NHS
Knowsley
Clinical Commissioning Group

ANNUAL REPORT
April to June 2022

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1. OVERVIEW

1.1 Statement from the Chief Executive

1.1.1 This final annual report covering April to June 2022 summarises the CCG's activities and performance, against a backdrop of the challenge to restore services, meet new care demands and reduce the care back logs that are a direct consequence of the COVID pandemic, whilst preparing for the closedown of the CCG and transition to the Integrated Care Board.

1.1.2 NHS Knowsley Clinical Commissioning Group's (CCG) work into the first quarter of 2022/23 has continued to be dominated by the effects of the COVID pandemic. In this, our final annual report, we provide detail of recovery activity, together with our other work on quality and safety as well as our performance during the quarter, and key risks to the achievement of objectives. It is a statutory requirement that we publish an annual report.

1.1.3 This overview report provides a short summary of our organisation, our purpose, our performance during the year, and key risks to the achievement of our future objectives. More detail on these matters is provided in the performance analysis.

1.1.4 Whilst the CCG is responsible for commissioning most acute hospital, mental health and community services, and general practices under delegated authority from NHS England, much of its usual activity has been paused since the start of the pandemic in order to support the national, regional and local pandemic response and recovery.

1.1.5 Demand for urgent care has been exacerbated by the various waves of COVID infections during the pandemic as well as a reduced capacity in the system due to staff isolation and infection and infection control measures across the health care system. The CCG, in collaboration with local authority and system partners, has commissioned a range of admission avoidance and community-based care initiatives to address this.

1.1.6 Elective care has been severely impacted by both the pandemic and urgent care pressures. The CCG is working collaboratively within the Cheshire & Merseyside Health and Care Partnership. This includes with hospitals and primary care on plans to meet Government aims to reduce waiting times and increase capacity to pre-pandemic levels plus 30%. This will include the development of diagnostic hubs to ensure diagnostic tests are available as required to further reduce delays.

1.1.7 Community, mental health and primary care services have continued to maintain critical and essential services shifting to a blended model including both face to face and remote access, in response to both COVID levels and patient needs.

1.1.8 Additional investment has been made in mental health services responding both to increased need arising from the pandemic and addressing, and in some cases accelerating, the requirements of the Long Term Plan for Mental Health.

This has included a dedicated 24/7 freephone crisis line for those experiencing a crisis and enhancement of the Mid Mersey Children's Eating Disorder Service.

1.1.9 Despite the continuing challenges in the first quarter of 2022/23 posed by the COVID pandemic, the local system has sought to prioritise A&E waiting time performance, ambulance quality indicators, referral to treatment times, and cancer waiting times performance.

1.1.10 NHS England holds the NHS locally to account through the NHS System Oversight Framework. We are pleased that the CCG received a positive assessment for 2021/22 acknowledging that the CCG had continued to work alongside system partners to rise to the challenges faced by it, partners and the people of Merseyside.

1.1.11 The CCG was successful in meeting both its statutory financial duties and the business rules set by NHS England for the first quarter of 2022/23, achieving a break-even position.

1.1.11 We aim to be open and transparent about the work that we do and how we use the public resource made available to us to plan, buy and monitor health care services. This is our full annual report which contains all of the statutorily required information for such reports.

1.1.12 During the first quarter of 2022/23 the CCG has worked with CCGs across Cheshire and Merseyside to prepare for the establishment of the Cheshire and Merseyside Integrated Care Board (ICB). In addition, it has worked with the Council and health partners in Knowsley to establish the Knowsley Healthier Together Partnership. This builds on the strong foundations of the Knowsley Better Together Strategic Partnership, whose strategic aims include for Knowsley by 2030 to be 'A place where people are active and healthy and have access to the support they need'.

1.1.13 We are proud of our achievements over the past 9 years but there is still much to do to improve health outcomes for all living in our Knowsley 'place'. We look forward to working with local and system partners in the new arrangements to deliver the best outcomes for Knowsley people for years to come.

Graham Urwin

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

1.2 The Purpose and Activities of the CCG

1.2.1 The CCG has now been in existence for 9 years. It is made up of the 25 GP practices in the borough working alongside health practitioners from pharmacy, community, mental health and secondary care services. It covers a geographical area from Kirkby in the North to Halewood in the South and also encompasses Huyton, Prescot, Whiston, Cronton and Knowsley Village, sharing the same boundaries as the Council. The CCG has a registered population of approximately 168,000.

1.2.2 The CCG is responsible for commissioning most acute hospital, mental health and community services and commissions general practice services under delegated authority from NHS England. However, as NHS national or regional command, control and coordination arrangements have been in place for the last 2 years in response to the COVID pandemic, much of the CCG's usual activity has been paused to support the national, regional and local response and recovery.

1.2.3 Integrated Care Systems (ICS) have been put on a statutory footing. CCGs were abolished, and their functions transferred to new statutory Integrated Care Boards (ICB) on 1 July 2022. Locally this means the creation of the Cheshire and Merseyside ICB. ICBs are able to arrange for functions to be exercised and decisions to be made, by or with place-based partnerships, and locally the Knowsley Healthier Together Partnership has been created.

1.2.4 In 2022/23 the NHS will continue to rise to the challenges of restoring services, meeting the new care demands and reducing the care backlogs that are a direct consequence of the pandemic. The 3-month deferment to the implementation of the new statutory arrangements provided extra flexibility for systems preparing for the new statutory arrangements and managing the immediate priorities in the pandemic response, while maintaining momentum towards more effective system working.

1.2.5 The CCG, as part of the Cheshire and Merseyside Health and Care Partnership (C&MHCP) system, has contributed to the development and delivery of system level plans to meet the national priorities. The CCG has worked with locally commissioned providers and partners to support the response to and recovery from successive pandemic waves, the vaccination programme, maintaining critical and priority services, and expanding capacity to meet increased demand.

1.2.6 During the first quarter of 2022/23 the CCG has continued to work with CCGs across Cheshire and Merseyside to prepare for the establishment of the ICB. In conjunction with the Council and health partners in Knowsley, the Knowsley Healthier Together Partnership has been established and a Place Director appointed for Knowsley. This builds on the strong foundations of the Knowsley Better Together Strategic Partnership, whose strategic aims include for Knowsley by 2030 to be 'A place where people are active and healthy and have access to the support they need'. This recognises the importance of the wider determinants of health and social care and how education, employment, the environment, public health, economic prosperity, housing, sport and leisure impact on the health and wellbeing of the local population.

1.2.7 The CCG was formed to deliver a new way of commissioning health services in the borough and is engaging with and listening to local people, using clinical knowledge and close working relationships with patients and partners in order to improve services. Patients are at the heart of all we do, and the CCG strives to involve them in decisions, especially those involving the design and commissioning of services, including procurement and awarding of contracts. Formal consultation and engagement and face to face engagement activities have paused during the pandemic. The CCG has worked with local partners and stakeholders, using digital and social media channels, to ensure key messages are communicated and local people involved in service changes.

1.3 Performance Summary

1.3.1 Much of the CCG's usual commissioning activity has been paused through the pandemic and instead operational planning and delivery has focussed on maintaining critical services and priority performance and supporting the response to and recovery from successive waves of the pandemic. Key performance achievements in this context during 2021/22 and continuing through the first quarter of 2022/23 were:

a) Commissioning a range of services to support patients and prevent unnecessary hospital admissions thus alleviating demands on hospital beds.

b) Commissioning additional capacity to support discharges from hospital.

c) Maintaining some key standards in relation to cancer waiting times and emergency ambulance response times despite pressures on services due to increased demand and reduced capacity.

d) Innovations and new service delivery models for community cardiovascular and respiratory services to maintain patient care through the pandemic.

e) Enhanced mental health services for children in response to specific demands arising from the pandemic e.g., doubling of funding for eating disorder services.

f) Adult mental health services were largely maintained, and critical services specifically fully maintained, throughout the pandemic.

g) Working with partners to support people with learning disabilities and people with severe mental illness to access COVID vaccinations and treatment.

h) All 25 GP practices in Knowsley were rated as 'Good' by the Care Quality Commission at June 2022.

i) A range of medicines management initiatives to ensure the quality, safety and cost effectiveness of prescribing have been completed.

j) The CCG has continued to support the health and wellbeing of its staff through a range of wellbeing measures and is embedding new ways of working adopted during the pandemic as part of a new hybrid working model.

The focus has been on working collectively with neighbouring CCGs in anticipation of the establishment of the Cheshire and Merseyside Integrated Care Board to achieve the required recruitment to senior roles and smooth transition of existing CCG staff.

k) The CCG met its key statutory financial duties during 2021/22 and the first quarter of 2022/23.

1.3.2 Inevitably the demands placed upon healthcare services locally to treat patients with COVID and roll out the vaccination programme have diverted resources, increased waiting times for other treatment, and resulted in reduced performance. This reflects the regional and national picture.

1.3.3 Our priority going forward through 2022/23, together with our partners locally and regionally, is to address the backlog of treatment and to start to recover performance in relation to referral to treatment times across the full range of health conditions and services. In addition, we will continue to commission services to address the increased demands e.g., for mental health services that have arisen as result of the pandemic.

1.3.4 **Financial performance:** The CCG must ensure that health services are delivered within its programme and running cost allowance as set by NHS England. The CCG was successful in meeting both its statutory financial duties and the business rules in the first quarter of 2022/23, achieving a break-even position. The CCG had a cumulative surplus of £4.4m at 31st March 2022, this will form part of the cumulative opening position for Cheshire & Merseyside ICB.

1.3.5 **Statutory duties:** The CCG is committed to fulfilling its statutory duties. Within this annual report there is a particular focus on demonstrating how the CCG meets the following duties:

a) Duty to improve the quality of services (Section 14R of Health and Social Care Act 2012 (HSCA).

b) Duty to reduce inequalities (Section 14T of HSCA 2012).

c) Public involvement and consultation by clinical commissioning groups (Section 14Z2 of HSCA).

d) Contribution to the delivery of the Joint Health and Wellbeing Strategy.

e) Sustainable development.

1.3.6 The CCG is confident that it meets its statutory duties in respect of the above, and this report provides details of the arrangements in place to facilitate delivery, which include roles and responsibilities, governance structures; strategies and plans; partnership and joint working arrangements; engagement and participation mechanisms.

1.4 Key Issues and Risks that could affect the Delivery of Future Objectives

1.4.1 The key issues and risks, nationally and locally, which may impact on future delivery and performance are described below, together with mitigating actions the CCG is taking to address these.

1.4.2 As a result of the COVID pandemic over the last 2 years, public health reshaped their focus to protect the most vulnerable, the NHS mobilised in different ways to support those directly affected by the virus, and social care, facing incredible pressures, was impacted significantly.

1.4.3 The impacts included the immediate health impact and disease burden of COVID and longer-term effects; urgent non-COVID conditions and patients with exacerbated chronic disease, arising from the disruption to health and care services; and burdens arising from the impact of the COVID control measures on the wider determinants of health.

1.4.4 COVID has highlighted the significance of inequalities in the health and wellbeing of our population. People in Knowsley have been disproportionately affected by the pandemic, and it is these unequal impacts, in deprived communities like Knowsley, that will last long into the future. COVID has not only exacerbated existing health inequalities, but its reach has also expanded. People living in poverty, those with disabilities or mental health issues, obesity, cancer or other underlying health conditions, need targeted support. We know that many people haven't accessed services or attended screening programmes which will inevitably lead to both under-diagnosis of potential conditions and an increased risk of poor outcomes due to late diagnosis.

1.4.5 Key risks identified within the CCG's Governing Body risk and assurance framework are summarised below:

a) **Providers fail to deliver quality standards resulting in patient harm.** Monitoring the quality of care provided to CCG patients has remained a priority throughout the pandemic. The CCG participates in provider quality meetings and collaborative commissioning forums across Cheshire and Merseyside. A range of quality concerns have arisen, and these are being addressed with providers, including through enhanced surveillance measures and consideration of alternative options for future provision;

b) **Potential patient harm due to excessive waiting times for diagnostics and treatment.** The COVID pandemic required the NHS to change how it worked and what was prioritised. This has resulted in a substantial increase in waiting times beyond the limits set by the NHS Constitution. Clinically urgent patients continue to be treated first to minimise harm. Recovery plans are in place to address the backlog and reduce waiting times.

c) **Surge in demand for healthcare arising from pandemic exceeds planned capacity resulting in financial and performance pressures.** This arises from both needs not met during the pandemic while health services were focussed on the COVID response and from increased needs e.g., mental health issues linked to the pandemic and to restrictions imposed on people's lives. Funding has been allocated to increase capacity

and the CCG continues to support collaborative system working to plan recovery and use resources effectively.

1.4.6 **Looking forward to the remainder of 2022/23 and beyond:** the focus will continue to be on restoring services and reducing the COVID backlogs. Building on progress made to date, this will mean increasing the number of people diagnosed, treated and cared for in a timely way. This will depend on doing things differently, accelerating partnership working through integrated care systems (ICSs) to make the most effective use of the resources available across health and social care, and ensuring a reduction in inequalities in access is embedded in the approach.

1.4.7 The CCG's functions, staff, property and liabilities transferred to the Cheshire and Merseyside ICB on 1 July 2022. We are proud of our achievements over the past 9 years but there is still much to do to improve health outcomes for all living in our Knowsley 'place'. We look forward to working with local and system partners in the new arrangements to deliver the best outcomes for Knowsley people for years to come.

2. PERFORMANCE ANALYSIS

2.1 How the CCG's Performance is Measured

2.1.1 NHS England has a legal duty to annually assess the performance of each CCG. Historically, this has been carried out under the auspices of the CCG Improvement and Assessment Framework and, more recently, the NHS Oversight Framework. CCGs were rated according to a set of criteria to arrive at a rating of Outstanding, Good, Requires Improvement or Inadequate. Knowsley CCG achieved a rating of 'Good' in all years in which this framework was in place.

2.1.2 As a result of the continued impact of COVID and the need for the NHS to set new and updated priorities across the different phases of the response, it was not possible to apply the established methodology to determine CCGs' ratings for 2021/22. Therefore, a simplified approach to the 2021/22 CCG annual performance review was taken, and CCGs received a narrative assessment identifying areas of good and/or outstanding performance, areas of improvement, as well as areas of particular challenge across: quality (including reducing health inequalities), leadership, and finance and use of resources.

2.2 NHS System Oversight Framework

2.2.1 2022/23 is a year of transition as ICBs are formally established and new collaborative arrangements are developed at system level. The oversight arrangements set out in the NHS System Oversight Framework for 2021/22 continued until the demise of the CCGs on 30 June 2022. This focusses on the priorities set out in the Operational Planning Guidance, including the NHS Mandate, the aims of the NHS Long Term Plan and the NHS People Plan. As part of this, a set of oversight metrics is used by NHS England and NHS Improvement and ICSs to flag potential issues and prompt further investigation of support needs with ICSs, place-based systems and/or individual trusts and commissioners.

2.2.2 The oversight framework is built around:

2.2.2.1 Five national themes that reflect the ambitions of the NHS Long Term Plan and apply across trusts, commissioners and ICSs: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability.

2.2.2.2 A single set of metrics across ICSs, trusts, clinical commissioning groups (CCGs) and primary care, aligned to the five national themes.

2.2.2.3 A sixth theme, local strategic priorities, recognises that ICSs each face a unique set of circumstances and challenges in addressing the priorities for the NHS. There is a renewed ambition to support greater collaboration between partners across health and care. This aims to accelerate progress in meeting the most critical health and care challenges and support broader social and economic development.

2.2.2.4 A description of how ICSs work alongside regional and national NHS England and NHS Improvement teams to provide effective, streamlined oversight for quality and performance across the NHS.

2.2.2.5 A three-step oversight cycle that frames how NHS England and NHS Improvement teams and ICSs work together to identify and deploy the right delivery support and intervention to drive improvement and address the most complex and challenging problems, respectively.

2.2.3 The CCG received its final assessment in 2021/22 which focused on the 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 review included reviewing evidence of delivery against performance targets, key lines of enquiry, discharge of statutory duties, along with engagement with the local Health & Wellbeing Board.

2.2.4 The CCG received a positive assessment acknowledging that the CCG had continued to work alongside system partners to rise to the challenges faced by it, partners and the people of Merseyside.

2.2.5 In particular, the assessment highlighted:

2.2.5.1 The continued contribution of the CCG Leadership Team and staff to supporting various elements of the wider system response, such as C&M Gold Command and Urgent and Emergency Care, as well as continuing to support and manage testing and vaccination programmes.

2.2.5.2 The continued strong contribution of Primary Care Networks (PCNs) to the COVID-19 response, with the resulting progress in terms of how PCNs continue to come together to meet local challenges and needs of the population they serve.

2.2.5.3 Positive examples of integrated working, including addressing existing inequalities and those exacerbated by the COVID-19 Pandemic. This included the Knowsley Better Together Partnership and contribution to the Health and Wellbeing Board.

2.2.5.4 Statutory duties to improve quality were met, and a comprehensive governance statement.

2.2.5.5 The CCG met its statutory financial duties and relevant business rules in delivering a small in-year surplus, not exceeding its Running Cost Allowance and delivering the Mental Health Investment Standard.

2.2.6 The assessment concluded that, as part of the transition phase to the ICS, the CCG was in a strong position to handover the legacy work and corporate memory which it has formed. This will place the ICS in a strong position, as it continues to strive to address inequalities and improve the health needs and outcomes of its local population.

2.3 Performance Monitoring Systems and Processes

2.3.1 The usual NHS planning cycle and performance management framework has been paused for the duration of the pandemic. Instead, a more agile approach has been adopted, responding to the prevailing situation, and more narrowly focussed on the priorities set through national and regional command, control and coordination.

2.3.2 The CCG has continued to adopt a programme management approach to the delivery of its plans and priorities. Regular progress reports against key milestones are provided to the CCG's Executive Management Team, Finance and Performance Committee, and Governing Body.

2.3.3 The CCG is responsible for monitoring and assuring itself of the quality and performance of the services it commissions. During the COVID-19 pandemic, the NHS has had to change how it works and what is prioritised. This has meant that information on several national standards and indicators used to monitor quality and performance of services has not been collected. The CCG has maintained a dialogue with providers, working collaboratively across the system as required, and has continued to monitor and report on quality and performance using the information available.

2.3.4 Performance is reported to the Governing Body and to relevant committees, in particular the Performance Committee, the Primary Care Committee and the Quality Committee. Regular performance updates are also provided to the Executive Management Team and other key CCG officers as necessary. During this first quarter of the year reporting on quality, performance and resources has continued to the sub-committees of the Joint Committee of Cheshire and Merseyside CCGs, with key issues and assurances reported back to the CCG Governing Body.

2.4 Delivering the NHS Priorities

2.4.1 **Operational Performance:** Usual performance management and reporting requirements have changed during the COVID-19 response, in line with NHS England and NHS Improvement guidance entitled 'Reducing the Burden' which required a specific focus in the following key areas:

a) A&E four hour waiting time performance.

b) Ambulance quality indicators.

c) Referral to treatment waiting times.

d) Cancer waiting times performance (2 week, 31 days, 62 days)

NHS Constitution standards							
		National Target		Apr-22	May-22	Jun-22	2022/23 YTD
RTT 18 weeks	Incomplete patients treated < max 18 weeks from referral	92%		60.9%	62.3%	59.7%	-
52 week waits	Number of patients waiting 52 weeks or more	0		1296	1452	1572	4320
Cancer waiting times	CWT 2wk - Patients referred by a GP with suspected cancer	93%		74.2%	78.3%	69.6%	74.0%
	CWT 2wk - Breast symptom patients (where cancer not initially suspected)	93%		45.7%	38.5%	60.9%	48.9%
	CWT 31-day - From diagnosis to first definitive treatment, all cancers	96%		98.8%	96.3%	98.9%	98.1%
	CWT 31-day - Subsequent treatments where that treatment is surgery	94%		100.0%	95.0%	94.4%	95.8%
	CWT 31-day - Subsequent treatments where treatment is an anti-cancer drug	98%		100.0%	100.0%	100.0%	100.0%
	CWT 31-day - Subsequent treatments where treatment is radiotherapy	94%		100.0%	100.0%	100.0%	100.0%
	CWT 62-day - For urgent GP referrals for cancer	85%		68.6%	64.9%	75.0%	69.4%
	CWT 62-day - For referrals from an NHS screening service	90%		83.3%	50.0%	75.0%	68.2%
	CWT 28-day FDS two week wait referral	75%		66.1%	68.3%	68.6%	67.7%
	CWT 28-day FDS two week wait breast symptoms referral	75%		79.5%	69.2%	81.0%	76.8%
	CWT 28-day FDS Screening referral	75%		33.3%	36.8%	43.3%	37.8%
	CWT 28-day FDS Total	75%		65.6%	67.0%	68.3%	67.0%
Ambulance Waiting Times	Category 1 - Life Threatening	mean	7 minutes	00:09:06	00:08:31	00:08:31	00:08:44
	Category 2 - Emergency	mean	18 minutes	01:07:06	00:44:32	00:50:45	00:53:59
	Category 1 - Life Threatening	90th centile	15 minutes	00:14:28	00:13:44	00:13:36	00:14:01
	Category 2 - Emergency	90th centile	40 minutes	02:28:27	01:34:18	01:47:07	01:54:42
	Category 3 - Urgent	90th centile	120 minutes	11:42:01	06:30:04	08:29:13	08:55:35
	Category 4 - Less Urgent	90th centile	180 minutes	N/A	15:54:54	N/A	17:20:18
A&E waiting times	Patients admitted, transferred or discharged within 4 hours of arrival at A&E - all types	95%		70.0%	68.9%	69.1%	69.3%

2.4.2 Despite the unprecedented challenges posed by the COVID-19 pandemic, the CCG has been working hard to ensure that it delivers against these revised national priority areas. For much of the year, some key standards in relation to some cancer waiting times and the most urgent emergency ambulance response times have been met despite pressures on services due to increased demand and reduced capacity, but other key indicators such as A&E waiting times and referral to treatment times and other cancer waiting times have not performed as well.

2.4.3 Performance against the four-hour Accident and Emergency Department target remains a challenge at both local and national levels. Performance for all A&E activity types was 69.3% in quarter one (at June 2022) against a target of 95% and was below the national average (72.5%). Long standing issues affecting performance against the four-hour target relate to increases in demand, patient flow, and discharges, but a change in activity levels due to COVID-19 has also influenced performance against the four-hour standard. As activity volumes have increased across all settings in recent months (evidence of increased activity in primary care, walk in centres, and A&E departments) this is not a shift in activity from one setting to another but likely genuine growth in all types of illnesses requiring contact with health services, which may have been

exacerbated by the pandemic due to delays in seeking or accessing care. COVID-19 has impacted different parts of the country to different extents, and there is a known link between poorer A&E four-hour performance and COVID-19 case rates and hospitalisations. With people living in the most deprived geographies tending to have greater health need as well, the impact is even more pronounced on health, and the restoration of activity therefore greater which describes the unprecedented levels of activity currently being seen. The CCG is a key partner in two 'systems': north Mersey and mid Mersey and has developed winter plans to maximise the use of other alternatives such as 111 First, and ambulance service protocols such as 'Hear and Treat' and 'See and Treat' to reduce pressure on A&E departments as well as admission avoidance schemes such as the two-hour Urgent Community Response service in Knowsley.

2.4.4 **Ambulance response times** were below target in quarter one for all measures except for Category 1 – Life Threatening. This mirrors national performance. The North West Ambulance Service (NWAS) have reported a mismatch between planned demand and resource levels, and the impact of COVID-19 as reasons for not reaching response time targets. The ambulance trust has continued to focus on maintaining an effective response to life threatening calls with increased funding and a number of operational actions to increase capacity and in turn improve response time performance including support from the military at times of greatest pressure.

2.4.5 **Referral to Treatment Time** performance remains challenging for Knowsley **CCG with only 59.7% of patients receiving treatment in 18 weeks or less from** GP referral in June 2022 against the 92% standard. A total of 12,481 from 120,915 patients waited 18 weeks or longer for treatment and 1,572 Knowsley CCG patients waited longer than 52 weeks for treatment at the end of quarter one. Knowsley performance has declined throughout the year, as has been the case nationally. All providers with Knowsley CCG patients identified as long waiters have provided assurance as how they plan to recover performance and restore activity. All have reported that they have systems and processes in place whereby they have clinically reviewed all long waiting patients and continue to treat patients in order of clinical priority, and then the longest waiting patients in turn.

2.4.6 Performance against cancer waiting time standards has been inevitably impacted upon by COVID-19. Levels of urgent suspected cancer referrals reduced significantly in March 2020 due to a significant reduction in patient contacts in both primary and secondary care. Patients avoided healthcare settings due to concerns about exposure to the virus, cancer screening programmes were postponed, and some diagnostic tests rescheduled. **Suspected cancer referrals have increased to a point where they are now significantly higher than pre-pandemic referral levels**. Against the two week waiting time standard, Knowsley performance was below the 93% target at 74% in quarter one. Performance against waiting time standards for breast symptomatic patients was also below the 93% standard at 48.9%. Performance against the 31-day waiting time standard has consistently met or exceeded the 96% target throughout the year reaching 98.1%, but despite this, performance against the 62-day treatment standard of 85% has not been met, with 69.4%

performance against the standard overall and 68.2% for referrals from a cancer screening service. Many of the breaches of waiting time standards have been due to inadequate outpatient capacity, though a significant number also relate to patient choice of appointment date. Below target screening performance is due to the national suspension of cancer screening services in the early months of the pandemic which took several months to restart safely in line with national guidance. The CCG is a key partner of the Cheshire and Merseyside Cancer Alliance who are providing system leadership and operational oversight for the restoration of cancer services. This is because some of the issues are the same across the region and similar solutions can be implemented across a number of providers. All providers have undertaken clinical reviews of patients on waiting lists to ensure their priority level is correct, virtual appointments are being offered to patients if appropriate, and a surgical 'hub' model is in operation whereby some providers have taken a lead on certain cancer specialties and provided services and support to other providers in an effort to reduce waiting times.

2.5 Urgent Care

2.5.1 The urgent care system has remained very challenging for Knowsley reflecting the position nationally. Demand has been exacerbated by the various waves of COVID-19 infections during the pandemic as well as a reduced capacity in the system due to staff isolation and infection and infection control measures across the health care system. The CCG, in collaboration with local authority and system partners, has focused on a range of admission avoidance and community-based care initiatives described below to address this.

2.5.2 Whilst COVID-19 pressures have eased for the urgent care system challenges remain due to continued high demand and patient acuity. While access to primary care continues to be cited as one of the reasons for pressure, evidence for this is anecdotal currently.

2.6 Admission Avoidance and Community Care

2.6.1 An increase in investment in the urgent care community response has been aimed at providing an urgent community response for patients within 2 hours of referral. However, this has been hampered by staff recruitment and the omicron variant wave in late 2021/early 2022 and this scheme is being rolled out fully in the first half of 2022 to include all over 18-year-olds in the borough. The service will provide community nursing and therapy support as well as social care if required. The service is now fully operational 12 hours a day, 7 days a week for Knowsley. We are working with primary care, North West Ambulance Service and emergency departments to utilise this service to support patients to remain at home if appropriate.

2.6.2 The respiratory response car service provided by Liverpool Heart and Chest Hospital and the North West Ambulance Service takes calls from 999 for appropriate patients with breathing difficulties and supports and manages patients at home if appropriate, it is planned that this service will be available to support for winter 22/23.

2.6.3 The falls/frailty car service will visit appropriate patients and provide support at home and refer to community services or refer for ambulance transport if a patient needs to go into hospital.

2.6.4 The respiratory in-reach service continues to review patients who attend Whiston Emergency Department. It supports with treatment to avoid patients being admitted to hospital unnecessarily and refers them to Knowsley's existing community respiratory service.

2.6.5 The Knowsley falls services continues to support patients who may be at risk of falls at home as well as the 'safe and steady' scheme to prevent future falls.

2.6.6 Patients are also being supported to avoid admission and can be monitored at home with the 'oximetry at home' service. This monitors patients at home and any deterioration in a patient's condition can be managed by community teams.

2.6.7 The CCG is planning a 'frailty in-reach' service to support patients in the emergency department in Whiston to avoid admissions and support the patient at home if appropriate.

2.7 Supporting discharge

2.7.1 The CCG, with local authority partners, continues to support patients to be discharged from hospital as soon as they are fit to do so. This prevents long hospital stays which can be harmful for patients, prevents more patients requiring long term care and improves hospital flow for patients who need a hospital bed.

2.7.2 There are daily reviews of patients with the relevant acute trust to support discharge and to proactively plan.

2.7.3 Additional resource has been identified and utilised for extra community beds, required to support patients and alleviate constraints in capacity caused by homes being closed as a result of COVID-19 infections.

2.7.4 There has also been additional capacity for domiciliary care identified as part of the ageing well resource which funds Urgent Care Response to provide additional care packages for discharge. This sector has been particularly challenged due to infection and isolation requirements for staff.

2.8 Elective Care

2.8.1 Elective care has been severely impacted by both the pandemic and urgent care pressures. The Government has recently published the plan to reduce long waits for elective care over the next few years. This will entail the CCG working closely with hospitals and primary care to reduce waiting times and increase capacity to pre-pandemic levels plus 30%. The CCG will also support the development of diagnostic hubs to ensure diagnostic tests are available as required to further reduce delays.

2.9 Cancer Care

2.9.1 Cancer care has also been affected by the pandemic and the focus is now on recovery and ensuring that people who need to access services, including primary care, are encouraged to do so and are able to access these services in a timely manner.

2.9.2 Diagnostic hubs will also support the cancer pathways, alongside new initiatives for screening tests for bowel cancer which are being rolled out. Rapid diagnostic services will be developed by hospitals to allow 'one stop shops' for patients with suspected cancer to ensure tests and specialist reviews can be undertaken in as short a period of time as possible. Knowsley has also started targeted lung health checks across the borough to screen patients who may be at higher risk of lung cancer. This aims to diagnose and treat patients at an early stage of the disease, increasing the chance of survival.

2.9.3 This year targeted lung health checks have been rolled out in Knowsley to screen appropriate patients for possible lung cancer. This aims to diagnose lung cancer early where it is more treatable, and chances of survival are increased.

2.9.4 The CCG is working closely with public health and primary care colleagues to increase screening programmes including breast and bowel following the pandemic.

2.10 Knowsley Community Cardiovascular (CVD) & Respiratory Services (KCRS)

2.10.1 Knowsley community services continue to deliver high quality care to the population. Throughout the pandemic, services have collaborated and worked in partnership with primary care, local district general hospitals, Northwest Ambulance Service (NWAS) and wider partners across Cheshire and Merseyside. This integrated approach to care and delivery has never been needed more with increased pressures in the NHS. The innovative Knowsley model captures the passion and drive from the teams, and their commitment to always go above and beyond.

2.11 Knowsley CVD Service

2.11.1 Community consultant led clinics have continued to be delivered across Knowsley with co-located cardiac diagnostics and heart failure nurse clinics.

2.11.2 New pathways and competencies have been reviewed ensuring patients have clear management plan across their journey of care from admission to discharge to recovery. The shared expertise, knowledge base and development of new pathways has ensured proactive care to deliver safer services.

2.11.3 On a positive note, the pandemic provided the opportunity for the pulmonary and cardiac teams to review service delivery, introducing new innovations providing high quality care to our patients. Our new models of delivery and risk assessments were shared with cardiac and pulmonary rehabilitation providers locally.

2.12 Knowsley Respiratory Service

2.12.1 The Respiratory Service has continued to flex and adapt to meet demands. Consultant clinics continue to offer face to face and remote reviews with spirometry being offered in clinic across the week. The Rapid Response Service continues to provide timely reviews and treatment, preventing hospital admission. This has been further enhanced by the introduction of the respiratory car in partnership with North West Ambulance Service (NWAS) achieving over 50% of patients reviewed being kept safely at home. “Swiss” nurses/In-reach nurse bases in St Helens and Knowsley Hospital Trust review patients in the emergency departments and support early discharge, reducing pressure on much needed hospital beds.

2.12.2 The service, in collaboration with Mersey Care and St Helens and Knowsley Hospital Trust, has also continued to provide the COVID virtual ward and NHS COVID Medicine Delivery Unit’s (CMDU) to offer neutralising monoclonal antibodies (nMABs) and antivirals for non-hospitalised patients at higher risk of admission. These services have continued to deliver impressive results into the first quarter of 2022/23.

2.13 Mental Health and Learning Disabilities

2.13.1 NHS Knowsley CCG, with our partners and key stakeholders have been collaborating to improve the range and delivery of services for emotional health and wellbeing for children and young people and adults in Knowsley.

2.13.2 Despite the disruption, both to service provision and to the progress of strategic developments, created by the COVID-19 pandemic, we have increased the range of services (including targeted and specialist provision) available to the population of Knowsley.

2.13.3 During the first wave services adapted quickly and efficiently, for example we introduced a dedicated 24/7 freephone crisis line for those experiencing a crisis scenario. This was implemented at the start of the pandemic and brought forward the ambition in the Long-Term Plan for Mental Health.

2.13.4 Compounding the challenges already faced within Knowsley, is the impact upon mental health of both COVID-19 virus and the anticipated impact of the cost of living crisis. In terms of COVID-19 Knowsley was disproportionately affected when compared to many other local authorities across the country. The pandemic has had a negative impact on the mental health of many. Existing mental health problems have been exacerbated, and new mental health problems have been created. The full impact of the mental health of the Knowsley population is still emerging. In reaction to and in anticipation of increased levels of need and acuity, the CCG’s made additional mental health investments, with Mental Health System Development Funding (SDF) and Spending Review (SR) funding allocations supporting services to recover to pre COVID-19 performance and to develop to achieve the ambitions outlined by the NHS Long Term Plan for Mental Health. This was invested throughout provision to support service.

2.14 Children and Young Persons

2.14.1 A recommendation from the NHSE/I Intensive Support Review undertaken in 2020 was that Knowsley should work collaboratively at a system-wide level to implement an iTHRIVE approach to CYP mental health provision in the borough. To facilitate this, the CCG commissioned the Tavistock Centre to provide 3 iTHRIVE multi-agency sessions in June 2021. The sessions encouraged the partnership to consider the current service landscape and the challenges that we may need to overcome to implement an iTHRIVE system approach in Knowsley. This provided a detailed analysis of the current position which will enable us to move forward with all stakeholders. We are now moving forward on the implementation of the graduated iTHRIVE approach to service delivery.

2.14.2 Children's health and wellbeing has been significantly impacted by the COVID-19 pandemic. Overall, referrals to children's mental health services have increased in number and complexity during the pandemic. Initial school closures / lockdowns meant that children's support networks diminished, and services had reduced access to children and young people through school and clinic settings to enable support and therapeutic interventions to take place.

2.14.3 In terms of specific service demand during the pandemic period, we saw an increase in referrals for more general anxieties related to COVID-19 (isolation, health, etc.) as well as for bereavement and loss. Also, referral patterns changed for example, referrals for the domestic abuse service were noticeably lower when full lockdown was in place and have been increasing steadily as lockdown restrictions eased.

2.14.4 Another service that had an increase in both demand and acuity was the Mid Mersey Children's Eating Disorder Service (CEDS). Children and young people with eating disorders are particularly vulnerable and investment in the service was recurrently doubled to meet this increase in demand. CEDS have sought to enhance the offer and have engaged in the Triangle project in conjunction with a team from Kings College, London, for patients with anorexia and eating disorders.

2.14.5 Further analysis of referrals into Knowsley CAMHS and CEDS has identified that children looked after and children with a diagnosis of autism have been particularly hit by the pandemic. While the national picture for children and young people with autism and eating disorder is that they are more likely to require an inpatient tier 4 referral, Knowsley has not had an increase in tier 4 admissions during the COVID-19 period.

2.14.6 Over the course of the pandemic face-to-face delivery has gradually increased as social distancing measures eased but some challenges were still evident in accessing children in schools due to the introduction of 'Bubbles'. All services have now returned to a blended offer of face-to-face delivery, while maintaining their online/remote delivery for those who prefer this method of interaction.

2.14.7 Alongside the recent increase in referrals, services across the range of provision continue to have a high number of children not being brought for appointments (DNAs) which impacts on overall waiting times for appointments.

Face to face appointments have been impacted more acutely. The CCG is working closely with providers to review DNAs and Knowsley Parent Carer Voice (KPCV) and SENCOs are providing support through reminders directly and via social media.

2.15 Adult Mental Health

2.15.1 Services for adults were largely maintained during the pandemic. For services that could be delivered online such as bereavement and loss services and IAPT, online therapy was introduced. Comparatively the recovery rates from online interventions have been slightly higher when compared to face to face. Where face to face was clinically necessary this was provided.

2.15.2 Most of the secondary care provision (services including Early Intervention in Psychosis, Assessment Services, Home Treatment Services, Recovery Services, In- Patient services and Crisis services) were classified as critical and remained in place throughout the pandemic. These services were at times impacted by both staff and (in the case of in-patient services) patients being COVID-19 positive. Wider workforce was drafted in to support these critical services.

2.15.3 This meant that for periods less critical services were reduced, for example the wellbeing practitioners were at times temporarily relocated. This service supported the wider mental health and wellbeing provision as evidenced through the roll out of COVID-19 vaccinations to the Severe Mentally Ill (SMI) population. However, this has had an impact with a reduction in the numbers of those with SMI completing annual physical health checks.

2.15.4 There continues to be a high level of pressure on in-patient provision for both adults and older person's provision. The impact of this has been increased risks for people being managed in community settings and increased resources required including 1:1 support. Despite this with our partners Knowsley has managed to keep the number of delayed transfers of care (DTOCs) from acute wards to a minimum demonstrating that there is an effective system in place to move patients on.

2.15.5 It is estimated that in Knowsley there are 1,610 people aged 65+ with dementia. During the COVID-19 period there has been a reduction in the dementia diagnosis rates and in performance against the national target for two thirds of this population to be diagnosed. Prior to the pandemic the dementia diagnosis rate was above target at 68.5% (March 2020). This reduced trend is mirrored locally and nationally.

2.15.6 Analysis of the Knowsley service provision indicates that referrals to the Later Life and Memory Service (LLAMS) have reduced during the COVID-19 period. This potentially reflects that people have had limited contact with their families and wider communities so opportunities for others to spot early signs of memory loss are not being identified as quickly and raised as an area of concern. Also, the virtual world has limitations when diagnosing dementia and during the pandemic there has been a reluctance from patients and families to attend face to face appointments.

2.16 Learning Disabilities

2.16.1 The Transforming Care Programme for people with learning disabilities and/or autism remained in place during the pandemic.

2.16.2 Under host commissioner guidance the CCG is designated host commissioner for Victoria Gardens, Elysium Healthcare. Victoria Gardens has patients nationwide and while individual patients remain the responsibility of the placing commissioner, the CCG has responsibility for oversight of the hospital.

2.16.3 The CCG with our partners supported the identification and roll out of the COVID-19 vaccination to those identified with a learning disability. A similar process was employed for those with SMI.

2.17 Primary Care

2.17.1 The CCG has continued to actively support general practices throughout Knowsley to ensure that services were delivered in line with relevant national standard operating procedures for primary care providers which have been in place during differing stages of the COVID pandemic.

2.18 Primary Care Networks

2.18.1 A key building block for the NHS Long Term Plan, Primary Care Networks bring general practices and other community partners together to work at scale, providing a wider range of services to patients and to more easily integrate with the wider health and care system. All of the CCG's general practices are members of one of the three Primary Care Networks in Knowsley.

2.18.2 Primary Care Networks, supported by CCG teams, continue to play a crucial role in coordinating and delivering the continuing rollout of the COVID vaccination programme in Knowsley.

2.18.3 PCNs have also delivered on plans to identify and prioritise patients who would benefit from a Structured Medication Review (SMR) and undertaking a volume of reviews as agreed with the CCG which maximises use of available pharmacist capacity.

2.18.4 Primary Care Networks have also taken advantage of the opportunity to recruit staff to support delivery of care to local populations under the 'Additional Roles Scheme' during 2021/22 and provided an update to the Primary Care Committee on progress of further recruitment to an extended range of roles for 2022/23.

2.19 Contract Reviews

2.19.1 Individual GP Practice contract reviews are structured to follow one of three processes, desktop review, contract review visit, multi-disciplinary team contract review.

2.19.2 During contract review visits practices are required to provide evidence of adherence to standards within the contract.

2.19.3 A post-visit report, highlighting areas of good practice, recommendations or actions required for areas needing improvement is then agreed with the practice, and reported to the Primary Care Committee.

2.20 GP Practice Quality

2.20.1 The Care Quality Commission (CQC) has continued to inspect general practice within Knowsley and during 2021/22 five practices were inspected with all receiving an overall inspection rating of 'Good'. All 25 GP practices in Knowsley continued to be rated as 'Good' at June 2022.

2.21 Medicines Management

2.21.1 Medicines management support into all of our care homes has continued into the first quarter of 2022/23. All care homes and aligned GP practices with proxy access to allow a more efficient method of care home staff ordering medication on behalf of their residents. Refining prescribing through introducing bulk prescribing is also being implemented where possible.

2.21.2 The CCG Medicines Management Team continued to progress areas of the Medicines Management Workplan in all CCG registered practices. 4 key workplan areas are described below.

2.21.3 **Review of medication/treatments included in the NHS consultation guidance**: Items which should not routinely be prescribed in primary care: Guidance for CCGs. This guidance is addressed to CCGs to support them to fulfil their duties around appropriate use of prescribing resources – supporting CCGs in their decision-making, to address unwarranted variation, and to provide clear national advice to make local prescribing practices more effective.

2.21.4 **Quality of Prescribing:** This area of the workplan includes a review of prescribing in line with our local Pan Mersey Area Prescribing Committee formulary and national guidance to ensure prescribing is in line with recommendations, an example of this would include a review of patients prescribed dual antiplatelet therapy, ensuring treatment course length had been adhered to.

2.21.5 **Prescribing productivity:** This area of the workplan includes a review of prescribing to ensure all prescribing is cost effective, examples include reviewing patients prescribed azithromycin capsules and changed to tablets.

2.21.6 **Safety:** This area of the workplan will include a review of prescribing in line with safety audits to ensure appropriate and safe prescribing, an example of this is supporting practices to review all female patients prescribed valproate.

2.21.7 The Knowsley CCG Control Drug Working Group provides prescribers with a forum to share best practice and discuss any issues around control drug prescribing in a safe and supportive environment and develop policies around safe prescribing of controlled drugs.

2.21.8 The CCG Medicines Management Team continue to review all patients prescribed control drugs with quantities over 30 days and bringing to the attention any prescribing that requires a review on a quarterly basis in line with NHS guidance.

2.21.9 Appropriate antimicrobial prescribing remains a high priority for the CCG. Monthly updates for antibiotic prescribing figures continue to be shared with practices. Practices who continue to be high prescribers of antibiotics have continued to be issued with prescriber level data to allow peer review at practice level.

2.22 Going Concern

2.22.1 The financial statements have been prepared on a going concern basis. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. Knowsley CCG ceased to exist on 1 July 2022 however, its services continue to be provided, using the same assets, by Cheshire and Merseyside ICB. The statement of financial position has therefore been drawn up at 30 June 2022 on a going concern basis.

2.23 Financial Performance

2.23.1 The CCG has a total in year budget of £88.8 million, which includes a running cost (management) allowance. For the 2022/23 financial year, CCG's were in operation for the first quarter and budgets and allocation were apportioned accordingly to deliver a break-even position.

2.23.2 Allocations to the CCG were spent as follows:

23	2022/23 Q1 £m
Programme Expenditure	
Acute Services	42.3
Mental Health Services	8.9
Community Health Services	8.8
Continuing Healthcare & Council Pooled Budgets	8.6
Prescribing & Primary Care	18.1
Other Programme Services	1.3
Total Programme Expenditure	**88.0**
Running Cost (Admin) Expenditure	0.8
Total Expenditure	**88.8**

2.24 Statutory duties

2.24.1 The CCG is committed to fulfilling its statutory duties in relation to improving the quality of services, reducing inequalities, public involvement and consultation, contribution to the delivery of the Joint Health and Wellbeing Strategy and sustainable development. The sections below demonstrate how the CCG has continued to meet those duties within the context of the emergency arrangements in place during the first quarter of 2022/23.

2.25 Duty to improve the quality of services (Section 14R of Health and Social Care Act 2012 (HSCA):

2.25.1 During the COVID pandemic, the NHS has had to change how it works and what is prioritised. This has required changes to some quality and patient safety functions and has meant that information on several national standards and indicators used to monitor quality of services has not been collected. However, monitoring the quality of care provided to CCG patients has remained a priority and responsibility of the CCG through 2022/23.

2.25.2 The CCG has remained in dialogue with providers and neighbouring CCGs regarding the quality of care provided to CCG patients throughout the pandemic. It has continued to monitor and report on the quality of commissioned services using the information available. Scrutiny and assurance have continued through the Quality Committee or Governing Body and participation in the local provider Clinical Quality & Performance Groups, Clinical Quality & Safety Groups and other quality and safeguarding forums. In addition, the CCG has continued to provide assurance to the Cheshire & Merseyside NHSE/I Quality Surveillance Group.

2.25.3 During the year the CCG identified, along with collaborative CCGs, services and providers where there were concerns with the quality of care provided. The CCG is actively addressing these concerns with providers, one of which is subject to an enhanced level of quality surveillance. Alternative options are being considered for the future provision of some services where it is considered that quality concerns will not be adequately addressed within a reasonable timescale.

2.26 Duty to reduce inequalities (Section 14T of HSCA 2012):

2.26.1 The COVID-19 pandemic has exposed health inequalities locally, nationally and globally. Data from the Office of National Statistics showed that the mortality rate from COVID-19 is higher in the most deprived areas of England, including Knowsley, compared to the least deprived areas.

2.26.2 The CCG has worked with the Knowsley Better Together Partnership on the place level response to the pandemic to minimise the impact on residents and exacerbation of existing inequalities. This has included collaboration on the early introduction of testing, supporting care homes and the vaccination programme, in addition to coordinating the health response locally within regional and national command and control arrangements. The Enhanced Health in Care Homes programme has continued in 2022/23 with significant

developments to enhance access to appropriate healthcare to care home residents, including care home alignment to a specific GP practice, weekly check-in meetings between each care home, GP practice and the Care Home Liaison Team from Mersey Care. Additional alignment with local and national Ageing Well programmes will continue to enhance the quality and access of care available to care home residents, as available to Knowsley residents residing in their own homes.

2.26.3 Through its COVID-19 Vaccination Sub-group, and working with Knowsley Council, local GPs and Healthwatch, the CCG analysed vaccination uptake data, identified inequalities, developed and implemented action plans to address these. These included running specific vaccination clinics for people with learning disabilities, reducing anxiety by using familiar settings or undertaking home visits, working with Knowsley partners to encourage vaccination uptake by asylum seekers, homeless people and rough sleepers, arranging transport, targeted communications campaigns, a vaccination bus being located in areas of low vaccination uptake, and outreach work. This will continue throughout 2022/23 to ensure high levels of uptake across the whole eligible population.

2.26.4 Moving beyond addressing the immediate impact of COVID-19, the continued restoration of both acute and community services, and recovery planning to prioritise urgent non-COVID-19 conditions which contribute to health inequalities in the borough is a priority. This includes the continued restoration of all cancer screening programmes and treatment, planned care for clinically urgent and longest waiting patients, support to long term conditions, reaching out to vulnerable patients, mental health, learning disability and autism services.

2.26.5 A formal response was received following a Knowsley Special Educational Needs and Disability (SEND) inspection. The SEND Inspection Report has been published with inspectors acknowledging many strengths within the local area, including leadership, joint commissioning work and Continuing Care transition to adulthood arrangements. The areas identified for improvement will form the basis of a Written Statement of Action that will be monitored by the Department for Education (DfE) and the CQC, and supported by regional DfE and NHSE/I colleagues.

2.27 Equality and Diversity:

2.27.1 The CCG has an Equality and Diversity Strategy, Equality and Diversity Policy and Equality Objectives Plan. These documents were produced to ensure the CCG meets the requirements of the Equality Act 2010.

2.27.2 Our equality objectives are:

1. To make fair and transparent commissioning decisions.

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

3. To improve the equality performance of our providers through collaboration and partnership working.

4. To empower and engage our workforce.

2.27.3 We want everyone in the local population to feel engaged with, listened to, and cared for, in a way that ensures inclusivity for all people, including those who reside in areas of deprivation or are deemed hard to reach due to their protected characteristics under the Equality Act. The CCG has in place a Lay Member for Patient and Public Involvement to help us to do this. This role includes ensuring that equality and diversity is championed throughout the organisation and is embedded into policy development. Additionally, their role is to ensure that the CCG enhances its methods and levels of public, patient and carer engagement and involvement, with all sections of the community.

2.27.4 We also have an Assistant Director – Corporate Services who is the designated lead officer for equality and diversity, with the Governing Body, CCG membership, and all staff also having key roles in promoting equality and in ensuring that statutory duties are met. Specialist support and advice is procured from a shared Equality and Inclusion Service for Merseyside hosted by NHS South Sefton CCG. The Governing Body has received twice yearly updates on progress against the Equality Objectives Plan and an Equality and Diversity Annual Report.

2.27.5 Good progress has been made to complete most of the actions on our Equality Objectives Plan, but as NHS Cheshire and Merseyside system, places and governance structures continue to evolve, it is relevant for the few residual actions to be completed by the ICB and Knowsley Place post 1 July 2022. These have been identified as part of the transition plan in preparation for that change taking place and include the cultural competency training planned for CCG staff and the development of a system-wide approach to positive action initiatives allowed under the Equality Act 2010. Our Equality and Inclusion Service will, of course, continue to facilitate the Cheshire and Merseyside Equality Focused Forum and patient focused task and finish groups and ensure that Knowsley is represented at the Cheshire and Merseyside Workforce Equality Focused Forum.

2.28 Public involvement and consultation by clinical commissioning groups (Section 14Z2 of HSCA):

2.28.1 The CCG's vision, values and strategy were developed in consultation with stakeholders, including, patients and the public. The CCG aims to continually engage with and involve patients and the public in its work. While the COVID pandemic has continued to impact on engagement with patients and public, the CCG has adapted, using digital channels including social media, online surveys, phone engagement, the website, email, text messaging, and video conferencing to maintain communication and engagement activity.

2.28.2 Members of the CCG Team have attended online forums to provide updates and engage regarding NHS services. In addition, they continued to engage with the Knowsley population on a number of services and service changes as described below.

2.28.3 **Improving Hospital Stroke Care**

2.28.4 During 2021/22, a 12-week public consultation was held about proposals for a Comprehensive Stroke Centre at Aintree University Hospital, which would bring together the hyper-acute care currently provided at Aintree, the Royal Liverpool, and Southport hospitals.

2.28.5 A number of mechanisms were used to reach the local population and gather feedback, including: a questionnaire (online and other formats) about the proposal; a phone line members of the public could use to share views and request materials; attendance at virtual Stroke Association events, and other groups and networks; direct letters to patients who had previously used stroke services at Liverpool University Hospitals or Southport and Ormskirk Hospital; and active promotion of the consultation across a range of different channels. 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.

2.28.6 A comprehensive report on the findings from the consultation exercise was presented at a meeting of the Joint Committee of the Cheshire and Merseyside CCGs in May held in public and published on CCG websites. A range of feedback was provided, and a number of issues raised. This will be used to identify any mitigations or actions to be included in the final business case. Feedback will also be used to look at any additional work that might need to take place to build on some of the themes that have come up.

2.28.7 **Promoting Access to Primary Care**

2.28.8 Local insight gathered in 2021/22 highlighted the need to engage with patients and communicate regarding primary care access. GP services are delivered through a blended approach which includes face to face, phone and e-consultations. The CCG developed a toolkit to promote information about how people could access these services and how appointment systems work. This work was further expanded over winter 2021/22, with extensive social media advertising, production of printed materials, targeted SMS messages, and direct letters to people who could not be reached via text.

2.28.9 This work has continued through the first quarter of 2022/23 and beyond, with primary care access recognised as a priority for the Knowsley place. Additional engagement work is planned including improvements to build in more effective continuous feedback on patient experience.

2.28.10 COVID-19 Vaccination Programme

2.28.11 Supporting the COVID vaccination programme and ensuring that people were able to access clear information about when and how they could receive the vaccine, was a key focus for the CCG's communications and engagement team during 2021/22 and has continued in the early part of 2022/23. This included developing and actioning a comprehensive range of engagement and communications support for a vaccination bus and a wider campaign around local drop-in vaccination opportunities, in partnership with Knowsley Borough Council and local voluntary sector organisations.

2.29 Contribution to the Delivery of the Joint Health and Wellbeing Strategy:

2.29.1 The CCG has a shared statutory duty with the Council to produce a Joint Strategic Needs Assessment (JSNA), identifying the health and wellbeing needs of the Knowsley population, both now and in the coming years. Overall, Knowsley's JSNA process involves the preparation of reports on nearly forty topics, and is an ongoing process, as new data and intelligence emerges all the time. JSNA summaries are available online at www.knowsleyknowledge.org.uk

2.29.2 During the first part of 2022/23 the CCG has worked on preparations for engagement with the Knowsley Health and Adult Social Care and Children's Scrutiny Committee. The themes to be covered during the coming year include:

- Adult mental health
- Children's mental health
- Update on GP services funding and access
- The proposal for an Eastern Sector Cancer Hub

2.29.3 During the early part of 2022/23 the CCG has continued to work with the Health and Wellbeing Board.

2.29.4 As with all its commissioning decisions, the CCG will continue to consider the impact on services to its patients whenever any specific proposals aligned to delivery of the new strategy are being developed.

2.30 Sustainable Development

2.30.1 Sustainability is about meeting the needs of today without compromising the needs of tomorrow. It is about using resources wisely to make sure that resources will still be available in the years to come. It's also about balancing social, economic, and environmental considerations. It is not just a question of using financial resources carefully but also ensuring that we do not have a negative impact upon the local environment.

2.30.2 Sustainability has been recognised at a national level as an integral part of delivering high quality healthcare efficiently. The urgent need for organisations to reduce carbon emissions and embed sustainability within their operations is particularly important in the NHS given its significant contribution to the country's overall emissions. As well as reinforcing the link between sustainability and public health, a clear focus on sustainable development will enable organisations, including the CCG, to capture a range of financial and non-financial benefits as well as the benefit of a reduced carbon footprint.

2.30.3 As a commissioning organisation, we will continue to support sustainable development in the local health economy by acting in 3 key areas:

a) **Commissioning for sustainability** – ensuring that our commissioning process supports environmental and social sustainability, as the indirect

environmental impact of the CCG through the services it commissions is far greater than its direct environmental impact as covered below.

b) **Being a sustainable organisation** – having policies and plans as a CCG that enhance environmental and social sustainability directly through our own corporate activities.

c) **Promoting sustainability amongst our GP members** – promoting and supporting action on sustainable development across our 25 Practices.

2.30.4 As a commissioning organisation, our procurement and contract mechanisms are important to the delivery or our ambitions for sustainable healthcare delivery and clear outcomes for services and the local system. The requirements placed on NHS commissioners and providers to operate in a sustainable manner is set nationally.

2.30.5 The CCG's own operations, accommodation and practices contribute towards carbon emissions. The COVID pandemic accelerated the roll out of digital equipment by the CCG to its staff and all Knowsley GP Practices, enabling them to operate from home. This approach has delivered significant carbon reduction benefits while also supporting the sustainability commitments of the NHS Long Term Plan.

2.30.6 Other sustainability improvements have continued to be made this year:

a) Online consultations continue to be provided by all of our GP Practices, reducing patient travel to avoiding unnecessary face to face appointments and support social distancing.

b) Use of telephone and video consultation is used wherever possible across all health services to avoid unnecessary travel and again support social distancing.

c) CCG staff work to a hybrid model mixing office-based and home working and are close to becoming a paperless organisation. When in the office, staff continue to make use of video calls, rather than off-site face-to-face meetings, to avoid travel as much as possible.

2.30.7 We will continue to endeavour to mainstream sustainable development into everything we do, through integration into our daily operations, as well as seeking to positively and actively influence our providers, suppliers, contractors and stakeholders, as we strive to meet the NHS net zero carbon targets. This will support our aim to achieve a sustainable future, recognising the importance of working with 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 NHS Trusts perform against the Public Services (Social Value) Act 2012 and sustainable development can be found within their annual reports.

2.30.8 The CCG is confident that it meets its statutory duties in respect of the above, and this report details the arrangements in place to facilitate delivery, which include roles and responsibilities, governance structures; strategies and plans;

partnership and joint working arrangements; engagement and participation mechanisms.

2.31 **Looking forward to the remainder of 2022/23 and beyond:** the focus will continue to be on restoring services and reducing the COVID backlogs. Building on progress made to date, this will mean increasing the number of people diagnosed, treated and cared for in a timely way. This will depend on doing things differently, accelerating partnership working through integrated care systems (ICSs) to make the most effective use of the resources available across health and social care, and ensuring a reduction in inequalities in access is embedded in the approach.

2.31.1 The CCG's functions, staff, property and liabilities transferred to the Cheshire and Merseyside ICB on 1 July 2022. We are proud of our achievements over the past 9 years but there is still much to do to improve health outcomes for all living in our Knowsley 'place'. We look forward to working with local and system partners in the new arrangements to deliver the best outcomes for Knowsley people for years to come.

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ACCOUNTABILITY REPORT

Corporate Governance Report

- Members' Report
- Statement of Accountable Officer's Responsibilities
- Governance Statement

Remuneration and Staff Report

3.0 CORPORATE GOVERNANCE REPORT

3.1 Members' Report

3.1.1 Chair and Chief Executive

3.1.2 Dr Andrew Pryce is the Chair of the CCG and has been in post for the duration of the first quarter of 2022/23. Jan Ledward was the Interim Chief Officer of the CCG until 30th June 2022, taking over from Dianne Johnson who was seconded to the Cheshire and Merseyside Health and Care Partnership, on 1 October 2021.

3.1.3 The Clinical Membership Group

3.1.4 The Clinical Membership Group (CMG) is responsible for making key decisions regarding the CCG's Constitution, strategy, budget and partnership arrangements. The group is made up of representatives from each of the 25 Member Practices, who ensure that information is communicated and discussed within the practices, and their views are reflected in decision-making processes. Appendix 1 details the composition of the Clinical Membership Group throughout the year.

3.1.5 The Governing Body

3.1.6 The Governing Body is responsible for approving policies, systems and arrangements for delivering the CCG's statutory duties safely, effectively, efficiently and economically.

3.1.7 The membership of the Governing Body comprises clinical representatives from the CCG's General Practices, senior officers from within the organisation, nursing and secondary care representatives, and lay members. Appendix 2 details the composition of the Governing Body throughout the year, and the 'About us' page on the CCG's website provides information about members and the role they play in planning and buying healthcare services in Knowsley: http://www.knowsleyccg.nhs.uk/governing-body1/. The Governing Body is supported in its role by a number of committees and a sub-committee, as illustrated in the governance structure shown overleaf.

3.1.8 The Audit Committee provides the Governing Body with an independent and objective view of the CCG's governance and financial systems. Appendix 3 highlights the members of the Audit Committee throughout the year and up to the signing of the Annual Report and Accounts.

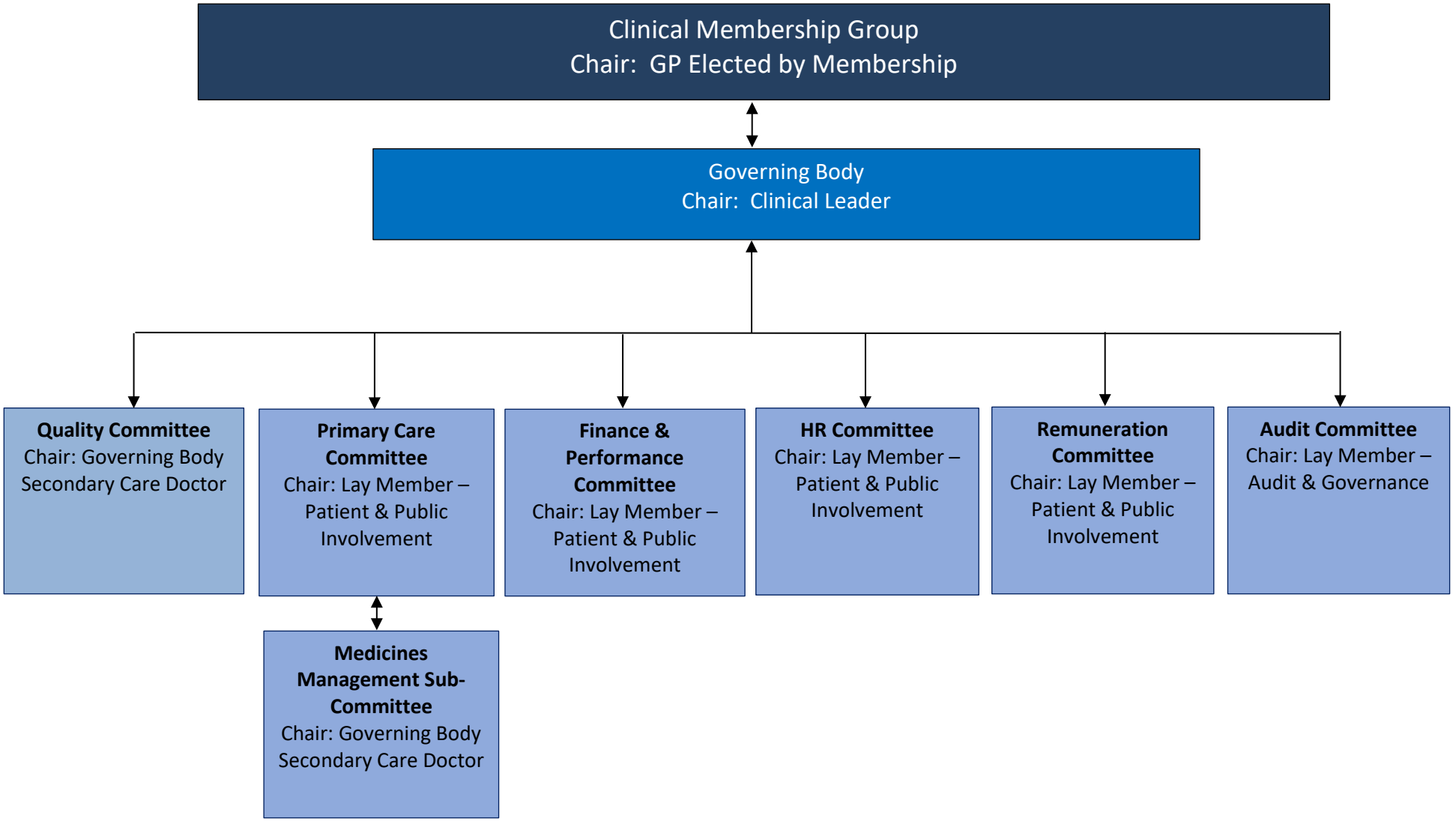
3.1.9 The Remuneration Report on pages 62 and appendix 2 provide further details of the role and membership of the Remuneration Committee.

3.1.10 The Governance Statement on pages 37-58 and appendix 2 provide further details of the role and membership of all of the Governing Body Committees.

3.1.11 Governance Structure

3.1.12 The CCG's Governance structure is shown in the diagram overleaf:

GOVERNANCE STRUCTURE



3.1.13 **Register of Interests**

3.1.14 A copy of the CCG's 'Register of Interests of Decision Makers' can be found at http://www.knowsleyccg.nhs.uk/register-of-interest1/

3.1.15 **Personal Data Related Incidents**

3.1.16 The CCG's arrangements for information governance are described in the Governance Statement on pages 37-58.

3.1.17 There were no incidents involving data loss or confidentiality breaches during the year.

3.1.18 **Modern Slavery Act**

3.1.19 Knowsley CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but is outside the scope of the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

3.1.20 The CCG's safeguarding policy sets out the CCG's arrangements to meet its statutory duties in relation to the eradication of modern slavery and human trafficking, including in delivering its own functions and in the services that it commissions from other organisations.

3.2 Statement of Accountable Officer's Responsibilities

3.2.1 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 Knowsley Clinical Commissioning Group.

3.2.2 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).

3.2.3 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.

3.2.4 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.

3.2.5 As the Accountable Officer, I confirm that there was adequate and sufficient handover from the previous Accounting Officer to provide me with the assurances required to make these statements. I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Graham Urwin

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

3.3 Governance Statement

3.3.1 Introduction and Context

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

3.3.3 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.

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

3.3.5 Scope of Responsibility

3.3.6 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.

3.3.7 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.

3.3.8 Governance Arrangements and Effectiveness

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

3.3.10 The constitution commits the CCG to observe principles of good governance in the way it conducts its business, including the Nolan principles, NHS Constitution, Equality Act 2010, and probity in stewardship of public funds, business conduct and the management of the organisation.

3.3.11 The constitution commits the CCG to demonstrating its accountability to its members, local people, stakeholders, and NHS England by publishing information; appointing lay members, and including GPs, other clinicians and patient representatives on decision-making forums; involving patients, clinicians and community groups in

commissioning; responding to complaints and requests for information; and encouraging and acting on feedback.

3.3.12 The Group's constitution sets out the governance structure, including responsibility and authority for exercising the CCG's statutory functions. The scheme of reservation and delegation sets out those decisions which are reserved to the membership as a whole and those which are delegated to the Governing Body, its committees and sub-committee, and to individual officers.

3.3.13 The CCG's governance structure comprises the Clinical Membership Group (CMG), the Governing Body and its committees, which are the Audit Committee, the Human Resources Committee, the Remuneration Committee, the Finance and Performance Committee, the Primary Care Committee, the Quality Committee, and the Medicines Management Sub-Committee which is accountable to the Primary Care Committee. The Governance Structure Chart is in the Members Report.

3.3.14 NHS national or regional command, control and coordination arrangements have been in place for the duration of 2021/22 in response to the COVID pandemic. The CCG enacted its emergency preparedness, resilience and response, and business continuity plans during the final quarter of 2019/20, and these have remained in operation throughout 2020/21, 2021/22 and the first quarter of 2022/23. As a result, the CCG's governance arrangements have been streamlined and focussed on pandemic response and recovery and business critical activity.

3.3.15 The **Clinical Membership Group** comprises representatives from each of the 25 Member Practices, listed at appendix 1. It has reserved to itself the power to approve: changes to the constitution for submission to NHS England; the scheme of reservation and delegation; who can execute a document; the arrangements for identifying practice representatives, appointing to the Governing Body and post of Accountable Officer; the vision, values, strategy, commissioning plan, annual budget and variations of more than 1%; arrangements for risk sharing or pooling and pooled budgets; and arrangements for coordinating the commissioning of services with other CCGs/Local Authorities.

3.3.16 The CMG's work during 2022/23 focussed on Government proposals for the abolition of CCGs and transfer of their functions to Integrated Care Boards (ICBs) which were established from 1 July 2022.

3.3.17 The **Governing Body** membership includes 4 clinical representatives from within the CCG membership to bring the unique understanding of the Member Practices. Lay members and clinical advisors who are independent of the CCG have been appointed to the Governing Body to bring specific, including multi-professional healthcare, expertise and experience, as well as their knowledge as a member of the local community, to the work of the CCG. Their focus is strategic and impartial, providing an independent view of the work of the CCG. Knowsley Metropolitan Borough Council and Healthwatch Knowsley representatives attend Governing Body meetings. The full membership of the Governing Body is listed in appendix 2.

3.3.18 The Governing Body is responsible for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and

economically and in accordance with the CCG's principles of good governance (its main function); determining remuneration, fees and other allowances; and approving any functions of the CCG that are specified in regulations.

3.3.19 In addition, the Clinical Membership Group has delegated to the Governing Body power to approve: the operational scheme of delegation; the annual report and accounts; arrangements for making individual exceptional funding requests; arrangements, including supporting policies, to minimise clinical risks and improve quality; proposals for action on litigation against or on behalf of the CCG; arrangements for business continuity and emergency planning, arrangements for information governance; contracts for any commissioning support; contracts for corporate support; arrangements for discharging commissioning statutory duties, financial statutory duties, and statutory duties as an employer; arrangements for handling freedom of information requests; risk management arrangements; system of internal control, including budgetary control; and arrangements for handling complaints.

3.3.20 The Governing Body has continued to meet virtually through the final quarter of the CCG. During this period, it has focussed on oversight of the CCG's pandemic response and recovery, the governance of the CCG and closedown and transition to the new statutory arrangements. The Governing Body has oversight of the work of its' committees through receipt of minutes and key issues reports.

3.3.24 The **Audit Committee** provides the Governing Body with an independent and objective view of the CCG's financial systems and financial information; together with compliance with laws, regulations and directions governing the group in so far as they relate to finance. In addition, the Governing Body has delegated authority to the Audit Committee to approve the detailed financial policies, and anti-fraud and security management arrangements.

3.3.25 The Audit Committee is chaired by the Lay Member for Audit and Governance and comprises lay and clinical members with current and past governance, risk, engagement, clinical, and senior NHS managerial experience.

3.3.26 The final meeting of the Audit Committee reviewed the Head of Internal Audit Opinion; External Auditor's Annual Audit Letter and the draft Annual Report and Accounts for 2020/21. It maintained its scrutiny of the assurance framework and the arrangements for information governance.

3.3.27 The Human Resources Committee makes recommendations on Human Resources policies for approval to the Governing Body. It is also responsible for preparing disciplinary arrangements for employees, the Accountable Officer and where the Accountable Officer or Chief Finance Officer is an employee or member of another CCG.

3.3.28 There was no requirement for the **Human Resources Committee** to meet during the first quarter of 2022/23.

3.3.30 The **Remuneration Committee** makes recommendations on the remuneration, fees and other allowances for Governing Body members and employees.

3.3.31 There was no requirement for the **Remuneration Committee** to meet during the first quarter of 2022/23.

3.3.32 The **Finance and Performance Committee** monitors the CCG's overall financial position, delivery of the QIPP programme, the performance of commissioned services, and CCG key performance indicators. It advises the Governing Body on all financial and performance matters, oversees the delivery of plans by CCG senior officers, and provides assurance to the Audit Committee in respect of the discharge of statutory functions in line with the prime financial policies.

3.3.33 During the first quarter of 2022/23 the **Finance and Performance Committee** met to review performance, operational planning, and risks. Additional assurances were provided by the Finance Sub-Committee and Performance Sub-Committee of the C&M Joint Committee.

3.3.34 The **Quality Committee** oversees the quality and safety of all commissioned services and provides assurance to the Governing Body. There are a number of groups reporting to it, including the Healthcare Acquired Infections Sub Group and the Serious Incident Review Sub Group, and key issues are reported from attendance at the NHS England Cheshire and Merseyside Quality Surveillance Group. The committee also receives reports from quality assurance visits to a variety of commissioned services.

3.3.35 The Quality Committee has established monitoring and quality assurance arrangements through quality performance reports covering the range of services commissioned by the CCG, the work of the Serious Incident and Healthcare Acquired Infection Sub-Groups, Clinical Quality and Performance Groups, Safeguarding Boards, and the NHSE Quality Surveillance Group. During the first quarter of 2022/23 it also received Public Health Local COVID Updates, a report on community services waiting times and contributed to the development of the future Knowsley Place Quality Group. Additional assurances were provided by the Quality Sub-Committee of the C&M Joint Committee.

3.3.36 The **Primary Care Committee** functions as a corporate decision-making body for the management of delegated functions and the exercise of the delegated powers under Section 13Z of the National Health Service Act 2006 (as amended). The committee carries out the functions relating to the commissioning of primary medical services under Section 83 of the NHS Act.

3.3.37 During the first quarter of 2022/23 the Primary Care Committee considered proposed changes to Primary Care Network (PCN) configurations and received updates on additional roles recruitment, local funding changes and Datix implementation. In addition, the committee continued its oversight of primary care through routine reporting on contract management, quality and performance, budgets, and risks.

3.3.38 The **Medicines Management Sub-Committee** develops and reviews recommendations, including policy statements on new drugs, local formulary and

guidelines, shared care agreements, local action on safe use of medicines and NICE guidance, ensures safe effective and economic use of medicines, improves consistency of patient experience and provides assurance to the Governing Body that safe, effective and good governance procedures are adopted relating to all aspects of medicines and prescribing.

3.3.39 The Medicines Management Sub-Committee met during the first quarter of 2022/23 to review and approve prescribing and medicines policies recommended by the Pan Mersey Area Prescribing Committee. It also reviewed delivery of the Medicines Management work plan, anti-microbial resistance strategy and action plan, controlled drugs monitoring, incidents and risks reports.

3.3.40 The CCG reviews effectiveness and forward plans annually across the governance structure to ensure that statutory functions, Constitution requirements and terms of reference are fully covered. The focus for the first quarter of 2022/23 was on the transition to the new statutory arrangement across C&M and at place, while ensuring that the Governing Body continues to receive the assurance it requires in relation to delivery of the CCG's duties and functions.

3.3.41 Details of attendance at meetings of the CMG, the Governing Body and its committees and sub-committees are provided in appendix 3.

3.3.42 **UK Corporate Governance Code**

3.3.43 NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG.

3.3.44 The table below illustrates how we have reported on our corporate governance arrangements and demonstrates how this reflects relevant aspects of the UK Corporate Governance Code.

Components	Reporting of CCG Arrangements
Leadership – covering the role of the board, division of responsibilities, and the Chair, and non-executive directors.	The role, operation and effectiveness of CMG and the Governing Body are reported in paragraphs 3.1.3 – 3.1.4 and 3.1.6 – 3.1.10. Membership during 2022/23 is listed in appendices 1 and 2. The provisions of the constitution in respect of the exercise of CCG functions and decision-making, and the role of lay members, are reported in paragraph 3.3.4.
Effectiveness – covering the composition of the board, appointments to the board, commitment, development, information and support, evaluation, and re-election.	The composition of CMG and the Governing Body are reported in appendices 1 and 2. The role of independent members of the Governing Body is reported in paragraph 3.3.4. The appointment process, eligibility, term of office, grounds for removal and notice period for roles on CMG and the Governing Body are set

	out in the CCG's constitution and comply with the requirements of the Health and Social Care Act 2012. Development activity undertaken by the Governing Body is described in paragraph 3.3.8 Membership Group and Governing Body effectiveness is reported in 3.3.8.
Accountability – covering financial and business reporting, risk management and internal control, audit committee and auditors.	The CCG's annual report and accounts has been prepared in accordance with all relevant requirements and guidance and subject to independent external audit. The audit opinion is reported in paragraph 3.3.127. The CCG's risk management and internal control arrangements are reported in paragraphs 3.3.48 3.3.80. The composition and role of the Audit Committee are reported in paragraph 3.3.24 – 3.3.27, and appendix 2.
Remuneration – covering the level and components of remuneration and procedure.	The role of the Remuneration Committee, the CCG's remuneration policies and the remuneration of Governing Body members and senior managers are reported in paragraph 3.3.28 – 3.3.31.
Relations with shareholders – covering dialogue with shareholders, constructive use of general meetings.	The CCG does not have shareholders but, instead, has a duty to ensure public involvement and consultation, and its arrangement for discharging this are reported in paragraph 1.3.5 – 2.29 of the Performance Report.

3.3.45 **Discharge of Statutory Functions**

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

3.3.47 Responsibility for each duty and power has been clearly allocated to a lead Director. Directors have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

3.3.48 **Risk Management Arrangements and Effectiveness**

3.3.49 The CCG's Risk Management Strategy sets out statement of intent, strategic objectives for risk management, risk appetite, the accountability and organisational structure for risk management, systems and processes for managing risk, training and development, communication and monitoring effectiveness.

3.3.50 Risk management is an integral part of the CCG's wider business resilience arrangements, which also include business continuity and emergency planning. Collectively, the CCG's Risk Management Strategy, Emergency Preparedness, Resilience and Response Policy, and Business Continuity Policy and Strategy aim to ensure that the CCG is able to consistently deliver its objectives and planned levels of service to the local population.

3.3.51 Strategic and operational risks are identified from external sources, including external assessments and inspections, patient and provider feedback; and internal sources, including members, staff, governance committees, planning, project management, incidents and audits.

3.3.52 Risk assessments are completed, and mitigating actions identified as required, which are recorded, registered and scrutinised. Risk assessments and risk registers are regularly reviewed and updated and reported to CCG committees and Governing Body. The risk management strategy defines criteria, reflecting the organisation's risk appetite for evaluating, treating and escalating risk.

3.3.53 Key control mechanisms are in place providing a holistic system for prevention, deterrence and management of risks including:

a) Governance structures, with clearly defined terms of reference, roles and explicit responsibilities for scrutiny and assurance

b) An accountability and reporting framework, with clearly defined roles and responsibilities

c) Clear strategies and plans with associated monitoring and review mechanisms

c) Policies, procedures and guidance, supported by communication, training and development

d) Robust contracts and service level agreements and effective contract management processes

e) Robust and effective performance, financial, risk, and project management

g) An internal control framework, including independent, external assurance.

3.3.54 The Governing Body has assessed risk appetite and approved the risk appetite including a generic statement and specific detailed statement in relation to each of the CCG's strategic goals, which are set out below.

3.3.55 The CCG must take risks in order to achieve its aims and deliver beneficial outcomes to patients, the public and other stakeholders. Risks will be taken in a considered and controlled manner. Exposure to risks will be kept to a level deemed acceptable by the Governing Body. The acceptable level may vary from time to time.

3.3.56 The CCG's current overall risk appetite is defined as OPEN. This means the organisation is willing to consider all delivery options and may accept higher levels of risk in order to achieve improved outcomes and benefits for patients.

3.3.57 Some particular risks above the agreed acceptable level may be accepted because of the reward/benefit that might arise, the cost of controlling them or the period of exposure.

3.3.58 No risks will be acceptable (and therefore must always be controlled) if they have the potential to cause harm to patients or employees, compromise severely the organisation's reputation, have financial consequences that could endanger the organisation's viability, jeopardise substantially the organisation's ability to deliver its core purpose or threaten the organisation's compliance with law and regulation.

Detailed Statement			
Strategic Goal	**Risk Appetite**	**Statement**	**Target Score**
1. Commission high quality services to meet the needs of the patients and the requirements of the NHS Constitution	**MODERATE**	The CCG is willing to accept modest levels of risk, in order to achieve acceptable outcomes	≤ 9
2. Work effectively with partners to improve health outcomes for all local people	**OPEN**	The CCG is prepared to consider all partnership options and select those with the highest probability of improved health outcomes even with associated increased risks	≤ 12
3. Ensure effective and efficient governance of the CCG meeting financial and statutory duties	**MODERATE**	The CCG is willing to accept modest levels of risk, in order to achieve acceptable outcomes	≤ 9

3.3.59 These statements provide a framework against which the CCG can consider strategic options, inform future control efforts and take an appropriate level of risk in the achievement of its objectives. These risk appetite statements are reviewed regularly to ensure their continued accuracy and relevance to the organisational challenges and strategic goals.

3.3.60 Risk management is embedded into the governance and decision-making of the CCG, planning and performance management, and is a key element of the commissioning and project management processes. A risk assessment is included in all decision-making reports, and risks to the CCG are highlighted in briefing and performance reports. All commissioning and other projects are required to complete risk assessments and registers. The committees of the Governing Body have a key role in seeking and providing assurance to the Governing Body in relation to the effective operation of control to manage risks to the CCG's goals. During the first quarter of 2022/23, additional assurances in relation to quality, performance and

finance have been provided through the work of the sub-committees of the C&M Joint Committee.

3.3.61 Throughout 2021/22 and the first quarter of 2022/23 the NHS nationally, regionally and locally has been focused on responding to and recovering from the COVID pandemic. There has also been a significant emphasis on system level working in transition to the future organisational structures. This has impacted on the CCG's role and risk profile, and the risk and assurance framework has adapted through the period to reflect the prevailing situation, to ensure that risks continue to be managed effectively during this period.

3.3.62 Assurance continues to be provided through evidence and information from a range of sources. These include performance information, contract reviews, quality visits, patient feedback, audits, incidents and complaints. The inclusion of Lay Members and Clinical Advisors in the membership of committees and the attendance of Healthwatch Knowsley, Public Health, Health and Wellbeing Board representatives, and CCG executives and managers, specialist roles and support functions provides a wide perspective and range of knowledge and expertise. As a result of activities paused at the direction of NHSE/I to release capacity to respond to the pandemic, such as performance and contract management, some assurance sources were no longer available. Alternatives were identified where possible, and controls and risk ratings adjusted where necessary to reflect this.

3.3.63 Formal patient and public consultation and engagement requirements, and face to face engagement activity, have been paused during the COVID pandemic. However, the CCG has continued to use virtual forms of engagement and the input of Lay Members and Healthwatch Knowsley in governance structures as a source of both risk identification and risk mitigation.

3.3.64 Equality impact assessments have continued to be undertaken in relation to changes to service delivery models during the pandemic. They constitute a form of risk identification and management to mitigate the risk of failing in our equality duties.

3.3.65 The Quality Surveillance Group for Cheshire and Merseyside, chaired by NHS England, maintains a strategic oversight of quality risks and issues across the local provider landscape. This supports the identification and management of risks, and a collective approach and shared learning, and the CCG has been an active member of this group throughout the year.

3.3.66 Through these processes, risks to the quality, effectiveness, and delivery of commissioned services, in a way which meets the needs of all parts of the community, are identified, evaluated and mitigated throughout the design and management of commissioned services.

3.3.67 In addition to proactively managing risk, incidents and issues are used as a learning tool to develop and improve the control framework. The CCG co-operates with other CCGs to review serious incidents reported by providers. The Knowsley Serious Incident (SI) Review Group provides thorough and timely review of all serious incidents.

3.3.69 The effectiveness of the SI Review Group has been monitored through the development of a range of key performance indicators to measure provider serious incident performance and also the SI Review Group's performance. The work of the SI Review Group is reported to the CCG's Quality Committee and through to the Governing Body.

3.3.70 **Capacity to Handle Risk**

3.3.71 As Accountable Officer I have overall accountability for the management of risk, and discharge this duty by:

a) Continually promoting risk management and demonstrating leadership, involvement and support.

b) Ensuring an appropriate committee structure is in place, with regular reports to the Governing Body.

c) Ensuring that senior officers of the CCG are appointed with managerial responsibility for risk management.

d) Ensuring the development of appropriate policies, procedures and guidelines for the CCG in relation to risk management.

e) Identifying risks to the achievement of the CCG's strategic goals.

f) Monitoring these via the CCG risk and assurance framework.

3.3.71 As the CCG's Accountable Emergency Officer (AEO), I have statutory responsibility for ensuring the CCG meets its obligations in respect of the Civil Contingencies Act 2004, through establishing appropriate and effective EPRR arrangements. In this I am supported by the Secondary Care Doctor, who holds the EPRR portfolio on the Governing Body which includes to endorse assurance to the Governing Body that the CCG is meeting its EPRR obligations and relevant statutory duties under the CCA 2004 and the NHS Act 2006 (as amended).

3.3.72 Roles and responsibilities across the CCG in relation to the management of risk are summarised below:

a) Governing Body – collective ownership of the risk and assurance framework and determining risk appetite

b) Committees – oversight of committee risks, holding executive leads to account, and providing assurance to the Governing Body

c) Audit Committee – scrutiny and challenge and providing assurance to the Governing Body regarding the effectiveness of the risk and assurance framework

d) Executive Leads – ownership of risks, approving risk assessment and mitigation strategy

e) Operational Leads – operational responsibility for managing and reviewing risk

f) Governance Team – advice, challenge, support, reporting and management of the risk and assurance process

g) Executive Management Team – oversight of risks and process across CCG, supporting and challenging executive leads and supporting the Audit Committee role.

3.3.73 Nominated operational and executive leads and committees are identified with responsibility for each of the CCG's risks. The Governing Body and its committees scrutinise risks at their meetings and consider the level of assurance that is provided to the Governing Body in relation to management of their risks. The Governing Body reviews the risk and assurance framework quarterly.

3.3.74 The Audit Committee oversees and scrutinises the CCG's governance, risk management and internal controls systems. This includes oversight of the risk and assurance framework as a whole, together with more detailed scrutiny of risks related to the governance of the CCG.

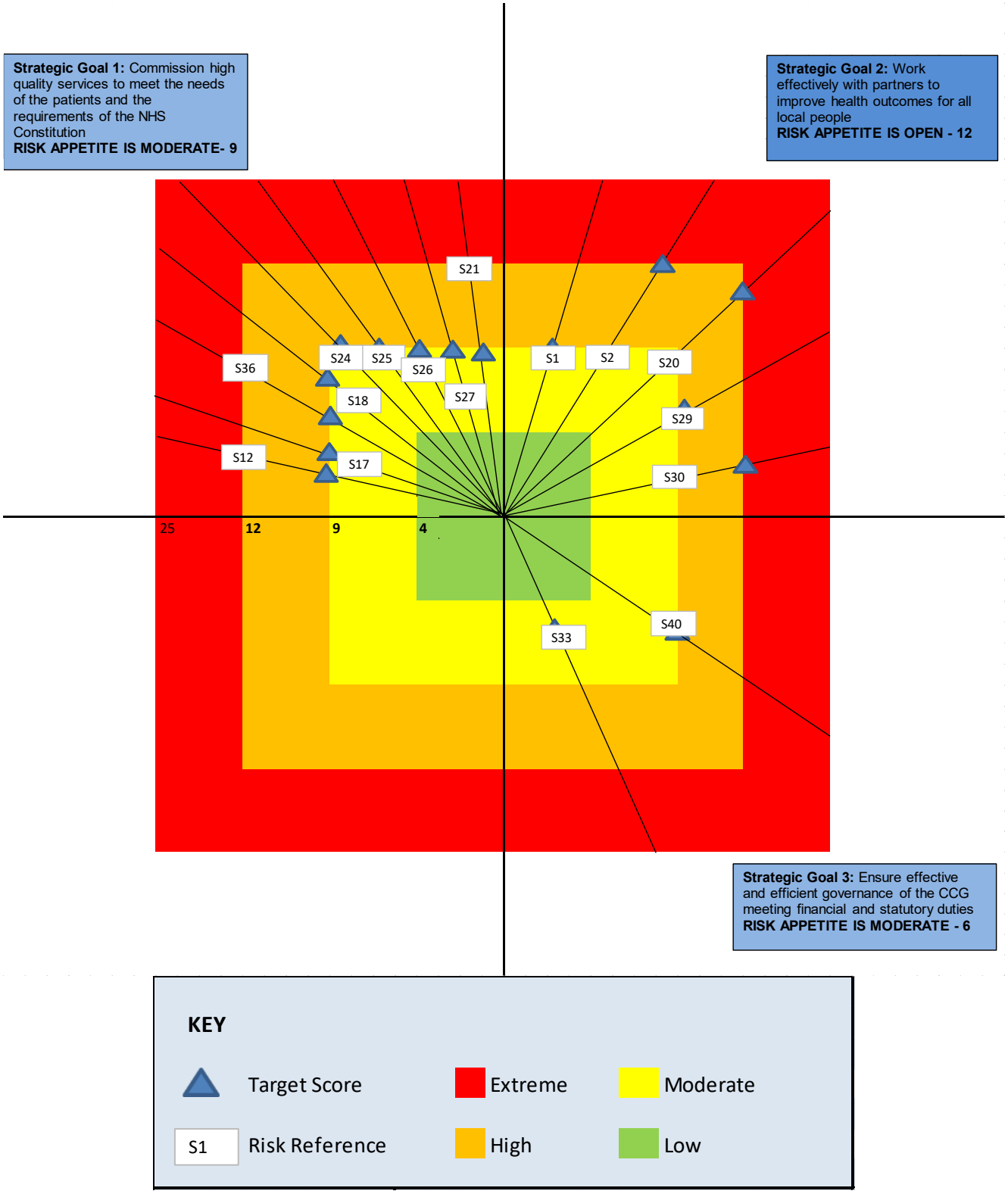
3.3.75 The CCG is required to undertake an annual self-assessment against required areas of the NHS England Core Standards for EPRR and submit a statement of compliance. The CCG declared itself as demonstrating 'full' compliance with the 29 EPRR core standards for 2021/22 and this was approved by the Governing Body in October 2021.

3.3.76 Operation of the risk and assurance framework is supported by training, guidance, coaching and support to executive and operational leads, committee chairs and other staff in the identification and assessment of risks and review of the risk register and assurance framework.

3.3.77 **Risk Assessment**

3.3.78 The CCG's risk and assurance framework identifies 16 strategic risks to the delivery of the CCG's goals and objectives, as summarised in section 1.4.4 of the performance report. The level and spread of all of the CCG's strategic risks is indicated overleaf.

Risk Profile as at June 2022



3.3.79 Risks to governance, risk management and internal control are summarised below. There are effective controls in place, including policies, processes, communications, training, information security systems and effective contracts and contract

management in relation to commissioning support services. Assurance is provided through regular scrutiny and reporting at the Audit Committee.

Risk	Risk Rating	Assurance Level
Breach of financial controls leads to failure to achieve financial duties	Moderate	Significant
Business continuity incident reduces CCG's ability to deliver statutory functions	Moderate	Reasonable
Reportable Data security and protection incident arising from non-compliance with information governance policies	Moderate	Reasonable
Significant disruption to commissioned services and delivery of CCG functions as a result of cyber attack	Moderate	Reasonable
Commissioning support providers breach statutory or regulatory requirements	Moderate	Reasonable
Fraudulent activity results in financial loss and reputational damage	Moderate	Significant
Unable to maintain sufficient capacity or capability to continue to deliver statutory duties, CCG closedown and a smooth transition	Moderate	Reasonable

3.3.80 **Other Sources of Assurance**

3.3.81 **The CCG's Internal Control Framework**

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

3.3.83 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.

3.3.84 The CCG's internal control framework comprises:

a) The Governing Body risk and assurance framework, which is framed around the CCG's strategic goals. This is developed, reviewed and managed by the CCG's Executive Management Team, reported quarterly to the Governing Body and scrutinised by the Audit Committee.

b) An internal audit service commissioned from Mersey Internal Audit Agency (MIAA) and delivering a comprehensive and balanced audit plan which is approved and monitored by the Audit Committee. This provides an objective challenge and valuable insight into risks, control weaknesses and opportunities for improvement

c) Anti-fraud arrangements described in paragraphs 3.3.115 to 3.3.126.

d) The governance framework described in paragraphs 3.3.94 to 3.3.95 .

e) The Executive Management Team and Governing Body Lay Members for Audit and Governance and Patient and Public Involvement.

f) The application of agreed policies and procedures, including the prime and detailed financial policies.

3.3.85 This internal control framework is informed and assured by external scrutiny and review, including the NHS England Oversight Framework and External Audit.

3.3.86 **Annual Audit of Conflicts of Interest Management**

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

3.3.88 An internal audit of conflicts of interest has been completed by MIAA and found the CCG to be fully compliant in 3 aspects of the requirement and partly compliant in 2 aspects. Action has been taken to address the issues identified.

3.3.89 **Data Quality**

3.3.90 The CCG has identified and specified the data requirements for both effective monitoring of the performance, quality and safety of commissioned services and to support its plans to redesign and re-commission services. These form the basis of regular reporting to the Clinical Membership Group, Governing Body and its committees.

3.3.91 The CCG's data quality standards and requirements from commissioned providers are set out in data and quality contract schedules. The service agreements with the CCG's commissioning support providers include requirements for data validation and quality control.

3.3.92 The CCG has worked in partnership with its commissioning support providers to further develop the quality and design of the reports and other business intelligence products. Performance data has been supplemented by intelligence from patient feedback, quality monitoring visits, audits, and contract monitoring activity.

3.3.93 **Information Governance**

3.3.94 The CCG has a robust information governance framework, which includes:

a) The roles of Senior Information Responsible Officer (SIRO), Caldicott Guardian, and the Information Governance Lead, who advise and support the Executive Management Team in relation to information governance matters

b) An information governance strategy and policies and information security policies, supported by briefings and training for all Governing Body members and staff

c) An information asset register, and data flows map which record the nature and security arrangements for the data held and transmitted, including sensitive and confidential data, and the risks and security arrangements, which are regularly assessed and reviewed

d) Access to specialist expertise and advice, including scrutiny, challenge and spot checks, through commissioning support arrangements

e) Quarterly reports on compliance which are reported to the Audit Committee and an annual review by internal audit.

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

3.3.96 The CCG has completed the data security and protection toolkit self-assessment providing evidence to demonstrate that it meets the Data Security and Protection Standards for health and care relevant to CCGs. The CCG received substantial assurance in the most recent 2021/22 audit by Mersey Internal Audit Agency.

3.3.97 The CCG places high importance on ensuring that there are robust information governance systems and processes in place to help protect patient and corporate information. The CCG has established an information governance management framework and has developed information governance processes and procedures in line with the data security and protection toolkit. The CCG has ensured that all staff complete annual data security and protection training and have implemented staff briefings to ensure that staff are aware of their information governance roles and responsibilities.

3.3.98 There are processes in place for incident reporting and investigation of serious incidents. The CCG has developed information risk assessment and management procedures, and a programme is in place to fully embed an information risk culture throughout the organisation against identified risks. There were no serious incidents relating to data security breaches during the first quarter of 2022/23.

3.3.99 **Business Critical Models**

3.3.100 The data and intelligence provided through the CCG's commissioning support provider to inform needs analysis and service commissioning is subject to robust quality assurance both internally by the provider and by the CCG. The CCG's plans and forecasts are also subject to external scrutiny and sign off by NHS England.

3.3.101 **Third Party Assurances**

3.3.102 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.

3.3.103 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.

3.3.104 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.

3.3.105 The service auditor reports are not available to cover the period 01 April 2022 to 30 June 2022 but bridging letters have been supplied confirming no changes in the CCG's control environment, for the following services used by the CCG:

- NHS England and NHS Improvement - South, Central and West Commissioning Support Unit
- NHS Shared Business Services Limited
- NHS England and Improvement - Midlands and Lancashire Commissioning Support Unit
- NHS Digital GP Payments
- The Electronic Staff Record Programme
- NHS Business Services Authority: Prescription Payments
- Capital Primary Care Support England

3.3.106 All of the 2021/22 reports included qualifications, these qualifications relate to controls operating in the third party and not the CCG. The CCG considers the issues identified are not significant enough to impact the CCG directly and believe the CCG has sufficient compensating controls in place to mitigate any risk.

3.3.105 **Control Issues**

3.3.106 There were no significant control issues during the first quarter of 2022/23.

3.3.107 **Review of Economy, Efficiency & Effectiveness of the Use of Resources**

3.3.108 The CCG has established effective leadership, commissioning, financial planning and management, data quality and external relationships to ensure that resources are used economically, efficiently and effectively. An opinion on these arrangements will form part of the external audit.

3.3.109 The CCG's arrangements for ensuring financial resilience include robust financial planning, effective financial governance and financial control. These arrangements are supported and delivered through the Clinical Membership Group, Governing Body, Audit Committee, Chief Finance Officer and Finance Team alongside key partnerships and collaborative working.

3.3.110 For 2021/22 a narrative assessment, based on performance, leadership and finance, replaced the ratings system previously used for CCGs. The CCG received a positive assessment acknowledging that the CCG had continued to work alongside system partners rise to the challenges faced by it, partners and the people of Merseyside, and this is described in more detail at 2.2.5 above. Internal audit reviews have provided high assurance in respect of financial systems. These controls have been effective in ensuring that the CCG has met its key financial targets.

3.3.111 During 2021/22 and continuing into the first quarter of 2022/23 the CCGs operational objectives have been reviewed and prioritised based on intelligence about performance and outcomes and the national requirements set out by NHS England in response to the pandemic.

3.3.112 **NHS Pension Scheme**

3.3.113 The CCG as an employing authority complies with the NHS Pension Scheme Regulations.

3.3.114 **Delegation of Functions**

3.3.115 The Audit Committee has delegated responsibility for approving the detailed financial policies, and anti-fraud arrangements. Feedback is provided through key issues reports, the risk and assurance framework and receipt of committee minutes by the Governing Body. External assessment of effectiveness is available through the audit plan and annual letter from the CCG's external auditors.

3.3.116 The Primary Care Committee has responsibility for the arrangements to deliver delegated commissioning responsibilities in relation to primary medical services, and for approving primary care commissioning plans and budgets. Feedback is provided through key issues reports, the risk and assurance framework and receipt of committee minutes by the Governing Body. External assessment of effectiveness is available through the NHS England improvement and assessment framework and the audit plan.

3.3.117 NHS England has required an internal audit of delegated CCGs primary medical care commissioning arrangements effective from 2018/19. This is to be delivered as a 3-4 year programme of work covering commissioning and procurement of services,

contract oversight and management functions, primary care finance, and governance. An audit of commissioning and procurement of primary medical services has been completed during this year and provided substantial assurance in relation to the effectiveness of the arrangements put in place by the CCG to exercise the primary medical care commissioning function.

3.3.118 The CCG has entered into a Section 75 partnership agreement with Knowsley Metropolitan Borough Council relating to the commissioning of health and care services. This includes the delegation of NHS functions to the Council, including lead and joint commissioning and pooled funds in relation to the services covered by the agreement. Feedback is provided through key issues reports, the risk and assurance framework, and receipt of Partnership Board minutes by the Governing Body.

3.3.119 The CCG participated in the North Mersey Committees in Common, together with Liverpool, South Sefton and Southport and Formby CCGs. Its purpose is the governance of hospital services reconfiguration in North Mersey and feedback and assurance is provided through key issues reporting and joint overview and scrutiny committee arrangements.

3.3.120 In November 2021 the Governing Body, together with the other 8 CCG Governing Bodies across Cheshire & Merseyside delegated its duties and functions, with the exception of those which cannot legally be delegated or are specific to Knowsley arrangements, to a Joint Committee of CCGs in Cheshire and Merseyside. This was to enable shadow operation across the system footprint as we transitioned to the new organisational structure in 2022/23. The Governing Body remained accountable for discharging the CCG's functions and duties during this period. It received assurance that delegated functions were delivered effectively through the membership of the Joint Committee and its sub-committees, receipt of reports, minutes and key issues reports, and the assurance work of the Merseyside Internal Audit Agency.

3.3.121 **Counter Fraud Arrangements**

3.3.122 The NHS Counter Fraud Authority Standards for Commissioners: Fraud, Bribery and Corruption cover requirements for strategic governance, inform and involve, prevent and deter and hold to account, both within the CCG and its commissioned providers. The CCG's self-review indicates a green rating overall, and for each element, with the exception of hold to account which is rated amber as the CCG has not had the opportunity to fully evidence the standards; for instance, there has been no requirement to pursue sanctions or seek to recover funds as a result of a fraud referral.

3.3.123 During the first quarter of the year no fraud referrals were received.

3.3.124 The CCG contracts with MIAA's Anti-Fraud Services to undertake anti-fraud work, including an annual risk assessment, and the development and delivery of an annual anti-fraud plan, based on assessed risks and approved by the CCG's Audit Committee.

3.3.125 The Chief Finance Officer has executive leadership responsibility for tackling fraud, bribery and corruption. This is achieved through the leadership of the risk assessment and work plan delivery, supported by the Accredited Anti-Fraud Specialist.

3.3.126 There has been an increase in fraudulent activity directed at the NHS and patients related to COVID. In addition to guidance on specific fraud risks, MIAA have issued special edition information alerts, a dedicated, regular series of frauds, scams and cyber-crime alerts related specifically to the COVID emergency, which have been widely distributed to CCG staff and primary care. The Accredited Anti-Fraud Specialist (AFS) has worked with finance, payroll and IT teams to assess risks and implement additional control measures in relation to national fraud prevention notices and intelligence bulletins. A Fraud Champion/AFS Protocol and a Freedom to Speak up Guardian/AFS joint working protocol have been developed and agreed.

3.3.127 **Head of Internal Audit Opinion**

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

3.3.129 *The overall opinion for the period 1st April 2022 to 30th June 2022 provides* **Substantial Assurance,** *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.*

The basis for forming our opinion is as follows:

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

<u>Commentary</u>

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

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

Compliance with Statutory Functions

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

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

CCG Transition – System Support

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

Cheshire & Merseyside

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

CCG Transition – Local Support

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

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

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

Note: the assurance provided above does not provide confirmation of the accuracy and completeness of the Due Diligence Checklist/ Transition Plan.

Follow Up

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

8 recommendations have been assessed as not fully implemented. 3 of the recommendations have been superseded due to CCG closedown and 5 are for transfer to the ICB. The recommendations requiring transfer are in relation to the reviews of Minor Surgery, Partnership Working with the Council, Conflicts of Interest and the Assurance Framework and will be included in MIAA's handover document to the ICB.

Wider Organisation Context

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

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

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

Chris Harrop
Managing Director, MIAA
June 2022

Louise Cobain
Assurance Director, MIAA
June 2022

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

3.3.131 My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

3.3.132 Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principal objectives have been reviewed.

3.3.133 I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and the Quality Committee, and Internal Audit.

3.3.134 The effectiveness of the system of internal control has been maintained and reviewed through the Executive Management Team, with oversight and scrutiny by the Governing Body and Audit Committee, and assurance of key elements through the internal audit plan. The mechanisms used have included the Governing Body assurance framework, review, scrutiny and approval of policies and processes, reports on compliance, external review, and managerial scrutiny through the Executive Management Team.

3.3.135 **Conclusion**

3.3.136 No significant internal control issues have been identified during the first quarter of the year.

Graham Urwin

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

4.0 REMUNERATION AND STAFF REPORT

4.1 The CCG's senior managers comprise the Chief Executive, the Chief Finance Officer and the Chief Nurse who are members of the Governing Body.

4.2 Remuneration Committee Report

4.2.1 The Remuneration Committee is responsible for recommending to the Governing Body the remuneration, fees and other allowances for governing body members and employees. In doing so it is conscious of relevant national guidance.

4.2.2 The key duties of the Remuneration Committee are to:

- Recommend to the Governing Body the pay, terms and conditions, including allowances and gratuities for governing body members
- Recommend to the Governing Body the pay, terms and conditions, including allowances and fees for employees and other persons providing services to the CCG, including opting out of agenda for change
- Review pay, terms and conditions for governing bodies and employees.

4.2.3 Appendix 3 provides a full list of all Remuneration Committee members and their level of attendance at meetings throughout the year.

4.2.4 Neither Dianne Johnson, Chief Executive nor Jan Ledward, Interim Chief Officer until the 30th June 2022, are members of the Remuneration Committee, but have provided information to the committee to assist the committee in their consideration of matters.

4.3 Remuneration Policies

4.3.1 The remuneration of the CCG's Chief Executive and Chief Finance Officer is recommended to the Governing Body by the Remuneration Committee.

4.3.2 The remuneration package for the Chief Executive and Chief Finance Officer has been set in line with the guidance provided by NHS England.

4.3.3 From 1 October 2021, the Chief Executive has taken up a role as Executive Director of Transition with the Cheshire & Merseyside Health & Care Partnership, supporting the work of the development of the Cheshire & Merseyside Integrated Care Board with effect from 1st July 2022. During this period, Knowsley CCG has continued to incur costs on a 'leaning in' basis but reached an agreement with Liverpool CCG, that their Accountable Officer also acted as Knowsley CCG's Interim Accountable Officer, in addition to her substantive post, for the period 1st October 2021 to 30 June 2022.

4.3.4 The Chief Finance Officer is a shared post between Liverpool CCG (host) and Knowsley CCG which operates under a memorandum of agreement. The current Chief Finance Officer commenced on 1 October 2019.

4.3.5 The notice period for the Chief Executive and the Chief Finance Officer is 6 months. Compensation for early termination of contract will be in line with national policies and procedures.

4.3.6 In respect of remuneration and pay awards for other members of the Governing Body (Lay Members/Advisors, Secondary Care Doctor and Registered Nurse), these are made in line with Department of Health guidance for non-executive directors of NHS Trusts and are reviewed annually. Lay Member/Advisor contracts are for 2 years, with the option for a further 1-year extension. The termination period is one month. Any payments for early termination of contract would be made in line with Department of Health guidelines.

4.3.7 The remuneration (pay and conditions) for the Chief Nurse is in line with the national Agenda for Change policy.

4.3.8 None of the CCG's senior managers are paid more than £150,000 per annum.

4.3.9 The CCG's remuneration arrangements will be reviewed annually to ensure the organisation is able to recruit, motivate, reward and retain senior managers of the highest standard.

4.3.10 The CCG follows national HR policies and procedures in line with nationally recognised pay scales, duration of contracts, notice periods and termination payments.

4.3.11 The CCG has a robust appraisal process in place for Governing Body members, but does not, at this time, operate a performance-related pay framework.

4.3.12 The Clinical Governing Body members representing member practices have been paid via the CCG payroll since 1st April 2015. However, remuneration is paid directly to the GP Practice to provide backfill for the release of the office holder to carry out the role. Remuneration for Clinical Lead roles continues to be paid to the GP Practice, again to provide back fill for the release of the office holder to carry out the role.

4.3.13 The remuneration (pay and conditions) of all other employees is in line with the national Agenda for Change policy.

4.3.14 Appendix 1 and appendix 2 provide a full list of the members of both the Clinical Membership Group and the Governing Body.

4.4 Salaries and Allowances

4.4.1 Table 1 overleaf highlights the salaries and allowances of each of the CCG's senior managers, in a table format.

4.4.2 The CCG does not provide senior managers with taxable benefits, other than those of salary, i.e., expenses allowances and travel allowances, and access to lease cars.

4.4.3 The CCG does not pay its senior managers annual performance related bonuses, long-term performance related bonuses, performance bonuses classed as 'additional matters'.

4.4.4 No payment has been paid this year or in the previous year, to any senior manager for loss of office.

4.4.5 The CCG has also not made any payments this year to any past senior manager not in post during the year.

4.5 Pension Benefits

4.5.1 Table 2 overleaf shows the pension benefits of the CCG's senior managers. The table also highlights Cash Equivalent Transfer Values (CETV).

Remuneration tables 1 & 2, notes, fair pay disclosure, and cash equivalent transfer values

Table 1 – 2022/22 Salaries and 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	
		d)	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 Period Governing Body Members													
Ledward, Jan	Governing Body Member, Chief Executive	a) c)	15 - 20	35 - 40	0	0	0	0	0	0	7.5 - 10	10 - 12.5	25 - 30	45 - 50
Bakewell, Mark	Governing Body Member, Chief Finance Officer	b) c)	15 - 20	65 - 70	0	0	0	0	0	0	2.5 - 5	15 - 17.5	15 - 20	85 - 90
Pryce, Dr Andrew	Governing Body GP Chair		5 - 10	60 - 65	0	0	0	0	0	0	0	0	5 - 10	60 - 65
Bedwell, David	Governing Body Member, Lay Member for Patient and Public Involvement		0 - 5	10 - 15	0	0	0	0	0	0	0	0	0 - 5	10 - 15
Benbow, Dr Susan	Governing Body Member, Secondary Care Doctor		5 - 10	25 - 30	0	0	0	0	0	0	0	0	5 - 10	25 - 30
Chan, Kwok (Allan)	Governing Body Member, Lay Member for Audit and Governance		0 - 5	10 - 15	0	0	0	0	0	0	0	0	0 - 5	10 - 15
Mawer, Judith	Governing Body Member, Lay Member for Patient and Public Involvement		0 - 5	10 - 15	0	0	0	0	0	0	0	0	0 - 5	10 - 15
Conway, Dr Paul	GP on the Governing Body, Clinical Quality & Safety Lead		0 - 5	30 - 35	0	0	0	0	0	0	0	0	0 - 5	30 - 35
Perritt, Dr Simon	GP on the Governing Body, Clinical Lead for Unplanned Care		0 - 5	30 - 35	0	0	0	0	0	0	0	0	0 - 5	30 - 35
Kanczes-Daly, Sandra	Nurse on the Governing Body		0 - 5	5 - 10	0	0	0	0	0	0	0	0	0 - 5	5 - 10
Johnson, Dianne	Governing Body Member, Chief Executive		0	135 - 140	0	3200	0	0	0	0	-	2.5 - 5.0	-	140 - 145
Sadiq, Dr Pervez	GP on Governing Body, Clinical Lead for Women and Children		0	30 - 35	0	0	0	0	0	0	0	0	0 - 5	30 - 35

a) From 1 October Jan Ledward was appointed as Chief Officer at Knowsley CCG in a joint role capacity and accordingly 50% of remuneration costs have been charged to Knowsley CCG. The above table reflects Knowsley CCG share of the total costs (including pension related benefits), with the total banded remuneration (in bands of £5,000) being £35K and inclusive of an additional 10% in respect of coering an additional CCG consistent with remuneration guidance.

b) Mark Bakewell was appointed as Chief Finance Officer at Knowsley CCG in a joint role capacity and acccordingly 50% of remuneration costs have been recharged to Knowsley CCG share of total costs (including pension related benefits), with the total banded remuneration (in bands of £5,000) being £30-£35K and inclusive of an additional 10% in respect of coering an additional CCG consistent with remuneration guidance.

c) The All Pension Benefits Table 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.

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

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	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	12%	0%

Reduction in the average percentage change from the previous financial year in respect of employees of the entity is due to staff mix changes in year.

	Salary and allowances	Performance pay and bonuses
highest paid		
2022/22	138,651.89	0
2021/22	138,651.89	-
2020/21	140,509.10	-
Average percentage change		
2022/22	47,672	0
2021/22	42,672	-
2020/21	48,637	-

Pay Multiples

Reporting bodies are required to disclose the relationship between the total 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 of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in NHS Knowsley CCG in the financial year 2022/22 was £135-£140k (2021/22, £135k - £140k). 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	5.36 : 1	5.16 : 1	2.88 : 1	2.78 : 1	2.45 : 1	2.36 : 1
Total remuneration (£)	25,655	25,655	47,672	47,672	56,164	56,164
Salary component of total remuneration (£)	25,655	25,655	47,672	47,672	56,164	56,164
2021/22	6.16 : 1	5.93 : 1	3.52 : 1	3.40 : 1	2.51 : 1	2.42 : 1
Total remuneration (£)	22,339	22,339	39,027	39,027	54,764	54,764

In 2022/22, no employees/members (2021/22, nil) received remuneration in excess of the highest-paid director / member. Remuneration ranged from £10k-£15k to £135-140k (2020/21 £10k-£15k to £135k-£140k).

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.

Table 2 – 2022/22 Pension Benefits as at 30 June 2022

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

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 0.5% 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 Knowsley 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.

4.6 Staff Report

4.6.1 Staff Numbers and Composition (Subject to audit)

4.6.2 The number of FTE senior managers in post within the CCG (based on headcount) during the first quarter of 2022/23 was:

Senior Managers by Band	Average
Very Senior Manager	2
Band 9	3
Band 8D	1
Band 8C	4
Total	**10**

4.6.3 The average number of employees within the CCG in the first quarter of 2022/23 was 53.12 in total, including 49.16 permanent employees.

	2022/23			2021/22
	Total Number	Permanently Employed Number	Other Number	Total Number
Total	53.12	49.16	3.96	55.51
Of the above: Number of whole-time equivalent people engaged on capital projects	0	0	0	0

4.6.4 A further breakdown of the average number of permanently employed staff is provided overleaf:

Grouping	Average Numbers
Administrative and Estates Staff	36.43
Nursing, midwifery and health visiting staff	5.90
Scientific, therapeutic and technical staff	6.83
Other	0
Total	**49.16**

Note: The average numbers of staff relate to those staff included in note 4; Employee benefits and staff numbers of the financial statements, these numbers exclude the Chair, Non-Executive Governing Body members and staff on secondment.

4.6.5 The staff costs incurred by the CCG in the three months to 30 June 2022 and the year 2021/22 ending on 31 March 2022 are provided below:

2. Employee benefits and staff numbers			
2.1 Employee benefits	**Total**		**3 months to 30 June 2022**
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	696	108	804
Social security costs	66	-	66
Employer Contributions to NHS Pension scheme	100	-	100
Other pension costs	-	-	-
Apprenticeship Levy	-	-	-
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Gross employee benefits expenditure	862	108	970
Less recoveries in respect of employee benefits	-	-	-
Total - Net admin employee benefits including capitalised costs	862	108	970
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	862	108	970

	Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	2,651	393	3,044
Social security costs	237	-	237
Employer Contributions to NHS Pension scheme	440	-	440
Other pension costs	-	-	-
Apprenticeship Levy	-	-	-
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Gross employee benefits expenditure	3,328	393	3,721
Less recoveries in respect of employee benefits	-	-	-
Total - Net admin employee benefits including capitalised costs	3,328	393	3,721
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	3,328	393	3,721

4.6.6 The gender of staff as a whole, which includes Clinical Membership and Governing Body members at 30 June 2022, is:

Grouping	Male (Headcount)	Female (Headcount)
Clinical Membership Group representatives	11	12
Governing Body	7	5
Senior Managers in attendance at the Governing Body	0	0
Employed Staff (excluding members of Governing Body and CCG Senior Managers)	10	40

4.7 Sickness Absence Data

4.7.1 The cumulative sickness absence rate for the CCG for the calendar year 2021/22 was an average of 7.0 days of absence per full-time equivalent member of staff. The sickness absence rate for the CCG is 3.1%.

4.7.2 The Attendance Management Policy ensures that the CCG has a robust policy and procedure in place for supporting its staff with attendance issues and managing these in a fair and equitable way. The CCG proactively managed both short-term and long-term sickness absence in line with this policy, with sickness absence being reported on a monthly basis in the Human Resources Performance Report.

4.7.3 The CCG recognises the importance of a positive approach to the management of sickness absence to enable it to operate effectively. The CCG is committed to providing the necessary support to employees for them to attend work regularly and to ensure that all employees are treated in a consistent, fair, and sympathetic manner.

4.7.4 The CCG's commitment to the welfare of employees includes the following initiatives: counselling, redeployment where appropriate, and training for all new employees on health and safety issues. Employees are also encouraged to use the confidential services of Occupational Health that can be accessed directly.

4.8 Disabled Employees

4.8.1 The CCG has duties to meet under the Equality Act 2010 in relation to workforce and organisational development. These include all listed public authorities' legal obligations relating to Section 149 of the Equality Act 2010 (the Public Sector Equality Duty), and the Equality Act 2010 (Specific Duties) Regulations 2011.

4.8.2 The CCG has, therefore, taken positive steps to ensure that policies across the CCG deal with equality implications around recruitment and selection,

pay and benefits, flexible working hours, training, development and promotion, policies around managing employees, and protecting employees from harassment, victimisation and discrimination.

4.8.3 The CCG ensures that full and fair consideration is given to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities.

4.8.4 The CCG's Attendance Management Policy supports disabled employees and states that where the employee is disabled, within the meaning of the Equality Act 2010, or where employees become disabled and wish to remain in employment, every effort will be made to make reasonable adjustments, provide appropriate training, or find an alternative post.

4.8.5 The CCG is continually working closely with our key NHS providers to ensure that providers work within the confines of the Public Sector Equality Duty.

4.9 Other Employee Matters

4.9.1 We have an Equality and Diversity Strategy and Equality and Diversity Policy. These documents were produced to ensure the CCG meets the requirements of the Equality Act.

4.9.2 We also have a wide range of Human Resource policies and supporting procedures, complying with employment legislation and NHS Terms and Conditions. These were developed after consultation, as required, with staff and via the Staff Partnership Forum (which includes Trade Union (TU) representatives, however, the CCG does not currently have any directly employed TU representatives as can be seen here on the CCG's website http://www.knowsleyccg.nhs.uk/trade-union-regulation/ in accordance with the 'The Trade Union (Facility Time Publication Requirements Regulations 2017).

4.9.3 Our policies include a Health and Safety Policy and associated procedures to ensure compliance with rules and regulations on health and safety at work.

4.9.4 The policies and procedures ensure the consistent equal treatment of staff, for example in relation to recruitment and selection and pay and development and are kept under regular review.

4.9.5 The CCG's Equality Objective Plan, includes a Workforce Equality and Diversity Plan, laying out clear work streams to support the CCG to meet and pay due regard to meeting the Public Sector Equality Duty by:

a) Eliminating discrimination

b) Advancing equality of opportunity

c) Fostering good community relations.

4.9.6 The Workforce Equality and Diversity Plan has supported the CCG to meet its equality objectives. This includes action required in relation to the Workforce Race Equality Standard (WRES) which aims to identify discrimination against black and minority ethnic (BME) staff in the NHS, and to galvanise cultural and organisational change. As recommended to all NHS Trusts by Amanda Pritchard, Chief Operating Officer for NHS England and Improvement, the CCG also benchmarked its Disciplinary Policy against Imperial College Trust's policy, updating it as required.

4.9.7 We have continued to use the Equality Delivery System (EDS2) as our performance toolkit, to support us in demonstrating our compliance with the Public Sector Equality Duty. The toolkit is used to improve the services provided for local communities, consider health inequalities and provide better working environments, free of discrimination, for those who work in the NHS. The CCG Equality Delivery System self-assessment is 'Achieving' in relation to the outcomes for fair recruitment and selection, for equal pay for work of equal value, and flexible working, and 'Developing' for the remaining 3 workforce elements.

4.9.8 The CCG holds a monthly 'Chat with the Chief' meeting, which is open for all staff to attend. The Chief Officer leads the meeting and shares key messages and updates. Staff also have the opportunity to raise any questions, suggestions or concerns they may have.

4.9.10 The CCG provides staff development sessions on various subject areas to raise awareness, develop ideas and engage/involve staff in the different work streams that are taking place.

4.9.12 The CCG participates in the NHS Skills Development Network Apprenticeship Scheme. There are currently two apprentices working in the organisation.

4.9.13 The CCGs staff turnover percentages will be published at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics when available.

4.9.14 The CCG continues to be represented at a Workforce Equality Focused Forum attended by equality leads, HR leads and key officers from NHS Trusts across Cheshire and Merseyside. Its focus is on staff network opportunities and opportunities for sharing learning.

4.9.15 The CCG continues to promote opportunities for staff to join various networks to share the issues and challenges they face, to inform decision-making and identify actions that would help to make a difference and ensure fairness and equality in the workplace e.g., CCG staff have been invited to attend the North Mersey CCGs Menopause Support Group, Staff Equality Network and Black, Asian and Minority Ethnic (BAME) Peer Support Group. A survey has also been issued to all CCG staff, seeking to understand what would help BAME staff to engage with the North Mersey group, in recognition of the fact that more needs to be done to support them.

4.9.16 Allan Chan is nominated Governing Body Lay member with responsibility for Whistleblowing as the CCG's Freedom to Speak Up Guardian. His details have been shared with staff as a safe speaking option should they have a concern about a risk, malpractice or wrongdoing at work.

4.9.17 Staff working within the CCG undertake equality and diversity training every 3 years. As at 31st March 2022 88.5% of our staff had completed their training (against a target of 85%). The training is designed not only as an introduction to diversity and cultural awareness, but also as a practical guide to making our organisational culture an inclusive one. It combines a focus on personal and organisational beliefs, values and behaviours, and the impact they have on our interactions in the workplace, internally and externally. Furthermore, programme leads within the CCG who are responsible for commissioning and transforming health services have received training and one-to-one coaching on undertaking Equality Impact Assessments. Cultural competency training is also planned for CCG staff in May 2022.

4.10 Expenditure on Consultancy

4.10.1 During the first quarter of 2022/23 the CCG incurred no expenditure on consultancy services.

4.11 Off Payroll Engagements

4.11.1 The following tables provide details of off-payroll engagements as at 31 March 2022.

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

	Number
Number of Existing Engagements as of 30th June 2022	16
of which that have existed for …	
less than one year at time of reporting	2
between one and two years at time of reporting	0
between two and three years at time of reporting	11
between three and four years at time of reporting	3
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	**24**
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	23
No of engagements reassessed 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.	13

4.12 Exit Packages

4.12.1 There have been no exit packages paid by the CCG in 2022/23 or 2021/22.

4.13 Analysis of other agreed departures

4.13.1 There were no agreed departures in 2022/23 or 2021/22 where special payments have been made.

Graham Urwin

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

5.0 PARLIAMENTARY ACCOUNTABILITY AND AUDIT REPORT

5.1 Knowsley CCG is not required to produce a Parliamentary Accountability and Audit Report. An audit certificate and report is also included in this Annual Report at pages 78 to 83. 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

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

AUDIT OPINION

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

Report on the audit of the financial statements

Opinion on financial statements

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

In our opinion, the financial statements:

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

Basis for opinion

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

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 1.1 to the financial statements, which indicates that the Health and Care Act allowed for the establishment of Integrated Care Boards (ICBs) and abolished Clinical Commissioning Groups (CCGs). The functions, assets, and liabilities of NHS Knowsley CCG transferred to NHS Cheshire and Merseyside ICB on 1 July 2022. When NHS Knowsley CCG ceased to exist on 30 June 2022, its services continued to be provided by NHS Cheshire and Merseyside ICB from 1 July 2022.

Conclusions relating to going concern

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

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

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

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

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

Other information

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

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

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

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

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

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

Matters on which we are required to report by exception

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

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

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

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 35 to 36, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

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

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

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

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

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

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources were operating effectively during the three-month period ended 30 June 2022.

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

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

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

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of NHS Knowsley Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Board of NHS Cheshire and Merseyside Integrated Care Board, as a body, in respect of NHS Knowsley CCG, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of NHS Cheshire and Merseyside Integrated Care Board those matters we are required to state to them in an auditor's report in respect of the CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NHS Cheshire and Merseyside Integrated Care Board and the CCG and the members of the Governing Body and Board of both entities, as bodies, for our audit work, for this report, or for the opinions we have formed.

Michael Green

Michael Green, Key Audit Partner

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

Manchester

29 June 2023

FINANCIAL STATEMENTS

FOR THE QUARTER
ENDED 30 JUNE 2022

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the three month period ended 30 June 2022	**Note**	**3 month period to 30 June 2022 £'000**	2021-22 £'000
Income from sale of goods and services		-	-
Other operating income		-	-
Total operating income		**-**	**-**
Staff costs	2	970	3,721
Purchase of goods and services	3	87,540	347,494
Depreciation and impairment charges	3	50	55
Provision expense		-	-
Other Operating Expenditure	3	189	430
Total operating expenditure		**88,749**	**351,700**
Net Operating Expenditure		**88,749**	**351,700**
Finance income		-	-
Finance expense		2	-
Net expenditure for the Period / Year		**88,751**	**351,700**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Period / Year		**88,751**	**351,700**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of right-of-use assets		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Net (gain)/loss on assets held for sale		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net (gain)/loss on revaluation of other Financial Assets		-	-
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Total other comprehensive net expenditure		**-**	**-**
Comprehensive Expenditure for the period / year		**88,751**	**351,700**

Statement of Financial Position as at 30 June 2022			
		3 month period to 30 June 2022	2021-22
	Note	**£'000**	£'000
Non-current assets:			
Property, plant and equipment	6	20	23
Right-of-use assets	6a	711	-
Intangible assets	7	28	35
Investment property		-	-
Trade and other receivables		-	-
Other financial assets		-	-
Total non-current assets		**759**	58
Current assets:			
Inventories		-	-
Trade and other receivables	8	3,145	4,391
Other financial assets		-	-
Other current assets		-	-
Cash and cash equivalents	9	140	57
Total current assets		**3,285**	4,448
Non-current assets held for sale		-	-
Total current assets		**3,285**	4,448
Total assets		**4,044**	4,506
Current liabilities			
Trade and other payables	10	(15,897)	(16,201)
Other financial liabilities		-	-
Other liabilities		-	-
Lease liabilities	6a	(148)	-
Borrowings		-	-
Provisions		-	-
Total current liabilities		**(16,045)**	(16,201)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(12,001)**	(11,695)
Non-current liabilities			
Trade and other payables		-	-
Other financial liabilities		-	-
Other liabilities		-	-
Lease liabilities	6a	(565)	-
Borrowings		-	-
Provisions		-	-
Total non-current liabilities		(565)	-
Assets less Liabilities		**(12,566)**	(11,695)
Financed by Taxpayers' Equity			
General fund		(12,566)	(11,695)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(12,566)**	(11,695)

The notes on pages 88 to 108 form part of this statement

The financial statements on pages 84 to 87 were approved by the Board of NHS Cheshire and Merseyside on 29th June 2023 and signed on its behalf by:

Graham Urwin

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

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

Changes in taxpayers' equity for the three month period ended 30 June 2022	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2022	(11,695)	-	-	**(11,695)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-	-	-
Adjusted CCG balance at 01 April 2022	**(11,695)**	**-**	**-**	**(11,695)**
Changes in CCG taxpayers' equity for the three month period ended 30 June 2022				
Total transition adjustment for initial application of IFRS 16	-			-
Net operating expenditure for the period / financial year	(88,751)			**(88,751)**
Net gain/(loss) on revaluation of property, plant and equipment		-		-
Net gain/(loss) on revaluation of right-of-use assets		-		-
Net gain/(loss) on revaluation of intangible assets		-		-
Net gain/(loss) on revaluation of financial assets		-		-
Total revaluations against revaluation reserve		**-**		**-**
Net gain (loss) on available for sale financial assets	-	-	-	-
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			-	-
Net gain (loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain (loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	-
Transfers by absorption to (from) other bodies	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Net Recognised CCG Expenditure for the Period / Financial year	**(88,751)**	**-**	**-**	**(88,751)**
Net funding	87,880	-	-	**87,880**
Balance at 30 June 2022	**(12,566)**	**-**	**-**	**(12,566)**

Changes in taxpayers' equity for 2021-22	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2021	(10,151)	-	-	**(10,151)**
Transfer of assets and liabilities from closed NHS bodies	-	-	-	-
Adjusted CCG balance at 01 April 2021	**(10,151)**	**-**	**-**	**(10,151)**
Changes in CCG taxpayers' equity for 2021-22				
Net operating costs for the financial year	(351,700)			(351,700)
Net gain/(loss) on revaluation of property, plant and equipment		-		-
Net gain/(loss) on revaluation of right-of-use assets		-		
Net gain/(loss) on revaluation of intangible assets		-		-
Net gain/(loss) on revaluation of financial assets		-		-
Total revaluations against revaluation reserve		-		**-**
Net gain (loss) on available for sale financial assets	-	-	-	-
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	-	-	-	-
Net gain (loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain (loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	-
Transfers by absorption to (from) other bodies	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Net Recognised CCG Expenditure for the Financial Year	**(351,700)**	**-**	**-**	**(351,700)**
Net funding	350,156	-	-	350,156
Balance at 31 March 2022	**(11,695)**	**-**	**-**	**(11,695)**

The notes on pages 88 to 108 form part of this statement

Statement of Cash Flows for the three month period ended 30 June 2022

	Note	3 month period to 30 June 2022 £'000	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the period / financial year		(88,751)	(351,700)
Depreciation and amortisation	3	50	55
Impairments and reversals		-	-
Non-cash movements arising on application of new accounting standards		-	-
Movement due to transfer by Modified Absorption		-	-
Other gains (losses) on foreign exchange		-	-
Donated assets received credited to revenue but non-cash		-	-
Government granted assets received credited to revenue but non-cash		-	-
Interest paid		2	-
Release of PFI deferred credit		-	-
Other Gains & Losses		-	-
Finance Costs		-	-
Unwinding of Discounts		-	-
(Increase)/decrease in inventories		-	-
(Increase)/decrease in trade & other receivables	8	1,246	1,203
(Increase)/decrease in other current assets		-	-
Increase/(decrease) in trade & other payables	10	(304)	345
Increase/(decrease) in other current liabilities		-	-
Provisions utilised		-	-
Increase/(decrease) in provisions		-	-
Net Cash Inflow (Outflow) from Operating Activities		**(87,757)**	(350,097)
Cash Flows from Investing Activities			
Interest received		-	-
(Payments) for property, plant and equipment		-	(4)
(Payments) for intangible assets		-	-
(Payments) for investments with the Department of Health		-	-
(Payments) for other financial assets		-	-
(Payments) for financial assets (LIFT)		-	-
Proceeds from disposal of assets held for sale: property, plant and equipment		-	-
Proceeds from disposal of assets held for sale: intangible assets		-	-
Proceeds from disposal of investments with the Department of Health		-	-
Proceeds from disposal of other financial assets		-	-
Proceeds from disposal of financial assets (LIFT)		-	-
Non-cash movements arising on application of new accounting standards		-	-
Loans made in respect of LIFT		-	-
Loans repaid in respect of LIFT		-	-
Rental revenue		-	-
Net Cash Inflow (Outflow) from Investing Activities		**-**	(4)
Net Cash Inflow (Outflow) before Financing		**(87,757)**	(350,101)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		87,880	350,156
Other loans received		-	-
Other loans repaid		-	-
Repayment of lease liabilities		(40)	-
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		-	-
Capital grants and other capital receipts		-	-
Capital receipts surrendered		-	-
Non-cash movements arising on application of new accounting standards		-	-
Net Cash Inflow (Outflow) from Financing Activities		**87,840**	350,156
Net Increase (Decrease) in Cash & Cash Equivalents	9	**83**	55
Cash & Cash Equivalents at the Beginning of the Financial Year		57	2
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Period / Financial Year		**140**	57

The notes on pages 88 to 108 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England (NHSE) has directed that the financial statements of clinical commissioning groups (CCGs) shall meet the accounting requirements of the Group Accounting Manual (GAM) issued by the Department of Health and Social Care (DHSC). Consequently, the following financial statements have been prepared in accordance with the GAM 2022-23 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to CCGs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

The Health and Care Act was introduced into the House of Commons on 6 July 2021 and received royal assent on 28th April 2022. The Act allowed for the establishment of Integrated Care Boards (ICBs) across England and abolished CCGs. From 1st July 2022, ICBs took on the commissioning functions of CCGs. As a result, the functions, assets and liabilities of the CCG transferred to NHS Cheshire and Merseyside ICB.

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 CCG 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 ICB. 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 **Pooled Budgets**

The CCG has entered into a pooled budget arrangement with Knowsley Metropolitan Borough Council (KMBC) in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Adult's Learning Disability, Mental Health, Community Support Services and the Better Care Fund. The Better Care Fund is a plan for the CCG and Local Authority to work closely together, driving integration and improved outcomes for the three core initiatives being Localities, Safe Supported Discharge and Access Knowsley.

Note 13 in the accounts provides details of the income and expenditure.

The pool is hosted by KMBC. The CCG 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

1.4 **Operating Segments**

Expenditure is analysed in the Operating Segments note and is reported in line with management information used within the CCG.

1.5 **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 CCG will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The CCG 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 CCG to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the CCG 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 CCG accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.6 **Employee Benefits**

1.6.1 **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.

1.6.2 **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 period. 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 CCG 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.

1.7 **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.

Notes to the financial statements

1 **Accounting Policies (cont)**

1.8 **Grants Payable**

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

1.9 **Property, Plant & Equipment**

1.9.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the CCG;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.9.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.9.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.10 **Intangible Assets**

1.10.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.10.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

Notes to the financial statements

1 **Accounting Policies (cont)**

1.10.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the CCG expects to obtain economic benefits or service potential from the asset. This is specific to the CCG and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each period end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

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

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

1.11 **Leases**

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 CCG assesses whether a contract is or contains a lease, at inception of the contract.

1.11.1 **The CCG as Lessee**
A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.
Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.
Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.
Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.
For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.12 **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 CCG's cash management.

1.13 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the CCG 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 the CCG.

1.14 **Non-clinical Risk Pooling**

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

1.15 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG, 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 CCG. 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.

Notes to the financial statements

1 Accounting Policies (cont)

1.16 **Financial Assets**

Financial assets are recognised when the CCG becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.16.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.16.2 **Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.16.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.16.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the CCG recognises a loss allowance representing the expected credit losses on the financial asset.

The CCG 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 CCG 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 CCG does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.17 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the CCG becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.17.2 **Financial Liabilities at Fair Value Through Profit and Loss**

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 CCG's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.17.3 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 **Value Added Tax**

Most of the activities of the CCG 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.

Notes to the financial statements

1 Accounting Policies (cont)

1.19 **Losses & Special Payments**

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

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

1.20.1 **Critical accounting judgements in applying accounting policies**

The CCG has made no critical judgements in applying accounting policies.

1.20.2 **Sources of estimation uncertainty**

The CCG has made no assumptions or estimations that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.21 **Adoption of new standards**

On 1 April 2022, the CCG 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 CCG will recognise a right-of-use asset representing the CCG'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 CCG will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the CCG will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Impact assessment

The CCG 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 CCG has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The CCG 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 CCG recognised £0.751m or right-of-use assets and lease liabilities of £0.751m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was an £0.040m impact to tax payers' equity.

The CCG 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 CCG's operating lease obligations at 31 March 2022, disclosed in the group's 2021-2022 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		-
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		-
Add: Finance lease liabilities at 31 March 2022		751
Add: Peppercorn leases revalued to existing value in use		-
Add: Residual value guarantees		-
Add: Rentals associated with extension options reasonably certain to be exercised		-
Less: Short term leases (including those with <12 months at application date)		-
Less: Low value leases		-
Less: Variable payments not included in the valuation of the lease liabilities	-	751
Lease liability at 1 April 2022		**-**

1.22 **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.

2. Employee benefits and staff numbers

2.1 Employee benefits

	Permanent Employees £'000	Other £'000	Three Month Period Ended 30 June 2022 £'000
Employee Benefits			
Salaries and wages	696	108	804
Social security costs	66	-	66
Employer Contributions to NHS Pension scheme	100	-	100
Gross employee benefits expenditure	862	108	970
Less recoveries in respect of employee benefits	-	-	-
Total - Net admin employee benefits including capitalised costs	862	108	970
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	862	108	970

	Permanent Employees £'000	Other £'000	2021-22 Total £'000
Employee Benefits			
Salaries and wages	2,651	393	3,044
Social security costs	237	-	237
Employer Contributions to NHS Pension scheme	440	-	440
Gross employee benefits expenditure	3,328	393	3,721
Less recoveries in respect of employee benefits	-	-	-
Total - Net admin employee benefits including capitalised costs	3,328	393	3,721
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	3,328	393	3,721

2.2 Average number of people employed	2022-23			2021-22		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**49.16**	**3.96**	**53.12**	**51.46**	**4.05**	**55.51**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

2.3 Exit packages agreed in the three month period ended 30 June 2022

There were no exit packages agreed in the three month period ended 30 June 2022 (2021-22: nil).

2.4 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:

2.4.1 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.

2.4.2 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.

3. Operating expenses	Three Month Period Ended 30 June 2022 Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	519	1,343
Services from foundation trusts	35,001	137,277
Services from other NHS trusts	22,057	87,007
Purchase of healthcare from non-NHS bodies	8,358	31,942
Purchase of social care	3,678	15,957
Prescribing costs	8,306	35,629
GPMS/APMS and PCTMS	8,128	32,741
Supplies and services – clinical	105	294
Supplies and services – general	15	69
Consultancy services	-	19
Establishment	25	507
Premises	1,248	4,501
Audit fees	64	62
Other non statutory audit expenditure		
· Other services	3	12
Other professional fees	4	2
Legal fees	29	108
Education, training and conferences	-	24
Total Purchase of goods and services	**87,540**	**347,494**
Depreciation and impairment charges		
Depreciation	43	22
Amortisation	7	33
Total Depreciation and impairment charges	**50**	**55**
Provision expense		
Provisions	-	-
Total Provision expense	**-**	**-**
Other Operating Expenditure		
Chair and Non Executive Members	36	155
Grants to Other bodies	153	273
Other expenditure	-	2
Total Other Operating Expenditure	**189**	**430**
Total operating expenditure	**87,779**	**347,979**

* The auditor's liability for external audit work carried out in the period is limited to £2m.

** Other Services from external audit of £3k have been accrued in respect of the 2022-23 Mental Health Investment Standard Audit (2021-22; £12k).

4. Better Payment Practice Code

Measure of compliance	Three Month Period Ended 30 June 2022 Number	Three Month Period Ended 30 June 2022 £'000	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Period / Year	1,321	20,680	5,078	91,844
Total Non-NHS Trade Invoices paid within target	1,256	20,481	4,913	89,972
Percentage of Non-NHS Trade invoices paid within target	**95.08%**	**99.04%**	**96.75%**	**97.96%**
NHS Payables				
Total NHS Trade Invoices Paid in the Period / Year	188	56,759	668	227,641
Total NHS Trade Invoices Paid within target	184	56,549	651	227,504
Percentage of NHS Trade Invoices paid within target	**97.87%**	**99.63%**	**97.46%**	**99.94%**

5. Finance costs

	Three Month Period Ended 30 June 2022 £'000	2021-22 £'000
Interest		
Interest on loans and overdrafts	2	-
Other interest expense	-	-
Total interest	**2**	**-**
Other finance costs	-	-
Total finance costs	**2**	**-**

6. Property, plant and equipment Three month period ended 30 June 2022	Information technology £'000	Total £'000
Cost or valuation at 01 April 2022	108	108
Additions purchased	-	-
Cost/Valuation at 30 June 2022	**108**	**108**
Depreciation 01 April 2022	85	85
Charged during the period	3	3
Depreciation at 30 June 2022	**88**	**88**
Net Book Value at 30 June 2022	**20**	**20**
Purchased	20	20
Total at 30 June 2022	**20**	**20**
Asset financing:		
Owned	20	20
Total at 30 June 2022	**20**	**20**

2021-22	Information technology £'000	Total £'000
Cost or valuation at 01 April 2021	108	108
Additions purchased	-	-
Cost/Valuation at 31 March 2022	**108**	**108**
Depreciation 01 April 2021	63	63
Charged during the year	22	22
Depreciation at 31 March 2022	**85**	**85**
Net Book Value at 31 March 2022	**23**	**23**
Purchased	23	23
Total at 31 March 2022	**23**	**23**
Asset financing:		
Owned	23	23
Total at 31 March 2022	**23**	**23**

6.1 Economic lives	Minimum Life (years)	Maximum Life (Years)
Information technology	1	2

6a. Leases

6a.1 Right-of-use assets

Three month period ended 30 June 2022	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2022	-	-
IFRS 16 Transition Adjustment	751	751
Additions	-	-
Cost/Valuation at 30 June 2022	**751**	**751**
Depreciation 01 April 2022	-	-
Charged during the period	40	40
Depreciation at 30 June 2022	**40**	**40**
Net Book Value at 30 June 2022	**711**	**711**

6a.2 Lease liabilities

	3 month period to 30 June 2022 £'000	2021-22 £'000
Lease liabilities at 01 April 2022	-	-
IFRS 16 Transition Adjustment	751	-
Repayment of lease liabilities (including interest)	2	-
Lease remeasurement	(40)	-
Lease liabilities at 30 June 2022	**713**	-

6a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	3 month period to 30 June 2022 £'000	2021-22 £'000
Within one year	(162)	-
Between one and five years	(565)	-
After five years	-	-
Balance at 30 June 2022	**(727)**	**-**
Effect of discounting	14	-
Included in:		
Current lease liabilities	(148)	-
Non-current lease liabilities	(565)	-
Balance at 30 June 2022	**(713)**	**-**

6a. Leases cont'd

6a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	Three Month Period Ended 30 June 2022 £'000	2021-22 £'000
Depreciation expense on right-of-use assets	40	-
Interest expense on lease liabilities	2	-
Total	42	-

6a.5 Amounts recognised in Statement of Cash Flows

	Three Month Period Ended 30 June 2022 £'000	2021-22 £'000
Total cash outflow on leases under IFRS 16	(40)	-

7. Intangible non-current assets Three month period ended 30 June 2022	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2022	169	**169**
Additions purchased	-	**-**
Cost / Valuation At 30 June 2022	**169**	**169**
Amortisation 01 April 2022	134	**134**
Charged during the period	7	**7**
Amortisation At 30 June 2022	**141**	**141**
Net Book Value at 30 June 2022	**28**	**28**
Purchased	28	**28**
Total at 30 June 2022	**28**	**28**

2021-22	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2012	169	**169**
Additions purchased	-	**-**
Cost / Valuation At 31 March 2022	**169**	**169**
Amortisation 01 April 2021	101	**101**
Charged during the year	33	**33**
Amortisation At 31 March 2022	**134**	**134**
Net Book Value at 31 March 2022	**35**	**35**
Purchased	35	**35**
Total at 31 March 2022	**35**	**35**

7.1 Economic lives	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	1	1

8.1 Trade and other receivables	Current 3 month period to 30 June 2022 £'000	Current 2021-22 £'000
NHS receivables: Revenue	61	182
NHS prepayments	108	-
NHS accrued income	-	42
NHS Non Contract trade receivable (i.e pass through funding)	33	75
Non-NHS and Other WGA receivables: Revenue	117	2,578
Non-NHS and Other WGA prepayments	1,703	287
Non-NHS and Other WGA accrued income	28	7
VAT	8	5
Other receivables and accruals	1,087	1,215
Total Trade & other receivables	**3,145**	**4,391**
Total current and non current	**3,145**	**4,391**

There were no Non Current Trade and Other Receivables in 2022-23 (2021-22: nil).

8.2 Receivables past their due date but not impaired	3 month period to 30 June 2022 DHSC Group Bodies £'000	3 month period to 30 June 2022 Non DHSC Group Bodies £'000	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	41	2	24	200
By three to six months	-	115	-	7
By more than six months	-	-	-	-
Total	**41**	**117**	**24**	**207**

In 2018-19 the CCG adopted the new standard IFRS 9 Financial Instruments. The CCG developed a provision matrix using historic data and applied it to the CCG's 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 for the three month period ended 30 June 2022 (2021-22: nil).

9. Cash and cash equivalents	3 month period to 30 June 2022 £'000	2021-22 £'000
Balance at 01 April 2022	57	2
Net change in period / year	83	55
Balance at 30 June 2022	**140**	**57**
Made up of:		
Cash with the Government Banking Service	140	57
Cash in hand	-	-
Cash and cash equivalents as in statement of financial position	**140**	**57**
Bank overdraft: Government Banking Service	-	-
Total bank overdrafts	**-**	**-**
Balance at 30 June 2022	**140**	**57**

10. Trade and other payables	Current 3 month period to 30 June 2022 £'000	Current 2021-22 £'000
NHS payables: Revenue	78	609
NHS accruals	2,346	503
Non-NHS and Other WGA payables: Revenue	2,297	1,423
Non-NHS and Other WGA accruals	2,464	4,627
Social security costs	45	38
Tax	37	34
Other payables and accruals	8,630	8,967
Total Trade & Other Payables	**15,897**	**16,201**
Total current and non-current	**15,897**	**16,201**

There were no Non Current Trade and Other Payables in 2022-23 (2021-22: nil).

Other payables include £45,448 outstanding staff pension contributions as at 30 June 2022 (31 March 2022: £48,296) and £133,065 outstanding GP Pension contributions (31 March 2022: £177,205).

11. Financial instruments

11.1 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 the CCG 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 CCG 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 CCG in undertaking its activities.

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

11.1.1 Currency risk

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

11.1.2 Interest rate risk

The CCG 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 CCG therefore has low exposure to interest rate fluctuations.

11.1.3 Credit risk

Because the majority of the CCG revenue comes from parliamentary funding, the CCG 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.

11.1.4 Liquidity risk

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

11.1.5 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.

11. Financial instruments cont'd

11.2 Financial assets

	Financial Assets measured at amortised cost 3 month period to 30 June 2022 £'000	**Total 3 month period to 30 June 2022 £'000**	Financial Assets measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Trade and other receivables with NHSE bodies	33	33		
Trade and other receivables with other DHSC group bodies	89	89		
Trade and other receivables with external bodies	1,204	1,204		
Cash and cash equivalents	140	140		
Total at 30 June 2022	**1,466**	**1,466**	**-**	**-**
Non Financial Assets	1,819	1,819		
Total Assets at 30 June 2022	**3,285**	**3,285**	**0**	**0**

11.3 Financial liabilities

	Financial Liabilities measured at amortised cost 3 month period to 30 June 2022 £'000	**Total 3 month period to 30 June 2022 £'000**	Financial Liabilities measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Trade and other payables with NHSE bodies	831	**831**		
Trade and other payables with other DHSC group bodies	1,645	**1,645**		
Trade and other payables with external bodies	14,052	**14,052**		
Total at 30 June 2022	**16,528**	**16,528**	**-**	**-**
Non Financial Liabilities	**82**	**82**		
Total Liabilities at 30 June 2022	**16,610**	**16,610**	**-**	**-**

12. Operating segments

The CCG considers that it only has one operating segment: commissioning of healthcare services.

13. Joint arrangements - interests in joint operations

The CCG has entered into a pooled budget with Knowsley Metropolitan Borough Council (KMBC). The pool is hosted by KMBC.

Under the arrangement, funds are pooled under Section 75 of the NHS Act 2006 and are used for the provision of Learning Disability, Mental Health, Community Support Services and the Better Care Fund. The Better Care fund is a plan for the CCG and the Local Authority to work more closely together, driving integration and improved outcomes for three core initiatives being Localities, Safe Supported Discharge and Access Knowsley.

13.1 Interests in joint operations

			Amounts recognised in Entities books ONLY Three month period ended 30 June 2022				Amounts recognised in Entities books ONLY 2021-22			
Name of arrangement	Parties to the arrangement	Description of principal activities	Assets as at 30 June 2022	Liabilities as at 30 June 2022	Income	Expenditure	Assets as at 31 March 2022	Liabilities as at 31 March 2022	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pooled Funds under the Section 75 of the NHS Act 2006	NHS Knowsley CCG / Knowsley Metropolitan Borough Council	To support intergrated working.	1,088	(1,088)	(6,593)	6,703	1,215	(1,215)	(25,278)	25,873

14. Related party transactions

Details of related party transactions with individuals are as follows:

Three month period ended 30 June 2022	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
The CCG has a contract with Dinas Lane Medical Centre which is a related party as Dr Paul Conway (Governing Body Member: GP and Clinical Lead for Long Term Condtions) are partners in that practice.	469	-	-	-
The CCG has a contract with Colby Medical Centre Ltd which is a related party as Sandra Kanczes-Daly (Governing Body Member: Nurse) is a shareholder.	154	-	-	-
The CCG has a contract with Wingate Medical Centre which is a related party as Dr Simon Perritt (Governing Body Member: Clinical Lead for Unplanned Care) is a partner in that practice.	543	-	-	-
The CCG has a contract with Hillside House Surgery which is a related party as Dr Pervez Sadiq (Governing Body Member: GP and Clinical Membership Group Practice Representative) is a partner in that practice.	158	-	-	-
The CCG has shared service contracts with NHS Liverpool CCG which is a related party as Mark Bakewell (Chief Finance Officer) was also Chief Finance Officer of that CCG.	261	-	298	-
The CCG has shared service contracts with NHS Liverpool CCG which is a related party as Jan Ledward (Chief Finance Officer) was also interim Chief Officer of that CCG.	261	-	298	-

14. Related party transactions
Details of related party transactions with individuals are as follows:

2021-22	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
The CCG has a contract with Dinas Lane Medical Centre which is a related party as Dr Paul Conway (Governing Body Member: Clinical Quality and Safety Lead) are partners in that practice.	2,064	-	-	-
The CCG has a contract with Colby Medical Centre Ltd which is a related party as Sandra Kanczes-Daly (Governing Body Member: Nurse) is a shareholder.	626	-	-	-
The CCG has a contract with Wingate Medical Centre which is a related party as Dr Simon Perritt (Governing Body Member: Clinical Lead for Unplanned Care) is a partner in that practice.	2,360	-	-	-
The CCG has a contract with Hillside House Surgery which is a related party as Dr Pervez Sadiq (Governing Body Member: Clinical Lead for Women and Children) is a partner in that practice.	687	-	-	-
The CCG has shared service contracts with NHS Liverpool CCG which is a related party as Mark Bakewell (Chief Finance Officer) was also Chief Finance Officer of that CCG.	305	-	64	(8)
The CCG has shared service contracts with NHS Liverpool CCG which is a related party as Jan Ledward (Interim Chief Officer) was also Chief Officer of that CCG.	305	-	64	(8)

The Department of Health is regarded as a related party. In the three month period ended 30 June 2022 the CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department, including:

Alder Hey NHS Foundation Trust
Bridgewater Healthcare NHS Foundation Trust
Liverpool Heart & Chest Hospital NHS Foundation Trust
Liverpool University Hospitals NHS Foundation Trust
Liverpool Women's Hospital NHS Foundation Trust
Merseycare NHS Foundation Trust
NHS Business Services Authority
NHS England (including NHS Arden & GEM Commissioning Support Unit and NHS Midlands & Lancashire Commissioning Support Unit)
North West Ambulance NHS Trust
North West Boroughs Healthcare NHS Foundation Trust
Southport & Ormskirk Hospitals NHS Trust
St Helens & Knowsley Teaching Hospitals NHS Trust
The Walton Centre NHS Foundation Trust
Warrington & Halton Hospitals NHS Foundation Trust
Wirral University Teaching Hospitals NHS Foundation Trust
Wrightington Wigan & Leigh NHS Foundation Trust

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Knowsley Metropolitan Borough Council, NHS Property Services Limited and Community Health Partnerships Limited.

15. 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 ICB on 1 July 2022 as summarised below:

Amounts transferred to NHS Cheshire and Merseyside ICB from 1 July 2022:

	£'000
Non-current Assets	756
Current Assets	3,286
Current Liabilities	(16,043)
Non-current Liabilities	(566)
Net Assets/Liabilities	**(12,567)**

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

Due to the demise of the CCG on 30 June 2022, these financial statements have been prepared for the three-month period 1 April 2022 to 30 June 2022. Comparative figures within the financial statements are for a full year and therefore not truly comparative with this shortened accounting period.

16. Losses and Special Payments

The CCG did not incur any losses nor any special payment cases during the three month period ended 30 June 2022 (2021-22: nil).

17. Financial performance targets

The CCG has a number of financial duties under the NHS Act 2006 (as amended).
The CCG's performance against those duties was as follows:

	Three Month Period Ended 30 June 2022 Target £'000	**Three Month Period Ended 30 June 2022 Performance £'000**	2021-22 Target £'000	2021-22 Performance £'000
Expenditure not to exceed income	88,751	88,751	351,720	351,700
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	88,751	88,751	351,720	351,700
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	828	828	3,216	3,189

APPENDICES

Appendix 1 - Member Practices and Clinical Membership Group Composition

The CCG comprises the 25 GP practices in the borough of Knowsley:

Practice Name	Address	CMG Representative
Aston Healthcare Ltd	Manor Farm Primary Care Resource Centre, Manor Farm Road, Huyton, Liverpool, L36 0UB	Dr C Kenny
Bluebell Lane Medical Practice	The Bluebell Centre, Bluebell Lane, Huyton, Liverpool L36 7XY	Dr F Maassarani
Cedar Cross Medical Centre	Whiston Primary Care Resource Centre, Old Colliery Road, Whiston, Merseyside, L35 3SX	Dr K Kyaw
Colby Medical Centre	The Bluebell Centre, Bluebell Lane, Huyton, Liverpool,L36 7XY	S Kanczes-Daly
Cornerways Surgery	Woolfall Heath Avenue, Huyton, Liverpool, L36 3TN	L Panter
Dinas Lane Medical Centre	Dinas Lane Medical Centre, 149 Dinas Lane, Huyton, Liverpool, L36 2NW	Dr B Loughran
Dr Maassarani & Partners	Tower Hill Primary Care Resource & Community Centre, Ebony Way, Kirkby, Liverpool, L33 1XT	Dr F Maassarani
Hillside House Surgery	The Bluebell Centre, Bluebell Lane, Huyton, Liverpool, L36 7XY	Dr P Sadiq
Hollies Medical Centre	Hollies Medical Centre, Hollies Road, Halewood Village, Liverpool, L26 0TH	Dr S Rai
Longview Medical Centre	Longview Primary Care Centre, Longview Drive, Huyton, Liverpool, L36 6EB	Dr M Alexander
Millbrook Medical Centre	Southdene Primary Care Resource Centre, Bewley Drive, Kirkby, L32 9PF	Dr G West
Nutgrove Villa Surgery	Nutgrove Villa, Westmorland Road, Huyton, Liverpool, L36 6GA	Dr R Kulandaisamy
Park House Medical Centre	Prescot Primary Care Resource Centre, Sewell Street, Prescot, Merseyside, L34 1ND	Dr P Akbionbare
Pilch Lane Surgery	Pilch Lane Surgery, Pilch Lane, Huyton, Liverpool, L14 0JE	Dr Joy Kulangara
Prescot Medical Centre	Prescot Primary Care Resource Centre, Sewell Street, Prescot, L34 1ND	Dr D Heath
Primrose Medical Practice	The Bluebell Centre, Bluebell Lane, Huyton, Liverpool L36 7XY	Dr S Choudarapu
Roby Medical Centre	70-72 Pilch Lane East, Roby, Liverpool, Merseyside, L36 4NP	Dr A Amir
Roseheath Surgery	Roseheath Drive, Halewood, Liverpool, L26 9UH	Dr F Maassarani
St Laurence's Medical Centre	St. Laurence's Medical Centre, 32 Leeside Avenue, Southdene, Kirkby, Liverpool, L32 9QU	Dr A Fell

Practice Name	Address	CMG Representative
Stockbridge Village Health Centre	Stockbridge Village Health Centre, Waterpark Drive, Stockbridge Village, Liverpool, L28 3QA	Dr S Sekhar
Tarbock Medical Centre	Manor Farm Primary Care Resource Centre, Manor Farm Road, Huyton, Liverpool, L36 0UB	Dr R Rashid
The Health Centre Surgery	The Health Centre Surgery, Roseheath Drive, Halewood, Liverpool, L26 9UH	Dr F Maassarani
The MacMillan Surgery	St Chads Centre, St Chads Drive, Kirkby, Merseyside, L32 8RE	Dr K F Thong
Trentham Medical Centre	St Chads Centre, St Chads Drive, Kirkby, L32 8RE	Dr F Maassarani
Wingate Medical Centre	79 Bigdale Drive, Northwood, Kirkby, Liverpool, L33 6YJ	Dr S Wee

Appendix 2 - Governing Body and Committee Composition

Governing Body				
Title	**Name**	**Start**	**End**	**Comments**
Chair	Dr A Pryce	01-Apr-13	30-Jun-22	
Chief Executive	D Johnson	01-Apr-13	30-Sep-21	
Interim Chief Officer	J Ledward	14-Sep-21	30-Jun-22	
Chief Finance Officer	M Bakewell	02-Oct-19	30-Jun-22	
	Name	**Start**	**End**	**Comments**
Member Practice Representative	Dr P Conway	01-Apr-13	30-Jun-22	
Member Practice Representative	S Kanczes-Daly	01-Aug-16	30-Jun-22	
Member Practice Representative	Dr P Sadiq	01-Apr-13	30-Jun-22	
Member Practice Representative	Dr S Perritt	01-Apr-14	30-Jun-22	
Lay Members	**Name**	**Start**	**End**	**Comments**
Audit and Governance	A Chan	29-Jan-18	30-Jun-22	
Patient and Public Involvement	J Mawer	20-Feb-17	30-Jun-22	
Patient and Public Involvement	D Bedwell	13-Jan-20	30-Jun-22	
Clinical Advisors	**Name**	**Start**	**End**	**Comments**
Secondary Care Doctor	Dr S Benbow	01-Aug-16	30-Jun-22	
Registered Nurse	H Meredith	19-Apr-19	30-Jun-22	Note – Helen undertakes this in addition to her permanent role of Chief Nurse which she has held since 01-Feb-15

Audit Committee

Members	
Chair – Lay Member Audit and Governance	A Chan to 30-Jun-22
Lay Member/Clinical Advisors	J Mawer to 30-Jun-22
	D Bedwell to 30-Jun-22
	Dr S Benbow to 30-Jun-22
CMG Representative (not on GB)	Dr B Loughran to 30-Jun-22
In attendance	
Internal Audit Representative	G Baines to 30-Jun-22 N Woodcock to 30-Jun-22
External Audit Representative	G Winstanley to 30-Jun-22 M Green to 30-Jun-22
Counter Fraud Representative	K McArdle to 30-Jun-22
Chief Finance Officer	M Bakewell to 30-Jun-22
Assistant Director – Corporate Services	D Boyer to 30-Jun-22
Principal Accountant	C Hinchliffe to 30-Jun-22

Remuneration Committee

Members	
Chair – Lay Member	J Mawer to 30-Jun-22
Lay Member /Clinical Advisors	Dr S Benbow to 30-Jun-22
	A Chan to 30-Jun-22
	D Bedwell to 30-Jun-22
Chair of Governing Body	Dr A Pryce to 30-Jun-22
GP or Health Professional representing member practices on the Governing Body	Dr P Sadiq to 30-Jun-22
CSU HR Business Partner	G Roberts to 30-Jun-22
In Attendance	
Chief Executive	D Johnson to 30-Sep-21
Interim Accountable Officer	Jan Ledward from 14-Sep-21 to 30-Jun-22
Executive Services Manager	V Parsonage-Howard to 30-Jun-22
Assistant Chief Executive	P Thomas to Nov-21 to 30-Jun-22

HR Committee

Members	
Chair – Lay Member	J Mawer to 30-Jun-22
Lay Members /Clinical Advisors	Dr S Benbow to 30-Jun-22
	A Chan to 30-Jun-22
	D Bedwell to 30-Jun-22
Chair of Governing Body	Dr A Pryce to 30-Jun-22
GP or Health Professional representing member practices on the Governing Body	Dr P Sadiq to 30-Jun-22
Chief Executive	D Johnson to 30-Sep-21 to 30-Jun-22
Interim Chief Officer	J Ledward from 14-Sep-21 to 30-Jun-22
CSU HR Business Partner	G Roberts to 30-Jun-22
Assistant Director - Corporate Service	D Boyer to 30-Jun-22
In Attendance	
Executive Services Manager	V Parsonage-Howard to 30-Jun-22
Assistant Chief Executive	P Thomas to Nov-21 to 30-Jun-22

Finance and Performance Committee

Members	
Chair – Lay Member /Clinical Advisor	D Bedwell to 30-Jun-22
Lay Members	A Chan to 30-Jun-22
	Dr S Benbow to 30-Jun-22
	J Mawer to 30-Jun-22
Chief Executive	D Johnson to 30-Sep-21
Interim Chief Officer	J Ledward from 14-Sep-21 to 30-Jun-22
Chair	Dr A Pryce to 30-Jun-22
GP or other healthcare professional representing member practices on the Governing Body x 2	Dr S Perritt to 30-Jun-22 *Vacant*

Members	
Chief Finance Officer	M Bakewell to 30-Jun-22
Lead CCG Officer responsible for Commissioning / Primary Care	P Thomas to Nov-21 to 30-Jun-22
In attendance	
Contracting Lead Officer	C Tyghe to 30-Jun-22
Deputy Chief Finance Officer	R Tunstall to 30-Jun-22

Quality Committee

Members	
Chair – Lay Member	Dr S Benbow to 30-Jun-22
Lay Member /Clinical Advisors	Judith Mawer to 30-Jun-22
	A Chan to 30-Jun-22
	D Bedwell to 30-Jun-22
Chief Executive	D Johnson to 30-Sep-21
Interim Chief Officer	J Ledward from 14-Sep-21 to 30-Jun-22
Chief Nurse	H Meredith to 30-Jun-22
Governing Body Clinical Lead x 2	Dr P Conway to 30-Jun-22
	Vacant
Lead CCG Officer responsible for Commissioning/Primary Care	P Thomas to Nov-21 to 30-Jun-22
In attendance	
Healthwatch Representative	P Coogan to 30-Jun-22
Public Health Representative	Dr S McNulty to 30-Jun-22
Safeguarding Service Representative	D Goncalves to 30-Jun-22

Primary Care Committee

Members	
Chair – Lay Member	J Mawer to 30-Jun-22
Lay Members	A Chan to 30-Jun-22
	D Bedwell to 30-Jun-22
Secondary Care Doctor	Dr S Benbow to 30-Jun-22
Chief Executive	D Johnson to 30-Sep-21
Interim Chief Officer	J Ledward from 14-Sep-21 to 30-Jun-22
Chief Finance Officer	M Bakewell to 30-Jun-22
Lead Officer responsible for Commissioning	P Thomas to Nov-21 to 30-Jun-22
Chief Nurse	H Meredith to 30-Jun-22
Lead Officer responsible for Primary Care	Alistair MacFarlane to 30-Jun-22
Non-voting members	
A maximum of four GPs including the Clinical Chair of the Governing Body and the Clinical Lead for Primary Care	Dr A Pryce to 30-Jun-22
	Dr M Alexander to 30-Jun-22
In attendance	
Healthwatch Knowsley Representative	P Mavers to 30-Jun-22

Members	
Health and Wellbeing Board Representative	Dr S McNulty to 30-Jun-22
LMC Representative	Dr M Alexander to 30-Jun-22

Medicines Management Sub Committee

Members	
Chair – Lay Member	Dr Sue Benbow to 30-Jun-22
Clinical Lead – Prescribing	Dr Adit Jain to 30-Jun-22
GP locality representative (practice prescribing leads)	Dr Andrew Pryce to 30-Jun-22
	Dr Ronnie Thong to 30-Jun-22
LMC GP Representative	Dr M Alexander to 30-Jun-22
LPC Pharmacist representative	L Gatley to 30-Jun-22
Lead CCG Officer responsible for Medicines Management	H Meredith to 30-Jun-22
Senior Finance Representative	Christine Warburton to 30-Jun-22
In attendance	
Deputy Lead CCG Officer responsible for Medicines Management	Carolyn Barton to 30-Jun-22
A nominated Secondary Care prescriber	*Vacant*
Mental Health Services representative	L Prescott to 30-Jun-22
Senior Pharmacist from Acute Trust	*Vacant*
Senior Pharmacist from CSU	Helen Dingle to 30-Jun-22
Community Services Representative	Fiona Boyd to 30-Jun-22

Appendix 3 – Clinical Membership Group, Governing Body and Committee Attendance

Clinical Membership Group Meeting Attendance	Practice Lead	F/M	12/04/22	07/06/22
Aston Healthcare Ltd	Dr C Kenny	F	X	✓
Bluebell Lane Medical Practice	Dr F Maassarani	M	X	✓
Cedar Cross Medical Centre	Dr K Kyaw	F	✓	X
Colby Medical Centre	S Kanczes-Daly	F	X	✓
Cornerways Surgery	Dr F Maassarani	M	X	✓
Dinas Lane Medical Centre	Dr B Loughran	F	✓	Dr Rachel Russell
Dr Maassarani & Partners	Dr C Kenny	F	X	✓
Hillside House Surgery	Dr P Sadiq	M	X	X
Hollies Medical Centre	Dr S Rai	M	X	X
Longview Medical Centre	Dr M Alexander	M	X	✓
Millbrook Medical Centre	Dr G West	F	✓	✓
Nutgrove Villa Surgery	Dr R Kulandaisamy	M	✓	X
Park House Medical Centre	Dr H Sukhavasi (left 19/07/22)	F	✓	Dr P Akbionbare
Pilch Lane Surgery	Dr Joy Kulangara	F	✓	✓

Appendix 3 – Clinical Membership Group, Governing Body and Committee Attendance

Clinical Membership Group Meeting Attendance	Practice Lead	F/M	12/04/22	07/06/22
Prescot Medical Centre	Dr D Heath	F	✓	✓
Primrose Medical Practice	Dr S Choudarapu	F	✓	✓
Roby Medical Centre	Dr Aman Amir	M	X	Erika Howell
Roseheath Surgery	Dr F Maassarani	M	X	✓
St Laurence's Medical Centre	Dr A Fell	F	✓	X
Stockbridge Village Health Centre	Dr S Sekhar	F	X	✓
Tarbock Medical Centre	Dr R Rashid	F	✓	✓
The Health Centre Surgery	Dr M Wijesinghe	M	Dr Carmen Simo-Garcia	Dr Carmen Simon-Garcia
The MacMillan Surgery	Dr K (R) Thong	M	✓	X
Trentham Medical Centre	Dr V Tewari	M	X	Lee Panter
Wingate Medical Centre	Dr S Wee	M	X	X

Name	Title	M/F	Governing Body	Audit Committee	Remun-eration Committee	Quality Committee	Primary Care Committee	Medicines Management Sub-Cttee	HR Committee	Finance & Performance Committee
Alison Lee	Place Director, Knowsley		1/2							
Andrew Pryce	Chair	M	2/2		0/0	3/3	1/1	0/1	1/1	0/1
Pervez Sadiq	GP on the Governing Body	M	0/2		0/0				0/1	
Allan Chan	Lay Member- Audit & Governance	M	2/2	1/1	0/0	1/3	0/1		1/1	0/1
Judith Mawer	Lay Member- Patient & Public Involvement	F	2/2	1/1	0/0	3/3	1/1		1/1	1/1
David Bedwell	Lay Member - Patient & Public Involvement	M	2/2	1/1	0/0	1/3	1/1		1/1	1/1
Sue Benbow	Secondary Care Doctor	F	2/2	1/1	0/0	3/3	1/1	1/1	1/1	0/1
Jan Ledward	Interim Accountable Officer	F	1/2		0/0	2/3	0/1			
Gillian Roberts	Senior HR Advisor, Midlands & Lancashire CSU	F			0/0				1/1	
Dianne Johnson	Chief Executive/Executive Director of Transition	F	0/2			0/3	0/1		1/1	0/1
Mark Bakewell	Chief Finance Officer	M	2/2	1/1			1/1		1/1	1/1
Paul Conway	GP on the Governing Body	M	2/2			2/3				
Sandra Kanczes-Daly	Nurse on the Governing Body	F	0/2							
Simon Perritt	GP on the Governing Body	M	1/2							0/1
Helen Meredith	Registered Nurse	F	2/2							
Helen Meredith	Chief Nurse	F				3/3	1/1	1/1		
Breige Loughran	CMG Representative on Audit Committee	F		0/1						
Manu Alexander	CMG Representative on Primary Care Committee and LMC GP Representative on Medicines Management Sub-Committee	M					1/1	1/1		
Adit Jain	Clinical Lead - Prescribing	M						0/1		
Dr Ronnie Thong	GP Locality Representative	M						1/1		
Louise Gatley	LPC Pharmacist Representative	F						0/1		
Michelle Clunie	Senior Finance Manager	F						0/1		
Paul Coogan	Healthwatch Knowsley	M	2/2			3/3				
Sarah McNulty	Director of Public Health, KMBC	F	0/2			0/3	0/1			
Philip Thomas	Assistant Chief Executive/transition Programme	M	0/2			0/3	0/1			0/1
Dawn Boyer	Assistant Director, Corporate	F	2/2	1/1						1/1
Gary Baines	Internal Audit Representative	F		1/1						
Nigel Woodcock	Internal Audit Representative	M		1/1						
Karen McArdle	Internal Audit Representative	F		0/1						
Gareth Winstanley	External Audit Representative	M		1/1						
Michael Green	External Audit Representative	M	1/2	1/1						
Charlotte Hinchcliffe	Principal Accountant	F		1/1						
Debbie Hammersley	Designated Safeguarding Nurse-Children	F				0/3				
Josette Niyokinda	Deputy Chief Nurse	F				3/3				
Dianne Goncalves	Designated Safeguarding Nurse-Adults	F				2/3				
Kelly Hurn	Healthwatch Knowsley	F					1/1			
Bindhu Sukhavasi	LMC Representative	F					1/1			
Carolyn Barton	Lead Pharmacist	F						1/1		
Lorraine Prescott	Mental Health Services Representative	F						0/1		
Fiona Boyd	Senior Pharmacist from Acute Trust	F						1/1		
Helen Dingle	Senior Pharmacist from CSU	F						1/1		
Annie Loi	Safety & Quality Pharmacist	F						1/1		
Becky Tunstall	Deputy Chief Finance Officer	F								1/1
Claire Tyghe	Contracts Manager	F								0/1
Val Attwood	Deputy Chief Contracting Officer	F								0/1
Becky Williams	Head of Planning & Performance	F								1/1

* Includes attendance by designated deputies