NHS
Liverpool
Clinical Commissioning Group

NHS Liverpool CCG

Report and Accounts

1 April – 30 June 2022

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1. Performance Report

1.1 Welcome and Introduction

Welcome to the NHS Liverpool CCG Annual Report for the period from 1st April to 30th June 2022.

NHS Liverpool Clinical Commissioning Group became operational as an NHS Body on 1st April 2013 and as at 30th June 2022 includes 85 GP Member Practices and is co-terminus with the boundaries of Liverpool City Council. The CCG serves a growing registered population of 568,551 and had a resource allocation of £404.5m for quarter one of the 2022/23 financial year of which £139.1m relates to system funding held on behalf of Cheshire & Merseyside Healthcare Partnership.

This annual report incorporates the period from 1st April to 30th June 2022, which are the final three months of the existence of Liverpool CCG in the 2022/23 financial year.

In July 2021, the Government published the Health and Care Bill, setting out legislative proposals to reform the delivery and organisation of health services in England, intended to promote integration of health and care services and more of a focus on improving health. Liverpool CCG's statutory responsibilities transferred to the Cheshire and Merseyside Integrated Care Board (ICB) in July 2022. The ICB is responsible for NHS strategic planning and allocation decisions. Within these new arrangements, activity to integrate care and improve population health will be driven by commissioners and providers collaborating over smaller geographies within Integrated Care Systems (ICSs), referred to as 'Places', and through teams delivering services working together in neighbourhoods.

The COVID-19 pandemic continued to have an impact on NHS services and social care into 2022/23. Waiting lists for planned care are being tackled by all health and care partners collaboratively, but waiting times remain high.

The health and care system is under sustained pressures, across all settings of care, including primary care, mental health, community and acute services. The CCG and system partners in Liverpool and the wider Cheshire and Merseyside system continue to work together to recover services, ensuring this is done in a way that also addresses health inequalities. This will continue to be a challenge for the foreseeable future.

This annual report for the first quarter of 2022/23 reflects the fact that Liverpool CCG remained accountable until the Cheshire and Merseyside ICB was established in July 2022. The CCG during this period was focused on maintenance of its responsibilities alongside managing the risks relating to organisational change, to ensure a seamless transition.

Health and care partners in Liverpool are agreed that the successful development and delivery of the outcomes for better population health, set out in the One Liverpool Strategy, will depend on the ability to make local decisions and effectively combine

expertise and resources. The One Liverpool Partnership Board will be seeking maximum autonomy, delegation of NHS resources and decision-making from the Cheshire and Merseyside ICB.

During this period, the CCG remained financially stable, able to meet all its financial duties, despite increasing demand, cost pressures and the challenges of the pandemic.

I want to thank all CCG staff, GP membership, NHS and local authority partners for their sustained commitment and flexibility to support the city's population in terms of the ongoing COVID-19 response, the recovery of essential services and the transition to new health and care structures from July 2022.

Graham Urwin
Chief Executive, NHS Cheshire and Merseyside ICB
29 June 2023

1.2 Member Practices Introduction

The CCG is a membership organisation, which is fortunate to have had strong clinical leadership and broad GP involvement since its inception in 2013. Clinical leaders have been an influential, compassionate voice, shaping the CCG's vision, providing insight from their frontline experiences and connecting with clinical partners across all settings of care.

General practice has been under sustained pressure since the outset of the COVID-19 pandemic, requiring GPs and their teams to be ever more resilient and selfless in responding to the needs of their patients and communities. General practice, along with all other NHS services, is dealing with significantly increased demand, due in part to the impact of the pandemic which led to people not presenting at earlier stages of an illness or condition. General practice has innovated in response, introducing a blended approach, with consultations delivered by way of telephone calls, video or online, with face-to-face consultations offered where clinically appropriate.

Primary Care Networks have led delivery of the city's vaccination programme, with an approach focused on maximising access and addressing inequalities. GPs continue to be at the forefront of planning and delivery of the 2022/23 Covid vaccine roll out and efforts to promote greater uptake of other vaccines and immunisations which have declined during the pandemic.

Thank you to the Clinical Directors of the PCNs, all GP members and their teams for their leadership and commitment in managing the current demands within general practice and playing a key role in the One Liverpool Partnership.

Thank you also to the Local Medical Committee (LMC) for their work in providing expert counsel to the CCG and representing General Practice effectively and pragmatically.

Dr Janet Bliss, GP/Liverpool CCG Governing Body Chair, from 1st March 2022

1.3 Introduction to NHS Liverpool CCG

1.3.1 Introduction

Liverpool Clinical Commissioning Group became operational as an NHS Body on 1st April 2013 and as at 31st March 2022 includes 85 GP Member Practices and is co-terminus with the boundaries of Liverpool City Council. The CCG serves a growing registered population of 568,551and had a resource allocation of £404.5m for quarter one of the 2022/23 financial year of which £139.1m relates to system funding held on behalf of Cheshire & Merseyside Healthcare Partnership.

The accounts in this report have been prepared in accordance with the Department of Health Group Accounting Manual for 2022/23 and associated guidance.

The CCG vision, values and strategic objectives:

Our Vision

Liverpool CCG has adopted a shared vision, alongside all other health and care partners in the city, for a **healthier, happier and fairer city**.

Our primary ambition was to halve the life expectancy gap between Liverpool and England by 2024. Our combined efforts will continue to focus on reducing health inequalities between the most affluent and deprived communities in the city. The impact of COVID-19 in widening health inequalities means that the Liverpool health and care system will need to establish a new baseline and agree a new, still ambitious but achievable target for closing the inequality gap, focusing resources where there is greatest need.

Strategic Objectives

The CCG's strategic objectives reflect the organisation's core purpose and statutory responsibilities:

- **Commissioning for better health outcomes**
- **Ensure commissioning of high quality, safe and responsive health services**
- **Reduced health inequalities**
- **Ensure maximum value from available resources**
- **Decisions that are evidence based**
- **Maintain the CCGs reputation and safeguard public confidence**

The delivery of these strategic objectives shape and direct the commissioning strategies and business of the organisation. The CCG is a clinically led body, which works in partnership with other commissioners and with providers of health and care to determine commissioning and investment strategies to achieve our enduring objectives.

Our Values

Compassionate: supporting, trusting, listening and showing kindness

Inclusive: recognising, respecting and celebrating differences, ensuring fairness and consistency

Progressive: passion for improvement and innovation, doing the right thing and continuously learning

Together: working across boundaries in co-production, recognising and valuing everyone's contribution and taking responsibility

1.3.2 Governing Body Members and Staffing

The office of Chair of the CCG was held by Dr Janet Bliss for this period. The role of Chief Officer (Accountable Officer) has been held by Jan Ledward.

The membership of the Governing Body up to the signing of the Annual Report and Accounts is as follows:

Governing Body Members:

Jan Ledward	Chief Officer (Accountable Officer)
Mark Bakewell	Chief Finance & Contracting Officer
Jane Lunt	Director of Quality, Outcomes and Improvement
Helen Dearden	Lay Member Governance / Non-Clinical Vice Chair
Gerry Gray	Lay Member Financial Management and Oversight
Sally Houghton	Lay Member / Audit Chair
Carol Rodgers	Lay Member, Patient and Public Involvement
Cathy Maddaford	Non-Executive Nurse
Dr Janet Bliss	GP/Clinical Vice Chair
Dr Monica Khuraijam	GP
Dr Paula Finnerty	GP
Dr Fiona Ogden-Forde	GP
Dr Shamim Rose	GP
Dr David O'Hagan	GP
Dr Stephanie Gallard	GP

Co-opted Members (non-voting):

Dr Rob Barnett	Secretary, Liverpool LMC
Cllr Fraser Lake	Adult and Social Care, Liverpool City Council
Matthew Ashton	Director of Public Health, Liverpool City Council

The table on page 64 provides details of the membership of CCG Committees.

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

The Governing Body (Voting/full members) in post at 30th June 2022 comprises 3 male members and 12 female members.

The CCG directly employs a total of 160 staff, comprising 31 male and 129 female. This number excludes staff seconded from external organisations, agency staff and contractors. For this period the CCG employed a total of 4 Very Senior Management (VSM) posts (includes 1 Governing Body member); 3 of which were male and 1 female.

1.3.3 CCG Profile

Over the next ten years the largest population increase in the city will be in over 65s (27.1%) and the number of under 15s in the city set to increase by 6.8%. This demographic data informs strategic planning and prioritisation for future allocations of funding.

Life expectancy at birth in Liverpool, is 76 years, although this masks variation, with an average of 76.4 years in Anfield and Everton compared to 83.1 years in Childwall and Wavertree. The gap between female and male life expectancy stands at 3 years (Females 78.5 years and Males 75.4 years).

Mortality from COVID-19 has had an unequal impact on different population groups, which has exacerbated inequalities. Most recent data for Liverpool shows that between 2019 and 2020, life expectancy in males fell by almost 2 years in the poorest decile of areas (from 74.3 to 72.4 years) compared with 1 year in the wealthiest decile (from 83.6 to 82.6). For females, in the poorest areas it fell by 1.6 years (from 78.9 to 77.3) compared with 1 year in the wealthiest (86.8 to 85.8).

Nationally, the gap in life expectancy between the most affluent and deprived areas widened in 2020 to 10.2 years for males and 8.5 years for females, compared with 9.3 and 7.9 years respectively in 2019. Liverpool's life expectancy decreased by 2.4 years in 2020 after being at the highest level in 2019. This decrease has continued into 2021/22.

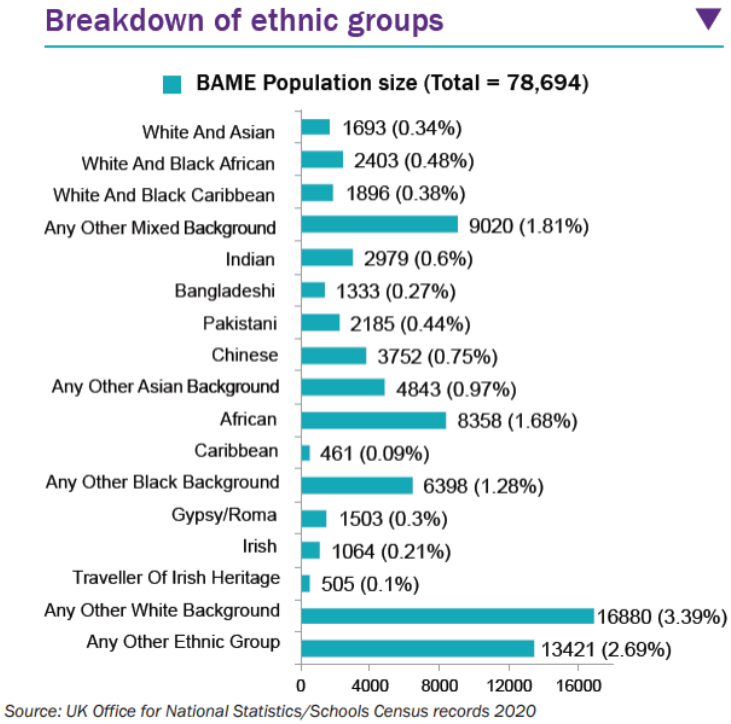
The disruption to NHS services caused by the pandemic is likely to have caused diagnostic delays for many diseases, including cancer. Modelling suggests that there may be upwards of a 10% increase in breast cancer deaths, a 17% increase in colorectal cancer deaths, a 5% increase in lung cancer deaths, and a 6% increase in oesophageal cancer deaths over the next 5 years. This would equate to an additional 44 potentially avoidable cancer deaths in Liverpool.

Other potential impacts from COVID on life expectancy include changes to planned care resulting in longer waiting times for treatment.

Assessments of inequalities in COVID-19 infection and mortality in England done by the Marmot team show clear relationships with deprivation, prior health status, ethnicity, age and gender.[1]

Health and care partners in Liverpool have embarked on a collaboration with the Marmot team at the Institute of Health Equity to look into what contributed to the significant drop in life expectancy at local level during the COVID pandemic and to develop plans to tackle inequalities in life expectancy and other indicators that will support local recovery after the COVID pandemic. These plans will enhance the One Liverpool Strategy and the wider Liverpool City Plan.

Reflecting the diverse heritage of our maritime city and recent patterns of global migration, Liverpool has a vibrant and diverse ethnic population of 78,694 people.



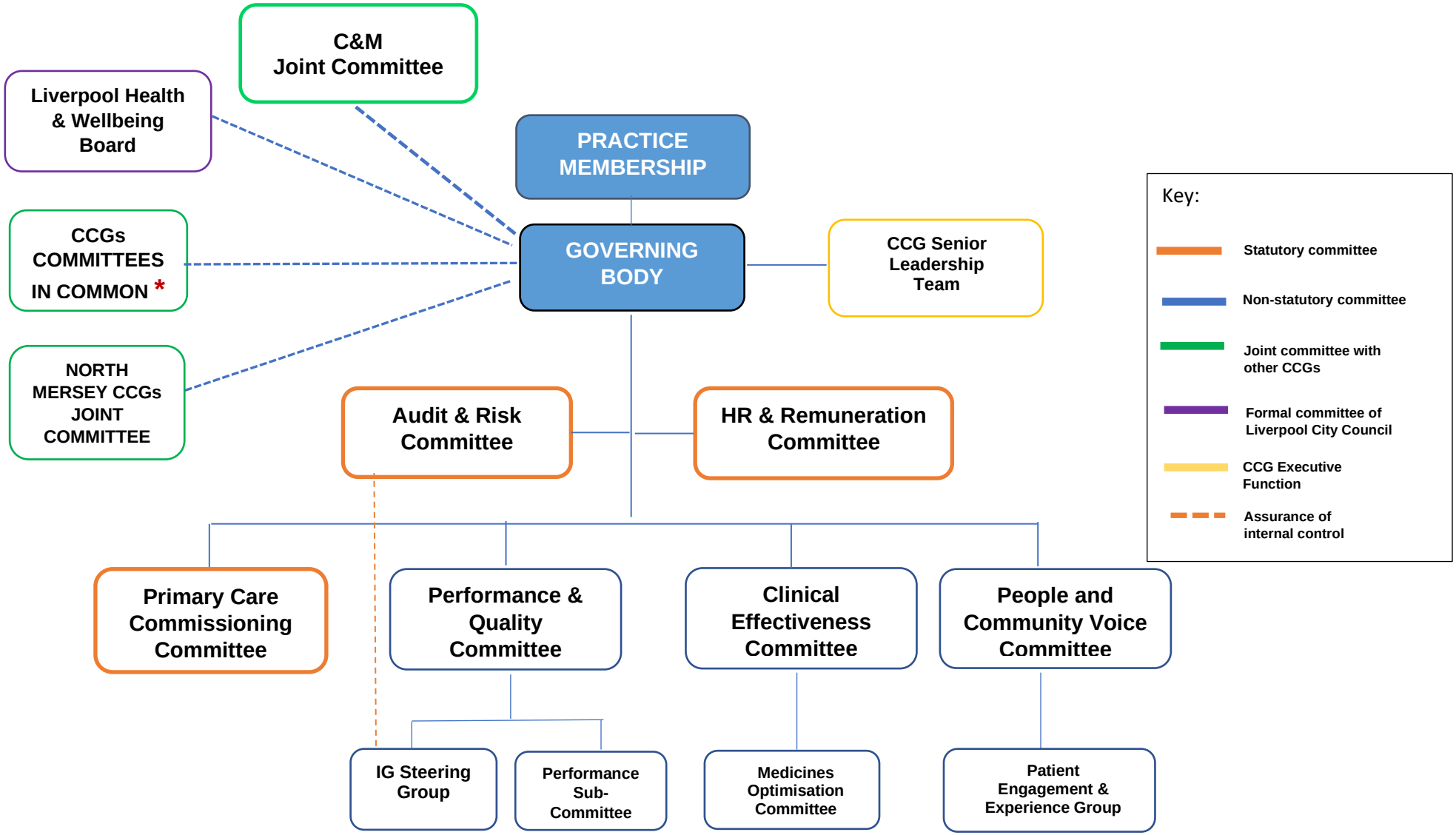
Source: UK Office for National Statistics/Schools Census records 2020

[1] Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives. UCL Institute of Health Equity. June 2021

The CCG operates from headquarters in the Department, 2 Renshaw Street, Liverpool, L1 2SA.

The CCG operated through the governance structure as illustrated below during quarter one of the 2022/23 financial year:

NHS Liverpool CCG Governance Structure



* Numbers of committees in common subject to variation

1.3.4 Commissioning Landscape

NHS Liverpool CCG is responsible for commissioning primary, community, mental health and secondary care services, along with emergency and patient transport ambulance services, GP out of hours services and the NHS 111 service. The following list highlights hospital, community and mental health providers whose contract value exceeded £0.5M in value.

Primary Care

- Liverpool CCG commissions services from 85 GP practices, under delegated commissioning arrangements with NHS England

Acute Hospitals

- Liverpool University Hospitals NHS Foundation Trust *
- Alder Hey Children's NHS Foundation Trust *
- Liverpool Heart & Chest Hospital NHS Foundation Trust *
- Liverpool Women's NHS Foundation Trust *
- St Helens & Knowsley Teaching Hospitals NHS Trust
- Southport & Ormskirk Hospitals NHS Trust
- Spire Hospital Liverpool, Spire Healthcare Limited *
- The Walton Centre NHS Foundation Trust *
- Warrington & Halton Hospitals NHS Foundation Trust
- Wirral University Teaching Hospitals NHS Foundation Trust
- The Clatterbridge Cancer Centre NHS Foundation Trust *
- Manchester University NHS Foundation Trust
- Wrightington, Wigan & Leigh NHS Foundation Trust

Mental Health

- Mersey Care NHS Foundation Trust *
- Northwest Boroughs Partnership NHS Foundation Trust
- Cheshire & Wirral Partnership NHS Foundation Trust

Community Services

- Mersey Care NHS Foundation Trust*

Other

- North West Ambulance Service NHS Trust (ambulance services and NHS 111)
- Primary Care 24 Limited (GP out of hours provider) *

* Where Liverpool CCG acts as the co-ordinating commissioner

The Liverpool health economy consists of a unique mix of NHS/Foundation Trusts (four of which are 'specialist' Trusts that are also commissioned by NHSE Specialist Services), with strong interdependencies and relationships with primary and community providers, independent sector providers and numerous providers accredited under 'any qualified provider' (AQP). Liverpool is fortunate to have a wealth of voluntary, community and social enterprise (VCSE) partners and has a diverse but challenged market of nursing, residential home and domiciliary care providers.

As already stated, the NHS commissioning environment will change from July 2022 with the establishment of the Cheshire and Merseyside Integrated Care Board (ICB).

The Bill proposes a substantial change in how the NHS in England is organised. CCGs, which have been the primary budget holders for NHS services since 2013, will be abolished. In their place, ICBs will be put on a statutory footing to support multi-agency planning and delivery of health and care services. Liverpool CCG staff will transfer to the Cheshire and Merseyside ICB.

The nine CCGs across Cheshire and Merseyside have worked closely together to support the transition of their functions, statutory responsibilities and workforce to the ICB. A Cheshire and Merseyside Joint Committee of CCGs was established with delegated authority from each CCG to oversee a defined whole-system commissioning work programme. Local matters remain within the remit of each CCG. Sub-committees were also established to oversee system level quality, performance and finance issues. However, Liverpool CCG remained accountable for all its statutory responsibilities until the ICB is established.

Within the new commissioning environment there is still a requirement for strong place-level health and care system collaboration and governance. The proposals provide flexibility for places to work with the Cheshire and Merseyside ICB to define local arrangements. The Liverpool Health and Care system is committed to delivering the outcome ambitions set out in the *One Liverpool* strategy and our intention is that the capacity and talent within Liverpool CCG will predominantly be focused locally, working in an integrated way with local NHS providers, Liverpool City Council and other place partners.

A cornerstone of *One Liverpool* is a single approach to health and care commissioning, focused on population outcomes and collective ownership of the financial envelope. The Health and Care Bill supports further integration of NHS and social care commissioning which is in line with the direction of travel for partners in Liverpool.

As commissioners, both organisations have committed to moving from counting activity to a value and outcomes-based approach, for the best use of the Liverpool health and care pound. *One Liverpool* set out clear commissioning commitments that the CCG and Liverpool City Council have continued to embed; harnessing intelligence, focused on outcomes, making connections across contracts and ensuring that health and care commissioning becomes more consistent and streamlined.

Liverpool CCG has played a key leadership role across the Health and Care Partnership for Cheshire and Merseyside during this period, with the CCG Chief Officer and senior staff involved in a range of Cheshire and Merseyside-wide programmes.

Liverpool CCG is an active member of the Liverpool Health and Wellbeing Board. The work of the Board has informed this annual report, including the Accountability Report and in particular the Corporate Governance Report.

The Liverpool Health and Wellbeing Board has overseen strategic development across the Liverpool health and care system. There were standing items on COVID-19 epidemiology and the health and care response to the pandemic in Liverpool. In addition, updates were provided at every board meeting on the work of the Liverpool Integrated Care Partnership Board in delivering the *One Liverpool* Strategy and from the Liverpool Joint Commissioning Group in taking forward integrated health and care commissioning. The key items for the one Health and Wellbeing Board meeting that took place in this period, in June 2022 were:

- An update on the development of the Cheshire and Merseyside ICS and Place arrangements
- Forward Plan for the Joint Strategic Needs Assessment (JSNA), incorporating updated recommendations from the Marmot report which have informed seven system-wide recommendations for action across the Cheshire and Merseyside system
- Pharmaceutical Needs Assessment for 2022-2025
- Marmot Community Status Award Progress

1.4 Overview Summary

This report provided by the Chief Officer (Accountable Officer) sets out the performance of the organisation over the reporting period from April to June 2022.

1.5 Purpose and Activities of the Organisation

NHS Liverpool CCG is a statutory organisation responsible for commissioning health services to meet the needs of the population of Liverpool, including those registered with the city's 85 general medical practices and people resident in the city not registered with a GP.

The period covers the final three months of the CCG's operation.

During this period, the CCG has met all of the required financial duties placed upon it and ends the year having delivered the required in year break even position against its resource allocation in line with its control total as set by NHS England.

The CCG has worked to an even greater degree in its partnerships with member GP Practices, commissioning partners in Liverpool City Council, the Health and Care Partnership for Cheshire and Merseyside, the commissioning regulator - NHS England and the CCG's providers.

The CCG is committed to an evidence-based approach to commissioning, as well as meaningful engagement and involvement with patients and the population in order to respond to and commission services that meet local needs, improve health outcomes and reduce inequalities within the city, and in comparison, with other parts of the country.

Key Governing Body Business

The emphasis of the Governing Body during this period was to ensure a smooth and safe transition of responsibilities to the Cheshire and Merseyside ICS. The items considered by the Governing Body in its final June meeting:

- Approval of the 2021/22 CCG Annual Report
- Oversight of Due Diligence and CCG Closedown
- Complaints, FOIs and MP Queries Annual Report

In addition to the Board items above, standard Governing Body updates were received from the Chief Officer and Director of Public Health, as well as Corporate Performance and Finance reports.

1.6 Key Issues and Risks

Liverpool CCG has a statutory responsibility to ensure effective systems of control are in place to minimise the impact of any risks that could destabilise the proper functioning of the organisation and the wider health and care system. Every activity that the CCG undertakes, or commissions brings with it some element of risk that has the potential to undermine, threaten or prevent the organisation from achieving its vision and corporate objectives.

Risk Management and robust systems of internal control are embedded at all levels of the CCG. The Risk Management and Assurance Strategy reflects Liverpool CCG's philosophy towards risk and its commitment to good governance. The strategy provides the framework by which the CCG's Governing Body receives the appropriate assurance that risks against the CCG's corporate and strategic objectives are consistently being identified, managed and mitigated.

Each year, the CCG identifies its key strategic risks which are set out in the Governing Body Assurance Framework (GBAF). This framework enables the Governing Body to seek assurance that the organisation's key strategic risks are being controlled effectively, highlighting where controls are not effective or there are gaps that need to be addressed.

The key strategic risks for the CCG in 2021/22 were understandably related to the transition to new commissioning arrangements and the impact of the COVID-19 pandemic and associated demand pressures on services and health inequalities. These risks were carried forward into the remaining period of the CCG's operations, from April to June 2022. The strategic risks that the governing body have sought assurance on were:

1. The CCG fails to commission care that meets the whole population needs and meet NHS Oversight Framework requirements.
2. System pressures, financial challenges and structural changes could lead to a loss of focus on ensuring quality, safety and patient experience of services.
3. Failure to direct resources towards most deprived wards and communities with greatest need will widen health inequalities.
4. The CCG will be unable to agree a credible and financially sustainable medium-term plan due to uncertainty around future financial, contracting and governance frameworks (H2).
5. NHS finance and contracting arrangements for H1 and potentially H2 (first and second halves of the financial year) will limit / inhibit the CCG's autonomy for evidence-based decision making.
6. Uncertainty of future of commissioning structures at 'place' level and system level leads to disengagement or loss of influence / direction locally.

In addition, the CCG maintained a corporate risk register, which is a mechanism to manage specific risks from a clinical quality, finance, performance, resilience, commissioning/procurement, reputational or legal perspective. During this period, work was undertaken to transition risks to ensure continued oversight and management of risk as the ICS came into being from July 2022.

1.7 Performance Summary

During the first quarter of 2022/23 the same challenges remained from 2021/22. Another wave of higher COVID-19 positive cases emerged from June 2022.

Fig2: Number of Confirmed Covid-19 Cases; Cheshire & Mersey 7 day moving average

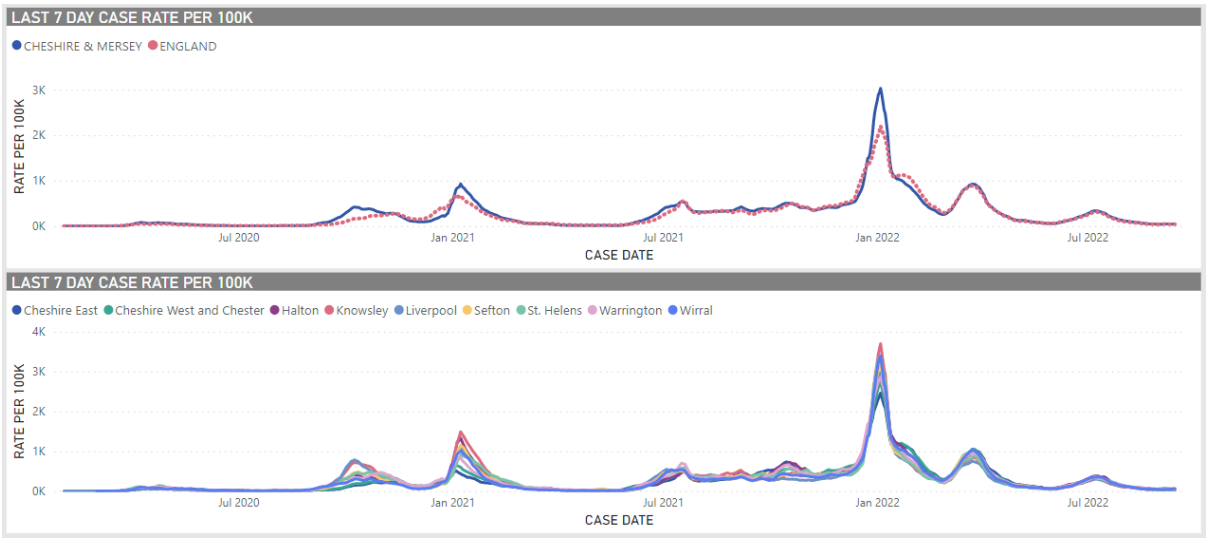


Fig1

Source: CIPHA

Liverpool hospitals have consistently had to manage admissions from patients with Covid-19 throughout this period, with the impact impacting on frontline care to some extent.

Fig2: Hospital Bed Occupancy due to Covid-19 and use of High Dependency and Intensive Therapy Beds: Liverpool University Hospital Foundation Trust

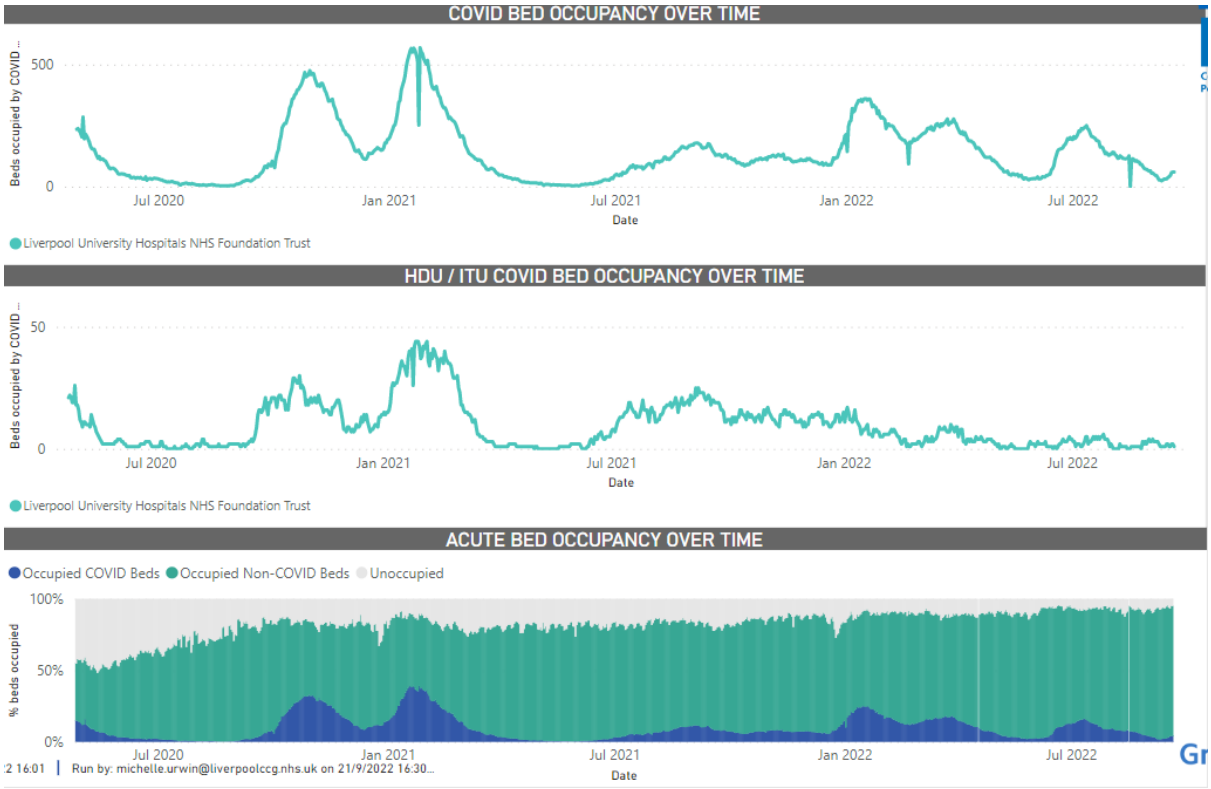
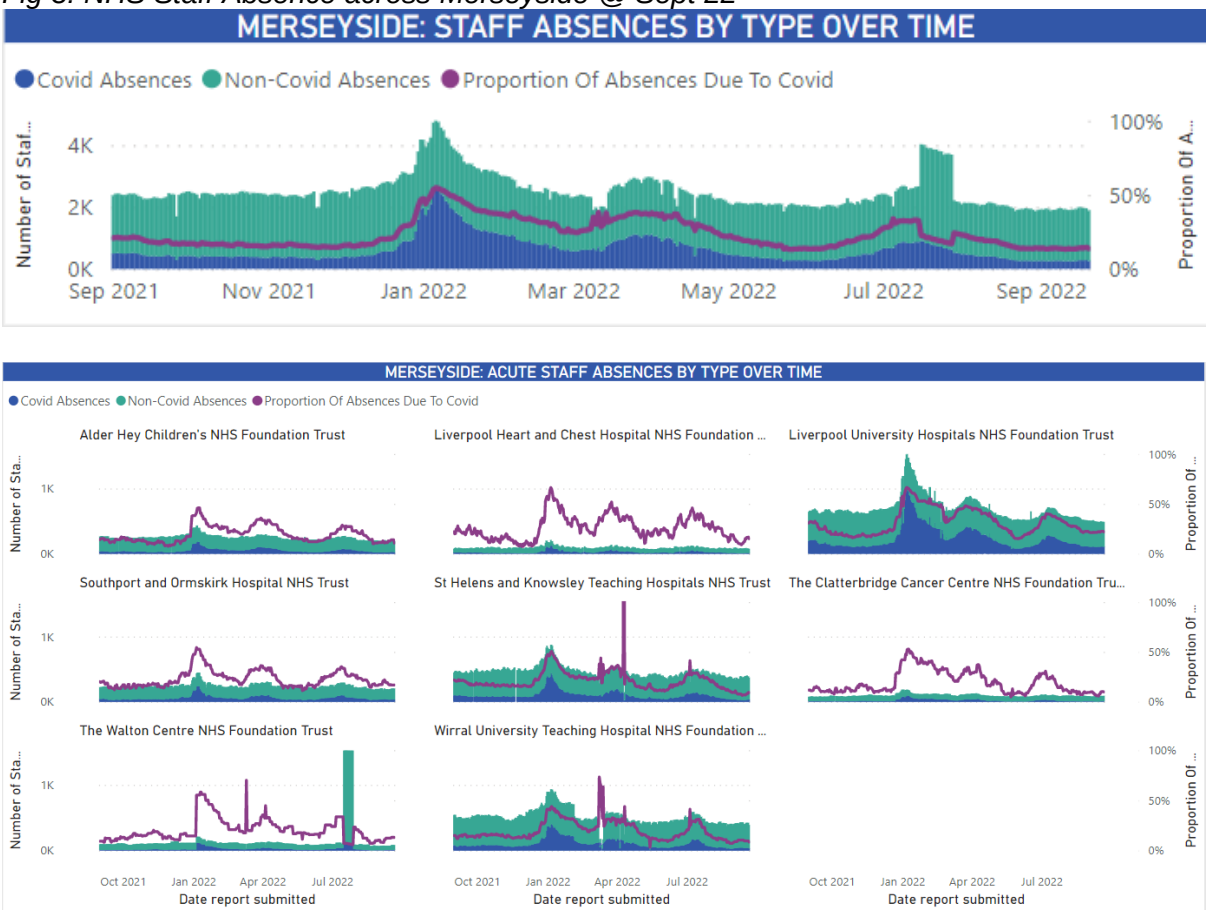


Fig2

Source: CIPHA

Covid-19 circulating in the community, continues to have some impact on the NHS workforce, both through infection and higher levels of associated staff sickness.

Fig 3: NHS Staff Absence across Merseyside @ Sept 22



Despite the continued challenges from COVID-19, providers have continued to respond rapidly and with resilience to adapt service delivery and balance the pressures of high demand, recovering services and addressing the backlog of planned care.

Recovery has been supported by increased use of digital technology to improve the efficiency and productivity of NHS services by providing the tools to enable patients to continue to access health services remotely, whilst also supporting services to make the most productive and best use of clinical time to see more patients.

Digital technology is now mainstream in all care settings. Developments continue to be made to ensure patients can still access their appointments whilst avoiding a hospital visit, be remotely monitored within their own home/ care home and be able to access primary care through a much wider range of options.

The CCG has continued to monitor provider performance against key NHS Constitutional measures. The focus during this period has been on maintaining patient

safety and high-quality care as services start to restore and recover. Performance against the measures is detailed in the dashboard on pages 33 to 34.

The following sections will describe key areas in more detail.

1.7.1 Urgent care

NHS Liverpool CCG has failed to meet the standard of 95% of patients spending less than four hours in Accident and Emergency (AED) during this period. As of June 2022, performance was 74.5% against the standard, however this was a better position than the national average of 71.62% and the North West average of 68.5%

Urgent care services have seen an increase in demand. The table below demonstrates the increases across all sectors.

	19/20 Outturn	20/21 Outturn	21/22 Outturn	22/23 (rolling 12M up to Jul-22)	22/23 YTD (Jul-22)
GP Appointments (*Liverpool CCG Only)*	2,287,695	2,248,384	2,589,792	2,588,153	820,077
NHS111 (*Liverpool CCG Only)*	90,027	116,514	112,707	102,712	34,439
Walk in Centres (*Liverpool CCG Only)*	141,780	111,285	178,166	154,831	43,745
NWAS PES Incidents (*Liverpool CCG Only)*	95,093	90,516	98,975	96,045	30,870

The nationally mandated urgent care self-service tool, known as the e-streaming and redirection tool, is being embedded in urgent care settings. Patients who attend without a pre-booked appointment are asked to answer a set of questions about their symptoms on arrival so that the service can direct them to the most appropriate care, in some instances this may be being redirected to another service in the city.

The CCG and partners have worked collaboratively and prioritised a number of schemes, including increased use of community beds to support safe discharge of patients, increased input from the community rapid response team, use of telehealth to enable remote monitoring of patients in their own homes and communications and engagement schemes to signpost people to the right services at the right time and the right place.

From 2022/2023, ten new Emergency Department clinical quality standards were introduced to monitor areas that will improve the patient experience of urgent care.

NORTH WEST AMBULANCE SERVICE

Pressures on ambulance services have become more severe during this period, due to high demand and staffing challenges. This period has seen significant volatility in emergency call volumes, patient demand, acuity and the ability of Trusts to turnaround and release ambulances in a timely way. Like all parts of the service, staff absences due to COVID and the general impact of the pandemic have affected control room staff and operational crews. Inevitably, this has had an adverse impact upon ambulance call pick up and response times in the community, which have fallen below the standards required, despite the efforts of all concerned.

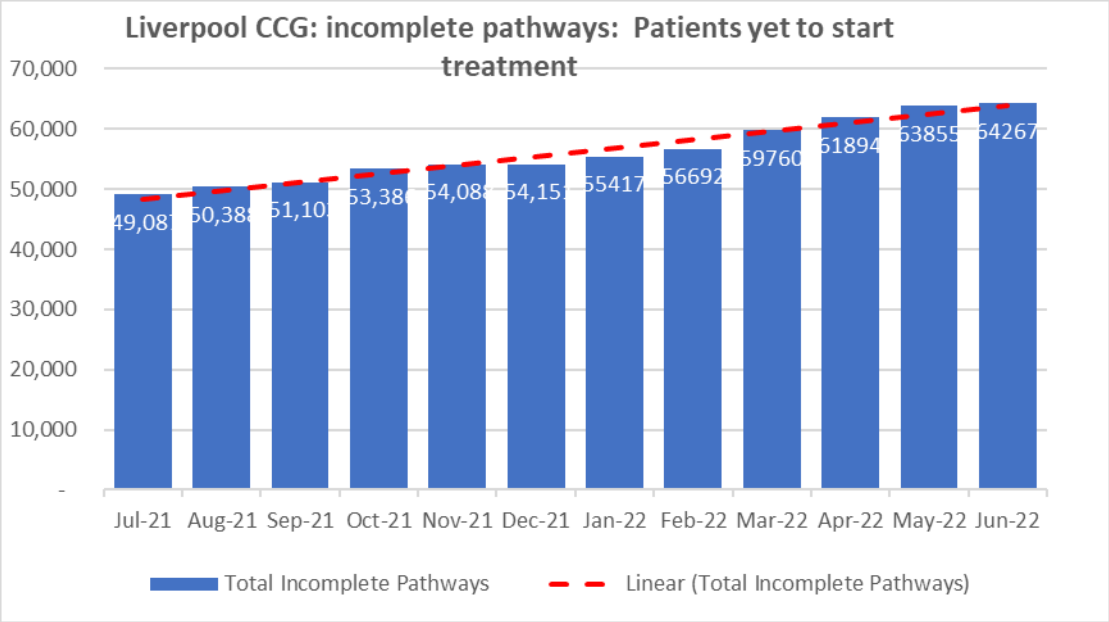
Commissioners and North West Ambulance Service (NWAS) have worked collaboratively to put into place a series of actions and mitigations to improve service responsiveness and delivery. Additional resources have allowed NWAS for example to recruit additional control and dispatch staff into the emergency operations control centres to improve call pickup times, supported by additional clinical staff; additional double crewed ambulances have been deployed by training a cohort of Patient Transport Staff as 'blue light drivers'; retaining road worthy vehicles that would ordinarily be replaced by new ambulances to temporarily bolster the emergency fleet; and there has been an increase in the use of voluntary aid society (St John Ambulance) and Private ambulances for lower acuity incidents, thereby releasing Paramedic crews.

1.7.2 Elective care

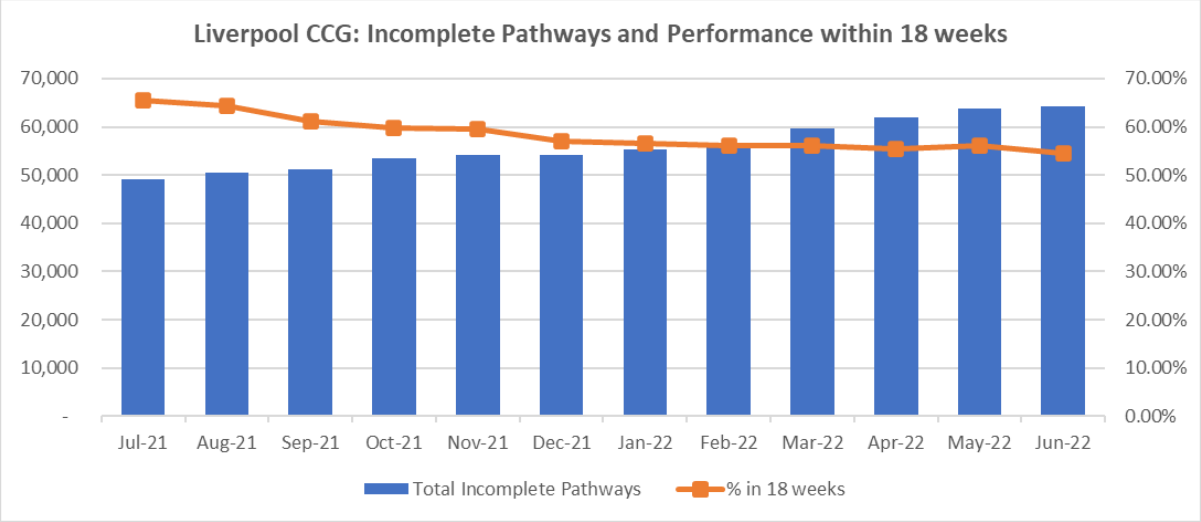
Elective care (planned care) activity has been maintained throughout this period, with committed, whole-system efforts to reduce waiting times, in line with the NHS Operational Guidance and both regional and local plans.

- **Referral to Treatment Standard**

The 18-week Referral to Treatment (RTT) standard is a core measure within the NHS constitution and mandates that no patient should wait more than 18 weeks from initial GP referral to receiving treatment. The chart below shows that the waiting list size has continued to grow between April 2022 and June 2022, with an increase of 2,373 patients.



As waiting list sizes have increased, the percentage of patients being seen within the 18-week standard have fallen, as shown below.



NHS England reports the number of patients waiting more than 104 weeks, in addition to those waiting over 52 weeks. Both metrics have shown a steady increase in the number of patients waiting in excess of these times. In March 2022, 173 patients registered with a Liverpool GP were waiting more than 104 weeks as shown in the table below. The national drive to reduce patients waiting more than 104 weeks to zero by July 2022, other than those patients choosing to defer treatment, meant that this figure had reduced to 90 in June 2022.

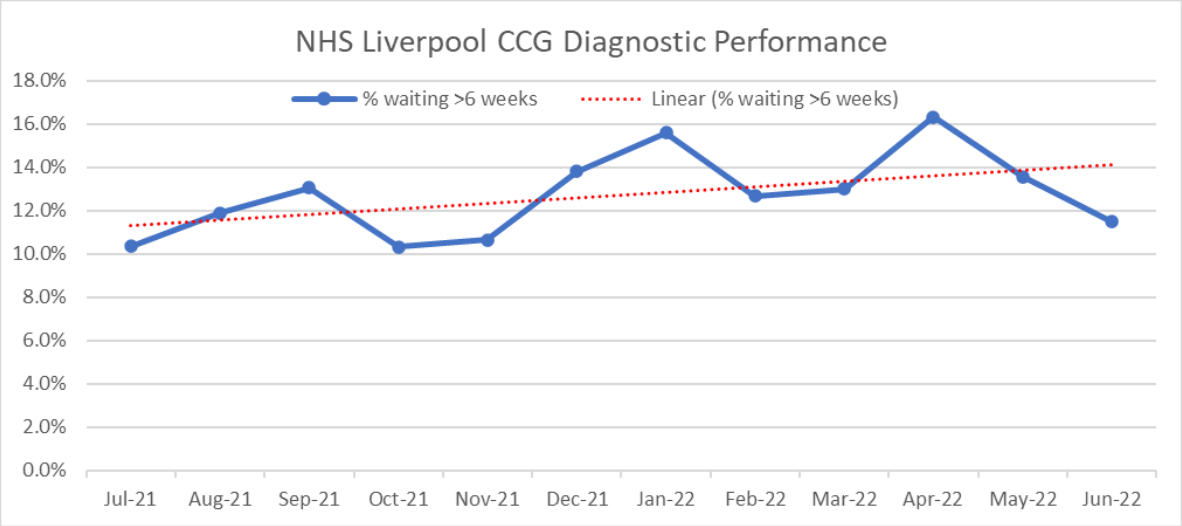
	Mar-20	Mar-21	Mar-22	Jun-22
Total Incomplete pathways	32338	38485	59760	64267
Over 18 weeks	6490	13493	26199	29226
Over 52 weeks	0	3234	4045	5713
Over 104 weeks	0	0	173	90
% over 18 weeks	79.90%	64.90%	56.20%	54.50%

The use of digital appointments for out-patient consultations has continued, with approximately 20-25% of patients accessing their appointment via a telephone or video call. The use of 'advice and guidance' (A&G) continues to be a key focus for primary care clinicians to access early advice from secondary care consultants and avoid unnecessary referrals and delays in care. Liverpool CCG has continued to work with primary care to increase utilisation. Between April-June 2022, 3000 A&G requests were made. This is an increase from 2753 requests reported in the same period in 2021.

The national Clinical Prioritisation programme supported by NHS England and the Royal Colleges requires that all patients on a waiting list have been reviewed against nationally set criteria to ensure patients are seen in order of clinical need. The impact of this has meant that the number of patients waiting in excess of 52 weeks for treatment increased in year as more clinically urgent cases have been seen, however the focus on improving the number of patients waiting more than 104 weeks for treatment is now an improving picture as providers work hard to reduce long waiting times.

1.7.3 Diagnostics

Liverpool CCG has not met the standard that no more than 1% of patients should wait more than 6 weeks for a diagnostic test in this period. However, significant progress has been made since December 2020 and the Liverpool position is positive compared to the North West and national average. This metric reports performance against 15 key diagnostic procedures, the most common being MRI scan, CT scan and endoscopy.



Endoscopy continues to be the most challenged in terms of performance, which is replicated nationally due to the volume of procedures undertaken and a national shortage of nurse endoscopists. Endoscopy services at Liverpool University Hospital NHS Foundation Trust are the busiest of all Liverpool providers and they have continued throughout this period to provide additional activity through insourcing and additional clinic provision and have been pro-active in recruiting additional staff.
The Cheshire and Merseyside Endoscopy Network have continued to work with all endoscopy units to drive improvement and work flexibly across the region to manage demand.

1.7.4 Mental health

Liverpool has some of the highest prevalence rates of anxiety and depressive disorders compared to other core cities. Improving Access to Psychological Therapy (IAPT) is a 'stepped care' treatment model, designed to offer people with anxiety and depression a 'first line' treatment, which has the best chance of delivering positive outcomes. IAPT services are subject to nationally mandated targets within the NHS Constitution, which include 6 and 18 week waiting time measures, in addition to targets for access to treatment and recovery rates.

Access targets are measured by the proportion of patients with 'common' mental health disorders who are assessed and receive treatment in accordance with NICE guidance, whilst recovery standards measure the rates of people with common mental health disorders who achieve reliable improvement in their presenting condition following treatment.

There were significant pressures within mental health services during this period. Liverpool CCG has consistently achieved both the 6 and 18 week IAPT standards, with performance levels above both the North West and national average. The service, delivered by Mersey Care NHS Foundation Trust, has been remodelled to maintain safe and effective service delivery, including the provision of telephone assessments, more focussed initial assessments and more clearly defined pathways through to treatment.

Recovery targets have been narrowly missed in Liverpool. Work is underway to understand the reasons why patients drop out before completion of treatment and any actions needed to improve patient experience and performance.

Cheshire and Merseyside IAPT steering group is driving a strategic approach to improvements within IAPT services across the region. Liverpool CCG and Mersey Care are active participants in this workstream.

Demand for Child and Adolescent mental health services (CAMHS) has also increased. The Liverpool CAMHS Partnership (a partnership of services commissioned by Liverpool CCG) work together to promote positive mental wellbeing of children, young people and their families. In response to increased demand, the Partnership have adapted their delivery models. This has included a blended delivery model of virtual and face to face therapeutic appointments, increased support for parents/carers, increased practical support for families, virtual therapeutic and psycho education groups, bitesize virtual training for the workforce, virtual workshops for CYP and improved use of digital approaches. There has also been significant increased investment from Liverpool CCG and Liverpool City Council into children's mental health services.

The Children's Commissioner identified Liverpool CCG as one of the top ten performing CCGs in England in providing access to Children and Young People's mental health services. However, the CCG is not complacent in its approach to responding to the ongoing challenges in supporting children with mental health needs.

Eating Disorders Service

There has been rising demand for both adult and children & young people's (CYP) eating disorders services in recent times, with services also reporting an increase in the acuity of patients presenting. This is understood to be, in part, a result of the COVID-19 pandemic.

The adult service, provided by Mersey Care Trust, has failed to meet the 18 week referral-to-treatment standard. The Trust has taken several improvement actions, which include the recruitment of additional staff, continued use of virtual appointments where appropriate, and an increase in face-to-face appointments. Additional support in the form of well-being calls and access to an education group has been offered for individuals experiencing long waiting times for treatment. Liverpool CCG has approved additional investment funding during 2022/23 for further service recovery improvements.

Children and Young Peoples (CYP) eating disorders service have been challenged in meeting both the urgent (1 week) and routine (4 week) waiting times standards, along with an increase in the number of CYP requiring inpatient admission.

The service has introduced multi-disciplinary assessment clinics to ensure robust clinical decision-making and an increase in capacity for new assessments. Additional

staff have been recruited to ensure service sustainability and to support those young people most at risk, including home visits to support meal times.

A telemedicine pilot project is underway to deliver physical health checks virtually. The waiting times for both adult and CYP eating disorders continue to be closely monitored through regular meetings between the CCG and providers.

Neuro Development; Autistic Spectrum Disorder (ASD) / Attention Deficit Hyperactivity Disorder (ADHD)

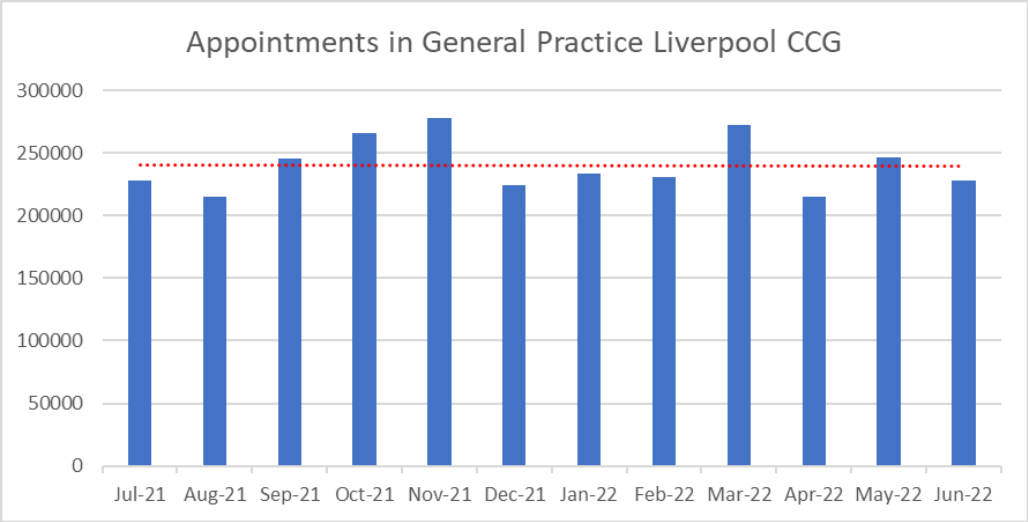
Both the children's ASD/ADHD assessment pathway and the adult ASD service have seen an increase in referrals, again a phenomenon noted nationally as a result of the stressors caused by the pandemic.

Waiting times for the adult ASD service were recognised as being unacceptably long and a number of measures, including bi-annual wellbeing calls, have been introduced to provide support whilst on the waiting list. NHS Liverpool CCG has worked with Mersey Care to identify and agree the additional investment needed to further support service recovery.

Children's ADHD and ASD diagnostic services have been unable to maintain the NICE compliant waiting time standard of 30 weeks. The CCG has committed additional funding of £981k over 21/22 and 22/23 to improve waiting times and meet additional demand. This funding will enable recruitment to additional specialist clinical posts.

1.7.5 Primary care

Demand for primary care services has remained high and following a steady increase in GP appointments delivered post-pandemic, high levels of activity continued to be delivered.



Source: NHS Digital 'Appointments in General Practice'

There has been an expansion in primary care workforce, in line with the national programme, with new roles created such as first contact practitioners, clinical pharmacists, social prescribers, all of which support greater primary care workforce resilience and the response to unprecedented demand.

Routine services to protect the most vulnerable groups in the city have continued to be prioritised e.g., health checks for patients with a learning disability, physical health checks for patients with Serious Mental Illness (SMI), services to refugees and homeless people. During periods where demand from the national vaccination programme has eased, work to reduce the backlog of patients requiring long term condition reviews has been prioritised.

GP appointments in the city have continued to be delivered by a variety of methods, according to clinical need. Face to face appointments have increased and are broadly in line with the national picture of 60% of appointments provided via face to face delivery and the remainder via domiciliary visits, telephone, video, or electronic consultation.

The CCG worked jointly with the local authority and charities to support the recent increase in refugees; providing accommodation, undertaking initial health checks and registering people with local GP practices.

COVID-19 Vaccination Programme

The system response to rapid delivery of the vaccination programme has been both a huge challenge and success in the previous year. The programme was co-ordinated by the CCG and Liverpool City Council public health. Primary care has been pivotal in delivery of the programme; in a truly collaborative effort with community pharmacy and local community and secondary care providers making significant contributions.

All partners have worked innovatively to tackle vaccine hesitancy and improve access for vulnerable communities, including people in care homes and domiciliary settings.

Liverpool University Hospitals continues to offer a static vaccine centre at the Pier head and there are regular vaccine walk-in sessions across the city to ensure there are opportunities for people to come forward who haven't yet been vaccinated.

Despite the immense effort, vaccine uptake in Liverpool is below the national average, although it compares with other core cities. The vaccination rates for Liverpool residents on 7th July 2022 are detailed below:

Age Group	Dose 1 Uptake (%)	Dose 2 uptake (%)	Dose 3/ Booster Uptake (%)
80+	95.6%	94.9%	90.3%

75-79	95.1%	94.3%	90.3%
70-74	93.4%	92.4%	87.1%
65-69	90.9%	89.5%	82.3%
60-64	88.9%	87.0%	76.7%
55-59	85.5%	82.9%	70.0%
50-54	80.9%	77.8%	62.8%
45-49	75.1%	71.4%	53.4%
40-44	69.6%	65.3%	45.5%
35-39	64.9%	60.1%	38.4%
30-34	59.6%	54.5%	32.4%
25-29	56.9%	51.5%	29.6%
18-24	64.6%	57.1%	31.5%
16-17	47.5%	34.0%	
12-15	36.5%	22.6%	
Total 18+	73.7%	69.7%	52.5%

% = percentage of the Liverpool total population vaccinated
Source: Weekly COVID-19 Vaccinations, NHS England as at 07.07.2022

1.7.6 Incidences of Healthcare Associated Infections (HCAI)

Liverpool CCG has continued to apply rigour to reducing the incidence of HCAIs and their associated risks, across the health economy during this period. Every avoidable infection has an impact on patient safety, experience and effectiveness. Tackling HCAI requires a multi-agency and multi-factorial approach. Whilst considerable progress has been made, there is still much work to be done. Significant improvements will only be brought about by harnessing a joined up and transparent approach; sharing innovation and lessons learnt across all public health, provider and commissioning organisations.

All providers of healthcare services are required to report all incidences of:

- Methicillin-resistant staphylococcus aureus (MRSA) bloodstream infections.
- Clostridium difficile infection (CDI)
- Escherichia coli (E. coli) bloodstream infections

The following narrative provides a summary of cases reported by Liverpool CCG commissioned providers from April to June 2022.

Methicillin-Resistant Staphylococcus Aureus (MRSA)
MRSA bloodstream infection carries a nationally mandated ‘zero tolerance’ threshold. All cases of MRSA bloodstream infections which occur in Liverpool CCG commissioned providers (where the CCG is the Lead Commissioner) are subject to robust multidisciplinary Post Infection Reviews (PIRs). A total of 5 cases relating to patients registered with a Liverpool GP have been reported and attributed to Liverpool CCG providers between April - June 2022. For the 5 cases reported, 3 were attributed to a community setting and 2 attributed to Liverpool CCG commissioned providers.

All MRSA bacteraemia are subject to robust post infection reviews. Learning and good practice from reviews is shared within the health and care system.

Clostridium Difficile (CDI)
Work continues across the health system to address CDIs. Reviews of all cases of CDI are carried out by providers. Where any lapses in care are identified, action plans are developed and implemented to prevent re-occurrences.

During April – June 2022, there were 83 cases of CDI. These numbers are above the year to date trajectory of 173.

2022/23	2021/22 OT	2022/23 Plan	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend
Monthly Plan		173	14.4	14.4	14.4	14.4	14.4	14.4	14.4	14.4	14.4	14.4	14.4	14.4	72.0	
Hospital Onset - Healthcare Associated.			7.0	6.0	8.0	10.0	9.0								40.0	
Community Onset - Healthcare Associated			3.0	4.0	5.0	1.0	5.0								18.0	
Community Onset - Indeterminate Association			1.0	3.0	3.0	3.0	2.0								12.0	
Community Onset - Community Associated			1.0	4.0	2.0	4.0	2.0								13.0	
Total Monthly Actual		0	12.0	17.0	18.0	18.0	18.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	83.0	

Escherichia Coli
E. coli is the most common causative organism in gram-negative bloodstream infections (GNBSIs). The NHS Long Term Plan sets out a target for a 50% reduction by 2024/25. The complex nature of E. coli bloodstream infection means that a single intervention is unlikely to result in significant change.

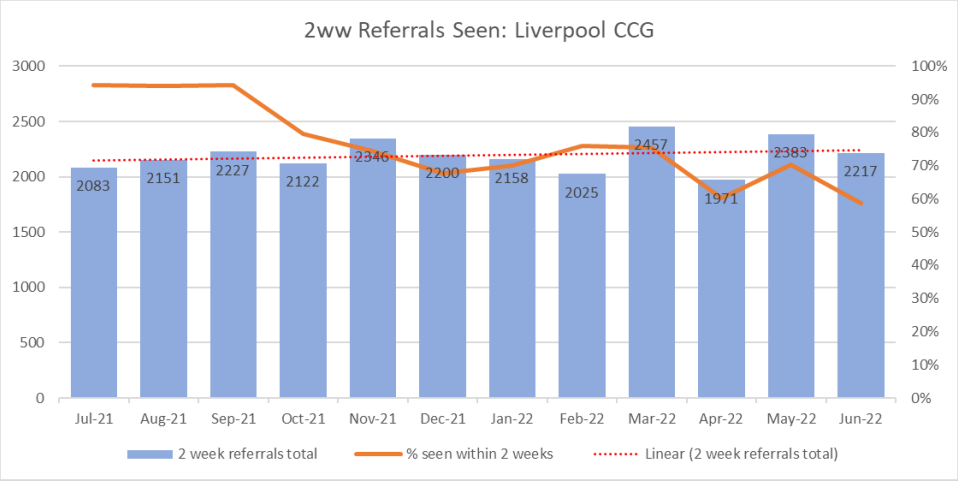
121 E. coli bloodstream infections were reported across Liverpool providers for residents registered with a Liverpool GP during April- June 2022, above the trajectory of cases 91.2 year to date and an annual plan of 365 cases for 2022/23.

In order to maintain quality oversight across the region, a North Mersey Gram Negative Blood Stream Infection Reduction (GNBSI) group is hosted between commissioners in Liverpool and Sefton CCGs' and public health and providers. This also promotes learning, shares best practice and innovation and decides where to focus efforts at scale for the greatest impact. The CCG has continued to align resource with the Sefton CCGs' for representation at the Cheshire and Merseyside Joint oversight Antimicrobial Resistance (AMR)/GNBSI/Sepsis/HCAI/IPC Programme Board.

Liverpool CCG quality team continue to work closely with commissioned providers to ensure that IPC/HCAI is a regular quality focus item at Clinical Quality Performance Groups and Contract Quality Review Meetings (CQPG/CQRM). The CCG Governing Body maintains oversight of the delivery of these key work streams though regular updates, highlighting CCG and individual provider performance against monthly trajectories and annual plans.

1.7.7 Cancer care

Restoration of cancer care services has been a key priority; it is recognised that early diagnosis and treatment has a direct impact on outcomes. Referral rates into cancer services dropped significantly during the pandemic. Referrals have continued to steadily rise and have remained above pre-pandemic levels, as can be seen below.



2 week wait targets have remained challenged during April 2022 to June 2022 with performance below the national average. This is as a result of high referral rates and workforce challenges within some cancer pathways with high numbers of patients. The CCG continues to work with providers to improve performance.

62 day performance from referral by a GP to a patient receiving their first definitive treatment has remained challenged. In June 2022, 61.6% of patients in England were seen within 62 days, Liverpool CCG performance was below the national average and is impacted due to the number of tertiary services it provides.

The use of virtual clinics, telephone assessment or virtual video conferencing, has been embedded where a face to face appointment is not clinically required. This has enabled vulnerable patients to continue their care and for clinicians to be able to assess patients in a timely manner. There have also been a range of service improvements undertaken in partnership with the Cancer Alliance, to embed national optimal clinical pathways into service and to provide wider support to people affected by cancer through access to social prescribing.

Liverpool commenced invitations to Targeted Lung Health checks from 2021. The programme aims to diagnose lung cancer at an early stage by systematic assessment of those at higher risk. The programme aims to have covered the eligible population within the city by March 2023.

Liverpool CCG has a robust cancer harm review process in place to review any pathways which breach 104 days in line with national guidance. Any key themes and

trends identified are discussed with the provider to drive improvements in care and performance and this process has continued during the year.

The impact of COVID-19 on health inequalities in cancer health is monitored by Cheshire and Merseyside Cancer Alliance. Despite the low referral levels seen during 2020 and the early part of 2021 as a result of COVID-19, there is currently no statistically significant evidence that cancer is being diagnosed at a later stage than pre-pandemic. Liverpool CCG continues to work with its partners to encourage patients to present for early assessment with any suspected cancer symptoms and to increase uptake of screening programmes.

1.7.8 New Models of Care

Several new care models were introduced over the last 12 months in response to Covid-19, which are now being embedded into the way services are delivered going forward, due to the benefits that have been evidenced.

Telehealth

The use of Health Technology (Telehealth) allows remote monitoring by clinicians of various health indicators such as blood pressure, oxygen levels, body weight and allows users and clinicians to ask/answer questions about an individual's health. Pre-COVID-19, Telehealth was already in use in Liverpool to monitor patients with long term conditions e.g. diabetes, heart failure and chronic obstructive pulmonary disease and had enabled patients to manage their condition at home and avoid emergency hospital admission.

The foresight of Liverpool CCG to establish these services in Liverpool pre-covid was important in responding to the pandemic and it continues to be developed.

Neutralising Monocolonal Antibodies (nMABs);

Recent evidence suggests that antivirals and neutralising monoclonal antibodies (nMABs) significantly improve clinical outcomes in non-hospitalised patients with COVID-19 who are at high risk of progression to severe disease and/or death.

The development and mobilisation of the pathway has been an excellent example of Provider collaboration across Merseyside.

Long Covid Service

Long COVID is a new and evolving condition, with a worldwide research effort underway to understand the condition and test effective treatments. A Long Covid service has been established to provide support and rehabilitation. The service is based on a tiered approach, based on the severity of the condition and the level of intervention necessary for each patient.

		Tier 1 Self Care	Tier 2 Care by the GP	Tier 3 Specialist referral and rehabilitation	Tier 4 Specialist Management of complications
CHILDREN & YOUNG PEOPLE	Service Delivered by	-	General Practice	Alder Hey NHS Trust	Alder Hey NHS Trust
	Population covered	All	All	Cheshire & Mersey	Cheshire & Mersey
ADULTS	Service delivered by	-	General Practice	Mersey Care With - psychological support by Liverpool Heart & Chest Hospital plus - pulmonary rehabilitation from various providers	Liverpool University NHS Trust With - psychological support by Liverpool Heart & Chest Hospital plus - pulmonary rehabilitation from various providers
	Population covered			Liverpool Knowsley South Sefton Southport & Formby St Helens	Cheshire & Mersey

From April to June 2022, the Mersey Care tier 3 adult service received 200 referrals for Liverpool residents. This is in addition to the patients who have been referred and assessed in Liverpool University Hospital.

Virtual Wards

Virtual wards enable patients to receive the acute care, remote monitoring, and treatment they need, safely and conveniently in their own home or usual place of residence, rather than in hospital. Patients admitted to a virtual ward have their care reviewed daily by a consultant practitioner (including a nurse or allied health professional) or suitably trained GP, via a digital platform that allows for the remote monitoring of a patient's condition and escalation to a multidisciplinary team.

The implementation of virtual wards is a national NHS priority, as they enable to be cared for at home and narrow the gap between demand and capacity for secondary care beds, by providing an alternative to admission and/or early discharge.

Liverpool Heart & Chest Hospital and Mersey Care as the providers that delivered Covid Virtual Wards have worked to further develop the clinical pathways to establish a respiratory virtual ward.

1.8 Performance Analysis

Liverpool CCG - Performance Dashboard 2021/22

NHS Liverpool Clinical Commissioning Group

Metric		2021/22 Q2 Jul	Aug	Sep	Q3 Oct	Nov	Dec	Q4 Jan	Feb	Mar	2022/23 Q1 Apr	May	June	Latest National	Latest NW	Trend
URGENT AND EMERGENCY CARE																
Accident & Emergency																
4-Hour A&E Waiting Time Target % of patients who spent less than four hours in A&E	Actual	72.3%	75.7%	74.0%	73.3%	72.4%	75.3%	77.3%	76.3%	74.5%	75.4%	74.3%	74.7%	71.0%		
	Plan	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%		
REFERRAL TO TREATMENT TIMES & ELECTIVE CARE																
Referral to Treatment (RTT) & Diagnostics																
% of patients waiting 6 weeks or more for a diagnostic test	Actual	10.40%	11.90%	13.06%	10.30%	10.70%	13.83%	15.60%	12.67%	13.01%	16.30%	13.60%	11.50%	27.5%	24.9%	
	Plan	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		
Incomplete Pathways: % of RTT incomplete pathways (patients yet to start treatment) within 18 weeks	Actual	65.5%	64.4%	61.1%	59.7%	59.5%	57.0%	56.6%	56.0%	56.2%	55.4%	56.2%	54.5%	62.2%	58.8%	
	Plan	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		
Total No of RTT incomplete pathways (patients yet to start treatment)	Actual	49,087	50,387	51,103	53,386	54,088	54,151	55,417	56,692	59,760	61,894	63,855	64,267			
No of Incomplete Pathways Waiting over 52 weeks	Actual	3,271	3,401	3,640	3,821	3,773	3,639	3,732	3,663	4,045	4,624	5,156	5,713			
	Plan	0	0	0	0	0	0	0	0	0	0	0	0			
No of Incomplete Pathways Waiting over 104 weeks	Actual	29	57	104	148	178	176	221	233	173	104	120	90			
	Plan	0	0	0	0	0	0	0	0	0	0	0	0			
CANCER																
Cancer Waiting Times																
% Patients seen within two weeks for an urgent GP referral for suspected cancer *Yellow denotes achieving 1920 trajectory but not national standard	Actual	94.3%	94.0%	94.2%	79.8%	74.4%	67.8%	69.9%	76.0%	75.6%	60.2%	70.3%	58.8%	77.8%		
	Plan	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%		
% of patients seen within 2 weeks for an urgent referral for breast symptoms	Actual	94.3%	93.5%	92.1%	20.9%	26.6%	20.3%	25.6%	25.0%	21.9%	15.0%	30.8%	31.1%	68.5%		
	Plan	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%		
28 day faster diagnosis	Actual	75.6%	75.1%	71.9%	71.6%	69.3%	65.4%	60.7%	64.6%	64.4%	61.0%	64.6%	66.1%	71.1%		
	Plan	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%		
% of patients receiving definitive treatment within 1 month of a cancer diagnosis -31 days	Actual	96.2%	95.1%	93.8%	93.8%	93.9%	96.7%	93.3%	92.3%	95.7%	94.9%	94.5%	96.2%	92.9%		
	Plan	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%		
% of patients receiving subsequent treatment for cancer within 31 days (Surgery)	Actual	94.3%	87.5%	90.6%	84.1%	92.5%	83.3%	79.4%	91.7%	80.0%	94.1%	92.7%	86.7%	82.1%		
	Plan	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%		
% of patients receiving subsequent treatment for cancer within 31 days (Drug Treatments)	Actual	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	100.0%	98.6%	100.0%	100.0%	98.3%		
	Plan	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%		
% of patients receiving subsequent treatment for cancer within 31 days (Radiotherapy Treatments)	Actual	100.0%	97.3%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	100.0%	98.2%	100.0%	100.0%	92.3%		
	Plan	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%		
% of patients receiving 1st definitive treatment for cancer within 2 months (62 days)	Actual	67.0%	51.4%	73.6%	66.7%	73.6%	63.3%	66.0%	71.2%	57.1%	63.0%	62.6%	41.5%	61.6%		
	Plan	85%	85.0%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%		
% of patients receiving treatment for cancer within 62 days from an NHS Cancer Screening Service	Actual	85.7%	81.0%	46.2%	44.4%	53.3%	66.7%	30.0%	61.1%	60.9%	67.7%	36.8%	47.1%	70.2%		
	Plan	85%	85.0%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%		
% of patients receiving treatment for cancer within 62 days upgrade their priority	Actual	87.8%	83.3%	74.2%	80.0%	78.8%	91.2%	77.8%	72.2%	87.5%	71.9%	73.3%	80.6%	74.7%		
	Plan	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%		

MENTAL HEALTH																
Dementia Diagnosis																
Estimated diagnosis rates	Actual	60.4%	60.3%	60.9%	60.2%	61.4%	61.5%	61.5%	61.5%	61.9%	61.3%	61.6%	61.4%	62.0%		
	Plan	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%			
IAPT																
% of people who receive psychological therapies - Access * rolling 3 months	Actual	3.6%	2.4%	2.5%	2.7%	3.8%	3.5%	3.5%	3.2%	3.4%	3.4%	3.8%				
	Plan	5.8%	5.8%	5.8%	5.8%	5.8%	5.8%	5.9%	5.9%	5.9%	5.9%	5.9%	5.9%			
% of people who finish treatment having attended at least two treatment contacts and are moving to recovery * rolling 3 months	Actual	47.6%	46.4%	43.5%	43.3%	42.7%	44.3%	45.3%	47.9%	48.4%	45.8%	43.9%		50.5%		
	Plan	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50%		
IAPT Waiting Time -6 weeks % ended referrals that finish a course of treatment in period who received their first appointment within 6 weeks of referral	Actual	97.4%	-	97.3%	94.6%	87.9%	86.0%	86.5%	92.5%	91.1%	92.8%	92.6%				
	Plan	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%		
IAPT Waiting Time - 18 weeks % ended referrals that finish a course of treatment in period who received their first appointment within 18 weeks of referral	Actual	100%	-	100%	100%	99%	99%	96%	98%	96.0%	97.9%	95.9%				
	Plan	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%		
Early Intervention in Psychosis																
Early intervention in Psychosis waiting times: % referrals with suspected first episode psychosis that start a NICE-recommended package care package within 2 weeks of referral ***rolling 3 months**	Actual	77%	76%	86%	83%	74%	64%	54%	61%	63%	-	79%	78%	69.5%		
	Plan	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60%		
CYP - Eating Disorders																
Waiting Times for Routine Referrals to CYP Eating Disorder Services - Within 4 Weeks (rolling 12 months - completed pathways)	Actual	49.0%			29.1%			16.4%			21.4%			68.9%	70.6%	
	Plan	95.0%			95.0%			95.0%			95.0%					
Waiting Times for Urgent Referrals to CYP Eating Disorder Services - Within 1 Week (rolling 12 months - completed pathways)	Actual	89.5%			84.0%			77.3%			81.0%			68.1%	84.6%	
	Plan	95.0%			95.0%			95.0%			95.0%					
People with a severe mental illness receiving a full annual physical health check and follow-up interventions																
% of People with a severe mental illness receiving a full annual physical health check	Actual	**26.6%**			**31.0%**			**35.4%**			**36.4%**			43.5%	42.0%	
	Plan	60%			60%			60%			60%					
LEARNING DISABILITIES																
AHCs delivered by GPs for patients on the Learning Disability Register																
Patients aged 14 or over on the GPs Learning Disability Register receiving a health check within the quarter	Actual	**26.0%**			**37.9%**			**68%**						71.3%		
	Plan	35.0%			52.5%			70.0%								
HEALTHCARE AQUIRED INFECTIONS																
HCAI																
Number of MRSA Bacteraemias	Actual	0	0	0	0	1	2	1	2	1	2	0	1			
	Plan	0	0	0	0	0	0	0	0	0	0	0	0			
Number of C.Difficile infections	Actual	20	20	16	13	17	9	9	11	15	12	17	18			
	Plan	12.7	12.7	12.7	12.7	12.7	12.7	12.7	12.7	12.7	14.4	14.4	14.4			
Number of E Coli infections	Actual	39	39	32	28	32	30	41	24	42	35	45	41			
	Plan	36	36	36	36	36	36	36	36	36	30	30	30			
NWAS Paramedic & Emergency Services: Liverpool CCG																
Respond to Category 1 calls in 7 minutes on average: Cat 1 mean		00:07:54	00:07:53	00:08:19	00:08:18	00:07:39	00:08:17	00:07:44	00:07:42	00:09:49	00:07:53	00:08:45	00:08:57		00:08:12	
Respond to 90% of Category 1 calls in 15 minutes		00:13:15	00:13:29	00:13:22	00:13:35	00:12:42	00:13:42	00:12:17	00:12:49	00:16:51	00:13:17	00:14:55	00:15:22		00:13:59	
Respond to Category 2 calls in 18 minutes on average: Cat 2 mean		01:03:16	01:07:15	01:11:30	01:22:20	00:59:38	01:47:43	01:03:44	00:51:58	01:26:18	00:24:24	00:41:12	00:48:55		00:39:45	
Respond to 90% of Category 2 calls in 40 minutes		02:19:57	02:16:14	02:32:22	02:59:37	02:06:30	03:49:18	02:24:24	01:51:06	03:11:33	00:49:49	01:29:32	01:45:08		01:27:30	
Respond to 90% of Category 3 calls in 120 minutes		09:49:47	10:39:48	10:30:39	11:10:22	06:25:18	13:31:09	06:49:34	04:28:38	03:40:55	03:14:25	06:39:05	07:52:13		07:20:40	
Respond to 90% of Category 4 calls in 180 minutes		16:11:46	16:40:36	17:01:00	19:37:40	13:45:20	22:32:37	17:20:48	11:08:53	19:35:06	05:56:07	11:24:31	16:46:05		12:38:49	

1.9 Financial Performance Quarter 1 – April- June 2022

The financial duties of Clinical Commissioning Group are set out by NHS England and are listed below:

- Expenditure not to exceed the revenue resource limit in any one year
- Expenditure not to exceed the capital resource limit in any one year (not applicable to Liverpool CCG)
- To remain within the cash limit in any one year
- To remain within the running costs target
- To maintain a minimum of 1% recurrent surplus

NHS Liverpool CCG delivered all of these duties in Quarter 1, 2022. Further details can be found in this annual report, with the financial statements supporting this position being detailed in section 3.

The CCG has delivered a breakeven position for quarter one and therefore retained a cumulative surplus of £16.1m as at 31st March 2022 (equivalent to circa 1.5%) in full compliance with the mandated NHSE business rules and exceeds the minimum 1% recurrent surplus duty as outlined above.

The CCG continued as the designated lead CCG for Cheshire & Merseyside system allocations for quarter one in 2022/23 in respect of additional resources to cover additional COVID and restoration costs. These resources had to be managed through a system lead CCG, which was agreed as Liverpool. Liverpool CCG has then made payments to NHS providers as directed by the Cheshire & Merseyside Healthcare Partnership.

The CCG performance for expenditure and resources for quarter one 2022/23 is shown in the table below:

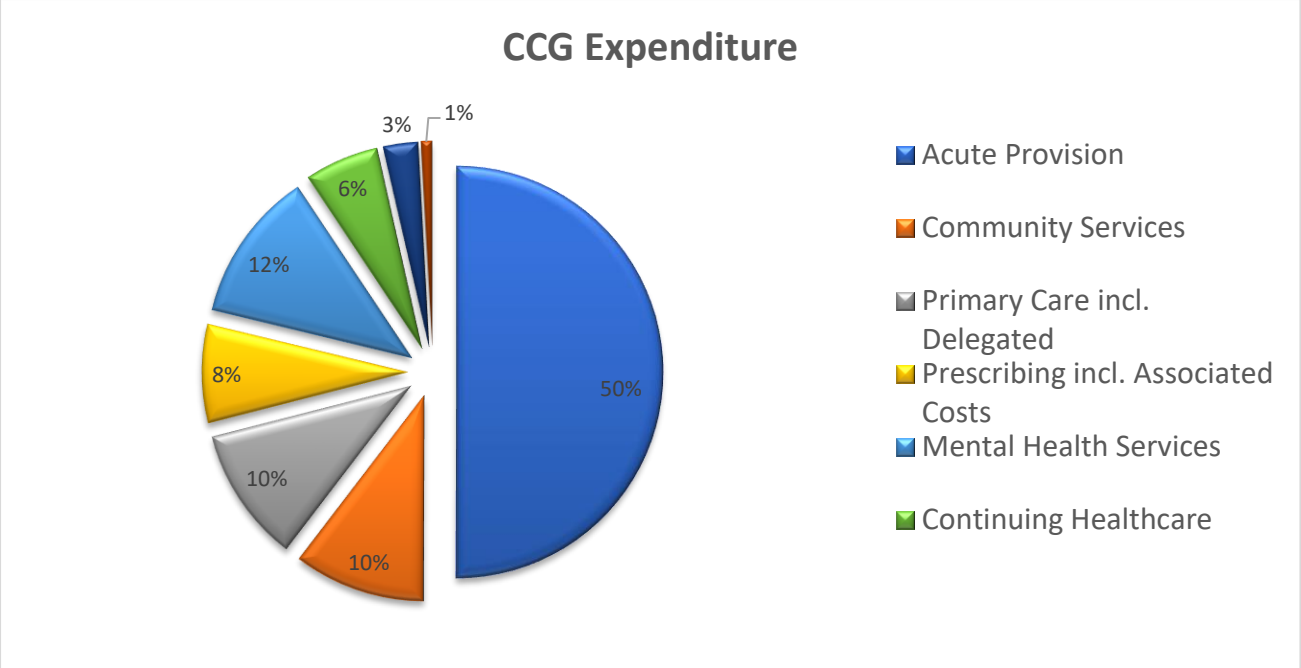
Area of Expenditure	**Quarter 1 2022/23**		
	In Year Allocation £ 000's	Expenditure £ 000's	Surplus / (Deficit) £000's
Programme	263,186	263,187	0
Running Costs	2,208	2,208	0
Total Liverpool CCG	**265,394**	**265,395**	**0**
C&M System	139,109	139,109	0
Total Liverpool CCG inc. C&M System	**404,503**	**404,503**	**0**

Financial Analysis

The analysis below provides further information regarding the CCG expenditure for the first quarter of the 2022/23 financial year (excluding the Cheshire & Merseyside system expenditure).

Allocation of Expenditure

The pie chart below shows the relative percentage of CCG expenditure against the reporting categories:



Provider Information

The table below provides information with regard to the CCG's programme expenditure at a provider level, in excess of £5m for quarter 1 2022/23. These six providers account for £171.9m or 65% of overall CCG expenditure and include a combination of contract and other programme expenditure.

Name of Provider	£000's
Liverpool University Hospitals NHS Foundation Trust	85,992
Mersey Care NHS Foundation Trust	47,752
Liverpool Women's NHS Foundation Trust	12,982
Alder Hey Children's NHS Foundation Trust	11,358
St Helens & Knowsley Teaching Hospitals NHS Trust	7,149
North West Ambulance Service NHS Trust	6,628

The remaining 35% expenditure includes primary care expenditure £27.7m (circa 11%), prescribing costs of £20.6m (circa 8% of overall spend), continuing healthcare and packages of care £15.5m (circa 6%), which are not material at an individual contract level.

1.10 NHS System Oversight Framework

The purpose of the NHS System Oversight Framework (SOF) is to:

- align the priorities of Integrated Care Systems (ICS) and the NHS organisations within them
- identify where ICSs and NHS organisations may benefit from or require support to meet the standards required of them in a sustainable way, and deliver the overall objectives for the sector in line with the priorities set out in the 2021/22 Operational Planning Guidance, the NHS Long Term Plan and the NHS People Plan
- provide an objective basis for decisions about when and how NHS England and NHS Improvement will intervene in cases where there are serious problems or risks to the quality of care.

The SOF has a single set of metrics across integrated care systems, trusts, clinical commissioning groups and primary care which are aligned to five national themes. The 5 national themes reflect the ambitions of the NHS Long Term Plan: quality of care; access and outcomes; preventing ill health and reducing inequalities; people, finance and use of resources; and leadership and capability. There are 99 metrics in total in the SOF, a number of which are still in development; trusts, ICSs and CCGs are measured against those metrics which are appropriate to their part of the system.

NHS England then allocate ICSs and trusts into one of 4 segments which indicates the scale and nature of support needs.

NHSE Support segments: description and nature of support needs

Segment	Scale & Nature of Support Needs
1	No specific support needs identified.
2	Flexible support delivered through peer support, clinical networks, the NHS England and NHS Improvement universal support offer (e.g. GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs.
3	Bespoke mandated support through a regional improvement hub, drawing on system and national expertise as required.
4	Mandated intensive support delivered through the Recovery Support Programme.

NHS Provider segmentation (SOF segmentation as at 1st February 2022)

Trust	SOF segmentation
Alder Hey Children's NHS Foundation Trust	2
Liverpool Heart and Chest NHS Foundation Trust	1
Liverpool University Hospitals NHS Foundation Trust	4
Liverpool Women's Hospital NHS Foundation Trust	3
Mersey Care NHS Foundation Trust	3
The Walton Centre NHS Foundation Trust	1

CCGs were not assigned a SOF rating. Cheshire and Merseyside Health and Care Partnership were assigned a SOF segmentation 3 in November 2021.

1.11 Friends and Families Test

NHS Friends and Family test (FFT) has collected data since 2013 and asks people if they would recommend the services they have used in a number of healthcare settings. The information is collected in a number of different ways; text messaging, online, paper and is available in 20 languages and an easy read version.

The percentage of people who recommend services in Liverpool providers are detailed in the table below. FFT data is not intended to compare different organisations but rather to be a continuous feedback tool for providers to identify areas of good practice and opportunities for improvement.

Percentage of people who recommend service by Provider; 12 month rolling average rate reported to June 2022:

	Inpatient	A&E	Outpatients	Community	Mental Health
England Average	94%	76%	93%	93%	86%
Liverpool University Hospital NHS Foundation Trust	92%	61%	94%		
Alder Hey Children's NHS Foundation Trust	93%	67%	92%	94%	96%
Liverpool Heart and Chest Hospital NHS Foundation Trust	99%		-		
Liverpool Women's NHS Foundation Trust	93%	86%	92%		
The Walton Centre NHS Foundation Trust	98%		94%		
Spire Liverpool	96%				
Mersey Care				96%	90%

Source: https://www.england.nhs.uk/fft/friends-and-family-test-data/

1.12 Sustainable Development

Liverpool CCG provided good leadership in this area as an early developer of a Social Value and Sustainability Strategy and Action Plan which was co-developed with NHS partners. More recently, the NHS has made commitment at a national level to address carbon emissions with production of the NHS Net Zero plan.

Building Social Value means using the NHS's position and responsibilities to increase the social, economic and environmental wellbeing of people in Liverpool. The strategy brings together obligations for a Sustainable Development Management Plan with The Public Services (Social Value) Act 2012 and to place this approach at the centre of policy, commissioning and practice. Liverpool CCG contributed to the development of the ICS Green Plan which will inform Liverpool based action plans in the NHS. Commitments to sustainable development and the NHS anchor institution role are included within the One Liverpool Strategy.

It is recognised that most of the CCG's carbon footprint is associated with commissioning health and care services, prescribing and the procurement of other services. The CCG works with providers, Liverpool City Council and other partners to improve performance and to minimise the harm and maximise the positive gain that can be made to health from the way NHS services operate. Information regarding how providers perform against The Public Services (Social Value) Act 2012 and sustainable development updates can be found within each trust's annual report and Green Plans produced this year.

Liverpool CCG has supported Liverpool First Primary Care Network (PCN) and North PCN with primary care led plans to implement green respiratory care programmes. These two PCNs led an application for funding to develop and implement respiratory care improvements through asthma reviews and to facilitate switches to inhalers with lower greenhouse gas emissions. This local approach to implementing a key NHS Net Zero target will inform roll out across Liverpool CCG.

As a commissioning organisation, Liverpool CCG needs effective contract mechanisms to deliver its ambitions for sustainable healthcare delivery and clear outcomes for services and the system. The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. From April 2022, Social Value will be required to comprise at least 10% of the score in large tenders and Liverpool CCG is working with system partners and procurement colleagues in developing robust and co-ordinated approaches to this.

The CCG's own operations, accommodation and practices contribute towards carbon emissions. As at June 2002, CCG were predominantly working from home, although there is a plan for hybrid working in 2022/23. This model has led to a reduction in office space retained, significant reductions in resource use and travel.

As part of the national requirements to plan to meet the likely climate change challenges ahead, the CCG has, through the Emergency Preparedness and Resilience agenda, ensured that plans are cognisant of these risks and make provision for mitigating actions.

1.13 Engaging People and Communities

Overview

Liverpool CCG needs to understand the views and experiences of local people to carry out its role effectively. Making sure that people and communities are involved in decision-making, planning and delivery is vital to shaping the future of health services, improving the care that patients receive, and holding the local NHS to account.

The CCC adapted to the constraints of the pandemic and used it as an opportunity to develop new ways of reaching out to our population.

Current engagements as at 30th June include;

- **Improving hospital stroke care**

During 2019, the NHS in Knowsley, Liverpool, South Sefton, Southport & Formby, and West Lancashire began a review of local hyper-acute stroke services – the care provided in the critical 72-hours after having a stroke.

A 2-week public consultation took place in 2021/2022 for people to share their views, and ensure the NHS has all the information needed to make a final decision. More than 440 people completed the online questionnaire. In addition, people took part in virtual events and discussions, or shared their views over the phone.

The feedback from the consultation is reported in a consultation report, which has informed a final business case to be considered by the ICB Board in August 2022. It is anticipated, subject to approval, that the first phase of this service change proposal will be implemented in September 2022, establishing a single service for the people of North Mersey and West Lancashire. Phase 2 of the new service, to establish a stroke assessment unit co-located with A&E at Aintree Hospital, will be implemented in 2023.

- **Liverpool University Hospitals Clinical Integration**

In 2019, Aintree University Hospital NHS Foundation Trust and the Royal Liverpool and Broadgreen Hospitals NHS Trust merged to form a single organisation – Liverpool University Hospitals NHS Foundation Trust (LUHFT). The merger business case set out how bringing single service teams would improve patient experience and outcomes as well as opening up opportunities for patients to participate in clinical trials; maximising research and development and helping attract and retain the best staff.

The current phase of LUHFT clinical integration proposals is to establish single services and single teams for the following services:

- General surgery

- Vascular services
- Urology services
- Nephrology services
- Breast services

This a complex set of proposals, encompassing five distinct service changes, each of which needed to be clearly articulated. However, they are all informed by the same clinical objectives and an overarching vision and rationale for the delivery of services across one trust and its three hospital sites.

The CCG is leading a public consultation, from to 7th June to 2nd August, to seek feedback and suggestions on the proposals. Once completed, feedback will be incorporated into a consultation report which will inform the final proposals to be considered by the Trust and the ICB in September 2022. If approved, the changes would take place in October 2002, some of which are linked to the opening of the new Royal Liverpool Hospital.

- **COVID-19 vaccination programme**

Supporting the COVID-19 vaccination programme and ensuring that people were able to access clear information about when and how they could receive the vaccine, remains a key focus for the CCG's communications and engagement efforts, and will extend into an autumn campaign in 2022. Our focus is raising awareness amongst all eligible groups of the population, particularly targeting geographical areas of the city, population cohorts and age groups with lower uptake.

Engagement Framework

The CCG's engagement infrastructure supports the ability to reach out to the individuals and groups who need to be involved in our work. It is built around the following elements:

- **People and Community Voice Committee:** This committee reflects the commitment in the One Liverpool Strategy to "move involvement from the margins to the mainstream to inform planning, commissioning and provision of health services". Four public advisors were recruited to the committee, with the aim of embedding a strong patient voice within our governance structures.

- **Patient Engagement and Experience Group:** This is a long-standing CCG group, consisting of representatives from the CCG, Healthwatch Liverpool and patient/public voices from the CCG's volunteer programme. The group reviews engagement plans and processes, providing an important source of input ahead of consideration by the People and Community Voice Committee, as well as reflecting on information from Healthwatch reports.

- **Engagement Partners Programme:** The CCG aims to continuously improve how people participate in decision-making, ensuring diversity of participation. The CCG has a well-established network of voluntary and community organisations that work with us in involving people from the city's diverse communities and individuals. There are currently around 150 partners in the programme.

- **Volunteer Programme:** The CCG volunteer programme was established to broaden opportunities for participation, to empower and support the wellbeing of individual volunteers and to inform health commissioning. Currently there are around 80 volunteers, and anyone can apply to join. Activities that volunteers carry out include asking members of the public to complete surveys; sitting on panels for the procurement of services; and providing feedback on materials such as leaflets to ensure that they are clear and meaningful to the lay person.

- **Patient Participation Groups (PPGs):** It is a contractual requirement for all GP practices to form a patient participation group (PPG) and to make reasonable efforts for this to be representative of the practice population. The CCG encourages GP practices with established patient groups to gather insight to inform decisions about their own care. PPGs have opportunities to influence at both individual practice and neighbourhood level.

- **Digital Engagement:** Online channels continue to grow in their importance for sharing information and promoting engagement opportunities. At the time of writing the @liverpoolccg Twitter account has over 10,000 followers. The CCG social media accounts will change title to *One Liverpool* from 1st July 2022.

From July 2022 the People and Community Voice Committee of the CCG will cease, but all system partners are committed to developing a new forum for city-wide health and care engagement and involvement. Liverpool Place teams will also collaborate with other Places in the ICS to enable engagement across bigger footprints where this makes sense.

1.14 Improve Quality

Quality improvement and assurance is central to the purpose of the CCG, which continues to take a holistic and methodical approach to quality assurance of commissioned services.

Ongoing COVID-19 Pandemic Response and recovery

The Coronavirus pandemic continues to require a flexible approach to quality, supporting the regional and local response, including providing clinical advice and guidance in relation to access to services, workforce enquiries and queries from patients and families around vaccinations and wider system support. The CCG's quality team has continued to work collaboratively across organisational boundaries

to support COVID-19 mass testing and vaccinations, as well as providing Infection Prevention and Control support.

The internal governance route for escalation of strategic risks to quality is via the CCG's Performance and Quality Committee. The committee meets monthly in recognition of the complexity of the provider landscape and the breadth of oversight required. The Performance & Quality Committee enables improved triangulation of quality and performance data and associated intelligence. From November 2021, the Committee regularly reviewed its workplan and frequency of meeting in response to the creation of the Integrated Care Board (ICB) shadow committees, whilst recognising the CCG's accountability until the 1st July, when CCGs are formally disestablished and new quality governance will be established, both at Liverpool Place and for Cheshire and Merseyside.

Serious Incident Management
Provider organisations have continued to report serious incidents (SIs) to commissioners via the Strategic Executive Information System (StEIS).

Incidents reported undergo comprehensive 72-hour reviews and reports are submitted to the CCG for review, with either a recommendation from the CCG quality team for closure; further information required or progression to a full investigation and root cause analysis (RCA). The CCG reviews all RCA reports via remote multidisciplinary Serious Incident Panel Meetings, where assurance is sought regarding the robustness of investigations, any learning identified and actions which must be addressed. Themes and trends are identified and triangulated with those from previous SIs.

Learning from Never Events
Learning from when things go wrong in healthcare is essential in preventing future harm, however it requires a culture of openness and honesty to ensure staff, patients, families and carers feel supported to speak up in a constructive way. It is important that there are robust and reliable processes in place to effectively manage adverse events, and that lessons are shared widely and used to support improvements in care and service delivery.

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

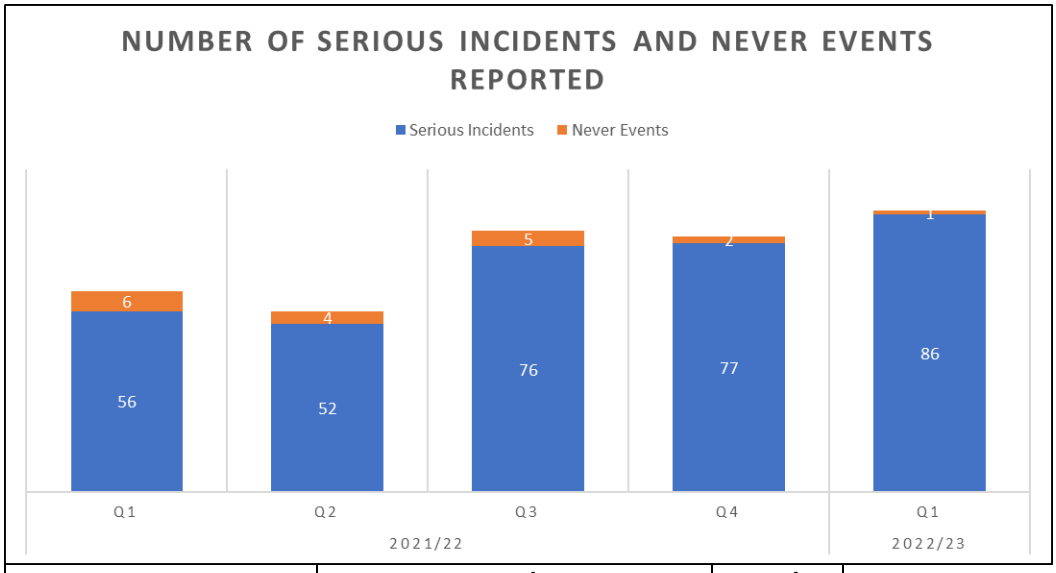
The CCG quality team works closely with providers to review Never Events and to support the development and monitoring of robust action plans which address gaps in safety systems, processes and behaviours to promote a safety culture and prevent future harm.

The CCG continues to:

- place emphasis on providers to evidence learning from serious incidents and monitoring processes to ensure improvements required, are quality focused and deliverable

- have panel oversight and focus on patient safety, the patients and or family's voice and Duty of Candour
- have a focus on staff voice and evidence of involvement in learning from serious incidents
- ensure evidence of national and regional patient safety alerts/ guidance was considered in the investigation to support learning

Number of Serious Incidents/ Never Events Reported, April to June 2022:



	2021/22				2022/23
	Q1	Q2	Q3	Q4	Q1
Serious Incidents	56	52	76	77	86
Never Events	6	4	5	2	1

Long Wait Harm Review Process

Although the NHS is implementing recovery plans from the impact of the Covid pandemic, delays to planned surgery have created lengthy waits for treatment, which may lead to adverse outcomes. Liverpool CCG quality team gain assurance from providers around their processes for harm review of long waits across all its associated commissioned services. The CCG seeks assurance from providers regarding clinical prioritisation and arrangements for undertaking clinical harm reviews.

Cancer Long Wait Harm Review Process

The coronavirus pandemic continues to impact on waiting times as the healthcare system endeavours to recover. All providers are asked to review their long wait patients to see if there has been any harm from the delays in treatment. The CCG re-established the Cancer Harm Review Panels (CHR) in March 2021, implementing the Northwest Guidelines: Managing Long Waiting Cancer Patients, NHS England/Improvement (North-West) (October 2021). The panel use agreed key lines of enquiry (KLOE) in reviewing the submissions. Following each panel, providers are given feedback, advising of levels of assurance, and making recommendations for quality improvement.

To date of the Cancer Harm Reviews submitted to panel and reviewed, they evidence a range of harms with the majority being no harm. If severe harm is identified this would trigger a serious incident review according to the National Serious Incident Framework. There is the legal duty that providers have to inform and apologise to patients if mistakes have been made in the delivery of their care or treatment, or where moderate or severe harm has been caused. This should include an offer of support and where appropriate a serious incident review being undertaken. Themes include delayed referrals from other Trusts, delays to investigations, complex pathways, and patient fitness. Areas for improvement identified include improved communication with the patient and GP, and more provision for psychological and social support.

In 2022/23, work will begin to review cancer pathways which have breached the national cancer standards and have ten or more individual long waiter breaches; this will allow a focus on a whole cancer pathway and what is needed to improve the patient journey and reduce waiting times. This work will be jointly with the Cancer Alliance.

Referral to Treatment (RTT) 52+ weeks waits Harm Review Process

The disruption to elective treatment due to the pandemic is still being reflected in increased waiting times for patients and specifically the number of patients waiting over 52 weeks. Providers continue to report considerable pressure on waiting lists, despite prioritising patients in greatest need.

During 2021/22, CCG's across Cheshire and Merseyside have come together with NHS England to agree a collective approach to seek assurance regarding clinical harm reviews. A set of "Quality Principles" has been developed and implemented with the aim of reducing health inequalities and promoting learning across Cheshire and Merseyside. This shared approach will improve the overall patient experience, by adopting the principles of duty of candour and improving the process of conducting Clinical Harm Reviews. Liverpool CCG is continuing to seek assurance regarding long wait harm review process and clinical harm reviews quality via CQRM/CQPG and the quality schedule.

CCG's across Cheshire and Merseyside have come together with NHS England to agree a collective approach to seek assurance regarding clinical harm reviews. A set of "Quality Principles" has been developed with the aim of reducing health inequalities and promoting learning across Cheshire and Merseyside. This shared approach will improve the overall patient experience, by adopting the principles of duty of candour and improving the process of conducting Clinical Harm Reviews.

Support for Vulnerable patients

Care Homes

Many care homes are challenged in being able to provide the care they would wish to, in part due to staff shortages, although they seek to minimise the risks to their residents and do all they can to provide safe and quality care. The CCG has worked with Liverpool City Council (LCC) to provide quality oversight, ongoing support around

infection prevention control, Personal Protective Equipment (PPE), vaccinations and safeguarding.

A new initiative, developed nationally, is being rolled out across all care homes in Liverpool. Restore2 is a physical deterioration and escalation tool for care/nursing homes based on nationally recognised methodologies including early recognition (Soft Signs) and the national early warning score (NEWS2). It is designed to support homes and health professionals to recognise when a resident may be deteriorating and to take action to proactively protect and manage a person's health and to provide a concise history when escalating to health care professions such as GPs and the community nursing team.

Safeguarding

Liverpool CCG is committed to safeguarding children and adults and works with all organisations in Liverpool to deliver this. This is reflected in the strong governance and accountability frameworks within the CCG which clearly demonstrate that safeguarding children and adults is a core priority.

A key focus area for the CCG is to actively improve outcomes for children and adults at risk and that this supports and informs decision making with regard to the commissioning and redesign of health services within the city.

The CCG has governance and accountability arrangements in place including. Liverpool CCG is a statutory partner of the Liverpool Safeguarding Children Partnership, the Liverpool Safeguarding Adults Board and a key member of the City Safe Partnership Board and Corporate Parenting Board.

Following the Mental Capacity (Amendment) Act 2019, the Liberty Protection Safeguards (LPS) were due to replace the Deprivation of Liberty Safeguards (DoLS) with a new system allowing people to access protections quickly, whilst working with existing care plans. The CCG is undertaking preparatory work in readiness for the new responsibilities.

With the introduction of the new requirements under the Domestic Abuse Act (2021) a Domestic Abuse Partnership Board (DAPB) has been developed to provide governance and direction to domestic abuse and violence. Liverpool CCG is a member of the Domestic Abuse Partnership Board. The Partnership Board will be guided by the proposed National 'Tackling Violence Against Women and Girls Strategy' and complementary 'Domestic Abuse Strategy' that will go beyond the implementation of the Domestic Abuse Act.

Liverpool has a high rate of Children in Care (CiC) compared to the Core City average; this figure has continued to rise over the last few years resulting in increased demand for specialised health provision. It is the role of the CCG and commissioned services to address the unmet health needs of children in care by working in collaboration to empower young people and enable them to reach their full potential. The CCG Safeguarding Team and Children's Commissioners have supported provider services to identify gaps in provision, but more importantly to assist in developing solution-focused responses to reduce risk to children and young people.

Referrals for safeguarding and domestic abuse have steadily increased during 2021/22, resulting in an increased number of statutory reviews; Child Safeguarding Practice Reviews (formally known as Serious Care Reviews), Safeguarding Adults Reviews and Domestic Homicide Reviews. The purpose of these reviews is to determine if anything could have been done differently to prevent harm or death and to identify what multi agency learning is required to change practice. The safeguarding team are members of the statutory review panels and provide the health oversight to the process.

Children's Mental Health

There has been a sharp increase in the number of children experiencing mental health problems. Despite this there has been good progress to reduce the gap between the number of children with an emerging mental health need and the support available. LCCG is working with providers across the system to ensure that quality and access to care is maintained and further improved.

Special Educational Needs and Disability (SEND)

The Children and Families Act 2014 placed duties on local authorities and partner organisations to ensure that children and young people with SEND are supported to achieve the "best possible educational and other outcomes" (Section 19 (d) of the Act).

There continue to be challenges around SEND delivery, exacerbated during the Covid pandemic. The CCG and Liverpool City Council work closely with providers to make continuous improvements. Areas of focus for 2022/23 include:

- Timeliness and quality of Education and Health Care Plans (EHCPs), which are improving month and becoming more specific and quantifiable, enabling children, young people and their families to access appropriate provision;
- Responding to the significant increase in referrals for both Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) diagnostic pathways. The CCG has agreed additional investment to respond to increased need.

A review of current Personalisation arrangements in Liverpool health and care services for children and young people with SEND was completed between January and May 2021 in order to meet one of the objectives within the local Written Statement of Action (WSoA). The review set out ten recommendations for change based upon the findings and focus groups held with Liverpool Parent and Carer Forum (LivPac) who represent individuals, families and carers within the local SEND Partnership. Further work will be progressed in 2022/23 with LivPac to deliver improvements.

Following a SEND reinspection by Ofsted and the Care Quality Commission (CQC) in May 2022, it was concluded that Liverpool had made sufficient progress in addressing weaknesses detailed in the inspection from 2019 which led to a written statement of action. Inspectors cited the benefits of new, stronger SEND leadership and maturing joint commissioning arrangements. This was evidenced particularly in

improvements to EHC processes and the timeliness of response, which are crucially important to the development and wellbeing of children and their families.

It is clear from the Ofsted revisit that good progress is being made, however there is more to do, and partners will continue to work together to drive further improvement.

Learning Disability and Acquired Brain Injury
Liverpool CCG continues to work to reduce inpatient rates for those with a learning disability.

Following the closure of Cawston Park Hospital in Norfolk in May 2021 a Safeguarding Adults Board review found major failures of governance, commissioning, oversight, planning for individuals and professional practice. As a result there was a national Safe and Wellbeing Review Process established for all children and young people and adults with a learning disability and autism or both that are placed in an inpatient setting. Liverpool CCG successfully completed the reviews and learning will inform future work programmes.

Liverpool CCG has worked closely with NHS England to ensure patient rehabilitation pathways are appropriate and delivered in a timely manner. Through good communication and engagement, local professionals from all agencies have worked together to manage discharges in the best interests of people with learning disabilities and acquired brain injury.

Focus on Personalisation

Personal Health Budgets (PHBs)
Progress has been made this year in developing the personal health budget offer for both children and adults. Liverpool CCG has worked with local delivery partners to implement appropriate systems and governance arrangements to deliver personal health budgets for adults and children with Continuing Care needs and people eligible for Section 117 Aftercare under the Mental Health Act. This is an interim arrangement, as work is underway with partners across the Cheshire and Merseyside Integrated Care System (ICS) to develop a service specification to deliver a comprehensive Continuing Health Care service (CHC). Delivery of PHBs will be an integral part of any future CHC service.

Support for Medicines Optimisation
The Medicines Optimisation Committee (MOC), working with the CCG Medicines Management Team to put in place a number of treatment pathways to enable more people to access care in community pharmacies using prescription only medicines. These pathways are an extension of the existing minor ailment service, and titled *Pharmacy First.*

The MOC has developed a dashboard of safety indicators which highlight areas where practices need to review their systems and processes, particularly with regard to high risk drugs. Engagement from general practices has been good and prescribing of very high risk combinations of drugs has reduced by 39% in 6 months.

Discharge to Assess (D2A) and Continuing Healthcare (CHC)
Guidance to health and care providers informs ways to enable safe and effective discharge of patients from hospital. Throughout 2021/22 this D2A pathway has been essential in supporting capacity and flow through the system, during continual high demand for acute services. Work has progressed to streamline the pathway, reduce delays in the system and ensure patients are discharged safely.

The CCG advises and facilitates appropriate discharge of patients, assessment within the community, advice on appropriate pathways and delivery of the NHS Continuing Healthcare Framework.

Looking to the future- quality within the Integrated Care System (ICS)
People who use NHS services deserve and should expect health care that Is safe; effective; patient-centred; timely; efficient and equitable.

Directors of Quality (Chief Nurses) across Cheshire and Mersey have been working together to prepare for the transition to Integrated Care System (ICS). They have been developing robust quality governance arrangements that will ensure:

- quality intelligence is shared regularly with all key stakeholders;
- systems consistently monitor quality measures and outcomes
- use professional insight to identify risks to the quality of care (including unwarranted variation);
- risks and issues are appropriately managed and escalated, particularly where they cannot be resolved locally or where the quality risk has wider implications;
- effective place-based and system solutions are delivered; and quality improvement is ongoing to ensure high-quality care services for patients.

1.15 Reducing Health Inequality

Under Section 14T of the National Health Service Act 2006 (as amended), the CCG has a legal duty to have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved. The CCG is required to exercise its functions with a view to securing that health services are integrated with health-related and social care services, where it is considered that this would improve quality, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved.

Tackling inequalities is at the heart of Liverpool CCG's core purpose and is also a core component of the *One Liverpool* Strategy, which is focused on tackling the long-term health inequalities that leave the vulnerable and disadvantaged in our city with a poorer experience of care, fewer years of healthy life and earlier death.

Targeted Lung Health Checks

A ground-breaking health check programme which has saved lives across the city restarted in 2021 after pausing during the Covid-19 pandemic. The Liverpool Targeted Health Check programme is focused on communities with high lung disease prevalence, which aligns with wards of higher deprivation.

There were 2,616 new diagnoses of lung cancer in the city in 2014-18, or 523 new cases per year. Lung cancer incidence in Liverpool was 82% higher than expected when compared to overall figures for England. Sadly, in most cases, the disease is incurable. However, when diagnosed at its earliest stage, around 57% of people with lung cancer will survive their disease for five years or more, compared with only 3% when the disease is diagnosed at the latest stage.

Targeted lung health checks have the power to change this by detecting it at the earliest opportunity, potentially cutting lung cancer deaths by almost a third. The lung health check scheme has also diagnosed people with many other conditions, including chronic obstructive pulmonary disease (COPD) and asthma, and even other forms of cancer.

The programme was relaunched in 2021/21 and will be rolled out across the city from 2022/23.

Covid-19 Vaccine Equalities Plan

Liverpool, along with other major cities with diverse populations, faces greater challenges in achieving high levels of vaccine uptake. There is a clear relationship between deprivation and lower levels of vaccine uptake, which prompted the CCG, working with Liverpool's Primary Care Networks and other partners including Liverpool University Hospitals, Mersey Care, Community pharmacies and Alder Hey, to develop an ambitious vaccine equalities plan to ensure equitable access to the vaccine across every area of the city and to target communities and groups where evidence indicated that uptake was low. This partnership approach continues into 2022/23, with an 'evergreen offer' for people who have not yet had vaccines and preparations for an autumn 2022 booster campaign.

1.16 Health and Wellbeing Strategy

The delivery of the city's Health and Wellbeing Strategy requires involvement from all members of the Liverpool Health and Wellbeing Board and its partner organisations.

Liverpool CCG is formally represented on the Health and Wellbeing Board and has been an integral partner since it was established in 2013. A summary of the business of the Health and Wellbeing Board can be found in section 1.3.4.

Partners have made a pledge to supercharge efforts to respond to poor health and inequalities, building resilience, supporting the most vulnerable and those who have struggled the most throughout the pandemic.

1.17 Better Care Fund (BCF)

The Better Care Fund (BCF) was launched in the 2013 Government spending round, with the intention to support integration of health and social care through a single pooled budget.

The total value of the BCF in Liverpool for 2022/23 is £159.7M with a CCG contribution of £64.5M and Liverpool City Council's contribution of £95.2M.

The national conditions for the BCF in 2022/23 are:

- a jointly agreed plan between local health and social care commissioners, approved by the Liverpool Health and Wellbeing Board.
- The CCG contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution.
- invest in NHS-commissioned out-of-hospital services.
- Implementing the BCF policy objectives:
    - Enable people to stay well, safe and independent at home for longer
    - Provide the right care in the right place at the right time
    - Focus on Support for Unpaid Carers

The BCF Policy Framework requires places to agree improvement metrics for the BCF. Health and care partners in the city agreed the following improvement metrics for this year:

- Avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Percentage of people discharged home (discharge to their usual place of residence)
- Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population
- Effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation)

Liverpool BCF priorities for 2022/23 are:
1. Prevention and Early Intervention
2. Enabling People to Live Independently in their Own Home for Longer
3. Support for Unpaid Carers
4. Proactive and Integrated Community (out of hospital) Offer
5. Personalised Health and Care
6. Supporting People to Live Well in the Community
7. Complex Lives
8. Enablers for Integration
9. Winter Pressures & Opening of New Royal Liverpool Hospital

1.18 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 respond to the impact of 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 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 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 last year 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 by NHS England, the CCG's Equality and Inclusion Service will now work closely with commissioners and providers on a system approach to implementation.

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 HR and Remuneration 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.

Key areas of focus include:

- ✓ 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.

Key highlights against our equality objectives include:

- In collaboration with Cheshire and Merseyside NHS trusts, best practice guidance has been developed in relation to reasonable adjustments for patients. All trusts have either implemented this within their own organisation, undertaken a gap analysis against their existing standard operating procedures or are progressing this through their internal governance process for implementation.

- Planned rollout of a transgender pathway across Cheshire and Merseyside.

- Working closely with our commissioned Black, Asian and Minority Ethnic community development worker service to address any barriers for people accessing healthcare 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 during the last 12 to 18 months the CCG has introduced further mandatory training modules such as unconscious bias and training specific to Healthcare for the Armed Forces. The CCG also has a workforce equality plan which includes actions following our review of workforce race (in accordance with the Workforce Race Equality Standard). The plan also incorporates actions to implement the 6 inclusive recruitment actions as nationally requested by NHS England.

The CCG hosts a number of staff networks, for CCG, general practice staff and staff from North Mersey CCGs.

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

A representative from the CCG BAME group attends the HR and Remuneration Committee. The CCG is represented on the North West Black, Asian and Minority Ethnic Advisory Group. The ambition is for the NHS in the North West to at the forefront of challenging and tackling racism and the health inequalities face and experienced by people in our communities.

2. Accountability Report

2.1 Members Report

2.1.1 Member Practices

The following table includes details of the 85 Practices that comprise the membership of Liverpool CCG as at the 31st March 2022:

Liverpool North Locality

Practice Name	Practice Address
Abingdon Family Health Centre	361/365 Queens Drive, Walton, L4 8SJ
Aintree Park Group Practice	46 Moss Lane, Orrell Park, L9 8AL
Albion Surgery	45 Everton Road, Liverpool, L6 2EH
Anfield Group Practice	Townsend Lane Neighbourhood Health Centre 98 Townsend Lane L6 0BB
Bousfield Health Centre (N82077)	Westminster Road, Liverpool, L4 4PP
Bousfield Health Centre (N82078)	Westminster Road, Liverpool, L4 4PP
Ellergreen Medical Centre	24 Carr Lane, Norris Green, Liverpool, L11 2YA
Fir Tree Medical Centre	Fir Tree Drive South, L12 0JE
Gillmoss Medical Centre	48 Petherick Road, Gilmoss, L11 0AG
Great Homer Street Medical Centre	Mere Lane Neighbourhood Health Centre 49-51 Mere Lane, Liverpool, L5 0QW
Islington House Surgery	45 Everton Road, Liverpool, L6 2E
Jubilee Medical Centre	52 Croxteth Hall Lane, Croxteth, L11 4UG
Kirkdale Medical Centre	14 Waller Close, Kirkdale, L4 4QJ
Langbank Medical Centre	Broad Lane, Norris Green, L11 1AD
Long Lane Medical Centre	Long Lane, Aintree, L9 6DQ
Mere Lane Practice	Mere Lane Neighbourhood Health Centre 49-51 Mere Lane L5 0QW
Moss Way Surgery	51-53 Moss Way, Croxteth, L11 0BL
Poulter Road Medical Centre	34 Poulter Road, Fazakerley, L9 0HJ
Priory Medical Centre	Belmont Grove, Liverpool, L6 4EW
Stanley Medical Centre	60 Stanley Road, Liverpool, L5 2QA
Stopgate Lane Medical Centre	Stopgate Lane, L9 6AP
The Grey Road Surgery	Breeze Hill Neighbourhood Health Centre, 1-3 Rice Lane, Walton, L9 1AD
Townsend Medical Centre	Townsend Lane Neighbourhood Health Centre 98 Townsend Lane L6 0BB
Walton Medical Centre	Breeze Hill Neighbourhood Health Centre, 1-3 Rice Lane, Walton, L9 1AD
Walton Village Medical Centre	172 Walton Village, L4 6TW
Westminster Medical Centre	Aldams Grove, L4 3TT
Westmoreland GP Centre	Fazakerley Hospital, Longmoor Lane, Fazakerley, L9 7AL

Liverpool Central Locality

Practice Name	Practice Address
Abercromby Health Centre	Grove Street, Liverpool, L7 7HG

Benim MC	2 Penvalley Crescent, L6 3BY
Bigham Road MC	Bigham Road, L6 6DW
Brownlow Group Practice	70 Pembroke Place, Liverpool, L69 3GF
Brownlow Health @ Kensington	Kensington Neighbourhood Health Centre, 157 Edge Lane, L7 2PF
Brownlow Health @ Marybone Health Centre	Unit 1, 2 Vauxhall Road, Islington, L3 2BG
Brownlow Health @ Princes Park	Bentley Road, Toxteth, L8 0SY
Calvary Health Centre	Pilch Bank Rd, Liverpool L14 7PH
Derby Lane MC	88 Derby Lane, Liverpool, L13 3DN
Dovecot HC	Longreach Rd, L14 0NL
Dunstan Village Group Practice	131 Earle Road, Liverpool, L7 6HD
Earle Road Medical Centre	131 Earle Road, Liverpool, L7 6HD
Edge Hill MC	Kensington Neighbourhood Health Centre, 157 Edge Lane, L7 2AB
Fairfield General Practice	2 Penvalley Crescent, L6 3BY
Green Lane MC	15 Green Lane, L13 7DY
Hornspit MC	Hornspit Lane, Liverpool, L12 5LT
Old Swan HC	Crystal Close, L13 2GA
Park View	Orphan Drive, Liverpool, L6 7UN
Picton Green	The Picton Medical and Children's Centre, 137 Earle Rd, L7 6HD
Rock Court Surgery	Crystal Close, L13 2GA
Sefton Park MC	Smithdown Road, Liverpool, L15 2LQ
St James MC	29 Great George Square, Liverpool, L1 5DZ
Stoneycroft MC	Stoneville Rd, L13 6QD
Vauxhall Health Centre	Limekiln Lane, Liverpool, L5 8XR
West Derby Medical Centre	3 Winterburn Crescent, West Derby, L12 8TQ
Yew Tree Centre	Berryford Rd, L14 4ED

Liverpool South Locality (Matchworks)

Practice Name	Practice Address
Belle Vale Health Centre	Hedgefield Road, Belle Vale, L25 2XE
Dingle Park Practice	Park Street, Toxteth, L8 6QP
Drs Hegde and Jude's Practice	Park Street, Toxteth, L8 6QP
Edge Hill Health @ Mossley Hill Surgery	73 Queens Drive, Mossley Hill, L18 2DU
Fulwood Green MC	Jericho Lane, Aigburth, L17 5AR
Garston Family Health Centre	SLTC, 32 Church Road, Garston, Liverpool, Merseyside, L19 2LW
Gateacre Brow Surgery	1 Gateacre Brow, Gateacre, L25 3PA
Gateacre Medical Centre	49 Belle Vale Road, Gateacre, L25 2PA
GP Practice - Riverside	Park Street, Toxteth, L8 6QP
Grassendale Medical Practice	23 Darby Road, Grassendale, L19 9BP
Greenbank Drive Surgery	8 Greenbank Drive, Liverpool, L17 1AW

Greenbank Road Surgery	1B Greenbank Road, Liverpool, L18 1HG
Hillfoot Health	70 Hillfoot Road, Liverpool, L25 0ND
Lance Lane	19 Lance Lane, Wavertree, L15 6TS
Margaret Thompson M C	105 East Millwood Road, Speke, L24 6TH
Mather Avenue Surgery	584 Mather Avenue, Allerton, L19 4UG
Netherley Health Centre	Middlemass Hey, Netherley, L27 7AF
Oak Vale Medical Centre	The Fiveways Centre, 215 Childwall Road, L15 6UT
Penny Lane Surgery	7 Smithdown Place, Wavertree, L15 9EH
Rocky Lane Medical Centre	80 Rocky Lane, Childwall, L16 1JD
Rutherford Medical Centre	1 Rutherford Road, Mossley Hill, L18 0HJ
Sandringham Medical Centre	1A Aigburth Road, Aigburth, L17 4JP
Speke Neighbourhood Health Centre (Dr Singh & Dr Bicha)	Speke Neighbourhood Health Centre, 75 South Parade, Speke, Liverpool, L24 2SF
Speke Neighbourhood Health Centre (Dr Thakur)	Speke Neighbourhood Health Centre, 75 South Parade, Speke, Liverpool, L24 2SF
Storrsdale Medical Centre	1 Storrsdale Road, Allerton, L18 7JY
The Ash Surgery	1 Ashfield Road, Aigburth, L17 0BY
The Elms Medical Centre	3 The Elms, Liverpool, L8 3SS
The Valley Medical Centre	75 Hartsbourne Avenue, Childwall, L25 1RY
The Village Medical Centre	20 Quarry Street, Woolton, L25 6HE
Village Surgery (Long Lane)	South Liverpool NHS Treatment Centre, Church Road, Garston, L19 2LW
West Speke Health Centre	Blacklock Hall Road, Speke, L24 3TY
Woolton House Medical Centre	4/6 Woolton Street, Woolton, L25 5JA

2.1.2 Chair and Accountable Officer

For the period from 1st April – 30th June, office of Chair of the CCG was held by Dr Janet Bliss. The role of Chief Officer (Accountable Officer) has been held by Jan Ledward, who also held the post of interim Chief Officer for Knowsley CCG.

2.1.3 Composition of the Governing Body

The membership of the Governing Body up to the signing of the Annual Report and Accounts has been as follows:

Governing Body Members:

Jan Ledward	Chief Officer (Accountable Officer)
Mark Bakewell	Chief Finance & Contracting Officer
Jane Lunt	Director of Quality, Outcomes and Improvement
Helen Dearden	Lay Member Governance / Non-Clinical Vice Chair
Gerry Gray	Lay Member Financial Management and Oversight
Sally Houghton	Lay Member / Audit Chair

Carol Rodgers	Lay Member, Patient and Public Involvement
Cathy Maddaford	Non-Executive Nurse
Dr Janet Bliss	GP/Clinical Vice Chair
Dr Monica Khuraijam	GP
Dr Paula Finnerty	GP
Dr Fiona Ogden-Forde	GP
Dr Shamim Rose	GP
Dr David O'Hagan	GP
Dr Stephanie Gallard	GP

Co-opted Members (non-voting):

Dr Rob Barnett	Secretary, Liverpool Local Medical Committee
Cllr Fraser Lake	Cabinet Member for Social Care and Health, Liverpool City Council
Matthew Ashton	Director of Public Health, Liverpool City Council

The table on page 64 provides details of the membership of CCG Committees.

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

The Governing Body (Voting/full members) in post at 30th June 2022 comprises 3 male and 12 female representatives.

The CCG directly employs a total of 160 staff, comprising 31 male and 129 female. This number excludes staff seconded from external organisations, agency staff and contractors. For this period the CCG employed a total of 4 Very Senior Management (VSM) posts (includes 1 Governing Body member); 3 of which were male and 1 female.

2.1.4 Committee(s), including Audit Committee

The CCG has in place the following committees:

- Audit and Risk Committee
- Primary Care Commissioning Committee
- HR & Remuneration Committee
- Performance & Quality Committee
- People and Community Voice Committee
- Clinical Effectiveness Committee

Further details of their role and membership can be found on pages 64 to 70.

The membership of the Audit and Risk Committee is as follows:

- Sally Houghton – Lay Member/Audit Committee Chair
- Helen Dearden – Lay Member / Audit Committee Vice Chair
- Cathy Maddaford – Non-Executive Nurse
- Carol Rogers – Lay Member/Patient and Public Involvement
- David O'Hagan – GP Director

In attendance:

- Mark Bakewell – Chief Finance and Contracting Officer
- Internal Audit Representative – Mersey Internal Audit Agency
- Counter Fraud Representative - Mersey Internal Audit Agency
- External Audit Representative – Grant Thornton UK LLP

2.1.5 Register of Interests

Conflicts of interest are inevitable in commissioning, and it is therefore essential that the CCG has robust arrangements in place to manage actual or potential conflicts appropriately. The CCG complies with the revised 2017 statutory guidance published by NHS England (NHSE) that includes a number of strengthened safeguards to mitigate the risk of real and perceived conflicts of interest arising in CCGs. All formal Governing Body and Committee meeting agendas commence with a 'Declaration of Interest' and the Chair of the meeting will address any declarations made in accordance with the formal Conflicts of Interest Policy, recording any such matters and actions in the formal minutes of the meeting.

Each CCG has a statutory requirement to ensure uptake of mandatory conflicts of interest training for specific groups, including Governing Body Members, senior managers, and officers/ clinicians involved in commissioning and procurement. Liverpool CCG mandates all staff to complete at least one module of the NHS England online training. Compliance with the NHSE requirements and uptake amongst staff is regularly monitored and audited in-year.

All CCGs are required to make publicly available their Registers of Interest, Register of Gifts and Hospitality and Register of Procurement Decisions. The most up-to-date versions of each register can be found on the Liverpool CCG website:

https://www.liverpoolccg.nhs.uk/about-us/publications/registers-and-policies/registers-of-interest/

All the above registers are also available in paper format and are accessible to the public at the CCG's Headquarters in Liverpool City Centre.

2.1.6 Personal Data Related Incidents

During this period there were no Serious Incidents (SI) relating to data security breaches in the CCG and no incidents in the CCG that were required to be reported to the Information Commissioner.

2.1.8 Modern Slavery Act

Liverpool CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in The Modern Slavery Act 2015.

2.2 Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Executive to be the Accountable Officer of Liverpool Clinical Commissioning Group.

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:

a) The propriety and regularity of the public finances for which the Accountable Officer is answerable;
b) 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);
c) For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities);
d) The relevant responsibilities of accounting officers under Managing Public Money;
e) 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));
f) Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts 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 income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

a) Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
b) Make judgements and estimates on a reasonable basis;
c) State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts;
d) Prepare the accounts on a going concern basis; and
e) Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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
Chief Executive, NHS Cheshire and Merseyside ICB
29 June 2023

2.3 Governance Statement

2.3.1 Introduction and Context

The Liverpool Clinical Commissioning Group is a body corporate established by NHS England on 1st April 2013 under The National Health Service Act 2006 (as amended) and is licensed by NHS England.

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

As at 30th June 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.

2.3.2 Scope of Responsibility

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

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

2.3.3 Governance Arrangements and Effectiveness

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

The CCG Constitution is constructed around the exemplar model constitution provided by NHS England, with the Governing Body advised as to the need for any specific amendments by our legal advisers Hill Dickinson LLP. The agreed amendments made from the exemplar model primarily reflected the landscape of the membership practices in the city and the committee structure adopted by the CCG.

The Constitution includes the CCG's 'Scheme of Reservation and Delegation' which sets out those matters that are reserved for the membership as a whole and those that are the responsibilities of the Governing Body. The Constitution also sets out the Groups arrangements for 'whistle blowing' (Freedom to Speak Up), conflicts of interest management and standards of business conduct.

The Governing Body – The CCG Governing Body has continued to provide strategic leadership and accountability for the organisation's business and activities during the final three months of its operation.

The CCG's robust governance arrangements have provided the assurance and accountability for decision-making and response activities during this period.. The CCG Governing Body has continued to hold its Board meetings via video conferencing (as did its statutory committees), the CCG has remained accountable for its statutory commitments and has maintained the same level of transparency and probity expected of a public body.

Members of the Governing Body have continued to make significant and valuable contributions to the work of Liverpool CCG. GP members have, inevitably had to commit a sizeable amount of time and dedication to clinical practice in response to the demands placed on primary care during this period.

The CCG's Incident Management Team and Senior Leadership Team have continued to meet to ensure business objectives and statutory responsibilities are met. The CCG has also consistently delivered on objectives set by NHS England & NHS Improvement's North West Regional Team, whilst working at a system level to prepare for the closedown and transfer of the 9 CCGs into a single Cheshire & Merseyside Integrated Care Board (ICB).

The CCG has also continued to review, adjust and improve its Business Continuity Plans based on the learning gained from the first wave of the pandemic, whilst clear executive leadership has ensured our business-critical responsibilities are prioritised for delivery.

Summary of GB & Committee Attendance from GB Members 01/04/2022 to 30/06/2022

The Governing Body holds its formal public meetings on a bi-monthly basis and receives standing agenda reporting on financial performance, provider and CCG performance against delivery of NHS Constitutional standards – in addition to quality and safety and operational/strategic risk management. Business transacted in this period has focused on the 'due diligence' process for the closedown and transfer of 9 CCGs into one ICB. Attendance of Governing Body members at Governing Body meetings and committee meetings for this period is summarised below:

2022-23	Audit, & Risk (2)	Clinical Effectiveness (0)	Governing Body (1)	People and Community Voice (2)	Performance and Quality (3)	Primary Care Commissioning (2)	RemHR (1)
Mark Bakewell	2		1		2	2	0
Dr Janet Bliss (CCG Chair from 1st March 2022)			1	0			
Helen Dearden	2		1			2	1
Dr Paula Finnerty			1		2	2	
Dr Steph Gallard (Joined August 2021)			1			2	
Gerry Gray (31/07/2019)			1		3	2	1
Carole Hill	2		0	2			
Dave Horsfield	1		0		2	2	
Sally Houghton	2		1				1
Dr Monica Khuraijam			1				1
Jan Ledward	1		1			1	
Jane Lunt			1	2	3	0	
Catherine Maddaford (STARTED 01/04/2019)	2		1	2	3	2	
Dr Fiona Ogden-Forde			1		2		
Dr David O'Hagan (STARTED 01/11/19)	2		1		3	2	
Carol Rogers (STARTED 01/10/19)	1		1	2		2	
Dr Shamim Rose			1				1
Jo Twist			0				1
+ - committee chair							
* - only required to attend when relevant agenda item							
** - attended to observe for role development							
Lay members							
LCCG staff							

The Committees of the Governing Body are as follows:

Audit & Risk Committee – the Committee's purpose is to review the establishment and maintenance of an effective system of integrated governance across the whole of the CCG's activities. The Committee's annual work plan is based on best practice guidelines under the NHS Audit Committee Handbook, published by the Healthcare Financial Management Association (HFMA). The work plan ensures that the Committee covers all areas of work to fulfil its responsibilities under the agreed Terms of Reference and properly discharge those duties delegated to it by the Governing Body.

The annual workplan for 2021/22 was extended to the three months to 20th June 2022. At each meeting the Committee receives a 'risk management oversight report' which brings together the risks from the Governing Body Assurance Framework (GBAF), Corporate Risk Register (CRR), committee risk registers and Fraud Risk Register. Internal audit services are provided by Mersey Internal Audit Agency (MiAA) which meets the mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee on the CCG's internal systems of control. The Committee maintains oversight of the findings and management responses to Internal Audits and seeks assurance of timely delivery of actions. NHSE/I mandates some internal audit work; each annual plan must include a review of the Data Security & Protection Toolkit (DSPT), conflicts of interest and a review of the commissioning and contracting of local GP services (Primary Care).

Other aspects of the Committee's work plan included:

- **Counter-Fraud** – the Committee reviewed the adequacy of the CCG's counter fraud arrangements and the delivery and outcomes of the annual Counter Fraud Work Plan. The MiAA Anti-Fraud Specialist (AFS) provided services in line with the counter fraud work plan.
- **External audit** – Grant Thornton LLP was appointed as the CCG's external auditor in 2017. The primary role of the external auditor is to provide assurances that the Group's accounts are prepared in line with statutory (and other) requirements.
- **Transition to the Integrated Care Board (ICB)** –The Audit & Risk Committee received reports from CCG officers and MiAA relating to the ICB transition (and associated 'due diligence' programme of work). The Committee has been an integral component of the internal assurance process for this complex programme to 1st July 2022.
- **Other sources of assurance** - the Committee continued to review and challenge the assurance process, requesting and receiving reports from the CCG's management and various other internal and external sources; ranging from subjects such as the CCG's approach to cyber and data security to the use of the CCG seal. The Committee received regular updates relating to the CCG's Register of Interests and Register of Gifts & Hospitality, enabling the Committee to maintain oversight of issues that may lead to a conflict of interest (actual or perceived).

HR & Remuneration Committee – The CCG's Governing Body established the Remuneration & HR Committee (The Committee) to carry out the duties as set out in section 5.9.4 of the constitution.

The Committee, which is accountable to the CCG Governing Body, is responsible for recommending to the Governing Body the remuneration, fees and other allowances for employees and for other persons providing services on behalf of the CCG.

The Committee's annual work plan was extended to 30th June 2022.

The committee received updates / assurances in relation to ICB transition plans in relation to workforce.

Other areas of the Committee's focus and work plan included:

- **Review of internal workforce recovery plans** - the Committee were reassured that staff safety had been paramount and at the centre of all decision making in relation to staff working arrangements. The Committee has sought and received assurances that any staff requiring additional support in relation to physical and/or mental wellbeing have received it via a comprehensive risk assessment process;

- **MiAA reports on controls, Payroll / HR and sickness absence** - the Committee were assured that the CCG had received excellent feedback on both self-assessment reports in relation to good practice;
- **Workforce KPI data** - the Committee maintained oversight and scrutiny of key workforce data throughout the financial year, challenging any areas of concern relating to performance and following up lines of enquiry where data presented a risk;
- **Equality & Diversity** - NHS Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) data was presented to the Committee. The data provided assurance against all Equality & Diversity statutory requirements;
- **HR Risk Register** - The Committee undertook a 'deep dive' of HR and HR related fraud risks as part of its risk management responsibilities, and were satisfied with the level of assurance provided in relation to the management of the 'live' risk register by the Governance and HR leads;

Primary Care Commissioning Committee - the Primary Care Commissioning Committee was re-constituted in April 2020 following NHS England's approval of the CCG's revised Constitution. The CCG has maintained delegated responsibility from NHS England for the commissioning of primary medical services since 2015 and is therefore bound by statute to maintain this committee.

The Committee, which is accountable for making recommendations to the CCG Governing Body, has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary (medical) care services in NHS Liverpool CCG, under delegated authority from NHS England.

When private or contractual items are discussed, or conflicts of interest are declared attendees are not included in those meetings and separate agendas and minutes taken and circulated. Members of the public are also excluded from such 'private' meetings.

The following key areas are standing performance and quality agenda items within the agreed work plan;

- Performance, Quality & Contract reporting;
- Monitoring of all aspects of primary care performance;
- Local Quality incentive Schemes (LQIS), Direct Enhanced Services (Bi-annually);
- Finance Report;
- CQC Summary Report;
- Performance & Quality Committee referrals

Strategy and commissioning elements of the annual work plan delivery included:

- Annual budget setting and management;

- Alternative Primary Medical Services (APMS) options appraisals;
- Annual approval of LQUIS;
- Quarterly feedback on schemes approved at PCCC and cost savings (included in Performance, Quality and Contract Report);
- GMS, PMS and APMS contractual action (i.e., issuing branch/remedial notices/removing a contract (regular updates in performance report);
- Needs assessment and review of requests to establish new practices in an area;
- Approval of practice mergers (when required);
- Sign-off of discretionary payments;
- Review, sign off and support for infrastructure, premises and estates plans;
- PCN delivery, development, ARRS and specifications.

Performance & Quality Committee - the Committee has been established in accordance with the CCG's constitution and considers CCG performance in respect of finance, quality contracting and assurance framework performance.

The Committee has a very wide remit, combining the areas of Quality, Safety, Finance, Procurement & Contracting to enable better understanding of the risks associated with the quality and performance of commissioned services.

Delivery of the Committee's Work Plan included the following:

- **Performance**
    - Financial Performance Updates including (Cash Releasing Efficiency Savings);
    - Performance update against local/ national standards (CPR);
    - Contract Performance updates;
    - Operational Plan delivery update;
    - Procurement Plan updates;
    - CHC progress updates (review of work between Mersey Care Foundation Trust and Midlands & Lancs Commissioning Support Unit);
    - HCAI bi-annual review of HCAIs/AMR/Sepsis work

- **Strategy & Commissioning**
    - Review Financial Strategy, Planning and Procurement / Contracting Requirements (in line with NHS planning requirements)
    - Review Procurement Decisions
    - Deep Dives/Quality Profiles from acute trusts
    - Review Joint Commissioning / Pooled Budget Arrangements

- **Governance**
    - Continued review of the Committee Risk Register;
    - Information Governance Exception Reports;

- Review Corporate Risk Register for Quality, Performance, Finance, Contracting and Procurement Risks;
- Scheme of Reservations & Delegation (SORD) Updates;
- Oversight of complaints, FOIs, MP enquiries;
- Review of Performance and Quality committee work plan
- Information Governance Policy updates;
- Safeguarding Annual Report
- LeDer annual report

- **Reporting arrangements – Quality Overview Report includes:**

  - COVID Recovery update (briefing)
  - Harm Review update
  - Serious Incident quarterly review of numbers reported and exception reporting
  - Safeguarding quarterly update
  - Staff flu /winter plan updates
  - HCAI exception reporting

People & Community Voice Committee – the Committee provides the CCG Governing Body with strategic leadership, assurance and scrutiny in relation to its duties to involve patients and the public in shaping NHS services. The Committee oversees the development and embedding of systems and processes in relation to people and community voice and involving patients and the public in the work of the CCG.

The delivery of work against the agreed Annual Work plan for 2021/22 and extended to 30th June 2022 included the following:

- **Vaccine programme overview, including inequalities plan** - the Committee received regular briefings on the ongoing vaccination programme and the inequalities plan which supports it;

- **Hyper-acute stroke services in North Mersey (public consultation report)** – this proposal to establish a North Mersey comprehensive stroke centre for all hyper acute services has progressed through required governance and assurance processes.

- **Liverpool University Hospitals Clinical Integration Proposals** - the Trust has proposed 5 major service reconfigurations, establishing integrated teams across the former two trusts for:

  - Breast services
  - Urology
  - Vascular surgery
  - General surgery
  - Nephrology

- **Planning for transition and handover to new structures – Cheshire and Merseyside ICS** –The Committee has been engaged in the progression of plans for the transition of communications and engagement functions and structures to the ICS. Decisions about the future of these functions resides with the Integrated Care Board 'Transition Board'. However, the committee is providing input into new engagement approaches for the Liverpool 'Place'. The committee is unanimous about the benefits of the voice of people being part of formal governance arrangements, both at ICS and 'Place' level.

Clinical Effectiveness Committee – The Committee was set up to assist the CCG in the exercise of its functions relating to the provision of healthcare and related services by:

- Providing assurance that the CCG is developing clinical policies in line with the organisations strategic direction and in accordance with national guidance and local priorities;
- Provide clinical advice to ensure effective use of resources for clinical purposes;
- Providing clinical advice on the implementation of prescribing policies;
- Prioritising clinical advice on clinical policy prioritisation;

The CEC is heavily reliant on clinical input to function, and the effects of the pandemic on clinician availability have meant that the Committee has struggled to carry out its duties over the last year.

Delivery of work programme –The key deliverables of the 2021/22 Committee work plan included the following:

- **Committee reporting** - the Committee received the minutes and maintained oversight of regular reports from the Clinical Forum, the Research and Development Group and the Medicines Optimisation Committee (including Area Prescribing Committee feedback);
- **Committee Risk Register** – the Committee established a risk register, with clear links to the CCG's Corporate Risk Register (CRR) and Governing Body Assurance Framework;
- **Clinical policies** – the Committee reviewed specific clinical policies for forward recommendation of adoption by the CCG's Governing Body as and when required. In view of the transition to ICBs, the CEC agreed to make reviewing and standardising clinical policies a priority and a standing item on the agenda;
- **Patient Group Directions** – the Committee reviewed Patient Group Directions (directions which allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription) as and when required.

North Mersey Committee(s) in Common – the Committee brings together representatives from the four North Mersey CCGs; Liverpool, Knowsley, Southport &

Formby and South Sefton, as well as NHS England/Improvement Specialised Commissioning to provide oversight of the development of acute service change and other proposals that impact on our populations. The committee did not meet between April – June 2022, as oversight of service change across a wider footprint was delegated by CCGs to the Cheshire and Merseyside CCGs Joint Committee during this period.

Cheshire & Merseyside CCGs Joint Committee – the nine Cheshire and Merseyside Clinical Commissioning Groups (CCGs) established a Joint Committee in December 2021. The nine CCGs comprise of: NHS Cheshire CCG, NHS Halton CCG, NHS Knowsley CCG, NHS Liverpool CCG, NHS Southport and Formby CCG, NHS South Sefton CCG, NHS St Helens CCG, NHS Warrington CCG and NHS Wirral CCG.

The overarching role of the Joint Committee was to enable the Cheshire and Merseyside CCGs to work effectively together and make binding decisions on agreed service areas, for the benefit of both the resident population and population registered with a GP practice in Cheshire and Merseyside. The Committee ceased on 1st July 2022 when the Cheshire and Merseyside ICB was established.

2.3.4 UK Corporate Governance Code

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

2.3.5 Discharge of Statutory Functions

In light of the recommendations in the 2013 Harris Review, the Clinical Commissioning Group has continued to comply with all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions. Responsibility for each duty and power has been clearly allocated to a senior manager or Governing Body member. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the Clinical Commissioning Group's statutory duties.

As at 30th June 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.

2.3.6 Risk management Arrangements and Effectiveness

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

2.3.7 Capacity to Handle Risk

The risk management process is led by the Head of Corporate Services & Governance, reporting to the Chief Officer, providing professional leadership and oversight of risk management and its application throughout the organisation. Underpinned by a Risk Management Strategy and access to best practice and guidance, staff in lead roles across the CCG are appropriately trained and supported to ensure that the risk management approach is embedded at all levels in the CCG.

Risks as already described are assessed and managed in accordance with the Risk Management and Assurance Strategy approved by the Governing Body. The effective management of risk is the responsibility of all members of staff and Governing Body members, who all play a role in ensuring that risks are managed and mitigated in an effective and sustainable manner. Strategic and significant operational risks are reported to the Governing Body via the Governing Body Assurance Framework and Corporate Risk Register and are subject to regular review, reassessment and profiling.

2.3.8 Risk Assessment

From April – June 2022, the CCG maintained its commitment to operating an effective and efficient Assurance Framework in the face of significant challenges on multiple fronts; the ongoing response to Covid; the transition to replace CCGs with Integrated Care Boards and the ongoing system pressures across all aspects of health and social care.

These factors combined have substantially affected the risk landscape for all NHS organisations and system partners, making the balancing of existing risks to operational and strategic objectives with emerging risks a challenging task.

Despite these challenges, the Internal Audit Review of the CCG's Assurance Framework concluded that it met NHS requirements in respect of defining objectives, risks, controls, assurances and gaps.

Strategic risks and operational risks have continued to be managed, monitored and reported via the Governing Body Assurance Framework (GBAF) and Corporate Risk Register (CRR) respectively.

Each committee of the Governing Body maintains a risk register, with clear lines of accountability and escalation processes in place to the Corporate Risk Register. There was a robust and consistent internal reporting and escalation process from the Governing Body through its committee structure and the CCG Senior Leadership Team (SLT).

Key risks identified and managed in 2021/22 continued into the final three months of the CCG's operation:

- System capability to meet sustained increases in Urgent Care (including Mental Health) and general demand whilst balancing workforce capacity and recovery of services from Covid-19 response;
- National discharge guidance relating to 28-day pathway is inappropriately implemented, with patients who do not meet the National Framework Criteria streamed into the fast-track pathway in error. This would lead to delays in discharge, inappropriate placement of patients for assessment and delays in discharging fast track patients to their preferred place of death;
- Lack of 'provider' compliance with the Continuing Healthcare (CHC) National Framework, leading to delays in CHC assessments and reviews (community referrals and 28 day 'Discharge to Assess' beds). Clinical quality and financial risks to individuals and families in addition to reputational and financial risks to the CCG (two risks relating to two providers);

The CCG will not accept any risk which would potentially/actually result in non-compliance with legislation, statutory responsibilities, cause significant financial loss or would compromise patient/staff safety. As a public body, there is naturally a low tolerance threshold for any risks of this nature.

Compliance with CCG Operating Licence

For the period from 1st April – 30th June 2022, Liverpool CCG has remained fully compliant with its Operating Licence.

2.3.9 Other Sources of Assurance

2.3.9.1 Internal Control Framework

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

The system of internal control allows 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.

My review of the effectiveness of the system of internal control during this financial year has been informed by the work of the internal auditors, CCG senior managers and the Senior Leadership Team within the CCG who have responsibility for the development and maintenance of the internal control framework. I have also drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

The Governing Body Assurance Framework and Corporate Risk Register 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 my review of the effectiveness of the system of internal control by the Governing Body, the Audit & Risk Committee and Performance and Quality Committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

During the year, the Governing Body and Audit & Risk Committee have kept under regular review the application of the system of internal control. With the support of Internal Audit where areas for improvement have been identified, appropriate actions have been taken and changes made to ensure that the systems in place remain robust and effective. The formal process of an annual assurance review of the CCG by NHS England & NHS Improvement has also provided a further external insight and commentary as to the performance of the CCG.

Overall, the system of internal control in 2022/23 has been found to be effective and has met the needs of the organisation. However, as already identified there have been some areas where issues and gaps in control have been identified and specific prompt action has been taken to address these gaps in an effective and sustainable manner.

One such area where improvements have been necessary is the CCG's control design framework in relation to Personal Health Budgets (PHBs). The review covered both adults and children and the overall findings of the audit determined a 'Limited Assurance' rating, concluding that there was a "compromised system of internal control and weaknesses in the design and/or inconsistent application of controls which put the achievement of system objectives at risk." A total of 20 actions were agreed as part of the CCG management response to the audit recommendations. Of these 20 actions, 7 have been partially implemented (as at March 2022) with one action being superseded by a 'Controls in Practice' audit. Further details are provided in the Head of Internal Audit Opinion on page 80.

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the Clinical Commissioning Group's system of risk management, governance and internal control.

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

- Continued adherence to the updated remuneration framework for Governing Body members and clinical lead roles in the organisation;

- Maintaining a cohort of four Lay Members on the Governing Body;

- Adherence to the Group's Constitution and committee structure (implementation from 1st April 2020);

- Maintaining an assurance framework (AF) which meets the NHS requirements in respect of defining objectives, risks, controls, assurances and gaps.

2.3.9.2 Annual Audit of Conflicts of Interest Management

The revised statutory guidance on managing conflicts of interest (published June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

Management of conflicts of interest is taken very seriously by the CCG and we work within a robust Conflict of Interest Management Policy and Framework in undertaking our CCG Business. The CCG undertakes annual training and development with all staff (including Governing Body Members and Clinical Leads). Our corporate policy regarding the Management of Conflicts of Interest, Gifts and Hospitality is based on NHSE guidance was reviewed and updated during 2021/22. In addition, the CCG has a robust Standards of Business Conduct Policy and Anti-Fraud, Bribery & Corruption Policy which complement the Conflicts of Interest Policy.

As per national guidance, the CCG has appointed a 'Conflicts of Interest Guardian' (a role undertaken by the Lay Member for Governance). There have been no conflict-of-interest breaches reported during April-June 2022.

We recognise that failure to manage Conflicts of Interest effectively can and will result in a loss of public and partner confidence in the CCG. In addition to reporting all breaches, we also published our registers of interest on the CCG website, which are independently reviewed by Audit & Risk Committee each year:

https://www.liverpoolccg.nhs.uk/about-us/publications/registers-and-policies/registers-of-interest/

Mersey Internal Audit Agency (MIAA) undertook a full audit of our Conflict-of-Interest Management policy and processes during Quarter 3 of 2021/22 as part of the Annual Internal Audit Plan. The outcome of the Annual Audit (including its recommendations) can found within the CCG's 2021/22 Annual Report. An audit will be carried out on NHS Cheshire & Merseyside's Conflicts of Interest processes during Quarter 3 2022/23 and will be published in the NHS Cheshire & Merseyside Annual Report & Accounts in 2023.

2.3.9.3 Data Quality

The importance of data quality is well recognised by the CCG and is critical in the production of accurate analysis which underpins and influences commissioning decisions, priorities and contractual performance.

To ensure regular oversight and review of data quality, the Performance and Quality Sub Committee receives a monthly data quality briefing report. This report reviews the key contractual and performance data sets required to be submitted by providers either to meet national data requirements e.g., Secondary Users Services (SUS), Community Services Data Set (CSDS) or any local data requirements to support contracts e.g. SLAM.

The monthly report scrutinizes the timeliness of data submissions, data quality, data validity e.g., a recent focus on the ethnicity coding to enable analysis to support targeted action to reduce health inequalities. The report provides benchmarking of the national datasets against our peers in addition to a regular overview of the Data Quality Maturity Index which provides an overview of data quality in the NHS by provider across the numerous data sets submitted. Actions to pick up on the findings from the report are led by the CCG Business Intelligence team, working with providers through the respective information sub groups, which form part of the contractual governance structure.

2.3.9.4 Information Governance

The legal framework governing the use of personal confidential data in health care is complex. It includes the NHS Act 2006, the Health and Social Care Act 2012, General Data Protection Regulations (GDPR), Data Protection Act 2018, and the Human Rights Act 1998.

The law allows personal data to be shared between those offering care directly to patients, but it protects patients' confidentiality when data about them are used for other purposes. These "secondary uses" of data are essential if we are to run a safe, efficient, and equitable health service. They include:

- Reviewing and improving the quality of care provided
- Researching what treatments work best
- Commissioning clinical services
- Planning public health services

The NHS Information Governance Framework is supported by a Data Security & Protection (DSP) toolkit; with an annual submission process providing assurances to the Clinical Commissioning Group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.

The CCG places high importance in ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. There is an established information governance management framework and processes and procedures in line with the Data Security and Protection Toolkit. All staff undertake annual data security awareness training to ensure they are aware of

their information governance roles and responsibilities. The robustness of the CCG's information governance is evidenced by the substantial assurance opinion in this domain from internal auditors.

In line with the General Data Protection Regulations (GDPR) the CCG has a Data Protection Officer (DPO) to inform and advise the CCG and employees about the GDPR obligations and other data protection laws. The CCG also has an appointed Chief Clinical Information Officer / Caldicott guardian.

There are processes in place for incident reporting and the investigation of serious incidents. During 2022/23 we reported that there had been no serious incidents relating to information governance including data loss or confidentiality breaches.

2.3.9.5 Business Critical Models

The CCG maintains a strong relationship with NHS Digital through the establishment of robust systems, processes, and data sharing agreements, demonstrating confidence in the CCG to manage personal identifiable information (PID) safely and securely where there is a legal basis to do so. The CCG is compliant with the Data Security and Protection Toolkit. All of the CCGs Business critical models have been identified and noted on the CCG Information Asset Registers.

The CCG has an appropriate framework and environment in place to provide quality assurance of business-critical models, in line with the recommendations made within the 2013 Treasury publication 'Review of quality assurance of Government analytical models'. The CCG has implemented the following quality assurance systems to mitigate business risks:

- Reviews of stakeholder experience including patient complaints and serious incident management arrangements;
- Risk assessment, through the Corporate Risk Register, Governing Body Assurance Framework (GBAF), Fraud Risk Registers and Assurance Framework;
- Annual Internal Audit Programme and External Audit Review;
- Public and Patient Engagement;
- Business Continuity Management

2.3.9.6 Third Party Assurance

The CCG seeks assurances from our providers of external support through a variety of means to provide assurance to the senior management team and Governing Body. Typically, each area with the exception of the Capita primary care support services, NHS Shared Business Services Limited and NHS Digital, which are the responsibility of NHSE, has a lead officer who maintains a client relationship with the service provider. Those relations extend to regular contact and meetings with the providers, participation in client satisfaction ratings and where required intervention where performance falls below a satisfactory level. As appropriate, external standards

and service delivery levels are monitored and by exception any assurance failings brought to the immediate attention of the CCG.

Assurance is provided collectively to CCGs using these third party providers through service auditor reports, undertaken by independent auditors, on the effectiveness of the internal controls in place in these providers. These service auditor reports are reviewed by the CCG and by the CCG's own auditors to determine the level of reliance that can be placed on the third party providers systems and controls and to identify any areas that may require additional testing for audit purposes.
Issues highlighted by the service auditor reports or through the work of the CCG's own auditors are raised with third party providers, and improvements agreed through the contract management processes in place.

The review of these reports is performed on an annual basis, and the full reports were not available for the period 1 April 2022 - 30 June 2022. However, the CCG has received Bridging letters for the period 1 April 2022 - 30 June 2022 for the following services used by the CCG:

NHS Shared Business Services Limited
Capital Primary Care Support England

The bridging letters confirmed that there was no adverse change in control environment since the previous annual review of controls and that in some instances the control weaknesses identified in the previous year had been strengthened or addressed. The CCG considers the issues identified in these reports and the reports obtained in the previous year are not significant enough to impact the CCG directly and believe the CCG has sufficient compensating controls in place to mitigate any risk.

2.3.10 Control Issues

There are no significant control issues facing the CCG. Whilst some risks have been identified in the main body of the Governance Statement above, none present a significant control issue.

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

The CCG was assessed by NHS England for 2021/22 against a set of five 'national themes' that reflect the ambitions of the NHS Long Term Plan (applied across trusts, commissioners and ICSs). The five themes include quality of care; access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources and leadership and capability. The outcome of the assessment was communicated to the CCG by NHS England in June 2022 and is used as the baseline for quarter 1 of 2022/23.

The 2020/21 NHSE/I assessment focused on CCG's contributions to local delivery of the overall system plan for recovery, with emphasis on the effectiveness of working relationships in the local system. The outcome of the assessment recognised that the

CCG was continuing its good work, both at the level of Place/ICP and through its contribution to work at a pan Cheshire & Merseyside level. The CCG was also commended for its positive examples of integrated working. The assessment concluded that our PCNs had made a strong contribution to the COVID- 19 response, particularly with the vaccination rollout, which demonstrated progress in how PCNs were coming together to meet local challenges. In terms of financial performance, it the CCG had met its statutory financial duties and relevant business rules (which did not reflect the breadth of work that was taken on by CCGs in terms of flows of monies to support the COVID-19 response).

On nursing and quality, it was recognised that the CCG had taken a balanced but robust approach to reduce the burden of reporting requirements and focusing efforts on practical help and support (for example, providing extensive support and quality oversight to care homes). On patient experience, good practice was noted in the approaches the CCG had taken to eliciting patient feedback, with views obtained from Healthwatch, Patient & Community Voice Committee and Liverpool Parents & Carers and the Children's Safeguarding Partnership.

The Governing Body, informed by its committees and in particular the Performance & Quality Committee, oversees and directs the use of 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, benchmarking and comparative assessment. Programmes of work and service redesign and transformational programmes are all clinically led by Governing Body members who are supported by project leads and a project management infrastructure.

All significant investment decisions are subject to a rigorous assessment and prioritisation process that is applied in such a way as to determine the relative effectiveness of the proposal, including the impact upon key strategic outcomes and objectives. Use is also made of data and support from our public health colleagues in the local authority. Where available, use is particularly made of comparative data, including that from the 'Core Cities' to ensure a rigour behind all decisions. Support is also provided by our internal auditors from the Mersey Internal Audit Agency who provide an important source of objective advice, assessment and oversight.

2.3.12 Delegation of Functions

During 2022/23 the CCG had delegated arrangements in place with providers external to the CCG for the following:

- St Helens and Knowsley NHS Trust: Payroll processing;
- Shared Business Services: Financial Systems – Transactional Processing;
- Midlands and Lancashire Commissioning Support Unit: elements of Business Intelligence (including data processing); Human Resources Management; Continuing Healthcare (CHC), Funded Nursing Care and individual complex packages of care; Emergency Planning support; urgent care system

reporting; Individual Funding Requests (IFR); strategic engagement advice and support; and some aspects of Continuing Healthcare processes.
- Capita: provision of support services to primary care practitioners (including General Practice).

During the year risks associated with these activities have been monitored through the development of close partnership working; participation at local user groups and regular monitoring including periodic evaluation of key performance indicators. Any identified risks have been monitored through the CCG's governance and risk management processes.

2.3.13 Counter Fraud Arrangements

The CCG is compliant with the relevant NHS Counter Fraud Authority standards for commissioners regarding fraud, bribery and corruption. Specifically, the CCG commissions from Mersey Internal Audit Agency (MIAA) an appropriate and accredited Anti-Fraud (AF) service to directly assist and support the CCG through its existing Internal Audit, Anti-Fraud and Anti-Bribery and Corruption plans in ensuring that the additional necessary measures (or the amendment of existing policies) are carried out in a timely and integrated manner with minimal business interruption. Although bribery legislation has been in place for a number of years, the CCG regularly reviews its Anti-Bribery and Corruption Strategy through the work of MIAA's Anti-Fraud Service in order to satisfy the adequate procedural defence.

The executive lead role for Anti-Fraud and Anti-Bribery and Corruption sits with the Chief Finance & Contracting Officer (as a member of the CCG Governing Body). The Anti-Fraud Specialist (AFS) attends the regular meetings of the Audit and Risk Committee, providing formal updates against an agreed annual programme of activities. Those activities include strategic governance work e.g., proactive testing of conflicts of interest; 'prevent and deter' work (e.g., National Fraud Initiatives); regular updates to CCG and general practice staff; the sharing of intelligence and fraud awareness training. If required, the AFS would also undertake investigatory work.

There were no new cases of fraud reported during 2022/23. A case dating back to 2018 is still awaiting closure (pending the outcome of an ongoing NMC investigation).

2.3.14 Head of Internal Audit Opinion

Following completion of the planned audit work for quarter 1 2022/23 for the Clinical Commissioning Group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the Clinical Commissioning Group's system of risk management, governance and internal control. The Managing Director Mr Chris Harrop and Assurance Director Louise Cobain, Mersey Internal Audit Agency concluded that:

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.	✓

The Quarter 1 2022/23 Internal Audit Plan has been delivered with the focus on transition support and the provision of your Head of Internal Audit Opinion. This position has been reported within the progress reports across the quarter. Review coverage has been focused on:

- CCG Closedown/ICB Transition reviews and support;
- CCG compliance with statutory functions; and
- Follow up of outstanding internal audit recommendations.

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

2.3.15 Emergency Preparedness, Resilience and Response

The CCG has in place a qualified, competent and suitably experienced designated Senior Leadership Team lead for Emergency Preparedness, Resilience and Response (EPRR) who has played a full and active role in the Cheshire & Merseyside Local Health Resilience Partnership (LHRP) and NHS Command and Control structure during the COVID-19 response. The CCG commissions a standard service from Midlands and Lancashire Commissioning Support Services Unit which provides

access to additional support and operational support to the CCG, from a similarly qualified Emergency Planner; supplementing the in-house resources and acting as a contingency measure.

All CCGs have a statutory responsibility to formally assure Governing Bodies and NHS England / Improvement of EPRR readiness and capability, and Liverpool CCG has continued to ensure that its Governing Body is consistently informed and assured of the EPRR function through the Chief Officer's Report, presented at every public Governing Body meeting. The CCG's COVID Incident Management Team (IMT) has continued to support the ongoing local system response with city partners during this period.

The IMT continued to act as the 'Single Operating Model' for the management of COVID-19, winter surge planning and response, system resilience, and CCG monitoring of the vaccination programme during the period April – June 2022.

Liverpool CCG reported 'Substantial Compliance' against the NHS England & Improvement EPRR 'Core Standards' for 2021/22; returning the same level of compliance as previous years. This self-assessment provides the Governing Body with an adequate level of assurance of the effectiveness of its EPRR arrangements. NHS Cheshire & Merseyside will be assessed against the 2022/23 EPRR Core Standards, the results of which will be included in the Integrated Care Board's Annual Report and Accounts 2022/23.

2.3.15.1 Accountable Officer EPRR Self-certification

I certify that NHS Liverpool Clinical Commissioning Group has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework. The Clinical Commissioning Group regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Governing Body**.**

2.3.16 Principles of Remedy

During the financial year no complaints have progressed to the Parliamentary & Health Service Ombudsman.

2.3.17 External Audit

The CCG is externally audited by Grant Thornton LLP, for Quarter 1 2022/23 the total external audit fees were £99,600.

- 2021/22 Audit services £81,600 (inclusive of VAT)
- Further assistance services £0
- Other services £18,540 (inclusive of VAT)

At the time of reporting the final audit fee was not agreed and therefore an accrual of £2,448 was accrued as an estimated inflationary uplift. A further £18,540 has been accrued in respect of the 2022/23 Mental Health Investment Standard audit required by NHS England. The final fee and audit plan has not yet been agreed, however, it is expected that this will once again be performed by the CCG's external auditors.

2.3.18 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 and the senior 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 management letter and other reports.

The Governing Body Assurance Framework and associated Corporate Risk Register itself provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit and Risk Committee and the Quality, Safety and Outcomes Committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

During this period the Governing Body and Audit & Risk Committee have kept under regular review the application of the system of internal control. With the support of Internal Audit where areas for improvement have been identified, appropriate actions have been taken and changes made to ensure that the systems in place remain robust and effective.

Overall, the system of internal control has been found to be effective and has met the needs of the standards. However as already identified there have been some areas where issues and gaps in control have been identified and specific prompt action has been taken to address these gaps in an effective and sustainable manner.

The CCG underwent an Internal Audit review of its Assurance Framework during 2021/22 which concluded that it met NHS requirements. There has been no change to the framework's structure during the period April – June 2022.

Following completion of the planned audit work for the financial year for the Clinical Commissioning Group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the Clinical Commissioning Group's system of risk management, governance and internal control.

Overall, the CCG is vigilant to the potential risks to the CCG operating licence and maintains a system of strong internal control and risk management. However, there is

no room for complacency and the CCG has taken steps during the year in a number of key areas to ensure that compliance with the operating licence is maintained and protected.

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

Performance information –the corporate performance report which is presented formally on a bi-monthly basis 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.

Governance and risk – during the last 15 months to 30th June 2022, the CCG has developed its Governing Body Assurance Framework and revised its Corporate Risk Register as further enhancements to strengthen the organisations approach and management of risk.

2.3.19 Conclusion

Whilst some risks have been identified in the main body of the Governance Statement above, none present a significant control issue.

Graham Urwin
Chief Executive, NHS Cheshire and Merseyside ICB
29 June 2023

2.4 Remuneration and Staff Report

Note: Sections marked with # are auditable elements of the Remuneration Report

2.4.1 Introduction

Section 234B and Schedule 7A of The Companies Act, as interpreted for the public sector in the Government Financial Reporting Manual, requires NHS bodies to prepare a Remuneration Report containing information about directors' remuneration.

In the NHS, the report will be in respect of the Senior Managers of the NHS body. 'Senior Managers' are defined as: 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the CCG 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.

2.4.2 Remuneration Committee

The Committee role is to make recommendations about pay and remuneration for Governing Body members, senior managers and the wider senior management team. This remit includes recommending pay levels, reviewing conditions of service and allowances. During the 2021/22 year the Committee has considered the Accountable Officer remuneration package, the Chief Finance and Contracting Officer remuneration, a Clinical Leadership and Lay member Remuneration Framework and VSM remuneration.

2.4.3 Appraisal of Chair, Governing Body Members and Chief Officer

The CCG has in place a robust procedure for assessing the performance and delivery of the Chair, Accountable Officer and Governing Body members. The CCG has a Governing Body appraisal system including a 360 degree multi -stakeholder assessment for the Chair and a light touch 360 degree programme for all other governing body members. The Chair appraises the performance and delivery of the Accountable Officer; the Lay Member for Governance appraises the Chair. Governing Body members are subject to appraisal by the Chair. Objectives are set for each person alongside agreement as to any developmental needs, with full records of the appraisal meetings made and retained.

2.4.4 Governing Body Members

The dates of contracts and unexpired terms of office for the Governing Body members are shown in the table below:

Name	Appointment Start Date	Appointment End Date
Mark Bakewell	Permanent appointment from 1st December 2018	N/A Permanent contract of employment
Dr Janet Bliss	Re-appointed 1st June 2018	31st May 2021
Helen Dearden	30th January 2018	29th January 2022
Dr Paula Finnerty	1st June 2018	31st May 2021
Gerry Gray	1st January 2018	31st December 2021
Sally Houghton	Re-appointed 9th May 2020	8th May 2023
Dr Monica Khuraijam	Re-appointed 1st June 2018	31st May 2021
Dr Fiona Lemmens	Re-appointed 4th July 2020	3rd July 2021
Jan Ledward	Permanent appointment from 1st May 2018	N/A Permanent contract of employment
Jane Lunt	Permanent appointment from 1st April 2013	N/A Permanent contract of employment
	Re-appointed 1st June 2018	31st May 2021

Dr Fiona Ogden-Forde		
Dr Shamim Rose	Re-appointed 1st June 2018	31st May 2021
Dr Maurice Smith	Re-appointed 4th July 2020	3rd July 2021
Dr Peter Kirkbride	1st April 2019	31st March 2022
Cathy Maddaford	1st April 2019	31st March 2022
Carol Rogers	1st October 2019	30th September 2022
Dr David O'Hagan	1st November 2019	31st October 2022
Dr Stephanie Gallard	1 July 2021	30th June 2023

Dispensation from NHS England & NHS Improvement was given to CCGs to 'roll over' any Governing Body Member's Terms of Office which were due to expire. This was to ensure retention of clinical leaders and to maintain business continuity during the transition to ICBs.

2.4.5 Policy on the Remuneration of Senior Managers

Senior Managers (Officers) hold permanent contract of employment and are subject to six months' notice. Governing Body members, excluding the Chief (Accountable) Officer, Chief Finance Officer and Director of Quality, Outcomes and Improvement, are Officer Holders and have various lengths of tenure as highlighted in the table above.
Amendments to salary are recommended by the Remuneration Committee to the Governing Body. When required the Remuneration Committee can access professional advice from NHS England, Midlands and Lancashire CSU's HR team and also the CCG legal advisers, Hill Dickinson LLP. In setting policy for current and future years, the Committee has access to guidance, best practice and benchmarking from comparative CCGs, such as those in the 'core cities' group.

Senior manager performance is monitored through the formal appraisal process, based on organisational and individual objectives. Senior managers are not subject to an element of performance related pay as part of their remuneration packages. The following table provides details of senior manager's remuneration, including salary and pension entitlements:

Salaries & Allowances #

Name	Title	Notes	Salary (bands of £5,000)		Expense payments (taxable) (to nearest £100)		Performance pay and bonuses (bands of £5,000)		Long term performance pay and bonuses (bands of £5,000)		All pension related benefits (bands of £2,500)		TOTAL	
		j)	2022/23 £'000	2021/22 £'000	2022/23 £'	2021/22 £'	2022/23 £'000	2021/22 £'000	2022/23 £'000	2021/22 £'000	2022/23 £'000	2021/22 £'000	2022/23 £'000	2021/22 £'000
Current year Governing Body Members														
Jan Ledward	Governing Body Member - Chief Officer	a) b) c) k)	15 - 20	110 - 115	0	0	0	0	0	0	7.5 - 10	32.5 - 35	25 - 30	145 - 150
Mark Bakewell	Governing Body Member - Chief Finance and Contracting Officer	a) c) k)	15 - 20	65 - 70	0	0	0	0	0	0	2.5 - 5	15 - 17.5	15 - 20	80 - 85
Jane Lunt	Governing Body Member - Director of Quality, Outcomes & Improvement	a) c) k)	10 - 15	85 - 90	0	0	0	0	0	0	5 - 7.5	22.5 - 25	20 - 25	110 - 115
Dr Janet Bliss	Governing Body Member - Chair/Vice Chair/GP	d)	20 - 25	80 - 85	0	0	0	0	0	0	0	0	20 - 25	80 - 85
Dr Shamim Rose	Governing Body Member - GP	d)	10 - 15	50 - 55	0	0	0	0	0	0	0	0	10 - 15	50 - 55
Dr Stephanie Gallard	Governing Body Member - GP	d) f)	10 - 15	35 - 40	0	0	0	0	0	0	0	0	10 - 15	35 - 40
Dr Fiona Ogden Forde	Governing Body Member - GP	d) i)	20 - 25	85 - 90	0	0	0	0	0	0	0	0	20 - 25	85 - 90
Dr Monica Khuraijam	Governing Body Member - GP	d) j)	10 - 15	50 - 55	0	0	0	0	0	0	0	0	10 - 15	50 - 55
Dr Paula Finnerty	Governing Body Member - GP	d) i)	15 - 20	75 - 80	0	0	0	0	0	0	0	0	15 - 20	75 - 80
Dr David O'Hagan	Governing Body Member - GP	d) j)	10 - 15	50 - 55	0	0	0	0	0	0	0	0	10 - 15	50 - 55
Cathy Maddaford	Governing Body Member - Registered nurse	g)	0 - 5	15 - 20	0	0	0	0	0	0	0	0	0 - 5	15 - 20
Sally Houghton	Governing Body Member - Lay - Audit and Financial Management		0 - 5	15 - 20	0	0	0	0	0	0	0	0	0 - 5	15 - 20
Helen Dearden	Governing Body Member - Lay - Governance		0 - 5	15 - 20	0	0	0	0	0	0	0	0	0 - 5	15 - 20
Gerard Gray	Governing Body Member - Lay - Finance		0 - 5	10 - 15	0	0	0	0	0	0	0	0	0 - 5	10 - 15
Carol Rogers	Governing Body Member - Lay - Patient & Public Involvement		0 - 5	15 - 20	0	0	0	0	0	0	0	0	0 - 5	15 - 20
Dr Fiona Lemmens	Governing Body Member - Chair/GP	d) h)	0	80 - 85	0	0	0	0	0	0	0	0	0	80 - 85
Dr Maurice Smith	Governing Body Member - GP	d) e) i)	0	15 - 20	0	0	0	0	0	0	0	0	0	15 - 20
Dr Peter Kirkbride	Governing Body Member - Secondary Care doctor		0	10 - 15	0	0	0	0	0	0	0	0	0	10 - 15

Notes

a) The Chief Officer, Chief Finance and Contracting Officer and Director of Quality, Outcomes and Improvement are engaged under contracts of services and are employees.

b) During the period, Jan Ledward decided to receive the car allowance of £5,000 as a cash altenative. This has therefore been included in the above Salary column.

c) From 1 October 2019 Mark Bakewell was appointed as Chief Finance Officer at Knowsley CCG in a joint role capacity and accordingly 50% of remuneration costs have been recharged to Knowsley CCG. The above table reflects Liverpool CCG share of total costs (including pension related benefits), with the total banded remuneration (in bands of £5,000) being £30k -£35k and inclusive of an additional 10% in respect of covering an additional CCG, consistent with remuneration guidance. From 1 October 2021, Jane Lunt has also been supporting both South Sefton CCG and Southport and Formby CCG as part of senior management team with 25% of remuneration costs (50% total) being recharged to CCGs. The above table reflects Liverpool CCG share of costs, with banded remuneration (in bands of £5,000) totalling £25k-£30k, consistent with remuneration guidance. From 1 October 2021 Jan Ledward was appointed as Chief Officer at Knowsley CCG in a joint role capacity and accordingly 50% of remunerattion costs have been recharged to Knowsley CCG. The above table reflects Liverpool CCG share of total costs (including pension related benefits), with the total banded remuneration (in banks of £5,000) being £35k-£40k, consistent with remuneration guidance.

d) Governing body members (both medical/ non-medical) practitioners are classified as 'Office Holders' in accordance with HMRC and legal advice. This means that they hold a 'statutory office' with the organisation, but do not have a contract 'of' service or contract 'for' service with the CCG. The CCG has determined that with regards to the remuneration report requirements for medical practitioners who are governing body members that, in accordance with the Group Accounting Manual guidance (and given the practical arrangements in place with regards to tax, national insurance and pension arrangements) that the 'contract for service' methodology is the most appropriate representation of remuneration for the financial year. Gross payment to the individual is therefore disclosed in the salary column including employer pension contributions (where applicable) as per the NHS Group Accounting Manual.

e) Maurice Smith resigned from his governing body role on 3 July 2021, he subsequently resigned from his clinical Lead role on 31 August 2021. The pay for his clinical lead role, up to 3 July 2021 has been included, consistent with remuneration guidance.

f) Stephanie Gallard was appointed to the governing body on 1 July 2021

g) Cathy Maddaford received an increase to her salary to take into account her increase sessional work, backdated to 1 April 2021

h) Dr Fiona Lemmens resigned from her role supporting the Cheshire & Merseyside elective care recovery programme on 30 June 2021. This role was fully recharged to Health Care Partnership with the above table reflecting Liverpool CCG share of costs.
Dr Fiona Lemmens resigned from the Governing body on 28 February 2022.

i) Janet Bliss was appointed Chair of the Governing Body from 1 March 2022

j) The following Governing Body GP's have a secondary appointment as clinical leads under a contract of service with Liverpool CCG during the period:
Paula Finnerty (£5-£10k), Fiona Ogden-Forde (£5k -10k)

k) The all pension related benefits figure during the period is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.
The pension benefit table provides further information on the pension benefits accruing to the individual.

j) 2022/23 figures reflect the 3 month period to 30 June 2022.

2.4.6 Remuneration of Very Senior Managers

There are no CCG senior managers with salaries in excess of £150,000 and remuneration has been recommended by the Remuneration Committee.

2.4.7 Pension Benefits as at 30th June 2022

Pension Benefits Table#

Name	Title	Notes	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 (Note 4)	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	£00
Jan Ledward	Chief Officer	a) b) c)	0 - 2.5	0 - 2.5	70 - 75	185 - 190	1,631	22	1,672	0
Mark Bakewell	Chief Finance & Contracting Officer	a) c)	0 - 2.5	0 - 2.5	35 - 40	55 - 60	478	5	492	0
Jane Lunt	Director of Quality, Outcomes & Improvement	a) b) c)	0 - 2.5	0 - 2.5	70 - 75	110 - 115	1,216	16	1,253	0

a) The pension entitlement above is the total pension entitlement for each Governing Body member, it is not split across other organisations.
b) In line with the Group Accounting Manual Guidance 2022/23, when the real increase in pension or lump sum returns a negative value, the disclosure must be amended to zero.

c) Cash Equivalent Transfer Values at 1 April 2021 have been recalculated to include 3.1% inflation which is calculated in accordance with SI 2008 No. 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008 (33)

d) Real Increase in Cash Equivalent Transfer Value is 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 pension scheme or arrangement).
e) Non-Executive Governing Body lay members do not receive pensionable remuneration and therefore no disclosure is required in respect of pensions.
f) The CCG has determined that GP Governing Body members, for the purposes of the remuneration report are classified as contract 'for' service practitioners and therefore, in line with the Group Accounting Manual, pension disclosures for these individuals are not required to be disclosed.

g) The Liverpool 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.

2.4.8 Compensation on Early Retirement or for Loss of Office

During the period from 1st April – 30th June 2022, the CCG has not made any payments of compensation for early retirement or for loss of office (Nil).

2.4.9 Payments to Past Members

During the period from 1st April – 30th June 2022, the CCG has not made any payments to any past members (Nil).

2.4.10 Percentage change in remuneration of highest paid director

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	1%	-
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	-4%	-

2.4.11 Pay Multiples

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 NHS Liverpool CCG in the financial period to 30 June 2022 was £105-£110k (2021/22, £105-£110k).
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
2022/22	3.46 : 1	3.46 : 1	2.45 : 1	2.45 : 1	1.91 : 1	1.91 : 1
Salary component of total remuneration (£)	31,031	31,031	43,806	43,806	56,164	56,164
Total remuneration (£)	31,031	31,031	43,806	43,806	56,164	56,164
2021/22	3.42 : 1	3.42 : 1	2.35 : 1	2.35 : 1	1.68 : 1	1.68 : 1
Salary component of total remuneration (£)	31,410	31,410	45,839	45,839	63,862	63,862
Total remuneration (£)	31,410	31,410	45,839	45,839	63,862	63,862

In 2022/22, 0 employees (2021/22, 3) received remuneration in excess of the highest-paid director / member. Remuneration ranged from £5-10k to £105-110k (2020/21 £5-10k to £105-110k).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but no severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Staff Report

2.4.12 Number of Senior Managers

The CCG employs a total of 4 senior managers on a VSM contract, including 3 Governing Body members (Chief Officer, Chief Finance and Contracting Officer and Director of Quality, Outcomes & Improvement).

2.4.13 Staff Numbers and Costs

Average staffing numbers by occupation can be summarised in the following table:

Average WTE	**PERMANENT**	**OTHER**
Administrative and Clerical	134.21	8.32
Medical and Dental	0.80	1.11
Nursing and Midwifery Registered	2.91	-
Scientific / Therapeutic / Technical	1.00	-
Grand Total	**139.96**	**11.88**

The staffing costs associated are summarised in the following table:

2022/22	Permanent Employees £'000	Other £'000	Total £'000
	N4G	N4H	N4I
Salaries and wages	1,654	4	1,658
Social security costs	220	-	220
Employer contributions to the NHS Pension Scheme	356	-	356
Apprenticeship Levy	6	-	6
Gross Employee Benefits Expenditure	**2,236**	**4**	**2,240**

2021/22 - Prior year	Permanent Employees £'000	Other £'000	Total £'000
	N4G	N4H	N4I
Salaries and wages	6,770	86	6,856
Social security costs	815	-	815
Employer contributions to the NHS Pension Scheme	1,439	-	1,439
Apprenticeship Levy	23	-	23
Gross Employee Benefits Expenditure	**9,047**	**86**	**9,133**

Note: NHS Liverpool CCG policy is for all annual leave due to be taken in the year it is earned, the cost of leave earned but not taken is minimal and has not therefore been included in expenditure

2.4.14 Staff Composition

Breakdown of staff by gender at the 30/6/2022:

	Female	Male
Governing Body (including office holders)	12	3
Very Senior Managers (not included above)**	1	1
Other members of staff *	126	31

*This excludes workers seconded from external organisations, agency staff and contractors
** Employed on a VSM contract

2.4.15 Sickness Absence Data

The CCGs latest sickness absence data as reported on NHS Sickness Absence rates, August 2022.xlsx (live.com) was as follows:

This is included as per the table below:

NHSE Region name	NHSE code	Organisation name	Org code	April 2022	May 2022	June 2022
North West	Y62	NHS Liverpool CCG	99A	1.2	.	.

Available at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates
Sickness absence rate is calculated by dividing the sum total sickness absence days (including non-working days) by the sum total days available per month for each member of staff.

Sickness absence data for May and June 2022 is not available given the 2 month time lag. Sickness absence data for this period was reported as a whole for Cheshire and Merseyside ICB.

2.4.16 Staff Turnover Percentages

The CCG Staff Turnover Rate has been calculated by dividing the total FTE Leavers in the period by the average FTE Staff in Post during the period. The CCG's Total FTE Leavers in the period was 4.1. The CCG's Average FTE Staff in Post during the period was 147. The CCG Staff Turnover Rate for the year was 2.76%
This is included in the table below:

Staff Turnover 2022-22	
Average FTE Employed 2022-22	147
Total FTE Leavers 2022-22	4
Turnover Rate	2.76%

The CCGs latest staff turnover percentages are available at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

2.4.17 Staff Engagement Percentages

The CCG have opted not to use the most recent national staff survey from 2021/22 due to the timings of when results are available and the end date for the CCG. Instead the CCG has been participating in Cheshire and Merseyside wide staff check-in surveys which are running every other month.

2.4.18 Staff Policies

The CCG is committed to promoting equality and embraces diversity as an employer. It adheres to legal and performance requirements and mainstreams its equality and diversity principles through its policies, procedures and processes. To ensure that policies do not have an adverse impact in response to the requirements of The Equality Act 2010, all policies are equality impact assessed during the development processes.

The CCG will take action when necessary to address any unexpected or unwarranted disparities and monitor workforce and employment practices to ensure that

employment policies are fairly implemented. The Organisation is committed to ensuring that staff receive appropriate awareness training in Equality, Inclusion and Diversity to undertake their role. Equality, Inclusion and Diversity training is mandatory for all staff commensurate with the duties that they are required to undertake.

The CCG operates a fair and objective system for recruiting, which places emphasis on individual skills, abilities and experience. This enables a full diversity of people to demonstrate their ability to do a job. Selection criteria contained within Job Descriptions and Person Specifications are regularly reviewed to ensure that they are justifiable and so do not unfairly discriminate directly or indirectly and are essential for the effective performance of the role. The CCG offers a guaranteed interview scheme for disabled applicants who meet our essential selection criteria. The CCG is a 'Disability Confident Committed' employer and is committed to making reasonable adjustments in the workplace, including appropriate training, to support the continuation of employment.

The CCG strives to enable all staff to achieve their full potential in an environment of dignity and mutual respect. This is underpinned by ensuring that every employee is in possession of a Personal Development Plan (PDP) and has an annual "Talent Conversation" (appraisal). All employees are supported to develop the skills and abilities they require to carry out their current and any likely future role in the organisation.

2.4.19 Employee Consultation and Engagement

The CCG places a high importance on the delivery of effective communications, involvement and engagement with all of its employees. Since the onset of the Covid pandemic, the majority of CCG staff have been working from home, although plans have been developed for staff to return to the office using a hybrid working approach. The CCG has adapted its communication delivery to ensure staff remain engaged during these unprecedented times. It discharges these duties through a variety of means including:

- A regular virtual 'floor meeting' which provides a valuable opportunity for the Chief Officer and senior managers to brief staff on important matters concerning the business and operations of the organisation, and to hear views and news from all team members.

- A weekly electronic bulletin available to all staff that provides a short and digestible summary of key internal and external issues of relevance to the staff and CCG.

- An internal online intranet resource.

2.4.20 Other Employee Matters

COVID-19 –The CCG has fully supported staff and ensured all had wellbeing discussions with their line managers and risk assessments completed for staff working from home and more detailed risk assessments for the minority of staff required to work in a different location including those redeployed elsewhere in the system.

2.4.21 Expenditure on Consultancy

During the period from 1st April - 30th June, the CCG has not incurred any expenditure on external consultancy.

2.4.22 Off-payroll Engagements

Table 1: Length of all highly paid off-payroll engagements - For all off-payroll engagements as of 30st June 2022, for more than £245 per day:

	Number
Number of Existing Engagements as of 30 June 2022	4
of which that have existed for …	
less than one year at time of reporting	0
between one and two years at time of reporting	0
between two and three years at time of reporting	3
between three and for years at time of reporting	1
four or more years at time of reporting	0

Table 2: 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 per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	**8**
Of which …	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35	1
No. subject to off-payroll legislation and determined as out of scope of IR35	7
No of engagements reassesed for compliance or assurance purposes during the year	0
Of which: no of engagements that saw a change to IR35 status following review	0

Table 3: Off Payroll Board Member/Senior Official Engagements

For any off payroll engagements of Board members and/or senior officials with significant financial responsibility between 1st April 2022 and 30 June 2022

	Number
No. of off-payroll engagements of Board members and/or senior officials with significant financial responsibility during the financial year.	0
Total no 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 must include both on-payroll and off-payroll engagements.	15

2.4.23 Exit Packages, Including Special (non-contractual) Payments

During this period the CCG has made no exit package payments including special (non-contractual).

2.4.24 Analysis of Other Departures

In this period, the CCG paid no other agreed departures.

2.4.25 The Trade Union (Facility Time Publication Requirements) Regulations 2017

In compliance with the above Regulations the following information is provided:

Relevant union officials - What was the total number of your employees who were relevant union officials during the relevant period?

Number of your employees who were relevant union officials during the relevant period	Full time equivalent number
0	0

NHS Liverpool CCG is wholly supportive of partnership working and as such is an active participant in the Staff Partnership Forum facilitated by NHS Midlands and Lancashire Commissioning Support Unit. The CCG utilises this forum as a vehicle and mechanism to support proactive staff engagement, consultation and, where appropriate, negotiation. The CCG does not employ anyone who undertakes relevant union official duties as outlined in the Trade Union (Facility Time Publication Requirements) Regulations 2017 and therefore no time is released from this employer in relation to official duties. The CCG liaises and works with CSU TU representatives and area/regional representatives from those recognised unions whose time will be recorded with their employing authority.

2.5 Parliamentary Accountability and Audit Report

NHS Liverpool CCG is not required to produce a Parliamentary Accountability and Audit Report. An external audit certificate and report is also included in this Annual Report at page 94. 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.

Graham Urwin
Chief Executive, NHS Cheshire and Merseyside ICB
29 June 2023

Independent auditor's report to the members of the Governing Body of NHS Liverpool CCG

Data entered below will be used throughout the workbook:

Entity name:	NHS Liverpool CCG
This period end	Period to June 22
Last year	2021-22
This period ended	30 June 2022
Last year ended	31-March-2022
This period commencing:	01-April-2022
Last year commencing:	01-April-2021

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Statement of Comprehensive Net Expenditure for the period ended 30 June 2022

	Note	Period to June 22 £'000	Restated 2021-22 £'000
Income from sale of goods and services	3	(2,837)	(6,076)
Other operating income	3	(12)	(81)
Total operating income		**(2,849)**	**(6,157)**
Staff costs	4	2,240	9,133
Purchase of goods and services	5	404,320	1,881,459
Depreciation and impairment charges	5	50	-
Provision expense	5	-	(1,187)
Other Operating Expenditure	5	741	4,134
Total operating expenditure		**407,351**	**1,893,539**
Net Operating Expenditure		**404,502**	**1,887,382**
Finance income	7	-	-
Finance expense	7	1	-
Net expenditure for the Period		**404,503**	**1,887,382**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Period		**404,503**	**1,887,382**
Comprehensive Expenditure for the period		**404,503**	**1,887,382**

Statement of Financial Position as at 30 June 2022

	Note	Period to June 22 £'000	2021-22 £'000
Non-current assets:			
Right-of-use assets	8	281	-
Total non-current assets		**281**	-
Current assets:			
Trade and other receivables	9	12,478	14,576
Cash and cash equivalents	10	535	1,046
Total current assets		**13,013**	15,622
Total current assets		**13,013**	15,622
Total assets		**13,294**	15,622
Current liabilities			
Trade and other payables	11	(112,998)	(102,025)
Lease liabilities	8	(189)	-
Total current liabilities		**(113,187)**	(102,025)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(99,893)**	(86,402)
Non-current liabilities			
Lease liabilities	8	(48)	-
Total non-current liabilities		**(48)**	0
Assets less Liabilities		**(99,941)**	(86,402)
Financed by Taxpayers' Equity			
General fund		(99,941)	(86,402)
Total taxpayers' equity:		**(99,941)**	(86,402)

The notes on pages 107 to 131 form part of this statement

The financial statements on pages 103 to 131 were approved by the board of Cheshire and Merseyside ICB on 29 June 2023 and signed on its behalf by:

Graham Urwin
Chief Executive, NHS Cheshire and Merseyside ICB

Statement of Changes In Taxpayers Equity for the period ended 30 June 2022

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for Period to June 22				
Balance at 01 April 2022	(86,402)	-	-	**(86,402)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-	-	-
Adjusted NHS Clinical Commissioning Group balance at 01 April 2022	**(86,402)**	**-**	**-**	**(86,402)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for Period to June 22				
Net operating expenditure for the financial year	(404,503)			**(404,503)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial period	**(404,503)**	**-**	**-**	**(404,503)**
Net funding	390,965	-	-	**390,965**
Balance at 30 June 2022	**(99,941)**	**-**	**-**	**(99,941)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22				
Balance at 01 April 2021	(50,217)	-	-	**(50,217)**
Transfer of assets and liabilities from closed NHS bodies	-	-	-	-
Adjusted NHS Clinical Commissioning Group balance at 01 April 2021	**(50,217)**	**-**	**-**	**(50,217)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22				
Net operating costs for the financial year	(1,887,382)			(1,887,382)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(1,887,382)**	**-**	**-**	**(1,887,382)**
Net funding	1,851,197	-	-	1,851,197
Balance at 31 March 2022	**(86,402)**	**-**	**-**	**(86,402)**

The notes on pages 107 to 131 form part of this statement

Statement of Cash Flows for the period ended 30 June 2022

	Note	**Period to June 22 £'000**	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year/period		(404,503)	(1,887,382)
Depreciation and amortisation	8	50	-
(Increase)/decrease in trade & other receivables	9	2,098	987
Increase/(decrease) in trade & other payables	12	10,973	37,992
Provisions utilised		0	(563)
Increase/(decrease) in provisions		(0)	(1,187)
Net Cash Inflow (Outflow) from Operating Activities		**(391,382)**	(1,850,153)
Cash Flows from Investing Activities			
Net Cash Inflow (Outflow) from Investing Activities		**-**	-
Net Cash Inflow (Outflow) before Financing		**(391,382)**	(1,850,153)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		390,966	1,851,197
Repayment of lease liabilities	8	(96)	-
Net Cash Inflow (Outflow) from Financing Activities		**390,871**	1,851,197
Net Increase (Decrease) in Cash & Cash Equivalents	11	**(511)**	1,043
Cash & Cash Equivalents at the Beginning of the Financial Period		**-**	-
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		1,046	3
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Period		**535**	1,046

The notes on pages 107 to 131 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

These accounts have been prepared on a going concern basis.
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 Liverpool 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 Joint arrangements

Arrangements over which the clinical commissioning group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.
A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the clinical commissioning group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts. See note 18 for further information on the Liverpool Clinical Commissioning Group's joint arrangements.
A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.5 Pooled Budgets

Liverpool Clinical Commissioning Group has entered into a pooled budget arrangement with Liverpool City Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the provision of Integrated Community Equipment and Disability Advice Services (ICEDAS) and to operate a pooled budget for the required Better Care Fund arrangements and note 17 provides details of the income and expenditure.

The Better Care Fund is hosted by Liverpool City Council. The ICEDAS is hosted by the Liverpool Clinical Commissioning Group. Liverpool 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.

1.6 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.

1.7 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.

Notes to the financial statements

1.8. Employee Benefits

1.8.1 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.

1.8.2 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 if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

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.

1.8.3 Nest Pension Scheme

Some employees who cannot, or do not wish to be members of the NHS Pension Scheme, are members of the NEST scheme. NEST is a workplace pension, set up by the government in advance of the changes to auto enrolment. The scheme is a defined contribution scheme and therefore the cost to the Clinical Commissioning Group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

1.9 Other Expenses

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

1.10 Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.11 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The clinical commissioning group assesses whether a contract is or contains a lease, at inception of the contract.

1.12.1 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.

Notes to the financial statements

1.13.1 **Services Received**

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.14 **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.

1.15 **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 0.47% (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 0.70% (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 0.95% (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 0.66% (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.

1.16 **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.

1.17 **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.

1.18 **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.

1.19 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at 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.

1.20.1 **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.

Notes to the financial statements

1.21.2 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.

1.22.3 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.

1.23.4 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.

1.24 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.

1.25.1 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.

1.26.2 Financial Liabilities at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.27.3 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health 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.

1.28 Value Added Tax

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

1.29 Foreign Currencies

The clinical commissioning group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.30 Losses & Special Payments

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

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

1.31 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.

1.32.1 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 have been included in the financial statements to the extent that the Clinical Commissioning Group 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.

● 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. Management had made an assessment for the period ended 31 March 2021 and concluded that one provision is required relating to Continuing Healthcare. See Note 11.

● Better Care Fund accruals have been based upon information available at the year end and a review of the joint commissioning group approved schemes. For those Better Care Fund schemes which are based upon activity, critical judgements apply. When information has been delayed, a best estimate of the activity to year end has been used.

Whilst these are judgements made by management these are not considered to be significant in line with accounting principles.

Notes to the financial statements

1.32.2 Sources of estimation uncertainty

The CCG does not have any estimates that would give rise to major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts for next year

1.33 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.34 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:
a) The election to not make an adjustment for leases for which the underlying asset is of low value.
b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
c) 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.
As of 1 April 2022, the group recognised £331K or right-of-use assets and lease liabilities of £329K. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was £nil impact to tax payers' equity.
The group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.

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	(339)
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	(339)
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)	7
Less: Low value leases	-
Less: Variable payments not included in the valuation of the lease liabilities	(329)
Lease liability at 1 April 2022	**-**

1.35 New and revised IFRS Standards in issue but not yet effective

● 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 application of the Standards as revised would not have a material impact on the accounts for the Period to June 2022 were they applied in that period.

2 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:

	Period to June 22 Target	Period to June 22 Performance	2021-22 Target	2021-22 Performance
Expenditure not to exceed income	412,850	412,849	1,918,504	1,918,494
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	404,503	404,503	1,887,392	1,887,382
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	2,208	2,207	9,714	9,260

Note: For the purposes of 223H(1); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial period/year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial period/year (whether under provisions of the Act or from other sources, and included here on a gross basis). The in-period/year surplus for the period ended 30 June 2022 was £0k (2021-22: £10k)

3 Other Operating Revenue

	Period to June 22 Admin	Period to June 22 Programme	Period to June 22 Total	Restated 2021-22 Total
	£'000	£'000	£'000	£'000
Income from sale of goods and services (contracts)				
Education, training and research	-	-	-	-
Non-patient care services to other bodies	68	3,022	**3,090**	5,177
Patient transport services	-	-	-	-
Prescription fees and charges	-	-	-	-
Dental fees and charges	-	-	-	-
Income generation	-	-	-	-
Other Contract income	70	(323)	**(253)**	899
Recoveries in respect of employee benefits	-	-	-	-
Total Income from sale of goods and services	**138**	**2,699**	**2,837**	6,076
Other operating income				
Rental revenue from finance leases	-	-	-	-
Rental revenue from operating leases	-	-	-	-
Charitable and other contributions to revenue expenditure: NHS	-	-	-	-
Charitable and other contributions to revenue expenditure: non-NHS	-	-	-	-
Receipt of donations (capital/cash)	-	-	-	-
Receipt of Government grants for capital acquisitions	-	-	-	-
Continuing Health Care risk pool contributions	-	-	-	-
Non cash apprenticeship training grants revenue	12	-	**12**	31
Other non contract revenue	-	-	-	50
Total Other operating income	**12**	**-**	**12**	81
Total Operating Income	**150**	**2,699**	**2,849**	6,157

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.

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies	Other Contract income
	£'000	£'000
Source of Revenue		
NHS	1,958	(584)
Non NHS	1,132	331
Total	**3,090**	**(253)**

	Non-patient care services to other bodies	Other Contract income
	£'000	£'000
Timing of Revenue		
Point in time	-	-
Over time	3,090	(253)
Total	**3,090**	**(253)**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total Permanent Employees £'000	Other £'000	Period to June 22 Total £'000
Employee Benefits			
Salaries and wages	**1,654**	**4**	**1,658**
Social security costs	**220**	**-**	**220**
Employer Contributions to NHS Pension scheme	**356**	**-**	**356**
Other pension costs	**-**	**-**	**-**
Apprenticeship Levy	**6**	**-**	**6**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	2,236	4	2,240
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	2,236	4	2,240
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	2,236	4	2,240

4.1.1 Employee benefits

	Total Permanent Employees £'000	Other £'000	2021-22 Total £'000
Employee Benefits			
Salaries and wages	**6,770**	**86**	**6,856**
Social security costs	**815**	**-**	**815**
Employer Contributions to NHS Pension scheme	**1,439**	**-**	**1,439**
Other pension costs	**-**	**-**	**-**
Apprenticeship Levy	**23**	**-**	**23**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	9,047	86	9,133
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	9,047	86	9,133
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	9,047	86	9,133

4.2 Average number of people employed

	Period to June 22			2021-22		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**138.92**	**11.13**	**150.05**	**139.96**	**11.88**	**151.84**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Ill health retirements

Ill-health retirement costs are met by the NHS Pension Scheme. Where the Clinical Commissioning Group has agreed early retirements, the additional costs would be met by the Clinical Commissioning Group and not by the NHS Pension Scheme. The Clinical Commissioning Group had no ill health retirements in the 3 month period to June 2022 (2021-22: nil).

4.4 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:

4.4.1 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.

4.4.2 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.

5. Operating expenses

	Period to June 22 Total £'000	Restated 2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	(85)	3,397
Services from foundation trusts	264,825	1,274,285
Services from other NHS trusts	51,710	245,088
Provider Sustainability Fund	-	-
Services from Other WGA bodies	-	-
Purchase of healthcare from non-NHS bodies	37,384	141,584
Purchase of social care	-	-
General Dental services and personal dental services	-	-
Prescribing costs	20,422	92,759
Pharmaceutical services	39	113
General Ophthalmic services	-	-
GPMS/APMS and PCTMS	26,703	108,852
Supplies and services – clinical	-	-
Supplies and services – general	447	3,214
Consultancy services	3	-
Establishment	715	3,982
Transport	6	11
Premises	1,926	7,445
Audit fees*	84	82
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services**	19	18
Other professional fees	73	336
Legal fees	33	239
Education, training and conferences	4	23
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Non cash apprenticeship training grants	12	31
Total Purchase of goods and services	**404,320**	1,881,459
Depreciation and impairment charges		
Depreciation	50	-
Total Depreciation and impairment charges	**50**	-
Provision expense		
Change in discount rate	-	-
Provisions	-	(1,187)
Total Provision expense	**-**	(1,187)
Other Operating Expenditure		
Chair and Non Executive Members	124	601
Grants to Other bodies	81	308
Clinical negligence	-	-
Research and development (excluding staff costs)	485	2,562
Other expenditure	51	663
Total Other Operating Expenditure	**741**	4,134
Total operating expenditure	**405,110**	1,884,406

The CCG continued as the designated lead CCG for Cheshire & Merseyside system allocations for the Period to 30 June 2022 in respect of additional resources to cover additional COVID and restoration costs. These resources had to be managed through a system lead CCG, which was agreed as Liverpool. Liverpool CCG has then made payments to NHS providers as directed by the Cheshire & Merseyside Healthcare Partnership. These system payments are included in Services from foundation trusts and Services from other NHS trusts, total spend for the Period 30 June 2022 is £139.1m (2021-22: £843m)

*External audit fees as disclosed above are inclusive of VAT

** Other services from external audit of £19,000 have been accrued in respect of the 2022-23 Mental Health Investment Standard audit required by NHS England.

Internal audit services during the year were provided by Mersey Internal Audit Agency, hosted by Liverpool University

5.1 Limitation on auditor's liability

The limitation on auditors' liability for external audit has been confirmed as £2m.

Auditor's liability is limited with regard to the following:

Limitation period - Any claim must be brought no later than two years after the claimant should have been aware of the potential claim and, in any event, no later than four years after any alleged breach.

Liability - Total liability (including interest) for all claims connected with the services (including but not limited to negligence) is limited to three times the fees payable for the services or £2m, whichever is the greater.

6.1 Better Payment Practice Code

Measure of compliance	Period to June 22 Number	Period to June 22 £'000	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	4,126	65,486	19,830	258,524
Total Non-NHS Trade Invoices paid within target	4,061	65,126	19,566	255,899
Percentage of Non-NHS Trade invoices paid within target	**98.42%**	**99.45%**	98.67%	98.98%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	416	305,899	1,983	1,519,131
Total NHS Trade Invoices Paid within target	411	305,812	1,954	1,518,042
Percentage of NHS Trade Invoices paid within target	**98.80%**	**99.97%**	98.54%	99.93%

7.1 Finance costs

	Period to June 22 £'000	2021-22 £'000
Interest		
Interest on loans and overdrafts	-	-
Interest on lease liabilities	1	-
Total interest	**1**	-
Other finance costs	-	-
Provisions: unwinding of discount	-	-
Total finance costs	**1**	-

8a Leases

8a.1 Right-of-use assets

Period to June 22	**Buildings excluding dwellings £'000**	**Total £'000**
Cost or valuation at 01 April 2022	-	-
IFRS 16 Transition Adjustment	331	331
Cost/Valuation at 30 June 2022	**331**	**331**
Depreciation 01 April 2022	-	-
Charged during the year	50	50
Depreciation at 30 June 2022	**50**	**50**
Net Book Value at 30 June 2022	**281**	**281**

8a Leases cont'd

8a.2 Lease liabilities

Period to June 22	Period to June 22 £'000	2021-22 £'000
Lease liabilities at 01 April 2022	-	-
IFRS 16 Transition Adjustment	329	-
Addition of Assets under Construction & Payments on Account	329	-
Repayment of lease liabilities (including interest)	1	-
Lease remeasurement	(96)	-
Other	2	-
Lease liabilities at 30 June 2022	**565**	-

8a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	Period to June 22 £'000	2021-22 £'000
Within one year	(190)	-
Between one and five years	(48)	-
After five years	-	-
Balance at 30 June 2022	**(238)**	-
Effect of discounting	1	-
Included in:		
Current lease liabilities	(189)	-
Non-current lease liabilities	(48)	-
Balance at 30 June 2022	**(236)**	-

8a Leases cont'd

8a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

Period to June 22	**Period to June 22** £'000	2021-22 £'000
Depreciation expense on right-of-use assets	50	-
Interest expense on lease liabilities	1	-

8a.5 Amounts recognised in Statement of Cash Flows

	Period to June 22 £'000	2021-22 £'000
Total cash outflow on leases under IFRS 16	(96)	-

9.1 Trade and other receivables

	Current Period to June 22 £'000	Current 2021-22 £'000
NHS receivables: Revenue	822	1,349
NHS accrued income	2,160	3,556
NHS Non Contract trade receivable (i.e pass through funding)	2	-
Non-NHS and Other WGA receivables: Revenue	2,526	3,808
Non-NHS and Other WGA prepayments	1,349	840
Non-NHS and Other WGA accrued income	5,457	131
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	4,791
VAT	162	102
Total Trade & other receivables	**12,478**	14,576
Total current and non current	**12,478**	14,576
Included above:		
Prepaid pensions contributions	-	-

9.2 Receivables past their due date but not impaired

	Period to June 22 DHSC Group Bodies £'000	2022-23 Non DHSC Group Bodies £'000	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	762	1,473	811	2,249
By three to six months	2	198	(44)	92
By more than six months	(29)	849	(30)	1,419
Total	**735**	**2,520**	737	3,760

In 2018-19 the CCG adopted the new standard IFRS 9 Financial Instruments. The CCG applied a provision matrix to the entities financial assets, NHS and Local Authority are excluded from the calculation as they are within the Whole of Government accounts. The calculation was minimal value, therefore there has been no impairment to financial assets in 2022-23 (2021-22 nil).

10 Cash and cash equivalents

	Period to June 22 £'000	2021-22 £'000
Balance at 01 April 2022	1,046	3
Net change in year	(511)	1,043
Balance at 30 June 2022	**535**	1,046
Made up of:		
Cash with the Government Banking Service	535	1,046
Cash with Commercial banks	-	-
Cash in hand	-	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**535**	1,046
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	-
Balance at 30 June 2022	**535**	1,046
Patients' money held by the clinical commissioning group, not included above	-	-

11. Trade and other payables	Current Period to June 22 £'000	Current 2021-22 £'000
NHS payables: Revenue	96	735
NHS accruals	53,848	38,701
Non-NHS and Other WGA payables: Revenue	10,862	10,817
Non-NHS and Other WGA accruals	44,553	50,101
Non-NHS and Other WGA deferred income	-	171
Non-NHS Contract Liabilities	-	3
Social security costs	141	126
Tax	111	108
Payments received on account	(4)	-
Other payables and accruals	3,391	1,262
Total Trade & Other Payables	**112,998**	102,025
Total current and non-current	**112,998**	102,025

There were no Non Current payables in 2022-23 (2021-22 – nil).
No liabilities due in future years are included above under arrangements to buy out liability for early retirement over 5 years.
Other payables include £824k outstanding pension contributions at 30 June 2022 (2021-22 £761k).

12. Contingencies

As explained in note 1.1, the Liverpool CCG ceased to exist on 30 June 2022. The NHS has provided an employment guarantee for staff and expressed its intent to retain Board level talent. Accordingly, no provision for restructuring is required or contingent liability can be quantified.

13. Clinical Negligence Costs

A CNST claim of £0 has been included in the accounts of Liverpool CCG for 2022-23. (2021-22: £985)

14.1 Other financial commitments

The Clinical Commissioning Group has not entered into any non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements).

15. Financial instruments

15.1 Financial risk management

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

Because 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.

15.1.1 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.

15.1.2 Interest rate risk

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

15.1.3 Credit risk

Because the majority of the 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.

15.1.4 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.

15.1.5 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.

16 Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost Period to June 22 £'000	Total Period to June 22 £'000	Financial Assets measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Trade and other receivables with NHSE bodies	2,979	2,979	1,732	1,732
Trade and other receivables with other DHSC group bodies	5,216	5,216	3,259	3,259
Trade and other receivables with external bodies	2,772	2,772	8,642	8,642
Other financial assets	-	-	-	-
Cash and cash equivalents	535	535	1,046	1,046
Total at 30 June 2022	**11,502**	**11,502**	14,680	14,680

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost Period to June 22 £'000	Total Period to June 22 £'000	Financial Liabilities measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Trade and other payables with NHSE bodies	1,527	1,527	1,313	1,313
Trade and other payables with other DHSC group bodies	53,438	53,438	38,243	38,243
Trade and other payables with external bodies	58,022	58,022	62,063	62,063
Total at 30 June 2022	**112,987**	**112,987**	101,619	101,619

17 Operating segments

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

18 Joint arrangements - interests in joint operations

The Clinical Commissioning Group has entered into the following joint arrangements with Liverpool City Council.
CCGs should disclose information in relation to joint arangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

18.1 Better Care Fund

With effect from 1st April 2015, the CCG has had arrangements in place (using powers under Section 75 of the National Health Service Act 2006) to operate a pooled budget for the required Better Care Fund arrangements.

The Better Care Fund functions as a joint arrangement, consequently the CCG has recognised expenditure in 2022-23 when an obligation has arisen. Liverpool City Council operates as host Commissioner for services and transactions have been accounted for accordingly as per the CCG's accounting policies.

The CCG contribution to the pooled budget in Quarter 1 2022-23 was £16,203k (year 2021-22: £58,556k) which was used to commission a range of health and social care services in line with the agreed objectives of the BCF. This contribution to the BCF is recognised within the financial statements as CCG expenditure.

18.2 Integrated Community Equipment and Disability Advice Services

A partnership agreement was entered into by the predecessor organisation, Liverpool Primary Care Trust (using powers under Section 75 of the National Health Service Act 2006), to 'pool' budgets from the two organisations for the creation of a single budget for the provision of Integrated Community Equipment and Disability Advice Services (ICEDAS). This Partnership came into effect on 1 January 2004.

The ICEDAS pool acts as a joint arrangement, consequently the CCG has recognised expenditure in 2022-23 when an obligation has arisen. Liverpool CCG (LCCG) acts as host commissioner in this agreement and procures this service from Mersey Care NHS Foundation Trust (previously Liverpool Community Health NHS Trust) with Liverpool City Council (LCC) contributing to the service through payments made to the CCG. An element of the ICEDAS pool is included within the Better Care Fund pool and has therefore been disclosed below:

18.3 Interests in joint operations

			Amounts recognised in Entities books ONLY Period to June 22				Amounts recognised in Entities books ONLY - Restated 2021-22			
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Assets**	**Liabilities**	**Income**	**Expenditure**	**Assets**	**Liabilities**	**Income**	**Expenditure**
			£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Better Care Fund	Liverpool City Council	Better Care Fund joint health and social care	-	-	(250)	16,203	-	-	-	58,556
ICEDAS (not included above)	Liverpool City Council	Community equipment pool	-	-	(281)	281	-	-	(1,077)	1,077
Total			**-**	**-**	**(531)**	**16,484**	-	-	(1,077)	59,633

19 Related party transactions

Details of related party transactions with individuals are as follows:

	Period to June 2022				2021-22			
	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Dr Fiona Lemmens - Governing Body Member - Chair/GP - Aintree Group Practice	591	-	43	(7)	5,593	-	608	-
Dr Monica Khuraijam - Governing Body Member - GP - Oakvale Medical Centre	483	-	77	(5)	4,342	-	460	-
Mark Bakewell- Governing Body Member - Chief Finance and Contracting Officer - Knowsley CCG (joint post with Liverpool CCG) & Jan Ledward - Governing Body Member - Chief Officer - Knowsley CCG (joint post with Liverpool CCG)	4	(274)	-	(298)	55	(300)	11	(63)

A related party disclosure is required if a person, or a close member of their family has control or joint control of an entity, has a significant influence over a entity or is a member of key management of the entity. For the CCG the above disclosures are included as they are Governing Body Members and are partners within the listed practices.

The Department of Health is regarded as a related party. In the financial year 2022-23 the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent, including:

- Alder Hey Children's NHS Foundation Trust
- Bridgewater Community Healthcare NHS Foundation Trust
- Cheshire And Wirral Partnership NHS Foundation Trust
- Community Health Partnership
- Countess Of Chester Hospital NHS Foundation Trust
- East Cheshire NHS Trust
- Liverpool Heart and Chest NHS Foundation Trust
- Liverpool University Hospitals NHS Foundation Trust
- Liverpool Women's Hospital NHS Foundation Trust
- Manchester University NHS Foundation Trust
- Mersey Care NHS Foundation Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- NHS Business Services Authority.
- NHS England
- NHS Midlands and Lancashire CSU
- NHS Property Services
- North West Ambulance Service NHS Trust
- North West Boroughs Healthcare NHS Foundation Trust
- Southport And Ormskirk Hospital NHS Trust
- St Helens and Knowsley Hospitals NHS Trust
- The Clatterbridge Cancer Centre NHS Foundation Trust
- Walton Centre NHS Foundation Trust
- Wirral Community NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust

20 Events after the end of 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	281
Current Assets	13,013
Current Liabilities	(113,187)
Non-Current Liabilities	(48)
Net Assets/Liabilities	**(99,941)**

There were no further events after the end of the reporting period that would have a material effect on the financial statements of NHS Liverpool 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.

21 Losses & Special Payments

The Clinical Commissioning Group did not incur any losses nor any special payments cases during 2022-23 (2021-22: nil).

22 Prior Period Adjustment

During the three months ended 30 June 2022, it became apparent that following a review of income classifications transferred to the Cheshire & Merseyside ICB, the Clincal Commissioning Group had been incorrectly accounting for income within the pooled budget rather than showing a "net position" and consequently income and expenditure reported in the year ended 31 March 2022 was overstated by £24,955k.
In these accounts, comparative figures relating to 31 March 2022 have been restated to correct this error. The amount of the correction for each financial statement line affected, and the amount of the correction at the beginning of the prior year is shown below:

Adjustments relating to 2021-22	**Reported at 31 March 2022 £'000**	Adjustment relating to 2021/2022 £'000	**Restated at 31 March 2022 £'000**
Statement of Total Comprehensive Net Expenditure			
Income - Income from sale of goods and services	31,031	(24,955)	6,076
Expenditure - Purchase of goods and services	1,906,414	(24,955)	1,881,459
Income Note 3			
Non-patient care services to other bodies	30,132	(24,955)	5,177
Expenditure Note 5			
Services from other CCGs and NHS England	3,512	(115)	3,397
Services from foundation trusts	269,668	(23,152)	246,516
Services from other NHS trusts	51,740	(118)	51,622
Purchase of healthcare from non-NHS bodies	38,010	(1,570)	36,440