Body[10] providing independent representation from patients and residents. We hold bi-monthly Governing Body meetings. We have not been able to hold meetings in public but we continue to publish papers and meeting notes, which contain any questions our residents ask us to consider and the responses.

EPEG - our Sefton wide engagement and patient experience group, known as EPEG is embedded in the structures and processes that oversee our involvement work. For the first part of 2022 it reported directly to our Quality and Performance Committee, a committee of the governing body that oversaw patient experience as one of its key functions. As our governance structures changed to help us prepare for transition to integrated care board arrangements, this important group began to report to our senior leadership team. You can read more about these governance changes on page 96.

EPEG was chaired by our Governing Body lay representative for patient involvement and their counterpart from our neighboring CCG in Sefton until the end of June 2022 when the membership and chairing arrangements will be reviewed. The group brings us together with patient representatives and key partners from across health and care in the borough to provide us with assurance and advice about our statutory responsibilities around engagement and consultation including considerations around equality and health inequalities. The group also

[9] https://www.southportandformbyccg.nhs.uk/get-involved/
[10] https://www.southportandformbyccg.nhs.uk/about-us/governing-body/governing-body-meetings/

monitors involvement and patient experience in the services we commission. EPEG has continued to meet virtually during the year and during the early part of 2022 members are beginning to look at the future form of the group so that it better supports local health and care organisations as they work together in new ways as a result of the Health and Social Care Bill through Sefton Partnership.

Friend and Family - Friends and Family Test (FFT) gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care or treatment. Data on all these services is published on a monthly basis and this is included in the CCG patient experience report.

Our policies and processes – we have a number of important strategies, policies and protocols, such as our disinvestment policy and procedures which also contribute to our involvement framework.

External assurance mechanisms

As well as our internal committees, groups, policies and processes there are a number of external committees and forums that provide helpful challenge to help shape our work.

We keep Sefton Council's relevant **Overview and Scrutiny Committees** (OSCs) up to date on our work and involved in any plans we have to change or reconfigure local health services, in line with our responsibilities to them. In early 2022, our chief officer continued to attend meetings of the OSC for Adult Social Care and Health to present update reports and more focused presentations.

We are also able to test our involvement plans with **Sefton Council's Engagement and Consultation Standard Panel**. This well established partnership forum provides valuable advice and guidance. The panel's local knowledge is particularly useful in helping us to identify groups and contacts that are often difficult to involve in our work, such as those that are homeless and from lesbian, gay, bisexual and transgender (LGBT) communities. We are also members of the panel, enabling us to share our good practice with partners and learn from their examples too.

Strategic programmes and service developments or changes

As part of our planning for any strategic transformation programmes, or service developments or changes, we design and carry out specific involvement exercises. These vary in scale depending on the degree of change and the impact of these changes for patients and residents. Stakeholder mapping and equality impact assessments (EIAs) are integral to developing our involvement plans, as well as data analysis, reviewing any existing insight and demographic monitoring of those who take part in our exercises. This ensures that all our communities are involved in our engagement exercises, such as health inequality groups, those with disabilities and ethnic minority residents. You can read more about how we embed this work in the equality, diversity and human rights obligations section on page 72.

Co-production - working with patient, public or carer representatives

Whenever appropriate, we invite patient, public or carer representatives to get directly involved in our day to day commissioning work, such as taking part in procurement processes or joining our working groups to enable services and programmes to be 'co-produced'.

We have been working closely with parents and carers of children and young people with **special education needs and disabilities (SEND)** to improve services. Last year we worked with partners and parents to design and carry out a further survey to gauge people's experiences and views of our SEND services, as well as exploring how we might increase uptake of personal health budgets to provide greater choice and flexibility of care to those eligible.

Our involvement database

We invite residents who are interested in getting involved or who want to learn more about our work to join our mailing list[11]. We send everyone on our mailing list a monthly email newsletter to inform them about opportunities to get involved, including local and national engagement and consultation. We also use our database to contact people directly about any specific involvement activities we are running, like our survey on the reconfiguration of stroke services and our Big Chat events. The number of residents and stakeholders interested in getting involved in our work continues to grow.

Our communication and feedback systems

We use all our communication channels and networks to keep people informed about healthcare developments and provide opportunities to get involved and comment. We also use these channels as part of our approach to feedback the outcomes of our involvement activities.

As well as providing daily updates and news, our website and Twitter account invite people to comment or ask questions. This two way communication is an important way to hear from residents about their experiences and views of local healthcare, and is captured and used in the same way as other feedback we collect.

When we talk to local residents and partners about our work, we often capture some of their views through filmed interviews, which we then share more widely on our websites and through our Twitter[12] and You Tube[13] channels.

This year we widened the information included on our website to better reflect the range of involvement work we carry out and to better promote opportunities for our residents to take part.

11 https://www.southportandformbyccg.nhs.uk/get-involved/join-our-mailing-list/
12 https://twitter.com/NHSSFCCG
13 https://www.youtube.com/channel/UC3zskxhEM5dWeJtypBBmTOA

Working with partners and the community

We always look to build on our networks and further developed the close working relationship we enjoy with partners. As well as supporting us to share and cascade information about how people can learn more and have their say on local healthcare developments, we have been using their meetings and groups to undertake more face to face engagement.

Below are some examples of how we have done this:

Healthwatch Sefton

We continue to collaborate with Healthwatch Sefton on its 'Community Champion' sessions. These sessions invite Community Champions – who represent specific Sefton localities and and hard to reach resident groups – to learn more about specific healthcare topics, such as GP access, our local COVID-19 vaccination service, our mental health review and our review of hyper acute stroke services. We also routinely ask for views to help shape future healthcare and plans.

We are also working closely with Healthwatch Sefton to support practices in strengthening their patient participation groups (PPG). We have planned a further online event bringing together practice staff and PPG representatives as the last one was such a success. We have also developed information support packs for patients and practices to help grow their PPGs.

Working with other groups and forums

We link with our Sefton CVS colleagues to ensure our database of stakeholder groups and contacts is up to date and continues to expand on the number and types of groups that we work with. Sefton CVS also supports us to directly engage with local voluntary, community and faith (VCF) groups and networks. A BAME development worker hosted by Sefton CVS on our behalf strengthens our links with ethnic minority communities to ensure we are enabling participation in our activities as well as routinely feeding in intelligence and insight around access issues and indirect discrimination. Sefton CVS also coordinates a number of well established forums that we regularly engage with – including Equal Voice Network (ethnic minority communities) Ability Network (disability) and Embrace (LGBTQ+). All this work helps us to establish links with our most hard to reach communities, including those representing individuals with learning disabilities, who are homeless, military veterans and from the gypsy/traveller communities.

We also attend meetings and events organised by our partners to gain views about our current involvement activities or to feedback on how we have used peoples views from previous exercises. This year the meetings and networks we attended included Sefton Older Persons Forum and Sefton Health and Social Care Forum to discuss COVID-19 related topics including our local vaccination programme and updates on the development of the emerging Sefton Partnership.

Sefton Information and Communications Group

This group was formed in 2020 bringing together communications professionals from partners across health and care in Sefton to work together more closely to promote key information about COVID-19 to Sefton residents. The group is co-chaired by representatives from the CCG and Sefton Council's Public Health team. During the year the group has continued to focus on coordinating COVID-19 responses, such as producing regular community gatekeeper

communications packs that provide resources to aid the dissemination of information to some of the borough's communities that have been hardest impacted by COVID-19, as well as coordinating winter and urgent care communications and designing a dedicated training session for community champions and connectors to support the cascade of winter health messages to some of our most vulnerable and hard to reach residents.

During 2021-2022 the group reviewed its terms of reference to support the work of the emerging Sefton Partnership in addition to **Sefton's Health and Wellbeing Strategy** and our underpinning strategy for local NHS services, **Sefton2gether**. The group reports to Sefton Health and Wellbeing Board.

Supporting and developing involvement

As well as inviting and encouraging people to get involved in our work and routinely asking residents and stakeholders about how we can do this better, this last year we have also been looking at other ways we can support involvement more widely.

National consultations

Where relevant we always support and promote national consultations, encouraging local residents and stakeholders to get involved and share their views.

Promoting involvement and training opportunities

We have also been looking at other ways we can support involvement over the past year. Examples of this include promoting local and national opportunities to get involved, such as becoming a Healthwatch Sefton member or CVS volunteer and joining NHS England's involvement hub which provides information and training to support people to get more actively involved both locally and nationally. As well as our public, we also provide support to our commissioning staff to ensure they are able to build involvement activities into their work.

How we use the feedback we receive

After each of our involvement exercises has ended, we collate and analyse the feedback we receive and produce a report of the key findings. We share these reports with our public and partners and we use them to inform the development of the services we commission. The insight we gather from the involvement activities we carry out helps us to understand what patients and the public think about local services and our plans for developing or changing them. In particular, it helps us to identify what is working well and if there are any specific areas of patient concern that we need to address as we take plans forward.

In addition, as part of the decision making process about changes to the future provision and delivery of any service, our CCG Governing Body is required to take account of the views of local patients and residents in line with statutory duties[14].

You can find our involvement reports and any updates about how we have used the information to inform service delivery or development on our website, along with reports carried out by our partners that affect our residents[15].

How we evaluate our involvement work

We assess the effectiveness of our involvement activities in a number of different ways, from external assurance mechanisms, to regularly asking residents about how well we involve them. In the last annual NHS England and Involvement self-assessment process against community and patient involvement standards we received the highest green star rating.

[14] https://www.england.nhs.uk/participation/involvementguidance/
[20] https://www.southportandformbyccg.nhs.uk/get-involved/previous-exercises/

Equality, diversity and human rights obligations

Promoting equality is at the heart of our core values, ensuring that we commission services fairly and that no community or group is disadvantaged by commissioning decisions as the NHS continues to restore services affected by the COVID-19 pandemic and deliver the requirements outlined in the NHS Long Term Plan.

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

Due regard to the Equality Act 2010

We are required to pay 'due regard' to the Public Sector Equality Duty (PSED) as defined by the Equality Act 2010. Failure to comply has legal, financial and reputational risks.

The key functions that enable us to make commissioning decisions, and monitor the performance of our providers, must demonstrate (in an auditable manner) that the needs of protected groups have been considered in:

- Commissioning processes
- Consultation and engagement
- Procurement functions
- Service specifications
- Quality and Performance monitoring
- Governance systems

The Equality Act 2010 requires us to meet our Public Sector Equality Duty (PSED) across a range of protected characteristics, including; age, disability, gender reassignment, race, sex, sexual orientation, religion and belief, marriage and civil partnership status and pregnancy and maternity status.

Due regard' is a legal requirement and means that our decision makers have to give *advanced* consideration (consider the equality implications of a proposal before a decision has been made) to issues of 'equality and discrimination' before making any commissioning decision or implementing any policy that may affect or impact on people who share protected characteristics. It is vitally important to consider equality implications as an integral part of the work and activities that we carry out, particularly during these difficult and challenging times.

The CCG carries out equality analysis reports – commonly known as equality impact assessments (EIAs). These reports test a service change or policy change proposal and say whether it meets PSED and ultimately complies with the Equality Act 2010. Failure to carry out equality considerations would be grounds for judicial review and may result in poor outcomes and widen health inequalities.

CCG staff have continued to access support from the CCG's Equality and Inclusion Service throughout the few months to develop and deliver timely and accurate equality analysis reports.

Equality Delivery Systems 2 (EDS2)

The CCG uses the Equality Delivery System (EDS2) toolkit as its performance toolkit to support the NHS England assurance process on equality and diversity. The CCG is 'achieving' status across fifteen of the eighteen outcome areas and 'developing' status across the rest. Caution should always apply to performance managing equality performance as health inequalities across the north of England are poor and PSED is an anticipatory duty and always applies to us

as and when we make commissioning decisions that impact on people.

Following the recent publication of the revised Equality Delivery System framework for 2022 by NHS England, the CCG's Equality and Inclusion Service is now working closely with commissioners and providers on a system approach to implementation of Domain 1, patient related indicators.

Equality objectives

The CCG's four-year Equality Objectives Plan were originally approved in 2019 and refreshed in 2020. Regular progress updates and further recommended inclusions to the plan have continued to be considered by the CCG's Finance and Resource Committee. The latest version of the plan is published on the CCG's website. The CCG's equality objectives are as follows:

- Make fair and transparent commissioning decisions
- Improve access and outcomes for patients and communities who experience disadvantage
- Improve the equality performance of our providers through robust monitoring and collaboration
- Empower and engage our workforce

Good progress has been made to complete most of the actions on our Equality Objectives Plan, but as NHS Cheshire and Merseyside system, places and governance structures continue to evolve, it is relevant for a few residual actions to be completed by the ICB and Sefton Place post 1 July 2022. These have been identified as part of the transition plan and include actions in relation to inclusive recruitment. Our Equality and Inclusion Service will, of course, continue to facilitate the Cheshire and Merseyside Equality Focused Forum and patient focused task and finish groups.

The focus over the few months has been to ensure that the CCG continues to meet its' equality legal duties.

Key areas of focus include:

- ✓ Continued adaptation of a COVID-19 equality briefing which highlights issues for people with protected characteristics and people who experience health inequalities, recommendations, guidance and resources for NHS organisations to consider in their response to COVID-19. The resources include for example materials to support local organisations to meet accessible information standards compliance.

- ✓ Monitoring decision making across our providers to pay 'due regard' to our Public Sector Equality Duty prior to decisions being made.

- ✓ Ensuring specific duties are met.

- ✓ Working with the providers to develop a standardised narrative for external websites to support the armed forces community to access healthcare services and support information

- ✓ Working closely with commissioner and provider colleagues in North Mersey on service change proposals including Stroke, Breast, Vascular, Nephrology, General Surgery and Urology services.

Our staff

We have a duty 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 undertake equality training, and in addition, we have a workforce equality plan. The workforce equality plan includes actions following our review of workforce race (in accordance with the Workforce Race Equality Standard), and whilst the Workforce Disability Standard is not currently mandated for CCGs, the CCG undertook a review of its workforce disability data for the first time in 2021. The CCG uses the staff bulletin to promote disability awareness and encourage staff reporting.

Access to staff network groups hosted by Liverpool CCG have been temporarily paused whilst a staff networking scoping exercise is undertaken by the Cheshire and Merseyside Health and Care Partnership as part of the transition to an Integrated Care Board. The CCG's Sounding Board is currently the main forum for equality related issues to be discussed/ the forum to increase awareness of equality and health inequalities issues.

The CCG is also part of a Cheshire and Merseyside Workforce Equality Focused Forum which has been focusing on:

- Developing a range of programmes, resources and shared system learning to enhance opportunities for staff
- Utilising Workforce Equality Standards to bring about change and opportunity

Reducing health inequality

You can read examples of how we are addressing health inequalities throughout this report – such as our involvement activities, service developments and joint work with partners across health and care - and here are some notable examples that illustrate how we are tackling health inequalities in our day to day work.

Learning Disability Directed Enhanced Service (DES)

A Learning Disability Annual Health Check Direct Enhanced Scheme (DES) is available to GP practices nationally to deliver to their own registered population. The scheme is optional for practices to participate in and is over and above the GP core contract.

Historic participation in the DES has been low, and to increase the number of health checks delivered, we have worked to create a local solution to provide a flexible option for practice participation.

Each practice within the CCG has delivered LD Health Checks. To do this we secured participation from South Sefton Primary Health Care Limited (SSPHC) (the South Sefton GP Federation) to work alongside practices to deliver the DES in a different way, with the aim of increasing the number of health checks delivered

In June 2022 Sefton the CCG were successful in securing a bid for funding a project to focus on those patients with learning disabilities who have not accessed an annual health check in the previous twelve months. Two registered nurses were recruited initially to support the planning of the programme.

'Trans Health Sefton' – a unified approach to gender care

This service offers a unified approach to gender care and in its five years of operation has achieved some significant results for the trans and non-binary community.

Trans Health Sefton GP led service is the first of its kind and was truly co-designed with service users from the In-Trust Transgender Support Group Merseyside. Developed in 2010, the service is improving access and patient experience, as well as reducing health inequalities.

The aim of the service was to achieve an integrated approach to care with primary care providers and ensure close links with local Trans support services and expert centres at a national level, which it has been successful in doing across Sefton.

Since the Sefton service opened its doors in April 2017, 209 patients have been seen and an additional five patients per month. Levels of patient satisfaction are high with staff gaining praise for their awareness of trans people's issues.

Outcomes so far include:

- Streamlined referral process to regional Gender Identity Clinics (GICs)
- Increased shared care arrangements between GICs and primary care
- Reduction of poor patient experience using primary care services
- Improved mental wellbeing for patients

The service was named a winner in the Healthcare Transformation Awards 2019, which recognise the very best in innovation and improvement across the NHS.

A model for better regional care

The success of the Sefton service led to a regional approach to improving the care received by the trans and non-binary community through the Cheshire & Merseyside Gender Identity Collaborative (CMAGIC), which brings together clinicians, providers and service users.

Building on Trans Health Sefton, CMAGIC designed a wider pilot service to work with patients on waiting lists with regional specialist clinics and it was awarded funding by NHS England and Improvement. Mersey care was awarded the contract to deliver the regional service in 2020. The pilot offers a flexible range of tailored support options, assessment for and diagnosis of gender incongruence, hormone therapy (including prescriptions and monitoring), referrals to voice therapy, hair removal, psychological therapy to help improve mental, emotional and sexual wellbeing and referral to surgical providers.

Special Educational Needs and Disabilities (SEND)

Services for Children and Young People with SEND continue to be prioritised. This is in-line with the revised SEND improvement plan (2021/22), with performance being monitored internally at the CCG SEND health performance improvement group and through to Governing Body. There is ongoing oversight and scrutiny at the SEND Continuous Improvement Board.

Since the pandemic, services have been implementing recovery plans to return to pre-COVID delivery and to improve waiting times. In 2021/22 and through to Q1 2022/23, many of the therapy services have been back on track, but there have been ongoing challenges with the increase in referrals received to the 0- 25 years ASD/ADHD pathways, speech and language services and specialist CAHMS. Performance and improvement plans for these are being closely monitored through CCG internal performance management systems and the SEND governance framework as described above.

Voluntary, Community and Faith (VCF) sector

We commission a range of services from local voluntary, community and faith organisations towards improving wellbeing and addressing health inequalities in Sefton. This supports our priority work in Sefton2gether, our annual operational plan, 'Highway to Health', as well as the Joint Strategic Needs Assessment and Health and Wellbeing Strategy that we work on together with the council.

Below is a list of these services:

Organisation	Description of the service	Priority health areas addressed by services
Sefton Advocacy	Advocacy service for people aged 16+	Advocacy Supporting mental health, older people and Learning Disabilities agendas
Sefton CAB	Mental Health Project. Supporting in-patients at Clockview hospital	Advocacy Mental health support Supporting hospital discharges
Imagine	Individual Placement Support & Employment Service	Mental health support
Sefton CVS	Children, Young People and Family Lead (Every Child Matters) Health and Wellbeing Development Officer & Support Officer Health & Wellbeing Trainers x 4 (Supporting South Sefton Virtual Ward Programme) Community Development Worker BME Communities	Children and families Wellbeing and reablement Community and housing for people with mental health issues Support for BME communities
Alzheimer's Society	Dementia Community Support Service. Dementia Peer Group Support Service. Improving Public and Professional Awareness Service	Dementia support for patients and their families/carers
SWACA, Sefton Women's and Children's Aid	Women and Children's Aid centre, Child and Adolescent Mental Health	Children and families – Domestic Violence Support
SWAN Centre	Counselling and Listening Service	Women's Mental Health Support

	Outreach Service Support Group - Staying Out Project	
Sefton Age Concern	Befriending and Reablement Service	Older people Health & Wellbeing Support
Expect	Day service provided at Bowersdale Resource Centre	Support for people with mental health issues
Sefton Carers Centre	Advocacy for all carers	Children and families
CHART, Crosby Housing Reablement Team,	Crosby Housing Re Enablement Team	Wellbeing and reablement
Netherton Feelgood Factory	Health Promotion & Mental Health support service	Wellbeing and reablement
Parenting 2000	Children and families needing support: special needs, low self-esteem and confidence, emotional issues, drugs and alcohol, domestic abuse, bereavement	Children and families
Stroke Association	Intermediate Care (Carers and advocacy, Communication)	Wellbeing and reablement
Macmillan Cancer Support	Support for people suffering with cancer and their families	Cancer support
Venus Centre	Children and families needing support: special needs, low self-esteem and confidence, emotional issues, drugs and alcohol, domestic abuse, bereavement	Women and families

We commission a range of services from the Voluntary, Community and Faith Sector (VCF Sector) providing valuable benefits to the population of Sefton.

The impact of COVID-19 is still having an effect on all of the VCF services, face to face meetings have resumed but restrictions are much more stringent for vulnerable groups and volunteers.

Most services have reported service users presenting with multiple complex issues. Including increased anxiety and confidence issues for those who shielded during the pandemic, now trying to integrate back into communities. Addictions to gambling, drugs and alcohol have increased significantly during the pandemic along with debt, fuel and food poverty and with the current concerns around cost-of-living increases. Domestic violence particularly child on parent abuse is also on the rise, counselling and support have proven vital for families faced with these issues.

We assisted with extra funding so that these vital services could be adapted and continue to support carers and the more vulnerable in our population. We invested in our VCF providers and agreed longer contracting arrangements to help alleviate pressures within the system.

Our funding of the VCF sector remains a vital asset for Sefton and plays a significant role in supporting the NHS, Sefton Council and the vulnerable general public.

The contracted VCF organisations that we support have an important role in the recovery of services supporting the physical and mental health and wellbeing of vulnerable, socially isolated adults and older adults across Sefton.

The VCF sector demonstrated a clear ability to adapt and transform services quickly and effectively to support vulnerable and isolated groups, as well as those suffering the greatest health inequalities in our least affluent communities. Those most severely affected by COVID-19 benefitted from services delivered by the VCF sector. These services continue to be a valuable asset for Sefton's and in particular the work we are doing in line with Sefton2gether around Social Prescribing, through our PCNs and the integration of services going forward.

Working towards a sustainable NHS

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.

The COVID-19 pandemic has exacerbated health inequalities, disproportionately affecting disadvantaged communities. NHS organisations aim to provide high quality care for all. This requires a resilient NHS and, in the same way that the NHS has responded to the COVID-19 emergency, it also needs to respond to the health emergency that climate change brings. This will need to be embedded into everything we do now and in the future.

The NHS has formed a NHS Net Zero Expert panel working on identifying the most credible date that the health service could reach net zero emissions. The report "Delivering a 'net zero' National Health Service"[1] describes the direction, scale and pace of change required.

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint and implement the targets for the NHS net zero commitment. These are:

- For the emissions the NHS controls directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- For emissions the NHS can influence (NHS Carbon Footprint Plus) net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

Delivering these trajectories will require action across all parts of the NHS. The main areas for action by all NHS partners can be categorised into:

- Direct interventions within estates and facilities, travel and transport, supply chain and medicines.
- Enabling actions, including sustainable models of care, workforce, networks and leadership, and funding and finance mechanisms.

These are the most ambitious targets of any healthcare system in the world and as an organisation we have a collective responsibility to address the impact of the sector and the climate and health emergency. We have ensured that sustainability is fully embedded within CCG policies and we run awareness campaigns that promote the benefits of sustainability to our staff.

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 through the requirements of "Delivering a 'net zero' National Health

[1] https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/

Service" set the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a CCG, evidence of this commitment will need to be provided in part through contracting mechanisms.

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

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 Sefton Metropolitan Borough Council, and we will work with them to provide all the required information about carbon emissions in future years.

Electric car charging points have been fitted at the headquarters, supporting one of the main themes of Conference of the Parties 26 (COP26), the transition to electric cars. We also offer a salary sacrifice scheme for low emission and electric cars for employees to consider minimising their impact on the environment, which is in line with the UK Governments roadmap to phase out the sales of combustible engine vehicles by 2030.

As part of the response to the COVID-19 restrictions, the CCG implemented a working from home policy, mobilising staff through use of IT to work remotely. With the exception of the Medicines Management team who have continued to work from CCG premises for operational reasons, the vast majority of staff have worked from home through the year.

Staff travel has reduced significantly in recent years and we have continued with the utilisation of video conferencing for meetings. As a responsible employer and we encourage our employees to use public transport where possible. The location of our offices in Southport and Bootle are 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.

To support the Net Zero NHS strategy, in the latter half of 2021-22, the CCG requested that all suppliers operate on a 'paperless invoicing' basis by 31 March 2022. It is too early at this stage to determine how successful this request has been however, it demonstrates the CCG's full commitment to carbon reduction and ensures that social and environmental considerations are integrated into the procurement process overall. The savings which can be generated as a result can be redistributed to directly support patient care.

We will continue to develop plans to assess risks, enhance performance and reduce our 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. The CCG will ensure it complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

Accountability report

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

Corporate governance report

Members report

Governing Body membership

The table below shows the people who made up our Governing Body in 2022-23, their roles and the committees they were a part of.

Name	Role	Governing Body PTI	Governing Body PTII	Approvals Committee	Audit Committee	Clinical QIPP Advisory	Finance and Resources Committee	Joint QIPP & Financial Recovery Committee	Joint Quality and Performance Committee	Primary Care Commissioning Committee	Remuneration Committee
Dr Peter Chamberlain	Chair & GP Clinical Director	Yes	Yes	X	X	Yes	X	X	X	Non-voting member	X
Alan Sharples	Deputy Chair and Lay Member - Governance	Yes	Yes	Chair	Chair	X	Chair	X	X	Yes	Chair
Director *or deputy*	Director of Public Health, Sefton MBC *(co-opted)*	Co-opted	X	X	X	X	X	X	X	X	X
Steven Cox	Lay member – Patient and Public Engagement	Yes	Yes	Yes	Yes	X	Yes	X	Yes	Yes	Yes
Bill Bruce	Healthwatch	Co-opted – 1st Nov 2020	X	X	X	X	X	X	X	Diane Blair for Healthwatch	X
***Debbie Fagan**	Chief Nurse	Stepped down from May 2019	Stepped down from May 2019	Stepped down from May 2019	X	Stepped down from May 2019	x	Stepped down from May 2019	Stepped down from May 2019	X	X
Director *or deputy*	Director of Social Services & Health, Sefton MBC *(co-opted)*	Co-opted	x	x	X	X	X	X	X	X	X

Name	Role	Governing Body PTI	Governing Body PTII	Approvals Committee	Audit Committee	Clinical QIPP Advisory	Finance and Resources Committee	Joint QIPP & Financial Recovery Committee	Joint Quality and Performance Committee	Primary Care Commissioning Committee	Remuneration Committee
Jane Lunt	Interim Chief Nurse	Yes	Yes	Yes	X	Yes	X	Yes	Yes	X	X
Martin McDowell	Chief Finance Officer	Yes	Yes	Yes	X	*Yes (deputy)*	Yes	Yes	Yes	Yes	X
Dr Reehan Naweed	GP Clinical Director	Yes	Yes	X	X	*X*	X	X	Yes	Yes	Yes
Dr Alison Rowlands	GP Clinical Director	Yes	Yes	X	X	*X*	X	X	X	X	X
Dr Sunil Sapre	GP Clinical Director	Yes	Yes	x	X	X	Yes	X	X	X	X
Dr Jeff Simmonds	Secondary Care Doctor	Yes	Yes	Yes	Yes	Yes	X	X	Yes	X	Yes
Fiona Taylor	Chief Officer	Yes	Yes	Yes	X	X	Ex officio member	Ex officio member	Ex officio member	Yes	X
Dr John Wray	GP Clinical Director	Yes	Yes	x	X	Yes	Yes	Yes	X	X	X

* Debbie Fagan: Seconded May 2019.

Conflicts of interest

We have a managing conflicts of interest and gifts and hospitality policy that can be found on our website[1]. To accompany the policy we have a formal register of interests and a register of hospitality and gifts, all of which can be found on our website. All formal meeting agendas commence with a 'declaration of interest' and the chair of the meeting will address any declarations made in accordance with the policy and record any such matters and actions in the formal meeting minutes

Personal data related incidents

Our Joint Quality Committee ensures that any information we hold about our patients' care is held securely and in line with data protection legislation and wider information governance requirements. We report any personal data breaches to the Information Commissioner's Office (ICO). We also report breaches in our information governance annual report that we publish on our website. When breaches do occur, we work hard to strengthen our systems, and our staff carry out regular training to ensure their work complies with national standards and regulations. In Q1 2022-23 there were no breaches of personal data reported to the ICO.

Modern Slavery Act

We fully support the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement is published on our website[2].

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

Statement of accountable officer's responsibilities

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

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

In preparing the financial statements, the accountable officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements
- Prepare the financial statements on a going concern basis

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

As the Accountable Officer, I confirm that there was adequate and sufficient handover from the previous Accounting Officer to provide me with the assurances required to make these statements. 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. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Graham Urwin

Graham Urwin

Chief Executive, Cheshire & Merseyside ICB

29 June 2023

Governance statement

Introduction and context

We are a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

Our statutory functions are set out under the National Health Service Act 2006 (as amended). Our general function is arranging the provision of services for persons for the purposes of the health service in England. We are, 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.

As at 1 April 2022, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As accountable officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my CCG accountable officer appointment letter.

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

Governance arrangements and effectiveness

The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it. We are a clinically led membership organisation made up of general practices. Member practices are responsible for determining the governing arrangements for the organisation which are set out in its constitution.

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

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

challenge at Governing Body and sub-committee level.

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

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

To implement Sefton2gether and realise the vision and ambition of the refreshed Health and Wellbeing Strategy.
To drive quality improvement, performance and assurance across the CCG's portfolio.
To ensure delivery of the CCG's financial plan and align it with Sefton2gether and the work plan of transformation programmes
To support primary care development ensuring robust and resilient general practice services and the development of Primary Care Networks (PCNs).
To progress the changes for an effective borough model of place planning and delivery and support the ICS development.

The governing body is assured of its effectiveness in terms of performance management through the regular corporate performance reports on finance, QIPP and financial recovery, 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	
42 Kingsway Surgery	42 Kingsway, Waterloo, Liverpool, L22 4RQ
Aintree Road Medical Centre	1B Aintree Road, Bootle, Liverpool, L20 9DL
Blundellsands Surgery	1 Warren Road, Blundellsands, Liverpool, L23 6TZ
Bootle Village Surgery	204 Stanley Road, Bootle, Liverpool, L20 3EW
Bridge Road Medical Centre	66-88 Bridge Road, Litherland, Liverpool, L21 6PH
Concept House Surgery	17 Merton Road, Bootle, Liverpool, L20 3BG
Crosby Village Surgery	3 Little Crosby Road, Crosby, Liverpool, L23 2TE
Crossways Practice	168 Liverpool Road, Crosby, Liverpool, L23 0QW
Drs McElroy & Thomson Surgery	15 Sefton Road, Litherland, Liverpool, L21 9HA
Eastview Surgery	81-83 Crosby Road North, Waterloo, Liverpool, L22 4QD
Ford Medical Practice	91-93 Gorsey Lane, Litherland, Liverpool, L21 0DF
Glovers Lane Surgery	Glovers Lane, Netherton, Liverpool, L30 5TA
High Pastures Surgery	138 Liverpool Road North, Maghull, Liverpool, L31 2HW
Hightown Village Surgery	1 St Georges Road, Hightown, Liverpool, L38 3RY
Kingsway Surgery	30 Kingsway, Waterloo, Liverpool, L22 0QW
Litherland Practice	Hatton Hill Road, Litherland, Liverpool, L21 9JN
Liverpool Road Surgery	133 Liverpool Road, Crosby, Liverpool, L23 5TE
Maghull Family Surgery (Dr. Sapre)	Maghull Health Centre, Maghull, Liverpool, L31 0DJ
Maghull Practice (PC24)	Maghull Health Centre, Maghull, Liverpool, L31 0DJ
Moore Street Medical Centre	77 Moore Street, Bootle, Liverpool, L20 4SE
Netherton Practice	Netherton Health Centre, Magdalen Square, Bootle, Liverpool, L30 5SP
North Park Health Centre	290 Knowsley Road, Bootle, Liverpool, L20 5DQ
Orrell Park Medical Centre	Trinity Church, Orrell Lane, Liverpool, L9 8BU
Park Street Surgery	Park Street, Bootle, Liverpool, L20 3DF
Rawson Road Medical Centre	136-138 Rawson Road, Liverpool, L21 1HP
Seaforth Village Surgery	20 Seaforth Road, Liverpool, L21 3TA
The Strand Medical Centre	272 Marsh Lane, Bootle, Liverpool, L20 5BW
Thornton Practice	Bretlands Road, Thornton, Liverpool, L23 1TQ
Westway Medical Centre	Westway Medical Centre, Maghull, Liverpool, L31 0DJ

NHS England is legally required to review CCGs' performance on an annual basis. Historically, this has been carried out under the auspices of the CCG Improvement and Assessment Framework and, more recently, the NHS Oversight Framework, with the overall assessment ratings based on a CQC-style four label categorisation. The CCG only existed for Q1 of 2022/23 and therefore an assessment was not carried out however, the outcome reported back to the CCG in June 2022 demonstrated that the CCG had made good progress against the relevant lines of enquiry in respect of leadership, quality, finance, health inequalities, PCN development and the learning from the COVID-19 pandemic.

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 the new NHSE Oversight Framework.

During Q1 of 2022/23 the Governing Body is supported by a sub-committee structure comprising the committees listed below.

Audit committee

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

In September 2017 our Governing Body in conjunction with NHS Southport & Formby CCG Governing Body agreed to support the proposals for the respective audit committees to meet as "committees in common" as a more efficient and effective way of supporting the statutory business of the CCGs. That arrangement came into effect during October 2017 and continued to operate in that way throughout Q1 2022/23.

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

The principal functions of the committee are as follows:

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

All are members of the Clinical Commissioning Group Governing Body.

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 - Mersey Internal Audit Agency (MIAA)
- Anti-fraud specialist - MIAA
- Audit director - Grant Thornton
- Audit manager - Grant Thornton

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

Internal audit

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

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

Internal audit, together with CCG management, prepared a plan of work that was approved by the Audit Committee and progress against that plan has been monitored throughout the year. During Q1 2022/23, MIAA has reviewed the arrangements in place to ensure that the CCG continued to discharge its statutory duties and was able to issue a report confirming compliance.

In respect of Q1 2022/23, key items of note are:

- CCG registers of interest
- GP Pensions update
- Audit committee self assessment
- Information Governance Service report
- CCG closedown report
- DPST toolkit update
- Policy tracker
- Annual report and accounts
- External audit findings report (ISA 260)
- Draft letter of representation
- Service audit reports

External audit

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

Anti-fraud specialist

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

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

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

The anti-fraud specialist, together with CCG management, prepared a plan of work that was approved by the Audit Committee and progress against that plan continues to be monitored throughout the year.

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.

In September 2017 our Governing Body in conjunction with NHS South Sefton CCG Governing Body agreed to support the proposals for the respective Remuneration Committees to meet as "committees in common" as a more efficient and effective way of supporting the statutory business of the CCGs. That arrangement came into effect during October 2017 and continued to operate this way during 2021-2022.

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

During the Q1 2022/23, the committee did not meet.

Joint QIPP Delivery Group

This group evolved from the substantive Joint QIPP Committee and became a sub-group of the finance and resources committee. The membership, roles and responsibilities all transferred.

The responsibilities in respect of QIPP programme management were also acquired by the new group and decision making responsibility in respect of resource allocation, was delegated to the Finance and Resources Committee.

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 Delivery Group and also to any other forum or individual that maybe require clinical inputs. The group is not decision making, but advisory in its capacity.

Primary Care Commissioning Committee

The Committee was established in April 2019 to enable members to make collective decisions on the review, planning and procurement of primary care services in Southport and Formby under delegated authority from NHS England. The role of the committee is to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act. The Committee has a “committees in common” arrangement with NHS South Sefton CCG.

However, each respective committee remains accountable for decisions pertaining to their relevant CCG.

In respect of Q1 2022/23, key items of note are:

- PCN Update
- Primary Care Finance
- Quality Updates
- Primary Care Procurements
- Primary care risk registers

Cheshire and Merseyside joint committee of CCGs

The Cheshire and Merseyside Joint Committee is a Joint Committee of: NHS Cheshire CCG; NHS Halton CCG; NHS Knowsley CCG; NHS Liverpool CCG; NHS South Sefton CCG; NHS Southport and Formby CCG; NHS St Helens CCG; NHS Warrington CCG; and NHS Wirral CCG established through the powers conferred by section 14Z3 of the NHS Act 2006 (as amended). Its primary function is to make collective binding decisions on agreed service areas, for the Cheshire and Merseyside population within its delegated remit.

The overarching role of the Joint Committee is to enable the Cheshire and Merseyside CCGs to work effectively together and make binding decisions on agreed service areas, for the benefit of the both the resident population and population registered with a GP practice in Cheshire and Merseyside.

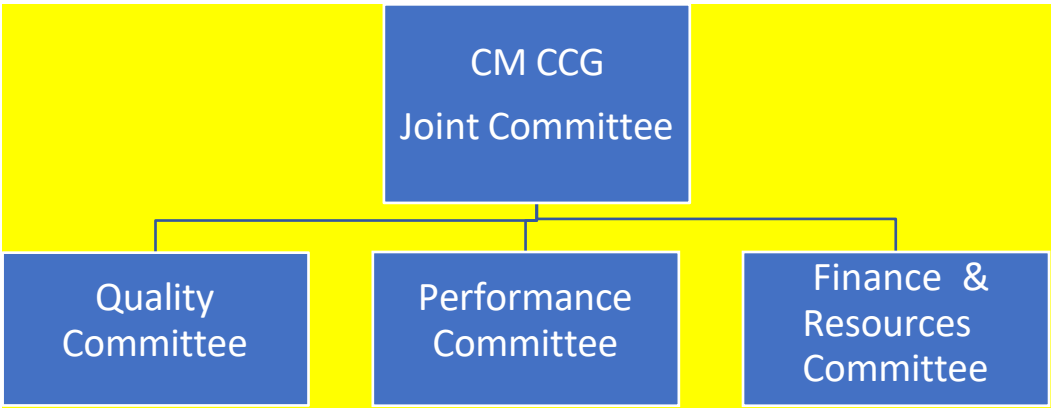
In April 2021 the committee was established to take on the following functions and workplan and the CCG formally authorised the respective delegations in February 2021 to come into effect April 2021.

Service area to be commissioned 'at scale'	Specific services to be included in the workplan of the Joint Committee of Cheshire and Merseyside CCGs
Mental Health Services	A. Children and Young People mental health services • Crisis services • Eating disorder services B. Agree common standards and develop a common workforce strategy to address widespread variation in access, provision, quality and outcomes C. Out of area placements
Acute services	A. Specialist Rehabilitation services (Neuro, Mental Health, Stroke, complex cases) B. To re-procure Bariatric services during 2021/22. C. Spinal services D. Standardise clinical commissioning policies e.g. IVF, interventions of low clinical importance E. Agree to adopt the National Specification for Stroke services across C&M.

The inaugural meeting was held on 20th July 2021 just shortly after the publication of the Health and Care Bill on 6 July 2021 the Health and Care Bill. The bill sets out how the Government intends to reform the delivery of health services and promote integration between health and care in England. This is the first major piece of primary legislation on health and care in England since the Health and Social Care Act 2012.

The new legislation will establish an NHS body to be known as the NHS Integrated Care Board (ICB) on 1st July 2022. ICBs will bring partner organisations together in a new collaborative way with common purpose. They will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place. It further identifies what cannot be delegated, for example Primary Care (general medical services), Audit, Remuneration and duty to consult – and notes that these are 'out of scope'. Given the stipulated timelines, it was imperative that the Joint Committee was enabled to take can take on additional functions so as to progress to shadow ICB form at pace.

In November 2021 the governing body authorised the delegation of relevant functions to the joint committee and in doing so also disestablished the finance and resources committee and the joint quality and performance committee. The roles and responsibilities of those committees were transferred to a new Cheshire and Merseyside joint committee sub-committee structure as set out below.



Senior leadership team

At the same time as further delegations were given to the joint committee, the CCG's existing senior leadership team was also given further delegations to preside over matters that were bespoke to the place of Sefton and also those functions that are not able to be delegated elsewhere; matters retained to SLT relate to HR and workforce, budget setting for 2022-23, SEND, risk management and S75.

Governing Body Members - Committee Attendance 2022 – 2023

South Sefton CCG Governing Body Member Through 2022/23	Governing Body PTI	Governing Body PTII	Approvals Committee	Audit Committee	Clinical QIPP Advisory Group	Finance & Resource Committee	Joint QIPP and Financial Recovery Committee	Joint Quality and Performance Committee	Primary Care Commissioning Committee PTI	Primary Care Commissioning Committee PTII	Remuneration Committee
Dr Peter Chamberlain	2/2	2/2	***	-	-	**	***	**	-	-	***
Alan Sharples	2/2	2/2	***	2/2	-	**	***	**	1/1	1/1	***
Director or *Deputy*	0/2	-	***	-	-	**	***	**	-	-	***
Director or *Deputy*	1/2	-	***	-	-	**	***	**	-	-	***
Steven Cox	1/2	1/2	***	1/2	-	**	***	**	-	-	***
Bill Bruce	1/2	-	***	-	-	**	***	**	-	-	***
Jane Lunt	0/2	0/2	***	-	0/3	**	***	**	-	-	***
Martin McDowell	2/2	0/2	***	-	-	**	***	**	0/1	0/1	***
Reehan Naweed	2/2	2/2	***	-	*3/3*	**	***	**	1/1	1/1	***
Alison Rowlands	2/2	2/2	***	-	*1/3*	**	***	**	-	-	***
Dr Sunil Sapre	0/2	0/2	***	-	-	**	***	**	-	-	***
Dr Jeff Simmonds	1/2	1/2	***	1/2	0/3	**	***	**	-	-	***
Fiona Taylor	2/2	2/2	***	-	-	**	***	**	1/1	1/1	***
*Dr John Wray	2/2	2/2	***	-	2/3	**	***	**	-	-	***

*John Wray: There is a long standing conflicting commitment in relation to the role with NWAS emergency planning.
** Meeting stood down in November 2021
*** No meetings in Q1

UK corporate governance code

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

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

Discharge of statutory functions

In light of recommendations of the 2013 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, the CCG 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 and this is evidenced in the Leadership Team Accountability Framework. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties. These are reviewed regularly and any gaps in capacity are addressed.

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.

We have embedded processes in place to manage risks associated with service development or change. Stakeholder mapping, quality impact and equality impact assessments are integral to developing plans for proposed change and to manage risks which may impact on those affected by change.

Capacity to handle risk

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

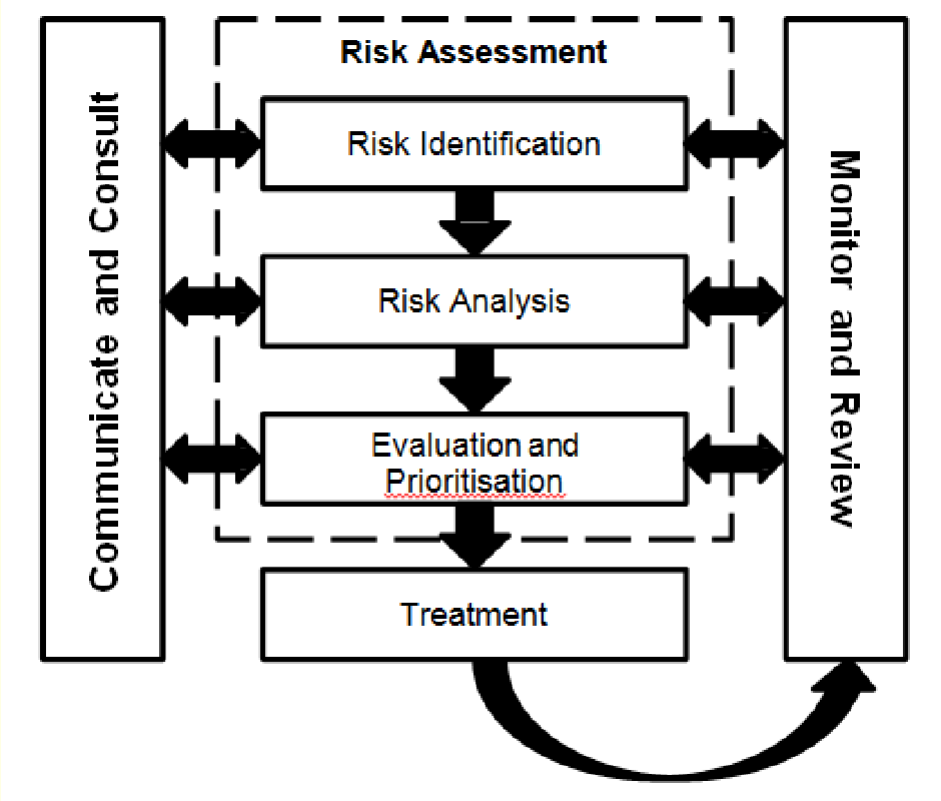
document that is used to inform and give assurance to the Governing Body that the risks to achieving key objectives are recognised and that controls are in place or being developed to manage these risks.

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

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

Risk management framework

We have 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. During 2021-22 the corporate risk register was updated to

capture all COVID-19 related risks impacting on the CCG and this continued during Q1 2022/23 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.

We commission 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, such as information governance, counter fraud, fire, health and safety, equality and diversity and safeguarding training are mandatory training requirements for all staff.

To ensure that there is a mechanism for public stakeholders to assist in the management of risks that impact on the public, the CCG has established an Engagement and Patient Experience Group (EPEG). This group reviews proposals for service change ensuring compliance with the Public Sector Equality Duty and other relevant laws before progressing further with consultation. We also consult with the Overview and Scrutiny Committee on any proposals potentially impacting on the public so that there is holistic and system wide assessment and mitigation of risks.

Other sources of assurance internal control framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them, efficiently, effectively and economically. The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk it can therefore only provide reasonable and not absolute assurance of effectiveness.

Annual audit of conflicts of interest management

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

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

Data quality

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

Midlands and Lancashire CSU is commissioned to provide the CCG with inter alia, performance reports, contract monitoring reports, quality dashboards and other activity and performance data. Our 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 a Data Security and Protection Toolkit (DSPT) 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 Data Security and Protection 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 and we continue to work to ensure that a risk culture remains fully embedded throughout the organisation against identified risks.

Business critical models

Officers of the CCG have reviewed the Macpherson report to consider the implications for the CCG. A report was provided to Audit Committee in April 2022 which provided assurance on CCG processes in place for business critical models.

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

We have delegated arrangements in place with providers external to the CCG for some services. Where we rely 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.

Pension obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with.

This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

A national issue has been identified whereby GP Governing Body and Clinical Lead roles have not been treated correctly for the purposes of pension. These roles were considered to be non-pensionable however following contract review it has come to light that these roles should have been subject to contributions. Current GP Governing Body and Clinical Lead roles now attract pension deductions. The CCG is working with Business Advisors to resolve the historical impact of this issue.

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. Throughout the COVID-19 pandemic and since March 2020 we regularly updated our Equality Impact Analysis to ensure we were continuing to discharge our statutory duties.

Sustainable developments obligations

We will develop plans to assess risks, enhance performance and reduce our 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. The CCG will ensure it 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

We have a risk management strategy. The following key elements are contained within the strategy:

- Aims and objectives
- Roles, responsibilities and accountability
- The risk management process – risk identification, risk assessment, risk treatment, monitoring and review, risk prevention

- Risk grading – criteria
- Training and support

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

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

Risk description	Key controls and assurances in place			
There is a risk that an Increase in size of elective care waiting lists, caused by reduced activity during COVID-19 pandemic, will have adverse effects on wait times for patients and possibly health outcomes.	Mitigations scrutinised included – The operational planning guidance, 22/23, outlines expectations for the reduction of elective care waits. These plans are being co-ordinated by the system with expectations that Providers will deliver 10% more activity than 19/20 out-turn and priority on long waiters and reducing waiting lists. 104 week waits predicted to be eliminated by July 22, with S&O not anticipated having any 104 week waiters and LUFT forecasting no 104 waiters by July. The CCG is participating in the planning rounds as and where directed by the system and continue to monitor and support the system in developing sustainable services that will provide the capacity required to deliver against the plan. Continued frequent engagement with Trusts and other CCGs.	4	4	16
There is a risk to performance, quality and delivery of the CHC programme caused by COVID-19 resulting people being lost in the system, care packages not being appropriate to patient need and a post Covid 19 backlog of referrals and assessments.	Mitigations scrutinised included - SFIs; SOs; Established Financial Controls; Audits of Financial Systems • Regular bi-monthly meetings with NHSE/I with bi-monthly SitRep submissions will continue through Q3/Q4 2021. • A single point of access for patient appeal/complaints is now in place to ensure all cases can be considered. • CHC CQPG established in order to review and challenge current CHC activity (Feb 21). • North Mersey Steering Group established to develop an agreed process to complete all deferred assessments by March 2021. • MIAA audit carried out to review performance of ADM DPS.	4	4	16

	• Service Specification review carried out. • Review of CHC performance reports.			
There is a risk of reduced survival outcomes due to delays in diagnosis and treatment of cancer	Mitigations scrutinised included - • Recovery planning trajectories for H1 • Strengthened process for harm review reporting on patients who have waited 104 days or more from referral to treatment or 73 days or more from decision to treat to treatment • Cancer Deep Dive at SO-CCQRMat November meeting. Recovery planning Trajectories for H2. • Cancer improvement plan developed by S&O which has protectories to restore performance to operational standards by March 23. COVID-19 rapid cancer registration and treatment data. • Cancer performance and improvement plan continues to be monitored via contract meetings and CCG bi-weekly calls. Individual tumour action plans shared with CCG and trends and theme for long cancer waits are shared. RCAs submitted to CCG for 104 day breaches. • Endoscopy estates development and mutual aid from other providers, recruitment to cancer nurse specialist and tracker roles and strengthening of SLAs with partner providers.	4	4	16

There is a risk of non-implementation of integration plans caused by financial pressures resulting in a negative impact on local services.	Mitigations scrutinised included - • Self Assessment taken place for integration plans - current level at 'evolving', action plan is in place - risk score re-evaluated with impact and likelihood score reassessed. • Establishment of Strategic Task and Finish group to progress development of ICP in Sefton	5	5	25
Adult Eating Disorder service has had long standing challenges around achieving 18 week waits. In addition the service is not NICE compliant	Mitigations scrutinised included - • CCGs (including Liverpool) have agreed that funding for eating disorders needs to be on a phased basis over the next 3 years • Sefton CCGs have agreed an initial investment of £106K £112k as part of the 21/22 long term plan investment. • SSCCG have agreed their share of the £112k investment, SFCCG have still to confirm their share • SFCCG have agreed their share of the £112k investment • the provider is currently recruiting to a dietician post and psychology post to support the service. • MC have attempted to recruit the above posts, due to a national shortage, they have been unable to fill the gaps, they are still attempting to recruit. • The service has been asked for an outline and costings for a new service model that is MDT led. • GB and SLT have all had recent updates so are aware of the risks	4	5	20

There is a risk that the CCG will not fully deliver its planned QIPP target in 2021-22 caused by non-delivery of high risk QIPP schemes resulting in a failure to deliver required levels of savings.	Mitigations scrutinised included – • Monthly review and monitoring of all QIPP schemes to assess delivery in year and highlight risks and issues affecting delivery of planned QIPP savings. • Revised QIPP reporting arrangements through F&R Committee anticipated to enable greater impact of "check and challenge". • Continued focus on QIPP through the emergency response through CCG PMO/ Committee meetings. Ongoing discussions with system partners to ensure progression with QIPP activities where appropriate and to understand timescales for the recovery period and work on further QIPP schemes in the recovery period. • PMO to develop an understanding of system partner CIP/ QIPP schemes which will continue to be progressed during the COVID response period and maintain communications with all parties.	5	5	25
There is a risk that Children in Care do not receive timely care caused by a lack of capacity and resource (staffing) within the commissioned Children in Care Health Teams. There is also an increase in the number/complexity of children entering the care system. This is resulting in poorer health outcomes for children and poor performance.	Mitigations scrutinised included - • The CCGs Continuing Healthcare Programme Lead is in the process of finalising the service specification across the North Mersey area. Support is being provided by colleagues from Finance, Contracting and PHB managers to ensure the specification is robust and accurate. The CCGs Continuing Healthcare Programme Lead is working with colleagues in the Contracting Team to draft the breach notice to MCLSU, which	4	4	16

	is yet to be finalised and approved by SMT. • The monthly IPA CQPGs have been re-instated, these had been stepped down due to the national response to COVID. The CCGs strategic board chaired by the CCGs Chief Officer, is currently being reviewed with the plan to reduce the frequency to monthly. • NHS EI C&M confirmed at the February Quality Surveillance Group (QSG), their intention to undertake a deep dive of CHC across the C&M CCG areas. This will provide a full picture of performance across all CCGs and support the future model of CHC as we transfer across to ICS.			
The risk that the health related targets of the SEND improvement plan will not be met due to the impact of covid-19 on progress and ability to deliver, specifically the waiting times for therapy services and CAMHS. This may impact on the provision of services to SEND CYP and result in reputational damage for the CCGs and SEND partnership.	• Monitored via the SEND partnership's governance structures ie; the SEND Continuous Improvement Board (SENDCIB) and subgroups • Waiting times reported and monitored monthly via SEND Health Improvement Group and internal IPR process • Sep 21 - LT using the MHIS, SR/SDF and MHST funding approved Alder Hey business case to match the current and projected levels of demand to achieve the 92% waiting time target. Providers developing revised COVID recovery plans and trajectories detailing the timeframes to achieve a staged and sustainable return to the 92% waiting time measure. AHCH recruitment to posts has begun. • Services focussing on reducing the numbers of children and young people who have been waiting the longest whilst	3	4	12

	managing increases in referrals. Notably for SALT, there continues to be an ongoing increase in referrals which has been evident since the schools initially reopened in September. This is being closely managed by the service and all referrals are clinically triaged at the point of receipt and prioritised according to need. The trust has just commenced reporting monthly physiotherapy performance which is also within the 92% waiting time target. • March 22 - The CCG has agreed additional investment into ASD and CAMHS and improvment plans are currently being shared with SLT and LT			
There is a risk of non delivery of the CCG's control total in 2020/21 due to emerging pressures on expenditure or non-delivery of its savings plan.	• Robust review of all CCG expenditure through monthly management accounting routines. • Examination of QIPP savings and opportunities at beginning of financial year as part of financial planning. On-going monitor throughout the year. • Scheme of delegation in place internally to limit authority to commit CCG resources to senior management. • Revised QIPP reporting arrangements through F&R Committee anticipated to enable greater impact of “check and challenge”. • Monthly reporting process to the Governing Body. • Finance involvement in multi-disciplinary COVID working groups to monitor discharge arrangements and to design and implement information capture/reporting mechanisms to ensure that all COVID related	3	3	9

	expenditure is recorded appropriately. • Use of the ADAM system to capture all COVID associated packages of care based on information provided via discharge to assess processes through MLCSU. • Monitoring of prescribing changes due to COVID-19 in development with the BI team. Monitoring information will provide a more accurate assessment of level of risk.			

Overall, we are vigilant to the potential risks to the CCG operating licence and maintain a system of strong internal control and risk management. However, no organisation can be complacent, and we recognise this and have 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 we keep 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

We seek to gain best value through all of our contracting and procurement processes. We have 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.

We buy procurement expertise and support from the Midlands and Lancashire CSU and this service is delivered by appropriately trained and accredited individuals.

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

The Governing Body is informed by its committees on the economic, efficient and effective use of resources and in particular by the Audit Committee and the Joint 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.

Our Joint QIPP Committee programmes of work are clinically led by clinical Governing Body members and are evaluated to determine that they represent the best use of available resources. All programmes are supported by designated commissioning leads and a wider 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

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

- Shaping Care Together Programme has been delegated to a Joint Committee of NHS Southport and Formby CCG and NHS West Lancs CCG
- North Mersey Joint Committee with NHS Knowsley CCG, NHS South Sefton CCG and NHS Liverpool CCG
- St Helens and Knowsley Teaching Hospitals NHS Trust – payroll processing
- NHS Shared Business Services – provision of transactional finance services
- Midlands and Lancashire Commissioning Support Unit –aspects of Continuing Healthcare (CHC), Individual Funding Requests (IFR) and Funded Nursing Care (FNC) reviews, Business Intelligence, Human Resources and Organisational Development, Medicines Management, Risk Management, Corporate Governance and compliance
- Informatics Merseyside that provides our information technology services and support

During Q1 2022/23 any identified risks associated with delegated arrangements have been monitored through our governance and risk management processes. We have 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

We comply with the NHS Counter Fraud Authority Standards for Commissioners: Fraud, Bribery and Corruption as found at the following link https://cfa.nhs.uk/government-functional-standard/NHS-requirements

An accredited anti-fraud specialist is contracted via Mersey Internal Audit Agency to provide counter fraud services. The chief finance officer is the CCG executive Governing Body member. The anti-fraud specialist attends Audit Committee meetings, providing formal updates of progress against the annual counter fraud plan and programme of activities.

We perform a self-assessment of the NHS Counter Fraud Authority for Commissioners, the results of which are reported to Audit Committee.

Head of Internal Audit Opinion

4.1 Roles and responsibilities

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

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

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

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

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which can provide assurance, subject to the inherent limitations described below. The outcomes and delivery of the internal audit plan are provided in Section 4.

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

4.2 Opinion

Our opinion is set out as follows:

4.2.1 Basis for the opinion

The basis for forming our opinion is as follows:

1	An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account the relative materiality of systems reviewed and management's progress in respect of addressing control weaknesses identified.
2	An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

4.2.2 Overall Opinion

Our overall opinion for the period 1st April 2022 to 30th June 2022 is:

High Assurance, can be given that there is a strong system of internal control which has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed.	
Substantial Assurance, can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.	✓
Moderate Assurance, can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk.	
Limited Assurance, can be given that there is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls impacts on the overall system of internal control and puts the achievement of the organisation's objectives at risk.	
No Assurance, can be given that there is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the organisation's objectives.	

4.3.3 Commentary

The commentary overleaf provides the context for our opinion and together with the opinion should be read in its entirety.

Our opinion covers the period 1st April 2022 to 30th June 2022 inclusive, and is underpinned by the work conducted through the risk based internal audit plan.

4.3.3.1 Data Security and Protection Toolkit (DSPT) CCG to Integrated Care Systems (ICS) Handover Review

Clinical Commissioning Groups (CCGs) measure their compliance against law and central guidance and identified areas of full, partial or non-compliance through the completion of the Data Security and Protection Toolkit (DSPT). However, with the statutory abolishment of CCGs and statutory obligations being managed by Integrated Care Board (ICB) entities as the statutory body from 1st July 2022, it had been announced that CCGs would not be required to submit baseline assessments in February or to have an internal audit of their toolkit submission although they will be required to submit a final submission by 30th June 2022.

The CCG, as part of its due diligence activities and in preparation for the handover to the ICB, have recognised the value in assessing their DSPT position for the 2021/22 year and have commissioned a handover review of that position to provide assurance to management on its development activities to date.

We provided a high-level assessment of the CCG's intended DSPT submission and supporting guidance, and overall this resulted in **Substantial Assurance.**

4.3.3.2 Compliance with Statutory Functions

Assurance has been provided that the CCG has continued to comply with its statutory functions pre ICB transfer.

Scope limitations – this review focussed on overarching arrangements and detailed testing was not undertaken in line with the approved Internal Audit Plan.

4.3.3.3 CCG Transition - System Support

The following system support, covering a number of transition elements and workstreams, has been undertaken in year. This work complements and supports local transition work.

Cheshire & Merseyside

- **Audit Committee Engagement Events:** Briefing sessions facilitated for Audit Committee members on CCG Transformation and ICB Establishment.
- **SBS Project Board:** MIAA have continued to undertake a project assurance role supporting the SBS Project Board in the implementation of the ICS ledger.
- **Delegated Duties:** Undertook reviews of the transfer of delegated duties from CCGs to the Joint Committee of Cheshire and Merseyside CCGs and reviewed the operational effectiveness of the Joint Committee and its supporting Sub-Committees who have received the delegated duties.
- **System Group Representation and Reporting:** Attendance, contribution and adhoc support to:-
    - Finance Workstream Group
    - Governance Leads Workstream Group (including Policy Mapping, System Risk Collation etc).
- **SBS Ledger Implementation Project Board:** Attendance at Project Board in a Project Assurance capacity
- **Contracting:** Undertook a review of the process established to manage the collation of contracts across the Cheshire and Merseyside CCGs and management of the transition/identification of risks associated re: implied contracts etc.

4.3.3.4 CCG Transition - Local Support

To enable us to comment on the processes in place regarding the adequacy of transition plans, we have continued to undertake a number of activities including:

- Transition working group attendance; and
- Assessing the governance processes for the completion, monitoring and sign-off of the CCG's Due Diligence Checklist.

We can provide assurance that processes were established and maintained for the completion and monitoring of the Due Diligence Checklist over the period reviewed.

Note: theassurance provided above does not provide confirmation of the accuracy ***and completeness of the Due Diligence Checklist.***

4.3.3.5 Follow Up

During the course of the year we have undertaken follow up reviews and can conclude that the organisation has made **good progress** with regards to the implementation of recommendations.

2 recommendations have been assessed as not fully implemented, however, both recommendations have been superseded due to CCG closedown.

4.3.3.6 Wider organisation context

This opinion is provided in the context that the Governing Body like other organisations across the NHS is facing a number of challenging issues and wider organisational factors particularly with regards to ICB transition processes. The challenges for organisations have included continuing to ensure an effective pandemic response, delivering business as usual requirements and implementing and managing a transition process for the establishment of ICBs.

During the Covid response, there has been an increased collaboration between organisations as they have come together to develop new ways of delivering services safely and to coordinate their responses to the pandemic. This focus on collaboration will continue as the NHS progresses on its journey towards integrated care systems.

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.

Chris Harrop
Managing Director, MIAA
June 2022

Louise Cobain
Assurance Director, MIAA
June 2022

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 principal objectives have been reviewed.
I have been advised on the implications of the result of this review by the Governing Body, audit committee and senior leadership team.

Conclusion

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

Graham Urwin

Graham Urwin

Chief Executive, Cheshire & Merseyside ICB

29 June 2023

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.

In the NHS, the report is prepared in respect of the Senior Managers of the NHS body. 'Senior Managers' are defined as: 'those persons in senior positions having authority or responsibility for directing or controlling major activities of the NHS body. This means those who influence the decisions of the Clinical Commissioning Group as a whole, rather than the decisions of individual directorates or departments.' For the purposes of this report, this includes the CCG's Governing Body members.

Remuneration Committee

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

Our remuneration committee membership is made up Governing Body members from NHS South Sefton CCG and NHS Southport and Formby CCG. The committee is a joint Remuneration Committee due to the shared management relationship between the two CCGs. During Q1, the Committee did not meet.

Policy on remuneration of senior managers

NHS England's Guidance (Remuneration guidance for Chief Officers (where the senior manager also undertakes the Chief Officer role and Chief Finance Officers) and associated letters have been used since 2019-20 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. a 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 on pages 144 to 179 of the Financial Statements and pension liabilities existing at 30 June 2022 are disclosed within the Statement of Financial Position under other payables.

Under the Pensions Act 2008, every employer in the UK must put certain staff into a pension scheme and contribute towards it. This is known as 'automatic enrolment'. In addition to the NHS Pension Scheme detailed above, the CCG operates a National Employment Savings Trust (NEST) pension scheme as an alternative qualifying scheme. The CCG has worked with the outsourced payroll provider throughout the period to 30 June 2022 to ensure

compliance with all legal duties.

A national issue has been identified whereby GP Governing Body and Clinical Lead roles have not been treated correctly for the purposes of pension. These roles were considered to be non-pensionable however following contract review it has come to light that these roles should have been subject to contributions. Current GP Governing Body and Clinical Lead roles now attract pension deductions. The CCG is working with Business Advisors to resolve the historical impact of this issue.

Employer pension contributions were provided for at 20.68% for the period to 30 June 2022 financial year. CCGs are required to separately account for employer contributions paid on their behalf by NHS England on a gross basis. The contributions paid on behalf of the CCG have been accounted for as notional funding for commissioners.

Policy on senior manager's service contracts

Senior Managers (Officers) hold permanent contracts of employment and are subject to a six month notice period. Governing Body members, excluding chief officer, chief finance officer and chief nurse, are office holders.

All other members of staff 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 are compliant with both UK and EU legislation and approved by our remuneration committee. Any future amendments to these contracts or the remuneration associated with them are reviewed by the remuneration committee and recommended to the Governing Body for approval on an annual basis. Where required the committee has access to professional advice from the MLCSU HR team and CCG legal advisers, Hill Dickinson LLP.

We do not have any very senior managers paid in excess of £150,000 per annum.

Senior manager remuneration subject to audit

The table below sets out the salaries and allowances we have paid for the period to 30 June 2022 that are payable to our senior managers:

Name	Title	Salary	Taxable Benefits	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	2022/23	2021/22
		(Bands of £5,000)	(Rounded to the nearest £100) £	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)
Taylor FL	Chief Officer	15 - 20	600.00	-	-	0 - 2.5	15 - 20	75 - 80
McDowell M	Chief Finance Officer / Deputy Chief Officer	10 - 15	600.00	-	-	5 - 7.5	20 - 25	65 - 70
Lunt J***	Interim Chief Nurse	5 - 10	-	-	-	10 - 15	15 - 20	15 - 20
Cooke CA *	Chief Nurse	-	-	-	-	-	-	25 - 30
Wray J**	Clinical Vice Chair & GP Clinical Director	10 - 15	-	-	-	-	10 - 15	50 - 55
Rowlands A**	GP Clinical Director	5 - 10	-	-	-	-	5 - 10	20 - 25
Chamberlain PJ**	Chair & GP Clinical Director	25 - 30	-	-	-	-	25 - 30	50 - 55
Sapre S	GP Clinical Director	0 - 5	-	-	-	-	0 - 5	15 - 20
Halstead G*	GP Clinical Director	-	-	-	-	-	-	35 - 40
Simmonds J	Secondary Care Doctor	5 - 10	-	-	-	-	5 - 10	10 - 15
Sharples A	Deputy Chair & Lay Member - Governance	0 - 5	-	-	-	-	0 - 5	10 - 15
Cox S	Lay Member - Engagement and Patient Experience	0 - 5	-	-	-	-	0 - 5	5 - 10

* These members ceased tenure and have been included for comparative purposes only.
** Total paid in 2021-22 and 2022-23 includes payments for additional clinical roles and duties performed by members.
*** The interim Chief Nurse was appointed on 1 October 2021

Payments reflect the role in carrying out Governing Body duties. In addition, payments were made to the individuals highlighted to reflect the additional clinical roles and duties performed by GP Governing Body members.

We have a joint management arrangement with neighbouring NHS Southport and Formby CCG. Our chief officer (Fiona Taylor) and chief finance officer (Martin McDowell) receive remuneration for undertaking these roles for both CCGs. Their total banded remuneration for the period to 30 June 2022 from these roles is:

- Fiona Taylor £30,000 to £35,000 and £2,500 to £5,000 all pension related benefits
- Martin McDowell £25,000 to £30,000 and £2,500 to £5,000 all pension related benefits

The joint management arrangement with NHS Southport and Formby CCG is also in operation for the chief nurse post. With effect from 1st October 2021 Jane Lunt, chief nurse from NHS Liverpool CCG took up the position on an interim basis. The total banded remuneration for this role was £25,000 - £30,000.

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 Committee 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 subject to audit

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 30 June 2022 (bands of £5,000) (Note 4)	Lump sum at pension age related to accrued pension at 30 June 2022 (bands of £5,000) (Note 4)	Cash Equivalent Transfer Value at 1 April 2022	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 30 June 2022	Employer's contribution to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000
Fiona Taylor	Chief Officer	0 - 2.5	0	70 - 75	180 - 185	1571	8	1596	0
Martin McDowell	Chief Finance Officer	0 - 2.5	0	40 - 45	80 - 85	743	8	760	0
Jane Lunt	Director of Quality, Outcomes & Improvement	0 - 2.5	0 - 2.5	70 - 75	110 - 115	1224	16	1253	0

The information in the table above for our chief officer (Fiona Taylor), chief finance officer (Martin McDowell) and chief nurse (Jane Lunt) relates to their total pension benefits arising from their joint management roles in NHS South Sefton CCG and NHS Southport and Formby 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 at 1 April 2021 have been recalculated to include 0.5% inflation which is calculated in accordance with SI 2008 No. 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008 (33)

In April 2015 there were reforms to public service pension schemes (firefighters, judges, member of the armed forces, NHS staff, teachers and civil servants). This moved employees from final salary schemes to career average schemes with retirement age equal to state pension age.

For the NHS, this meant the introduction of the 2015 scheme with protected members remaining in their existing section of the 1995/ 2008 scheme. The Court of Appeal ruled on the 20th December 2018 that this protection amounts to direct unlawful discrimination on age grounds. This judgement is referred to as the McCloud judgement Pension benefits and related cash equivalent transfer values do not allow for a potential adjustment arising from the McCloud judgement. https://www.nhsemployers.org/pay-pensions-and-reward/pensions/mccloud-judgement

NHS South Sefton CCG was in operation from 1 April 2022 to 30 June 2022. The senior managers above therefore stepped down from their position from 30 June 2022. As such 1/4 of the annual pension totals only have been shown.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

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

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

Real increase in CETV

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

Compensation on early retirement or for loss of office subject to audit

For the period to 30 June 2022 the CCG has not made any payments for loss of office.

Payments to past members

For the period to 30 June 2022 we have not made any payments to any past senior managers.

Fair Pay Disclosure

For clarity, the values included in this section are not the amounts received in relation to work undertaken solely for this CCG because there are shared arrangements with NHS Southport and Formby CCG for the majority of the workforce. The values shown are calculated as though the individual worked full time (full-time equivalent) for the whole year (annualised), whereas in reality some individuals may only work part time.

The annualised full-time equivalent remuneration is not necessarily the amount physically paid to the individual. For example the highest paid director is identified as being the chief officer, however there are individuals who have a higher annualised full-time equivalent remuneration but only receive a portion of this due to not working full time.

Percentage change in remuneration of highest paid director subject to audit

3 months to 30 June 2022

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	3.21%	3.21%

2021-22

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	11.82%	11.82%

Pay ratio information subject to audit

As at 30 June 2022, remuneration ranged from £11,275 - £166,858 (2021-2022: £21,777 - £166,838) based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Remuneration of South Sefton's CCG staff is shown in the table below:

	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£32,306	£45,839	£63,862
salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£32,306	£45,839	£63,862

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director/member in South Sefton CCG in the period to 30 June 2022 was £130,000 - £135,000 (2021-2022: £130,000 – £135,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th percentile total remuneration ratio	25th percentile salary ratio	Median total remuneration ratio	Median salary ratio	75th percentile total remuneration ratio	75th percentile salary ratio
2022/23	4.1:1	4.1:1	2.9:1	2.9:1	2.1:1	2.1:1
2021/22	4.1:1	4.1:1	2.9:1	2.9:1	2.4:1	2.4:1

For the period to 30 June 2022, no employees (2021-2022: nil) received remuneration in excess of the highest-paid director/member.

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. At the start of 2020-21 we performed an assessment of the impact of COVID-19 on our workforce and implemented working from home arrangements as required. Arrangements have been kept under review throughout the year.

Our refreshed organisational development plan highlights five priority areas for actions that we have been progressing over the last twelve months. These are:-

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

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

Our Governing Body

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

Our members

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

- Continuing professional development sessions are regularly organised for clinical staff and these are called Protected Learning Time (PLT) events. The CCG also supports monthly “in-house” sessions, which enables all GP practices to hold individual educational and practice training events.
- Regular meetings of local groups of practices in ‘localities’ enable key issues relating to local services to be raised and discussed, so that the Governing Body and lead commissioners are kept informed in order to influence commissioning decisions.
- Our nurse facilitators support the development and access to education, training and mentoring for practice nurses and healthcare assistants and the CCG became one of the first in the county to host student nurse placements
- We hold quarterly membership meetings where practices come together to discuss wider CCG work and initiatives to improve patient care

- A weekly e-bulletin provides members with updates on CCG work, along with relevant national publications and development opportunities
- An intranet site provides a wide range of information designed to support our members, which we are continuing to update regularly based on member's feedback

Staff numbers and costs subject to audit

At the end of June 2022 we employed 171 people (132 whole time equivalents of which 76 relate to South Sefton CCG) 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.

	Permanent Employees £'000	Other Employees £'000	Total £'000
Salaries & Wages	684	36	**720**
Social Security	192	-	**192**
Employer Contributions to NHS Pension Scheme	304	-	**304**
Apprenticeship Levy	3	-	**3**
Total	**1,184**	**36**	**1,219**

	Permanent	Other	Total
Administration and estates staff	84	15	99
Nursing, midwifery and health visiting staff	8	-	8
Scientific, therapeutic and technical staff	59	5	64
Total	**151**	**20**	**171**

Staff composition

	Governing Body	Very Senior Managers	Other employees	Total
Male	9	1	36	**46**
Female	6	1	118	**125**
Total	**15**	**2**	**154**	**171**

There are two very senior managers (according to definition within the Group Accounting Manual) who were included in the membership of the CCG Governing Body.

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

- We are committed to being a fair and equal employer and our workplace policies are in line with all relevant equality, diversity and human rights legislation to ensure none of our staff are disadvantaged by our working, training or recruiting processes. More information on equality and diversity can be found on page 72.
- We meet regularly to discuss business and performance, and to share ideas and innovation.
- We ensure our staff have the resources and development opportunities to help them carry out their day to day work, including support to complete essential core training requirements, holding 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 2021-2022 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 June 2022, the latest available data, was 2.80%. 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 72.

The Trade Union (Facility Time Publication Requirements) Regulations 2017

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

The CCG had no relevant union officials as at 30 June 2022 and consequently the CCG can confirm the following:

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

Staff Partnership Forum

We acknowledge that the effective and productive conduct of employee relations benefits significantly from a recognised forum within which all stakeholders play an active role in partnership working. In support of this, we have a recognition agreement with trade unions and staff side representatives and actively participate in the Cheshire & Merseyside Staff Partnership Forum which aims to identify and facilitate the workforce and employment aspects of the NHS locally in developing arrangements to implement required changes which may affect the workforce. The Staff Partnership Forum is the main body for actively engaging, consulting and negotiating with key staff side stakeholders.

The forum is authorised to agree, revise and review policies and procedures which may relate to changes in employment legislation and regulation and the terms and conditions of employment affecting our staff covered by the national Agenda for Change Terms and Conditions.

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

Expenditure on consultancy

During the period to 30 June 2022 the CCG spent £46k on consultancy services. The majority of this was incurred on consultancy services to develop the CCG's Transformation Plan and Continuing Healthcare project work.

Length of all highly paid off-payroll engagements

For all off-payroll engagements for the period to 30 June 2022, for more than £245* per day:

The number that have existed:	Number
• For less than one year at the time of reporting	-
• For between one and two years at the time of reporting	-
• For between two and three years at the time of reporting	-
• For between three and four years at the time of reporting	-
• For four or more years at the time of reporting	1
Total number of existing engagements as of 30 June 2022	**1**

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

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.

Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2022 and 30 June 2022, for more than £245[(1)] per day:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2022 and 30 June 2022	-
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	-
• Assessed as caught by IR35	-
• Assessed as not caught by IR35	-
Number engaged directly (via PSC contracted to department) and are on the Departmental payroll	-
Number of engagements reassessed for consistency / assurance purposes during the year	-
Number of engagements that saw a change to IR35 status following the consistency review	-

[(1)] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

[(2)] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

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 2022 and 30 June 2022:

	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.	16

Exit packages, including special (non-contractual) payments subject to audit

Exit Packages

There were no redundancy or exit costs for NHS South Sefton CCG for the period to 30 June 2022.

Analysis of Other Departures

There were no costs of other departures for NHS South Sefton CCG for the period to 30 June 2022.

Graham Urwin

Graham Urwin

Chief Executive, Cheshire & Merseyside ICB

29 June 2023

Parliamentary accountability and audit report

NHS South Sefton CCG is not required to produce a parliamentary accountability and audit report. An audit certificate and report is also included in this Annual Report at pages 133 - 138. The auditor's report is in respect of the matters described in that report and hyperlinks included in the report and accounts are not audited by the auditors (Grant Thornton) unless expressly stated.

Independent auditor's report to the members of the Board of NHS Cheshire and Merseyside Integrated Care Board in respect of NHS South Sefton Clinical Commissioning Group

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS South Sefton Clinical Commissioning Group (the 'CCG') for the period ended 30 June 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 1 to the financial statements, which indicates that the Health and Care Act allowed for the establishment of Integrated Care Boards (ICBs) and abolished Clinical Commissioning Groups (CCGs). The functions, assets, and liabilities of NHS South Sefton CCG transferred to NHS Cheshire and Merseyside ICB on 1 July 2022. When NHS South Sefton CCG ceased to exist on 30 June 2022, its services continued to be provided by NHS South Sefton CCG and Merseyside ICB from 1 July 2022.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the CCG's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

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

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements the other information published together with the financial statements in the annual report for the financial period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

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

Matters on which we are required to report by exception

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

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we 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 make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

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

Responsibilities of the Accountable Officer

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

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

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

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

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

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).
- We enquired of management and the audit committee, concerning the CCG's policies and procedures relating to:

- the identification, evaluation and compliance with laws and regulations;
- the detection and response to the risks of fraud; and
- the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - Large and unusual journal entries, particularly those entered around or after the period-end or reducing expenditure.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on large and unusual items and those falling within identified risk criteria including; journals posted by senior management, period-end journals, journals posted after 30 June 2022, period-end accruals and journals reducing expenditure at the period-end;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of prescribing;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to the prescribing accrual.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.

- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The CCG's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework**.**

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

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

Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 30 June 2022.

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

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(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. 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 were operating effectively during the three month period ended 30 June 2022.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there were significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

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

Use of our report

This report is made solely to the members of the Board of NHS Cheshire and Merseyside Integrated Care Board, as a body, in respect of NHS South Sefton CCG, 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 Board of NHS Cheshire and Merseyside Integrated Care Board those matters we are required to state to them in an auditor's report in respect of the CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NHS Cheshire and Merseyside Integrated Care Board and the CCG and the members of the Governing Body and Board of both entities, as bodies, for our audit work, for this report, or for the opinions we have formed.

Georgia Jones

Georgia Jones, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Liverpool

29 June 2023

Statement of Comprehensive Net Expenditure for 3 month period ended 30 June 2022

	Note	3 month period to 30 June 2022 £'000	2021-22 £'000
Income from sale of goods and services	2	-	-
Other operating income	2	(1)	-
Total operating income		**(1)**	**-**
Staff costs	3	1,219	4,900
Purchase of goods and services	4	78,324	316,431
Depreciation and impairment charges	4	12	36
Provision expense	4	-	-
Other Operating Expenditure	4	15	572
Total operating expenditure		**79,571**	**321,940**
Net Operating Expenditure		**79,570**	**321,940**
Finance expense		1	
Comprehensive Expenditure for the period		**79,571**	**321,940**

Statement of Financial Position as at 30 June 2022

	Note	3 month period to 30 June 2022 £'000	2021-22 £'000
Non-current assets			
Property, plant and equipment	6	-	-
Right of use asset	7	454	-
Trade and other receivables	8	-	-
Total non-current assets		**454**	-
Current assets			
Trade and other receivables	8	1,696	1,488
Cash and cash equivalents	9	23	68
Total current assets		**1,719**	**1,556**
Total assets		**2,173**	**1,556**
Current liabilities			
Trade and other payables	10	(28,024)	(27,814)
Lease liabilities	7	(46)	-
Total current liabilities		**(28,070)**	**(27,814)**
Non-current liabilities			
Lease liabilities	7	(409)	-
Total non-current liabilities		**(409)**	
Assets less Liabilities		**(26,306)**	**(26,258)**
Financed by Taxpayers' Equity			
General fund		(26,306)	(26,258)
Total taxpayers' equity:		**(26,306)**	**(26,258)**

Note 1 to 18 form part of this statement.
The financial statements on pages 139 to 179 were approved by the Board of NHS Cheshire and Merseyside on 29 June 2023 and signed on its behalf by:

Graham Urwin

Graham Urwin
Chief Executive, Cheshire & Merseyside ICB
29 June 2023

Statement of Changes In Taxpayers Equity for the 3 month period to 30 June 2022

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 3 month period to 30 June 2022		
Balance at 01 April 2022	(26,258)	**(26,258)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	**-**
Adjusted NHS Clinical Commissioning Group balance at 30 June 2022	**(26,258)**	**(26,258)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23		
Net operating expenditure for the financial year	(79,570)	**(79,570)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(79,570)**	**(79,570)**
Net funding	79,523	**79,523**
Balance at 30 June 2022	**(26,306)**	**(26,306)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(21,986)	**(21,986)**
Transfer of assets and liabilities from closed NHS bodies	-	-
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(21,986)**	**(21,986)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22		
Net operating costs for the financial year	(321,940)	**(321,940)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(321,940)**	**(321,940)**
Net funding	317,668	**317,668**
Balance at 31 March 2022	**(26,258)**	**(26,258)**

Notes 1 to 18 form part of this statement

Statement of Cash Flows for the 3 month period to 30 June 2022

	Note	3 month period to 30 June 2022 £'000	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the period end		(79,570)	(321,940)
Depreciation and amortisation	4	12	36
(Increase)/decrease in trade & other receivables	8	(208)	689
Increase/(decrease) in trade & other payables	10	210	3,556
Increase/(decrease) in provisions		-	-
Net Cash Inflow (Outflow) from Operating Activities		**(79,557)**	**(317,659)**
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		-	-
Net Cash Inflow (Outflow) from Investing Activities		**-**	**-**
Net Cash Inflow (Outflow) before Financing		**(79,557)**	**(317,659)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		79,523	317,668
Repayment of lease liabilities		(12)	-
Non-cash movements arising on application of new accounting standards		1	-
Net Cash Inflow (Outflow) from Financing Activities		**79,512**	**317,668**
Net Increase (Decrease) in Cash & Cash Equivalents	9	**(45)**	**9**
Cash & Cash Equivalents at the Beginning of the Financial Year		**68**	**59**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**23**	**68**

Notes 1 to 18 form part of this statement.

Notes to the Financial Statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

The Health and Care Act was introduced into the House of Commons on 6 July 2021 and received royal assent on 28th April 2022. The Act allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG). From 1st July 2022, ICBs took on the commissioning functions of CCGs. As a result, the functions, assets and liabilities of NHS South Sefton Clinical Commissioning Group transferred to NHS Cheshire and Merseyside Integrated Care Board.

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.
When the clinical commissioning group ceased to exist on 30 June 2022, the services continued to be provided (using the same assets, by another public sector entity) from 1 July 2022 by NHS Cheshire and Merseyside Integrated Care Board. Accordingly, the CCG has determined that the going concern basis of preparation for the financial statements is appropriate. The financial statements of the CCG for the three months ended 30 June 2022 have therefore been prepared on a 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 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health and Social Care Group

are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Pooled Budgets

The clinical commissioning group has entered into a pooled budget arrangement with Sefton Metropolitan Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for:

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

The pool is hosted by Sefton Metropolitan Borough Council. 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

1.5 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

- As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.
The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

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

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

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a 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.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Following the government's introduction of automatic pension enrolment the CCG joined the government-operated National Employment Savings Trust (NEST) pension scheme in July 2017. Since July 2017 a minority of CCG employees (less than 5%) have joined the scheme. As a defined contribution scheme the cost to the CCG of participating in the NEST scheme is taken as equal to the contributions payable to the scheme for the accounting period.

1.8 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.

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 supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they

had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,

- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.9.2 Measurement

All property, plant and equipment is 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.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.
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. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are re-valued and depreciation commences when they are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, 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.

1.9.4 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 the shorter of the lease term and the estimated useful life, unless the clinical commissioning group expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible 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.

1.10 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.

1.10.1 The Clinical Commissioning Group as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.
Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories. The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.
Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.
For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.
Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.11 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.12 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:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 3,.27% (2021-22: 0.47%)for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 3.20% (2021-22: 0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 3.51% (2021-22: 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 3.00% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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.

1.13 Clinical Negligence Costs

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

1.14 Non-clinical Risk Pooling

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

1.15 Contingent liabilities and contingent assets

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.16 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 amortised cost;
- Financial assets at fair value through other comprehensive income and;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.16.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.16.2 Financial assets at fair value through other comprehensive income

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.16.3 Financial assets at fair value through profit and loss

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income.

This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.16.4 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.
The clinical commissioning group adopts the simplified approach to impairment in accordance

with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).
HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.17 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.

1.17.1 Financial Guarantee Contract Liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.17.2 Financial Liabilities at Fair Value through Profit and Loss

Derivatives that are liabilities are subsequently measured at fair value through profit or loss. Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through the clinical commissioning group’s surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.17.3 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 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.

1.19 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 accrual's 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).

1.20 Critical accounting judgements and key sources of estimation uncertainty

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.20.1 Critical accounting judgements in applying accounting policies

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

- Accruals – Included within the financial statement to the extent that the CCG recognises an obligation at the 31 March 2022 for which it had not been invoiced. Estimates of accruals are undertaken by management based on the information available at the end of the financial year, together with past experience, and
- Provisions – Recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

1.20.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

- Activity is accounted for in the financial year it takes place, and not necessarily when case 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 NHS Business Services Authority and estimates

undertaken by management based on information available at the end of the financial year, together with past experience, and

- Individual packages of care primarily fall into the areas of Continuing Healthcare (CHC) and Funded Nursing Care (FNC). Monthly financial information from DPS is one month in arrears, and so estimates are required to establish an expected monthly charge and year end forecast. The estimates are therefore a reflection of DPS data and local knowledge.

1.21 Adoption of new standards

On 1 April 2022, the clinical commissioning group adopted IFRS 16 'Leases'. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases. Under IFRS 16 the group will recognise a right-of-use asset representing the group's right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items. In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Impact assessment

The clinical commissioning group has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The group has utilised three further practical expedients under the transition approach adopted:

- The election to not make an adjustment for leases for which the underlying asset is of low value.
- The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
- The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.

The following table reconciles the group's operating lease obligations at 31 March 2022, disclosed in the group's 21/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

	Total £000
Operating lease commitments at 31 March 2022	- 466
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	-
Operating lease commitments discounted used weighted average IBR	- 466
Add: Finance lease liabilities at 31 March 2022	-
Add: Peppercorn leases revalued to existing value in use	-
Add: Residual value guarantees	-
Add: Rentals associated with extension options reasonably certain to be exercised	-
Less: Short term leases (including those with <12 months at application date)	-
Less: Low value leases	-
Less: Variable payments not included in the valuation of the lease liabilities	- 462
Lease liability at 1 April 2022	**-**

1.22 New and revised IFRS Standards in issue but not yet effective

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2022-23. These Standards are still subject to HM Treasury FReM adoption, with the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

The CCG has no insurance contracts therefore the application of the above Standard as revised would not have an impact on the accounts for 2022-23, were it applied in that year.

2. Other Operating Revenue

	3 month period to 30 June 2022 Total £'000	2021-22 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	-	-
Non-patient care services to other bodies	-	-
Prescription fees and charges	-	-
Other Contract income	-	-
Total Income from sale of goods and services	-	-
Other operating income	1	-
Total Operating Income	1	-

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. Employee benefits and staff numbers

3.1 Employee benefits

	Total		3 month period to 30 June 2022
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	684	36	720
Social security costs	192	-	192
Employer Contributions to NHS Pension scheme	304	-	304
Apprenticeship Levy	3	-	3
Gross employee benefits expenditure	1,184	36	1,219
Less recoveries in respect of employee benefits	-	-	-
Total - Net admin employee benefits including capitalised costs	1,184	36	1,219
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	1,184	36	1,219

	Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	2,678	193	2,871
Social security costs	735	-	735
Employer Contributions to NHS Pension scheme	1,283	-	1,283
Other pension costs	-	-	-
Apprenticeship Levy	11	-	11
Gross employee benefits expenditure	4,707	193	4,900
Less recoveries in respect of employee benefits	-	-	-
Total - Net admin employee benefits including capitalised costs	4,707	193	4,900
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	4,707	193	4,900

Please see pages 126 to 131 of the annual report for further information on staff costs

3.2 Average number of people employed

	3 month period to 30 June 2022			2021-22		
	Permanently employed	Other	Total	Permanently employed	Other	Total

	Number	Number	Number	Number	Number	Number
Total	**68.00**	**8.00**	**76.00**	**71.00**	**8.00**	**79.00**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

Please see pages 126 to 131 of the annual report for further information on staff costs

3.3 Exit packages agreed in financial year

There have been no exit packages in the 3 month period to 30 June 2022. (2021-22: Nil)

3.4 Ill Health Retirements

NHS Pensions have advised of no ill health retirement associated with the CCG in the 3 month period to 30 June 2022. (2021-22: Nil).

3.5 Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

3.5.1 Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.
The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

3.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

4. Operating expenses

	3 month period to 30 June 2022 Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	326	1,500
Services from foundation trusts	47,613	185,053
Services from other NHS trusts	4,485	17,698
Purchase of healthcare from non-NHS bodies	10,591	48,834
Purchase of social care	176	691
Prescribing costs	7,585	31,042
General Ophthalmic services	36	109
GPMS/APMS and PCTMS	6,194	26,244
Supplies and services – clinical	125	402
Supplies and services – general	28	41
Consultancy services	46	192
Establishment	883	3,230
Premises	48	850
Audit fees*	62	62
Other non-statutory audit expenditure		
· Internal audit services**	-	-
· Other services***	30	-
Other professional fees	74	422
Legal Fees	-	54
Education, training and conferences	22	8
Non cash apprenticeship training grants	1	-
Total Purchase of goods and services	**78,324**	**316,431**
Depreciation and impairment charges		
Depreciation	12	36
Total Depreciation and impairment charges	**12**	**36**
Other Operating Expenditure		
Chair and Non-Executive Members	27	131
Expected credit loss on receivables	(12)	442
Total Other Operating Expenditure	**15**	**572**
Total operating expenditure	**78,352**	**317,040**

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

include Value Added Tax (VAT).

**Internal audit services during the year were provided by Mersey Internal Audit Agency and hosted by Liverpool University Hospitals NHS Foundation Trust.

***Other non statutory audit expenditure - other services includes fees in relation to the Mental Health Investment Standard (MHIS) audits

5. Better Payment Practice Code

Measure of compliance	3 month period to 30 June 2022 Number	3 month period to 30 June 2022 £'000	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	1,404	19,401	5,277	78,190
Total Non-NHS Trade Invoices paid within target	1,330	18,381	5,020	76,440
Percentage of Non-NHS Trade invoices paid within target	**94.73%**	**94.74%**	**95.13%**	**97.76%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	182	52,612	740	208,096
Total NHS Trade Invoices Paid within target	167	52,374	704	207,669
Percentage of NHS Trade Invoices paid within target	**91.76%**	**99.55%**	**95.14%**	**99.79%**

The Better Payment Practice Code required the Clinical Commissioning Group to aim to pay all valid invoices by the due date or within 30 days of the receipt of a valid invoice, whichever is later. The Better Payment Practice Code sets out target compliance of 95%.

Percentages are calculated by taking the total number / value of paid invoices / credit notes and dividing this by the total number / value payable. Due to credit notes reducing the total value payable it is possible to result in a percentage greater than 100% when there are credit notes that have not been processed for 'payment'.

6.Property, Plant and Equipment

2022-23	Plant & machinery £'000	Information technology £'000	3 month period to 30 June 2022 Total £'000
Cost/Valuation at 01 April 2022	74	212	286
Additions purchased	-	-	-
Disposals other than by sale	(74)	(57)	(131)
Cost/Valuation at 30 June 2022	**-**	**155**	**155**
Depreciation at 01 April 2022	74	212	286
Charged during the year	-	-	-
Disposals other than by sale	(74)	(57)	(131)
Depreciation at 30 June 2022	**-**	**155**	**155**
Net Book Value at 30 June 2022	**-**	**-**	**-**
Purchased	-	-	-
Donated	-	-	-
Government Granted	-	-	-
Total at 30 June 2022	**-**	**-**	**-**

2021-22	Plant & machinery £'000	Information technology £'000	Total £'000
Cost or valuation at 01 April 2021	74	212	286
Additions purchased	-	-	-
Cost/Valuation at 31 March 2022	**74**	**212**	**286**
Depreciation 01 April 2021	74	176	250
Charged during the year	-	36	36
Depreciation at 31 March 2022	**74**	**212**	**286**
Net Book Value at 31 March 2022	**-**	**-**	**-**
Purchased	-	-	-
Donated	-	-	-
Government Granted	-	-	-
Total at 31 March 2022	**-**	**-**	**-**

6.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Plant & machinery	-	4
Information technology	-	4

7. Leases

Leases are recognised under the newly adopted leasing standard IFRS 16, applied on the 1 April 2022. Under IFRS 16 leases are recognised as a right of use asset with a corresponding lease liability on the Statement of Financial Position. Each lease payment is allocated between a reduction of the liability and the interest expense. The interest expense is charged to the Statement of Comprehensive Net Expenditure over the lease period. The right of use asset is depreciated over the shorter of the asset's useful life and the lease term on a straight line basis.

7.1 Right-of-use assets

2022-23	Buildings excluding dwellings £'000	3 month period to 30 June 2022 Total £'000
Cost/Valuation at 01 April 2022	-	-
IFRS16 transition adjustment	466	466
Cost/Valuation at 30 June 2022	**466**	**466**
Depreciation at 01 April 2022	-	-
Charged during the year	12	12
Depreciation at 30 June 2022	**12**	**12**
Net Book Value at 30 June 2022	**454**	**454**

7.2 Lease liabilities

2022-23	3 month period to 30 June 2022 £'000	2021-22 £'000
Lease liabilities at 01 April 2022	-	-
IFRS16 transition adjustment	466	-
Repayment of lease liabilities (including interest)	1	-
Lease remeasurement	(13)	-
Lease liabilities at 30 June 2022	**455**	**-**

7.3 Lease liabilities – maturity analysis of undiscounted future lease payments

	3 month period to 30 June 2022 £'000	2021-22 £'000
Within one year	(50)	-
Between one and five years	(200)	-
After five years	(225)	-
Lease liabilities at 30 June 2022	**(475)**	**-**
Effect of discounting	**20**	**-**
Included in:		
Current lease liabilities	(46)	-
Non-current lease liabilities	(409)	-
Lease liabilities at 30 June 2022	**(455)**	**-**

7.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2022-23	3 month period to 30 June 2022 £'000	2021-22 £'000
Depreciation expense on right-of-use assets	12	-
Interest expense on lease liabilities	1	-

7.5 Amounts recognised in Statement of Cash Flows

2022-23	3 month period to 30 June 2022 £'000	2021-22 £'000
Total cash outflow on leases under IFRS16	(13)	-

8. Trade and other receivables

	Current 3 month period to 30 June 2022 £'000	Current 2021-22 £'000
NHS receivables: Revenue	353	874
NHS Prepayment	14	-
NHS accrued income	297	43
NHS Non Contract trade receivable (i.e pass through funding)	205	327
Non-NHS and Other WGA receivables: Revenue	466	561
Non-NHS and Other WGA prepayments	161	58
Non-NHS and Other WGA accrued income	107	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	418	24
Expected credit loss allowance-receivables	(438)	(450)
VAT	53	7
Other receivables and accruals	60	44
Total Trade & other receivables	**1,696**	**1,487**
Included above:		
Prepaid pensions contributions	**-**	**-**

There were no non-current receivables in 3 month period to 30 June 2022. (2021-22: Nil)

8.1 Receivables past their due date but not impaired

	3 month period to 30 June 2022 DHSC Group Bodies £'000	3 month period to 30 June 2022 Non DHSC Group Bodies £'000	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	285	32	1,070	82
By three to six months	11	-	12	-
By more than six months	18	-	82	25
Total	**314**	**32**	**1,163**	**107**

9. Cash and cash equivalents

	3 month period to 30 June 2022 £'000	2021-22 £'000
Balance at 01 April 2022	68	59
Net change in year	(45)	9
Balance at 30 June 2023	**23**	**68**
Made up of:		
Cash with the Government Banking Service	23	68
Cash with Commercial banks	-	-
Cash in hand	0	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**23**	**68**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 30 June 2023	**23**	**68**
Patients' money held by the clinical commissioning group, not included above	-	-

10. Trade and other payables

	Current 3 month period to 30 June 2022 £'000	Current 2021-22 £'000
NHS payables: Revenue	689	680
NHS accruals	1,475	429
Non-NHS and Other WGA payables: Revenue	8,771	6,605
Non-NHS and Other WGA accruals	4,682	4,884
Social security costs	99	112
Tax	92	97
Other payables and accruals	12,215	15,006
Total Trade & Other Payables	**28,024**	**27,814**

There were no non-current payables in the 3 month period to 30 June 2022. (2021-22: Nil)

11. Provisions

	Current 3 month period to 30 June 2022 £'000	Non-current 3 month period to 30 June 2022 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	-	-
Continuing care	-	-	-	-
Other	-	-	-	-
Total	**-**	**-**	**-**	**-**
Total current and non-current	**-**		**-**	

12. Financial instruments

12.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

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

12.1.1 Currency risk

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

12.1.2 Interest rate risk

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

12.1.3 Credit risk

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

12.1.4 Liquidity risk

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

12.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and

NHS England is therefore exposed to little credit, liquidity or market risk.

12.2 Financial assets

	Financial Assets measured at amortised cost 3 month period to 30 June 2022 £'000	Total 3 month period to 30 June 2022 £'000
Trade and other receivables with NHSE bodies	621	**621**
Trade and other receivables with other DHSC group bodies	341	**341**
Trade and other receivables with external bodies	948	**948**
Cash and cash equivalents	23	**23**
Total at 30 June 2022	**1,933**	**1,933**

2021-22	Financial Assets measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Trade and other receivables with NHSE bodies	883	**883**
Trade and other receivables with other DHSC group bodies	366	**366**
Trade and other receivables with external bodies	625	**625**
Cash and cash equivalents	68	**68**
Total at 30 March 2022	**1,942**	**1,942**

12.3 Financial liabilities

	Financial Liabilities measured at amortised cost 3 months period to 30 June 2022 £'000	Total 3 month period to 30 June 2022 £'000
Trade and other payables with NHSE bodies	668	**668**
Trade and other payables with other DHSC group bodies	1,729	**1,729**
Trade and other payables with external bodies	25,890	**25,890**
Total at 30 June 2022	**28,288**	**28,288**

2021-22	Financial Liabilities measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Trade and other payables with NHSE bodies	322	**322**
Trade and other payables with other DHSC group bodies	1,056	**1,056**
Trade and other payables with external bodies	26,227	**26,227**
Total at 30 June 2022	**27,606**	**27,606**

13. Operating segments

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

3 month period to 30 June 2022

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare Services	79,571	(1)	**79,570**	2,173	(28,479)	(26,306)
Total	**79,571**	**(1)**	**79,570**	**2,173**	**(28,479)**	**(26,306)**

2021-22

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare Services	321,940	-	**321,940**	1,556	(27,814)	(26,258)
Total	**321,940**	**-**	**321,940**	**1,556**	**(27,814)**	**(26,258)**

14. Related party transactions

Details of related party transactions with individuals in the three month period to 30 June 2022 are as follows:

Name	CCG Role	Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
			£'000	£'000	£'000	£'000
Dr Gina Halstead	GP Clinical Director	Dr Goldberg	247	-	-	-
Dr Sunil Sapre	GP Clinical Director	Maghull Health Centre	381	-	-	-
Dr Sunil Sapre	GP Clinical Director	S2S Health LTD	357	-	-	-
Dr Peter Chamberlain	Chair and GP Clinical Director	Westway Medical Centre	3	-	1	-

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had significant number of material transactions with entities 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 Metropolitan Borough Council.

2021-22

Details of related party transactions with individuals in 2021-22 are as follows:

Name	CCG Role	Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
			£'000	£'000	£'000	£'000
Dr Gina Halstead	GP Clinical Director	Dr Goldberg	888	-	-	-
Dr Sunil Sapre	GP Clinical Director	Maghull Health Centre	1,238	-	-	-
Dr Sunil Sapre	GP Clinical Director	S2S Health LTD	1,131	-	-	-
Dr Peter Chamberlain	Chair and GP Clinical Director	Westway Medical Centre	35	-	1	-

15. Events after the reporting period

The Health and Care Act 2022 received Royal Assent on April 2022. As a result of this, the CCG demised on 30 June 2022.

The assets, liabilities, operations and services of the CCG transferred to NHS Cheshire and Merseyside Integrated Care Board on 1 July 2022 as summarised below:

Amounts transferred to NHS Cheshire and Merseyside Integrated Care Board from 1 July 2022

	£'000
Non-current Assets	454
Current Assets	1,719
Current Liabilities	(28,070)
Non-current Liabilities	(409)
Net Liabilities	**(26,306)**

There were no further events after the end of the reporting period that would have a material effect on the financial statements of NHS South Sefton Clinical Commissioning Group.

Due to the demise of the CCG on 30 June 2022, these financial statements have been prepared for the three-month period 1 April 2022 to 30 June 2022. Comparative figures within the financial statements are for a full year and therefore not truly comparative with this shortened accounting period.

16. Losses and Special Payments

16.1. Losses

There were no losses in the three month period to 30 June 2022 (2021-22: Nil)

16.2 Special payments

There were no losses in the three month period to 30 June 2022 (2021-22: Nil)

17. Pooled Budgets

Better Care Fund

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:

	2022-23	2021-22
	£'000	£'000
Income	(4,398)	(16,782)
Expenditure	4,398	16,782
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 BCF pooled budget arrangement with Southport & Formby CCG and Sefton Council. The income and expenditure referenced above, is analysed within note 4 Operating Expenses.

18. Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	3 month period to 30 June 2022	**3 month period to 30 June 2022**	2021-22	2021-22
	Target	**Performance**	Target	Performance
Expenditure not to exceed income	79,571	79,571	321,940	321,940
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	79,571	79,571	321,940	321,940
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	720	720	3,245	2,973

At the end of the three month period to 30 June 2022, the CCG reported a break even position (2021-22: £0).

NHS South Sefton CCG

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