NHS
Cheshire
Clinical Commissioning Group

ANNUAL REPORT AND ACCOUNTS
2022/23, Quarter 1

Contents

1. The Performance Report

1.1. Overview

The following section provides a brief overview of NHS Cheshire Clinical Commissioning Group (CCG), its purpose, the key risks to the achievement of its objectives and how it has performed during the first quarter of 2022/23. This was the last period of operation of NHS Cheshire CCG before statutory responsibilities passed to the Cheshire and Merseyside Integrated Commissioning Board (ICB) on 1 July 2022. More detail on the performance and activities of the CCG in delivering particular statutory duties is contained in the subsequent Performance Analysis section.

1.1.1 Statement from the Accountable Officer

When the Health and Social Care Act 2022 come into force on 1 July 2022, CCGs were abolished and NHS Cheshire and Merseyside Integrated Care Board (ICB) was created. The Health and Care Act placed a duty on NHS organisations and local authorities to collaborate and promote joint working across healthcare, public health, and social care. Under the Act, partners have a shared duty to have regard for the 'triple aim' of better health and wellbeing for everyone, better care for all people and sustainable use of NHS resources. This continued a direction of travel the CCG had been on for some time.

Within the Report you will find information on what the CCG did to deliver its objectives and statutory duties while continuing to develop collaborative arrangements and support the creation of the ICB.

I would like to take this opportunity to thank the staff and members of the CCG for their outstanding work and dedication in what has been an extraordinary period. Much good work has been done and the CCG, working with partners, rose to the significant challenges faced. The CCG handed over the legacy work and corporate memory it formed to the ICB. This will place the ICB in a strong position as it builds on the work of the CCG and continues to strive to address inequalities and improve health outcomes for the local population.

1.1.2 Statement of the Purpose and Activities of the Organisation

NHS Clinical Commissioning Groups (CCGs) were responsible for planning and buying local health services between April 2013 and 30 June 2022. CCGs combined the expertise of clinicians including family doctors (GPs), nurses and NHS managers – putting local doctors and nurses at the heart of decision-making.

NHS Cheshire Clinical Commissioning Group (CCG) was responsible for planning and buying healthcare services for a population of around 770,000 people. It was the CCG's responsibility to ensure the local health budget of c£1.2bn was well spent.

NHS Cheshire CCG was responsible for planning and buying:

- GP (family doctor) services – sometimes referred to as "primary care";
- Planned (or elective) hospital care;
- Urgent and emergency care including "blue light" ambulance services, Accident and Emergency (A&E) services, NHS 111 (non-emergency line) and out-of-hours services which operate when GP practices are closed;
- Community health services (e.g. district nursing);
- Maternity services;
- Older people's healthcare services;
- Healthcare services for children, including those with complex healthcare needs;
- Rehabilitation services;
- Healthcare services for people with mental health conditions;
- Healthcare services for people with learning disabilities and autism; and
- Continuing Healthcare and Funded Nursing Care support for people with complex needs who require specialist nursing support.

To achieve this, the work of NHS Cheshire CCG was organised across the following directorates:

- Clinical;
- Finance and Contracting;
- Governance and Corporate Development;
- Planning and Delivery;
- Quality, Patient Experience and Safeguarding; and
- Strategy and Partnerships.

A clinically-led organisation which encourages public involvement at all stages of the commissioning cycle, NHS Cheshire CCG ensured that the views of clinicians and residents were front and centre of our decision-making processes.

NHS Cheshire CCG worked with partners to ensure that the people of Cheshire are able to access consistently good care – wherever they lived – and worked together to deliver the priorities outlined in the NHS Long Term Plan. Central to this was the development of "Place" arrangements in both Cheshire East and Cheshire West.

The purpose and activities of the CCG were reflected in its strategic objectives:

1.1.3 Key Issues and Risks

Risks and issues affecting the CCG's ability to deliver its strategic objectives during the year were captured in the Governing Body Assurance Framework (GBAF). These were monitored as described in the Corporate Governance section of the Accountability Report. The highest rated strategic risks outlined in the Governing Body Assurance Framework (GBAF) at June 2022 related to:

- Failure to design and commission environmentally and socially sustainable services that incentivise and drive delivery across the CCG and with providers and partners;
- Failure of the CCG to assure the quality of care of its commissioned services due to insufficient capacity and/or ineffective monitoring systems;
- Inability of providers and partners to effectively deliver the standards of performance we have agreed with them, based on national and local priorities; and
- Being unable to plan or have resources and procedures in place to react and respond to the challenges a Pandemic brings.

Inevitably, performance during 2021/22 was affected by the pandemic – both in terms of the need to apply resources to tackle the pandemic (including delivery of the hugely successful vaccination programme) and the capacity issues caused by stringent infection prevention and control protocols and staff absence. Particular examples of capacity issues and actions taken to address them are contained throughout the report, particularly the **Performance Appraisal / Summary** section.

Going concern

The CCG ceased to operate on 30 June 2022. Its statutory duties were taken on by NHS Cheshire and Merseyside Integrated Care Board (ICB).

1.1.4 Performance Appraisal / Summary

As reported widely in the press, the challenges faced due to the COVID-19 pandemic have had a major impact on NHS services over the last 2 years. These include COVID-19 admissions restricting hospital capacity to undertake elective activity, challenges for urgent care services, in terms of demand for urgent care services, limitations on workforce capacity in both community and acute settings and high levels of waits for diagnostic tests and treatments.

Reporting of data by providers against a number of national and NHS Constitutional Targets, including the NHS System Oversight Framework, is being restarted in 2022/23, in addition local data is used to support the CCG to understand the performance challenges and enable performance reporting to the Quality, Safeguarding and Performance Group (QSP) and the Governing Body (GB). The CCG continues to hold Contract Performance and Quality Meetings with our providers to work with our partners to both identify issues and support development of mitigating actions. Within the CCG this is triangulated through an established internal governance structure feeding up to the QSP

The increase in referrals seen in 2021/22 continued into Q1 2022/23. Increased demand, alongside the ongoing reduction in clinical capacity due to sickness and isolation, and the need to prioritise urgent care, many national targets remain unachievable. The CCG, together with colleagues from Cheshire and Merseyside, NHS England, NHS Providers and Independent Sector Providers (ISPs), worked collaboratively to minimise the impact of this on patients and health outcomes.

Performance Monitoring

NHS England introduced an elective recovery plan in April 2022, process were updated by the CCG in Q1 2022 in order to monitor progress against these plans. The trusts were successful in the first target of eliminating the longest waits of over two years, except when it is the patient's choice, by July 2022. Work also began to support the achievement of the ambitions for 2022/23, i.e. to deliver over 10% more elective activity than before the pandemic and to reduce long waits, eliminate referral to treatment waits of over 18 months by April 2023 and return the number of people waiting more than 62 days from an urgent cancer referral back to pre-pandemic levels by 31st March 2023.

Prevention of Harm: All referrals to our Hospital Trusts are prioritised, high priority patients with an urgent need, e.g. cancer patients, are seen and/or treated before non-urgent referrals. The CCG

Quality Team evaluated all Harm Reviews and met regularly with clinical colleagues in our 3 NHS Trusts to discuss route cause analysis and lessoned learnt.

Increasing Capacity: In order to ensure NHS organisations can meet their statutory duties, continue to deliver key services, increase capacity and maintain equity of access for patients across the Cheshire and Merseyside system, the CCG and hospitals used various options and resources in Q1 2022/23 including:

- Support from other NHS organisations of either clinical staff that will go to work in the trust as additional resource for the hospital, or offering patients the choice of alternative hospitals with greater capacity for appointments or treatment, and shorter waiting times.
- contracting additional capacity with Independent Sector Providers (ISPs)
- increase community capacity, for example collective approaches to commissioning of additional home and bed-based support services for people leaving hospital leading to a reduction in hospital discharge delays.
- Local Authority and NHS partners are working closely to both develop roles and redirect financial resource to make employment in the care sector more attractive.

CCG Support: In Q1 2022/23 the CCG continued monthly Contract, Quality and Performance meetings between trusts' senior executives and managers and the CCG's senior executives, alongside Contracting, Quality, Commissioning and Performance Team representatives. The meetings focused on the reduction of Elective and Diagnostic waiting lists, achieving the Cancer 2 week wait and 62-day targets. Progress reports were provided on the work of the Urgent Care Board including winter pressures, risks to delivery of A&E services and system working across sectors.

Referrals and Elective waiting lists: Non admitted pathways remain a significant challenge across the system. Trusts are using both additional internal capacity as well as insourcing capacity to increase activity; this has led to a reduction in the number of 52-week breaches across all 3 providers.

The public facing 'MyPlannedCare', announced by the government on 7th February 2022 went live on 24th February and provides mean waiting times calculated from trust data for Referral to Treatment (RTT) admitted pathways – it does not include non-admitted RTT pathways. When using the website, it is important for patients and the public to consider the reported waiting times in context with the following information, which can also be found on the website:

- Data is provided directly by the hospital each week
- The 'average' waiting time is the mean of all patients waiting within the specialty at this hospital
- Some patients will wait less time than the average and some patients will wait longer than the average waiting time
- Patients are being managed in clinical priority and therefore waiting times can vary depending on clinical urgency
- Treatment definition refers to a clinical intervention which requires a hospital admission

This link - My Planned Care - takes you to the website

Diagnostics: Following the second COVID-19 wave, waiting lists have been increasing throughout the year, however the number seen within six weeks has started to improve, supported by the use of additional capacity in independent providers. This support will continue into 2022/23.

Cancer services: Trusts continue to maintain Patient Tracking Lists (PTL) and provide routine reports to the Trusts' Boards on cancer performance against each of the cancer operational standards by referral pathway. The PTL is discussed weekly, by specific tumour site, as well as individual patients waiting over 104 days (on a 62-day pathway) and 73 days (on a 31-day pathway), any reason/s for a delay must be clearly identified. Harm reviews are undertaken to minimise the reoccurrence of those issues again, these patients are not classed as breaches unless they are diagnosed with cancer and commence their cancer treatment beyond 104 days.

New cancer referrals in Q1 2022 remained at an average of 20% higher than before COVID-19; meaning there are more patients than ever currently on cancer pathways. The Cancer Alliances for

Cheshire and Merseyside and Greater Manchester have been central to the recovery plans and improvements can be seen in the 2 week waits and 31 day and 62-day treatment standards.

A&E 4hr and A&E 12hr trolley waits: A&E performance nationally has continued to be significantly affected into 2022 and Cheshire was not an exception. In Cheshire A&E Attendances during the year were 20% higher than pre COVID-19 levels, in addition Trusts have been required to continue ringfencing beds for those that test positive with COVID-19, away from those that have tested negative. Beds have been required for Elective admissions to support recovery against the backlog, while access to community bed based services has been restricted where COVID-19 outbreaks have occurred, increasing the length of stay for patients that could not be discharged, again restricting capacity.

Other Factors adding to the capacity issues includes: the additional time required waiting for Covid Test results in order to admit patients to the correct ward, infection, prevention and control procedures and distancing requirements. Q1 2022 continued to see the high level of 12 hour trolly seen in Q4 2021/22, both in Cheshire and Nationally.

Primary Care: Throughout 2021/22, practices have been reporting a high level of demand for appointments for routine care, NHS England data published on the 17th January 2022, indicates that the number of GP appointments between 1st September 2021 and 30th November 2021 at practices in Cheshire were up by 10% when compared to the same three-months in 2019. In addition clusters of sickness/isolation due to COVID-19 has been impacting on staffing levels. To support primary care, the CCG provided staff administrative volunteers to work with practices as required.

Throughout the pandemic, practices have continued to deliver core primary care services, e.g. timely access to urgent care with clinical prioritisation, the ongoing management of long-term conditions, suspected cancer referrals, routine vaccinations and screening, annual health checks for vulnerable patients, and tackling the backlog of deferred care events to ensure the public is still able to access non-COVID care for their most worrying conditions and symptoms.

In addition, they have led in the management of symptomatic COVID-19 patients in the community, as part of the local system approach, including supporting monitoring and access to therapeutics where clinically appropriate.

As well as our PCNs (Primary Care Networks) continuing to look to increase workforce capacity through the Additional Roles Reimbursement Scheme during the winter period the CCG worked with our GP Providers to develop a range of schemes to use national funding to increase capacity and access. This included expansion of capacity in core General Practice surgeries as well as in centralised services such as Clinical Assessment Services, to support NHS 111 and 999, and covid assessment “hot hub” sites.

Winter pressures and emergency demands

In Q1 2022/23 the CCG continued to

- Lead the Cheshire systems to develop the Urgent & Emergency Care work programme in its widest sense from self-care promotion, local 111 services, admission avoidance and community crisis response, to flow within A&E through the three hospitals wards along the discharge to assess pathways, with a continuous focus on “Home First” and addressing demand and capacity in balances caused primarily by limitations on workforce availability.
- Implement and monitor all the winter schemes through two Cheshire System Flow Groups including all partners.
- Support all capacity and discharge meetings at the four NHS trusts, Gold and Silver command meetings, Multi Agency Discharge Events and Cheshire and Mersey pandemic response cells. The pandemic increased challenges on capacity with both the reductions in workforce caused by infection rates and the need to maintain infection prevention and control procedures increasing operational challenges in all health and care sectors.
- Commission two hotel schemes, additional hospice beds, complex dementia beds and numerous community discharge to assess beds together with their wrap around services.
- Coordinate the system winter communications campaign, and at times of intense pressure messaged all System partners and provided instructive localised comms to the public.

- Facilitate pathways for Welsh patients and incentivised repatriation to create flow at the Countess of Chester hospital as well as supporting pathways for patients, from out of area, attending our A&E Departments in mental health crisis. This included commissioning additional services to “in reach” into our acute hospitals to support people awaiting a mental health placement to be identified.
- Work with A&E Consultants and primary care to review excessive attendances at A&E and support solutions, as well as monitor Urgent Treatment Centre utilisation and improve escalation processes for 12-hour breaches.
- work with partners to develop NHS111 Clinical Assessment Service, same day emergency care (SDEC), virtual wards and 2 hour crisis response services.
- Minimised discharge delays through an effective Patient Transport Service contract and an extended Acute Brain Injury placement service.

Planning and Restoration

Integrated Care Systems (ICS) Planning: Reporting and governance arrangements for ICSs commenced in February 2022 and continued into Q1 2022/23, in parallel with CCG level reporting to 30th June 2022. Performance and Outcomes from 1st July 2022 will be reported and measured against national requirements by the Cheshire and Merseyside Integrated Care Board (ICB) level.

Restoration: The Government Policy Paper *“Build Back Better: Our Plan for Health and Social Care”* will drive the restoration of health and social care services. Building on the excellent work already underway in hospitals and primary care, learning from the pandemic through use of virtual clinics and new ways of working, as well as harnessing the latest data and diagnostic techniques, will lead to better care and safer treatment.

Through this the NHS aim to deliver around 30 per cent more elective activity by 2024/25 than it was before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance. Further, once the NHS has recovered from the pandemic, activity should be the equivalent of ten per cent higher than under the NHS Long Term Plan.

C&M have in place Recovery Programmes for, Elective Care, Diagnostics, Cancer, Mental Health and Learning Disabilities

Reporting against Recovery and Restoration arrangements has been in place for C&M and CCGs since 2020 and will evolve to reflect new requirements.

1.2. Performance Analysis

1.2.1 Responding to the COVID-19 Pandemic

COVID-19 Vaccination Programme

On 28th March 2022, following the advice from the Joint Committee on Vaccination and Immunisation (JCVI), the national Covid-19 Vaccination Programme entered its fourth phase, often referred to as the Spring Booster phase. This phase of the programme was undertaken to provide a booster vaccination to our most vulnerable citizens to protect them from the worst effects of Covid-19 in Spring (6 months after their previous dose). Citizens eligible to receive a Spring Booster were:

- Citizens aged over 75 years of age
- Residents in older peoples care homes
- Individuals aged 12 years and over who are immunosuppressed

Healthy children aged 5-11 years old were also invited to be vaccinated during this phase of the programme.

The Spring booster was smaller in scale previous phases, focussing on a smaller cohort. Delivery of the programme was also different for this phase with most of the activity taking place in pharmacies and other providers, rather than by GPs who had undertaken most vaccines up to that point. The purpose of this shift in provider was to allow GP practices to support the wider healthcare in its recovery from the worst effects of the Covid-19 pandemic. This phase of the programme was supported by a range of providers from across the system. The number of providers supporting the programme throughout Spring Booster campaign can be seen below:

- 3 Primary Care Network (groups of GP practice working together) led sites
- 16 pharmacy led sites
- 1 large vaccination site
- 1 roving model service

Uptake across Cheshire has been consistently high and has outperformed the Cheshire & Merseyside average. Between 24 March 2022 and the 30 June 2022, the Spring Booster Programme achieved the following:

- **67,160** spring boosters delivered
- **86.1%** of eligible citizens received a spring booster
- **16.2%** of children aged 5-11 received a 1st vaccine
- **83.1%** citizens aged over 75+ years of age received a spring booster
- **94.5%** of eligible care home residents received their spring booster
- **92.3%** of eligible housebound residents received their spring booster
- **90.6%** of immunocompromised people received their spring booster

Marginalised groups

We are aware that there are barriers which prevent some of our vulnerable people from accessing more traditional healthcare routes. As a system we continue to work to ensure that every citizen can access a vaccination if they require one. A Cheshire-wide working group has been established to review the barriers which are preventing some of our most vulnerable people from coming forward to receive a vaccine. This group has reviewed and implemented a range of initiatives which include increasing communications to these groups and commissioning services which know and understand their needs and are helping to break down some of the barriers faced.

In early 2021 the CCG commissioned Cheshire and Wirral Partnership NHS Foundation Trust (CWP) to establish a roving model service. The purpose of this service was to deliver a mobile vaccination service which could be deployed around Cheshire in areas where uptake was low.

The locations for the clinics have been agreed by Cheshire East and Cheshire West partners, including the council Public Health teams. Every week a project team meets to review the uptake data in the context of areas of deprivation, nationality, known barriers such as language, access to transport, etc.,

and a range of other criteria. This intelligence is then used to plan an appropriate pop up in an area of need, supported by communications and engagement prior to the session. The roving model has been very successful in supporting people to come forward for a vaccine. The service commenced on 7 June 2021 and delivered has delivered vaccines to citizens who were primarily from underserved communities who are known not to engage with healthcare service and whom would likely not have been vaccinated were it not for the roving model.

Evergreen Offer

We are constantly working to encourage citizens who have not been vaccinated, regardless of the reason, to come forward. This is managed using a range of activities from targeted communications, to training staff to support citizens to overcome fears and worries. Across Cheshire our evergreen offer continues to see citizens coming forward for their Primary (1st and 2nd and Booster) doses. Throughout the Spring Booster programme, we delivered the following doses:

- **2,156** first doses
- **8,888** second doses
- **25,838** Booster doses (excluding Spring Boosters)

1.2.2 Performance against Key Metrics

The NHS Constitution sets out a number of key standards CCGs are required to deliver. Performance against the NHS Constitution targets is summarised below:

Urgent Care: A&E services have been under tremendous pressure in 2021/22, this is particularly noticeable in smaller hospital trusts. All three local hospitals had performance against the 4 hour target were below that of the national performance of 72.1% and the national target of 95%.

Diagnostics: Performance improved in Quarter 1 of 2022/23, but was marginally below national performance for Cheshire, this was mostly the impact of the Countess of Chester where a new system has been implemented and data was not fully validated at this time. Work continued with investment in additional equipment, use of Independent Sector Providers (ISPs), mutual support between hospital trusts and increased local capacity with the ongoing development of Community Diagnostic Hubs.

Referral to Treatment (RTT): The commitment to have no one waiting over 104 weeks by the 30th June 2022, unless clinically complex or unable to be treated, or the patient has chosen to delay their treatment, has been fully supported in Cheshire with 77 remaining on the lists o the three main trusts: Countess of Chester, East Cheshire Trust and Mid Cheshire Hospitals Foundation Trust in July 2022, with a further 49 at trusts outside of Cheshire.

Cancer: Urgent suspected cancer referrals remained approximately 19% above pre-pandemic levels in Q1. Performance against the national targets for cancer in Cheshire has been above national averages in Q1, although the targets have not been met. Further work is being undertaken on the 75% 28-day Faster Diagnosis Standard (FDS), which is not a formal national target as yet.

Table: *Cheshire performance against key NHS targets (to June 30th 2022)*[1]

Indicator	Target	Data Period	Countess of Chester	East Cheshire Trust	Mid Cheshire Trust	Cheshire CCG	England
Urgent Care							
A&E Waiting Times - 4-hour standard	95%	Jun-22	69.6%	57.1%	60.0%	N/A	**72.1%**
A&E - 12-hour trolley waits	0	Jun-22	268	78	192	N/A	**22,034**
Elective Care							
Diagnostics - % of patients waiting> 6 weeks	<1%	Jun-22	40.2%	24.7%	25.4%	**29.6%**	**27.5%**
Diagnostics - No. of patients on waiting list	n/a	Jun-22	7,791	3,742	9,331	**25,184**	**1,564,840**
RTT Incompletes - % 18-week compliance	92%	Jun-22	43.7%	68.8%	60.1%	**54.3%**	**62.2%**
RTT Incompletes - Waiting List Size	n/a	Jun-22	40,199	9,301	34,093	**97,504**	**6,725,633**
RTT - No of patients waiting >52 weeks	0	Jun-22	5,037	335	1,271	**7,593**	**355,774**
RTT - No of patients waiting >104 weeks	0	Jun-22	86	24	0	**126**	**3,861**
Cancer							
2 Week Waits	93%	Jun-22	70.7%	87.6%	90.9%	**82.0%**	**77.7%**
2 Week Waits - Breast Symptomatic	93%	Jun-22	N/A	95.7%	90.0%	**80.3%**	**66.1%**
28-Day FDS	75%	Jun-22	67.9%	58.4%	76.8%	**68.2%**	**70.4%**
31-Day Standard	96%	Jun-22	91.6%	89.3%	91.2%	**95.2%**	**88.0%**
62-Day Standard	85%	Jun-22	74.7%	54.2%	68.8%	**66.9%**	**57.8%**
104 Day Waits	0	Jun-22	5	3	9	19	N/A

Key to Performance:

X = target not achieved.

X = target achieved.

X = no target.

1.2.3 Working with Partners / Contributing to Joint Strategies

The NHS Long Term Plan states that CCGs were expected to become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and long-term plan implementation.

The CCG, along with both Cheshire West and Chester Council (CWaC) and Cheshire East Council (CEC), have held the ambition to develop an integrated health and social care economy within each "Place". The Health and Care Act 2022 (which received royal assent on the 28th April, 2022) continues this drive for greater collaboration across the wider health and care system. The CCG and local authorities have worked across organisational boundaries to establish arrangements to better join up health and care services and prepare for greater integration.

The Better Care Fund (BCF) underpins the ambition to work together to improve health and social care for all and will support both Places with their plans to integrate/pool funding for services as part of Place based arrangements.

The current BCF objectives within both Places include the following:

- focus on preventative and out of hospital services, reducing dependence on acute and bed-based services and working with a "home first" approach, promoting independence for the individual, living in a safe environment;
- services are commissioned and delivered in the most effective and efficient way; increasing collaborative commissioning and more coordinated system planning;
- invest in interventions that support timely discharge from bed-based services, delivering a greater focus on safe, timely and effective discharge, with seven-day-working.

[1] Please note that the local acute hospitals treat patients from outside of Cheshire, in addition some Cheshire Residents may choose to be treated in other areas, therefore the sum of our three local hospital trusts will not correlate directly to the performance for NHS Cheshire CCG.

Increasingly, work is being undertaken in an integrated manner. Examples of this integrated working with partners include:

- Cheshire West
  - Care Home Contract Framework
  - Carers Strategy
  - Sustainability Networks
  - All age Learning Disability Strategy
  - Community Equipment

- Cheshire East
  - Sustainability Networks
  - Living Well for Longer Strategy
  - Working to agree a joint policy for third sector grants
  - Community Equipment
  - Carers Strategy & Carers Hub

- Partnership working across mental health includes:
  - Mental health (MH) crisis beds for adults and on-going work to develop crisis services for MH for Children and Young People
  - Successful roll out of Mental Health support teams in schools
  - Improving Access to Psychological Therapies (IAPT) programme across Cheshire & Merseyside
  - Section 12 application implementation across Cheshire & Merseyside, to help mental health professionals efficiently complete Mental Health Act 1983 (MHA) processes to decide whether a person should be admitted to hospital for the assessment and treatment of a mental disorder
  - Provision of expertise / consultation / advice for parental mental health needs
  - Quicker support both at a preventative level and as part of the statutory social work offer
  - Launch of the Community Mental Health Transformation programme
  - Continued support for perinatal services and preparation for launch of the maternity mental health offer.

- Partnership working across the Acute Foundation trusts includes:
  - East Cheshire Trust / Stockport Foundation Trust Clinical Partnership.
  - Whole system approach to support trusts with recovery and restoration through use of Independent Sector providers, pathway redesign, Advice & Guidance and Patient Initiated Follow ups
  - Support to address fragile services.

The CCG's Strategy & Partnership directorate had five programme areas that work closely with partners to jointly commission and deliver services for the population of Cheshire. In addition, in the first quarter of 2022/23, all Programme areas prepared to support the pending transition from Clinical Commissioning Group to Integrated Care Board from 1st July 2022.

Programme Theme	Activity
Mental Health	For the Mental Health Programme area, the focus was on the ongoing delivery of the ambitions for mental health, as described in the NHS Long Term Plan. Key areas included: Continued support of women's access into perinatal mental health services. • Ongoing support for the launch of the Maternity Mental Health Services pilot, due to launch in Cheshire in August 2022, providing mental health support to families affected by loss and birth trauma. • Preparation for further expansion of mental health support in schools, via the Mental Health Support Teams (MHSTs) across Cheshire. Wave 10 is due to commence in January 2023 and further work is underway to enhance the MHST offer in Cheshire East. • The establishment of Urgent Support Teams for children and young people across Cheshire with plans to expand bases. This marks the early establishment of the development of the children and younger people's emergency care provision and will operate a crisis mental health assessment and intervention service available 24/7. • Following the success of the Individual Placement Support (IPS) project, which helps people with a mental illness to access training, education and employment, increased investment to continue the roll out of this programme. • Investment identified to support the Early Intervention in Psychosis (EIP) team to achieve standards that will ensure compliance with the NICE guidelines for people experiencing a first episode of psychosis, across all ages. • Continuing to work with partners to ensure that crisis home treatment teams for adults and access to psychiatric liaison cover is in all of our acute hospitals and is accessible and responsive. • Ongoing focus on expanding a database to record A&E activity for children who self-harm, replicating this approach across Cheshire. • Supporting the development of services in response to suicide and bereavement. • Our work in partnership with both Local Authorities, including joint funding initiatives to support the early intervention offer for children and the development of Joint Strategic Needs Assessments and Mental Health Strategies. • Working with our Primary Care Networks (PCN) and Public Health colleagues to develop a pilot to increase the numbers of people with a serious mental illness (SMI) to be supported and to receive a physical health check utilising the existing wellbeing buses to improve reach to this vulnerable cohort. Also scoping opportunity to include COVID and flu vaccination in the SMI cohort • Continuing to work in partnership across Cheshire and Merseyside to implement a commissioned audit examining workforce capacity across the system to develop a toolkit and competency framework to support our approach to meeting the challenges of capacity in the mental health workforce across the health and care system. The findings of this audit will support planning and expansion of the future children and young people's workforce across Cheshire and Merseyside. • Supporting the ongoing delivery and refining of a pilot of mental health transport, which is an Integrated Care System (ICS) offer delivered across Cheshire and Merseyside and to reduce waits, improve quality and avoiding police conveyance. • Continued work at Place to support the establishment of two crisis cafes in Cheshire East: Macclesfield and Crewe with plans to develop a crisis bed offer in Cheshire West Place during 2022.

Mental Health cont.	• Working closely with the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector to support and develop a demand and capacity approach to caseload management with a view to establishing a wider system approach during 2022/23. • The launch of the Adult Community Mental Health Transformation programme for Cheshire, with input from a range of health and social care representatives in partnership with people with lived experience. The development of this agenda will play a crucial role in modernising the new community-based offer and will improve access to psychological therapies and physical healthcare. • Following the successful application for transformation funding for crisis alternatives, core 24 liaison and community mental health transformation programmes, we have worked with partners to continue to support the development of community and crisis mental health services, which offer care and support closer to home. • Further developing and enhancing access to children and young people's mental health and wellbeing services, working in partnership with Local Authority colleagues and teams from across the VCFSE sector. This will involve the local development and roll-out of the Logic Model, a new Strategy around children's and young people's mental health.
Learning Disabilities and Autism	The focus of the Learning Disabilities and Autism Programme during Quarter 1 of 2022/23 included: Developing health priorities and action plans in relation to improving uptake and improving the quality of Annual Health Checks for people with Learning Disabilities (LD): • General Practices with low uptake offered additional support from health facilitators. • Support given to practices to review their Learning Disabilities registers and improve their recording on the patient electronic record systems. • Sharing best practice with easy read materials to support access. • Working with the Cheshire East Learning Disabilities Partnership Board Health Subgroup, a questionnaire has been developed with people with LD to find out the views and experiences of people who attend learning disabilities annual health checks. This will support quality improvement and improved outcomes. • Implementing a local plan to contact patients with a LD who did not receive a health check last year. • Local Plan in place to support the STOMP programme (Stopping over medication of adults with a learning disability). This has included the local work led by CWP on the development of a Dynamic Support Database (DSD) for physical health. This has supported the identification of key service data sets and wider person-centred outcomes.
	Children and Young People with LD and Autism: • The Children's Keyworker team is in place, comprising of a Keyworker Manager and four Keyworkers to work in Cheshire. The team is managing small caseloads of children and young people with LD and/or autism with complex needs, as per the national pilot guidance. • The Keyworker team is linked with multi-agency teams and working directly with families, to ensure the young people on their caseloads are getting the right support to avoid crisis.

Learning Disabilities and Autism cont.	• The new children and young people Intensive Support Function, provided by CWP, is now in place and providing support and consultancy to CAMHS practitioners to improve outcomes for children and young people. The Enhanced Support for Children and Young People Steering Group has overseen the mobilisation of these two new services / functions, working with children and young people with the most complex needs. The Steering Group is also overseeing the work in Cheshire to understand and develop the existing children and young people Dynamic Support Database (DSD), including embedding the expected national quality standards from NHSE.
	Autism Clinical Network: connecting clinical leadership for all age autism: • The Cheshire Autism Clinical Network continues to provide a child-centred approach to improving outcomes for children and young people by working to ensure timely access to integrated autism assessment services, the early identification of needs between 0-25 years, and a clear, consistent and coordinated pathway across Education, Health and the third sector. The group has shared advice, support and examples of good practice from a clinical perspective to support the consistency, quality and timeliness of clinical assessments across Cheshire.
	Sleep services for CYP with neurodevelopmental conditions: • Following a successful bid, a pilot project has started to deliver accredited sleep pilot projects via two third sector provider organisations: Peak Sleep and Koala North West . Since May 2022, the services have received over 300 referrals, delivered one to one and group courses and have produced performance returns with case studies highlighting successful outcomes for families.
	Post diagnostic support for Attention Deficit Hyperactivity Disorder (ADHD): • A number of clinical colleagues and members of the Parent Carer Forum have been trained in the Triple P Stepping Stones programme. This programme enables families to develop support strategies, behaviour management techniques and other skills for approaching dietary and sleep problems to improve the quality of life in a family affected by ADHD. Additionally, ‘Fear-less’, a new course to help reduce anxiety and updated Triple P online (TPOL), is available for to access from September 2022.
	Integration between health and social care practitioner teams: Adult Complex Care: • Following a successful funding bid to the Transforming Care Programme, an additional resource of specialist practitioners, sitting within the existing community LD team, has been providing clinical review, attending and supporting regular multi-disciplinary team decisions and support, to enable transition planning for people with learning disabilities, who have the most complex needs, including those who may be on the edge of contact with forensic services and the criminal justice system. • The team has demonstrated an improvement to the pathway working in an integrated way with social care and has enabled successful joint support of individuals with complex presentations who, in the past, have needed inpatient treatment periodically.

Living Well for Longer	The Living Well for Longer Programme's work, during Quarter 1 of 2022/23, has included: • Ensuring the national planning requirements are delivered in 2022/23. • Working collaboratively with the three Cheshire Community Service providers, Adult Social Care teams and the North West Ambulance Service to develop, coordinate and ensure a consistent approach to the mobilisation of Urgent Community Response (UCR) services across Cheshire, in adherence with the NHS 2021/22 operational planning guidance. The services are providing a rapid assessment and care for people whose health suddenly deteriorates or are experiencing health and social care crisis, • Maintaining the full geographic rollout and continuing to grow services to reach more people, extending operating hours where demand necessitates and at a minimum operating 8am to 8pm, 7 days a week in line with national guidance, • Increasing the number of referrals from all key routes, with a focus on Urgent and Emergency Care (UEC), 111 and 999, and increase care contacts, • Ensuring provider workforce plans support increasing capacity and development of skills and competencies in line with the service development, • Improving outcomes through reaching patients in crisis in under 2 hours, where clinically appropriate. Supporting providers to achieve the minimum threshold of reaching 70% of 2-hour UCR demand within 2 hours from the end of Q3 of 2022/23. • Improving data quality and completeness in the Community Services Dataset (CSDS), as this will be the key method to monitor outcomes, system performance and capacity growth. • Improved capacity in post urgent community response services to support flow and patient outcomes including avoiding deterioration into crisis again or unnecessary hospital admission. • All of these initiatives will support that fact that activity across Cheshire was significantly above plan expectations in each month of Quarter 1 2022/23.
	Specific programme work related to COVID-19 has included: • Collaboratively working with other CCGs across Cheshire and Merseyside, the Respiratory Clinical Network and NHS England and Improvement to develop the local pathway for Long COVID. This work resulted in the creation of three local Cheshire services, which started in November 2021. The service provides assessment and rehabilitation, including psychological and peer groups, to support people to manage the wide range of symptoms of Long COVID. • In March 2022, 400 people received support from the new Cheshire Long COVID services. This has had a positive impact on the experience of patients with Long COVID. This knowledge is also being shared more widely with Cheshire GPs, via a Long COVID network, which brings medical staff together to share learning, provide peer support and develop pathways. This shared learning and increased capacity has improved the support available to the wider health system. • Working collaboratively with public health colleagues to develop a health inequalities plan and to address unmet need for those with Long COVID in hard-to-reach communities. A webinar was developed and representatives from the minority communities were invited to increase awareness of the symptoms of Long COVID.
	Specific work with Cheshire East Council included:

Living Well for Longer cont.	• Working with Cheshire East Council to consult with the public on the Live Well for Longer Plan, which has been created with local people and charities. The outcome of the consultation will inform the final plan including its implementation and monitoring following publication later in 2022.
	Specific work relating to Care Homes included: • Working with a range of health and social care partners, including Healthwatch, we have established the Cheshire Enhanced Health in Care Home Group to oversee the implementation of the national Framework across all the 182 care homes who provide 7,364 beds in Cheshire. The work includes the commissioning of some new services, including: a bespoke Care Home Support Service offered to all care homes; additional Speech and Language Therapy support; education and training in medications; and additional equipment to support medication at the end of life, reminiscence and mental and physical health activities.
	For joint strategy development: • Working with Cheshire West and Chester Council in preparing and publishing the All-Age Carers Strategy, in June 2021, the CCG supported the implementation of the action plan in Quarter 1 of 2022/23. • Working with Cheshire East Council and partners to prepare the All-Age Carers Strategy, which is due to be published in 2022. • Both strategies and action plans are focused on early identification of carers and providing the support they need to maintain their own health and wellbeing and to continue in their caring role.
	Specific work relating to dementia included: • Working closely with Cheshire East Council and stakeholders to develop a Dementia Strategy and action plan. A public consultation has been conducted, the feedback from which is being used to inform the final version currently in production. • Working closely with Cheshire West and Chester Council to refresh the local Dementia Strategy and develop a new action plan. • Progressing work with a range of providers to improve the local Dementia diagnosis rate and reduce waits for memory assessments. This work will focus on streamlining care pathways and increasing the amount of post diagnostic support.
	Specific work relating to advocacy included: • Working closely with both Local Authority partners to prepare for the introduction of Liberty Protection Safeguards. A new advocacy service has been commissioned to take account of the pending changes. This will help to ensure vulnerable people are able to have a say in the way their care and support is provided.
Thriving and Prevention	The Thriving and Prevention Programme's work, during Quarter 1 of 2022/23, has included: • Working with NHS England and Improvement to rollout the National Diabetes Prevention Programme (NDPP). Increased referrals into the service are evident through data reporting, with Cheshire being the highest referrer across Cheshire and Merseyside. As part of this, the 'Healthier You' behaviour change programme has been mobilised, which looks into the factors that increase the risk of Type 2 Diabetes and supports patients to develop a personalised plan to make healthy lifestyle changes that will reduce or remove these risks.

	• Working with local partners to expand remote monitoring of patients for silent hypoxia, using pulse oximetry. The two Local Authority leisure service providers worked with commissioners and local community providers to offer a pick-up point for Pulse Oximeters within local communities. Patients receiving a positive COVID PCR test result were contacted via text message to inform them of how to access support, including obtaining the devices.
	• Working across Cheshire with both community providers and acute trusts to implement a pathway to provide a new COVID treatment: Neutralising Monoclonal Antibodies (nMABs), specifically for patients with Heart Failure. This treatment works by effectively blocking viral replication, 'neutralising' the virus, therefore, improving recovery time, reducing hospitalisation and mortality.
	• Partners focused on End-of-Life care working together to mobilise a new model of delivery for domiciliary care for people in the last stage of their life. The Cheshire Palliative Care in Partnership (PCIP) service supports patients in their own homes so that they can be cared for in their preferred place. Patients access the service through a single point, enabling better coordination of care and improved communications between care providers. The service is provided by a compassionate care team, with access to specialist practitioners, meaning that the physical, psychological and emotional needs of patients, who are in their final stage of life (and the needs of their carers' / families), can be met anytime day and night, and more people are able to die in their preferred place of death.
	• Working with local acute trusts to implement NICE approved pathways for Cardiovascular Disease. Included in these pathways is enhanced support to self-care / manage, with targeted work undertaken to expand the use of blood pressure monitoring tools so that patients can easily monitor their own readings and send them to their GP practice for review.

	During Quarter 1 of 2022/23, the Strong Start Programme's key areas of work have included: • Working with the Cheshire West 'Our Way of Working' programme to plan and design a tailored programme of trauma informed practice to roll out across all three Cheshire maternity providers.
	• Reinstating the maternity and paediatrics GP education programme, with training delivered on: ➢ Managing Paediatric allergies in primary care (April 2022). ➢ Prescribing for mental health during pregnancy and breastfeeding (May 2022). ➢ Working with Children and Families Through a Trauma Lens (June 2022).

Strong Start	• Following the Ofsted and Care Quality Commission (CQC) joint area Special Educational Needs and / or Disabilities (SEND) inspection, in Cheshire West and Chester (14-18 February 2022), the Partnership received a positive and constructive formal outcome letter. The Partnership has subsequently developed a detailed action plan in response and is working collectively to deliver it.
	• Formally responding to the SEND Green Paper: ➢ *SEND Review: Right support Right place Right time* in collaboration with both Cheshire East Council and Cheshire West and Chester Council.
	• Supporting the refresh of the *Cheshire East Children and Young Peoples Plan 2022-26.* We continue to work closely with our partners in Cheshire East to support the priority outcomes identified in the Plan.
	• Working in partnership with Cheshire and Merseyside Health Care Partnership, further developing the following pathways to support pregnant women with COVID-19: o Access to Pulse Oximetry through midwifery services to deliver remote monitoring of pregnant women for silent hypoxia and reducing the requirement of admission and emergency presentations. o Development of a Venous Thromboembolism (VTE) Risk Assessment pathway to support primary care and midwifery teams to detect the condition during pregnancy and with COVID-19 complications.
	• Working in partnership with Cheshire West and Chester Council, re-commissioning and mobilising a children and young people's (0-18 years) Speech and Language Therapy joint service, to go live in October 2022.
	• Launching a social media toolkit and application called 'Common Approach to Children's Health' (CATCH) in Cheshire West to secure a joined up self-care offer across the whole of Cheshire. The model will improve the sources of reliable information for parents / carers, the outcome of which should be a reduction in emergency presentations to both Primary and Secondary Care.
	• Continuing to work with the three Cheshire Maternity Voices Partnership groups to progress and strengthen engagement with pregnant women and partners across Cheshire to improve the quality of maternity services.
	• Securing funding for a further allocation of Paediatric Pulse Oximeters to General Practices across Cheshire, to ensure full coverage across GP practices. Increased access to the devices for children (0-5) within the Primary Care setting should lead to a reduction in admissions and presentations to emergency departments for children with respiratory conditions.
Strong Start cont.	• Engaging with partners to support initiatives to reduce smoking in pregnancy through: ➢ Working with Cheshire and Merseyside Local Maternity System to develop and implement a new smoke free pregnancy pathway for women across Cheshire and Merseyside, starting with Mid Cheshire Hospital NHS Foundation Trust, as a one of the first pilot sites for the project.

	➢ Working with Cheshire East Local Authority on the development of their incentivising scheme to reduce smoking in pregnancy across Cheshire East, in line with best practice guidance.
	• Assuring the Quality, Safeguarding and Performance Group, in June 2022, on the position of the three Cheshire maternity providers, in relation to the recommendations from the Immediate and Essential Actions (IEAs) from the Ockenden Emerging Findings and Recommendations Report (December 2020) and an update on the Ockenden – Final Report (March 2022). • Supporting East Cheshire Trust in the development of options to reinstate intrapartum maternity care, on the Macclesfield Hospital site, when it is safe to do so, via three Trust led multi-agency engagement workshops held on 27th April, 23rd May and 24th June 2022.

Contribution to the work of Health and Wellbeing Boards

NHS Cheshire CCG has maintained a strong commitment to supporting the Health and Wellbeing Board in both Cheshire East and Cheshire West despite the challenges relating to recovery following the pandemic and preparing for the major organisational changes required by the implementation of the ICB.

This has included maintaining a focus on the priorities within the Health and Wellbeing Board Strategies, particularly the need to enhance our emphasis on reducing health inequalities, which the COVID-19 pandemic so strongly highlighted. This has led to the development of place-based outcome frameworks to enable each system to hold itself to account for a shared set of health and care outcomes.

1.2.4 Improving Quality

It is paramount that the public feel safe and have confidence in services provided by the NHS and partner organisations. This is not only a statutory duty, but also the principles and values outlined in the NHS where quality, patient safety, clinical effectiveness and the experience of patients underpins the delivery of our health and social care services. There have been numerous high-profile cases that identified failings where people were not afforded basic standards of care and their fundamental rights to dignity were not respected. NHS Cheshire is committed to learning from these failings and proactively seeks evidence from our providers of NHS care that they have reflected on these reports to identify what they could do differently to improve their standards of care.

We know from the incident reports and complaints that we have received that what matters most to people who use services is:

- **that it is safe:** people are protected from avoidable harm and abuse. When mistakes occur lessons will be learned.
- **that it is clinically effective:** people's care and treatment achieves good outcomes and promotes a good quality of life and is based on the best available evidence.
- **that it is a good experience:** staff involve and treat patients with compassion, dignity and respect.

Our information tells us that through the pandemic our care services have faced challenges delivering high standards of high-quality care consistently. Through our 2022/23 contract arrangements with providers we have asked for evidence that learning has been adopted to drive up standards. In quarter one our providers have been able to show that they have made some progress in reducing variation in the care that people experience. The rate of this improvement is being tracked through a range of measures and valuable insight collected from patients using the services.

In a move towards greater system working across our population there has been sustained efforts to work more collaboratively across a number of organisations to identify key areas of focus for quality improvement, share best practice across and ensure that learning from incidents and events inform service improvements; for example impact of twelve-hour trolley breaches in emergency departments, mortality reviews and harm reviews for people waiting a long time for NHS care

NHS Cheshire CCG has an established governance process to support us in the delivery of our statutory duty to improve quality and provide assurance in relation to the delivery of those duties. The governance flows from the analysis of quality indicators, incident reporting and patient experience information which is reviewed at Contract Quality and Performance Review meetings. Intelligence and actions arising from these processes is reported through to the Quality & Performance Committee chaired by the Governing Body Registered Nurse and then ultimately provides assurance to the Governing Body in relation to the delivery of those duties. The Quality & Performance Committee has continued to meet monthly in the first quarter to:

- Monitor the quality and safety of services commissioned by the CCG and pro-actively challenge and review delivery against expected quality standards, agreeing any action plans or recommendations as appropriate.
- Monitor progress in delivery against the quality measures included within the NHS Outcomes Framework, challenge variances from plan and ensure actions are put in place to rectify adverse trends.
- Undertake "horizon scanning" to ensure the CCG keeps abreast of national, regional, and local issues relating to quality and safeguarding.
- Ensure that the CCG discharges the statutory duties in relation to the achievement of continuous quality improvement and safeguarding of vulnerable children and adults.

Details of complaints and enquiries received by the CCG were presented to the Quality & Performance Committee this quarter. Identified themes, actions taken to resolve concerns alongside lessons learned were discussed to inform and improve the quality of commissioned services. NHS Cheshire recognises the importance of complaints and the impact on patients and families. In view of this the CCG aims to resolve all complaints at a local level by thorough investigation and working with complainants throughout the complaints process. However, there are occasions when complainants remain unhappy

with the outcome of their concern and approach the Health Service Ombudsman for a review of their case. The Health Service Ombudsman is an independent complaint handling service for complaints that have not been resolved at a local level in the NHS. During this quarter the Health Service Ombudsman did not ask us review the outcome of any complaints that we handled.

The reports to our Governing Body highlight examples where we have identified when care could have been delivered differently and what plans were put in place to address this. Cheshire CCG has seen the impact that the pandemic has had on incident reporting patterns and the type of patient safety incidents reported as a direct consequence of the increased operational pressures. We have sought additional assurance from NHS providers in response to incidents, for example: reviewing Infection Control Trust Board Assurance Reports when nosocomial infections have increased; undertaking site visits to seek evidence of change in practice following a rise in pressure ulcers; reviewing Safe Staffing Reports against the harm levels reported.

Close partnership working with the CQC and local authorities to share information about care homes has led to changes in contracts and frequent site visits to support sustained practice improvements. A number of hospital and care sector providers have required support to move people to alterative services and accommodation and we have worked with residents and families to secure new services.

GP practices in Cheshire have continued to report concerns and queries through an electronic incident reporting system which provides essential insight about safety risks across pathways. This GP incident intelligence is a key early warning mechanism and has been critical in identifying service deficits, for example delays in hospital appointments for urgent referrals. Our Quality Team have used this intelligence to inform areas that have needed rapid quality improvement plans.

The CCG continued to work partnership with NHS England to use Enhanced Surveillance processes with an NHS provider to profile risks and work alongside partners to oversee implementation of sustainable improvements. This remains an open and active process.

Robust processes to enable the CCG to discharge its quality assurance role under the Serious Incident National Framework have continued. This included ensuring that all new serious incidents were appropriately scrutinised by senior representatives in the Quality Team to seek assurance that all necessary immediate actions had been taken to maintain patient safety while an investigation is undertaken as well as identify any emerging themes of concern.

To plan healthcare services the CCG constantly evaluates patient feedback from a wide range of sources, cross-referencing feedback received via our Patient Experience and Communications and Engagement teams with data from local NHS organisations, Healthwatch Cheshire and others. Since April 2020 the CCG has produced comprehensive Insight and Intelligence Reports every four months to ensure patient feedback is systematically collated and shared with senior managers and clinical leads. A final report for NHS Cheshire CCG was produced in this quarter which has been used to influence strategic priorities.

To ensure quality is embedded across all CCG business a Quality and Equality Impact Assessment is undertaken on all service improvements, developments, or commissioning of new services and those that are being decommissioned. The Quality Team have maintained oversight of this Impact Assessment process.

Safeguarding

As with all NHS bodies, the CCG had a statutory duty to ensure that it had arrangements to safeguard, protect and promote the welfare of children, young people, and adults at risk of abuse and harm. This quarter one 2022/23 report was produced in line with duties and responsibilities outlined in the key legislation, which informed our safeguarding statutory responsibilities and requirements regarding children, looked after children, adults, and child death review process.

Safeguarding was an integral part of our commissioning and quality assurance processes. In quarter one, the Safeguarding Commissioning Standards for Children, Looked After Children and Adults were

sent to all health providers for our commissioned services with an NHS England standard contract. This included all our Continuing Health Care providers who provide care packages under the contract. Working alongside our contract and continuing health care teams, the safeguarding team could effectively monitor performance of health providers in relation to safeguarding policy and practice to seek assurance that our health providers had effective safeguards in place and provided the highest possible standards of care to our children, young people, and adults at risk.

The Safeguarding Team remained responsive, creative, and flexible to demands and work positively across the system to support developments and ensure safeguarding process and practice was effective and robust. The team drove improvements through partnership working to ensure responsive safeguarding practice to address national and local priorities and influence safe and effective care and commissioning.

We recognised that safeguarding is a shared responsibility across the health economy and wider multiagency partnership. The safeguarding team continued to promote effective joint working between all agencies and professionals, sharing and learning from specialists to provide assurance to the CCG and as a statutory partner within our Cheshire East and Cheshire West and Chester Children Partnerships, Adult Safeguarding Boards, Corporate Parenting Boards, and Pan Cheshire Child Death Overview Panel.

During quarter one 2022/23, the CCG continued to meet statutory safeguarding duties and drive the safeguarding agenda by ensuring that the services we commissioned had the necessary systems, processes, policies, and procedures in place to protect and safeguard children, young people, and adults at risk. This was achieved by engagement as a statutory partner in Cheshire East and Cheshire West and Chester:

- Safeguarding Adult Boards and subgroups
- Children's Safeguarding Partnerships and subgroups
- Corporate Parenting Boards
- Pan Cheshire Child Death Overview Panel
- Domestic Abuse Partnership Boards
- Community Safety Partnerships

Methods of assurance the safeguarding team have provided included single agency and multi-agency audits, attendance at Provider Safeguarding and Quality Committees, submission of evidence to the NHS England Clinical Commissioning Group Safeguarding Assurance Template, delivering lunch and learn safeguarding sessions, Increased safeguarding training compliance for our staff, development of actions plans for local and national safeguarding reviews recommendations and learning, developing a new process to improve compliance of Initial Health Assessments and providing the Clinical Commissioning Group Governing Body quarterly safeguarding reports. The team also submitted the 2021/22 safeguarding annual report to the Governing Body which demonstrated assurance that Cheshire Clinical Commissioning Group had delivered against its safeguarding responsibilities and statutory functions and described achievements, challenges, and the priorities for the year ahead during the transition to the Integrated Care Board.

During quarter one the safeguarding team continued to support the transition of our safeguarding functions from the CCG into Integrated Care System. A key area of work has been to support the ongoing development of a safeguarding structure, safeguarding website and safeguarding policies ready for transition on 1st July 2022.

1.2.5 Engaging People and Communities

With the lifting of national restrictions combatting COVID-19, the CCG stepped up its engagement of communities to inform the commissioning intentions of the emerging Integrated Care Board (ICB) and to promote access to services while encouraging informed use of the NHS, thereby supporting effective management of system pressures at a time of significant demand. Engagement activity in pursuit of these aims was complemented by proactive public-facing communications.

Concurrently, the CCG's communications and engagement function played a lead role in establishing the broadcast channels of NHS Cheshire and Merseyside.

Promoting informed use and managing system pressures

The CCG devoted considerable resource to the Cheshire West launch in April 2022 of the award-winning CATCH app that has been available in Cheshire East since 2016. Its purpose is to support parents and carers of pre-school children to manage the health of their infants and to know when to seek medical advice. It offers NHS-assured content and allows users to register to receive alerts including notification of dates for childhood immunisations. It also includes resources for parents to be. In this way, it supports parents and carers to give their children a great start in life while reducing avoidable demand on urgent and emergency care.

An official launch event was preceded by sustained media relations and social media activity which led to several volunteers signing up as CATCH app ambassadors. The launch was followed in May by attendance at a community engagement event organised by Northwich Care Community. The CCG managed a stand offering assets promoting CATCH and self-care more generally. Attendees included third sector and primary care representatives who committed to promote the app across their networks.

The Northwich event was followed by attendance of Rhyme Time sessions for pre-school children at Neston and Tarvin Libraries.

In June, the communications and engagement team joined the quality and safeguarding team at a Pride of Romany event in Nantwich. Its purpose was to promote a wide range of health and wellbeing services to Gypsy and traveller communities that traditionally do not access NHS and social care support proactively. Again, the objective was to promote self-care and informed use of services while minimising avoidable contacts with urgent and emergency care. Services promoted included:

- ICON – supporting families and professionals to prevent injuries to babies because of stress induced by crying
- Lullaby Trust – promoting safer sleeping for babies
- Dad Pad – helping new fathers to give their baby the best start in life
- CATCH app
- NHS 111 first.

The CCG used traditional and social media, together with partner and stakeholder communications, to promote an innovative Urgent Community Response service launched across Cheshire in April to reduce avoidable hospital attendances and inpatient stays by frail and vulnerable people. The service guarantees to send a suitably-qualified healthcare professional to the patient's place of residence within two hours of referral. Thus, the service supports people to maintain their independence while minimising the deconditioning that results from lengthy stays in hospital beds. The service also eases pressure on hospital wards.

The purpose of the partner and stakeholder promotion, which included a GP video, was to encourage appropriate referrals while the external communications enhanced the reputation of the partners involved.

Similarly, the CCG worked with primary care networks across Cheshire to develop and deliver a social media campaign featuring videos in which general practice staff described new roles including those of community pharmacist, occupational therapist and social prescriber. The campaign demonstrated

steps taken to enhance access to services in response to COVID-19 while communicating the key message that an appointment with a GP is not always the most appropriate way forward.

In anticipation of the bank holidays from April to June, the CCG used traditional and social media to share a wide range of assets promoting self-care and informed use of the NHS. These included graphics and videos describing a well-stocked medicine cabinet, the typical duration of various self-limiting conditions, community pharmacy opening times, NHS 111 and when to attend A&E. Again, the activity supported access to services while reducing avoidable demand.

The CCG continued to promote the COVID-19 vaccination programme across its networks in the first quarter of 2022/23 while sharing assets with NHS, local authority and third sector partners to enable them to do likewise. In preparation for the seasonal flu vaccination programme of 2022/23, the CCG attended a North West regional review meeting convened by NHS England and Improvement to learn lessons from delivery of last winter's overarching communications and engagement plan.

Widespread promotion of Cheshire's "never too late" evergreen COVID-19 vaccination offer has continued, complemented by localised work with underserved communities and in communities with lower vaccine uptake.

Cheshire's roving COVID-19 vaccination service – operated by Cheshire and Wirral Partnership NHS Foundation Trust – was commissioned by the CCG to reach into underserved communities to ensure easy access to vaccination via walk-in, pop-up vaccination clinics.

The roving service continues to use vaccine uptake data and insights to specifically target clinics in underserved communities - including dedicated clinics at homeless shelters, mosques and Islamic centres, cathedrals, schools, colleges and Gypsy and traveller sites.

Bespoke "Love life, stop COVID" campaign materials were developed collaboratively by the Cheshire Communications Cell in response to extensive vaccine hesitancy insights work in Cheshire East.

Patient Insight and Intelligence

To inform the commissioning intentions of the emerging ICB, the CCG continued to evaluate patient feedback from a wide range of sources in the first quarter of 2022-23. This work included the cross-referencing of feedback received via the patient experience and communications and engagement teams with data shared by fellow NHS organisations, Healthwatch Cheshire and others.

In the first quarter of 2022/23, the CCG produced its final comprehensive Insight and Intelligence Report, previously published every four months, to ensure patient feedback was systematically collated and shared with senior leaders and clinical leads.

This rich source of real-time patient feedback was also shared with commissioning teams across the CCG to help ensure the patient voice remains right at the centre of decision making under NHS Cheshire and Merseyside.

Designed to reflect the diversity of the local population, the reports were used to influence every stage of the commissioning cycle.

The values informing the CCG's approach to engagement are illustrated in the graphic below and have been used to help shape NHS Cheshire and Merseyside's commitment to community empowerment.

Engaging with minority communities and our most vulnerable

COVID-19 brought into sharp focus the disproportionate impact of the pandemic on some of the most vulnerable people in our communities.

Local insight led to a targeted engagement approach – co-ordinated by the CCG – which included work to engage with ethnic communities, marginalised groups, people living with learning disabilities and / or autism, asylum seekers, people who are homeless and rough sleepers.

This work subsequently led to a targeted communications and engagement campaign – Spreading the Vaccine, Not the Virus – aimed at encouraging COVID-19 vaccine confidence and take-up among underserved communities.

Working in Partnership

In the first quarter of 2022/23, the CCG continued to manage a Cheshire Communications Cell established in 2021/22 to maximise the impact of collective work to involve residents. The cell comprises health and care system partners including GP practices, NHS trusts, local authorities, Healthwatch Cheshire and community sector organisations.

Much of this collaboration was co-ordinated in the fortnightly cell meetings attended by communications and engagement leads from NHS trusts, both local authorities and Healthwatch Cheshire.

Examples of collaborative work in quarter one of 2022/23 included:

- Co-ordinating Cheshire's system-wide communications and engagement response to COVID-19 and the COVID-19 vaccination rollout

- System-wide support for NHS trusts to help them manage system pressures, including via a joint behaviour change campaign
- Supporting the then Cheshire East and Cheshire West Integrated Care Partnerships to deliver engagement at care community level
- Ensuring a collaborative approach to engaging with marginalised and vulnerable groups.

Other examples of partnership working included membership of a communications and engagement team established with Cheshire East Council and Cheshire Constabulary to manage internal, partner and stakeholder messaging in the period preceding a multi-agency inspection of services to protect children and young people from criminality including sexual exploitation.

The CCG has also worked with Cheshire East Council to establish a communications and engagement team to promote SEND services to the parents and carers of children and young people receiving the services in question. In keeping with the partners' commitment to co-production, they have involved parents in the team and in the development and delivery of an engagement strategy. Products include a quarterly newsletter, SENDing you the News, which is issued to all families interacting with SEND services. The newsletter publicises achievements and ambitions, promoting access to services including new provision for parents and carers of young people who have been diagnosed with autism or ADHD and are awaiting treatment.

The CCG continued providing a full communications and engagement service to Cheshire West Integrated Care Partnership (CWICP) in the final three months before its dissolution in June 2022. This included production of a fortnightly e-bulletin published to more than 1,000 staff, partners and stakeholders; management of social media channels; quality assurance of communications and engagement activity carried out by the nine care communities; and execution of engagement events to inform care community priorities. In the first quarter of 2022/23, the CCG made presentations to each of the care community steering groups on strategic, tactical and operational approaches to communications and engagement. The aim of the presentations was to support the care communities to sustain their own engagement beyond the life of CWICP and the CCG.

Internal, partner and stakeholder communications and engagement

In the three months from April 2022, the CCG maintained a comprehensive suite of communications and engagement activity to ensure staff were fully informed of the ongoing transition to NHS Cheshire and Merseyside, and were aware of opportunities to shape the vision and values of the new organisation and to discuss any employment concerns with line management, Senior Leadership Team, HR services and union representatives.

Channels included a Weekly Update issued every Friday to all employees; and a fortnightly, interactive Team Brief held online and led by Executive Team members. Partners and stakeholders were kept informed by a monthly Partner Briefing, which also covered the CCG's achievements and wider system working in its final weeks.

A Primary Care Bulletin was issued each Thursday to general practice, partners and stakeholders to communicate operational information from the CCG, NHS England and Improvement, and provider trusts. The bulletin also included need-to-know information on the COVID-19 vaccination programme, together with news on training and development opportunities. The bulletin has continued since July 2022 as one of several place-based communication channels under NHS Cheshire and Merseyside.

The CCG also continued to publish a weekly COVID-19 Bulletin to partners and stakeholders for onward dissemination across their channels. The bulletin shared information on forthcoming vaccination opportunities plus assets to support partners in promoting the vaccination programme. Again, publication has continued from July under place-based arrangements.

Supporting health and care integration

The CCG was front and centre in developing public-facing communications channels for NHS Cheshire and Merseyside. The communications and engagement team managed the development of the ICB's website and social media channels while advising on the development of the staff intranet.

The CCG authored the media release that announced formation of the ICB and worked with other CCGs across the sub-region to produce an aligned social media planner that ensured an impactful launch. The CCG led the development of the ICB's brand guidelines and associated templates.

Media relations

Despite the pressures arising from supporting closure of the CCG and inception of the ICB, the communications and engagement team maintained a sustained programme of media relations and associated social media activity in the three months from April 2022. The purpose of this work was to socialise the ICB with the public and protect the CCG's reputation while promoting self-care, access to services and informed use of the NHS.

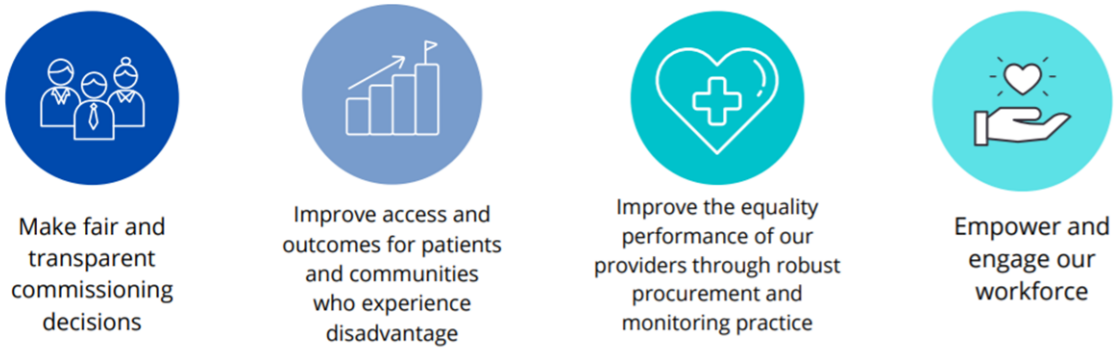
The following are among subjects for which significant coverage was achieved:

- The CCG's ongoing shrinking of its carbon footprint in pursuit of the NHS' ambition to achieve a net-zero position by 2040
- The findings of an Ofsted and CQC inspection of SEND services commissioned by the CCG and Cheshire East Council
- Opportunities to take part in a public consultation on proposals to meet pharmaceutical needs in Cheshire East
- Publication of the CCG's Engagement and Inclusion Annual Report 2021-22
- Public reassurance around the monkeypox outbreak.

1.2.6 Reducing Health Inequality

As a CCG we aimed to understand the experiences of patients and carers, communities and the workforce, ensuring the needs of protected and vulnerable groups are identified, considered and appropriately met.

The CCG had four equality objectives. These were:



These equality objectives guided the CCG to work towards improving wellness within our communities, ensure high quality services for everyone who needs them and ensure equity in health and care.

The CCG played an integral part in local actions to reduce health inequalities. Success in reducing inequalities will only come from a broader approach across health, social care and wider strategic partnerships pulling in the same direction to improve population health.

The CCG was a partner in and/or a co-signatory to a number of key plans and strategies that looked to address health inequalities across our two Places and Cheshire and Merseyside (C&M). This included membership of the Cheshire East Increasing Equalities Commission and the West Cheshire Poverty Commission.

Additionally, both Places have signed up to be a Marmot community as part of the work that has been undertaken under the direction of C&M in conjunction with Sir Michael Marmot and his team.

The CCG was also an active participant in the development of Joint Strategic Needs Assessment (JSNA) work in both Places and worked with partners to develop the approach to population health management in order to utilise and triangulate the data and intelligence at system level to identify inequalities and inequity in terms of access and offer. Taking account of protected characteristics in our planning and commissioning decisions aimed to address and further improve residents' outcomes.

This was supported by the production of data packs to PCNs/Care Communities showing population intelligence to support targeted proactive interventions and reduced health inequalities between PCN areas.

There was also a monthly equality and diversity board which helped inform CCG action requirements.

Examples of work undertaken/underway to address inequalities particularly those targeted groups such as Learning Disabilities and or Autism (LD&A) - which national evidence demonstrates that this group suffer many inequalities including health - included:

- **STOMP (stopping over medication of people with a learning disability) and STAMP (Supporting Treatment and Appropriate Medication in Paediatrics).** This is a national project set out by Public Health England; it involves many different organisations in order to help to stop the overuse of psychotropic medicines with the LD&A adults and children population.

  The CCG's role is to support the effective implementation of this work, ensuring that all the organisations and/or services who support children and people with LD&A are ensuring that they only receive the right medication, at the right time, for the right reason. Overall, the main aims of the project for the CCGs is about helping people to stay well and have a good quality of life and ensuring that prescribed psychotropic medications are reviewed or stopped when they are no longer needed.

  COVID-19 has significantly hindered the delivery of STOMP and STAMP throughout the last year. This is mainly due to the reduced capacity of GP Practices and Specialist Mental Health services to deliver comprehensive medication reviews. It is critical to have the capacity to engage and support people with learning disabilities and/or autism (LD&A) and their families in medication reviews, particularly if long-term medications are to be adjusted, or stopped. Some activities that are being undertaken include:
  - The clinical lead at CWP has completed 'virtual' specialist advice to support GP Practices to reduce medications, where appropriate.
  - CWP is collating the number of referrals, which include Positive Behavioural Support (PBS) Plans, as an alternative to medication.
  - There has been an increase in the number of staff trained in PBS and new multi-disciplinary Advance Practitioner roles within the LD adult team (including Physio, Speech and Language Therapy, Nurse).
  - The Primary Care Networks (PCNs) have achieved the annual health check (AHC) target for 2021/22 of 70%, which includes a medication review.
  - A pathway for 'behaviour that challenges' is now in place for Children and Young People (CYP) (LD Children and Adolescent Mental Health Services) to reduce the risk of initiating new medications.

- **Annual health checks** for people with learning disabilities have been a key part of NHS plans to improve health and reduce premature mortality since 2008 in people with LD&A.

  Evidence suggests that annual health checks (AHCs) are effective in identifying unmet health need. Conditions identified include serious and life-threatening illnesses as well as more minor health conditions. There is also evidence that health checks are effective in prompting health actions to address identified health needs. Practices providing AHCs have been shown to make more referrals to primary and secondary health services. NICE guidance on mental health and people

with learning disabilities explicitly recommends annual health checks.

- **COVID-19 and Flu vaccinations** – supporting making these more assessable to people with LD&A. Use of easy read material to support informed consent and involvement of partners across social care to support key messages.

- **Children and Young People** – Cheshire was a pilot site in Cheshire and Merseyside for Community Keyworking Early Adopters in 2021/22 The Keyworker project was underpinned by the requirements of the national Transforming Care Programme, as part of the NHSE and NHSI Long Term Plan to reduce hospital admissions for children and young people with LD and/or Autism by 2023/24.

  By 2023/24, children and young people with a learning disability, autism or both with the most complex needs will have a designated keyworker, implementing the recommendation made by Dame Christine Lenehan.

  Initially, keyworker support will be provided to children and young people who are inpatients or at risk of being admitted to hospital.

  The initial phase of the Keyworker function will focus on those children and young people who are inpatients, or at risk of hospital admission, including CYP with the most complex needs and vulnerabilities such as children who are looked after and/or adopted.

  The Keyworker function will facilitate targeted and intensive interventions to children and young people with LD and/or Autism up to the age of 25 years old, who are determined to be at risk of admission to hospital or 24-hour residential care.

  Additionally, examples of projects that have been implemented to reduce inequity of services across both Places in Cheshire include:
  - Cheshire wide SAXENDA (weight loss medication) pathway in line with NICE recommendations.
  - Rollout of the National Diabetes Prevention Programme (NDPP), including implementing NDPP Docmail in all GP Practices
  - Delivery of 3,000 blood pressure monitors to practices supporting the targeting and treatment of patients on the hypertension register
  - Implemented the Alcohol Care Pathway across West Cheshire
  - Telehealth – Docobo system to be implemented and patients onboarded by the services.
  - Single model of Domiciliary End of Life Care across Cheshire – using Continuing Healthcare (CHC) Fast Track funding (£2.5m) in a different way to reduce variation, address unmet need, improve quality and coordination of care and ultimately enable more people to die at home as their preferred place of choice.
  - Long COVID – activity has been undertaken by Business Intelligence to analyse the referrals to the service and take up across population areas in Cheshire to support engagement with minority groups, including ethnic minorities and LD&A, to increase awareness and promote access to the services.

- The **Primary Care** functions of Cheshire CCG were an integral part of supporting and improving the health outcomes and inequalities of the Cheshire population. A number of key priorities and areas of work that both the Primary Care Contracting and Transformation / Development Teams delivered had a specific focus on health inequalities and can demonstrate real and positive outcome improvement. In summary, these include:

  - Primary Care was a key stakeholder, represented on the Joint Strategic Needs Assessment (JSNA) steering groups within both Cheshire West and Cheshire East Place. This involvement has led to Primary Care working with partners to agree the vision for our Place Plans, with a key focus on health inequalities via the Marmot Review and the wider determinants of health. In addition, Primary Care has been a key part of the developing deep dive JSNAs and further work

programmes into specific locations where there are identified health inequalities, including Crewe, Macclesfield and Blacon

- In addition, through the investment within the Additional Roles Reimbursement Schemes, the Cheshire population has seen approximately 350 additional whole time equivalent members of staff, working on the front line, improving access to Primary Care. A part of this workforce has been focusing specifically on Social Prescribing and Care Co-ordination, supporting patients receiving inequitable healthcare due to their location (e.g. within rural communities) or health condition (e.g. mental health and parity of esteem)

- The Primary Care Team have continued to lead the roll-out of vaccination programmes for communities who may experience health inequalities. This has included Hepatitis A outbreaks within our traveller communities, Avian Flu outbreaks within our rural farming communities, and the COVID vaccination programme, specifically within hard-to-reach areas and for those who are homeless. This has been developed into a regular “health inequalities” clinic being set up within our JSNA deep dive area of Crewe, the development of a Health and Wellbeing Bus within East Cheshire and Complete Care Communities in two locations within Cheshire West

- The Primary Care Team’s focus on health inequalities has also taken specific emphasis on pockets of the population where additional requirements have been needed. For example, an “Enhanced Health in Care Homes Local Scheme” has been developed for those patients who may have additional health needs due to neuro-disability. Also, a Practice within central Chester has been developed to become a purely “Care Homes” Practice, giving support consistently to patients who call a Nursing or Residential setting as their main home. In addition, specific support and guidance has been given to local GP Practices, enhancing the care delivered to those living within the canal system, or those who have been displaced via an asylum seeker or refugee programme

- Finally, additional funding made available to Primary Care Networks and Clinical Leaders has ensured that time has been available to develop care communities, linking and flexibly developing plans to meet local population need, as well as developing clinical leadership, mentorship and pastoral care to our health sector workers that are delivering the care to our communities. This has allowed specific focus on some of the key programmes that aim to support health inequalities, including Connected Communities, Making Every Contact Count, whilst also developing Primary Care Network Data Packs that analyses and bring focus on key areas of health inequalities and link to the Core 20 PLUS 5 programme.

1.2.7 Sustainable Development

The CCG made good progress in Quarter 1 of 2022/23, despite the continued pressures resulting from the COVID-19 pandemic, and continued to uphold our commitment to climate change and social value in our commissioning and contracting intentions and strategic objectives which include:

- Ensuring all contracts include the principles of social value relating to economic, social and environmental wellbeing which encourage and support community asset building, local workforce development as well as enhancing volunteering opportunities. Social value will support providers to sustain local services whilst providing work opportunities for local people
- Ensure social value is embedded into contractual arrangements to encourage volunteering, apprenticeships and workforce diversity
- Working with Cheshire & Merseyside Health and Care Partnership to develop a Social Value Anchor Institute Charter for implementation in the Integrated Care System which will form core aspects of contracts.

This is in line with the Cheshire and Mersey HCP (ICS) Social Value Charter, emerging Cheshire and Merseyside Integrated Care System Green Plan, and "Delivering a 'Net Zero' National Health Service" Report setting the targets for achieving a net zero position across the NHS by 2040.

Following on from the work undertaken in 2021/22, the Governing Body continued to support the following:

- To place climate change at the highest risk level in the Governing Body Assurance Framework.
- To embed environmental and social sustainability in all CCG work the strategic objective "Commission environmentally and socially sustainably to meet the health and wellbeing needs of the population now and in the future"
- Action Plan priorities for the Climate Change Taskforce in the following key areas:
  - Corporate Approach
    - Embed sustainability within developing organisational vision, values, strategy and processes
    - Climate Change Champions from the Governing Body and staff teams
    - Embed sustainability and social values commitments in our commissioning and procurement policy, frameworks and processes
    - Ensure business processes reduce use of paper, use recycled paper and products where possible, reduce printing, reduce waste and consumables and promote recycling and energy conservation behaviours amongst all employees
    - A system-wide communications and engagement strategy to recognise and promote the role of the CCG and its partners in leading improvements in sustainability internally and externally.
    - Raise awareness of the impact of climate change on people's health and the need to respond to the climate emergency so people are informed about what they can do to play a part in reducing their own carbon footprint.
    - Ensure business continuity and emergency planning includes adaptation planning so that communities, services and infrastructure are prepared and resilient to weather event and crises
  - Workforce
    - Raise awareness across the workforce by providing on line training for staff from all of the CCG teams
    - Maintain the staff-led movement to raise awareness of and tackle climate change at work and home
  - Estates and Utilities
    - Reduce our carbon emissions by using a renewable energy
    - Reduce the water and electricity consumption in the CCG offices
    - Work with our supply chain to support innovation and low carbon services
  - Travel and Logistics
    - Reduce travel for staff, visitors and patients through the use of agile working supported by the use of technology
    - Encourage active travel e.g. walking and cycling for staff commuting and business travel

- Partnership
  - Align with the development of the Social Value policy and framework with the Local Authorities
  - Work with partners across Cheshire through Sustainability Networks for both Cheshire East and Cheshire West Places, and cross-Cheshire Trust Networks
- Commissioning and Transformation of Care
  - Ensure sustainability and social values commitments are in all our commissioning and transformation programmes and projects
  - Commission healthcare that is fit for the future that takes into account the effects of climate change on patients, the delivery of care and how diseases are spread
  - Ensure the Medicines Management Policies support sustainability

During Quarter 1 of 2022/23, the CCG continued to take action to address climate change and strengthen the organisations commitment to social value, here are some examples:

- Continued membership of the Cheshire and Merseyside Social Value Network.
- Continued to develop the Climate Change Staff Activist Group with members from across the CCG Directorates.
- Published the baseline carbon footprint for the CCG for 2019/20 and 2020/21 and produced recommendations for further reductions moving into the Cheshire and Merseyside Integrated Care System.
- Continued the Climate Change Taskforce who provide oversight and progress our key areas of work, with a view to transitioning all action points into Cheshire and Merseyside Integrated Care Board working from 1st July 2022.
- Continued promotion of the 10 Point Green Plan for Practices, produced in 2021/22 with a group of GPs and Practice Managers, to help practices reduce their environmental impact in Cheshire. This plan has been shared nationally and has been well received by NHS colleagues across the country, with adapted versions of the plan being adopted across various regions.
- Launched a trial scheme with a Chester GP Practice to encourage the recycling of medicine blister packets, utilising the existing Superdrug scheme.
- Undertaken multiple sustainability communication campaigns as outlined in the Communications and Engagement plan, including significant religious holidays and awareness events, such as Ramadan, Easter, Earth Day, The Big Plastic Count, Clean Air Day and Wild June.
- Developed a series of animated videos linking climate change to health and promoting healthy lifestyle changes which are also environmentally friendly, for the Winsford Cross Shopping Centre CineWindow. These videos were subsequently adapted for use across Cheshire & Merseyside and promoted as part of Clean Air Day.
- Held a promotional stand at the Cheshire Green Expo in June 2022 to raise awareness of the link between health and climate change, and to promote the sustainability work of the NHS.
- Included items in the Weekly Staff Newsletter from Staff Activist members sharing their experiences and tips to reduce carbon footprint both at home and in work.
- Included items in the Climate Change Update section of the weekly Cheshire GP news bulletin to raise awareness of local and national events and promotions relevant to primary care.
- Continued to update the Climate Change page on the CCG website with access to a directory map of Cheshire sustainable services as well as other useful information.
- Encouraged and supported each Directorate in reviewing their Team Green Plans, put in place in 2021 to encourage accountability and individual action both at home and as part of CCG work.
- Continued to develop Sustainability Networks across Cheshire for Trusts, and for Cheshire East and Cheshire West Places to include Council and emergency services representation.
- Established priority areas for collaborative working with both Cheshire East and Cheshire West Place Sustainability Networks.
- Successfully achieved the Cheshire & Merseyside Social Value Award, setting our organisational intentions going into the Cheshire & Merseyside Integrated Care System.

1.2.8 Financial Review

As explained previously, statutory responsibilities passed to the Cheshire and Merseyside Integrated Commissioning Board (ICB) on 1 July 2022 and therefore this review relates to the three months ending 30 June 2022.

The CCG ended the three months with an allocation of £336.9m which included a separate allocation of £3.5m to spend on running costs (employing staff, running the organisation and buying support services). From 1 July 2022, the remaining allocation for the year to 31 March 2022 has been transferred to NHS Cheshire and Merseyside ICB.

The net expenditure for the quarter to 30 June 2021 is a break-even position outlined below:

Category	Target Net Expenditure £'m	Actual Net Expenditure £'m	Over / (Underspend) £'m
Healthcare	333.4	333.4	-
Running Costs	3.5	3.5	-
Total	336.90	336.90	-

A breakdown of net expenditure across the CCG main expenditure categories is detailed in the following table:

Expenditure Category	Three months to 30 June 2022 Annual Net Expenditure £'m
Acute Service	165.3
Community Services	26.6
Mental Health	31.2
Continuing Healthcare / Complex Care	23.2
Primary Care (including Delegated)	40.1
Prescribing	32.7
Other	14.3
Running Costs	3.5
Total	**336.9**

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

NHS Act Section	Duty	Maximum performance (30 June 2022) £000's	Duty Achieved?
223H(1)*	Expenditure not to exceed income	337.0	Yes
223I(2)	Capital resource use does not exceed the amount specified in Directions	-	Yes
223I(3)	Revenue resource use does not exceed the amount specified in Directions	336.9	Yes
223J(1)	Capital resource use on specified matter(s)does not exceed the amount specified in Directions	-	Yes
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	Yes
223J(3)	Revenue administration resource use does not exceed the amount s pecified in Directions	3.5	Yes

* Note: For the purposes of 223H(1); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as receivable in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

The Financial Framework for 2022/23 will be aligned to the development of a Cheshire & Merseyside Integrated Care Systems which is required to deliver a balanced financial position as a whole system. To support this approach. the CCG continued to identify efficiencies and other savings both as an organisation and by working with other partners across the system in order to balance the books. There remains a significant challenge and risk to the delivery of the required efficiencies.

Accountable Officer's Statement

To the best of my knowledge and belief, the Performance Report presents a true and accurate picture of NHS Cheshire Clinical Commissioning Group.

Graham Urwin

Graham Urwin
Chief Executive, NHS Cheshire and Merseyside ICB

29 June 2023

2 The Accountability Report

The Accountability Report describes how the CCG met key accountability requirements and embodied best practice to comply with corporate governance norms and regulations. It comprises three sections:

- The **Corporate Governance Report** sets out how we governed the organisation during the period 1 April to 30 June 2022, including membership and organisation of the CCG's governance structures and how they supported the achievement of CCG objectives.
- The **Remuneration and Staff Report** describes the CCG's remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on workforce, remuneration and staff policies.
- The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

2.1 Corporate Governance Report

The purpose of the corporate governance report is to explain the composition and organisation of the CCG's governance structures and how they support the achievement of the CCG's objectives.

2.1.1 The Members' Report

The composition of the CCG's Membership during Quarter 1 of 2022/23 was:

	Practice Name	Address
1	**Alderley Edge Medical Practice**	Talbot Road Alderley Edge, Cheshire, SK9 7EP
2	**Ashfields Primary Care Centre**	Middlewich Road, Sandbach, Cheshire, CW10 1EQ
3	**Audlem Medical Practice**	16 Cheshire Street, Audlem, Cheshire, CW3 0AH
4	**Boughton Health Centre**	Hoole Lane, Boughton, Chester, Cheshire, CH2 3DP
5	**Broken Cross Surgery**	Waters Green Medical Centre, Sunderland Street, Macclesfield, Cheshire, SK11 6JL
6	**Bunbury Medical Practice**	Vicarage Lane, Bunbury, Tarporley, Cheshire, CW6 9PE
7	**Cedars Medical Centre**	Alsager Health Centre, Sandbach Road, Alsager, Cheshire, ST7 2LU
8	**Chelford Surgery**	Elmstead Road, Chelford, Cheshire, SK11 9BS
9	**City Walls Medical Centre**	St Martin's Way, Chester, Cheshire, CH1 2NR
10	**Cumberland House**	Waters Green Medical Centre, Sunderland Street, Macclesfield, Cheshire, SK11 6JL
11	**Danebridge Medical Centre**	London Road, Northwich, Cheshire, CW9 5HR
12	**The David Lewis Medical Centre**	Chelford Surgery, Elmstead Road, Chelford, Macclesfield SK11 9BS
13	**Drs Adey and Dancy**	Tarporley Health Centre, Park Road, Tarporley, Cheshire, CW6 0BE
14	**Dr Campbell & Partners**	Tarporley Health Centre, Park Road, Tarporley, Cheshire, CW6 0BE
15	**Earnswood Medical Centre**	Eagle Bridge Health and Wellbeing Centre, Dunwoody Way, Crewe, Cheshire, CW1 3AE
16	**Firdale Medical Centre**	Firdale Road, Northwich, Cheshire, CW8 4AZ

	Practice Name	Address
17	**Fountains Medical Practice**	Fountains Health, Delamere Street, Chester Cheshire, CH1 4DS
18	**Garden Lane Medical Centre**	19 Garden Lane, Chester, Cheshire, CH1 4EN
19	**Great Sutton Medical Centre**	Old Chester Road, Great Sutton, Cheshire, CH66 3PB
20	**Green Moss Medical Centre**	Portland Drive, Scholar Green, ST7 3BT
21	**Grosvenor Medical Centre**	Grosvenor Street, Crewe, Cheshire, CW1 3HB
22	**Handbridge Medical Centre**	Greenway Street, Handbridge, Chester, Cheshire, CH4 7JS
23	**Handforth Health Centre**	Wilmslow Road, Handforth, Cheshire, SK9 3HL
24	**Haslington GP Surgery**	Crewe Road, Crewe, Cheshire, CW1 5QY
25	**Heath Lane Medical Centre**	Heath Lane, Boughton, Chester, Cheshire, CH3 5UJ
26	**Helsby Health Centre**	Lower Robin Hood Lane, Helsby, Cheshire, WA6 0BW
27	**High Street Medical Practice**	Dene Drive Primary Care Centre, Dene Drive, Winsford, Cheshire, CW7 1AT
28	**High Street Surgery**	Waters Green Medical Centre, Sunderland Street, Macclesfield, , SK11 6JL
29	**Holmes Chapel Health Centre**	London Road, Holmes Chapel, Cheshire, CW4 7BB
30	**Hope Farm Medical Centre**	Hope Farm Road, Great Sutton, Cheshire, CH66 2WW
31	**Hungerford Medical Centre**	School Crescent, Crewe, Cheshire, CW1 5HA
32	**Kelsall Medical Centre**	Church Street, Kelsall, Cheshire, CW6 0QG
33	**Kenmore Medical Centre**	60 – 62 Alderley Road, Wilmslow, Cheshire, SK9 1PA
34	**Kiltearn Medical Centre**	Church View Primary Care Centre, Beam Street, Nantwich, Cheshire, CW5 5NX
35	**Knutsford Medical Partnership**	Mobberley Rd, Knutsford WA16 8HR
36	**Lache Health Centre**	Hawthorn Road, Lache, Chester, Cheshire, CH4 8HX
37	**Launceston Close Surgery**	9/10 Launceston Close, Winsford, Cheshire, CW7 1LY
38	**Malpas Surgery**	Old Hall Street, Malpas, Cheshire, SY14 8PS
39	**Lawton House Surgery**	Bromley Road, Congleton, Cheshire, CW12 1QG
40	**Meadowside Medical Centre**	Meadowside, Mountbatten Way, Congleton, Cheshire, CW12 1DY
41	**Merepark Medical Centre,**	Alsager Health Centre, Sandbach Road, Alsager ST7 2LU
42	**Middlewich Road Surgery**	163 Middlewich Road, Northwich, Cheshire, CW9 7DB
43	**Middlewood Partnership**	Bollington Medical Centre, Macclesfield Cheshire, SK11 5JH
44	**Millcroft Medical Centre**	Eagle Bridge Health and Wellbeing Centre, Dunwoody Way, Crewe, Cheshire, CW1 3AE

	Practice Name	Address
45	**Nantwich Health Centre**	Church View Primary Care Centre, Beam Street, Nantwich, Cheshire, CW5 5NX
46	**Neston Medical Centre**	Liverpool Road, Neston, Cheshire, CH64 3RA
47	**Neston Surgery**	Mellock Lane, Little Neston, Cheshire, CH64 4BN
48	**Northgate Medical Centre**	Fountains Health, Delamere Street, Chester, Cheshire, CH1 4DS
49	**Northgate Village Surgery**	Fountains Health, Delamere Street, Chester, Cheshire, CH1 4DS
50	**Oaklands Surgery**	St. Anne's Walk, Middlewich, Cheshire, CW10 9BE
51	**Oakwood Medical Centre**	Broadway Barnton, Northwich, Cheshire, CW8 4LF
52	**Old Hall Surgery**	26 Stanney Lane, Ellesmere Port, Cheshire, CH65 9AD
53	**Park Green Surgery**	Waters Green Medical Centre, Sunderland Street, Macclesfield, Cheshire, SK11 6JL
54	**Park Lane Surgery**	Waters Green Medical Centre, Sunderland Street, Macclesfield, Cheshire, SK11 6JL
55	**Park Medical Centre**	Shavington Avenue, Newton Lane, Chester, Cheshire, CH2 3RD
56	**Princeway Surgeries**	Princeway Health Centre, Princeway, Frodsham, Cheshire, WA6 6RX
57	**Readesmoor Medical Group Practice**	29/29a/31 West Street, Congleton, Cheshire CW12 1JP
58	**Rope Green Medical Centre**	Rope Lane – Shavington, Crewe, Cheshire, CW2 5DA
59	**South Park Surgery**	Waters Green Medical Centre, Sunderland Street, Macclesfield, Cheshire, SK11 6JL
60	**St Werburgh's Medical Practice for the Homeless**	2A George Street , Chester, Cheshire, CH1 3EQ
61	**Swanlow Medical Centre**	Dene Drive Primary Care Centre, Dene Drive, Winsford, Cheshire, CW7 1AT
62	**The Elms Medical Centre**	Fountains Health, Delamere Street, Chester CH1 4DS
63	**The Village Surgeries Group**	Tattenhall Village Surgery, Ravensholme Lane, Tattenhall, Chester, CH3 9RE
64	**Tudor Surgery**	Church View Primary Care Centre, Beam Street, Nantwich, Cheshire, CW5 5NX
65	**Upton Village Surgery**	Wealstone Lane, Upton, Chester, Cheshire, CH2 1HD
66	**Vernova Healthcare Community Interest Company**	Waters Green Medical Centre, Sunderland Street, Macclesfield, Cheshire, SK11 6JL
67	**Waters Edge Medical Centre**	Lex House, 10-12 Leadsmithy Street Middlewich, Cheshire, CW10 9BH
68	**Watling Street Medical Centre**	2 Watling Street, Northwich, Cheshire, CW9 5EX
69	**Weaverham Surgery**	Northwich Road, Northwich, Cheshire, CW8 3EU
70	**Weaver Vale Surgery**	Dene Drive Primary Care Centre, Dene Drive, Winsford, Cheshire, CW7 1AT
71	**Western Avenue Medical Centre**	Gordon Road, off Western Avenue, Chester, CH1 5PA

	Practice Name	Address
72	**Westminster Surgery**	12-18 Church Parade, Ellesmere Port, Cheshire, CH65 2ER
73	**Whitby Health Partnership**	Chester Road, Whitby, Ellesmere Port, Cheshire, CH65 6TG
74	**Willaston Surgery**	Greenbank, Neston Road, Willaston, Cheshire, CH64 2TN
75	**Willow Wood Surgery**	Crook Lane, Winsford, Cheshire, CW7 3GY
76	**Wilmslow Health Centre**	Chapel Lane, Wilmslow, Cheshire, SK9 5HX
77	**Witton Street Surgery**	162 Witton Street, Northwich, Cheshire, CW9 5QU
78	**Wrenbury Medical Centre**	Nantwich Road, Nantwich, Cheshire, CW5 8EB
79	**York Road Group Practice**	York Road, Ellesmere Port, Cheshire, CH65 0DB

The composition of the CCG's **Governing Body** during Quarter 1 of 2022/23 was:

Name and Role
Dr Andrew Wilson Clinical Chair
Clare Watson Chief Executive / Accountable Officer
Lynda Risk Director of Finance and Contracting
Dr Daniel Howcroft Independent Clinical Governing Body Member (Secondary Care)
Christine Morris Independent Clinical Governing Body Member (Registered Nurse)*
Dr Lesley Appleton General Practice Representative
Dr Rachel Hall General Practice Representative
Dr Fiona McGregor-Smith General Practice Representative
Dr Gwydion Rhys General Practice Representative and Assistant Clinical Chair
Suzanne Horrill Independent Lay Governing Body Member (Governance)
Peter Munday Independent Lay Governing Body Member (Governance)
Pam Smith Independent Lay Governing Body Member (Engagement, Involvement and Experience)
Wendy Williams Independent Lay Governing Body Member (Engagement, Involvement and Experience) and Lay Member Deputy Chair of the Governing Body
Chris Lynch Co-opted Independent Lay Governing Body Member (Engagement, Involvement and Experience) [1]
Standing Invitees:
Ian Ashworth Director of Public Health, Cheshire West and Chester Council
Matt Tyrer Director of Public Health, Cheshire East Council
Neil Evans

Name and Role
Executive Director of Planning and Delivery
Paula Wedd Executive Director of Quality, Patient Experience and Safeguarding
Matthew Cunningham Director of Governance and Corporate Development

Notes to the table

***1** Non-voting Member

Governing Body members' declarations of interests can be viewed on the CCG's website at: https://www.cheshireccg.nhs.uk/governance/registers-of-interest/

At 30 June 2022, the CCG had 4 male and 9 female voting members on the Governing Body (5 male and 9 female members in total). The Governing Body met in public on ten occasions during the year. All of those meetings were quorate. The agenda and papers for formal public meetings can be viewed at: https://www.cheshireccg.nhs.uk/meetings/governing-body/

A short biography of the Governing Body members is included at appendix 2.

There was one reportable IG incident. Information regarding domestic abuse and violence and detail of a MARAC (Multi-Agency Risk Assessment Conference) request for information was sent to the incorrect GP Practice and uploaded to an incorrect patient record, this information was then viewed by this patient on their online record who highlighted that this information did not relate to them. The GP replied with information they held on the patient (incorrect person) but the error was realised before this information was shared with MARAC. This was reported to the Information Commissioner on 20/05/2022.

Governance, Audit and Risk Committee

Between 01 April 2021 and 30 June 2022, the Committee met on four occasions and was quorate at each meeting. The membership of the Committee in Quarter 1 of 2022/23 was:

Name	Role
Peter Munday (Chair)	Lay Member for Governance
Suzanne Horrill (Deputy Chair)	Lay Member for Governance
Dr Fiona McGregor-Smith	GP Governing Body Member
Dr Gwydion Rhys	GP Governing Body Member
Wendy Williams	Lay Member for Engagement, Involvement and Experience

Please see the Governance Statement (section 2.1.3) for details of other committees and sub-committees. Information on the **Remuneration Committee** membership can be found in the Remuneration Report.

Modern Slavery Act

NHS Cheshire CCG fully supported the Government's objectives to eradicate modern slavery and human trafficking but did not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015. The CCG did however produce one which can be found on the CCG website at www.cheshireccg.nhs.uk

2.1.2 Statement by the Chief Executive of NHS Cheshire and Merseyside ICB, Graham Urwin, as the Accountable Officer

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 Officer to be the Accountable Officer of NHS Cheshire CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group 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 Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

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

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Cheshire 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

29 June 2023

2.1.3 The Governance Statement

2.1.3(1) Introduction and Context

NHS Cheshire CCG was a body corporate established by NHS England on 1 April 2020 under the National Health Service Act 2006 (as amended).

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

As at 30 June 2022, the clinical commissioning group was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

It is noted that from 1st July 2022 the CCG ceased to exist, and all assets, liabilities and functions transferred to the NHS Cheshire & Merseyside Integrated Care Board (ICB), part of the C&M Integrated Care System.

2.1.3(2) Scope of Responsibility

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

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

2.1.3(3) Governance Arrangements and Effectiveness

The main function of the governing body was to ensure that the group made appropriate arrangements for ensuring that it exercised its functions effectively, efficiently and economically and complied with such generally accepted principles of good governance as were relevant to it.

Information about the composition of the Membership Council, Governing Body and Governance and Audit Committee can be found in the Members' Report. Information on the Remuneration Committee membership can be found in the Remuneration Report. Please see appendix one for a diagram of the CCG's organisational structure.

Information on the roles and responsibilities of the Governing Body and its Committees is outlined below. Lay Members played a key role in providing additional scrutiny, challenge and an independent voice in support of robust and transparent decision-making on both the Governing Body and its Committees.

As outlined in the CCG's 2021/22 Annual Report and Accounts, the CCG had a made a number of changes to its governance structure in anticipation of the Health and Social Care Act which was to create the Cheshire and Merseyside Integrated Care Board (ICB) and abolish Clinical Commissioning Groups.

In order to align the Scheme of Reservation and Delegation with the other eight Cheshire and Merseyside CCGs to enable a smooth transition to the ICB, the Governing Body AGREED in March 2022 that:

"The responsibilities of the Governing Body be discharged via the Joint Committee of the Cheshire and Merseyside CCGs, other than the following responsibilities that would be retained by the Governing Body:

- *ensure 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)*
- *approve amendments to the CCGs constitution (subject to the caveats requiring membership approval)*
- *approve amendments to the CCG's overarching scheme of reservation and delegation for inclusion in the CCG's constitution*
- *approve amendments to the CCG's standing financial instructions that underpins the CCG's 'overarching scheme of reservation and delegation' as set out in its constitution*
- *approve who can execute a document by signature / use of the seal*
- *approve the annual report and accounts*
- *approve the CCG's counter fraud and security management arrangements*
- *approve the arrangements for discharging the CCG's statutory duties as an employer*
- *oversee risk assessment and securing assurance actions to mitigate identified strategic risks (Governing Body Assurance Framework risk)*

The financial authority of the Joint Committee reflect that of the Governing Body.

The delegated authority to the CCG Place Committees remain the same and that any variations above those limits (delegated to the Committee) that would be considered to have a "significant impact" (over the financial authority of the Executive Directors in attendance) would now require the approval of the Joint Committee instead of the Governing Body."

That agreement was reflected in a revised Scheme of Reservation and Delegation (SORD), agreed by the CCG Governing Body in April 2022.

On 1st June 2022, the CCG provided assurance to NHSEI that it had followed a robust due diligence process to prepare for closedown and safe transfer of staff and property (in its widest sense) to the Cheshire and Mersey Integrated Care Board on 1 July 2022.

The assurance provided was based on review of relevant documentation and assurances that the Accountable Officer had received from the CCG's senior team, internal auditors and the CCG Governance, Audit and Risk Committee (GARC) approving the recommendations of the Programme Group in a "Final Assurance" report that was submitted to the GARC on 18th May 2022.

The preparations took account of the NHSEI ICS implementation guidance: *'Due diligence, transfer of people and property from CCGs to ICBs and CCG close down'* and the accompanying due diligence checklist, covering all aspects of current operations, including people, quality, finance and commissioning. The CCG had delivered all the necessary actions prior to close down. Where there were outstanding matters relating to the CCG which could not be actioned prior to 1st July (for example, the closure of legacy bank accounts), these were clearly documented for the ICB for action.

The CCG's risk register was updated prior to 1st July to provide the ICB with a clear list and actions identified to mitigate the risks from July onwards.

A staff list that was in line with the expectation of NHSEI due diligence checklist was provided to NHSEI by the CCG's HR team.

The following section describes the broad role of each of the committees in operation during Quarter 1, 2022/23.

Governing Body - in operation throughout Quarter 1, 2022/23 (though the exercise of many of its functions was delegated to the Joint Committee of the Cheshire and Merseyside CCGs)
The Governing Body's overall responsibilities were to:

a) Ensure that the group has appropriate arrangements in place to exercise its functions *effectively, efficiently and economically* and in accordance with the groups *principles of good governance* (its main function);
b) Determine the remuneration, fees and other allowances payable to governing body members, employees or other persons providing services to the group, including nominated practice representatives, and the allowances payable under a pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act;
c) Approve any functions of the group that are specified in regulations;
d) With the exception of those functions reserved to the group's Membership, to discharge all of the groups remaining statutory functions including:
    - to lead and approve the setting of the group's vision and strategy and its annual commissioning and financial plans;
    - securing continuous improvement in the standards, quality and outcomes of care, and regularly discussing and monitoring quality issues;
    - financial and risk management;
    - jointly publishing, with the group's Membership Council, the group's annual report and annual accounts;
    - where not specified in the terms of reference of the Governing Body committees, receiving the minutes of meetings of joint or collaborative
    - arrangements between the group and another statutory body(ies).

The CCG maintained three **statutory committees** throughout the quarter. A number of additional committees were in operation during the year and the Governing Body delegated authority to these committees to deliver some of the functions of the CCG. These committees and their responsibilities are described in more detail in the following sections.

Statutory Committee: Remuneration Committee - in place throughout Quarter 1, 2022/23 though it did not meet

The Remuneration Committee was established to support the CCG in the delivery of its statutory duties and to provide assurance to the Governing Bodies in relation to the delivery of these duties. Its role was to:

- make recommendations to the Governing Body about the remuneration, fees and other allowances for employees and for people who provide services to the group and on determinations about allowances under any pension scheme that the group may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the Health and Social Care Act 2012.

Statutory Committee: Governance, Audit and Risk Committee - in operation throughout Quarter 1, 2022/23

The Governance, Audit and Risk Committee was established to support the CCG in the delivery of its statutory duties and to provide assurance to the Governing Bodies in relation to the delivery of these duties. Its role was to advise and provide assurance to the Governing Body on:

- The strategic processes for risk, control and governance and the Governance Statement.
- The accounting policies, accounts and annual report of the CCG.
- Planned activity and results of both internal and external audit.
- The adequacy of response to issues identified by audit activity, including any external audit management letter.
- The management of risk and corporate governance requirements for the CCG.
- Processes and policies for a number of areas including; risk management anti-fraud, corruption and bribery, whistle-blowing, conflicts of interest, information governance.

In particular, the committee will provide assurance to the Governing Bodies on delivery of the duty to prepare an annual report for each financial year.

Statutory Committee: Primary Care Commissioning Committee - in operation throughout Quarter 1, 2022/23

The Primary Care Commissioning Committee undertakes the function of commissioning a common approach to primary medical care services for the population of Cheshire. The Committee makes recommendation towards the commissioning of primary medical services that:

- Reflect the local requirements and population health needs for NHS Cheshire CCG
- Strengthen a collaborative approach towards Primary Care Commissioning
- Support the strategic ambitions of the CCG.
- Support a developmental approach of co commissioning in line with the strategic vision of the CCG.

Joint Committee of the Cheshire and Merseyside CCGs - in operation throughout Quarter 1, 2022/23

The overarching role of the Joint Committee was to enable the Cheshire and Merseyside CCGs to collectively work effectively together and make joint binding decisions on those CCG functions and responsibilities exercisable by CCGs that will be for the benefit of the both the resident population and population registered with a GP practice in Cheshire and Merseyside.

Decisions were to be taken by the Joint Committee in accordance with the delegated authority granted to the Committee from each member CCG.

The Committee supported the strategic aims and objectives of the C&M HCP and contributed to the sustainability and transformation of local health and social care systems at 'Place'. The strategic aims of C&M HCP were aligned to the NHS Long Term Plan (2019) and focussed on improving and modernising our health and care services by:

- delivering safe and sustainable high-quality services;
- improving the health and wellbeing of local communities and tackling health inequalities; and
- delivering better joined up care closer to home.

In accordance with the Constitutions and Scheme of Reservation and Delegations (SoRD) of each member CCG, the Committee had delegated authority to undertake decisions on all functions and responsibilities exercisable by CCGs which are normally reserved to a Governing Body and which were not otherwise:

- delegated to other Committees of the member CCGs, such as Audit and Remuneration
- retained by the GP membership of each member CCG
- the responsibility of a CCGs Primary (GP) Care Commissioning Committee
- delegated to other Joint Committee or joint legal arrangements with local authorities or with organisations outside of Cheshire and Merseyside, such as Section 75agreements
- agreed to be at or are required to remain at individual CCG and/or Place level.

The Joint Committee also established three key sub-committees from January 2022 on the following areas:

- Quality
- Finance and Resources
- Performance.

These committees took on the functions and responsibilities of their equivalent committees of the nine Cheshire and Merseyside CCGs. Each Sub-Committee was composed of members drawn from across the nine CCGs and provided key risk and issues reports to the Joint Committee. The key issues and risk reports from the Sub-Committees were reported for the purpose o**f Alerting** the Joint Committee, **Advising** the Joint Committee, or **Assuring** the Joint Committee in relation to key discussions, risks as well decisions requested.

As was the case for all Cheshire and Merseyside CCGs, a number of members of the Governing Body and the Executive Team of NHS Cheshire CCG formed part of the membership of the Joint Committee and its sub-committees.

NHS Cheshire CCG Place Committee (Cheshire East) – in operation throughout Quarter 1, 2022/23

The Committee was established to undertake all of the functions and responsibilities exercisable by the CCG which were not otherwise delegated to other Committees of the CCG or that which are retained by the CCGs GP membership, Governing Body, Primary (GP) Care Commissioning Committee) or

delegated to the Joint Committee of the Cheshire and Merseyside CCGs, in accordance with that outlined within the CCGs Constitution and Scheme of Reservation and Delegation (SoRD).

The Committee exercised these functions and responsibilities in relation to the residents of and/or patients registered with a GP Practice located within the Cheshire East geographical area ('known as the Cheshire East Place') with the objective of supporting the delivery of NHS Cheshire CCGs Strategic Objectives 2020-2023 and to address the wider determinants of health and health inequalities.

Such functions and responsibilities included but were not limited to:

- efficient joint decision making and clearer decision making;
- CCG decisions relating to Integrated Commissioning, including the Better Care Fund;
- CCG decisions related to primary care commissioning not covered within the delegation agreement between NHS England and NHS Cheshire CCG and not within the scope of the CCGs Primary Care Commissioning Committee
- approve service models, specifications, and business cases up to the value as determined by the CCG's SoRD;
- developing, agreeing and monitoring service transformation plans;
- overseeing quality of the CCG commissioned services across the Cheshire East place and making decisions on any improvement action required;
- reviewing and evaluating services, making decisions on commissioning and decommissioning as appropriate;
- approving the CCG's arrangements for safeguarding children and vulnerable adults in the Cheshire East Place;
- approving arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes; and
- providing assurance to the Governing Body, CCG members and other relevant parties on delivery of statutory functions and responsibilities exercisable by the CCG.

NHS Cheshire CCG Place Committee (Cheshire West) – in operation throughout Quarter 1, 2022/23

The Committee was established to undertake all of the functions and responsibilities exercisable by the CCG which were not otherwise delegated to other Committees of the CCG or that which are retained by the CCGs GP membership, Governing Body, Primary (GP) Care Commissioning Committee) or delegated to the Joint Committee of the Cheshire and Merseyside CCGs, in accordance with that outlined within the CCGs Constitution and Scheme of Reservation and Delegation (SoRD).

The Committee exercised these functions and responsibilities in relation to the residents of and/or patients registered with a GP Practice located within the Cheshire West geographical area ('known as the Cheshire West Place') with the objective of supporting the delivery of NHS Cheshire CCGs Strategic Objectives 2020-2023 and to address the wider determinants of health and health inequalities.

Such functions and responsibilities included but were not limited to:

- efficient joint decision making and clearer decision making;
- CCG decisions relating to Integrated Commissioning, including the Better Care Fund;
- CCG decisions related to primary care commissioning not covered within the delegation agreement between NHS England and NHS Cheshire CCG and not within the scope of the CCGs Primary Care Commissioning Committee
- approve service models, specifications, and business cases up to the value as determined by the CCG's SoRD;
- developing, agreeing and monitoring service transformation plans;
- overseeing quality of the CCG commissioned services across the Cheshire East place and making decisions on any improvement action required;
- reviewing and evaluating services, making decisions on commissioning and decommissioning as appropriate;
- approving the CCG's arrangements for safeguarding children and vulnerable adults in the Cheshire East Place;

- approving arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes; and
- providing assurance to the Governing Body, CCG members and other relevant parties on delivery of statutory functions and responsibilities exercisable by the CCG.

Membership performance and assessment of effectiveness

The role of clinical leadership is critical to the success of a clinical commissioning group and the health outcomes of its population. Clinical leadership was delivered through the CCG's directly employed clinical programme leads, its member practices and its wider clinical stakeholders, many of whom are within the NHS provider landscape, and clinical directors of the two Integrated Care Partnerships. The CCG had the benefit of two Joint Medical Directors from its member Practices.

Members of the CCG contributed active debate and discussion to the ongoing development of the CCG and the Cheshire and Merseyside Integrated Care Board. The Membership were aware of the significant challenges and opportunities ahead and are confident that, with our partners, we can commission patient-centred, high quality services for our patient population that will improve health outcomes locally.

Governing Body performance and assessment of effectiveness

The CCG's Governing Body, on behalf of the CCG Membership, ensured the CCG was well managed and met its statutory duties during the year. The Governing Body had good working relationships with the Membership.

The Governing Body ensured the delivery of clinical leadership and involvement which means that the patient remained at the heart of everything the CCG did and that patient services remained high quality. The Governing Body received regular update reports regarding the CCG's financial performance during the period. Discussions involved both clinicians and Lay Members who provided constructive challenge and debate in the continuous monitoring of the CCG's financial position.

Through scrutiny of quality and performance data, the Governing Body and its committees challenged outcomes for the population. Governing Body Lay Members and clinicians worked jointly with CCG staff and providers to focus on the patient journey, quality, experience and outcomes.

The CCG continued to monitor strategic risks aligned to the strategic objectives developed during 2020. The CCG's committees provided assurance to the Governing Body via regular Governing Body Assurance Framework reviews that strategic risks were being managed. Governing Body members also played an active role on the Joint Committee of the Cheshire and Merseyside CCGs and sub-committees of the Joint Committee.

The Governing Body had a good working relationship with both internal and external auditors throughout the year and both attend the Governance, Audit and Risk Committee on a regular basis.

At its final meeting, on 30 June 2022, the Governing Body considered the further development of governance arrangements at the two Cheshire "places".

For Cheshire West, the Governing Body:
- **ENDORSED** the new Cheshire West Place Partnership Committee Terms of Reference (ToR), Memorandum of Understanding (MOU) and Standing Orders (SO)
- **NOTED** that the MOU supersedes any previous place-based MOU/Partnership Agreements (e.g. Cheshire West Integrated Care Partnership (ICP) Agreement).

For Cheshire East, the Governing Body:
- **APPROVED** the new Cheshire East Section 75 Joint Committee Terms of Reference (ToR)
- **NOTED** that work is ongoing to confirm the future place-based partnership committee governance arrangements and ToR.

For both Places, the Governing Body:

- **NOTED** that new ToRs will be required to be created and agreed for any additional and/or new place-based committee or operational group governance arrangements that support or compliment the Cheshire East and Cheshire West Place arrangements
- **NOTED** that work continues to further understand the delegation of functions and alignment of staff to Place by the Integrated Care Board (ICB).

2.1.3(4) Compliance with the UK Corporate Governance Code

As an NHS body, the CCG was not required to comply with the UK Corporate Governance Code. The CCG's corporate governance arrangements are set out at section 2.1.3(3) this report.

2.1.3(5) Discharge of Statutory Functions

During establishment, the arrangements put in place by the CCG and explained within the Corporate Governance Framework were developed with extensive expert external legal input, to ensure compliance with the all-relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

In light of recommendation of the 2013 Harris Review into delegation of approval functions under the Mental Health Act 1983, 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 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.

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 clinical commissioning group's statutory duties.

2.1.3(6) Risk Management Arrangements and Effectiveness

The CCG maintained a policy for the management of risk as part of its overall governance arrangements. The policy provided a comprehensive guide to the CCG's approach to risk management, outlining committee and individual responsibilities. The aim was not to create a risk-free environment, but one where risk is identified and managed as a matter of course within the risk appetite of the CCG and where risk management was embedded in all aspects of the work of the CCG.

The Governing Body Assurance Framework (GBAF) set out how the CCG would manage the principal risks to delivering the strategic commitments of NHS Cheshire CCG. The GBAF enabled the Governing Body to corporately assure itself (gain confidence, based on evidence) that its strategic risks were being effectively managed.

The framework identified the principal risks to achieving these strategic commitments and highlighted key controls and assurances. Where gaps were identified, or key controls and assurances were insufficient to reduce the risk of non-delivery to acceptable levels (within the CCG risk appetite), mitigating actions were identified. Planned actions enabled the Governing Body and its Committees to monitor progress in addressing gaps or weaknesses and ensure that resources were allocated appropriately.

The programme management office approach helped to solidify the risk management process and ensure it was considered by staff at all levels in their day-to-day work. Quality Impact Assessments, Equality impact assessments, data protection impact assessments and risk logs were a standard part of all projects and risks identified at a project level were escalated, when appropriate, through the directorates to the corporate risk register. Where risks were identified in the planning of service developments that may impact on the public and users of services, consultations were carried out.

Risks were identified from a number of sources including staff identifying risks; via committees; incidents; patient, public and stakeholder feedback; complaints and incidents; external assessments and audits; programme and project management and general operation activity.

All risks were assigned a relevant Executive owner who had overall accountability, with an operational manager responsible for overseeing the effective management of each risk. CCG committees had oversight of risks within their remit.

Policies were in place around health and safety, emergency planning, whistleblowing, information governance and incident reporting, all of which contributed to the overall management of risk within the organisation. Training was regularly provided around privacy impact assessments, quality impact assessments and equality impact assessments, public engagement and consultation and risk management.

The CCG had local counter-fraud services in place provided by Mersey Internal Audit Agency. More information on counter-fraud arrangements is included at section 2.1.3(13).

2.1.3(7) Capacity to Handle Risk

The CCG managed operational and strategic risks to support effective decision making. The risk management process improves internal control and supports better decision making through an understanding of both individual risks and the overall risks that could affect the CCG. In order to be effective, risks needed to be identified, assessed and controlled. A Risk Management Framework was reviewed and approved by the CCG Governance Audit and Risk Committee during 2021/22 that set the detail of how the capacity to handle risk is managed in the CCG.

They key elements are summarised below:

- Managing risk is everyone's business. The CCG risk management framework set out how CCG Managers and Directors lead risk identification and management. The CCG ensured that risk management processes were embedded throughout the CGG, with clear direction and oversight from the Governing Body, Governance, Audit and Risk Committee, the Executive Team, CCG Committees and Assurance Groups, Operational Risk Group and Programme Governance. The responsibility and capacity for risk management was identified at all levels across the CCG, from governing body members, directors and to all managers and staff. Each risk had a day-to-day risk owner and an Executive Risk owner. The Governance, Audit and Risk Committee was responsible for overseeing the process by which risks are managed.
- Risks were regularly reported to CCG committees and escalated as appropriate to Executive Team and Governing Body. Risks were reviewed by senior managers and executives, with risks being escalated as appropriate. The Programme Management Office gave additional clarity to risk management, with clear reporting lines from project and programme level through to the operational risk register. The Operational Risk Group brought a cross-Directorate overview of Operational Risks.
- Table 1 below sets out a table on how risks are reviewed using various governance mechanisms.

Table 1 – Risk Measures and Mechanisms Summary

Level	Measure	Mechanism
Level 1	Those risks which potentially affect the CCG's Strategic Commitments, will populate the GBAF	Governing Body Assurance Framework
Level 2a	All operational risks from Directorate Registers rated 15-25 (red) will be reported to Senior Leadership Team and the Executive Team on a monthly basis	Operational Risk Report including a Report to the Senior Leadership Team and then Executive Team.
Level 2b	Specific Operational Risks will be presented to the relevant Committee or Assurance Group	Operational Risk Register for Committees or CCG Assurance Groups
Level 3	All risks over 15 or emerging in severity will be reviewed by the Operational Risk Group	Operational Risk Register and monthly Group review
Level 4	All risks can be reviewed by the	Risk Identification and

	Operational Risk lead for each Committee/Assurance Group with Chairs of Committees, Directorate Teams, CCG Programmes and individuals	Assessment

- Our staff are trained and equipped to manage risk in a way appropriate to their authority and duties. Risk Management training was provided to staff with additional support and advice being provided internally to anyone who required it. Role specific training was provided to the members of the risk management team to ensure they were fully up-to-date with current best practice and equipped to offer advice and guidance throughout the CCG.
- The Cheshire and Merseyside CCGs Joint Committee and three Sub Committees also had the ability to look across the nine CCGs of Cheshire and Merseyside so that they could monitor, escalate and review risks on behalf of all nine Cheshire and Merseyside CCGs.

2.1.3(8) Risk Assessment

The CCG's strategic and operational risk management arrangements, including the role of the Governing Body, are described in the preceding sections.

The Framework outlined a risk assessment matrix that set out how those risks were assessed using the likelihood of occurrence and their potential impact.

The Governing Body Assurance Framework (GBAF) was the key mechanism for identifying and ensuring the management of risks affecting the achievement of the CCG's strategic objectives. The GBAF report drew together the detail of the strategic risk and the supporting controls, assurances and planned actions. This enabled the governing body to focus on ensuring that the impact of these risks was minimised through the appropriate management and committee action.

An updated GBAF was agreed by the Governing Body in March 2021 and which continued into the period April – June 2022, with 11 strategic risks identified. The GBAF was supported by the Corporate Risk Register that provided a record of operational risks. The key strategic risks on the GBAF as presented to the Governing Body are included in the following table.

Risk Ref	Risk Description	Exec Risk Owner	Oversight Cttee/Assurance Group/Other	Mar 2022 Score (and direction)
21--01	Failure to design and commission environmentally and socially sustainable services that incentivise and drive delivery across the CCG and with providers and partners	Clare Watson	Programme Development Group and Executive Team	16 ↓
21-02	Failure to work effectively with our system and community partners due to differing institutional priorities and conflicting demands	Clare Watson	Executive Team	12 ↔
21-03	Failure of the CCG to assure the quality of care of its commissioned services due to insufficient capacity and/or ineffective monitoring systems	Paula Wedd	Quality Safeguarding Performance Assurance Group	16 ↔
21-04	Failure of the CCG to collaborate effectively with partners to commission services that safeguard and promote the welfare of children, looked after children and adults at risk	Paula Wedd	Quality Safeguarding Performance Assurance Group	9 ↓
21-05	Failure to embed values and behaviours to enable a compassionate and inclusive culture	Clare Watson	Executive Team	12 ↔

Risk Ref	Risk Description	Exec Risk Owner	Oversight Cttee/Assurance Group/Other	Mar 2022 Score (and direction)
21-06	Failure to attract, retain and develop staff with the skills and capacity to provide leadership to enable the delivery of CCG objectives and ensuring focus on transformational change	Clare Watson	Executive Team	12 ↓
21-07	The CCG is unable to develop or deliver a balanced and sustainable financial plan that reflects the commissioning intentions and need to innovate	Lynda Risk	Finance	12 ↓
21-08	Inability of providers and partners to effectively deliver the standards of performance we have agreed with them, based on national and local priorities	Neil Evans	Quality Safeguarding Performance Assurance Group	16 ↔
21-09	Ineffective public/patient communication and engagement arrangements and resource in place to secure diverse representation, involvement and expertise throughout the CCGs commissioning cycle and wider organisational strategy	Matthew Cunningham	Strategic Commissioning	8 ↔
21-10	Lack of clinical leadership, involvement and expertise from the CCG member practices and system partners throughout the commissioning cycle may lead to ineffective, inefficient, or inappropriate decision making in the absence of clinical input and broader clinical support"	Dr Andy McAlavey Dr Sinead Clarke	Strategic Commissioning	8 ↔
21-11	Being unable to plan or have resources and procedures in place to react and respond to the challenges a Pandemic brings	Clare Watson	Executive Team	16 ↔

Operational risks were the risks connected with the internal resources, systems, processes, and employees of the organisation. Risks were initially identified and assessed by a designated risk owner and then reviewed and approved by the Executive risk owner, with regular review through the risk register and risk reporting by the Operational Risk Group, Senior Leadership Team and at the Executive Team. Within this cycle feedback was common and supported a more accurate assessment of the operational risks.

As outlined above, the Cheshire and Merseyside CCGs Joint Committee and three Sub Committees also had the ability to look across the nine CCGs of Cheshire and Merseyside to monitor and review risks and the impact on the Cheshire and Merseyside CCGs' footprint.

2.1.3(9) Other Sources of Assurance

The Internal Control Framework

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

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

The Committee structure of the CCG ensured clear lines of accountability and defined responsibilities in order to provide assurance to the Governing Body and Membership that the CCG was discharging its duties effectively. All committees had terms of reference to define their remit and accountability.

Control mechanisms included:

- The scheme of reservation and delegation (SORD) which sets out the responsibilities of the Membership, Governing Body and its sub-committees. This makes clear where responsibilities lie and where assurance can be sought that these responsibilities are being carried out effectively.
- CCG Governing Body Assurance Framework and its Risk Management Framework which support the delivery of the CCG's objectives by establishing processes to identify and effectively manage risk, identifying gaps in control and providing assurance on the delivery of the objectives.
- Financial controls, which includes financial policies, standing orders, standing financial instructions and delegated limits which are reviewed annually.
- CCG policies and procedures.

The Governance, Audit and Risk Committee monitored the effectiveness of the CCG's internal controls on behalf of the Governing Body. Assurances were received from a range of sources including internal audit, external audit, local counter fraud services, management reports and committee reports.

The CCG relied on some systems that were centrally procured on behalf of the NHS such as the Electronic Staff Record and Primary Care payments systems. Any control weaknesses identified in those systems could lead to errors in processing transactions and the CCG monitored financial transactions using local information to ensure that these were in accordance with agreed contractual arrangements.

Annual Audit of Conflicts of Interest Management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2017) required 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.

An audit of arrangements for managing conflicts of interest was undertaken by Mersey Internal Audit Agency in Quarter in Quarter 4 of 2021/22. The results of that audit were reported in the CCG's 2021/22 Annual Report and Accounts.

The CCG maintained a Conflicts of Interest Policy during the period. In accordance with this Policy:

- Conflicts of interest were considered and recorded at formal CCG meetings;
- The CCG retained a Conflicts of Interest Guardian throughout the quarter;
- Staff were required to undertake training on the management of conflicts of interest; and
- The CCG continued to publish registers of interest.

Data Quality

The CCG was committed to maintaining high standards in its management of data, working in accordance with best practice to provide appropriate assurance regarding data quality, so continually worked with partners to maintain and improve data received. The CCG recognised its statutory responsibilities in relation to the quality and management of data under the Data Protection Act 2018, the Freedom of Information Act 2000, and associated Legislation. The underlining principles followed by the CCG were as follows:

- Accuracy – Data should be sufficiently detailed for the purposes for which it is collected.
- Validity – Data will be collected and used in compliance with internal and external requirements, to ensure consistency and it reflects the intended requirements.
- Reliability – Data is collected and processed consistently and in accordance with our defined processes to ensure that any changes in data are genuinely reflective of the activities represented.
- Timeliness – Data is collected as promptly as possible after the associated activity and be available for use within a reasonable timeframe.
- Relevance – Data collected should be relevant for the purposes for which they are obtained.
- Completeness – Data should be complete and as comprehensive as necessary to provide an accurate representation of the activity concerned and meet the information needs of the customer.

All of the organisation's main providers were required under their contract to have good quality data that was compliant with national standards and the CCG undertook validation processes to ensure data was complete, accurate, relevant and timely. That was undertaken by the Business Intelligence Team, who are part of the Midlands and Lancashire Commissioning Support Unit (CSU).

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients, the public and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by a Data Security and Protection Toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. The CCG completed the Data Security and Protection Toolkit and, at 30 June 2022, met all standards required as part of this assessment.

The CCG placed high importance on ensuring there were robust information governance systems and processes in place to help protect patient and corporate information. The CCG established an information governance management framework and developed information governance processes and procedures in line with the information governance toolkit. The CCG ensured all staff undertook annual information governance training and have implemented a staff information governance handbook to ensure staff were aware of their information governance roles and responsibilities.

There were processes in place for incident reporting and investigation of serious incidents.

Business Critical Models

The CCG had business critical models for planning, forecasting expenditure and commitments and financial evaluation of projects. Forecasting and financial planning systems were based on systems provided by NHS England and therefore were not subjected to specific assurance processes by the CCG. All business critical models were considered as part of the internal audit planning process and assurance as needed was gained through that process.

Pension Obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures were in place to ensure all employer obligations contained within the scheme regulations were complied with. This included ensuring that deductions from salary, employer's contributions and payments into the scheme were in accordance with the scheme rules, and that member pension scheme records were accurately updated in accordance with the timescales detailed in the Regulations.

Equality, Diversity and Human Rights Obligations

Control measures were in place to ensure that the CCG complied with the required public sector equality duty set out in the Equality Act 2010.

Third Party Assurances

Assurance on Information Governance and Counter Fraud arrangements were sought from Healthcare providers. The CCG received risk stratification assurance statements from Midlands and Lancashire Commissioning Support Unit (MLCSU), who provided business intelligence and HR support services, and Arden & Greater East Midlands (GEM) Commissioning Support Unit, who provided DSCRO service. These assurance statements were submitted to NHS England.

2.1.3(10) Control Issues

As of June 2022 there were a number of key areas where targets were being missed. The CCG recognised the significant impact that COVID-19 made on service capacity with a particular emphasis on increasing waiting lists for services. This was a system-wide issue rather than a CCG specific issue and partners will need to address them collectively to recover the position during the remainder of 2022/23. The highest rated risks reported to the final meeting of the CCG's Governing Body were:

- Failure to design and commission environmentally and socially sustainable services that incentivise and drive delivery across the CCG and with providers and partners

- Failure of the CCG to assure the quality of care of its commissioned services due to insufficient capacity and/or ineffective monitoring systems
- The CCG is unable to develop or deliver a balanced and sustainable financial plan that reflects the commissioning intentions and need to innovate
- Inability of providers and partners to effectively deliver the standards of performance we have agreed with them, based on national and local priorities

2.1.3(11) Review of Economy, Efficiency & Effectiveness of the use of Resources

To ensure that resources were used economically, efficiently and effectively:

- The Governing Body provided active leadership of the organisation within a framework of prudent and effective controls that enabled risk to be assessed and managed.
- The Governance, Audit and Risk Committee, as a committee of the Governing Body, was pivotal in advising the Governing Body on the effectiveness of the system of internal control and use of resources. Any significant issues would be reported to the Governing Body via the Audit Committee report to the Governing Body.
- The CCG's committees' responsibilities include overseeing the development and review of: strategy and commissioning plans, annual commissioning intentions, financial plans (including delivery), undertaking detailed scrutiny of performance, contract monitoring and financial management on behalf of the CCG, and also review and monitor the organisational improvement plan. The CCG's committees formally report to the Governing Body, escalating issues as required.
- Directors' roles and responsibilities were aligned to ensure systems of internal control were in place and implemented effectively throughout the organisation.
- Internal Audit provided reports to each meeting of the Audit Committee and full reports to the Chief Finance Officer. The Audit Committee also received details of any actions that remained outstanding from the follow up of previous audit work. The Chief Finance Officer also met regularly with the Audit Manager.
- External Audit provided external audit annual management letter and progress reports to the Audit Committee.
- CCGs did not receive a formal assessment rating in 2021/22. It did however receive a letter from NHSEI which noted the following:
  "*The annual assessment for 2021/2022 has continued to focus on the CCG contributions to local delivery of the overall system plan for recovery, with emphasis on the effectiveness of working relationships in the local system. This year's review has included reviewing evidence of delivery against performance targets, key lines of enquiry, discharge of statutory duties, along with engagement with your local Health & Wellbeing Board.*

  This is the last time that CCGs will be assessed, as the forthcoming Health and Social Care Act 2022 will supersede this requirement due to the establishment of Integrated Care Boards (ICBs) and the decommission of Clinical Commissioning Groups on 1st July 2022.

  The financial year of 2021/2022 has continued to be a particularly challenging year in every respect for the CCG, its partners, and the people of Cheshire. However, it is recognised that the CCG has continued to rise to the challenges along with its system partners.

  In particular, I note the continued contribution of CCG leadership team and staff who have continued to support various elements of the wider system response such as the C&M Gold Command and the elective recovery programme, as well as continuing to support and mange testing and vaccination programmes.

  Despite the challenging year, there have been some positive examples of integrated working which I would like to take this opportunity to commend the CCG on, particularly in relation to jointly commissioned services, campaigns, and initiatives to support engagement within communities.

  In terms of the development of Primary Care Networks, while PCNs are continuing on their development journey, their continued contribution to the COVID-19 response has remained strong, which has resulted in the continuous progress in terms of how PCNs continue to come together to meet local challenges and needs of the population they serve.

Subject to receipt of the CCG's final report, I am satisfied that the CCG has discharged its duty to reduce inequalities under Section 14T of Health & Social Care Act 2012. The draft report contains a detailed governance statement, which clearly outlines, context, scope of responsibility, governance arrangements and effectiveness. The CCG provides a description of key risks and associated issues. Head of Internal Audit concluded that substantial assurance can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Engagement between NHSEI and the C&M Health & Wellbeing Boards demonstrated strong partnership working between Cheshire CCG and both the Cheshire East Health & Wellbeing Board and the Cheshire West and Chester Health & Wellbeing Board. The Cheshire East Health & Wellbeing Board acknowledged the senior team's active roles within, and contributions to the board, noting the collaborative working with other partners has also been effective over the last year. The Cheshire West and Chester Health & Wellbeing Board acknowledged the strong commitment and support provided by the CCG and the key role the CCG plays in in implementing the key priorities. It is anticipated the CCG will fully evidence the consultation with each Health and Wellbeing Board in the delivery and preparation of any Joint Health & Wellbeing Strategy, to which it was required to have regard under Section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007, in the final report

On financial performance, it is noted that 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. The CCG was also supported via the COVID-19 nationally set finance regime and associated funding (block contract arrangements, top-up funding, COVID re-imbursement process). The CCG received a substantial assurance rating from its External Auditors in respect of having effective systems and processes in place.

As part of the transition phase to the ICS, the CCG is now in a strong position to handover the legacy work and corporate memory which it has formed. This will now 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."

2.1.3(12) Delegation of Functions

The delegation of the CCG's functions within the CCG were determined by the Constitution and the Scheme of Reservation and Delegation (SORD). These are available at the Corporate Governance Handbook section of the CCG's website. The CCG's constitution permitted the establishment of collaborative commissioning and required that "Where delegated responsibilities are being discharged collaboratively, they will be underpinned by a memorandum of understanding which will set out how the CCG will work with others".

In order to make decisions in a coordinated manner with other CCGs across Cheshire and Merseyside and support a smooth transition to the ICB, the Governing Body delegated certain functions to the Joint Committee of the Cheshire and Merseyside CCGs. This is described in more detail at section **2.1.3(3) Governance Arrangements and Effectiveness – developments during the year**.

2.1.3(13) Counter Fraud Arrangements

The CCG was committed to reducing the level of fraud, corruption and bribery within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care. The CCG did not tolerate fraud, bribery or corruption and aimed to eliminate all such activity as far as possible.

The CCG's anti-fraud, bribery and corruption service was provided by Mersey Internal Audit Agency (MIAA). Through MIAA, the CCG had a suitably qualified, nominated Anti-Fraud Specialist to support compliance with the *Government Functional Standard 013 for Counter Fraud (NHS Requirements)*, as introduced in 2021/22.

The CCG had in place an Anti-Fraud, Bribery and Corruption Policy, which related to all forms of fraud, bribery and corruption and was intended to provide direction and reporting lines for employees, office holders and all other staff who worked for and with the CCG on all aspects of fraud.

The CCG's constitution stated that the Lay Member whose role was to oversee the key elements of governance, Chaired the Governing Body's Governance Audit and Risk Committee and acted as the Conflicts of Interest Guardian, has a lead role in ensuring that appropriate and effective whistleblowing and counter fraud systems are in place. The Executive Lead responsible for fraud, bribery and corruption is the Executive Director of Finance and Contracting, with the Deputy Director of Finance and Contracting also nominated as the CCG's Counter Fraud Champion.

The CCG demonstrated compliance with the *Government Functional Standard 013 for Counter Fraud (NHS Requirements)* through activities including:

- MIAA undertake an annual fraud risk assessment to support the CCG in identifying fraud risks, with consideration to local and national intelligence and prioritising required action.
- The CCG's annual anti-fraud work plan was produced by the Anti-Fraud Specialist and agreed by the Governance Audit and Risk Committee. The work plan took into consideration the local fraud risk assessment as well as local and national intelligence and discussion with CCG management, including undertaking local proactive exercises in areas assessed to be a higher risk of fraud.
- The CCG's Anti-Fraud Specialist produced and presented the Governance Audit and Risk Committee with regular progress reports throughout the year, detailing progress against the anti-fraud work plan and assessment against the *Government Functional Standard 013 for Counter Fraud (NHS Requirements).*
- The CCG's Anti-Fraud Specialist produced and presented the Governance Audit and Risk Committee with an Annual Report, detailing work undertaken and an assessment against the *Government Functional Standard 013 for Counter Fraud (NHS Requirements).*
- Proactive exercises were undertaken in areas determined to be high fraud risk, and the Anti-Fraud Specialist was supported by executives in the undertaking of these exercises.

The CCG's self-assessed overall rating against the *Government Functional Standard 013 for Counter Fraud (NHS Requirements)* was "GREEN" for 2021/22, with an outcome of "GREEN" anticipated for 2022/23

2.1.3(14) Head of Internal Audit Opinion

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

Head of Internal Audit Opinion:
"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."*

Planned Audit Coverage and Outputs:
"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."*

2.1.3(15) Review of the Effectiveness of Governance, Risk Management & Internal Control

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 clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have

drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

Our Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principal objectives have been reviewed.

The Governing Body and the Governance and Audit Committee have advised me on the implications of the result of my review of the effectiveness of the system of internal control. Where appropriate they have provided advice and a plan to address weaknesses and to ensure that continuous improvement of the system is in place.

Following the passing of the Health and Care Act (2022), the CCG established a team to undertake due diligence in closing down the CCG and transferring its staff and property into the Integrated Care Boards whilst maintaining the level and quality of Local Health Services. A national due diligence and close down checklist ("the checklist") was cascaded to CCGs in September 2021.

A programme team was set up to oversee delivery of the checklist requirements. A governance framework was established to provide oversight and assurance of the process and programme team's progress to the Executive team and Governing Body.

The programme team was headed by the Accountable Officer and included a Programme Lead, programme manager, programme support plus key members from Human Resources, Organisational Development, Communication & Engagement, Finance & Contracting, Governance & Assurance, Quality & Safety, Estates & Assets, Programme Management Office, Information Technology, and Information Governance. Additionally, the chair of CCG's Audit Committee and the Senior Manager from Internal Audit.

The CCG made good progress in delivering the transition and that was reflected in the assurance letter that was approved by the CCG's Accountable Officer and Clinical Chair. The content of that letter is referenced in the following "Conclusion" section.

2.1.3(16) Conclusion

Mitigating actions were in place to address the key risks facing the CCG to ensure that continuous improvements of the system are in place. These risks and the mitigating actions are outlined within this Accountability Report.

On 31 May 2022 the Accountable Officer and Chair of the CCG wrote to me, as Accountable Officer of the Integrated Care Board with the following assurance:

> "I am writing to provide assurance that NHS – Cheshire Clinical Commissioning Group has followed a robust due diligence process to prepare for closedown and for the safe transfer of staff and property (in its widest sense) to Cheshire and Mersey Integrated Care Board on 1 July 2022.
>
> This assurance is based on review of relevant documentation and assurances that I have received from my senior team, internal auditors and the CCG Governance, Audit and Risk Committee (GARC) approving the recommendations of the Programme Group in the attached "Final Assurance" report that has gone through its governance stages in Cheshire CCG as follows:
> - Due Diligence and Close Down Group approval for recommendation to the GARC on 10 May 2022
> - Approval by the GARC on 18 May 2022
>
> Our preparations have taken account of the NHSEI ICS implementation guidance: *'Due diligence, transfer of people and property from CCGs to ICBs and CCG close down'* and the accompanying due diligence checklist, covering all aspects of current operations, including people, quality, finance and commissioning.

The CCG has undertaken all the necessary actions prior to close down. Where there are outstanding matters relating to the CCG which cannot be actioned prior to 1 July (for example, the closure of legacy bank accounts), these have been clearly documented in the attached list of outstanding items for the ICB for action.

The CCG's risk register will be updated prior to 1 July and shared so that the risks to be taken on by the ICB are clear.

A staff list has been in line with tab 2.2 of the NHSEI due diligence checklist and will be shared on a strictly 'need to know' basis. It will be kept up to date for 1 July 2022.

Records of CCG property (tangible and intangible assets (including contracts), rights and liabilities) are in good order, to provide the relevant teams in the ICB with a clear baseline position at 1 July 2022.

It is understood that the Staff, Property, Rights and Liabilities Transfer Scheme to be made by the NHS Commissioning Board (NHS England) will give legal effect to the transfer of staff and property from the CCG(s) to the ICB on 1 July 2022."

Graham Urwin

Graham Urwin
Chief Executive, NHS Cheshire and Merseyside

29 June 2023

2.2 Remuneration Report

The remuneration and staff report sets out the CCG's remuneration policy for directors and senior managers, reports on how that policy was implemented and sets out the amounts awarded to directors and senior managers and where relevant the link between performance and remuneration.

2.2.1 Remuneration Committee and Policy

The core responsibility of the CCG remuneration committee was to make recommendations to the Governing Body on:

- Determinations about the terms and conditions, remuneration, fees and other allowances for governing body members (other than lay members), employees of the CCG (including GPs performing roles within the CCG) and for people who provide services to the group;
- Determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme; and
- Arrangements for termination of employment and other contractual arrangements.
- All meetings of the committee are attended by an independent HR adviser.

NHS Cheshire CCG retained a Remuneration Committee with the following membership:

Name	Role
Pam Smith (Chair)	Governing Body Independent Lay Member
Suzanne Horrill	Governing Body Independent Lay Member
Wendy Williams	Governing Body Independent Lay Member
Dr Fiona McGregor-Smith	Governing Body GP Member
Dr Gwydion Rhys	Governing Body GP Member

The Committee did not meet during Quarter 1, 2022/23.

Remuneration of Senior Managers, including Very Senior Managers (VSMs)

'Senior manager' is defined as "those persons in senior positions having authority or responsibility for directing or controlling major activities of the CCG". This means those who influence the decisions of the CCG as a whole rather than the decisions of individual directorates or departments.

The CCG's Remuneration Committee determined the salaries of Governing Body members, including the Chair, Chief Executive / Accountable Officer and Chief Finance Officer as well as the Executive Directors of the CCG. The remuneration packages for senior posts were determined following specialist HR advice and in accordance with relevant NHS England guidance, including: "Clinical commissioning group guidance on senior appointments, including accountable officer" and "Clinical commissioning group governing body members: Role outlines, attributes and skills".

Three senior managers received remuneration in excess of £150,000 when calculated on a full time equivalent basis. The CCG remuneration committee consider that this level of remuneration is appropriate for the level of responsibility of the post and is in line with available benchmarking data and guidance. The full-time equivalent calculation means that the figure above has been calculated by increasing the amount paid to the employee who is working part time as if they worked full time.

The NHS England guidance details a number of allowances that can be applied for differing circumstances. These include a percentage increase for complexity and a percentage increase where joint management arrangements exist. Both of these were applied as per the Remuneration Committee's recommendations for the Chief Executive / Accountable Officer and the Chief Finance Officer. The percentage allowance relating to complexity has been applied for the GP Clinical Chair salary.

Pensions

All salaried Governing Body members had access to the NHS Pension Scheme, except for our Lay Members. Details of each pension scheme can be found at: https://www.nhsbsa.nhs.uk/member-hub (see note 4.5 of the Annual Accounts for further information).

Performance Management

The CCG operated an annual appraisal system for all its employees which assessed individuals' performance in relation to the delivery of organisational objectives. The CCG maintained a suite of associated policies including a Performance Management Policy.

2.2.2 Governing Body and Senior Manager Salary Disclosure (Subject to Audit)

Quarter 1, 2022/23 Overall remuneration of Governing body member or senior manager	Salary (bands of £5,000) £'000s	Expense payments (taxable) to nearest £100* £	Performance pay and bonuses (bands of £5,000) £'000s	Long term performance pay and bonuses (bands of £5,000) £'000s	All Pension Related Benefits (bands of £2,500) £'000s	Total (bands of £5,000) £'000s
Voting Governing Body members						
Dr Andrew Wilson Clinical Chair	20 - 25	-	-	-	0 – 2.5	25 – 30
Clare Watson Chief Executive / Accountable Officer	35 - 40	-	-	-	2.5 – 5	40 – 45
Lynda Risk Executive Director of Finance and Contracting	30 - 35	-	-	-	2.5 – 5	30 – 35
Daniel Howcroft Independent Clinical Member (Secondary Care)	5 - 10	-	-	-	-	5 – 10
Christine Morris Independent Clinical Member (Registered Nurse)	0 - 5	-	-	-	-	0 – 5
Dr Lesley Appleton General Practice Representative	5 - 10	-	-	-	-	5 – 10
Dr Rachel Hall *1 General Practice Representative	5 - 10	-	-	-	-	5 – 10
Dr Fiona-McGregor-Smith General Practice Representative	5 - 10	-	-	-	-	5 – 10
Dr Gwydion Rhys General Practice Representative	5 - 10	-	-	-	-	5 – 10
Suzanne Horrill Independent Lay Member (Governance)	0 - 5	-	-	-	-	0 – 5
Peter Munday Independent Lay Member (Governance)	0 - 5	-	-	-	-	0 – 5
Pam Smith Independent Lay Member (Engagement, Involvement and Experience)	0 - 5	-	-	-	-	0 – 5
Wendy Williams Deputy Chair and Independent Lay Member (Engagement, Involvement and Experience)	0 - 5	-	-	-	-	0 – 5
Non-Voting Governing Body member						

Quarter 1, 2022/23 Overall remuneration of Governing body member or senior manager	Salary (bands of £5,000) £'000s	Expense payments (taxable) to nearest £100* £	Performance pay and bonuses (bands of £5,000) £'000s	Long term performance pay and bonuses (bands of £5,000) £'000s	All Pension Related Benefits (bands of £2,500) £'000s	Total (bands of £5,000) £'000s
Chris Lynch	0 - 5			-	-	0 - 5
Senior Managers in regular attendance at Governing Body meetings						
Neil Evans Executive Director of Planning and Delivery	25 - 30	-	-	-	0 – 2.5	25 - 30
Paula Wedd Executive Director of Quality and Patient Experience	25 - 30	-	-	-	2.5 – 5	25 – 30
Matthew Cunningham Director of Governance and Corporate Development	20 - 25	-	-	-	0 – 2.5	25 – 30

2021-22 Overall remuneration of Governing body member or senior manager	Salary (bands of £5,000) £'000s	Expense payments (taxable) to nearest £100* £	Performance pay and bonuses (bands of £5,000) £'000s	Long term performance pay and bonuses (bands of £5,000) £'000s	All Pension Related Benefits (bands of £2,500) £'000s	Total (bands of £5,000) £'000s
Voting Governing Body members						
Dr Andrew Wilson Clinical Chair	95 – 100	-	-	-	35 – 37.5	130 – 135
Clare Watson Chief Executive / Accountable Officer	145 - 150	-	-	-	30 – 32.5	175 - 180
Lynda Risk Executive Director of Finance and Contracting	120 - 125	-	-	-	32.5 - 35	155 - 160
Daniel Howcroft Independent Clinical Member (Secondary Care)	30 – 35	-	-	-	-	30 – 35
Christine Morris Independent Clinical Member (Registered Nurse)	15 – 20	-	-	-		15 – 20
Dr Lesley Appleton General Practice Representative	30 – 35	-	-	-	-	30 – 35
Dr Rachel Hall *1 General Practice Representative	15 – 20	-	-	-	-	15 – 20
Dr Fiona-McGregor-Smith General Practice Representative	20 – 25	-	-	-	-	20 – 25
Dr Gwydion Rhys General Practice Representative	30 – 35	-	-	-	-	30 – 35
Suzanne Horrill Independent Lay Member (Governance)	15 – 20	-	-	-	-	15 – 20
Peter Munday Independent Lay Member (Governance)	15 – 20	-	-	-	-	15 – 20
Pam Smith Independent Lay Member (Engagement, Involvement and Experience)	15 – 20	-	-	-	-	15 – 20

2021-22 Overall remuneration of Governing body member or senior manager	Salary (bands of £5,000) £'000s	Expense payments (taxable) to nearest £100* £	Performance pay and bonuses (bands of £5,000) £'000s	Long term performance pay and bonuses (bands of £5,000) £'000s	All Pension Related Benefits (bands of £2,500) £'000s	Total (bands of £5,000) £'000s
Wendy Williams Deputy Chair and Independent Lay Member (Engagement, Involvement and Experience)	15 – 20	-	-	-	-	15 – 20
Non Voting Governing Body member						
Chris Lynch	15 – 20	-			-	15 – 20
Senior Managers in regular attendance at Governing Body meetings						
Tracey Cole *2 Executive Director of Strategy and Partnerships	60 - 65	100	-	-	-	60 - 65
Neil Evans Executive Director of Planning and Delivery	105 - 110	-	-	-	30 – 32.5	135 - 140
Paula Wedd Executive Director of Quality and Patient Experience	105 - 110	-	-	-	32.5 - 35	140 - 145
Matthew Cunningham Director of Governance and Corporate Development	90 - 95	-	-	-	30 - 32.5	125 - 130

******Note: Taxable expenses and benefits in kind are rounded to the nearest £100.*

The value of pension benefits accrued during the year 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. This 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.

Notes to the statements

***1** Remuneration for Rachel Hall is for seven months only
***2** Tracey Cole is seconded to another organisation with effect 25 October 2021 and this table includes her salary to that date.
***3** Taxable benefits in the year arise from the reimbursement of mileage expenses

2.2.3 Governing Body Pension Disclosure Quarter 1, 2022/23 (Subject to Audit)

Name	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 30 June 2022 (bands of £5,000	(e) Cash Equivalent Transfer Value at 1 April 2021	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 30June 2022	(h) Employers contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr Andrew Wilson	0 - 2.5	0 - 2.5	20 - 25	35 - 40	400	3	415	-
Clare Watson	0 - 2.5	2.5 - 5	55 - 60	120 - 125	1,052	10	1,104	-
Lynda Risk	0 - 2.5	-	50 - 55	100 - 105	1,035	7	1,071	-
Neil Evans	0 - 2.5	-	20 - 25	25 - 30	359	5	390	-
Paula Wedd	0 - 2.5	-	45 - 50	100 - 105	938	8	978	-
Matthew Cunningham	0 - 2.5	-	20 - 25	35 - 40	376	3	377	-
Dr Lesley Appleton	-	-	-	-	-	-	-	1
Dr Rachel Hall	-	-	-	-	-	-	-	-
Dr Fiona McGregor-Smith	-	-	-	-	-	-	-	-
Dr Gwydion Rhys	-	-	-	-	-	-	-	1

2.2.3 Governing Body Pension Disclosure 2021/22

Name	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000	(e) Cash Equivalent Transfer Value at 1 April 2021	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2022	(h) Employers contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr Andrew Wilson	0 - 2.5	0 - 2.5	20 - 25	35 - 40	343	31	389	-
Clare Watson	2.5 - 5	-	55 - 60	115 - 120	954	32	1011	-
Lynda Risk	2.5 - 5	0 - 2.5	45 - 50	100 - 105	935	41	998	-
Tracey Cole	0 - 2.5	-	20 - 25	15 - 20	298	20	334	-
Neil Evans	0 - 2.5	0 - 2.5	20 - 25	25 - 30	309	19	345	-
Paula Wedd	0 - 2.5	0 - 2.5	45 - 50	95 - 100	846	38	903	-
Matthew Cunningham	0 - 2.5	0 - 2.5	20 - 25	35 - 40	305	21	341	-
Dr Lesley Appleton	-	-	-	-	-	-	-	4
Dr Rachel Hall	-	-	-	-	-	-	-	-
Dr Fiona McGregor-Smith	-	-	-	-	-	-	-	3
Dr Gwydion Rhys	-	-	-	-	-	-	-	4

Note: Pension benefits and related CETVs do not allow for any potential future adjustment for eligible employees arising from the McCloud judgement which offers a choice to some employees on whether benefits are paid in accordance with legacy pension schemes or reformed schemes for the period 2015 to 2022.

Cash Equivalent Transfer Values (CETV)

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

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

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

Real Increase in CETV

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

Compensation on Early Retirement of for Loss of Office

There were no payments for compensation on early retirement or for loss of office in the quarter to 30 June 2023 (2021/22 - £Nil).

Payments to Past Members

No payments have been made to past senior managers in the quarter to 30 June 2023 (2021/22 - £Nil)

2.2.4 Fair Pay Disclosure (Subject to Audit)

Pay ratio information

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 [the organisation] in the financial year 2021-22 was in the range £145K to £150K (2020-21, £145K to £150K). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2022/23 to 30 June	25th percentile	Median	75th percentile
Total remuneration (£)	£31,534	£40,057	£52,319
Salary component of total remuneration (£)	£31,534	£40,057	£52,319
Pay ratio information	4.68:1	3.68:1	2.77:1
2021/22	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	£31,534	£40,057	£52,319
Salary component of total remuneration (£)	£31,534	£40,057	£52,319
Pay ratio information	4.68:1	3.68:1	2.77:1

During the reporting period 2022/23, no employee received remuneration in excess of the highest-paid director/member (2021/22: none). Remuneration in the period on a FTE basis ranged from £18,870 to £166,857 (2021-22 £18,546 -£166,857).

There is no difference between the total remuneration ratio and the salaries ratios because additional benefits and allowances are minimal. The highest paid director's median salary and remuneration was in the same band in both years and the ratios being the same reflects the timing of the production of the report being three months after the previous year end.

Percentage change in remuneration of highest paid director

Percentage increases in average staff pay for staff as a whole by comparison with the highest paid director (based on that director's midpoint banding) was as follows:

	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	4.65%	0%

The above table excludes pay awards that were agreed and made after the year end. The increase in average pay for employees , taken as a whole reflects the senior employees transferring from other NHS entities in preparation for the establishment of NHS Cheshire and Merseyside ICB on 1 July 2023.

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

2.3 Staff Report

2.3.1 Our Team

The CCG was a clinically-led organisation which encouraged public involvement at all stages of the commissioning cycle. NHS Cheshire CCG ensured that the views of clinicians and residents were front and centre of its decision-making processes.

The work of NHS Cheshire CCG was organised across six directorates:

1. Clinical;
2. Finance and Contracting;
3. Governance and Corporate Development;
4. Planning and Delivery;
5. Quality, Patient Experience and Safeguarding; and
6. Strategy and Partnerships.

As described elsewhere in this report, the CCG also had close working relationships with partners across the health and care system in Cheshire and more widely, across Cheshire and Merseyside.

2.3.2 Staff Numbers and Composition (Subject to Audit)

Number of Senior Managers and Staff Composition

	Headcount by Gender		
Staff Grouping	**Female**	**Male**	**Totals**
Governing Body	9	5	**14**
Other Senior Management (Band 8C+)	22	21	**43**
All Other Employees	241	53	**294**
Grand Total	**272**	**78**	**350**

	% by Gender	
Staff Grouping	**Female**	**Male**
Governing Body	64.3%	35.7%
Other Senior Management (Band 8C+)	51.2%	48.8%
All Other Employees	82.0%	18.0%
Grand Total	**77.71%**	**22.29%**

Pay Band	Headcount
Apprentice	0
Band 1	0
Band 2	12
Band 3	12
Band 4	15
Band 5	26
Band 6	39
Band 7	56
Band 8 - Range A	66
Band 8 - Range B	50
Band 8 - Range C	30
Band 8 - Range D	8
Band 9	5
Medical	4
VSM	21
Gov Body (off payroll)	18
Grand Total	**350**

Sickness Absence

The sickness absence data for the CCG in the quarter was whole time equivalent (WTE) days available of 68,155 and WTE days lost to sickness absence of 1,554 and average working days lost per employee was 5.13 which was managed through the absence management policy.

Staff sickness absence, Quarter 1 2022/23	Quarter 1 2022/3 Number
Total Days Lost	1,554
Total Staff Years	303
Average Working Days Lost	5.13

Staff Turnover

The CCG Staff Turnover Rate for Quarter 1, 2022/23 has been calculated by dividing the total Full Time Equivalent (FTE) Leavers during the quarter by the average FTE Staff in Post during the quarter. The CCG's Total FTE Leavers in year was 9.18. The CCG's Average FTE Staff in Post during the year was 304.63. The CCG Staff Turnover Rate for the year was 3.01%.

0CCG Staff Turnover, Quarter 1 2022/23	Quarter 1 2022/3 Number
Average FTE Employed, Q1 2021/22	304.63
Total FTE Leavers, Q1 2021/22	9.18
Turnover Rate	3.01%

Throughout the period the CCG Staff Turnover rate was reported regularly to the CCG Governing Body and the CCG Executive Team.

Staff Numbers and Costs (Subject to Audit)

Quarter 1, 2022/23

Employee benefits expenditure	Admin			Programme			Total		30 June 2022
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits									
Salaries and wages	2,045	60	**2,105**	1,129	165	**1,293**	3,173	225	**3,398**
Social security costs	229	-	**229**	140	-	**140**	368	-	**368**
Employer contributions to the NHS Pension Scheme	463	-	**463**	165	-	**165**	629	-	**629**
Other pension costs	0	-	**0**	1	-	**1**	1	-	**1**
Apprenticeship Levy	14	-	**14**	-	-	**-**	14	-	**14**
Employee benefits expenditure	**2,751**	**60**	**2,811**	**1,435**	**165**	**1,599**	**4,185**	**225**	**4,410**

2021/22

Employee benefits expenditure	Admin			Programme			Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits									
Salaries and wages	7,632	198	**7,830**	4,903	763	**5,665**	12,535	961	**13,495**
Social security costs	866	-	**866**	489	-	**489**	1,355	-	**1,355**
Employer contributions to the NHS Pension Scheme	1,913	-	**1,913**	620	-	**620**	2,532	-	**2,532**
Other pension costs	1	-	**1**	3	-	**3**	5	-	**5**
Apprenticeship Levy	54	-	-	-	-	-			
Employee benefits expenditure	**10,466**	**198**	**10,610**	**6,014**	**763**	**6,777**	**16,426**	**961**	**17,387**

2.3.3 Staff Engagement Percentages

The CCG proactively sought to engage its staff and ensure staff were informed and involved in key decision making. A Staff Engagement, Equality, Diversity and Inclusion Steering group brought together staff representees from our workforce with the aim of engaging across a variety of subject areas and staff development activities to seek feedback, co-design action plans and use as a focus group to discuss issues that affected the workforce. The group continued to meet on a monthly basis.

We focussed our efforts on continually seeking feedback from our staff and utilised the feedback from the 2021/22 NHS Staff Survey to inform Organisational Development and Wellbeing Action Plans. In addition, we sought regular feedback through pulse surveys, the 2021/22 NHS Staff Survey and the Time to Check in Survey which was subsequently extended to become a Cheshire and Merseyside ICB-wide staff survey. The qualitative and quantitative feedback gathered further informed our approach to Health and Wellbeing, agile working and embedding our values and behaviours.

The 2021/22 NHS Staff survey results, published in March 2022, demonstrated that the actions we had taken on the back of the feedback received in 2020/21 had delivered a number of improvements for our people, with the data demonstrating that staff were feeling a greater sense of being valued, showing respect for one another and increased levels of autonomy.

During 2021/22 we reopened our three office bases in line with national guidelines however we continued to support staff to work from home as well as the office under revised Agile working guidance. The Health and Wellbeing of our staff was a priority and delivering our Health and Wellbeing action plan was a key priority.

We continued to embrace remote working technology through *Microsoft Teams* and remained committed to flexible and agile working in the transition to the ICB.

The 2021/22 NHS staff Survey was rolled out in September 2021 and we took the decision to take part in the survey this year and seek the views of our staff in the second year of operation, with the aim of identifying those areas where improvements can be made and to help influence the priorities for all staff as we transition to an ICB. Our response rate to the survey was excellent with **79%** of staff taking part. The data we obtain from this survey, both qualitative and quantitative is a valuable source of information and we are in the process of reviewing the feedback and committed to learning from the issues raised.

The CCG continued a sustained and comprehensive programme of internal communications. We continued with weekly newsletters; fortnightly executive led team briefs and invited all staff to attend the “We are One” Cheshire and Merseyside all staff briefings.

Internal communications shared numerous health and wellbeing resources and have made creative use of home-grown videos plus assets produced by NHS England/Improvement and Public Health England.

2.3.4 Staff Policies and Other Employee Matters

The CCG assessed itself against the “*We are the NHS” NHS People Plan for 2020/21* we have further developed our response to the People Plan in 2021/22 and provided assurance to the Governing Body on our progress and where we have identified gaps.

The governing body supports the delivery of the objectives set out in the plan and work is ongoing in those areas where we need to focus to be fully compliant.

We continued to utilise a number of HR policies and protocols in the last twelve months. A large focus has been on supporting our staff and with that in mind we have supported staff using a range of tools and guidance to support our staff these have included:

- Carers Passport
- Menopause Guidance
- Health & Wellbeing conversation guides

Work was undertaken across Cheshire & Merseyside to co-ordinate HR policies and bring them in line to reflect national guidance and HR legislation, this exercise will future proof the CCGs as they transition into the ICB and provide a consistent and equitable platform as we bring staff together across the system. Going forward into 2022/23 work will continue to align policies and focus predominantly on those areas where local differences in terms and conditions may apply.

Working from home continued to bring many challenges to our staff and there was a continued focus on ensuring staff felt supported and did not feel isolated from colleagues and wider members of their team. We put in place a number of initiatives to bring staff together, both at team level and at organisational level.

The CCG held a staff recognition event in November 2021 which was aimed at celebrating the amazing achievements of our staff and recognising those people who had gone the extra mile to support the pressures of the Covid pandemic as well as those who remained focussed on our core business and did so with less resource. There is no doubt that our people are our greatest asset, and the event shone a light on many amazing achievements during 2021/22.

We continually looked at ways to encourage staff to focus on their own health and wellbeing, with access to healthy lifestyle tips, online informal time outs, support for the “time to talk” initiative as well as specific focussed events for example Menopause Cafes. We asked all of our managers to undertake health and wellbeing conversations with their teams and we have delivered a number of workshops for managers to support our approach to these.

Equality, diversity and human rights

CCG staff members participated in mandatory Equality, Diversity and Human Rights training through an e-learning module. We actively promoted Black History month and have linked our internal employee communications campaigns to a number of national and regional campaigns.

The CCG uses NHS Jobs in its recruitment activity, and we collect information relating to our candidates on *seven* of the protected characteristics and we review this data to provide assurance that our recruitment practices are fair and equitable.

We know that there are areas where we need to improve in the short, medium and longer term and where action is needed. Moving forward we will widen access to learning and development, and we can demonstrate that we have an effective well led organisation with an empowered and inclusive workforce.

Emergency Preparedness, Resilience & Response

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum requirements commissioners and providers of NHS funded services must meet. Commissioners and providers of NHS funded services must assure themselves against the core standards on an annual basis.

During 2021/22 NHS England and Improvement recognised that the detailed and granular process of previous years would be excessive while the NHS prepares for a potential further wave of COVID-19, as well as upcoming seasonal pressures and the operational demands of restoring services. The amended process for 2020/21 assessment focused on three key areas:

1) The updated assurance position of any organisations that were rated partially or non-compliant in 2020/21.
2) Assurance that all the relevant commissioners and providers of NHS-funded care have undertaken a thorough and systematic review of their response to the first wave of the COVID-19 pandemic, and a plan is in place to embed learning into practice.
3) Confirmation that any key learning identified as part of this process is actively informing wider winter preparedness activities for your system.

NHS Cheshire CCG was able to demonstrate that it was fully compliant in all three of these areas and submitted a return to NHS England and Improvement on this basis.

NHS Cheshire CCG maintained an on call managers system to ensure a 24/7 response for all CCG functions and responsibilities.

2.3.5 Trade Union Facility Time

The CCG had no employees acting as trade union representatives and accordingly there is no cost for Trade Union Facility Time.

2.3.6 Expenditure on consultancy

In Quarter 1 of 2022/23, NHS Cheshire CCG spent £Nil (2021/22 - £11k) on consultancy services.

2.3.7 Off Payroll Engagements

Off payroll engagements are payments made by the CCG to employees outside of its payroll system that are for more than £245 per day and that last for longer than six months. There were no off payroll engagements in the year.

	Number
Number of existing engagements as of 30 June 2022	-
Of which, the number that have existed:	
for less than one year at the time of reporting	-
for between one and two years at the time of reporting	-
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	-

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

Off-payroll engagements between 1 April 2022 and 30 June 2022, for more than £245(1) per day:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2022 and 30 June 2022	-
Of which:	
Number not subject to off-payroll legislation	-
Number subject to off-payroll legislation and determined as in-scope of IR35	-
Number subject to off-payroll legislation and determined as in-scope of IR35	-
Number of engagements reassessed for consistency / assurance purposes during the year	-
Of which:	
Number of engagements that saw a change to IR35 status following the consistency review	-

Off-payroll engagements - senior management engagements

Off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2022 and 30 June 2022

Number of off-payroll engagements of Governing Body members, and/or senior officers with significant financial responsibility during the financial year	-
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 should include both on payroll and off-payroll engagements.	14

2.3.8 Exit Packages, Including Special (Non-Contractual) Payments (Subject to Audit)

There were no exit packages applicable or agreed for the period.

2.4 Parliamentary Accountability and Audit Report

NHS Cheshire 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 Section 2.5. 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.

Accountable Officer's Statement

To the best of my knowledge and belief, the Accountability Report presents a true and accurate picture of NHS Cheshire CCG.

Graham Urwin

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

2.5 Independent Auditor’s Report

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

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Cheshire 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 Cheshire CCG transferred to NHS Cheshire and Merseyside ICB on 1 July 2022. When NHS Cheshire 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 and accounts, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

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

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

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

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

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

Matters on which we are required to report by exception

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

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

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

Responsibilities of the Accountable Officer

As explained more fully in the Statement by the Chief Executive of NHS Cheshire and Merseyside ICB, Graham Urwin , as the Accountable Officer set out on page 42, 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 Cheshire 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 Cheshire 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

3. The Financial Statements

3.1 NHS Cheshire CCG Annual Accounts 2022/23 (Quarter 1)

NHS Cheshire Clinical Commissioning Group
Accounts for the three months ended 30 June 2022

CONTENTS

NHS Cheshire Clinical Commissioning Group

Statement of Comprehensive Net Expenditure
for the three months ended 30 June 2022

	Note	Three months ended 30 June 2022 £'000	Year ended 31 March 2022 £'000
Income from sale of goods and services	2	(129)	(63)
Other operating income	2	(3)	-
Total operating income		**(132)**	**(63)**
Staff costs	4	4,410	17,441
Purchase of goods and services	5	332,799	1,307,324
Depreciation and impairment charges	5	91	193
Provision expense	5	(405)	1,160
Other Operating Expenditure	5	138	217
Total operating expenditure		**337,033**	**1,326,334**
Net Operating Expenditure		**336,902**	**1,326,271**
Finance expense		3	-
Comprehensive Expenditure for the year		**336,905**	**1,326,271**

The notes on pages 88 to 113 form part of these financial statements

NHS Cheshire Clinical Commissioning Group –

Statement of Financial Position
as at 30 June 2022

	Note	30 June 2022 £'000	31 March 2022 £'000
Non-current assets:			
Property, plant and equipment	7	187	216
Right-of-use assets	8	1,372	-
Total non-current assets		**1,559**	216
Current assets:			
Trade and other receivables	9	4,636	4,204
Cash and cash equivalents	10	0	146
Total current assets		**4,636**	4,350
Total assets		**6,195**	4,566
Current liabilities			
Trade and other payables	11	(71,563)	(69,376)
Lease liabilities	8	(240)	-
Borrowings	12	(3,589)	
Provisions	13	(1,539)	(1,944)
Total current liabilities		**(76,931)**	(71,320)
Non-Current Assets plus/less Net Current		**(70,736)**	(66,754)
Non-current liabilities			
Lease liabilities	8	(1,133)	-
Total non-current liabilities		**(1,133)**	**-**
Assets less Liabilities		**(71,869)**	(66,754)
Financed by Taxpayers' Equity			
General fund		(71,869)	(66,754)
Total taxpayers' equity:		**(71,869)**	(66,754)

The notes on pages 88 to 113 form part of these financial statements

The financial statements on pages 93 to 118 were approved by the Board of NHS Cheshire and Merseyside Integrated Care Board on 29 June 2023 and signed on its behalf by:

Graham Urwin

Graham Urwin
Chief Executive

29 June 2023

NHS Cheshire Clinical Commissioning Group

Statement of Changes in Taxpayers' Equity
for the three months ended 30 June 2022

	General fund £'000	Total reserves £'000
Balance at 1 April 2022	(66,754)	**(66,754)**
Changes in NHS Clinical Commissioning Group taxpayers' equity to 30 June 2022)		
Total net expenditure for the financial year	(336,905)	**(336,905)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(336,905)**	**(336,905)**
Net funding	331,789	**331,789**
Balance at 30 June 2022	**(71,869)**	**(71,869)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for Year ended 31 March 2022		
Balance at 1 April 2021	(70,202)	**(70,202)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for Year ended 31 March 2022		
Total net expenditure for the financial year	(1,326,271)	(1,326,271)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(1,326,271)**	**(1,326,271)**
Net funding	1,329,720	1,329,720
Balance at 31 March 2022	**(66,754)**	**(66,754)**

The notes on pages 88 to 113 form part of these financial statements

NHS Cheshire Clinical Commissioning Group

Statement of Cash Flows
for the three months ended 30 June 2022

	Note	Three months ended 30 June 2022 £'000	Year ended 31 March 2022 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(336,905)	(1,326,271)
Depreciation and amortisation	5	91	193
Interest paid		3	0
(Increase)/decrease in trade & other receivables	9	(432)	798
Increase/(decrease) in trade & other payables	11	2,187	(3,315)
Provisions utilised	13	0	(314)
Increase/(decrease) in provisions	13	(405)	1,160
Net Cash Inflow (Outflow) from Operating Activities		**(335,462)**	(1,327,750)
Net Cash Inflow (Outflow) from Investing Activities		**-**	-
Net Cash Inflow (Outflow) before Financing		**(335,462)**	(1,327,750)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		331,789	1,329,720
Repayment of lease liabilities including interest		(63)	-
Net Cash Inflow (Outflow) from Financing Activities		**331,726**	1,329,720
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(3,736)**	1,969
Cash & Cash Equivalents at the beginning of the Financial Year		**146**	(1,823)
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(3,590)**	146

The notes on pages 88 to 113 form part of these financial statements

NHS Cheshire Clinical Commissioning Group

Notes to the Accounts for the three months ended 30 June 2022

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on a going concern basis*.*

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

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

When the clinical commissioning group ceased to exist on 30 June 2022, the services continued to be provided (using the same assets, by another public sector entity) from 1 July 2022 by NHS Cheshire and Merseyside Integrated Care Board. Accordingly, the CCG has determined that the going concern basis of preparation for the financial statements is appropriate. The financial statements of the CCG for the three months ended 30 June 2022 have therefore been prepared on a going concern basis.

1.2 Accounting Convention

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

1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure and is disclosed separately from operating costs.

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

1.4 **Pooled Budgets**

NHS Cheshire CCG has entered into two pooled budget arrangements with Cheshire East Council and Cheshire West and Chester Council. Under the arrangements, funds are pooled for Cheshire East Better Care Fund and for Cheshire West and Chester Better Care Fund. Note 19 provides details of the income and expenditure. The pools are hosted by Cheshire East Council and Cheshire West and Chester Council under section 75 agreements between the clinical commissioning group and the other party. The agreements require that plans are jointly agreed and that services under the agreements are jointly commissioned. Regular meetings are held to monitor plans and commissioning arrangements. This is a joint arrangement and NHS Cheshire 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.

1.5 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the clinical commissioning group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation. Income is deferred when it is received for a specific performance obligation that is to be satisfied in the following year.

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

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

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

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 **Other Expenses**

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

1.9 **Grants Payable**

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

1.10 **Property, Plant & Equipment**

1.10.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; 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

1.10.2 **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.

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.

1.10.3 **Subsequent Expenditure**

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

1.10.4 **Depreciation, Amortisation & Impairments**

Depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset.. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment 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.

1.11 **Government grant funded assets**

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.12 **Leases**

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

The Clinical Commissioning Group as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.

"Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease. "

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the ‘Depreciation, amortisation and impairments’ policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

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

1.13 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

1.14 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate.

As provisions are expected to be settled within 12 months, HM Treasury's nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date has been used.

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

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

1.15 **Clinical Negligence Costs**

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

1.16 **Non-clinical Risk Pooling**

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

1.17 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.18 **Financial Assets**

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

Financial assets are classified into the following categories:

- Financial assets at 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.

1.18.1 **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.

1.18.2 **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.

1.18.3 **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.

1.18.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, The Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

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

1.19 **Financial Liabilities**

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

1.19.1 **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.

1.20 **Value Added Tax**

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

1.21 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of

payments. They are divided into different categories, which govern the way that individual cases are handled.

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

1.22 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.22.1 **Critical accounting judgements in applying accounting policies**

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

- ensuring that appropriate policies are in place for considering any claims legal or for continuing health care. This includes estimating liabilities from contract arrangements and from the clinical commissioning group’s legal obligation to fund care based on eligibility.

1.22.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- Data in respect of prescribing costs are received two months in arrears and the CCG estimates the amount that will be payable for the last two months of the year based on a spend profile issued by NHS England. The amount estimated is £22,501,000 (2021-221 - £21,250,000). The spend profile is based on national prescribing trends and the CCG estimates that any is accurate to within 5%. Pharmacy suppliers are paid on account whilst the data is being compiled and the CCG’s share of those payments at 30 June is £8,393,000 which has been offset against the estimate above. This means that net figure £14,108,000 is included in Note 11.

1.23 **Adoption of new standards**

On 1 April 2022, the clinical commissioning group adopted IFRS 16 ‘Leases’. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.

Under IFRS 16 the group will recognise a right-of-use asset representing the group’s right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Impact assessment

The clinical commissioning group has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The group has utilised three further practical expedients under the transition approach adopted:
a) The election to not make an adjustment for leases for which the underlying asset is of low value.
b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease."

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.

As of 1 April 2022, the group recognised £1.433m of right-of-use assets and lease liabilities of £1.433m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was an £Nil impact to tax payers' equity.

The group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.

The following table reconciles the group's operating lease obligations at 31 March 2022, disclosed in the group's 21/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

	Total £000
Operating lease commitments at 31 March 2022	(174)
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	2
Operating lease commitments discounted used weighted average IBR	(172)
Add: Residual value guarantees	(1,261)
Less: Variable payments not included in the valuation of the lease liabilities	(1,433)
Lease liability at 1 April 2022	**0**

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

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

2 Other Operating Revenue

	Three months ended 30 June 2022 Admin	Three months ended 30 June 2022 Programme	Three months ended 30 June 2022 Total	Year ended 31 March 2022 Total
	£'000	£'000	£'000	£'000
Sale of goods and services (contracts)				
Non-patient care services to other bodies	-	11	**11**	43
Other Contract income	-	117	**118**	20
Total Income from sale of goods and services	**-**	**129**	**129**	**63**
Other operating income				
Non cash apprenticeship training grants revenue	3	-	**3**	-
Total Other operating income	**3**	**-**	**3**	**-**
Total Operating Income	**3**	**129**	**132**	**63**

3 Contract income

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

	Non-patient care services to other bodies	Other Contract income
	£'000	£'000
Source of Revenue		
NHS	11	-
Non NHS	-	117
Total	**11**	**117**

	Non-patient care services to other bodies	Other Contract income
	£'000	£'000
Timing of Revenue		
Point in time	11	117
Over time	-	-
Total	**11**	**117**

4. Staff costs

4.1.1 Employee benefits	Total Permanent Employees £'000	Other £'000	Three months ended 30 June 2022 Total £'000
Employee Benefits			
Salaries and wages	**3,173**	**225**	**3,398**
Social security costs	**368**	**-**	**368**
Employer Contributions to NHS Pension scheme	**629**	**-**	**629**
Other pension costs	**1**	**-**	**1**
Apprenticeship Levy	**14**	**-**	**14**
Net employee benefits excluding capitalised costs	**4,185**	**225**	**4,410**

4.1.1 Employee benefits	Total Permanent Employees £'000	Other £'000	Year ended 31 March 2022 Total £'000
Employee Benefits			
Salaries and wages	12,534	961	13,495
Social security costs	1,355	-	1,355
Employer Contributions to NHS Pension scheme	2,532	-	2,532
Other pension costs	5	-	5
Apprenticeship Levy	54	-	54
Net employee benefits excluding capitalised costs	16,480	961	17,441

4.2 Average number of people employed

	Three months ended 30 June 2022			Year ended 31 March 2022		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**286**	**16**	**302**	**280**	**15**	**295**

No staff were engaged on capital projects in the year.

4.3 Exit packages agreed in the financial year

There were no exit packages in the period or in year ended 31 March 2022.

These tables report the number and value of exit packages agreed in the financial year.

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

5. Operating expenses

	Three months ended 30 June 2022 Total £'000	Year ended 31 March 2022 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	993	1,484
Services from foundation trusts	164,134	645,912
Services from other NHS trusts	42,944	167,761
Purchase of healthcare from non-NHS bodies	47,697	186,607
Purchase of social care	5,664	22,921
Prescribing costs	33,306	126,857
Pharmaceutical services	-	37
GPMS/APMS and PCTMS	34,603	145,069
Supplies and services – clinical	741	916
Supplies and services – general	537	1,036
Consultancy services	-	11
Establishment	1,107	6,134
Transport	11	18
Premises	459	834
Audit fees	120	121
Other non statutory audit expenditure		
· Other services	-	7
Other professional fees	395	965
Legal fees	32	296
Education, training and conferences	52	337
Non cash apprenticeship training grants	3	-
Total Purchase of goods and services	**332,799**	**1,307,324**
Depreciation and impairment charges		
Depreciation	91	193
Total Depreciation and impairment charges	**91**	**193**
Provision expense		
Provisions	(405)	1,160
Total Provision expense	**(405)**	**1,160**
Other Operating Expenditure		
Chair and Non Executive Members	117	379
Grants to Other bodies	11	44
Expected credit loss on receivables	10	(234)
Other expenditure	1	28
Total Other Operating Expenditure	**138**	**217**
Total operating expenditure	**332,623**	**1,308,893**

External audit fees
External audit fees for the period were **£120,000** (2021/22 - £121,000) inclusive of irrecoverable VAT. The auditor's liability for external audit work carried out is limited to **£2M**.

Other non statutory audit expenditure includes fees for the audit of the Mental Health Investment Standard and in the current period £Nil has been accrued because the expense will be met by NHS Cheshire and Merseyside UCB, the successor body to the CCG.

6 Better Payment Practice Code

Measure of compliance	Three months ended 30 June 2022 Number	Three months ended 30 June 2022 £'000	Year ended 31 March 2022 Number	Year ended 31 March 2022 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	12,603	90,580	70,403	363,373
Total Non-NHS Trade Invoices paid within target	12,346	89,828	69,064	354,934
Percentage of Non-NHS Trade invoices paid within target	**97.96%**	**99.17%**	**98.10%**	**97.68%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	193	205,714	1,012	825,707
Total NHS Trade Invoices Paid within target	181	205,367	984	825,147
Percentage of NHS Trade Invoices paid within target	**93.78%**	**99.83%**	**97.23%**	**99.93%**

No interest on late payment of commercial debt was paid or incurred.

7. Property, plant and equipment

30 June 2022	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 1 April 2022	1,234	36	1,271
Cost/Valuation at 30 June 2022	**1,234**	**36**	**1,271**
Depreciation 1 April 2022	1,019	35	1,054
Charged during the year	28	1	29
Depreciation at 30 June 2022	**1,047**	**36**	**1,084**
Net Book Value at 30 June 2022	**187**	**0**	**187**
Purchased	187	0	187
Total at 30 June 2022	**187**	**0**	**187**
Asset financing:			
Owned	187	0	187
Total at 30 June 2022	**187**	**0**	**187**

2021-22	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 1 April 2021	1,234	36	1,271
Cost or valuation at 31 March 2022	**1,234**	**36**	**1,271**
Depreciation 1 April 2021	836	26	862
Reclassifications	(2)	2	-
Charged during the year	186	7	193
Depreciation at 31 March 2022	**1,019**	**35**	**1,054**
Net Book Value at 31 March 2021	**399**	**10**	**409**
Net Book Value at 31 March 2022	**215**	**1**	**216**
Purchased	215	1	216
Total at 31 March 2022	**215**	**1**	**216**
Asset financing:			
Owned	215	1	216
Total at 31 March 2022	**215**	**1**	**216**

7. Property, plant and equipment (continued)

7.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	30 June 2022 £'000	31 March 2022 £'000
Information technology	720	720
Furniture & fittings	18	18
Total	**738**	**738**

7.2 Asset lives

	Minimum Life (years)	**Maximum Life (Years)**
Information technology	3	5
Furniture & fittings	3	5

8. Leases

8.1 Right of use assets

30 June 2022	**Buildings excluding dwellings £'000**	**Total £'000**
Cost or valuation at 1 April 2022	-	-
IFRS 16 Transition Adjustment	1,433	1,433
Cost/Valuation at 30 June 2022	**1,433**	**1,433**
Depreciation 1 April 2022	-	-
Charged during the year	61	61
Depreciation at 30 June 2022	**61**	**61**
Net Book Value at 30 June 2022	**1,372**	**1,372**

8.2 Lease liabilities

	30 June 2022 £'000	31 March 2022 £'000
Lease liabilities at 1 April 2022	-	-
IFRS 16 Transition Adjustment	1,433	-
Repayment of lease liabilities (including interest)	3	-
Lease remeasurement	(63)	-
Lease liabilities at 30 June 2022	**1,373**	-

8.3 Lease liabilities

	30 June 2022 £'000	31 March 2022 £'000
Within one year	(252)	-
Between one and five years	(638)	-
After five years	(536)	-
Balance at 30 June 2022	**(1,426)**	**-**
Effect of discounting	53	-
Included in:		
Current lease liabilities	(240)	-
Non-current lease liabilities	(1,133)	-
Balance at 30 June 2022	**(1,373)**	**-**

8.3 Amounts recognised in Statement of Comprehensive Net Expenditure

Three months ended 30 June 2022	**30 June 2022 £'000**	31 March 2022 £'000
Depreciation expense on right-of-use assets	61	-
Interest expense on lease liabilities	3	-

8.4 Amounts recognised in Statement of Cash Flows

	30 June 2022 £'000	31 March 2022 £'000
Total cash outflow on leases under IFRS 16	(63)	-
Total cash outflow for lease payments not included within the measurement of lease liabilities	-	-

9 Trade and other receivables

9.1 Receivables

	Current 30 June 2022 £'000	Non-current 30 June 2022 £'000	Current 31 March 2022 £'000	Non-current 31 March 2022 £'000
NHS receivables: Revenue	1,090	-	3,325	-
NHS prepayments	91	-	-	-
NHS accrued income	81	-	291	-
Non-NHS and Other WGA receivables: Revenue	348	-	276	-
Non-NHS and Other WGA prepayments	2,382	-	26	-
Non-NHS and Other WGA accrued income	507	-	268	-
Expected credit loss allowance-receivables	(868)	-	(858)	-
VAT	166	-	38	-
Other receivables and accruals	838	-	839	-
Total Trade & other receivables	**4,636**	**-**	**4,204**	**-**
Total current and non current	**4,636**		**4,204**	

9.2 Receivables past their due date but not impaired

	30 June 2022 DHSC Group Bodies £'000	30 June 2022 Non DHSC Group Bodies £'000	31 March 2022 DHSC Group Bodies £'000	31 March 2022 Non DHSC Group Bodies £'000
By up to three months	986	199	2,809	380
By three to six months	49	1	153	-
By more than six months	55	148	128	80
Total	**1,090**	**348**	**3,090**	**460**

9.3 Loss allowance on asset classes

17.3 Loss allowance on asset classes	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 1 April 2022	(858)	-	**(858)**
Lifetime expected credit losses on trade and other receivables-Stage 2	(10)	-	**(10)**
Total	**(868)**	**-**	**(868)**

10 Cash and cash equivalents

	30 June 2022 £'000	31 March 2022 £'000
Balance at 01 April 2022	146	(1,823)
Net change in year	(3,736)	1,969
Balance at 30 June 2022	**(3,589)**	**146**
Made up of:		
Cash with the Government Banking Service	0	146
Cash and cash equivalents as in statement of financial position	**0**	**146**
Bank overdraft: Government Banking Service	(3,589)	-
Total bank overdrafts	**(3,589)**	**-**
Balance at 30 June 2022	**(3,589)**	**146**

11 Trade and other payables

	Current 30 June 2022 £'000	Non-current 30 June 2022 £'000	Current 31 March 2022 £'000	Non-current 31 March 2022 £'000
NHS payables: Revenue	299	-	136	-
NHS accruals	4,390	-	642	-
Non-NHS and Other WGA payables: Revenue	8,087	-	14,381	-
Non-NHS and Other WGA accruals	55,655	-	50,602	-
Non-NHS and Other WGA deferred income	555	-	532	-
Social security costs	244	-	214	-
Tax	183	-	172	-
Other payables and accruals	2,151	-	2,698	-
Total Trade & Other Payables	**71,563**	**-**	**69,376**	**-**
Total current and non-current	**71,563**		**69,376**	

Other payables include £270k (2021/22- £267k) outstanding for employee pension contributions.

12 Borrowings

	Current 30 June 2022 £'000	Non-current 30 June 2022 £'000	Current 31 March 2022 £'000	Non-current 31 March 2022 £'000
Bank overdrafts:				
· Government banking service	3,589	-	-	-
· Commercial banks	-	-	-	-
Total overdrafts	**3,589**	**-**	**-**	**-**
Total Borrowings	**3,589**	**-**	**-**	**-**
Total current and non-current	**3,589**		**-**	

Borrowings reflect uncleared payments at 30 June 2022 and therefore all were due within one year.

13 Provisions

	Current 30 June 2022 £'000	Non-current 30 June 2022 £'000	Current 31 March 2022 £'000	Non-current 31 March 2022 £'000
Redundancy	161	-	351	-
Continuing care	1,379	-	1,594	-
Total	**1,539**	**-**	**1,944**	**-**
Total current and non-current	**1,539**		**1,944**	

	Redundancy £'000	Continuing Care £'000	Total £'000
Balance at 1 April 2022	**351**	**1,594**	**1,944**
Reversed unused	(190)	(215)	**(405)**
Balance at 30 June 2022	**161**	**1,379**	**1,539**
Expected timing of cash flows:			
Within one year	161	1,379	**1,539**
Balance at 30 June 2022	**161**	**1,379**	**1,539**

The clinical commissioning group came into existence on 1 April 2020 following the merger of four CCGs and it was considered likely that there would be a cost, including potential payment of exit packages. Some of these restructuring costs remain likely although they have not yet been paid. It is likely that any payment will occur in the coming twelve months.

As explained in accounting policies, the clinical commissioning group is legally obliged to fund certain services for individuals that are eligible for Continuing Health Care(CHC), Funded Nursing Care (FNC) and Section 117 aftercare and, as a consequence of the continuing COVID 19 pandemic in the year, a backlog of assessments and reviews has been accumulated at the year end. The CCG has estimated that 30% of reviews for CHC and FNC will result in a liability for an average period of 6 weeks and has assessed Section 117 reviews may result in a 50% eligibility rate with retrospective claims averaging one year per claim. Subject to uncertainty about the effect that the pandemic may continue to have on the CCG's ability to carry out reviews, the CCG expects that the reviews will be completed in the coming twelve months and that any payment will also be made in that period.

14 Contingencies

	Three months ended 30 June 2022 £'000	Year ended 31 March 2022 £'000
Contingent liabilities		
NHS Resolution Clinical Negliigence claims	6,064	6,064
Net value of contingent liabilities	**6,064**	**6,064**

Any liability arising from NHS Resolution Legal Claims will be met from pooled resources held by NHS England and any settlement may result in the CCG paying higher premiums to NHS Resolution in the future.

As explained in note 20, the NHS was restructured on 1 July 2022. The NHS has provided an employment guarantee for staff and expressed its intent to retain Board level talent. Accordingly, no additional provision for restructuring is required or contingent liability can be quantified.

15 Capital and other financial commitments

The clinical commissioning group had no capital commitments at 30 June 2022 and there were no other financial commitments at 30 June 2022.

15 Financial instruments

15.1 Financial risk management

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

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

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

Currency risk

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

Interest rate risk

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

Credit risk

Because the majority of the NHS clinical commissioning group revenue comes parliamentary funding, the NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

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.

15.2 Financial assets

	Financial Assets measured at 30 June 2022 £'000	Total 30 June 2022 £'000	Financial Assets measured at 31 March 2022 £'000	Total 31 March 2022 £'000
Trade and other receivables with NHSE bodies	813	813	3,129	3,129
Trade and other receivables with other DHSC group bodies	890	890	755	755
Trade and other receivables with external bodies	1,162	1,162	257	257
Cash and cash equivalents	0	0	146	146
Total at 30 June 2022	**2,865**	**2,865**	**4,287**	**4,287**
Non-financial instruments	1,771	1,771	63	63
Trade and other receivables as per balance sheet	**4,636**	**4,636**	**4,350**	**4,350**

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 30 June 2022 £'000	Total 30 June 2022 £'000	Financial Liabilities measured at amortised 31 March 2022 £'000	Total 31 March 2022 £'000
Loans with group bodies	-	-	-	-
Loans with external bodies	3,589	3,589	-	-
Trade and other payables with NHSE bodies	832	832	95	95
Trade and other payables with other DHSC group bodies	9,638	9,638	8,516	8,516
Trade and other payables with external bodies	61,485	61,485	59,847	59,847
Other financial liabilities	-	-	-	-
Private Finance Initiative and finance lease obligations	-	-	-	-
Total at 30 June 2022	**75,544**	**75,544**	**68,458**	**68,458**
Non-financial instruments	1,387	1,387	2,862	2,862
Total current liabilities as per balance sheet	**76,931**	**76,931**	**71,320**	**71,320**

16 Operating segments

The Clinical Commissioning Group has one operating segment which is Commissioning Healthcare and all income and expenditure, and assets and liabilities derive from the segment.

17 Joint arrangements - interests in joint operations

NHS Cheshire Clinical Commissioning Group is part of two Better Care Funds with Cheshire East Council and Cheshire West and Chester Council. The memorandum account below shows expenditure for NHS Cheshire Clinical Commissioning Group:

			Amounts recognised in Entity's books Three months ended 30 June 2022				Amounts recognised in Entity's books Year ended 31 March 2022			
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Assets**	**Liabilities**	**Income**	**Expenditure**	**Assets**	**Liabilities**	**Income**	**Expenditure**
			£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Better Care Fund	NHS Cheshire CCG & Cheshire East Council	Carers Breaks	-	-	-	0	-	-	-	324
Better Care Fund	NHS Cheshire CCG & Cheshire East Council	Local Authority s256	-	-	-	2,259	-	-	-	8,175
Better Care Fund	NHS Cheshire CCG & Cheshire East Council	BCF Home First	-	-	-	4,283	-	-	-	16,602
Better Care Fund	NHS Cheshire CCG & Cheshire East Council	Community Beds	-	-	-	0	-	-	-	2,077
Better Care Fund	NHS Cheshire CCG & Cheshire West & Chester Council	Carers Breaks	-	-	-	110	-	-	-	417
Better Care Fund	NHS Cheshire CCG & Cheshire West & Chester Council	Local Authority s256	-	-	-	2,286	-	-	-	8,654
Better Care Fund	NHS Cheshire CCG & Cheshire West & Chester Council	BCF Home First	-	-	-	3,980	-	-	-	15,632
Better Care Fund	NHS Cheshire CCG & Cheshire West & Chester Council	Care Act	-	-	-	313	-	-	-	1,185
Better Care Fund	NHS Cheshire CCG & Cheshire West & Chester Council	Community beds	-	-	-	1,903	-	-	-	1,149
			-	-	-	15,134	-	-	-	54,215

18 Related party transactions

Details of related party transactions with individuals are as follows:

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
Neston Surgery - Dr Lesley Appleton (Salaried GP)	387	-	44	-
Danebridge Medical Centre - Dr Fiona McGregor-Smith (Partner)	927	-	232	-
Ashfields Primary Care Centre - Dr Andrew Wilson (Partner)	1,291	-	260	-
Vernova - Joint Venture of Member Practices	842	-	439	-
South Cheshire & Vale Royal Alliance - Joint Venture of Member Practices	740	-	-	-
Mere Park Medical Centre - Dr Gwydion Rhys (Partner)	359	-	96	-
Middlewood Partnership - Dr Rachel Hall (Partner)	1,517	-	257	-

Year ended 31 March 2022	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Neston Surgery - Dr Lesley Appleton (Salaried GP)	1,459	-	48	-
Danebridge Medical Centre - Dr Fiona McGregor-Smith (Partner to Jan 22)	3,643	-	274	-
Ashfields Primary Care Centre - Dr Andrew Wilson (Partner)	4,734	-	228	-
Vernova - Joint Venture of Member Practices	3,773	-	450	-
South Cheshire & Vale Royal Alliance - Joint Venture of Member Practices	2,524	-	-	-
Mere Park Medical Centre - Dr Gwydion Rhys (Partner)	1,198	-	114	-
Middlewood Partnership - Dr Rachel Hall (Partner)	6,062	-	-	-

The CCG had material transactions and balances with the following group entities:

NHS England
East Cheshire NHS Trust
North West Ambulance Service NHS Trust
Countess of Chester NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
University Hospitals of the North Midlands NHS Trust

The Department of Health and Social Care is the ultimate controlling party.

19 Events after the end of the reporting period

The Health and Care Act 2022 received Royal Assent on April 2022. As a result of this, the CCG demised on 30 June 2022.

The assets, liabilities, operations and services of the CCG transferred to NHS Cheshire and Merseyside Integrated Care Board on 1 July 2022 as summarised below:

Amounts transferred to NHS Cheshire and Merseyside Integrated Care Board from 1 July 2022

	£'000
Non-current Assets	1,559
Current Assets	4,636
Current Liabilities	(76,931)
Non-current Liabilities	(1,133)
Net Assets/Liabilities	(71,869)

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

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

20 Financial performance targets

NHS Cheshire Clinical Commissioning Group has a number of financial duties under the NHS Act 2006 (as amended).

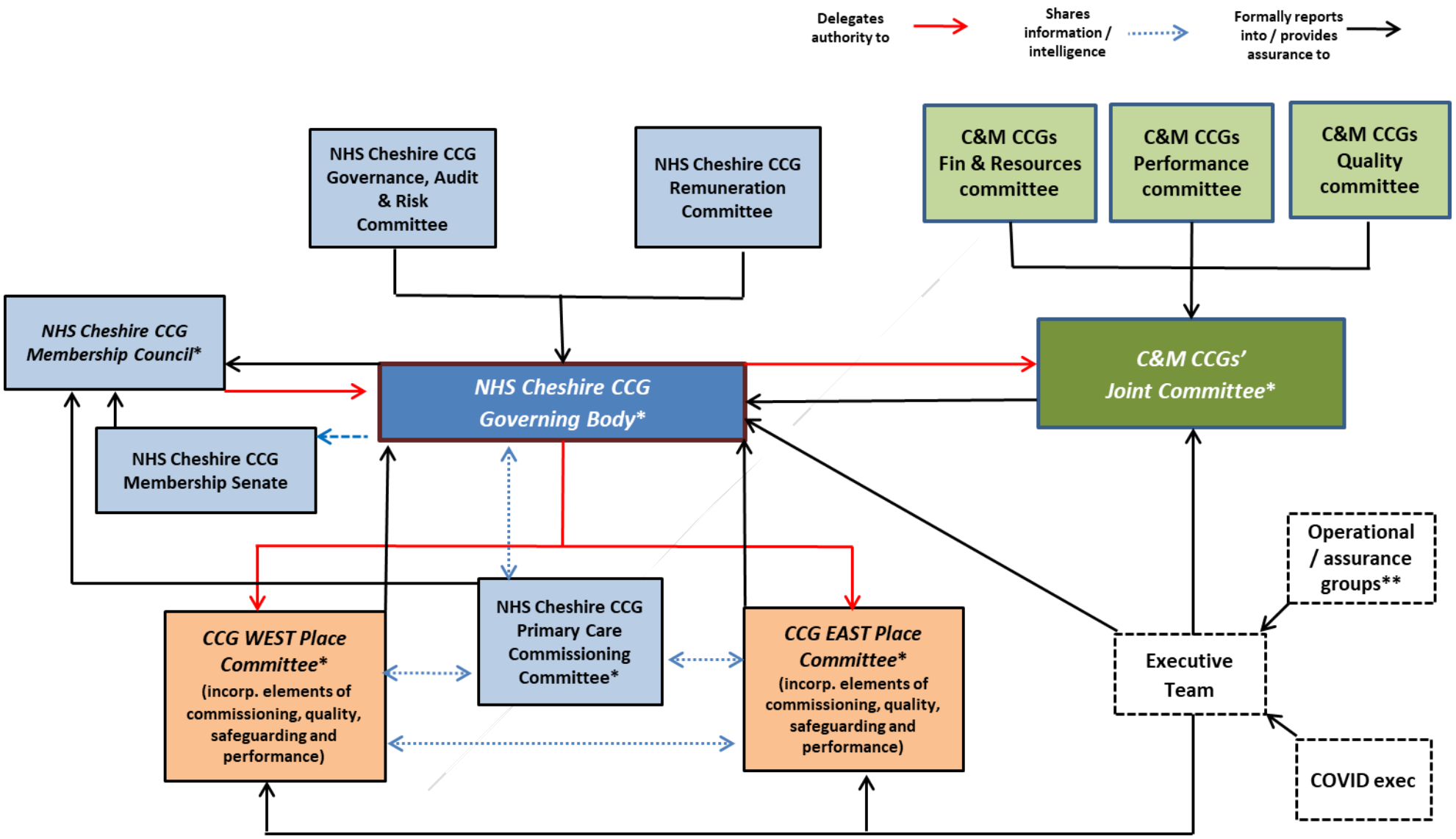
NHS Clinical Commissioning Group performance against those duties was as follows:

	30 June 2022 Target	**30 June 2022 Performance**	Year ended 31 March 2022 Target	Year ended 31 March 2022 Performance
Expenditure not to exceed income	337,036	337,036	1,326,692	1,326,334
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	336,904	336,904	1,326,629	1,326,271
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	3,523	3,523	14,754	13,620

21 Losses and special payments

NHS Cheshire CCG had no losses or special payments in the three months to 30 June 2022 (31 March 2022 - £1K loss relating to bad debts).

Appendix 1 – CCG Committee Structure



* *Decision-making*

** "Operational / assurance" Groups may also report directly into the relevant CCG / C&M committees, dependent on remit

Appendix 2 – Governing Body biographies

Clinical Chair - Dr Andrew Wilson

Dr Wilson trained as a pharmacist and completed an MPhil by research in pharmacology before training in medicine, graduating from the University of Birmingham in 1996.

He worked as a hospital doctor at both Leighton and Macclesfield hospitals before completing his training as a GP practice in Sandbach.

After times as a locum GP, salaried GP and then GP Partner in Crewe he returned to Sandbach where he's been a partner for the last 13 years.

As well has his varied clinical interests which include musculoskeletal medicine and holistic approaches, he is interested in quality improvement and leadership. He is particularly passionate about the value of generalist like district nurses, practice nurses and GPs and about the use of the front line the care professional voice alongside those that use the services, in the redesign and improvement of services.

Accountable Officer - Clare Watson

Clare Watson started her role as Accountable Officer for the four Cheshire CCGs on 1 January 2019.

Working in the NHS for over 25 years, Clare has a clear focus on integration and partnership working. Bringing her experience of transformation in Greater Manchester to commissioning in Cheshire, Clare has a passion for commissioning based on holistic health and wellbeing, making a real difference to local populations.

Clare was appointed as interim Accountable Officer of NHS South Cheshire CCG and NHS Vale Royal CCG in September 2017. Her leadership of both CCGs delivered organisational and financial turnaround, leading the organisations out of special measures moving from inadequate to requires improvement IAF ratings in the first six months of her leadership.

Clare has brought her experience and passion for delivering place based integrated care and sustainability to her role as Accountable Officer for NHS Cheshire CCG.

Executive Director of Finance and Contracts - Lynda Risk

Lynda is a chartered accountant by profession and has worked in the NHS for over 26 years. After qualifying as a chartered accountant, Lynda moved into the NHS in North Wales initially in audit and then as Associate Director of Finance, looking after the financial accounts, a number of secondary care contracts and GP fund holding. After a period of four years Lynda moved to the North West Regional Office as the primary care finance lead for the North West Region, and became the North West Primary Care Red Book expert. With the changes of government Lynda became involved in the development of many primary care initiatives including PCGs, PMS, PDS and ultimately PCTs.
Feeling the need to get back to the coal face, Lynda moved to South Cheshire and became the Head of Finance for the Central Cheshire and Crewe and District PCGs, this involved managing devolved PCG based financial budgets and a contracting portfolio including Mid Cheshire NHS Foundation Trust.
After the advent of PCTs, Lynda moved into the commissioning team, taking on performance, information and contracting and their related management accounting functions. This ultimately involved the development and implementation of payment by results. As the contracting function became more complex and the PCTs in East and Central Cheshire merged, Lynda became more focussed on the contracting agenda.

When CCGs were implemented Lynda decided to move back into mainstream finance and became the Chief Finance Officer for NHS Vale Royal and NHS South Cheshire CCGs. In 2019, Lynda interviewed for and was appointed to the Executive Director for Finance and Contracting for NHS Cheshire CCG. This is a role Lynda feels very privileged to have been awarded and hopes to help improve the health outcomes of the population of Cheshire.

General Practice Representative - Dr Rachel Hall

Dr Rachel Hall joined the Middlewood group as a clinical fellow in 2019 and became a GP Partner in 2020. She is based primarily at Disley. Rachel has an interest in Sports Medicine and Acute Medicine. Prior to becoming a doctor, Rachel was a management consultant and maintains her enthusiasm for quality improvement and service design. When not at work, Rachel enjoys running (marathons) and triathlons (she is an Ironman!) and spending time with her family and dog.

General Practice Representative - Dr Fiona McGregor-Smith

Dr Fiona McGregor-Smith BSc MB ChB MRCGP graduated from St Andrews University in 1983 and Manchester University in 1986.

Fiona has been a GP Partner at Danebridge Medical Practice since 1991. . She has a particular interest in women's health.

She has held roles in clinical auditing and medical advisory previously for NHS organisations, and prior to merger of the Cheshire CCGs wasthe prescribing lead for the Vale Royal area working with the medicine's management teams in the community and local hospitals.

General Practice Representative - Dr Gwydion Rhys

Originally from Aberystwyth in Wales, Gwydion most recently trained in Warwickshire and Staffordshire, and is currently doing research on musculoskeletal pain at Keele University. Gwydion has a variety of medical interests, particularly dermatology.

At weekends he enjoys gardening, woodworking and playing badminton. Gwydion is currently enjoying looking after a new brood of chickens.

General Practice Representative - Dr Lesley Appleton

Lesley has been a GP in Cheshire GP for 10 years following completion of her training in South Wales. Currently, she is a salaried GP in Neston.
Clinical Lead for NHS West Cheshire CCG in Planned Care for 8 years, in December 2019 she was voted by the West Cheshire GP Membership to become one of the Governing Body GPs for the NHS Cheshire CCG. She is also an Educational Lead for Health Education Northwest teaching GP trainees in Liverpool.

Lesley is passionate about leadership and education, through her role in the Governing Body she looks forward to improving care for patients across Cheshire.
Lesley lives in Cheshire with her family and enjoys being outdoors with them whatever the weather.

Independent Clinical Governing Body Member (Secondary Care) - Mr Dan Howcroft

Mr Dan Howcroft MBBS MRCS FRCS (Tr&Orth) graduated from Newcastle University in 2002. Dan undertook his Basic Surgical Training in South Manchester before securing specialist orthopaedic training on the West Midlands programme based out of the Robert Jones & Agnes Hunt (RJAH) orthopaedic hospital in Oswestry and the University Hospital of the North Midlands (UHNM) in Stoke. He was added to the GMC specialist register in 2013.

Since then he has worked for the Medical Protection Society (MPS) as a medicolegal adviser and now works as a medical director in the UK insurance business at Bupa. He is particularly involved in the network of clinicians and hospitals across the UK along with exploring novel ways of contracting that focus on getting the right outcome for patients. Aside from these roles Dan has been a member of the British Orthopaedic Association (BOA) medicolegal committee and was a former Governor at RJAH and is currently a Trustee of a small musculoskeletal charity in London.

He currently lives in North Cheshire with his wife and two young daughters.
Dan is looking forward to helping the Governing Body explore greater integration between services and organisations that will help achieve the very best health outcomes possible for the residents of Cheshire.

Independent Clinical Governing Body Member (Registered Nurse) - Christine Morris

Christine is a Registered Nurse who has had a long career in the NHS in a variety of roles from ward based roles in orthopaedics, hospital operational management to working with health and social care as a joint commissioner. Latterly working in a CCG as Executive Director for Quality and Safety and Deputy Chief Officer.

Independent Lay Member (Governance) - Suzanne Horrill

Suzanne graduated as a Chartered Accountant in 1996 having trained at Price Waterhouse first in Liverpool then in Manchester before working for several years in internal audit at Airtours plc. From there Suzanne moved back into practice at Ernst & Young as a senior manager in their Business Risk Services division based in Manchester.

In 2007 Suzanne moved into the public sector and joined Transport for Greater Manchester (TFGM) as their Head of Risk and Assurance. Other current roles include independent audit committee member for a social housing organisation in Lancashire, and lay member for NHS England's pharmaceutical regulatory committee.

Independent Lay Member (Governance) - Peter Munday

Peter is a qualified accountant living in Macclesfield. He works as a management consultant, coach and lecturer/trainer, predominantly in the healthcare sector. He has 25 years of working with NHS organisations and has experience of the healthcare systems in Ireland and the United States,

He operates mainly in service development and change roles, with a particular interest in health economics and new capital investment. He has extensive experience of delivering business cases for new schemes in primary, community and acute care, including mental health. He also has a strong interest in leadership and management development.

Peter is fully committed to the aims and values of the NHS and recognises the enormous effort made by its dedicated and professional staff. Given the huge challenges faced by the NHS, he is also committed to helping ensure that the people of Cheshire have continued access to first-class healthcare services.

He is active in the local community, as Welfare Officer at Tytherington Juniors Football Club and as a coach at Macclesfield Boys Boxing Club. He is married with four children.

Independent Lay Member (Engagement, Involvement and Experience) - Pam Smith

Pam is an Occupational Therapist by profession. She worked in Local Government for 32 years in social care, during which time she managed care homes, inspected and redesigned services and worked in various management positions. Her last role was Executive Director in Warrington where she managed adult social care; environmental health; trading standards; libraries; culture, sport and leisure services, and neighbourhood development. She was also a member of the PCT Board and Professional Executive Committee.

In the past, Pam had her own consultancy company advising health, local government and housing associations; was an AQuA associate and held a number of non-executive director posts in Housing Associations. She has a history of undertaking work in order to improve the quality of social care services. She has worked with the Care Quality Commission as a professional advisor and worked to produce the Department of Health document “Homes are for Living In” and the National Dementia strategy.

Pam has been responsible for working in partnership to deliver large housing with care services in the North West, and has worked with many health and local authorities to encourage Dignity in Care. Pam lives in Kelsall, Cheshire and likes travelling, cooking and gardening.

Independent Lay Member (Engagement, Involvement and Experience) - Wendy Williams

Wendy’s commitment to the NHS over the last 20 years has been extensive and she recently completed her term of office as Chair of the Clatterbridge Cancer Centre. She has held three previous Non-Executive Director positions in the NHS - Liverpool Heart and Chest Trust, Countess of Chester NHS Trust and the Walton Centre NHS Trust. Other NHS activities include assessing for the ACCEA (Clinical Excellence Awards), coaching doctors in difficulty and being a voluntary mentor for a wide range of NHS staff.Wendy is also a member of the Board of Governors for Liverpool John Moores University.

As a result of her experience as a Change Director in both the private and public sector, Wendy was brought in to lead large-scale change projects in several UK central government departments as well as private sector organisations in France, Germany and the USA. She continues to coach executives on handling change.

Wendy has always lived in the North West and has an honours degree in Psychology/Communication Studies from Liverpool University. She has served as a school governor twice: one comprehensive school and one private charitable status school. Wendy is also a Trustee on a private estate and was, for a time, a member of a regional NSPCC Business Board.

Co-opted Lay Member - Chris Lynch (Non-voting attendee)

After graduating with a Business degree and with ten years' experience in the restaurant industry Chris returned to university to study Psychology at the University of Chester and graduated in 2012. Having used mental health services on and off for over thirty years Chris is passionate about peer support and has helped run a small user-led organisation in Chester for the last decade (Chester PLUS).

In that time, he has also helped set up a number of peer support groups across Cheshire and has been involved with the running of both West Cheshire Mental Health Forum and West Cheshire Mental Health Partnership Board.

Chris has been a Service User, Involvement Representative and Service User Governor of Cheshire and Wirral Partnership NHS Foundation Trust. He has served as a Trustee of Rethink Mental Illness, is currently a Trustee of the British Psychological Society and a member of Time to Change's Senior Management Group.

Chris is currently a member of the National Institute for Health Research Mental Health Policy Research Unit's Lived Experience Working Group and sits on University College London's Institute of Mental Health Advisory Board. He is also a Lived Experience Advisor for Mind and Equally Well UK.

He has also been involved as a National Advisor in several pieces of work featured in the Long-Term Plan including the community mental health framework for adults and older adults and the mental health safety improvement programme.

Chris is passionate about reducing inequalities, peer support, co-production, patient leadership and asset-based community development.

Director of Public Health, Cheshire West and Chester Council - Ian Ashworth (Non-voting attendee)

Ian was appointed Director of Public Health for Cheshire West and Chester Council in June 2017. He has a background in delivering nationally recognised health improvement programmes within Local Authorities and NHS Trusts across the North West. Having completed his MPH at the University of Liverpool in 2009, Ian then commenced specialist public health training across Greater Manchester in 2010.

Joining Salford City Council's Public Health team in 2014, he was responsible for leading and managing the directorates commissioning spend and its innovative arrangement with Salford CCG. As the prevention lead for Salford's nationally recognised integrated care system, his leadership resulted in the City achieving the World Health Organisation Age Friendly City status and enabled it to become a successful demonstrator site for the National Diabetes Prevention programme.

Ian is now responsible for developing vibrant and healthy communities across Cheshire West and Chester with the aim of increasing inclusive leisure, heritage and culture opportunities recognising the many health benefits that this creates.

As a Fellow of the Faculty of Public Health and the lead DPH for sexual health in Cheshire and Merseyside, Ian is also overseeing the national Public Health England pilot for collaborative sexual health commissioning.

Director of Public Health, Cheshire East Council - Matt Tyrer (Non-voting attendee)

Matt leads the public health team at Cheshire East Council. Before becoming the Director of Public Health he led on health protection and the wider determinants of health as a Consultant in Public Health at Cheshire East Council since 2017. Before beginning his career in public health in 2013 Matt worked as a junior doctor. He gained his Masters in Public Health from the University of Birmingham in 2014 and worked in public health teams across the West Midlands before joining Cheshire and Merseyside. He is focussed on building sustainable communities and places, built on sound public health intelligence, in order to reduce inequity and to bring people and neighbourhoods together to address the wider determinants of health and wellbeing.

Matt is a Fellow of the Faculty of Public Health and an Honorary Lecturer in Public Health at Keele University, he is also an examiner for Keele Medical School.