Annual Report & Accounts
2016-17

Inspiring Better Health and Wellbeing
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## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword from Dr Paul Bowen, CCG Clinical Chair</td>
<td>4</td>
</tr>
<tr>
<td>Member Practices’ Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Performance Report</td>
<td>6</td>
</tr>
<tr>
<td>Accountability Report</td>
<td>52</td>
</tr>
<tr>
<td>Members’ Report</td>
<td>52</td>
</tr>
<tr>
<td>Statement of Accountable Officer’s Responsibilities</td>
<td>60</td>
</tr>
<tr>
<td>Annual Governance Statement</td>
<td>61</td>
</tr>
<tr>
<td>Remuneration and Staff Report</td>
<td>74</td>
</tr>
<tr>
<td>Biographies</td>
<td>82</td>
</tr>
<tr>
<td>Independent Auditor’s Report</td>
<td>90</td>
</tr>
<tr>
<td>Financial Statements</td>
<td>93</td>
</tr>
</tbody>
</table>
Foreword

The NHS remains a bastion of the public sector, with hard working people committing their energy, experience and time to improving the lives of people within the communities we serve. The Clinical Commissioning Group (CCG), as part of this NHS family, is no exception, and I am incredibly proud to be part of this family and to present our Annual Report and Accounts for 2016-17. I am not going to pretend that the NHS, and our local CCG, has achieved all it should. Bringing about the changes in the way care is orchestrated, financed, designed and delivered is a huge task, and not one that is achievable overnight. The CCG has to balance the challenges of maintaining the quality, safety and accessibility of services within a traditional NHS model today, whilst moving to a health and care system of tomorrow.

However, we are able to demonstrate that, for factors within our control – how we buy and design care, and how that care ensures high levels of patient experience, quality, accessibility and outcomes - we are doing very well.

At the frontline of our NHS, where 90% of all contacts take place, our GP practices continue to out-perform most of the country. All of our local GP practices have been rated as Good or Outstanding by the Care Quality Commission, a feat not achieved in the vast majority of England. We continue to invest in enhanced community based care to ensure that, as an Eastern Cheshire resident, you are more likely to have most of your needs met by your GP or community team than most parts of the North of England, avoiding often unnecessary and expensive hospital care. We have ensured the ongoing investment in quality stroke services, which are demonstrating improved stroke survival and less disability. We continue to invest responsibly, reducing our bills for medication through effective campaigns to reduce waste and promote self-care. And we continue to be regarded as leaders of the local care system, demonstrating an aspiration for more joined up care whilst backing this up with commitments to change the way health and social care is commissioned and delivered across Cheshire, through the Cheshire and Merseyside Sustainability and Transformation Plan and our local transformation programme called Caring Together.

I am most proud of the bravery this CCG continues to demonstrate. It has to make very difficult decisions, day in, day out, to ensure care is safe and effective, often against a back drop of political, financial and regulatory opinion and influence. This Annual Report will demonstrate not just our achievements, and challenges, but also the ongoing strength in leadership and commitment to our communities.
The last 12 months have seen significant strategic changes within the NHS despite the core model of delivery of general practice remaining very similar across the NHS as a whole. The announcement of the Five Year Forward View (FYFV) in October 2014 and the subsequent GP and Mental Health Forward Views (GPFV and MHFV) have set the tone and agenda for the NHS, Clinical Commissioning Groups and General Practices.

Today’s patient is very different from the patient who accessed the NHS at its inception in 1948. They now expect to be able to access and interact with services outside the historic core hours of service and through different ways using technology. The needs of patients are increasing with a greater focus on support in managing long term conditions, be that diabetes or heart disease, through to support after surviving a stroke or cancer. This has seen the NHS have to focus on its long term resilience against the backdrop of increasing demand and greater pressure on resources. This coincides with increased pressure on social care, both financially and as a result of increased demand.

For GP (member) practices in the Eastern Cheshire area, this is further emphasised by our population demographic, with a significantly higher elderly population living with more long term conditions. This requires greater emphasis on the prevention and detection of illness and support of patients in living well, with better quality years of life. To underpin this, last year, local practices saw a period of investment and transformation to move the focus to proactive care and care closer to home. We are all providing more flexible and responsive services and driving the shift of appropriate care and support back into the communities. This continues to be ongoing work, and throughout the next few years we will see practices working more closely with and based around the ‘Community Team’.

Through the GPFV the NHS hopes to invest in front end changes and also ensure practice back office activities are as efficient as possible, by making the use of technologies. In order for this to happen, practices will need work in different ways, maintaining the friendly “family based service”, but when necessary working collectively in groups, in order to be able to meet the offer proposed by NHS England.

During this time practices will continue to provide safe high quality care to our population, as evidenced by our continued Good and Outstanding assessments with the Care Quality Commission. This is only possible through the hard work of our practice teams and the links and relationships we have with our local providers, commissioners and our patients.

We look forward to rising to the challenges over the coming year.

**General Practice Locality Peer Group Leads**

**Dr Mike Clark**, Macclesfield  
**Dr Jennifer Lawn**, Knutsford  
**Dr Alex Garvey**, Alderley Edge, Chelford, Handforth and Wilmslow Group  
**Dr Robert Thorburn**, Congleton and Holmes Chapel  
**Laura Beresford**, Bollington, Disley and Poynton
Performance Report

Performance Overview

The accounts in this report have been prepared under a direction issued by NHS England (formerly NHS Commissioning Board) under the National Health Service Act 2006 (as amended).

The main factors likely to affect the future development, performance and position of our business are set out throughout this report.

Who we are

The CCG is a membership organisation made up of 23 Eastern Cheshire-based GP practices, working within five localities, as shown in Figure One, and managerial and clinical staff based at New Alderley House in Macclesfield.

Figure One: NHS Eastern Cheshire CCG geography and member practices

Our five localities, known as General Practice Locality Peer Groups, are:

- **Alderley Edge, Chelford, Handforth and Wilmslow**
- **Bollington, Disley and Poynton**
- **Congleton and Holmes Chapel**
- **Knutsford**
- **Macclesfield**.
**Vision and Values**

The vision of the CCG “inspiring better health and wellbeing” is a central tenet of its Constitution. It shapes the direction and behaviour of the CCG, its membership and its staff. This vision is embedded in all that we do and underpins all of the commissioning and business decisions that we undertake on behalf of our population. Our way of working is also guided by and measured against the values and principles of the CCG.

**Values**

Our values embody the culture and style of working that will enable us to be a CCG that our communities, practices and staff can be proud of. Our five corporate values are outlined in Figure Two.

**Figure Two: NHS Eastern Cheshire CCG Values**

**Valuing People**
Listening to and respecting the public, our patients, carers, communities and staff

**Working Together**
To deliver the right care, in the right place, at the right time

**Innovation**
Creating the culture and environment that inspires and supports good ideas

**Quality**
Striving for the best possible care to achieve the best possible outcomes

**Investing Responsibly**
Making the right decisions for the best value, affordable healthcare

**Principles**

Having an inspiring and successful place to work is at the centre of our commitment to the practices and staff that work for the CCG. We have five corporate principles that we consider as essential “foundation blocks” in determining what is core work for us, and what we believe is important to seek external support for. Our five corporate principles are:

- **Clinical leadership.**
  The CCG will be clinically led through its 23 practices, held in high esteem by all clinicians, valued and respected by communities and supported by a lean and supportive management team.

- **Local experts in health needs and improving health outcomes.**
  Our practices are the greatest source of knowledge and expertise in understanding local health needs and leading improvement in health outcomes, working closely with a variety of partners.

- **Local leadership and community engagement.**
  The CCG will be the local leader of the NHS, working in partnership with its stakeholders, communities and patients to shape our future.

- **Expertise in local provider relations and quality improvement.**
  Building effective and strong relationships with our key providers is central to a successful commissioning organisation. It supports high quality integrated care and improves access and choice. Most importantly we believe successful local provider relationships encourage a shared commitment to continuously improving the quality of care for our communities.

- **Local assurance in finance, performance and governance.**
  Our organisational structure reflects the importance of taking ownership of our governance arrangements, keeping them simple but effective. We recognise our responsibility for ensuring that we make the right decisions for best value affordable care and that these responsibilities are conducted in an open, honest and transparent way that instils confidence in our peers, stakeholders and communities.
Our Purpose

The main purpose of the CCG is to commission (buy) the highest quality of health care services within available funds, and monitor the quality of these services. We are responsible for commissioning health services to meet all the reasonable requirements of our local population, with the exception of certain services commissioned directly by NHS England, health improvement services commissioned by Cheshire East Council, and health protection and promotion services provided by Public Health England. Our main commissioning responsibilities include:

- elective hospital care
- rehabilitation care
- urgent and emergency care, including GP Out of Hours and NHS 111
- most community health services
- mental health and learning disability services
- prescribing and medicine optimisation
- emergency and patient transport ambulance services
- NHS continuing healthcare and NHS funded nursing care.

We also have the responsibility for commissioning emergency and urgent care services for the population within our boundaries as well as for commissioning services for any unregistered patients who live in our area. On the 1 April 2016 the CCG also undertook delegated arrangements for the commissioning of Primary (GP) care medical services. The CCGs full statutory responsibilities are detailed within its Constitution.

Strategic Objectives

Our strategic objectives are:

- to lead the development of a shared vision for the health and social care economy
- to use the knowledge and experience of clinicians and managers to improve care
- to work effectively with our members
- to place patients at the centre of our commissioning decisions
- to commission safe, effective care that continues to improve patient experience
- to continue to develop the effectiveness of the organisation
- to ensure financial sustainability for the health economy.

The main responsibilities include:

- upholding the NHS Constitution, CCG Constitution and governance standards
- quality assurance and quality improvement of commissioned services
- quality improvement of GP services in partnership with NHS England
- safeguarding children and vulnerable adults
- reducing health inequalities
- Public Sector Equality Duty
- public involvement in CCG and promotion of choice
- training, innovation and research
- environmental sustainability
- delivering on relevant areas of the Governments mandate to NHS England and the NHS England planning guidance ‘Everyone Counts’
- achieving financial balance.

1 www.easterncheshireccg.nhs.uk
2 http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx
4 http://www.england.nhs.uk/everyone-counts/
Ambitions

The CCG has seven ambitions:

• increase the number of people having a positive experience of care

• reduce the inequalities in health and social care across Eastern Cheshire

• ensure our citizens access care to the highest standards and are protected from avoidable harm

• ensure that all those living in Eastern Cheshire should be supported by new, better integrated community services

• increase the proportion of older people living independently at home and who feel supported to manage their condition

• improve the health-related quality of life of people with one or more long term conditions, including, mental health conditions

• secure additional years of life for the people of Eastern Cheshire with treatable mental and physical health conditions.

Our population

Eastern Cheshire is located in the North West of England and includes towns such as Macclesfield, Knutsford, Wilmslow, Poynton and Congleton as well as many villages and rural areas. It has a registered population of 207,000 and most local people are classed as ‘white British’, however census 2011 data indicates that within Eastern Cheshire there are over 110 different black and minority ethnicities.

The CCG area has 53% of the population of Cheshire East Borough Council. With NHS South Cheshire CCG, the two CCGs are coterminous with the boundaries of the Council. Within Eastern Cheshire:

• males and females have both a healthy life and overall life expectancy which are above the national averages (Figure Three). Whilst this is good news it does mask the large internal differences in life expectancy and healthy life expectancy between the more affluent and lesser affluent areas of Eastern Cheshire

Figure Three: Healthy and overall life expectancy by gender of residents in Eastern Cheshire against England average (2015-16)

![Overall Life Expectancy](image)

![Healthy Life Expectancy](image)

Figure Four: Age profile of residents NHS Eastern Cheshire CCG residents (2014-15)

- the population is predominantly older than the national average, with more than one in five people being over 65 (Figure Four). This ratio is anticipated to become nearer to one in four people by 2021

Data source: Aristotle Business Intelligence 2017
• The number of very elderly people (over 80) is growing even more rapidly, with a higher estimated average annual growth rate when compared to England.

• With an ageing population, more and more people are presenting with long-term conditions such as high blood pressure, liver failure, diabetes, cancer, dementia and other mental health problems (Figure Five).

• Two thirds of the premature deaths in Eastern Cheshire each year are preventable or avoidable. Most of these are caused by cancer, heart disease, stroke, lung disease and liver disease – diseases that are largely preventable by following a healthy lifestyle (Figure Six).

*Figure Five: Disease prevalence profile for residents of Eastern Cheshire (2015-16)*

![Disease prevalence profile](image1)

Data source: Aristotle Business Intelligence 2017

*Figure Six: Main causes of premature deaths in Eastern Cheshire (2014-15)*

![Premature deaths](image2)

Data source: Aristotle Business Intelligence 2017
Healthcare spending

For the 2016-17 financial year, our allocation was circa £290 million. This was a 3.05% uplift from our allocation for 2015-16. For our population we spend our money on a wide range of services that cover the health needs of our population. **Figure Seven** summarises the healthcare areas in which we spent this money.

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<table>
<thead>
<tr>
<th>Cost per Head of Population £</th>
<th>% of Total</th>
<th>£000</th>
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<tbody>
<tr>
<td>Hospital Service</td>
<td>46%</td>
<td>134,220</td>
</tr>
<tr>
<td>Prescribing</td>
<td>12%</td>
<td>33,466</td>
</tr>
<tr>
<td>Continuing Healthcare/Funded Nursing Care</td>
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<td>33,241</td>
</tr>
<tr>
<td>Primary Care (GP Practices)</td>
<td>9%</td>
<td>24,904</td>
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<tr>
<td>Mental Health</td>
<td>6%</td>
<td>18,132</td>
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<tr>
<td>Community Services</td>
<td>5%</td>
<td>14,329</td>
</tr>
<tr>
<td>Better Care Fund</td>
<td>4%</td>
<td>12,530</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
<td>8,760</td>
</tr>
<tr>
<td>Ambulance</td>
<td>2%</td>
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<tr>
<td>Running Costs</td>
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</tr>
<tr>
<td>Annual Spend</td>
<td>100%</td>
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Access to services

In Eastern Cheshire there are 38 Pharmacies, 42 Dentists, 48 Opticians, 62 care homes with nursing or residential homes and over 50 voluntary sector community groups. There is one District General Hospital in Macclesfield and two community hospitals (Congleton and Knutsford). In the main, general acute hospital and community health services including some public health improvement services are delivered within Eastern Cheshire by East Cheshire NHS Trust and mental health services by Cheshire and Wirral Partnership NHS Foundation Trust. Children’s, families and adult social care services and public health services are commissioned by Cheshire East Council.

The proximity of Eastern Cheshire to Greater Manchester provides the Eastern Cheshire population with significant access and choice of general acute services and access to a range of specialist care providers. There is already an innovative model of providing specialist services locally with larger, specialist hospitals like The Christie Hospital NHS Foundation Trust enabling chemotherapy to be administered at East Cheshire NHS Trust.

Figure Seven: CCG healthcare spend by area and amount

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Access to services

The CCG has a commitment to ensuring an active provider market seeking to secure the highest quality of care whilst recognising the need to ensure local access to services commensurate with an ageing population. In 2016 - 17 the CCG undertook or initiated procurement processes for the following areas in order to extend the availability of services to our local population:

- **Talking Therapies**
- **musculoskeletal and outpatient physiotherapy services**

Our structure

The CCG currently employs 75 staff who work alongside the clinicians and staff of the 23 practices to commission, plan and monitor health services. At the end of March 2017 NHS Eastern Cheshire CCG had 50 female employees which equates to 67% of the workforce. There were also 25 male employees which equates to 33% of the workforce. The ethnicity workforce profile of the CCG was 4% against an Office for National Statistics (ONS) ethnic population estimate across the NHS Eastern Cheshire CCG Area of 3.66%. The CCG is therefore representative of the population it serves.

The CCG Governing Body comprises 16 members, of which, as at 31 March 2017, nine (56%) are male and seven (44%) female. The CCG has four Very Senior Managers, three are male and one is female.


9 [https://www.easterncheshireccg.nhs.uk/Links/current-opportunities.htm](https://www.easterncheshireccg.nhs.uk/Links/current-opportunities.htm)
**Figure Eight** demonstrates how the operational and governance structure of the CCG is aligned to oversee and deliver on the Corporate, Governance, Commissioning, Transformational and Finance functions and requirements of the CCG.

Our staff and management structure is also aligned so as to be able to link into a number of programmes of work that span a larger geographical area than Eastern Cheshire but which will have a direct impact on benefitting health and care for Eastern Cheshire residents.

These include:

- **Healthier Together** – the CCG is an associate to the Greater Manchester Healthier Together transformation programme which is aiming to raise standards of hospital care and integrated care across Manchester.
- **Cheshire and Merseyside Sustainability and Transformation Plan** - the CCG is one of the 42 statutory bodies (health and local authority) that form the Cheshire & Merseyside Sustainability & Transformation Plan (CMSTP) membership.
  - Cheshire and Wirral CCG Commissioning Alliance - the five CCGs in Cheshire and Wirral (CW) have identified clear benefits in their executive leads (Accountable Officers and Chief Finance Officers) working collaboratively for the purpose of strategic planning and related commissioning activity. The Alliance enables each CCG to address cross-area issues and gives the maximum influence over decisions that span multiple CCGs. The Alliance allows a Cheshire and Wirral view of the challenges and opportunities that arise from sustainability and transformation planning within the Cheshire and Merseyside footprint.

All CCGs in England have the ability to receive support services from Commissioning Support Units (CSUs). These services support the CCG in the delivery of its objectives and day to day operations. During 2016-17 the CCG contracted from the Midlands and Lancashire Commissioning Support Unit (MLCSU) a limited number of services. These included support around Human Resources and Organisational Development, Information Governance, Information Communications Technology and Business Intelligence.

NHS Eastern Cheshire CCG is the lead commissioner on behalf of the Cheshire, Wirral and Warrington CCGs with MLCSU and is responsible for the ongoing contract management. The other organisations contribute towards the cost of this through a shared post – hosted by NHS Eastern Cheshire CCG - that manages the contract on their behalf. A Collaborative Agreement signed by all the CCGs sets out the nature of the responsibilities of each CCG.

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10 [https://healthiertogethergm.nhs.uk/](https://healthiertogethergm.nhs.uk/)
**Key performance indicators 2016-17**

**CCG Commissioning Priorities for 2016-17**

For 2016-17 our plans were themed around six major programmes of work to deliver on our identified priorities:

- **Quality, Innovation, Prevention and Productivity (QIPP)**
- **transformation of primary care**
- **commissioning an Integrated Care System**
- **transformation across a wider geographic footprint, with a focus on Learning Disability, developing a Cheshire wide mental health strategy, and Children’s and Maternity Services**
- **continuous service improvements in diabetes, stroke, primary mental health, CAMHS and the early detection and treatment of cancer**
- **Systems Resilience.**

Our plans in each of these six areas are summarised in our Operational Plan 2016-17 ‘Plan on a Page’ ([Figure Nine](#) on page 14). The CCG has delivered well across the majority of its 2016-17 operational plan priorities. How we have performed against these priorities is articulated in greater detail within the Performance Analysis section of this report.

**Meeting our financial duties**

As well as complying with relevant accounting standards, the CCG has a series of statutory financial duties it must meet each year. Section 223H of the Health and Social Care Act 2012 sets out the duty for CCGs to break even on their commissioning budget for both revenue and capital individually. Additionally, the CCG is required not to exceed the maximum cash drawdown agreed with NHS England, which restricts the amount of cash drawings that the CCG can make in the financial year. The CCG must also comply with the Better Payment Practice Code 10 which requires all CCGs to aim to pay all valid invoices by the due date, or within 30 days of receipt. **Figure Ten** demonstrates how the CCG has performed against these requirements:

**Figure Ten: CCG Performance against Financial Duties 2016-17**

Delivering a balanced financial position against agreed revenue resource limit

Revenue administration spending not to exceed the resources made available

Ensure that suppliers are paid promptly in accordance with the better payments code of practice

**Delivery against the NHS Constitution targets**

The CCG remains focused on the need for both short term continuous improvement in the quality of, and access to, care whilst leading substantial long term transformation programmes.

The CCG recognises that more needs to be done to address those areas where it has yet to achieve the improvement it has set itself or where there has been deterioration in performance. These will become the areas of additional focus during the period 2017-19. The CCG has delivered the NHS Constitutional targets well across a number of indicators, the only exceptions being:

- **patients on incomplete non-emergency pathways (yet to start treatment)**
- **patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department**
- **response times for ambulances were affected by the pressures experienced over winter.**

Further detail on our performance against NHS Constitution targets is provided within the Performance Analysis section of this report.
**Our Priorities 2017-19**

**Our Vision:**
‘Inspiring better health and wellbeing’

**Our Values:**
- Working Together
- Innovation
- Quality
- Investing Responsibly

---

**Our CCG ambitions 2014-19:**
1. Increase the number of people having a positive experience of care
2. Reduce the inequalities in health and social care across Eastern Cheshire
3. Ensure our citizens access care to the highest standards and are protected from avoidable harm
4. Ensure that all those living in Eastern Cheshire should be supported by new, better integrated community services
5. Increase the proportion of older people living independently at home and who feel supported to manage their condition
6. Improve the health-related quality of life of people with one or more long term conditions, including mental health conditions
7. Secure additional years of life for the people of Eastern Cheshire with treatable mental and physical health conditions

---

**Key programmes of work 2017-19:**

**System Transformation:**
1. Implementing our approach to preventing ill health
2. Supporting the delivery of high quality hospital services
3. Delivering the Caring Together Ambitions and Programme including the development of Accountable Care Arrangements
4. Reforming the Commissioning system
5. Implementing the General Practice and Mental Health Forward View
6. Implementing new approaches to improving wellbeing

**Effective Use of Resources:**
1. Delivering our Quality, Innovation, Prevention and Productivity Programme to ensure services are delivering the maximum value for money for the outcomes
2. Reducing avoidable (inappropriate) variation
3. Reviewing and improving the effectiveness of Continuing Healthcare packages
4. Service optimisation: Redesigning musculoskeletal and Intermediate Care

**Continuous Improvement:**
1. Reduce Delayed Transfers of Care
2. Improve Accident and Emergency performance
3. Implement a new approach for the management and prevention of falls
4. Improve the early detection and treatment of cancer
5. Implement a new approach to quality surveillance of service providers
6. Improve care provided to people receiving wound management, stoma care, continence and nutritional services

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**How we will measure success:**

**Patient Experience:**
- Achieve NHS Constitution standards
- Friends & Family Test
- Improve experience of making a GP appointment
- Feedback from HealthVoice
- Feedback from public and patients
- Staff survey results

**Effective Processes:**
- Deliver the financial plan
- Adherence to the Improvement Assessment Framework
- Improve the efficiency measures aligned to the RightCare priorities
- Deliver planned changes in hospital activity levels
- Reduce length of stay
- Improve Continuing Healthcare assessment processes
- Reduce inappropriate prescribing of antibiotics
- Reduce reliance on specialist inpatient care for people with a learning disability

**Improving Outcomes:**
- Perform well against other peer CCGs in the Improvement and Assessment Framework indicators
- Reduce Delayed Transfers of Care from Hospital
- Better access and outcomes for people using Improving Access to Psychological Therapies (IAPT)
- Achieve targets for earlier diagnosis and treatment of cancer
- More effective prescribing of antibiotics to reduce bloodstream infections
- Improve the measures identified in the Integrated Care Framework
- Achieve the measures identified in Transforming Care (National Learning Disability programme)
The CCG incurred a deficit of £12.4m against its spending allocation in its fourth year of operation, which is a deterioration against the previous year’s surplus of £1.4m. Our funding was uplifted by 3.05% on a like for like basis and the CCG also took over responsibility for Primary (General Medical) Care Services. The CCGs allocation was still 3.43% (£8.4 million) from the target allocation based on target funding per head of £1,222.

The overall cost of delivering services increased by £21.8 million due to increases in activity and in price. The main increases in costs were Hospital Services £9.3m, Mental Health Services £2.5m, Community Health Services £4.2m and Continuing Care Services £7.0m with smaller savings in other areas. The increased funding was not sufficient to manage these pressures on costs leading to the deficit position.

During 2016-17, the financial position of our main local acute hospital and community provider – East Cheshire NHS Trust – continues to be challenging incurring a deficit of approximately £20m for 2016-17 which was within the targeted figure for the year. However, the overall task of delivering financial sustainability for the Eastern Cheshire health economy as a whole remains challenging.

The 2017-18 financial year is set to be a challenging year for the CCG. The Financial Plan for 2017-18 predicts a forecast annual deficit of circa £13.4m including the requirement to deliver a Quality Innovation, Productivity and Prevention (QIPP) reduction (savings) of £17.9m. Throughout the 2017-18 financial planning submission process, NHS England has been actively engaged with the CCG in setting its Plan at the current deficit of £13.4m. Whilst this is an indicative plan, there are significant risks that the in-year position could deteriorate because of the size of the savings that need to be delivered and because of the phasing associated with the implementation of the QIPP schemes.

It is a requirement for all of the health economy to achieve financial sustainability and to deliver services within the funding available. As a result, our commissioning intentions for 2017-18 include the requirement for us to reduce the overspend in a challenging timeframe (in less than one year) as well as continuing with the longer term transformation of health service, through our local programme called Caring Together. One of the key aims of this programme is to ensure that Eastern Cheshire has high quality health and social care services for its population which are financially sustainable for the future.

The financial challenge faced by the CCG is being experienced by other CCGs across Cheshire and Merseyside. NHS England has appointed Deloitte as part of a “capped expenditure programme” to undertake an independent assessment of both the Cheshire CCGs’ and Cheshire NHS Trusts’ plans to deliver financial savings and to bring forward further ideas.

The CCG has strived to be open and transparent with regards informing members of the public and key stakeholders of the financial challenges faced by the CCG and the local health economy. Each month the CCG publishes and presents a Finance Performance Report at its Governing Body meetings held in public and which outlines the CCGs financial position. Throughout 2016-17 the CCG has also published numerous Health Matters columns and news articles in the local papers across Eastern Cheshire referencing the financial decisions required to be undertaken by the CCG. In June 2016 the CCGs Accountable Officer published an open letter to the public outlining the financial challenge faced in Eastern Cheshire. In November 2016 the CCG in partnership with NHS South Cheshire CCG and Cheshire East Council authored a briefing¹ for local councillors and MPs on the financial challenges faced by all health and care partners in Cheshire East.

¹https://www.easterncheshireccg.nhs.uk/News/An-open-letter-to-Eastern-Cheshire-residents-by-Jerry-Hawker-CCG-Chief-Officer.htm

In January 2017, our External Auditors – Grant Thornton LLP – submitted a Section 30 Referral as per the Local Audit and Accountability Act (2014). This letter was notification from External Audit to the Secretary of State that the CCG had breached its statutory duty around its finances and is therefore incurring unlawful expenditure (i.e. its expenditure is exceeding its allocation).

Going concern basis

NHS Eastern Cheshire CCG has entered into 2017-18 with a planned overspend of £13.4m against its fixed income of circa £279m. The reason for the deterioration in the position is well evidenced. NHS England has instituted a system whereby CCGs will have joint spending control totals and, in this context, we are undertaking a range of measures, formally known as QIPP schemes to assist with reducing expenditure to ensure that the joint spending control total can be met. The CCG has actively engaged with NHS England and key partners within the Eastern Cheshire economy to design a health service fit for the future that is both financially and clinically sustainable. The CCG is taking the necessary steps to reduce its spend, and it therefore remains appropriate to adopt the going concern basis for the preparation of these financial statements.

Performance Analysis

Figure Eleven provides a summary of progress by the CCG in achieving its commissioning intentions for 2016-17, as outlined within its measures of success for the Operational Plan 2016-17 (Figure Nine).

Balancing the books: the CCG incurred a deficit against its spending allocation of £12.44 million, a deterioration against the previous year’s surplus of £1.4m.

E-referrals: we continue to work with our main hospital providers to increase the service areas that are accessible by e-referral. In addition we have been working with GP Practices to encourage use of the e-referral system which has seen a positive improvement trend.

Good experience in making an appointment at GP surgery: During 2016 we have rolled out a revised service offer with our Practices which aims to improve the access to services and ensure patients have equity of available services across all of our practices.

Reducing the number of antibiotics prescribed in primary care: the CCG is achieving this target and continues to make ongoing improvements through development of local policies and training for our local clinical community.

Achieving NHS Constitution targets: most of the targets set out in the NHS Constitution have been met with some exceptions, particularly in respect of non-emergency referral to treatment targets and four hour wait in A&E.

51% of people dying in their preferred place of care: this target has been met and we continue to work with providers to ensure that end of life care is planned appropriately with individuals and their families.

Increasing the number of people with a learning disability receiving an annual health check: the CCG has been working with GPs to ensure that these health checks are provided annually. We have seen a positive increase in the number of checks which we are completing and benchmarking showing the CCG as having one of the highest rates nationally.

95% of people referred with a mental illness are seen within 18 weeks: this target has proved to be very challenging. The CCG continues to work with our Mental Health Providers to improve access to services. We have implemented a radically redesigned Primary Mental Health Service within the year that has been developed to support a wider number of people accessing the service in a timely manner.

Reducing by 5% the number of children being admitted to hospital for 0-1 days: although the target was achieved for the first two quarters of the year, the number of 0-1 day days increased in quarter 3. We continue to work with local clinicians to identify how we can better support children, and their parents, in a non-hospital based setting. This builds on existing developments such as the CATCH application.

Reducing the number of emergency admissions for diabetes related conditions: following a focus on diabetes, the reduction in admissions for diabetes related conditions was achieved in the year. This work includes the commissioning of a new community service provider, patient education programme and being a pilot for the national “pre-diabetes” programme.
Increase the percentage of people who spend 90% of their hospital stay on a stroke unit: following the transfer of stroke services to specialist units, the percentage of people spending time on a stroke ward has increased. The most recent national audit of stroke services showed Eastern Cheshire residents now access “A” rated hospital stroke care.

75% of people needing psychological services are seen and complete treatment within 6 weeks and 95% are seen and complete treatment within 18 weeks: the CCG has recommissioned our Primary Care Mental Health Service with an innovative new specification, developed with local clinicians and service users, which has helped to contribute to an improvement through the latter part of the year on the delivery of this target.

**Figure Eleven: Operational Plan 2016-17 Progress in achieving measures of success**

<table>
<thead>
<tr>
<th>Measure of Success</th>
<th>RAG SCALES / PARAMETERS</th>
<th>Baseline</th>
<th>Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balancing the books</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing by 20% the number of e-referrals made by GPs</td>
<td></td>
<td>62.0%</td>
<td>80.0%</td>
<td>73.0%</td>
</tr>
<tr>
<td>77% of patients say they had a good experience of making an appointment at their GP surgery</td>
<td></td>
<td>73.6%</td>
<td>77.0%</td>
<td>75.03%*</td>
</tr>
<tr>
<td>Reducing the number of antibiotics prescribed in primary care</td>
<td></td>
<td>1.143</td>
<td>1.0973</td>
<td>1.033</td>
</tr>
<tr>
<td>Reducing the number of antibiotics prescribed in primary care</td>
<td></td>
<td>9.25</td>
<td>7.4</td>
<td>7.25</td>
</tr>
<tr>
<td>Achieving NHS Constitution targets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing the number of people dying in their preferred place of care</td>
<td></td>
<td>49%</td>
<td>51%</td>
<td>51%</td>
</tr>
<tr>
<td>Increasing the number of people with a learning disability receiving an annual health check</td>
<td></td>
<td>56.80%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>95% of people referred with a mental illness are seen within 18 weeks</td>
<td></td>
<td>76%</td>
<td>95%</td>
<td>91%</td>
</tr>
<tr>
<td>Reducing by 5% the number of children aged 0-5 being admitted to hospital for 0-1 days.</td>
<td></td>
<td>380</td>
<td>361</td>
<td>379</td>
</tr>
<tr>
<td>Reducing the number of emergency admissions/month for diabetes related conditions</td>
<td></td>
<td>42</td>
<td>41</td>
<td>35</td>
</tr>
<tr>
<td>Increase the percentage of people who spend 90% of their hospital stay in a stroke unit</td>
<td></td>
<td>84%</td>
<td>90%</td>
<td>87.50%</td>
</tr>
<tr>
<td>75% of people needing psychological services are seen and complete treatment within 6 weeks</td>
<td></td>
<td>63%</td>
<td>75%</td>
<td>92%</td>
</tr>
<tr>
<td>95% of people needing psychological services are seen and complete treatment within 18 weeks</td>
<td></td>
<td>85%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Meeting the early cancer diagnosis target of 60% demonstrate a 4 percentage point improvement in the proportion of cancers (specific cancer sites, morphologies and behaviour*) diagnosed at stages 1 and 2 in the 2016 calendar year compared to the 2015 calendar year.</td>
<td></td>
<td>44%</td>
<td>48%</td>
<td>49.18%</td>
</tr>
<tr>
<td>No more than 2% of acute hospital bed stock is occupied by people who are ready to be discharged</td>
<td></td>
<td>13%</td>
<td>2%</td>
<td>9%</td>
</tr>
</tbody>
</table>
Meeting the early cancer diagnosis target of 60% or demonstrate a 4 percentage point improvement in the proportion of cancers (specific cancer sites, morphologies and behaviour*) diagnosed at stages 1 and 2 in the 2016 calendar year compared to the 2015 calendar: this 4 percentage point target has been met and we continue to prioritise the need to improve the numbers of cancers diagnosed at stages 1 and 2. The CCG is working collaboratively with Cheshire East Public Health and health and social care professionals to increase public awareness and the uptake of screening programmes.

No more than 2% of hospital bed stock is occupied by people who are ready to be discharged: this target continues to prove challenging. As explained in the section entitled Operational Pressures Escalation Levels (OPEL), formal procedures for assessing the flow of patients and escalating these with partners have been put in place. A number of specific challenges contribute to this position, including delays in people and their families finding and/or accessing suitable care home placements or packages of care at home, and increasing level of days from people living outside of Eastern Cheshire.

Delivery against the NHS Constitution targets

The CCG recognises that more needs to be done to address those areas where it has yet to achieve the improvement it has set itself or where there has been deterioration in performance. These will become the areas of additional focus during the period 2017-19.

The CCG has delivered the NHS Constitutional targets well across a number of indicators (Figure Twelve). The only exceptions are:

• patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral where the CCG fell below the 92% standard, achieving 90.7%

• diagnostics within six weeks where the CCG fell below the 99% standard, achieving 98.9%. Whilst not meeting the 99% standard, the 98.9% achievement is an improvement from 2015-16 (98.54%)

• during the year the CCG worked closely with our main provider of services, East Cheshire NHS Trust, to ensure that improved performance was achieved in both 18 weeks Referral to Treatment and four hour wait in A&E were achieved. However, as with nearly all areas of England we have seen unprecedented levels in winter pressures across all parts of the care economy, but most visibly in hospitals resulting in the A&E performance failing to meet the 95%, with a yearend figure of 82.3%. Achieving A&E performance has been affected by high levels of reported Delayed Transfer of Care (DTOC). The CCG together with East Cheshire NHS Trust has invested significant resources in identifying ways to improve DTOC whilst still maintaining patient’s dignity and good experience of care. Hospital staffing levels remain a challenge because of vacancies and sickness

• response times for ambulances were affected by the pressures experienced over winter.
<table>
<thead>
<tr>
<th>Referral to Treatment Waiting Times</th>
<th>Target</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral</td>
<td>92%</td>
<td>90.7%</td>
</tr>
<tr>
<td>Diagnostic waiting Times</td>
<td>Target</td>
<td>Performance</td>
</tr>
<tr>
<td>Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral</td>
<td>99%</td>
<td>98.9%</td>
</tr>
<tr>
<td>A &amp; E Waits</td>
<td>Target</td>
<td>Performance</td>
</tr>
<tr>
<td>Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department</td>
<td>95%</td>
<td>82.3%</td>
</tr>
<tr>
<td>Cancer Waits – 2 Week Wait</td>
<td>Target</td>
<td>Performance</td>
</tr>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP</td>
<td>93%</td>
<td>98.3%</td>
</tr>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)</td>
<td>93%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Cancer Waiting – 31 days</td>
<td>Target</td>
<td>Performance</td>
</tr>
<tr>
<td>Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers</td>
<td>96%</td>
<td>98.7%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery</td>
<td>94%</td>
<td>97.8%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy</td>
<td>94%</td>
<td>99.6%</td>
</tr>
<tr>
<td>Cancer waits – 62 days</td>
<td>Target</td>
<td>Performance</td>
</tr>
<tr>
<td>Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer</td>
<td>85%</td>
<td>86.4%</td>
</tr>
<tr>
<td>Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers</td>
<td>90%</td>
<td>93.7%</td>
</tr>
<tr>
<td>Maximum 62-day wait for first definitive treatment following a consultant’s decision to upgrade the priority of the patient (all cancers)</td>
<td>No standard set</td>
<td>93.1%</td>
</tr>
<tr>
<td>Category Ambulance Calls</td>
<td>Target</td>
<td>Performance</td>
</tr>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes - Red 1</td>
<td>75%</td>
<td>62.1%</td>
</tr>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes - Red 2</td>
<td>75%</td>
<td>59.6%</td>
</tr>
<tr>
<td>Category A calls resulting in an ambulance arriving at the scene within 19 minutes</td>
<td>95%</td>
<td>91.6%</td>
</tr>
<tr>
<td>Mixed Sex Accommodation Breaches</td>
<td>Target</td>
<td>Performance</td>
</tr>
<tr>
<td>Minimise Breaches</td>
<td>50</td>
<td>64</td>
</tr>
<tr>
<td>Cancelled Operations</td>
<td>Target</td>
<td>Performance</td>
</tr>
<tr>
<td>All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient’s treatment to be funded at the time and hospital of the patient’s choice.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Target</td>
<td>Performance</td>
</tr>
<tr>
<td>Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period</td>
<td>95%</td>
<td>98.5%</td>
</tr>
</tbody>
</table>
System Resilience

NHS Eastern Cheshire CCG Chaired the Eastern Cheshire System Resilience Group (SRG) up to August 2016. The purpose of the SRG was to ensure that there was sufficient capacity resilience in our providers of care services to respond to increases in demand safely throughout the year.


The focus of Eastern Cheshire’s A&E Delivery Board is on urgent and emergency care only. The NHS Constitution sets out that a minimum of 95% of people attending an A&E Department in England must be seen, treated and then admitted or discharged in under four hours. This is one of the ‘core standards set out in the NHS Constitution by Parliament and the NHS Mandate, often referred to as ‘The 4-hour A&E target’. The NHS has not met the 4-hour target failing it every month of the year in 2016-17 and during 2016-17 East Cheshire NHS Trust’s average performance was 80%. This equates to an average of 132 people attending A&E per day of which 106 people will wait less than 4 hours and 26 people wait over 4 hours.

Performance against the 4-hour A&E target is an indicator of quality and how easily people are able to move through the wider health and social care system. This requires all organisations to work in partnership to deliver their respective services towards meeting the target.

The A&E Delivery Board is chaired by the Chief Executive Officer of East Cheshire NHS Trust along with executive level managers from organisations within the local health and social care system. This includes NHS Eastern Cheshire Clinical Commissioning Group, East Cheshire NHS Trust (Macclesfield District General Hospital), Cheshire East Council (Social Care), Cheshire & Wirral Partnership NHS Foundation Trust (Mental Health) and North West Ambulance Service (Emergency Paramedic Transport & NHS 111). Primary care (GPs), NHS England and NHS Improvement are also represented.

A&E Improvement Plan

The 2016-17 Eastern Cheshire A&E Improvement Plan includes five nationally mandated initiatives to improve the 4-hour A&E target. Figure Thirteen indicates the position within Eastern Cheshire.

Operational Pressures Escalation Levels (OPEL)

Good management of increased demand for services happens when health and social care partners come together to put solutions in place across the whole system of health and social care. Eastern Cheshire A&E Delivery Board has developed ‘escalation protocols’ aligned to the single national system - the Operational Pressures Escalation Levels Framework (OPEL) which came into effect on the 5 November 2016 and is nationally mandated by NHS England.

Our local whole system dashboard (Snow White) is used to confirm and report daily the Eastern Cheshire A&E Delivery Board OPEL status. Snow White is an operational dashboard, using real-time information showing performance and outcome metrics across Eastern Cheshire’s health and social care economy, available to all stakeholders within the footprint of NHS Eastern Cheshire CCG. The aim of OPEL is to support and improve local and regional planning and to provide a consistent terminology and approach in times of increased pressure within the NHS and Social Care:

- to help maintain quality and patient safety
- ensure clear expectations of roles and responsibilities for all those involved in escalation in response to increased pressures.

The A&E Delivery Board held its first meeting on the 9 September 2016. In January 2017 Eastern Cheshire held its inaugural Operational Resilience Group meeting. The purpose of the Operational Resilience Group is to bring together operational managers and clinicians to:

- ensure delivery of the five mandated work streams within the A&E Improvement Plan
- provide oversight and management by bringing together urgent care to deliver system wide, year round resilience in line with the OPEL framework
- escalate any exceptions to the A&E Delivery Board with recommendations
- provide system resilience assurance to the A&E Delivery Board.

The Operational Resilience Group enables a greater focus on improvement and refreshed local leadership arrangements to encourage whole system focus and accountability in Eastern Cheshire.

The work of the A&E Board has been supported by the CCG’s Communication and Engagement Team through the development and promotion of

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**Figure Thirteen: Eastern Cheshire initiatives to improve the national 4-hour A&E target**

<table>
<thead>
<tr>
<th>Mandated Initiative</th>
<th>Position in Eastern Cheshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce primary and ambulatory care streaming in A&amp;E</td>
<td>Streaming is in place from A&amp;E to GP Out of Hours, GP Acute Visiting Service (24/7) and GPs working in the Frailty service (7 days a week). These services have been commissioned to respond more effectively to frail older people with urgent or emergency needs.</td>
</tr>
<tr>
<td>Increase the proportion of NHS 111 calls handled by clinicians</td>
<td>Partnership working with NHS 111, East Cheshire NHS Trust and the CCG has enabled the development of the Eastern Cheshire ‘Clinical Assessment Service’ due to go live May 2017. This means that people who currently call NHS 111 and are advised to go to A&amp;E in 4 hours/12 hours can be transferred to a clinician in the local GP Out of Hours Service who will then assess them further. This will divert people into primary care where appropriate and reduce referrals to A&amp;E. The vision for the Clinical Assessment Service is to offer patients improved access to a clinician. It will also ultimately offer advice to health professionals in the community.</td>
</tr>
<tr>
<td>Implement the Ambulance Response Programme</td>
<td>‘Dispatch on disposition’ went live October 2016 enabling the ambulance service to have up to 4 minutes to clinically triage calls (other than those classed as life threatening ‘Red 1’ incidents) to better decide on the most appropriate response.</td>
</tr>
<tr>
<td>Implement SAFER to improve in-hospital flow</td>
<td>East Cheshire NHS Trust has launched ‘the SAFER patient bundle’ which was developed by NHS Improvement. SAFER is a standardised way of managing how well people move through the hospital.</td>
</tr>
<tr>
<td>Implement best practice on hospital discharges to reduce the number of people delayed in hospital (Delayed Transfers of Care)</td>
<td>The aim is to enable people to return home (or to another more appropriate setting) without delay to receive ongoing care and support.</td>
</tr>
</tbody>
</table>

The local Choose Well campaign using targeted and global advertising, both digital and analogue, to promote informed use of urgent and emergency services, thus reducing avoidable demand.

Justification for the CCG’s investment in Choose Well is derived from data from the Eastern Cheshire “snow white” urgent care dashboard which revealed that, between November 2015 and January 2016, more than 3,300 people who visited A&E at Macclesfield District General Hospital were discharged with basic information only. It is probable, therefore, that the majority of these people should have been self-caring. Moreover, data from “snow white” found that the majority of people visiting their GP practice with common, self-limiting winter ailments were children aged 0 – 9 accompanied by a parent; unemployed people; and people aged 65 or over. While the ailments of some of the older patients may have been exacerbated by long-term conditions, it was again probable that most of them should have been self-caring or consulting their pharmacist.

Thus, the focus of the 2016-17 campaign was messaging targeted at key categories of people but supplemented by global communications. Targeted communications comprised articles for a primary schools newsletter published by Cheshire East Council, and equivalents for distribution by CVS Cheshire East to its organisations for older people. One of the articles for primary schools promoted the innovative CATCH16 app developed by the CCG with the council and NHS South Cheshire CCG to support parents and carers in self-caring for children aged 0 - 5. In addition, posters and flyers were distributed to Job Centres, GP surgeries, hospitals, libraries and leisure centres.

The campaign’s effectiveness is measured against data from “snow white” and by engaging the public through Cheshire East Council’s Citizens’ Panel to ascertain awareness, effectiveness of channels, clarity of messaging and influence on behaviour. Analysis had not taken place at the time of

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16 Common Approach to Children’s Health
http://www.catchapp.co.uk/
writing of this report, however, of citizens' panel members who saw the 2015-16 campaign, 79% said it was clear and easy to understand while 62% said they were now more confident about which health service to use.

The A&E objective to reduce avoidable demand was aided by exceptional uptake of the flu vaccine in Eastern Cheshire during the 2016-17 seasonal influenza vaccine programme. Figures published by Public Health England showed that flu uptake exceeded 2015-16 rates across all but one category, placing the Eastern Cheshire region near the top of the best performing regions in England, and the best performing region across Cheshire and Merseyside. Uptake rates can be seen in Figure Fourteen.

**Quality premium.**

Effective use of public resources is seen as an integral part of securing high-quality services. The Quality Premium (QP) scheme is about rewarding CCGs for improvements in the quality of the services they commission. The scheme also incentivises CCGs to improve patient health outcomes and reduce inequalities in health outcomes and improve access to services. Following on from the release of the Quality Premium payment notifications in December 2016 the CCG was awarded £427,000 for 2015-16 which was reinvested into services within 2016-17. Figure Fifteen identifies the areas where the CCG has been successful or unsuccessful in achieving the National and Local Measures that make up the CCGs Quality Premium Position.

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**Figure Fourteen: Seasonal Influenza Vaccine Programme uptake in Eastern Cheshire (Sept – Dec 2016)**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Year</th>
<th>Summary of flu vaccine uptake %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>65 and over</td>
</tr>
<tr>
<td>NHS Eastern Cheshire CCG</td>
<td>2016</td>
<td>76.3</td>
</tr>
<tr>
<td></td>
<td>2015</td>
<td>76.2</td>
</tr>
</tbody>
</table>

**Figure Fifteen: CCG Quality Premium position**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Current Performance</th>
<th>Percentage of Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancers diagnosed at early stage</td>
<td>Failing</td>
<td>20%</td>
</tr>
<tr>
<td>Increase in the proportion of GP referrals made by e-referrals</td>
<td>Failing</td>
<td>20%</td>
</tr>
<tr>
<td>Overall experience of making a GP appointment</td>
<td>Failing</td>
<td>20%</td>
</tr>
<tr>
<td>Reduction in the number of antibiotics prescribed in primary care</td>
<td>Achieving</td>
<td>5%</td>
</tr>
<tr>
<td>Reduction in the proportion of broad spectrum antibiotics prescribed in primary care</td>
<td>Achieving</td>
<td>5%</td>
</tr>
<tr>
<td>Mental Health - Access to IAPT services: People entering IAPT services as a % of those estimated to have anxiety/depression</td>
<td>Failing</td>
<td>10%</td>
</tr>
<tr>
<td>Other - Increase the proportion of people dying in their preferred place of care</td>
<td>Achieving</td>
<td>10%</td>
</tr>
<tr>
<td>Other - The number of children aged 0-5 being admitted to hospital for 0-1 day length of stay. Spell HRGs = PA11Z, PA15B &amp; PA14E</td>
<td>Failing</td>
<td>10%</td>
</tr>
</tbody>
</table>
Performance on other matters

Working in partnership to improve health and wellbeing, and reduce inequalities

The CCG is a partner with Cheshire East Council and neighbouring CCGs (such as NHS South Cheshire CCG) in local (and sub-regional) work to improve both the health of and the care provided to the population of Eastern Cheshire. Throughout this report there are a number of examples where the CCG has worked in partnership with local people, partner agencies, staff and member practices to help improve the health and wellbeing of our population.

In pursuit of its ambition to protect people from avoidable harm, the CCG commissioned in 2016 a dietetics service, provided by East Cheshire NHS Trust, to ensure that the nutritional needs of care home residents are met adequately and that they are only prescribed food supplements when necessary. The service advises on:

- nutritional care plans
- signs and symptoms of malnutrition and dehydration
- referring residents to other healthcare professionals.

The service is reducing hospital admissions and lengths of stay, pressure ulcers and inappropriate prescribing of supplements. In the first six months since its launch in April 2016, the service saved nearly £145,000 in reduced prescribing of nutritional supplements – or £22,000 more than the annual £123,000 cost of running the service. The reduced expenditure on supplements has brought the CCG in line with the national average and reversed a long-running trend of annual rises of up to 10 per cent, which saw the CCG spending around £1m on supplements in 2015-16. The Governing Body of the CCG received an update report on the progress of the service at its November 2016 meeting.

One of the CCG’s ambitions is to increase the proportion of older people living independently at home and who feel supported to manage their condition. As a result, the CCG is working with partners to reduce inappropriate use of intermediate care beds. The goal is being achieved through the adoption of revised admission criteria, reduction in delayed discharges, and development of an integrated system-wide frailty approach. The new approach will realise the following benefits:

- a joint approach between the CCG and Cheshire East Council to commissioning, service provision, demand management, workforce and training for older peoples’ services
- a system-wide approach to the identification and management of the needs of frail older people
- mapping and integration of existing service functions to match capacity with current and future predicted demand
- more balanced provision across the phases of care
- shifting investment from bed-based services to community-based support to enable people to remain independent at home for longer
- increased local access to step-up support, reducing unnecessary hospital admissions
- a single point of access and single assessment process across health and social care
- a financially sustainable model of care designed to meet the current and future needs of frail older people in Eastern Cheshire.

In England in 2015, dementia accounted for one in eight deaths, or 61,686 in total. In Central and Eastern Cheshire, it is estimated that approximately 70 to 80 per cent of care home residents have dementia. Therefore, in line with its ambition to improve the health-related quality of life of people with long-term conditions, the CCG partnered with NHS South Cheshire CCG and NHS Vale Royal CCG to establish an Advanced Dementia Support Team.

The team improves the experience of care for people with advanced dementia in their last phase of life by:

- reducing unnecessary hospital admissions and length of stay by promoting Advance Care Planning and good communication by services
- strengthening the knowledge, skills and confidence of health and social care professionals supporting people with dementia
- educating family and informal carers about dementia and the likely deterioration of their loved one to enable them to understand, cope and plan better.

The team promotes a palliative, compassionate approach to the care of people with dementia. This includes:

• supporting professionals in good decision making, taking into account the wishes of the person with dementia and their families
• providing professionals and families with a better understanding of dementia and its symptoms
• training in skills to enable professionals and families to communicate effectively with patients whose behaviour is perceived to be challenging. In this way, it is possible to pre-empt inappropriate, reactive measures.

The CCG has continued to work with its neighbouring Cheshire and Wirral CCGs and local authorities to improve provision of NHS continuing healthcare (CHC), funded nursing and complex care services. Since 2015-16, the CCGs of Cheshire and Wirral have operated a shared CHC team and a tremendous amount of work has been undertaken to improve and standardise the service across this region. Some key statistics and best practice examples show the improvements made by the CHC team in the last year, which ultimately provide a better experience for patients and their families. In 2016-17:

• the CHC service experienced a 20% increase in referrals compared to 2015-16
• 13% more patients were assessed for continuing healthcare/complex care compared to 2015-16
• 17% more patients who were in receipt of continuing healthcare/complex care were reviewed compared to 2015-16
• an in year increase of 18% of the number of fast-track patients for whom the CHC team have arranged a package of care within 48 hours. Average performance has gone up from 72% to 91%. Fast-track patients are often those who are approaching end of life and so this is particularly important when supporting someone who wishes to die at home
• the number of Personal Health Budgets in place has increased from 106 to 137 - a 23% increase. Personal health budgets offer patients greater control and flexibility and have been shown to bring about improved health outcomes
• a daily decision making system has been introduced so that all CHC eligibility decisions are peer reviewed by two senior and experienced staff members. This ensures a robust and consistent application of the framework and also quality assures the assessment to ensure that it has been completed to a new higher and thorough quality level
• introduction of a standardised letter suite so that all patients across Cheshire and Wirral receive proactive communication and information which is in line with the National Framework for Continuing Healthcare. The CHC teams worked with a patient group on this project so that the language used within them was easy to understand. As a result, patients are better able to understand the process that they are going through, they know what to expect and are able to contribute more fully
• patient stories now feature in our Leadership Meetings so that we can share learning throughout our teams as to what has gone well and what needs to improve
• enhanced transition arrangements have been brought into place for young people who are moving from children’s continuing healthcare services to adult services
• the CHC team have reduced the number of patients who are in receipt of care outside of Cheshire and Wirral. This is important so that patients are cared for nearer to friends and family
• introduction of a family/individual assessment process which means that the CHC team are more able to understand what matters to the individual. The form is used when family members cannot be present or as a prompt to ensure that the wishes and requirements which are most important to the patient are at the heart of the discussions
• a Patient Advisory Group has been set up so that the CHC team can receive guidance and feedback from patients and members of the public on service delivery and changes that might help improve the patient experience
• CHC team were successful in winning a grant that enabled staff to take place on NHS Northwest Leadership Academy Perform at Your Peak Programme. Staff have learnt more about taking care of themselves so that they are physically and mentally well. The impact of this is happier staff who are able to perform at their best both at home and in work

• the Cheshire and Wirral service has been selected as one of just 10 areas in the country to take part in the national Strategic development group.

Throughout 2016-17 the CCG has continued to be an active member of the Cheshire East Health and Wellbeing Board, influencing and contributing in its day to day operation and strategic delivery to the priorities of the Board. Both the Chief Officer and GP Chair are members of the Cheshire East Health and Wellbeing Board and a CCG representative has been at all meetings held in 2016-17. The CCG regularly raise as agenda items at the Board issues that relate specifically to Eastern Cheshire residents. The CCG in the past has presented its Annual Report and Accounts to the Health and Wellbeing Board for information and will present the 2016-17 Annual Report and Accounts upon its completion.

Within the Cheshire East Health and Wellbeing Board strategy, the CCG has indicated within its Appendix A its commitments as to how it intends to commission and monitor services that meet the priorities and objectives of the Health and Wellbeing Strategy Outcomes, and which have been reflected in the CCG Operational Plan 2017-19. Examples include:

**Outcome One – starting and developing well**

Children and young people have the best start in life; they and their families or carers are supported to feel healthy and safe, reach their full potential and are able to feel part of where they live and involved in the services they receive

- improving transition from children’s to adult services – initially focussing on CAMHS 16-19 service
- monitor the progress of the Children and Young People’s Improving Access to Psychological Therapies (CYP IAPT) pilot
- continuing to develop the Joint Early Years and Early Help Commissioning Strategies with Public Health, NHS England, NHS South Cheshire CCG and Cheshire East Council
- implement redesigned neuro-developmental pathways
- developing CCG capability to meet statutory responsibilities for children with Special Educational Needs.

**Outcome Two – working and living well**

Driving out the causes of poor health and wellbeing ensuring that all have the same opportunities to work and live well and reducing the gap in life expectancy that exists between different parts of the Borough

- development of services to deliver “24-7” access to care
- implementation of proactive systems to identify and recall patients with serious mental illness or learning disabilities for health checks
- improved access to primary mental health services, including IAPT (Improving Access to Psychological Therapies)
- improving a range of clinical pathways and services through application of best practice evidence.

**Outcome Three – ageing well**

Enabling older people to live healthier and more active lives for longer

- development of a Cheshire wide strategy and quality framework for care homes. Expansion of the care home doctors service and development of multidisciplinary support
- a range of quality improvement projects including reducing the prevalence of healthcare acquired infection, falls, pressure sores and medication errors
- developing ambulatory care services and urgent response services in order to support caring for patients closer to home rather than in a hospital setting
- further development of end of life care services
- enhancement of the range of support and services available for Carers in our community
- continued development of stroke care.

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Within the Chief Officer report to the monthly CCG Governing Body meetings of the CCG, the Chief Officer provides an overview of discussions and decisions made at any Health and Wellbeing Board meetings within that period of time.

Through its membership of the Cheshire East Health and Wellbeing Board, the CCG is jointly responsible for the production and use of the Cheshire East Joint Strategic Needs Assessment (JSNA).\(^\text{19}\) Along with a variety of other sources of data, including Commissioning for Value insight packs,\(^\text{20}\) the information and priorities identified by the JSNA have informed the commissioning intentions and decisions of the CCG and have been instrumental in helping us to determine our priorities for 2017-19.

The CCG believes that using different types of evidence can support the development of a constructive JSNA on which to base sound strategy development and commissioning decisions. Consideration of the JSNA has been included in the CCG’s new Programme Management Office (PMO) project documentation as a prompt for our commissioners when developing project mandates and business cases, and the PMO are working with the Cheshire East JSNA Manager to provide support in identifying JSNA implications of projects.

The CCG also believes that the Voluntary, Community and Faith sector (VCFS) organisations operating within Eastern Cheshire hold unique evidence about local community assets and needs and that VCFS knowledge can be combined with data collected by statutory bodies such as CCGs and local authorities to offer a richer, more accurate picture of its communities. As such, the CCG has continued to part fund the Cheshire East VCFS Community JSNA programme of work.\(^\text{21}\)

In year, the Community JSNA was commissioned to and has produced a project report on Perinatal Mental Health.\(^\text{22}\)

In 2016-17, staff of the CCG have been involved in the development and publication of the following sections of the Cheshire East JSNA:

- **community JSNA Technology Project** (published in May 2016)\(^\text{23}\)
- **self harm** (published in May 2016)
- **perinatal mental health in** (published in May 2016 and updated following the completion of the community JSNA perinatal mental project in February 2017)
- **children and young people’s mental health** (published in August 2016)

The identified mental health JSNA sections have helped to inform and shape the CCG’s refreshed children and young people’s mental health transformation plan.

The CCG in year has also been involved in the review of other JSNA sections to help identify opportunities for improvement. This has included the:

- **excess weight in children JSNA** (published November 2016)
- **alcohol and drugs JSNA** (published February 2017)
- **end of Life Care JSNA** (published in March 2017)
- **draft Special Education Needs and Disability (SEND) JSNA** (still in development).

The CCG also continues to host for one day a week the Cheshire East Council Public Health JSNA Manager.

The NHS Act 2006 (Section 242) explains that CCGs have a legal duty to involve current and potential service users or their representatives in everything to do with planning, provision and delivery of NHS services. Similarly, the Health and Social Care Act 2012 outlines that CCGs must show how the views of patients, carers, public, communities of interest and geography, Health and Wellbeing Boards, Local Authorities, and practice

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19 [http://www.cheshireeast.gov.uk/jsna](http://www.cheshireeast.gov.uk/jsna)
22 [https://www.cvsce.org.uk/perinatal-mental-health](https://www.cvsce.org.uk/perinatal-mental-health)
populations “... are translated into commissioning intelligence and shared decision-making.” As a CCG we believe that we meet this legal duty.

The CCG continues to work in partnership with a variety of organisations and partners in supporting or delivering health and wellbeing messages and health service access awareness initiatives so as to help ‘inspire health and wellbeing’ and reduce inequalities between and within our communities. Throughout 2016-17 the CCG has, for example:

- **continued to fund outdoor, print, radio and online advertising in support of its Choose Well and Think Pharmacy campaigns to raise awareness of appropriate access to health services in order to help manage demand effectively, especially over the winter period.** Further information about the success of our local Choose Well campaign can be seen on page 21

- **published weekly Health Matters columns in the Congleton Chronicle, Knutsford Guardian, Macclesfield Express and Wilmslow Guardian to promote healthy lifestyles and informed use of services while demonstrating accountability by reporting progress against commissioning intentions.**

The CCGs communications and engagement team has issued 100 media releases in 2016-17, reaching a combined audience of more than two million people and securing free advertising to a value of more than £120,000.

The CCG believes that it works well with its member practices, local partners and the public and actively invests time and resources to ensuring that its engagement and communication around its priorities and decision making is inclusive, open and transparent. The CCG receives feedback about how it is doing in meeting its statutory duties and stated strategic intentions from its partners and public via a variety of means, including directly via Eastern Cheshire Healthvoice and Healthwatch Cheshire East.

- **85% strongly/tend to agree that there is clear and visible leadership of the CCG**

- **87% strongly/tend to agree that improving patient outcomes is a core focus for the CCG.**

The CCG believes that another key feedback route is via the effective management of complaints and concerns raised by patients, which play an important role in ensuring that the CCG continues to improve the quality of care services provided to our patients.

In 2016-17 the CCG received 93 complaints from members of the public and 39 from Members of Parliament acting on behalf of constituents, as well as managing 182 Patient Advice and Liaison (PALS) enquiries and concerns from members of the public. Further details about the feedback received and learning implemented as a result are provided in the Accountability section later in the report.

### Strategic Planning for Eastern Cheshire

A key role of the CCG is to effectively combine short term commissioning and operational plans with longer term strategic plans that set a course for how care will be provided that meets the future needs of our population within available resources. Strategic planning is a complex, but increasingly important process, as organisations strive to improve people’s wellbeing and care outcomes against a

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24 [https://www.easterncheshireccg.nhs.uk/Your-Health/Urgent-Care-And-Other-Options.htm](https://www.easterncheshireccg.nhs.uk/Your-Health/Urgent-Care-And-Other-Options.htm)
25 [https://www.easterncheshireccg.nhs.uk/Your-Health/Pharmacy.htm](https://www.easterncheshireccg.nhs.uk/Your-Health/Pharmacy.htm)
27 [https://www.easterncheshireccg.nhs.uk/About-Us/stakeholder-feedback.htm](https://www.easterncheshireccg.nhs.uk/About-Us/stakeholder-feedback.htm)
trend of increasing demand from an ageing population and continued constraints on available funding. Through the NHS Five Year Forward View (FYFV) there has been an increasing recognition that strategic planning must transcend traditional organisational focus and move to wider health and social care system leadership.

In 2014, the CCG published its Five Year Forward View setting out its ambitions and plans through to 2019. The plan focused on four key elements:

- **investment and development of primary care**
- **development of integrated community teams**
- **ensuring hospital services meet the highest standards for safe, high quality care**
- **continuous focus on improving the quality, efficiency and productivity of all the services we commission.**

2016-17 has been year three of the CCG’s strategic plan, and we have seen the successful implementation of the development of new primary care services ensuring every person in Eastern Cheshire has the same access to high quality care services through their local practice. We continue to develop our approach to integrated community teams expanding our early pilot work.

In 2016-17 we successfully implemented a major change to the provision of acute stroke care with patients now accessing the highest standard of specialist stroke care from centres in Stockport and North Staffordshire. This is already seeing benefits in access to more specialist treatment and patients spending less time in hospital.

Our Governing Body has received quarterly updates on progress throughout the year, with the latest update being in February 2017, which indicated that we have achieved many of the planned improvements for the year. We will build on the progress made in 2016-17 as we move into year four (2017-18) of the strategic plan.

In 2016, NHS England established 44 Sustainability and Transformation (STP) footprints across the country to bring together NHS Organisations, Local Authorities and other partners to work together to deliver the NHS Five Year Forward View. NHS Eastern Cheshire CCG has been an active partner in developing plans for the Cheshire & Merseyside Sustainability and Transformation Plan (STP) and the aims of better wellbeing, better care and better value. The CCG Chief Officer has taken a lead role in developing a programme of work around Demand management and Prevention at Scale. Work on reducing the harmful effects of alcohol, high blood pressure and increased resistance to antimicrobials is progressing and is seen as some of the most effective ways to make the NHS sustainable in the longer term. The Cheshire and Wirral Local Delivery Plan is aiming to translate the STP plans into more local action, building on the existing programmes including Caring Together, Healthy Wirral, The West Cheshire Way and Connecting Care.

care services has been heightened by the worsening financial pressures in the care economy and growing concerns about the future clinical and financial sustainability of key services locally. The CCG, along with key partners, has been working with the health system regulators (NHS England and NHS Improvement) to identify ways in which as many services as possible can continue to be provided locally. At the same time, ensuring that services are clinically sustainable, financially viable and continue to offer the highest possible quality of care and treatment within the resources available.

The CCG anticipates that 2017-18 will be a critical year in determining the future configuration of care services in Eastern Cheshire including further progress in developing our integrated community neighbourhood teams and progress towards establishing new “accountable care arrangements” within Eastern Cheshire.

New ways of working will facilitate a more person centred and integrated approach to treatment and care within Eastern Cheshire and in so doing will make the best use of resources available locally and help improve the health and wellbeing of the population.

CCG Improvement and Assessment Framework

On 31 March 2016 NHS England launched a new CCG Improvement and Assessment Framework (IAF). The CCG IAF brought clarity, simplicity and balance to the conversation between NHS England and CCGs about what matters to patients. It draws together in one place NHS Constitution and other core performance and finance indicators, outcome goals, and transformational challenges. In combination these provide a more accurate account of the real job description of CCGs. The IAF has been designed to supply indicators for adoption in CCGs as markers of success. In turn those plans will provide vision and local actions that will

30 https://www.england.nhs.uk/2016/03/framework-launched/
populate and enrich the local use of the CCG IAF.

NHS England publishes online via MyNHS indicators to show patients how the local NHS in Eastern Cheshire is performing in six important clinical areas:

- **maternity**
- **dementia**
- **mental health**
- **cancer**
- **learning disabilities**
- **diabetes.**

As well as these six clinical areas, the IAF also report CCG performance in 29 key areas, including new models of care, efficiency and conflicts of interest management.

The Governing Body of the CCG receives regular updates on CCG performance against the IAF, with the last update provided at the February 2017 Governing Body meeting.32

**Our commitment to quality**

“Quality without efficiency is unsustainable, but efficiency without quality would be unthinkable” 33

The NHS Five Year Forward View (5YFV) acknowledged the challenge the NHS continues to face, balancing the dual responsibilities of maintaining and improving care whilst delivering within its financial allocation. There has never been a time in the NHS where the fiscal challenge has been so evident and it is necessary to understand the potential risk this could bring to Quality, take effective action and be true to our values as a CCG.

Transparency remains the key to improving standards of care. Our commitment to quality is clear and our aim is that time spent in the care of the NHS is a good experience for patients and that care is clinically effective and safe. Ensuring the delivery of compassionate, high quality care focused on achieving positive patient centred and beneficial outcomes is at the very heart of our clinical values. By establishing a shared understanding of quality and a commitment to place it at the centre of everything we do, the aspiration of high quality of care for all of our commissioned services will be achieved.

As a CCG this means we will hold the patient at the centre of everything we do and seek out and listen to what they are telling us and what they need. The CCG’s ability to capture feedback from patients and clinicians is enhanced through the CCGs Complaints, Concerns and Compliments team which strive to ensure that the feedback provided via complaints, professional concerns, general enquiries and incidents is used to continuously improve services. This involves working in partnership with colleagues in the contracting and clinical departments to use the intelligence gathered from patient and professional feedback to implement changes to improve the services we commission for patients to ensure they are as safe as possible, in line with best practice, to achieve the best reasonable outcomes for these patients and a good patient experience.

The Clinical Quality Performance Committee, and Governing Body, ensure that this feedback is utilised to continuously improve services. This information also includes complaints, concerns, compliments or safeguarding concerns received either directly from service users, from other NHS commissioners and regulators or from health care professionals involved in coordinating or delivering care.

The 2016 – 17 CCG 360° Stakeholder Survey indicated the following from stakeholders who took part in the survey:

- **97% of respondents strongly/tend to agree that if they had concerns about the quality of local services that they would be able to raise their concerns with the CCG**
- **77% strongly felt/tend to agree that they had confidence in the CCG to act on feedback it receives about quality of services**

31 https://www.nhs.uk/service-search/Perfor-
32 https://www.easterncheshireccg.nhs. uk/Downloads/Governing-Body/Mee-
• 54% strongly/tend to agree that the CCGs plans will deliver continuous improvements in quality within the available resources
• 69% strongly/tend to agree that they have confidence in the CCG to commission high quality services for the local population.
• 67% strongly/tend to agree that they have confidence that the CCG effectively monitors the quality of the services it commissions.

Our approach to quality

Delivery of our quality commitments is determined by the key principles set out in the NHS Constitution and our CCG values. Last summer we completely refreshed our Quality Strategy based on current learning from the Kings Fund approach to quality as detailed within the Kings Fund paper ‘Improving Quality in the NHS, a Strategy for action.’ This is now the central basis of the new strategic approach to our quality commitments. This includes a clear approach with prioritised actions and streamlined governance.

The CCG is in the process of finalising a mid-year review which will identify achievements to date and focus on what else needs to be done in line with the six mandated clinical priorities (maternity; dementia; mental health; cancer; learning disabilities and diabetes) and the CCG Improvement Assessment Framework (IAF) indicators.  

Since the launch of this IAF, we have refocussed the CCG quality work programmes to reflect where we are outliers, re-emphasised the six clinical priorities in the CCG Operational Plan for 2017-19 and continue to work to improve quality across a local and wider regional footprint working with neighbouring CCGs and Local Authorities. We are already showing improvements in a number of areas including Learning Disabilities, where we are in the top Quartile nationally, and Diabetes where we are developing an exciting community based Diabetes service and improving from an average position.

Where we are below average against the six clinical priorities, we are keen to learn from our peer CCGs, where we are excelling - we are happy to share. Progress on the IAF is monitored by the Clinical Quality Committee and reported quarterly to the Governing Body. The Clinical Quality and Performance Committee oversee the implementation of the CCG quality priorities which are identified in the annual plan.

Responsibility for quality lies in all parts of the Health and Social care system and we collectively work together to prevent systemic failure and maximise quality services. At a strategic level the CCG has prioritised that it will:

• ensure effective monitoring and delivery of contracted quality standards (national and local)
• continuously improve the quality of services being delivered to our population all sectors including General Practice
• learn from the Francis, Berwick, Keogh and other reports to ensure the key actions and recommendations from the report are embedded within our organisation.

The CCG has a responsibility to narrow the gap between our best and worst performing providers, raise the overall standard of quality for everyone, improve the quality of care, patient experience and reduce unacceptable variations in patient outcomes. We have developed a Quality Assurance Framework and a schedule of visits to monitor and assure the quality and safety of services we commission. Verbal feedback is given directly to the provider at the end of the visit and a report is written with action plans where appropriate. These plans are monitored at Quality Assurance meetings with our providers and any concerns escalated to the appropriate body. We have, in the main, found a culture of good leadership and a willingness to learn from mistakes.

We remain committed to ensuring our providers deliver compassionate, high-quality care which is focussed on improving outcomes. This commitment affords us a unique and important opportunity to continually improve and safeguard the quality of local NHS and NHS commissioned services for everyone, now and in the future.

Ensuring and improving quality throughout the patient journey

The CCG uses a range of evidence to identify local quality improvement priorities such as pressure ulcers and serious incidents. The specific objectives and initiatives that underpin the aim of ‘ensuring and improving quality throughout the patient journey’ are as follows:

• development of a whole health economy approach to prevent and effectively manage pressure ulcers through the “react to red” programme

35  https://www.england.nhs.uk/commissioning/ccg-assess/iaf/
• implement a range of patient safety improvement initiatives; including reductions in falls, improving kidney injury care and avoidance of Sepsis and care home safety improvement work
• reduce the incidence of falls with a specific focus on those occurring in a hospital and care home setting
• reduce rates of healthcare acquired infections (Methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile (C-Difficile))
• new development work for the reduction in microbial resistance by delivering the Quality Premium for Anti-Microbial Resistance both in Primary and Secondary Care
• development of all services to ensure high quality “24-7” care
• ensuring systems support consistently safe prescribing practice
• working with the Greater Manchester Academic Health Science Network to increase the number of people engaging in research
• working in partnership with regional, and national, improvement agencies to improve quality and support the CCG in applying transformational learning
• continue towards a quality framework for care homes.

Cancer and End of Life

It is important that people at the end of their life can spend their last days where they choose, wherever this might be. Evidence suggests that the majority of patients would choose to die at home (well over 50%). NHS Eastern Cheshire CCG clearly has a higher percentage of deaths occurring at home than the England average, with the data from Quarter Three suggesting that, in Eastern Cheshire, 51.4% of all deaths occurring in the usual place of residence. This is an increase of 2.2% from the February 2016 position and suggests that the CCG will achieve its target of 50% by the end of 2016-17.

The CCG remains a member of the Greater Manchester Cancer Vanguard and are involved in the development of Greater Manchester and Eastern Cheshire Living Well with Cancer service specification. This year we have launched a pharmacist direct referral process for lung cancer suspicion across Eastern Cheshire and developed a CCG level end of life care dashboard which includes data from all healthcare settings and identifies those patients at risk.

We are involved in the development of practice level Electronic Palliative Care Coordination System dashboard to support GP’s to communicate and coordinate end of life care (EoLC) whilst promoting patient choice. We continue to liaise with the Palliative and EoLC Strategic Clinical Networks team to ensure that NHS Eastern Cheshire CCG is represented and involved in ongoing innovation.

We continue to deliver high quality cancer care and maintained our close working relationships with local and regional health, social and public health partners to improve cancer and end of life care for the residents of Eastern Cheshire.

We have been successful in achieving the national quality indicators for cancer wait times, ensuring that cancer services are delivered to patients within a reasonable timeframe and supported a number of initiatives during 2016-17. Our aim was to sustainably improve patient and carer experience, co-ordinate care between provider organisations and to ensure the availability of service provision for patients living with and beyond a cancer diagnosis.

NHS Eastern Cheshire CCG highlights for cancer and end of life care for 2016-17 include:

• the development and launch of a number of urgent electronic referral forms in partnership with Greater Manchester and in line with the newly published NICE guidance
• working with the Greater Manchester Vanguard Team to ensure that the residents of Eastern Cheshire have access to specialist cancer centres
• NHS Eastern Cheshire CCG has a higher percentage of deaths in the usual place of residence than the England average, with the data from February suggesting 49.2% of all deaths occur in the usual place of residence
• supporting the Advanced Dementia Support Team to participate in the Care Home Collaborative and ensuring that they are involved in CCG led projects to reduce unnecessary A&E admissions for people with a diagnosis of end stage dementia.

For 2017-18 we aim to continue to drive up the quality of service provision with a particular focus on increasing the percentage of patients receiving treatment for...
cancer within 62 days from an NHS Cancer Screening Service.

Antimicrobial Stewardship

Antimicrobial stewardship is a key issue within the NHS and internationally. The CCG is working with member practices to manage prescribing practice to help slow the emergence of antimicrobial resistance and ensure that antimicrobials remain an effective treatment for infection. Antibiotics don’t work for everything, and using them when they aren’t needed encourages bacteria to become resistant to them. In turn, this means that infections with resistant bacteria may become untreatable in the future, putting lives at risk.

The CCG has worked with practices and local hospitals to put in place systems to reduce the unnecessary use of antibiotics, and to support GPs to prescribe the most appropriate antibiotics when they are needed. The programme of work has included:

- developing local guidelines for the management of infection
- monitoring antibiotic prescribing on a monthly basis, with clear targets for appropriate practice and supportive action plans and audits when those targets aren’t being met
- supporting patients to look after themselves without antibiotics when they have minor illnesses that will get better on their own or with treatments that can be purchased from pharmacies and shops
- encouraging practices to provide patients with information and guidance, so that they know when to seek further help if antibiotics aren’t appropriate immediately
- working with local community pharmacists to enable them to provide treatment, including antibiotics if necessary, for some less serious infections so that GP appointments can be freed up for people with more serious conditions
- supporting national and international campaigns including the Antibiotic Guardian programme and European Antibiotic Awareness Day.

Compassionate high quality care

The CCG is committed to supporting compassionate and high quality care as advocated by the Chief Nursing Officer for England through Compassion in Practice - a strategy that aims to achieve excellent health and wellbeing outcomes. It builds on the existing NHS Constitution and the 6Cs (which details six values):

- Care
- Compassion
- Communication
- Courage
- Competency
- Commitment.

The CCG has committed to embedding the 6Cs in all of its work and has taken an active role nationally and locally in its promotion, including an innovative scheme to share best practice between local care homes.

Improving quality in Care Homes

The CCG continues to actively input into the governance process for Care Homes in partnership with Cheshire East Council and the Care Quality Commission developing approaches to identify early any quality and safety issues. The CCG and Local Authority jointly visit Care Homes on a rotational basis and act quickly and collaboratively when Care Home safeguarding or quality issues are raised in order to support and improve care. We also facilitate a GP Care Home network to enhance quality, share intelligence, provide education and training, develop shared protocols and guidance and improvement through learning using case studies. In 2016-17 we have been developing a range of Care Specific Medicine guidance for Care Homes which we intend to roll out early in 2017-18. We have also developed a Care Homes Dashboard where we collect data and share intelligence around falls, infection and pressure ulcer care.

For the last 10 months, the CCG has been producing bi-monthly Care Home newsletters. The newsletter was first published in order to promote the work that the CCG conducted with care homes and other neighbouring organisations. One key area we have constantly included is the ‘Time to Go Home’ campaign in order to support timely discharges. Over time the newsletter has adopted much more regular content, including regular articles from the Community Dietetics Team, as well as trying to keep care homes aware of changes in policy in other organisations and advertising training opportunities for staff. Importantly, the newsletter is a great way of being able to share the successes of our care homes and celebrate examples of excellent practice, while sharing this knowledge.

38 http://www.england.nhs.uk/nursingvision/
with neighbouring homes. In our latest newsletter we surveyed care homes about the success of the newsletter and the results suggest that 100% of respondents noted find the newsletter ‘Relevant’ or ‘Very Relevant’. One home commented that “it is interesting and is very good at keeping homes up to date with relevant information”. We hope to continue to send out bimonthly newsletters in 2017-18.

In July 2016 we held a Care Home Quality and Patient Safety Event. The event was a welcome opportunity to share good practice, network and support care staff to improve quality and patient safety within their care homes. There were over fifty delegates at the event with twenty four Care Home representatives in attendance.

In 2016-17 the CCG also ran a Care Home Hygiene award scheme pilot and established a Care Home Quality Improvement collaborative to support care homes in driving forward quality improvement initiatives. The collaborative approach will support local care home providers to achieve the following ambitions:

- to connect and learn from each other
- to identify what good quality care looks like
- to develop a patient safety and quality improvement culture
- to put patient safety and experience at the heart of what we do first
- to support care homes to tackle key patient quality and safety priorities
- implement change based on feedback from patients and by constantly measuring and monitoring service improvements/change
- to take a lead role in supporting local collaborative learning
- to make improvements, share good practice and celebrate success.

As part of the NHS England React to Red® national pressure ulcer prevention programme, we have facilitated training to approximately a third of our local care homes. In each home we identified two or more link champions that could be trained and signed off as competent to then go on and train the rest of the staff. As part of the commitment with the programme each care home has agreed to share their pressure ulcer data with the CCG so that we can measure its success. Going forward, the collection and cross referencing of the care home data and our local data should give an accurate measure to the success of the React to Red training in the Homes.

The CCG has also begun to see successes from its Care Home collaborative falls project. The graph in Figure Seventeen illustrates the number in emergency admissions due to falls in Care Homes related to CCG registered patients between April 2013 – Feb 2017. There has been a downward trajectory in falls over the last three years (-3.4%) but a more significant reduction in falls over the last 11 months, with a 7.6% reduction.

Through the Care Home Quality Collaborative, the quality team have worked closely with care homes in developing falls reduction approaches. For example as part of the Care Home Quality Improvement collaborative programme, Park Lane Residential Home in Congleton has focussed on reducing the risk and incidence of falls and has seen a 50% reduction in the prevalence of falls, within the last nine months. Through developing a multi-factorial approach to falls, such as environment and individual care needs, the home has improved upon its ‘Post Fall Injury and Assessment and Management’ toolkit which provides a clear framework for conducting a Post Fall Review, re-assessing the falls risk status of each resident, updating and revising Care Plans and

![Figure Seventeen: Emergency Admissions due to falls in Care Homes (NHS Eastern Cheshire CCG registered patients) between April 2013 – Feb 2017](39 http://www.reacttoredskin.co.uk/)
communicating the post-fall outcome and revised care plan to all staff, strengthening action plans after a patient has had a fall. The home has developed plans for individuals and has made significant improvements to the home environment, such as researching the lighting levels within the home and replacing with strong illumination in hallways and communal areas, refurbishing the décor to include individual coloured doors to residents’ rooms and pictoral signage both of which particularly help people with memory problems.

Commissioning Quality and Innovation (CQUIN)

CQUIN is a method of incentivising our providers of NHS services to secure continuous improvement in services and is a key element of the CCG’s quality strategy. This is done through national, regional and local CQUIN schemes which are used to drive through quality improvements. CQUIN schemes are identified and developed in partnership with providers, ensuring they are challenging yet realistic and that, where possible, they address local quality improvement priorities. An established process is also in place for reviewing quarterly CQUIN evidence to ensure progress against agreed milestones. The CQUIN scheme reports are then reported through the Clinical Quality and Performance Committee and Governing Body on a quarterly basis.

CCG assurance through the Quality Assurance Group

Along with other local area CCGs, NHS Eastern Cheshire CCG attends the area wide Cheshire, Warrington and Wirral Quality Surveillance Group (CWWQSG) on a bi-monthly basis. This assurance meeting is hosted by NHS England and offers the opportunity for all local CCG commissioners, including primary care, local authorities, regulators such as the Care Quality Commission and NHS Improvement as well as organisations such as Healthwatch, a forum to share information and local intelligence about the health economy. This affords the opportunity to spot problems early and take corrective and supportive action to prevent early problems becoming more serious quality failures.

NHS Eastern Cheshire CCG works with NHS South Cheshire CCG and Cheshire East Council to prepare a regular intelligence report for the meeting outlining and highlighting key issues and current concerns from within the local health economy. This approach to intelligence sharing assures both the CCG and our area partners of any issues that have arisen across the economy.

Improving quality in Primary (General Medical) Care

From 1 April 2016 the CCG was authorised to undertake delegated arrangements for the commissioning of Primary (General Medical) Care Services. A primary care Team has been established to provide ongoing CCG focus on primary care commissioning, quality and performance. Regular monthly GP locality meetings are in place with the GP practices, facilitating communication and engagement, with a focus placed on quality improvement and the development of local primary care services. These meetings allow for regular sharing of innovation and good practice while also allowing for peer based challenge and discussion. GP practices have been reviewed against both national and local metrics in order to provide assurances on the high level of quality and performance delivered locally.

The CCG has worked with the local GP practices to implement a Caring Together GP Service Specification, in response to the widely recognised challenges being faced in primary care and the wider system - from rising demand due to more people living longer, and more people living with multiple long term conditions. This has provided an enhanced level of Primary (General Medical) Care Services to the population of Eastern Cheshire, above and beyond that commissioned in the national GP contract, along with the closer integrated working of the Eastern Cheshire GP practices, following the nationally recommended direction of travel for the future of primary care.

An outcome based phased implementation approach was followed, with phase 1 bringing equity in funding across the 22 GP practices, acknowledging previously unfunded activity provided by GP practices and enabling patient access to an equal level of services across Eastern Cheshire. Implementation of phase 1 was achieved across all 22 GP practices by the end of March 2016. Phase 2 then facilitated a rise in the level of patient services available across the GP practices in Eastern Cheshire to a level above the national contract standard, while promoting a greater
We are training the GPNs in improvement methodology to develop, share and implement small change initiatives. We are also developing protocols and guidelines for common use across the CCG practices to reduce unwarranted variation in clinical practice. We are looking to develop Quality leads in each GP practice, similar to our safeguarding and learning disabilities practice leads. GP locality meetings share innovation and good practice regularly and peer challenge is improving. We are in the early stages of developing a Quality dashboard to capture any key issues, identify themes and address quality issues as soon as possible.

In 2016-17 the CCG has also piloted a pressure ulcer prevention awareness raising campaign in thirteen of our GP Practices. The practices were sent a selection of the React to Red patient/carer leaflets, pocket guides and posters and we also got permission from NHS Shropshire CCG to tailor their Pressure Ulcer prevention campaign video for our area for some of the practices to use in the waiting areas. The next phase of this pilot will review how many enquiries the practice have received and if they feel it has made an improvement. The CCG will use this information to identify how the future process could be improved.

**Working in partnership to improve quality and reducing health inequalities**

In order for the CCG quality approach to be successful in delivering its aims and effective in improving quality of care, the CCG takes a whole systems approach to quality. The CCG works in partnership to support and achieve the development of a culture of quality improvement across the whole healthcare economy in Eastern Cheshire so that it is focused on the needs of patient and carers. This is a key priority of the CCG.

An example of a partnership approach to improving quality includes the work undertaken with the nursing homes sector where the CCG continues to invest in supporting continuous improvement. Elsewhere, initiatives include implementation of an enhanced (GP) primary care services and the ongoing development of a quality monitoring team for care homes, working with Cheshire East Council.

Reducing health inequalities is a multi-agency effort requiring sustained action at the prevention, detection and treatment levels. To this end, as a partner on the Cheshire East Health and Wellbeing Board, the CCG contributes through its directly commissioned services and by co-ordinating our efforts with partners under the auspices of the Board. The CCG recognises that it has an important role to play in local actions to reduce premature deaths amenable to health services, actions that can effectively promote healthy lifestyles, and actions to tackle socio-economic and environmental determinants in the longer term. The CCG continues to work with Cheshire East Council and Education partners to ensure we continue to make progress on the implementation of the Special Educational Needs and Disabilities (SEND) reforms as detailed in the Children and Families Act, 2014. The CCG will ensure that there is a clearer focus on the views of children, young people and the parents/carers of those with special educational needs and disabilities and that they are at the forefront of decision making at all levels. This will lead to a stronger focus on high aspirations and on improving outcomes for children and
young people with Education Health and Care Plans as well as those at SEN support level. The CCG employs a Designated Clinical Officer for SEND who ensures the CCG is working in line with statutory duties of the Children and Families Act and as well as ensuring that children and young people receive the appropriate health services to support them to achieve positive outcomes.

Within year, the CCG has increased its efforts to ensure that equality impact assessments and quality impact assessments are routinely completed, have prominence in decision making processes and are evidenced within Committee and Governing Body papers. The CCG has worked closely with specialist advisors from Midlands and Lancashire Commissioning Support Unit in forming robust impact assessments, and ensuring the process of completion is stringently adhered to, overseen by the CCG Programme Management Office. All Equality Impact assessments are routinely published on the CCG website.41

**Safeguarding**

As commissioners our prime responsibility is to protect children and adults at risk, operating in accordance with statutory guidance, taking account of our responsibility to assure ourselves that the organisations we commission local health services from have effective safeguards in place and provide the highest possible standards of care.

However, we also recognise that our responsibilities extend well beyond our local statutory duties and boundaries and we have been an active member of the Cheshire East Safeguarding hub working with NHS South Cheshire CCG, Cheshire East Council and Cheshire Police.

The CCG’s Governing Body is accountable for ensuring the CCG discharges its full duties with respect to safeguarding. The Clinical Quality and Performance Committee receive quarterly safeguarding children and adult updates and risk reports. The reports include key points of the Local Safeguarding Children and Adult Boards’ work. The Governing Body receives an annual update in relation to safeguarding children and adults.42

Regular Safeguarding and Assurance meetings provide assurance that all health providers from whom the CCG commissions services (both public and independent sector) have comprehensive single and multi-agency policies and procedures in place to safeguard and promote the welfare of children and to protect adults at risk from abuse or the risk of abuse. The acute and community providers are expected to be an active partner on the Cheshire East Local Safeguarding Children43

41 [https://www.easterncheshireccg.nhs.uk/About-Us/equality-impact-assessments.htm](https://www.easterncheshireccg.nhs.uk/About-Us/equality-impact-assessments.htm)


43 [http://www.cheshireeastlscb.org.uk/home.aspx](http://www.cheshireeastlscb.org.uk/home.aspx)

44 [http://www.stopadultabuse.org.uk/home.aspx](http://www.stopadultabuse.org.uk/home.aspx)

45 [https://www.england.nhs.uk/ourwork/safeguarding/our-work/](https://www.england.nhs.uk/ourwork/safeguarding/our-work/)
Adult
Safeguarding

The Care Act 2014 provides a clear legal framework for how CCGs work in partnership with other public services to protect adults at risk. As a statutory partner of the Local Safeguarding Adult Board, NHS Eastern Cheshire CCG works alongside Cheshire East Council, the Police and other partners to deliver both our corporate responsibility and our commitment to safeguard our communities.

Safeguarding means protecting a person’s right to live in safety, free from abuse and neglect. As commissioners we must demonstrate the aims of adult safeguarding, to prevent harm and reduce the risk of abuse or neglect to adults with care and support needs, to safeguard people in a way that supports them in making choices and having control in how they choose to live their lives. The CCG promotes an outcomes approach in safeguarding that works for people, resulting in the best experience possible and to raise public awareness so that professionals, other staff and communities as a whole play their part in preventing, identifying and responding to abuse and neglect.

NHS Eastern Cheshire Clinical Commissioning Group encourages an open working culture to ensure clear understanding between partner agencies, also promoting the health and well being of those who are at risk of being abused or neglected in the services commissioned including the needs of the wider health and social care community.

The Care Act 2014 constitutes the statutory safeguarding framework for adult safeguarding in which the Local Authorities with the support of statutory members under Sections 42-46 must:

- lead a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens
- make enquiries, or request others to make them when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed
- establish a Safeguarding Adults Board with the Local Authority, NHS and Police as core members and develop, share and implement a joint safeguarding strategy
- carry out Safeguarding Adult Reviews [SARs] when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have done more to protect them
- arrange for an independent advocate to represent and support someone who is the subject of a safeguarding enquiry or review, if required.

NHS Eastern Cheshire Clinical Commissioning Group has a responsibility to assure the quality and safety of the organisations with whom contracts are held, and ensure that those contracts have explicit clauses that hold the providers to account for preventing and dealing promptly and appropriately with any example of abuse and neglect.

This includes the use of the NHS Outcomes Framework which sets out the high-level national outcomes that the NHS should be aiming to improve, inclusive of standard 5: Treating and caring for people in a safe environment; and protecting them from avoidable harm.

To ensure effective responses where harm or abuse occurs through multi-agency adult safeguarding policies and procedures.

Over the last year in adult safeguarding a number of achievements have been made to ensure the statutory principles in protecting Adults at Risk in our communities have been made, the following illustrates the depth of partnership work undertaken to drive the adult safeguarding agenda in NHS Eastern Cheshire Clinical Commissioning Group:

- the Commissioning Standards for Safeguarding that sit alongside the NHS Standard Contract within the CCGs have now been adopted by the Local Authority as a standard of good practice
- in partnership with the Safeguarding and MCA / DoLS coordinator in the Merseyside CCG service an audit has been completed to identify the high level of restrictions imposed on people in hospitals and care homes in Cheshire and Merseyside. The findings of the audit have been shared with the MCA National group chaired by Baroness Finlay and further work is ongoing to better advise hospitals and care homes how they can reduce restrictions in care with the emphasis being for those in care homes. This will include access to outdoor space and person centred activity
- working in partnership with the Dementia end of life partnership and the Cheshire East Council Safeguarding Lead organised a study session for domiciliary staff working in Cheshire East to better support them in looking after people with dementia who lack mental capacity to make some
decisions and who may require Safeguarding, in their own homes

- further training has been delivered to the Continuing Health Care team to better support them in completing mental capacity assessments, best interest decisions and identifying a deprivation of liberty. In considering those living in their own home and funded by the NHS, work is ongoing to identify those who have a high level of restrictions imposed on them and

- Adult Safeguarding ‘pocket books’ which outline Safeguarding standards and expectations of staff have been reviewed and updated and are now in National circulation to all front line practitioners. The CCG has also worked with NHS England to develop a free NHS Safeguarding APP for all smart and android phones

- we have worked with Public Health England to raise awareness of suicide and promote support services

- the CCG has actively supported all the sub-groups to the Safeguarding Adult Boards to ensure health has a voice in policy/process changes

- we have actively driven the Trafficking/Modern Slavery agenda and PREVENT into front line practice. PREVENT has multiple aims including responding to the ideological challenge of terrorism and the threat from those who promote it, preventing people from being drawn into terrorism and ensuring that they are given appropriate advice and support

- we have delivered a bespoke adult safeguarding face to face training programme to primary care services and continue to provide direct support to all Trust Lead nurses for Safeguarding. Working alongside them we have improved the qualitative data to reflect Adult Safeguarding in the dashboards for the CCGs to enhance oversight

- providing safeguarding support to both CCG/ CEC quality leads with care home monitoring visits and, where serious safeguarding concerns are raised, leading health investigations

- the Designated Nurse for Adult Safeguarding now sits at the Cheshire East Council internal Governance Meeting to offer health advice.

The MCA/DoLS Practitioner has provided bespoke training sessions to GP practices and care homes. Joint working with CQC, CCG and Local Authority quality teams has raised the profile and knowledge of MCA DOLS. The quality teams and CQC maintain close monitoring

where they cannot be reduced, whether a deprivation of liberty should be considered by the Court of protection to ensure it is lawful. This will reduce the reputational and financial risk to the CCG

- changes to the current deprivation of liberty safeguards are likely with the draft Bill published by the Law Commission on the 13 March 2017, the recommendations will extend protections to all care settings such as supported living and domestic settings

- following recommendations and learning from a multi-agency Domestic Homicide there have been important changes made to front line practices to strengthen support for victims/ survivors of domestic abuse

- the Adult Safeguarding E-Learning programme has been completely revised by the CCG to standardise level 1 training and is supported by NHS England

Dementia Team. From left to right – Debbie Callow (Admiral Nurse), Jenny Casson (Occupational Therapist), Sian Harrison (Team Leader) and Nicola Wakefield (Business Support)
of processes relating to the Mental Capacity Act. This additional scrutiny has meant that those lacking capacity to make decisions are now more likely to have a voice heard and are better supported with decision making. Recent changes made to the acute provider dashboards will ensure that the CCG receive assurance that the Mental Capacity Act is embedded into every day clinical practice with an emphasis on identifying gaps in knowledge to enable this to be addressed.

The wealth of work undertaken both inside and outside of the CCG confirms the importance of health input within the safeguarding agenda and will continue to strengthen partnership working.

**Children’s Safeguarding**

The CCG has a statutory responsibility to safeguard and promote the welfare of children, including looked after children, who are living in our communities. Safeguarding is an integral part of its commissioning processes.

**Leadership in the Health Community**

As clinical experts and strategic leaders, the designated professionals for safeguarding and looked after children provide a vital source of advice to the CCG, NHS England, the Local Authority, Local Safeguarding Children Board and Police. They also provide advice and support for health professionals in provider organisations and independent contractors. The Designated Nurses for Safeguarding Children have this year re-established the Cheshire Safeguarding Professionals Network, bringing together named and designated professionals to share best practice.

The Designated Nurses Safeguarding Children have worked with NHS England and NHS Digital to progress the Child Protection – Information Sharing (CP-IS) system implementation by the providers and local authorities. Although the system is not yet fully implemented, all Cheshire providers and local authorities have made progress.

**Quality Outcomes for Children**

The CCG’s main safeguarding focus over the last year has continued to be on improving the quality of the health service’s contribution to support and protect children, through further developing the safeguarding standards which are included in NHS provider contracts. These include standards relating to Child Sexual Exploitation, Female Genital Mutilation, Prevent, Domestic Abuse and development of multi-agency integrated working in respect of front line staff. The standards set out requirements for organisations to have a well-trained workforce with robust safeguarding policies and procedures, including supervision that enables staff to take action when they identify any child who is in need of support or protection. Each organisation is required to complete an annual self-evaluation safeguarding audit. These are formally monitored for quality by the CCGs and a formal escalation process initiated when standards are not met.

Designated Professionals have worked with local authority partners to agree a common approach across organisations in relation to quality and monitoring in 2016-17. The Designated Nurses work closely with Public Health colleagues to support the quality of safeguarding within their NHS providers.

The CCG has produced a set of ‘dashboards’ for use by its main providers. These dashboards serve a dual purpose in both reporting on safeguarding activity, e.g. number of child protection medicals undertaken, and on quality, e.g. number of child protection medicals reported on within 72 hours. The dashboard information is formally monitored through quarterly safeguarding assurance meetings held by the CCG with its main providers. The dashboard information includes indicators set by the CCG in response to national and also Local Safeguarding Children Board (LSCB) priorities. For example ‘early help’ is seen as a key strategy in providing help for children and families when problems are first recognised, so preventing escalation into the child protection system.

**Inspections**

CQC carried out a review of health services for children looked after and safeguarding in Cheshire East. They identified a strong safeguarding culture across the health community alongside visible and effective leadership. An action plan is in place to address areas for development and improvement which is monitored through safeguarding assurance meetings.

**Multi-agency working**

As part of its role in working to safeguard children and vulnerable people, the CCG has developed a strong partnership working ethic and has contributed to the work of the Health and Well-Being Board, Children’s Trust Boards, Corporate Parenting Panel and to the LSCB and all of its sub groups. This has included the work of the Child Death Overview Panel, the multi-agency audit and case review process, including Serious Case Reviews and Practice Learning
Reviews, quality assurance and outcomes sub groups.

Promoting quality of the services provided for individual children and young people at risk or in care is integral to CCG and multi-agency working.

NHS Eastern Cheshire CCG has continued to work in partnership with Cheshire East Council in developing the multi-agency safeguarding hub and in particular facilitating the involvement of health providers. This has led to improved sharing of information and decision making about children and young people who are vulnerable and have been referred for support or safeguarding.

Audit

The CCGs have undertaken a Section 11 audit (which considers delivery of the statutory duty to safeguard and promote the welfare of children) and demonstrated that their statutory children’s safeguarding responsibilities have been met under section 11 of the Children Act 1989. The audit outcomes have been reported to the LSCB as part of their quality assurance process. In addition, the CCG has completed the NHS England Safeguarding Assurance Tool this year, providing assurance on the safeguarding standards in place.

As Child Sexual Exploitation (CSE) champion, the Designated Nurse has taken part in multi-agency CSE case audit. The Named GPs (who are funded by NHS England), Designated Nurses and Doctors for safeguarding children have contributed to all multi-agency safeguarding audits.

How we have captured the voice of the child

The quality of safeguarding is enhanced when children and young people are kept at the heart of services provided.

The CCG is committed to listening to the voice of young people when commissioning health care services. We work closely with youth advisors that have been drawn together from Cheshire schools, local employers and organisations representing young people. They engage young people in describing how services work for them and how they could be improved. The CCG has included ‘the voice and lived experience of the child’ in its safeguarding standards and expects its providers to evidence that this is being done in the course of their work. Patient stories evidencing the lived experience of children are being presented at the quarterly safeguarding assurance meetings by providers.

Safeguarding in GP Practice

During the year there have been changes to the Named GP team across NHS Eastern Cheshire CCG, NHS Vale Royal CCG and NHS South Cheshire CCG. The two Named GPs now job share and work across all CCGs to support GPs and practices to safeguard children and young people. The safeguarding forums for GP safeguarding leads and practice managers have continued during 2016 / 17. A number of multi-agency partners e.g. social workers, IDVA practice educator and others have attended the forums during the year to improve links with GP practices.

Designated Doctor Safeguarding Children

The Designated Doctor has been in post since July 2016 in accordance with statutory requirements (DH 2015). This post covers both NHS Eastern Cheshire CCG and NHS South Cheshire CCG areas.

Cared for Children

NHS Eastern Cheshire CCG in collaboration with NHS South Cheshire CCG commissioned a 16+ and Transition Specialist Nurse. She took up the post in July 2016 and is working to address priority areas for this vulnerable group of 16-25 year olds.

The Designated Nurse for Cared for Children in Eastern Cheshire has established stronger links with the Cheshire East Health and Well-being Board and a six monthly reporting process is becoming established. A number of changes to the commissioning arrangements for the Cared for Children’s Health Team have reduced the risks associated with sharing 0-19 community health information and continuity of care.
Work continues across Eastern and South Cheshire CCG areas, Cheshire East Local Authorities and health providers to further improve joint processes to share information and improve the timeliness of initial and review health assessments. This has included a root cause analysis in relation to delays with requesting and completing Initial Health Assessments and some positive recommendations for practice.

Recent changes within the Safeguarding Team have provided an opportunity to reconfigure the Designated Nurse Looked After Children role across Cheshire thus avoiding the conflict of interest raised by the Care Quality Commission inspection (Sept, 2016).

**Promoting innovation**

In accordance with its key programme of work to secure continuous service improvement in primary care mental health, the CCG in 2016-17 designed and undertook the commissioning of community-based service for people with low to moderate symptoms of stress, anxiety and depression. A contract to provide the Talking Therapies service was awarded to the Big Life group and Peaks & Plains Housing Trust. In an innovative approach to mental health services, the Big Life Group provides clinical interventions including cognitive behavioural therapy while Peaks & Plains supports people with issues that can cause or worsen mental health problems. A contract to provide the Talking Therapies service was awarded to the Big Life group and Peaks & Plains Housing Trust.  

**Promoting Education and Training**

As a CCG, we have a duty when exercising our functions to have regard for the need to promote education and training for our employees (Section 14Z NHS Act 2006). We actively encourage our employees to attend organisational and personal development opportunities. We have adopted an annual appraisal system and development of learning plans in order to support performance and development of our employees, which is further underpinned by regular 1-1s with line managers.

The CCG is a member of regional training / learning bodies such as the North West Leadership Academy and Advancing Quality Alliance (AQuA). CCG employees also have access to an extensive catalogue of online training courses which are hosted on the online Learning and Development Academy, operated by the Midlands and Lancashire Commissioning Support Unit. As a CCG we have supported a number of employees to complete the Mary Seacole and Nye Bevan Leadership courses.

The CCG also provides opportunity for University students to undertake a yearlong business placement with the various teams of the CCG. In its third year of student placements, the CCG has had two students working closely with CCG staff on a number of key programmes of work. Working within the CCG has helped students understand the varied roles available in the NHS but also provided them with valuable experience, skills and training that they can utilise when returning to University. The CCG has also benefitted from the enthusiasm and hard work undertaken by the students.

Both students have, in 2016-17, been instrumental in establishing a Care Homes Quality Improvement Collaborative within Eastern Cheshire, which brings together the area’s care home managers every six weeks to agree small-scale changes to improve outcomes for residents. Subjects on which collective action have been agreed include:

- **Advanced care planning**
- **Preventing pressure ulcers**
- **Falls prevention**
- **Effective management of dementia.**

47 https://www.thebiglifegroup.com/talking-therapies-eastern-cheshire/
Improving outcomes, experience and use of resources by identifying and addressing unwarranted variation is a key principle within ‘Leading Change, Adding Value.’ For many this is a new way of working. There is a need to help build the knowledge and skills within the nursing, midwifery and care workforce in order to support colleagues to identify unwarranted variation in practice, and lead the changes required to address this.

General Practice Nurses (GPN) can feel isolated and do not have the support or benefits from working in a large organisation, and this is manifest in a lack of training infrastructure, development and opportunity. The General Practice Nurse Leadership course, co-produced by NHS Eastern Cheshire and NHS South Cheshire CCGs, has been recognised as leading edge and is being adopted by Health Education England. Academic evaluation from Coventry University showed clear evidence of achievement in all levels of the Kirkpatrick framework i.e. positive learning experience, learning evidence, behavioural change and improvement in practice. The GPN were delighted to receive a personal invitation from the Chief Nursing Officer, Jane Cummings, to present the programme at the CNO Nursing Congress in March 2017. We maintain our links with local Universities and are keen to encourage emerging new roles e.g. Nursing Associates and apprenticeships.

We continue to develop and facilitate bespoke regular clinical training for General Practice Nurses for both registered nurses and Health Care Assistants (HCAs). Attendance has been excellent with 367 delegates attending in 2016-17. GPNs and HCAs have been represented from all practices showing a good level of engagement. Training has also been opened up to GPs where appropriate, for example for cytology update.

Diabetes and Respiratory forum events are held every month in the evening allowing GPNs to access further training. These events are used to continually upskill the GPNs and allow for clinical supervision.

This is instrumental in narrowing quality gaps in practice, sharing good ideas, solving issues and developing protocols and guidelines across the CCG. We have 5 Cluster Nurse leads who work together with the CCG practice nurse co-ordinator to share innovative practice, disseminate key National evidence, direction and local information and work on clinical quality projects to improve the quality of care to our population.

Risk Management and principal risks and uncertainties

The CCG adopts an embedded risk management framework, as detailed in the annual governance statement. On page 82 the Annual Governance Report identifies key risks and uncertainties together with related controls.

The CCG’s monthly Governing Body Assurance Framework provides the Governing Body with an up to date picture of key performance risks and progress against key targets. Throughout the year the Governing Body has received a number of deep dive presentations around key areas on the assurance framework which provide the opportunity for greater scrutiny and explanation of key issues that can affect the CCG’s performance. Page 77 of the Annual Governance Report details further the deep dive topic presentations received by the Governing Body during 2016-17.

Equality Report

NHS Eastern Cheshire CCG strives to commission services that meet the needs of all our communities, improving access and outcomes for residents and communities throughout Eastern Cheshire. We are dedicated to developing an organisational culture that promotes inclusion and embraces diversity, ensuring that the focus on equality is maintained and strengthened across the local NHS. This includes addressing health inequalities and embedding equality values into all commissioning activity. Our aim is to provide equality of opportunity to all our patients, their families and carers and to proactively eliminate direct or indirect discrimination of any kind.

A key principle of the NHS Constitution is that:

‘the NHS provides a comprehensive service, available to all - irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population’.

Equality is about creating a fairer society where everyone can participate and has the opportunity to fulfil their potential. This means treating individuals in a way that is appropriate to their needs, with dignity and worth regardless of their protected characteristics. Diversity builds on equality.

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48 https://www.england.nhs.uk/leadingchange/
49 https://www.england.nhs.uk/cnosummit/
and focuses on how individual differences and their strengths can be valued for the benefit of both society and the individual. Equality and diversity are not interchangeable but are interdependent. There is no advancement of equality if difference is not recognised and valued.

**Public Sector Equality Duty**

The CCG is required to pay due regard to the Public Sector Equality Duty (PSED) as defined by the Equality Act 2010. Failure to comply has legal, financial and reputational risks. Under the duty, the CCG is required to pay ‘due regard’ to eliminating unlawful discrimination, advancing equality of opportunity and fostering good relations between people who share protected characteristic(s) and those who do not, when carrying out its activities. It covers leadership and governance, decision making, policy development, budgeting, procurement and employment process. The CCG is also required to set equality objectives at least every four years, and publish at least annually information relating to compliance with the PSED.

In 2016-17 the CCG has taken the PSED in to account by regularly undertaking Equality Impact and Risk Assessments (EIRAs) on projects and service redesign programmes, and by completing the Equality Delivery Systems 2 (EDS2) toolkit in early 2017. The CCG also published an Equality and Diversity Annual Report 2016-17 articulating progress on the equality objectives, and this report sets out in detail how CCG is compliant with the PSED.

Over the last year the organisation has worked towards achieving the CCG’s 2015-19 equalities objectives:

- **improve commissioner understanding of the populations we serve**
- **ensure accessibility to services and information**
- **demonstrate a commitment to Equality and Diversity through training and development at all levels of the organisation**
- **ensure equality of opportunity in employment and training provision.**

Since April 2016, the CCG’s equality and diversity work has been supported by a Business Partner from the Midlands and Lancashire Commissioning Support Unit who has visited the CCG weekly to advise staff on completion of EIRAs and assisted with general equality matters. The CCG adopted the updated EIRA process introduced by the CSU, and training sessions for staff involved in designing, commissioning and monitoring of services were organised to demonstrate the process. Completed EIRAs are available for the public to see on the CCG’s website.

The annual EDS2 assessment was completed with staff and stakeholders, and following this, an Equality and Diversity Plan was developed with an action plan informed by the outcomes of the EDS2 assessment, and driven by the agreed equality objectives. The plan is available on the website.

The equality section of the CCG website had not been dated for some time, and was in need of a refresh. Given the developments and emergence of new initiatives and regulations with regards to equalities and inclusion, this section of the website was updated to include recent developments. The communications and engagement team over the year worked to engage with communities all over Eastern Cheshire via consultation and engagement exercises and through meeting with local community groups. The team led on two substantial pieces of engagement activity in the last year:

- **engagement on a draft policy to reduce consultations and prescriptions for minor conditions suitable for self-care**
- **12-week consultation on proposed changes to the Service Review Policy.**

In both exercises, efforts were made to engage with protected characteristic groups and others such as carers and those from low-income backgrounds. The questionnaires seeking responses from participants in the engagement processes included an equalities monitoring form which was completed by most respondents. Data collected through this form provided the team and service redesign managers with a better understanding of the individuals and communities which had been reached, and also identified gaps where more needed to be done. Looking ahead the team will consider innovative ways of more effectively reaching protected characteristic groups as well as other disadvantaged groups for involvement with the CCG’s work.

The CCG continued to support the community Joint Strategic Needs Assessment (JSNA) work.
being undertaken by CVS Cheshire East on behalf of NHS Eastern and South Cheshire Clinical Commissioning Groups and Cheshire East Council. This data gathered through the JSNA informs the CCG’s work to reduce disadvantages in accessing services and information for our most marginalised and hard to reach groups.

The CCG has continued to buy in audio support for Governing Body and Eastern Cheshire HealthVoice meetings to ensure that people with hearing impairments are not disadvantaged. This year the CCG also procured a portable hearing loop system for smaller meetings to be held in-house.

Equality Delivery System 2

NHS Eastern Cheshire CCG uses the Equality Delivery System 2 (EDS2) developed by and for the NHS to assess performance and demonstrate compliance against the Public Sector and General Equality Duty. It is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

At the heart of the EDS2 is a set of 18 outcomes grouped into four goals known as the EDS Outcomes Framework. These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. The four EDS2 goals are:

- **better health outcomes for all**
- **improved patient access and experience**
- **empowered, engaged and included staff**
- **inclusive leadership at all levels.**

The outcomes in full within the goals (or a selection of them) are assessed annually and graded as per the following categories:

- **Undeveloped** if there is no evidence one way or another for how a protected group of people fares, or if evidence shows that the majority of people in only two or fewer protected groups fare well
- **Developing** if evidence shows that the majority of people in three to five protected groups fare well
- **Achieving** if evidence shows that the majority of people in six to eight protected groups fare well
- ** Excelling** if evidence shows that the majority of people in all nine protected groups fare well.

The local approach to EDS2

This year the CCG completed the EDS2 assessment in February 2017. The assessment was completed with the support of a stakeholder panel which included CCG and CSU members of staff, Lay Member for PPI, representation from HealthVoice and CVS Cheshire East, and individuals from some of the protected characteristics groups.

It is worth noting that while the EDS2 tool is mandated for commissioning and provider organisations, not all 18 outcomes contained within it are directly applicable to CCGs. In this regard a view was taken following advice provided by the MLCSU Equality and Inclusion Business Partner to focus efforts on gathering evidence around six outcomes this year. The outcomes were identified based on availability of evidence (case studies, examples of good practice etc.) to demonstrate progress.

Following the collation of evidence for each of the respective outcomes to be assessed, a self-assessment was undertaken internally and provisional grades were awarded. The evidence and provisional grades were then shared with the EDS2 stakeholder panel...
by email in advance of the assessment meeting so as to provide them with the time to review. At the assessment meeting, an opportunity was provided to all those present to feedback their views on the evidence and grading, and ask questions of relevant CCG managers for clarification.

Overall the discussion with the stakeholder panel was productive and insightful, and they provided robust challenge where required. The need for greater engagement across the protected characteristics spectrum was highlighted, as was the need to engage with other disadvantaged groups.

The results of the CCG’s EDS2 assessment can be seen in the Figure Eighteen alongside the key providers’ results from East Cheshire NHS Trust and Cheshire and Wirral Partnership NHS Foundation Trust.

Monitoring the Equality and Diversity performance of our key NHS providers

The Quality Schedule contained within the CCG’s contracts with local providers includes an equalities clause which places various obligations on providers.

In 2016-17 providers were expected to:

- formulate an Equality Objectives Plan
- complete an EDS2 assessment covering at least five outcomes

![Figure Eighteen: EDS2 results 2016-17 by Organisation](image-url)

- provide evidence of compliance with the Equality Act 2010 specific duties; and including the implementation of the WRES
- ensure that any service redesign or changes only take place following an appropriate equalities assessment and that they demonstrate due regard to the PSED
- provide data on the use of translation and interpretation services.

The CCG has worked with providers to help ensure that they are meeting their obligations under the PSED, including completing the EDS2 assessment. The CCG’s contracts monitoring team, through regular meetings, assesses the progress of providers on all aspects of the contract, including equalities.
Equality and diversity as an employer

As an employer, the CCG is committed to ensuring that we have a diverse workforce by providing fair and equal access to all NHS Eastern Cheshire CCG jobs, including access to career development and training opportunities for existing and future staff. In the last year the CCG has continued to promote a recruitment pack that provides in-depth information about the benefits of working for the NHS and NHS Eastern Cheshire CCG, and commissioned the creation of short film of our staff outlining why they enjoy working for NHS Eastern Cheshire CCG. The organisation is committed to ensuring the working environment is inclusive and appropriate support is provided to any member of the organisation that may require it. The CCG has continued to ensure that robust arrangements are in place for staff to report any occasions where they or their colleagues have been subject to any intentional or unintentional discrimination in the workplace or when undertaking their duties when representing the CCG. All of the CCG’s internal workforce policies have been developed in line with current legislative requirements, including the Equality Act 2010. These policies cover the recruitment, selection and appointment process as well as all aspects of working for the CCG.

Further demonstrating the CCG’s commitment to having a representative and supportive workforce, the CCG continues to be signed up to the following Quality Standards:

- **Two Ticks Disability Symbol**
- **Mindful Employer**

Patient and Public Involvement

The CCG has a duty under Section 14Z2 of the NHS Act 2006 (as amended) to involve the public in commissioning. Throughout the Annual Report and Accounts 2016-17 we have highlighted various examples describing the ways in which we have informed our public, encouraged our public to participate in the work of the CCG and raised awareness around important health and care issues.

The CCG’s approach to communications and engagement is intended to achieve three key outcomes:

- a more informed and better engaged patient and carer population actively involved with the CCG
- increased ownership of and involvement in the CCG by member practices
- enhanced local and national reputation and perception of the CCG, built up through promotion of positive news stories.

Throughout 2016-17 the CCG has continued to support the development and operation of Eastern Cheshire HealthVoice, which is the public, patient and carer reference group for the CCG and which operates as an advisory committee to the CCG Governing Body. The HealthVoice group is a key route for public participation and involvement in the work undertaken by the CCG and has an influential voice in how we plan, prioritise and monitor the services that we commission. HealthVoice meets as a forum every eight weeks and Figure Nineteen demonstrates how the CCG and HealthVoice receives feedback and input from the many groups and organisations who have a remit, for or interest in, public engagement and participation.

Figure Twenty shows an overview of how members of HealthVoice play a proactive part in the development of CCG policies and strategies, have been instrumental in the prioritisation of the CCG commissioning intentions and provide public/patient representation on a variety of CCG meetings and groups. Members of HealthVoice have also provided insight and support to a number of work areas and the day to business of the CCG. The views and work of the HealthVoice membership are reported back via one of the CCG’s Lay Members for Public and Patient Involvement at the subsequent Governing Body meeting following a HealthVoice meeting.

In 2016-17, the communications and engagement team ran a number of engagement and involvement campaigns throughout Eastern Cheshire. These included a five-week period of public and stakeholder engagement on a draft policy to limit prescribing of over-the-counter medicines for minor, self-limiting conditions. Moreover, the CCG joined with four other Cheshire and Wirral CCGs to conduct a formal, 90-day consultation on proposals to restrict access to the services having the lowest impact on patient care, thereby helping the
CCGs achieve financial balance while protecting vital services, including urgent and emergency care. Both online and offline platforms were used in each of the engagement exercises to provide opportunities to the local population for participation and involvement. Online surveys were developed and promoted, while paper copies were printed and circulated in GP surgeries and other community locations; focus groups and drop-in sessions were held to allow face to face engagement; and opportunities for involvement were proactively promoted through various local media.

Nearly 500 people responded to the over-the-counter medicines engagement exercise, and the vast majority of questionnaires were completed online. The communications and engagement team held seven community engagement events across the CCG area and attended various Patient Participation Group (PPG) meetings to encourage people to take part.

Over the course of the 90-day consultation on proposals to restrict access to services, over 1800 people responded from across Cheshire and Wirral, of which 460 were from Eastern Cheshire. The majority of responses were received online but a sizeable number were submitted via the printed questionnaires. Five engagement events were organised in the form of drop in sessions and focus groups, and these were promoted through local media and on the CCG website.


Over the last year, patient and public advisory groups were established for two key programmes of work; Continuing Health and Complex Care and Caring Together. These advisory groups provide a platform for those with a keen interest in specific programmes of work to get involved and help shape and influence decisions that are made.

Patient representatives have continued to play a vital role in 2016-17 with regards to service redesign in the CCG. Almost all directorates in the CCG and most projects have
benefitted from direct patient representative involvement and this is expected to increase in the next year.

The communications and engagement team has continued to represent the CCG at various public events of all descriptions across Eastern Cheshire. Public meetings, PPG meetings, patient conferences and market places have all played host to a CCG presence and have afforded the organisation an opportunity to communicate its messages widely. Working collaboratively with partners on projects of mutual interest and benefit to communities has also helped raise the profile of the CCG and provided opportunity to attract wider public interest.

The communications and engagement team achieved increased involvement of member practices in various
ways including publication of the fortnightly Members’ News, external promotion of innovative work undertaken by practices, online advertising of vacancies in practices, and marking International Nurses’ Day by hand delivering cupcakes to all practice nurses in recognition of their fantastic work. Social media coverage of the visits went viral.

The CCG engages regularly with key audiences to review its approach to communications. For example, in January 2017 staff were surveyed on the effectiveness of internal communications mechanisms. Findings were universally positive and included the fact that 89% of colleagues found the fortnightly staff newsletter useful while 81% were similarly supportive of the monthly staff briefing. Informal weekly middle-of-the-room briefings were considered useful by 78% of staff while 96% of colleagues said the frequency and times of briefings were convenient. Nevertheless, employees made recommendations that have been adopted by Executive Team. For example, since February 2017 the agenda of the monthly briefings has included links to relevant Governing Body reports and presentations made to external audiences, together with an opportunity for Executive Team members to answer questions submitted by colleagues beforehand.

Similarly, in December 2016, the communications and engagement team published a survey to measure partner understanding of and interest in the Caring Together transformation programme, together with effectiveness of communications channels and the extent to which partners wished to participate in the integration of health and social care. The survey was promoted to CCG staff and to employees of:

- Cheshire East Council
- Cheshire and Wirral Partnership NHS Foundation Trust
- East Cheshire NHS Trust.

Of those who responded, more than two thirds said they understood the principles of what Caring Together was trying to achieve while 96% said they were interested in the programme. More than 70% of respondents identified the monthly Caring Together newsletter as their preferred method of keeping informed while 21% expressed an interest in becoming actively involved in the programme. Actions resulting from the survey included a refresh of a database of prospective Caring Together champions who had expressed an interest in supporting any public engagement or consultation planned by the programme.

The CCG Communications and Engagement team enhanced the CCG’s reputation by securing publicity in national publications for the short listing of the Caring Together programme and Cheshire Care Record for national awards, and for Bollington Medical Centre’s winning of two awards for medical research. In addition, the team contract managed, on behalf of the Cheshire Care Record partner agencies, the contract that was awarded to NHS Midlands and Lancashire...
Commissioning Support Unit on behalf of the Cheshire Pioneer Programme to promote the Cheshire Care Record.

In 2017-18, the CCG will continue its efforts to ensure that its population is well communicated and engaged with as the CCG considers the future of health and care services in Eastern Cheshire and undertakes consultation on local health services.

**Sustainability**

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of the rising cost of natural resources.

CCG policies and strategies, such as flexible working, lease car polices and our Information and Communication Technology strategy contribute towards meeting our sustainability obligations.

Eastern Cheshire has developed a Local Digital Roadmap which details the actions to deliver the ambition of being paper-free at the point of care by 2020 as outlined by NHS England’s Five Year Forward View. Local Digital Roadmaps will generate momentum and drive transformation across local health economies, inform local investment priorities and support local benefit realisation strategies.

The CCG will continue to work towards ensuring that it meets its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

The CCG recognises that its biggest impact can be made with regards to how it commissions and procures services. The CCG is committed to ensuring that within all of its commissioning and procurement processes it will ask all of its providers to ensure that they are committed to delivering the sustainability agenda. The CCG also believes that little changes can also make a difference and constantly reviews how changes to the operation of its office can help contribute towards sustainability. For example, implementing new policies and processes for the use of CCG photocopiers and printers has resulted in a reduction in associated costs for the CCG. Expenditure in 2016-17 was 8% less than in 2014-15 despite a 43% increase in the number of staff employed by the CCG within this same period, and despite an increase in costs for products.

We lease our office building from NHS Property Services and our business address is New Alderley House, Victoria Road, Macclesfield. It is based on the Macclesfield District General Hospital site which is run by East Cheshire NHS Trust. We do not have access to information such as our utilities usage for 2016-17.

**Performance Report Self Certification, Accountable Officer**

We certify that the Clinical Commissioning Group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended). We certify that the Clinical Commissioning Group has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2015. The Clinical Commissioning Group regularly reviews and makes improvements to its major incidence plan, proportionate to its duties/responsibilities as a category two responder, and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

**Signed**

**JERRY HAWKER**
Chief Officer (Accountable Officer)
30 May 2017

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64 http://www.legislation.gov.uk/ukpga/2012/3/enacted
Members’ Report

This report is prepared by the Governing Body on behalf of the members.

Our Member practices

Figure Twenty One includes details of the 23 GP Practices that comprise the membership of NHS Eastern Cheshire CCG.

Figure Twenty One: CCG member GP Practices

<table>
<thead>
<tr>
<th>Locality Peer Group</th>
<th>Member Practices</th>
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<tbody>
<tr>
<td>Alderley Edge, Chelford, Handforth, Wilmslow</td>
<td>Alderley Edge Medical Practice, Chelford Surgery, Handforth Health Centre, Kenmore Medical Centre, Wilmslow Health Centre</td>
</tr>
<tr>
<td>Bollington, Disley, Poynton</td>
<td>Bollington Medical Centre, McIlvride Medical Practice, Priorsleigh Medical Centre, The School House Surgery</td>
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<tr>
<td>Congleton, Holmes Chapel</td>
<td>Holmes Chapel Health Centre, Lawton House Surgery, Meadowside Medical Centre, Readesmoor Group Practice</td>
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<tr>
<td>Knutsford</td>
<td>Annandale Medical Centre, Manchester Road Medical Centre, Toft Road Surgery</td>
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<tr>
<td>Macclesfield</td>
<td>Broken Cross Surgery, Cumberland House, High Street Surgery, Park Green Surgery, Park Lane Surgery, South Park Surgery, Vernova Healthcare CIC</td>
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</table>

Chair and Accountable Officer

For the year 2016-17 the office of Clinical Chair of the CCG has been held by Dr Paul Bowen and Chief Officer (Accountable Officer) of the CCG by Jerry Hawker.

Governing Body

Figure Twenty Two indicates the composition of the Governing Body of NHS Eastern Cheshire CCG during the year 2016-17.

Figure Twenty Two: CCG Governing Body members

<table>
<thead>
<tr>
<th>Governing Body</th>
<th>Member Position</th>
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<tbody>
<tr>
<td>Dr Paul Bowen</td>
<td>GP Chair</td>
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<tr>
<td>Jerry Hawker</td>
<td>Chief Officer</td>
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<tr>
<td>Alex Mitchell</td>
<td>Chief Finance Officer</td>
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<td>Dr Alex Garvey</td>
<td>General Practice Locality Peer Group Lead</td>
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<td>Dr Robert Thorburn* (from 1 June 2016)</td>
<td>General Practice Locality Peer Group Lead</td>
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<td>Julie Sercombe* (until 1 June 2016)</td>
<td>General Practice Locality Peer Group Lead</td>
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<td>Dr Mike Clark</td>
<td>General Practice Locality Peer Group Lead</td>
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<td>Dr Jennifer Lawn</td>
<td>General Practice Locality Peer Group Lead</td>
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<td>Warren Tuite* (until 1 August 2016)</td>
<td>General Practice Locality Peer Group Lead</td>
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<td>Laura Beresford* (from 21 September 2016)</td>
<td>General Practice Locality Peer Group Lead</td>
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<td>Gill Boston</td>
<td>Lay Member (Public and Patient Involvement)</td>
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<tr>
<td>Bill Swann* (until 31 Aug 2016)</td>
<td>Lay Member (Public and Patient Involvement)</td>
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<tr>
<td>Gerry Gray</td>
<td>Lay Member (Governance &amp; Audit) Deputy Chair</td>
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<tr>
<td>Jane Stephens* (from 12 Sept 2016)</td>
<td>Lay Member (Public and Patient Involvement)</td>
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<tr>
<td>Sally Rogers</td>
<td>Registered Nurse</td>
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<tr>
<td>Duncan Matheson</td>
<td>Secondary Care Doctor</td>
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<tr>
<td>Julie Sin</td>
<td>Consultant in Public Health Medicine</td>
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* Member served for part of the year and did not stand for re-election
Members of the Governing Body without a vote are Neil Evans, Commissioning Director and Fleur Blakeman, Strategy and Transformation Director.

A biography of each member of the Governing Body can be seen on page 82.

At the year end, the CCG Governing Body had eight male and six female voting members. There are two members of the Governing Body without a voting right, one female and one male member. There have been 22 Governing Body meetings (Annual General Meeting included in this number) during 2016-17, 10 have been held in public and 12 have been in camera. All meetings have been held with a quorate membership. (Figure Twenty Three).

### Figure Twenty Three: CCG Governing Body Member meeting attendance record

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<td>Duncan Matheson</td>
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<td>Julie Sin</td>
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<td>Neil Evans</td>
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<td>Fleur Blakeman</td>
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** Also included Annual General Meeting

- **Attended**
- **Absent**
- [ ] Meeting took place in camera
- **Member no longer in position**
- **Meeting took place before member was in position**
Governance and Audit Committee Membership

*Figure Twenty Four* details the composition of the Governance and Audit Committee as at 31 March 2017.

**Figure Twenty Four: Membership of the Governance and Audit Committee**

<table>
<thead>
<tr>
<th>Committee Member (Voting)</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gerry Gray</td>
<td>Lay Member for Governance &amp; Audit (Chair)</td>
</tr>
<tr>
<td>Gill Boston</td>
<td>Lay Member for Public and Patient Involvement</td>
</tr>
<tr>
<td>Bill Swann</td>
<td>Lay Member for Public and Patient Involvement (until 31 Aug 2016)</td>
</tr>
<tr>
<td>Dr Alex Garvey</td>
<td>General Practice Locality Peer Group Lead</td>
</tr>
<tr>
<td>Dr Jennifer Lawn</td>
<td>General Practice Locality Peer Group Lead</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In attendance</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alex Mitchell</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>Mike Purdie</td>
<td>Corporate Programmes and Governance Manager</td>
</tr>
</tbody>
</table>

A biography of each voting member of the Governance and Audit Committee can be seen on page 82.

Clinical Quality and Performance Committee Membership

*Figure Twenty Five* details the composition of the Clinical Quality and Performance Committee as at 31 March 2017.

**Figure Twenty Five: Membership of the Clinical Quality and Performance Committee**

<table>
<thead>
<tr>
<th>Committee Member (Voting)</th>
<th>Position</th>
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<tbody>
<tr>
<td>Gill Boston</td>
<td>Lay Member for Public and Patient Involvement</td>
</tr>
<tr>
<td>Dr James Milligan</td>
<td>CCG GP Quality Lead</td>
</tr>
<tr>
<td>Duncan Matheson</td>
<td>Governing Body Member - Secondary Care Doctor</td>
</tr>
<tr>
<td>Dr Jennifer Lawn</td>
<td>General Practice Locality Peer Group Lead (Chair)</td>
</tr>
<tr>
<td>Dr Julia Huddart</td>
<td>Executive GP for Clinical Leadership Team</td>
</tr>
<tr>
<td>Sally Rogers</td>
<td>Governing Body Member - Registered Nurse &amp; Interim Quality and Safeguarding Director</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In attendance (Unable to vote)</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neil Evans</td>
<td>Commissioning Director</td>
</tr>
<tr>
<td>Jacki Wilkes</td>
<td>Associate Director of Commissioning</td>
</tr>
<tr>
<td>Andrew Binnie</td>
<td>Quality Performance Manager</td>
</tr>
</tbody>
</table>

A biography of each voting member of the Clinical Quality and Performance Committee can be seen on page 82.

Remuneration Committee Membership

Details of the composition of the Remuneration Committee are set out in the Remuneration Report.

A biography of each voting member of the Remuneration Committee can be seen on page 100.


Eastern Cheshire Primary (General Medical) Care Commissioning Committee Membership

Figure Twenty Six details the composition of the Eastern Cheshire (General Medical) Care Commissioning Committee as at 31 March 2017.

Figure Twenty Six: Membership of the Eastern Cheshire Primary (General Medical) Care Services Commissioning Committee Membership

<table>
<thead>
<tr>
<th>Committee Member (Voting)</th>
<th>Position*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gill Boston (Chair)</td>
<td>Lay Member for Public and Patient Involvement</td>
</tr>
<tr>
<td>Bill Swann (Vice Chair) (until 31 Aug 2016)</td>
<td>Lay Member for Public and Patient Involvement</td>
</tr>
<tr>
<td>Jane Stephens (Vice Chair) (12 Sept 2016)</td>
<td>Lay Member for Public and Patient Involvement</td>
</tr>
<tr>
<td>Jerry Hawker</td>
<td>Chief Officer</td>
</tr>
<tr>
<td>Joanne Morton</td>
<td>General Practice Representative</td>
</tr>
<tr>
<td>Dr Mike Clark</td>
<td>General Practice Representative</td>
</tr>
<tr>
<td>Dr Jennifer Lawn</td>
<td>General Practice Representative</td>
</tr>
<tr>
<td>Dr Victoria Buckley</td>
<td>General Practice Representative</td>
</tr>
<tr>
<td>Warren Tuite (until 1 Aug 2016)</td>
<td>General Practice Representative</td>
</tr>
<tr>
<td>Laura Beresford (from 21 Sept 2016)</td>
<td>General Practice Representative</td>
</tr>
<tr>
<td>Alex Mitchell</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>Neil Evans</td>
<td>Commissioning Director</td>
</tr>
<tr>
<td>Fleur Blakeman</td>
<td>Strategy &amp; Transformation Director</td>
</tr>
<tr>
<td>Sally Rogers</td>
<td>Governing Body Member - Registered Nurse &amp; Interim Quality and Safeguarding Director</td>
</tr>
</tbody>
</table>

In attendance

<table>
<thead>
<tr>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>Glenn Coleman Head of Primary Care, NHS England</td>
</tr>
<tr>
<td>Caroline O’Brien Healthwatch Cheshire East Representative</td>
</tr>
<tr>
<td>William Greenwood Cheshire Local Medical Committee Representative</td>
</tr>
<tr>
<td>Cllr Janet Clowes Cheshire East Health &amp; Wellbeing Board Representative</td>
</tr>
<tr>
<td>Lucy Heath Cheshire East Public Health Representative</td>
</tr>
<tr>
<td>John Adams Finance Manager, NHS England</td>
</tr>
</tbody>
</table>

*Governing Body member, staff member or member practice representative of NHS Eastern Cheshire CCG unless identified otherwise.

A biography of the CCG voting member of the Eastern Cheshire Primary (General Medical) Care Commissioning Committee can be seen on page 82.

Register of Interests

The CCG maintains a register of interest and publishes this on its website. It is updated on a quarterly basis. The Register of Interests can be found at:

https://www.easterncheshireccg.nhs.uk/Meetings/managing-conflicts-of-interest.htm

Political and charitable donations

In 2016-17 the CCG made charitable donations amounting to £0. No political donations were made.

Events since the year end

No significant events have occurred between the year end and the date of this report that affect the CCG.
**Likely future developments**

Likely future developments are set out throughout the performance report included within this annual report.

**Research and development**

As a commissioning organisation, we do not carry out research and development activities ourselves, but we have commissioned external organisations to carry out clinical research on our behalf.

**Branches outside UK**

We have no branches outside the UK.

**Pension liabilities**

Details of pension liabilities are set out in note 4 to the financial statements.

**External Auditor**

The external auditor in the year was Grant Thornton LLP. Fees for external audit services are set out in note 5 to the financial statements. These fees relate to the audit of the financial statements and the provision of a statutory report on value for money. No further assurance services or other services were provided by external auditors.

**Serious untoward incidents**

As identified in the Annual Governance Report on page 61 there have been no serious untoward incidents in relation to data losses.

The CCG has a well-developed process for overseeing Serious Incidents and Never Events to ensure it complies with its obligations under the 2015 ‘Serious Incident Framework’ to quality assure the services it commissions by holding providers to account for the robustness of their responses to Serious Incident investigations.

The Serious Incident Sub-Committee of the CCG’s Clinical, Quality and Performance Committee meets monthly to review the reports and action plans prepared by providers in response to Serious Incidents (including Never Events) to ensure that a robust investigation has been undertaken that identifies why the incident occurred and sets out what changes will be made to prevent the situation from occurring again. These meetings are attended by representatives of the CCG’s main providers (East Cheshire NHS Trust and Cheshire and Wirral Partnership NHS Foundation Trust) which allow for a direct feedback route from the committee to the provider. Where it is felt appropriate to the relevant incidents, the Serious Incident Sub-Committee also invites relevant experts from within the CCG, including Safeguarding and clinicians, to ensure that the CCG is undertaking a fully informed scrutiny of any report before signing it off.

The Serious Incident Sub-Committee has overseen 128 Serious Incidents in the 2016-17 year. The majority of these incidents involve our CCG’s patients, although the Serious Incident Sub-Committee has also overseen incidents from East Cheshire NHS Trust that relate to other CCGs’ patients as part of our role as Lead Commissioner for Serious Incidents for this provider. As part of this role, a CCG representative also attends the East Cheshire NHS Trust Serious Incident meeting (known as the SIRI committee) as an observer.

The Serious Incident Sub-Committee has escalated themes of concern to the Clinical, Quality and Performance Committee and the QUAG (Operational Performance Group).

Representatives from the Serious Incident Sub-Committee have also met with the Cheshire Coroner to gain further insight into the interface between Serious Incident investigations and Inquests.

Alongside the work of the Serious Incident Sub-Committee, CCG staff have provided support to providers in completing reports into Serious Incident investigations, including the facilitation of a joint report into an incident involving multiple providers and ongoing support to a Local Authority investigation.

To facilitate and support the sharing of learning across the local system, CCG staff have regularly attended the Cheshire and Merseyside ‘Quality and Safety Forum’, contributing to a joint presentation with East Cheshire NHS Trust in the March 2017 meeting.

The CCG’s Complaints, Incidents and Governance Manager has also been part of a ‘Multi-Organisational Serious Incident Task and Finish Group’ and a ‘Specialised Commissioning Serious Incident Task and Finish Group’ which has created guidance in these two areas to help providers and commissioners in Cheshire and Merseyside manage and learn from these incidents.

A number of ad hoc reviews have been completed at the request of NHS England to support the sharing of learning into emerging trends and themes across the healthcare system. The CCG has also been represented at an NHS England (North) learning event.

**Cost allocation and setting of charges**

The Governing Body of NHS Eastern Cheshire CCG can certify that the CCG has complied with HM Treasury’s guidance on cost allocation and setting of charges for information.
Complaints and Principles for Remedy

NHS Eastern Cheshire CCG believes that the effective management of complaints plays an important role in ensuring that the CCG continues to improve the quality of care and services provided to our patients. The Complaints, Concerns and Compliments Team strives to ensure that the complaints it receives about NHS Eastern Cheshire CCG and the services it commissions are investigated thoroughly and supported by changes to prevent issues from recurring.

The Complaints, Concerns and Compliments team recognise that making a complaint can sometimes be a difficult experience for patients and their families or carers. The Complaints, Concerns and Compliments Team therefore endeavour to ensure that the CCG complaints process is ‘patient friendly’. This means working with patients and individuals in a compassionate, sensitive and timely manner to resolve their concerns.

The Complaints, Concerns and Compliments Team work to ensure that its handling of complaints is in line with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the NHS Constitution.

The Complaints, Concerns and Compliments Team works towards the following Parliamentary and Health Service Ombudsman’s principles of good complaint handling:

- **getting it right:** All complaints receive a personalised response from a Senior Executive at the CCG
- **being customer focused:** All complaints are managed in partnership with the complainant who is kept up to date and encouraged to remain in contact with the Complaints, Concerns and Compliments Team throughout the investigation
- **being open and accountable:** Patients are encouraged to complain to the CCG, with all complaints provided with a full response that explains why issues occurred and what is being done to prevent matters from recurring
- **acting fairly and proportionately:** Complaints are subject to thorough investigations that involve input from multiple departments within the CCG as well as our commissioned providers, where appropriate
- **putting things right:** Where failings are identified, the CCG acknowledges mistakes and apologises, setting out the actions it will take to rectify the issue
- **seeking continuous improvement:** The intelligence gathered from complaints is regularly drawn upon to improve the design and delivery of our services.

In 2016-17, the CCG received 93 complaints from members of the public and 39 from Members of Parliament acting on behalf of constituents. Of the complaints received, 10 were not formally investigated by the CCG due to either not receiving consent from the complainant or because the complaint was managed by an alternative healthcare organisation, such as in cases where the complainant was not registered with an NHS Eastern Cheshire CCG GP Practice.

Of the 122 complaints received that have been subject to a formal investigation, the investigation has been completed for 84 of these complaints, of which 39 complaints were upheld.

The most common subject of the complaints received related to NHS Continuing Healthcare which accounted for 38 of the complaints received. 70% of the NHS Continuing Healthcare complaints related to decisions made in response to requests to retrospectively consider whether a patient may have met the criteria to receive NHS Continuing Healthcare funding during a past period. The remaining 30% of NHS Continuing Healthcare complaints related to current considerations of an individual’s NHS Continuing Healthcare funding.

The learning and insight identified from the CCG’s considerations of these complaints has been drawn upon to inform the current Service Transformation that is being undertaken by the shared NHS Continuing Healthcare service that is delivered across the Cheshire and Wirral Clinical Commissioning Groups. This has included representatives from the Complaints, Concerns and Compliments Team providing input into the drafting of a new suite of letter templates and a bespoke patient information leaflet for the NHS Continuing Healthcare team to ensure that these documents were patient friendly and provided all relevant pieces of information.

The second most common subject of the complaints received concerned patient experiences of care when accessing healthcare services from our commissioned providers. The majority of these complaints related to East Cheshire NHS Trust, Cheshire and Wirral Partnership NHS Foundation Trust or our individual GP Practices, which is reflective of the services most commonly used by our patient population. Where a complaint relates to a patient’s experience of care, the CCG asks for the provider to investigate and provide its comments on the issues raised. The CCG then reviews the Provider’s response to check that all issues have
been addressed and that remedial actions have been put in place where appropriate, as well as ensuring that any action required by the CCG in response to the complaint is also completed.

A notable example of the CCG using patient experiences of care to improve services in 2016-17 was the use of themes and trends identified in the complaints received about Mental Health services to draw up questions that the bidders for the new Talking Therapies service (being commissioned by the CCG) needed to answer. The questions were focused on ensuring that the issues experienced in the current provider did not recur in the new service.

The third most common theme of the complaints that were subject to investigation was concerns about the pathways commissioned for patients. In response to concerns raised about a particular therapeutic pathway, the Complaints, Concerns and Compliments team worked with the CCG Quality team to clarify the eligibility criteria and address the areas of confusion to prevent the issues from recurring for other patients.

To ensure that the Complaints, Concerns and Compliments Team are continuing to provide a good service to complainants, the CCG’s management of complaints is overseen by the Complaints and Concerns Sub-Committee of the CCG Clinical, Quality and Performance Committee that meets monthly and reviews anonymised copies of all complaint responses. A member of Healthwatch Cheshire East attended the meeting throughout 2016-17 and submitted patient stories which enhanced the Complaints and Concerns Sub-Committee’s insight into issues that are affecting patients in the local area.

The CCG are also represented on the Greater Manchester Complaints Manager Network and are soon to start attending the Cheshire and Merseyside Complaints Manager Meeting which provides insight into good practice and a peer network through which to discuss improvements and common issues.

In 2016-17 the CCG’s ability to capture and learn from feedback was enhanced when the Patient Advice and Liaison Service (PALS) was bought in-house. The PALs service is incorporated into the CCG’s front of house service, which has provided the CCG with a rich insight into what matters patients and other stakeholders may require advice or assistance in relation to. This was a particular valuable service while the CCG was undertaking a formal consultation into the service review policy in 2016-17, as it allowed the CCG to quickly and efficiently respond and signpost individuals to information about the consultation.

**Freedom of Information**

The CCG is committed to being open and transparent, treating its statutory requirement to respond under the Freedom of Information (FOI) Act as a core part of achieving this aim. In 2016-17, the CCG received 287 Freedom of Information requests. 100% of these requests were responded to within the statutory timescales, which continues the Complaints, Concerns and Compliments Team’s consistent achievement of compliance since the management of this process was bought in-house in 2015.

Further evidence of the CCG’s commitment to openness and transparency is demonstrated through its management of Subject Access Requests. The CCG has managed 47 requests for information from individuals that have been managed in accordance with the statutory guidance set out in the Data Protection Act and Access to Health Records legislation. The CCG has regularly met the NHS Best Practice timescale of responding to these requests within 21 calendar days.

**Professional Concerns**

As part of our ongoing commitment to gather intelligence that can be utilised to continuously improve services, the CCG encourages health professionals to provide feedback about quality and safety issues that affect patients through the Professional Concerns process.

The CCG has enhanced this process in 2016-17, with the move to a new Datix system which has been designed in collaboration with health professionals to make it quick and easy for them to raise their concerns.

In 2016-17, the CCG received 320 incidents. Each incident is reviewed by the CCG’s GP Quality Lead, and, where applicable, shared with the providers to investigate and put in place measures to prevent the issue from recurring.

To enhance the learning that is identified through the Professional Concerns process, concerns related to certain areas of care (including Care Homes and Urgent Care) are routinely shared with members of the Quality, Clinical or Contracts Team. In addition, regular meetings take place to review ongoing professional concerns to identify themes and trends as well as opportunities for learning, which include quarterly meetings with the Medicines Management Team.
The CCG has also encouraged our member practices to make use of the Professional Concerns process to provide examples of where themes and trends remain unresolved, such as in encouraging practices to report outstanding issues relating to Primary Care Support England.

**Employee consultation**

As a relatively small employer based in one office, our Governing Body and Senior Managers have day to day contact with all of our employees. In addition we systematically provide information on matters of concern to employees through:

- **Chief Officers briefings**
- **weekly centre of the room briefings**
- **fortnightly staff and membership e-newsletters**
- **monthly whole “team brief” meetings**
- **sharing of information on CCG intranet and via direct email on matters relating to such things as development opportunities, fraud awareness, and employment matters**
- **use of web based engagement/survey technologies, such as Survey Monkey and information sharing platforms, such as Twitter, that allows engagement and consultation of CCG staff and other staff within partner organisations**
- **regular 1:1s between staff and managers.**

Where appropriate, employees’ views are canvassed prior to key decisions being made and all employees receive formal letters of notification where any matters influence employment terms and conditions.

**Emergency preparedness, resilience and response**

Under guidance issued by NHS England and under the Civil Contingencies Act (2004) CCGs are classed as Category Two responders in emergencies. This means that the CCG must provide reasonable assistance when requested to do so. The CCG is also required to ensure that day to day health services are maintained by our providers in the event of an emergency. The CCG is also required to maintain and test a business continuity plan.

The CCG has ensured that our contracts with providers contain relevant emergency preparedness, resilience and response elements and seek assurance on those providers fulfilling contractual obligations. This is reported back on a regular basis to NHS England.

The CCG liaises with NHS England directly through its area team to support it in its role as co-ordinator of the emergency preparedness, resilience and response plan through the Local Health Resilience Partnership (LHRP) - of which the CCG is a member and of its sub-committees. The CCG also provides a point of escalation for the LHRP should a provider fail to maintain the capacity required.

The CCG maintains a 24/7 365 day a year on-call rota.

Our self-certification is included in the accounting officer’s statement in the performance report.

**Statement of Disclosure to Auditors**

Each individual who is a member of the Governing Body at the time the Members’ Report is approved confirms:

- **so far as the member is aware, that there is no relevant audit information of which the CCG’s external auditor is unaware; and**
- **that the member has taken all the steps that they ought to have taken in order to make themselves aware of any relevant audit information and to establish that the clinical commissioning group’s auditor is aware of that information.**

**Modern Slavery Act**

NHS Eastern Cheshire CCG fully supports the Government’s objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015. The CCG provides information on its website with regards Modern Slavery and provides resources for health professionals.

Signed on behalf of the members by:

**DR PAUL BOWEN**
Clinical Chair
May 2017

**JERRY HAWKER**
Chief Officer (Accountable Officer)
May 2017

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65 http://www.legislation.gov.uk/ukpga/2015/30/contents/enacted
66 https://www.easterncheshireccg.nhs.uk/Links/modern_slavery.htm
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 Officer to be the Accountable Officer of the Clinical Commissioning Group.

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

- 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 Section 14R of the National Health Service Act 2006 (as amended)),
- ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers’ equity and cash flows for the financial year.

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

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

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

Disclosures:
As described in the section on meeting our financial duties on pages 14 and 15, and also in note 23 to the Financial Statements, the CCG did not remain within its revenue resources limit in 2016/17. A planned deficit of £3.8M was agreed with NHS England at the beginning of the financial year. The final financial position was a deficit of £12.4M as outlined in the performance report.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG’s auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG’s auditors are aware of that information.
- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed

JERRY HAWKER
Chief Officer
(Accountable Officer)
30 May 2017
Annual Governance Statement

Introduction and Context

NHS Eastern Cheshire Clinical Commissioning Group (CCG) is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended). It is made up of 23 Eastern Cheshire based GP practices and has a population of over 207,000 residents in the towns of Alderley Edge, Bollington, Chelford, Congleton, Disley, Handforth, Holmes Chapel, Knutsford, Macclesfield, Poynton, Wilmslow and the surrounding villages and rural areas.

The CCG’s statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG’s general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population. The CCG is a major partner leading work to integrate local health and social care services so as to help improve the health and care experience and outcomes of our population and to ensure that we have a safe, effective, high quality and financially sustainable healthcare economy.

As at 1 April 2016, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006. Further detail about Eastern Cheshire and NHS Eastern Cheshire CCG can be found in the Performance Report on page 18 of the Annual Report and Accounts 2016-17.

Scope of responsibility

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

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

Compliance with the UK Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. This Governance Statement is intended to demonstrate our compliance with the principles set out in the UK Corporate Governance Code.

The Clinical Commissioning Group Governance Framework

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

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states: “The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.”

The CCG is a clinically led membership organisation made up of 23 practices. The members of the CCG are responsible for determining the governing arrangements for the organisation and are represented on the Governing Body by elected General Practice Locality Peer Group representatives.

The group demonstrates its accountability to its members, local people, stakeholders and NHS England in a number of ways, including:

- publishing its constitution
- appointing independent lay members/persons and non-GP clinicians to its Governing Body
- holding meetings of its Governing Body and its Primary (General Medical) Care Commissioning Committee in public

• publishing a commissioning (Operational) plan annually
• complying with local authority health and adult social care overview and scrutiny committee requirements
• meeting annually in public to publish and present its annual report
• producing externally audited annual accounts
• by being a member of the Cheshire East Health and Wellbeing Board and contributing to the development of the local Joint Strategic Needs Assessment and local Joint Health and Wellbeing Plan.

The CCG is accountable for exercising the statutory functions of the group and may grant authority to act on its behalf to:
• any of its 23 member practices
• its Governing Body
• its employees
• a committee or sub-committee of NHS Eastern Cheshire CCG.

The extent of the authority to act of the respective bodies and individuals depends on the power delegated to them by NHS Eastern Cheshire CCG’s Scheme of Reservation and Delegation and/or through the Terms of Reference of the:
• Governing Body
• Governing Body sub-committees
• Executive Committee
• Joint committees.

The CCG remains accountable for all of its functions, including those it has delegated. In discharging the functions of the CCG that have been delegated, its Governing Body and its committees, joint committees, sub-committees and individuals:
• comply with NHS Eastern Cheshire CCGs principle of good governance
• operate in accordance with NHS Eastern Cheshire CCG’s Scheme of Reservation and Delegation
• comply with NHS Eastern Cheshire CCG’s Standing Orders
• comply with NHS Eastern Cheshire CCG’s arrangements for discharging its statutory duties
• where appropriate, ensure the member practices have had the opportunity to contribute to NHS Eastern Cheshire CCG’s decision making process.

Figure Twenty Eight sets out the Governance Structure of the CCG.

In 2016-17 the CCG had the following sub-committees which were accountable to the Governing Body:

- Governance and Audit Committee
- Remuneration Committee
- Clinical Quality and Performance Committee
- Primary (General Medical) Care Commissioning Committee.

Governance and Audit Committee

The Governance and Audit Committee’s key role is to ensure that NHS Eastern Cheshire Clinical Commissioning Group has appropriate arrangements in place to ensure it exercises its functions effectively, efficiently and economically and in accordance with any generally accepted principles of good governance that are relevant to it. This includes ensuring that effective Internal and External audit functions are in place and reviewed on a regular basis.

Committees are generally scheduled bi-monthly and an indication of attendance is given in Figure Twenty Nine. Please note that there were changes to the membership of the committee in year.

Figure Twenty Eight: Governance Structure of NHS Eastern Cheshire CCG
**Figure Twenty Nine: Governance and Audit Committee member attendance 2016-17**

<table>
<thead>
<tr>
<th>Member</th>
<th>May</th>
<th>July</th>
<th>Sept</th>
<th>Nov</th>
<th>Jan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gerry Gray</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Gill Boston</td>
<td>Yes</td>
<td>Yes</td>
<td>Apol</td>
<td>Apol</td>
<td>Yes</td>
</tr>
<tr>
<td>Bill Swann</td>
<td>Yes</td>
<td>Apol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Jennifer Lawn</td>
<td>Yes</td>
<td>Apol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Alex Garvey</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

All meetings held have been quorate in membership as outlined within its Terms of Reference.

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**Remuneration Committee**

Please see page 74 for the Remuneration and Staff Report for more details on the remuneration committee and its attendance record.

**Clinical Quality and Performance Committee**

The role of the committee is to assure the CCG Governing Body that there is effective scrutiny relating to areas of concern and achievement that affect patient safety by reviewing the following areas by providers directly commissioned by the CCG:

- **patient experience**
- **patient safety incidents or serious untoward incidents**
- **complaints, PALs and professional concerns trends**
- **mortality and morbidity data**
- **progress against CQUIN**
- **key national targets**
- **Adult and Children’s Safeguarding**.

The committee also approves the annual quality improvement priorities, and objectives, contained within the Operational Plan and agrees key information requirements to monitor progress to meet these objectives.

Meetings are scheduled monthly and an indication of attendance throughout the year is given in **Figure Thirty**.

---

**Figure Thirty: Clinical Quality and Performance Committee Membership attendance 2016-17**

<table>
<thead>
<tr>
<th>Member</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sally Rogers</td>
<td>Apol</td>
<td>Yes</td>
<td>Apol</td>
<td>Apol</td>
<td>Yes</td>
<td>Yes</td>
<td>Apol</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Gill Boston</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Apol</td>
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<td>Yes</td>
<td>Yes</td>
<td>Apol</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Dr Jennifer Lawn (Chair)</td>
<td>Apol</td>
<td>Yes</td>
<td>Yes</td>
<td>Apol</td>
<td>Yes</td>
<td>Apol</td>
<td>Yes</td>
<td>Yes</td>
<td>Apol</td>
<td>Yes</td>
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</tr>
<tr>
<td>Dr James Milligan</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Apol</td>
<td>Yes</td>
<td>Yes</td>
<td>Apol</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Julia Huddart</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Apol</td>
<td>Yes</td>
<td>Apol</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Duncan Matheson</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Apol</td>
<td>Yes</td>
<td>Apol</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Andrew Binnie</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All meetings held have been quorate in membership as outlined within its Terms of Reference.

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Not in post / no longer in post
Primary (General Medical) Care Commissioning Committee

The role of the Committee shall be to carry out the functions relating to the commissioning, procurement and management of primary general medical services under section 83 of the NHS Act except those relating to the Reserved Functions of NHS England.

Meetings are held in public and in camera and indication of attendance throughout the year is given in Figure Thirty One.

The Terms of Reference for each of these Committees can be found in the current version of the CCG Constitution, available on the CCG website.68

NHS Eastern Cheshire CCG also operates an Executive Committee that is accountable to the Governing Body of the CCG. The purpose of the Committee is to take a holistic view of the work of the CCG with a focus on ensuring an efficient and effective organisation and delivery of its operational and strategic plans within agreed budgets.

The Committee has the responsibility of reviewing and monitoring those risks within the Governing Body Assurance Framework appropriate to the remit of Committee, ensuring that any identified risks allocated to the Committee are actioned appropriately and that assurances are sought. It is also responsible for providing assurance to the Governing Body that all corporate duties in relation to this agenda are compliant and in line with corporate aims and objectives. The Committee is also responsible for making recommendations to the Governing Body on:

- matters that may affect the CCG’s Constitution and statutory duties
- guidance, regulations and mandatory instructions that may be issued by NHS England or the Department of Health.

The Terms of Reference for this Committee can be found on the CCG website.69

NHS Eastern Cheshire CCG has three advisory committees to the Governing Body:

- Eastern Cheshire HealthVoice
- GP Locality Peer Group/ Locality Management Meetings
- Caring Together Programme Board.

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68 https://www.easterncheshireccg.nhs.uk/About-Us/our-structure.htm

69 https://www.easterncheshireccg.nhs.uk/About-Us/executive-committee.htm

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Figure Thirty One: Primary (General Medical Care) Commissioning Committee Membership attendance 2016-2017

<table>
<thead>
<tr>
<th>Member</th>
<th>June</th>
<th>Oct</th>
<th>Jan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gill Boston</td>
<td>Yes</td>
<td>NM</td>
<td>Yes</td>
</tr>
<tr>
<td>Bill Swann</td>
<td>Yes</td>
<td>NM</td>
<td>NM</td>
</tr>
<tr>
<td>Jane Stephens</td>
<td>Yes</td>
<td>NM</td>
<td>Yes</td>
</tr>
<tr>
<td>Sally Rogers</td>
<td>Yes</td>
<td>NM</td>
<td>Yes</td>
</tr>
<tr>
<td>Alex Mitchell</td>
<td>Yes</td>
<td>NM</td>
<td>Yes</td>
</tr>
<tr>
<td>Jerry Hawker</td>
<td>Yes</td>
<td>Apol</td>
<td>Apol</td>
</tr>
<tr>
<td>Neil Evans</td>
<td>Yes</td>
<td>NM</td>
<td>Yes</td>
</tr>
<tr>
<td>Fleur Blakeman</td>
<td>Apol</td>
<td>NM</td>
<td>Apol</td>
</tr>
<tr>
<td>Dr Mike Clarke</td>
<td>Yes</td>
<td>NM</td>
<td>Apol</td>
</tr>
<tr>
<td>Dr Jennifer Lawn</td>
<td>Apol</td>
<td>NM</td>
<td>Yes</td>
</tr>
<tr>
<td>Joanne Morton</td>
<td>Yes</td>
<td>NM</td>
<td>Yes</td>
</tr>
<tr>
<td>Laura Beresford</td>
<td>NM</td>
<td>Yes</td>
<td>NM</td>
</tr>
<tr>
<td>Dr Vicky Buckley</td>
<td>Yes</td>
<td>NM</td>
<td>Apol</td>
</tr>
<tr>
<td>Warren Tuite</td>
<td>Yes</td>
<td>NM</td>
<td>NM</td>
</tr>
</tbody>
</table>

Not in post / no longer in post  NM  No meeting  In Public  In Camera

All meetings held have been quorate in membership as outlined within its Terms of Reference.
In 2016-17 NHS Eastern Cheshire CCG has entered into joint arrangements with the following:

- **NHS South Cheshire and NHS Vale Royal CCGs for the provision of Medicines Management and Continuing Health Care**
- **NHS South Cheshire CCG, NHS Vale Royal CCG, NHS West Cheshire CCG and NHS Wirral CCG for the provision of Continuing Health Care**
- **NHS South Cheshire CCG, NHS Vale Royal CCG, NHS West Cheshire CCG and Cheshire East Council and Cheshire West & Chester Council for the Cheshire Care Record**
- **Joint Commissioning, comprises representatives from NHS Eastern Cheshire CCG, representatives from NHS South Cheshire CCG and representatives from Cheshire East Council.**

The performance of the Governing Body, its sub-committees and employed staff is routinely assessed for their effectiveness both internally and externally. In-house assessment and appraisal of CCG employees and Governing Body members are done through Personal Development Reviews with line managers, Chair of the Governing Body, self-appraisal and internal audit.

External audit and appraisal of effectiveness and appropriateness of the CCG and its Committees is also provided though arrangements with organisations such as Grant Thornton LLP and NHS England.

### The Clinical Commissioning Group Risk Management Framework

The CCG's approach to risk management is contained within its Integrated Risk Management Strategy and Policy document, which defines the risk management process, responsibilities and the identification and evaluation of operational and strategic risks as outlined within its Assurance Framework reporting. The identification of risks is the responsibility of all staff and these risks are captured through the following points of consolidation:

- **through the work of committees, where they are standing agenda items**
- **Programme and Project Boards, including public facing programmes**
- **Governing Body and Executive Committee**
- **external Providers and Stakeholders**
- **complaint management and serious untoward incident logs (Including Information Governance breaches).**

These risks are captured on the corporate risk log and evaluated by the Executive Committee, on a monthly basis who take a view on the appropriateness of controls, scoring and actions to mitigate the risks.

The Governing Body Assurance Framework is a document which contains a detailed view of risks that may have a significant impact on the achievement of corporate objectives. This document is published for consideration by the Governing Body each month and is available via the CCG website, prior to any meeting allowing it to be reviewed and challenged by the members of the public. Responses to the Assurance Framework by the Governing Body are managed by the Executive Committee who monitor and report progress.

Risk management is at the core of the commissioning process along with equality impact assessments and quality impact assessments which are considered as part of any new business case development and review and feature within all Governing Body papers.

The CCG Governance and Audit Committee is responsible for maintaining oversight of the risk management process and reviews the Risk Log and Assurance Framework on a regular basis. This committee is also responsible for gaining assurances that adequate arrangements are in place for counteracting fraud and reviews the outcomes of counter fraud work. The CCG Executive also has the responsibility of reviewing and monitoring those risks within the Governing Body Assurance Framework appropriate to the remit of Committee, ensuring that any identified risks allocated to the Committee are actioned appropriately and that assurances are sought.

### Risk Assessment

The system of internal control and governance within the CCG is based on an on-going risk management process that is embedded in the organisation and combines the following elements:

- **the CCG has a published Integrated Risk Management Strategy and Policy document that is available to all staff on the CCG’s Intranet. The purpose of this policy is to ensure that the CCG manages risk in all areas using a systematic and consistent approach.**
- **all risks are reviewed by the Executive Committee on a regular basis, thus ensuring that the level of risk reporting is in line with expectations and policy, as well as ensuring that adequate and timely mitigating actions are being undertaken.**
- **the Assurance Framework is the key**
risk identification tool for the CCG and informs its overall risk profile. It contains the significant risks to the achievement of the organisation’s objectives as identified by the Governing Body, Committees and staff within the organisation. The Assurance Framework enables the Governing Body to monitor the effectiveness of controls and governance arrangements required to minimise the principal risks.

- the Governance and Audit Committee has the delegated responsibility to keep the risk management processes and policies under scrutiny. It discharges this responsibility by reviewing the corporate risk log, the risk logs of significant programmes, the Governing Body Assurance Framework and the policies supporting risk management.

The CCG is confident that it has a robust Assurance Framework process in place that enables mitigating action plans to be effectively monitored by risk owners and the Governing Body. The Governing Body Assurance Framework is a published document available on the public facing CCG website. Through the Governing Body Assurance Framework, significant strategic risks are presented to the Governing Body on a monthly basis with a list of actions for review and comment and to provide a level of assurance to the CCG as a whole that these risks are being addressed appropriately. Each risk on the Governing Body Assurance Framework has an identified risk owner, Executive/Director level lead and designated CCG Committee responsible for oversight.

The Governing Body has a Governing Body Assurance Framework “deep dive” process where individual risks are examined in depth on a rotational basis, with risk owners required to present a detailed explanation of the risk, its background and the actions being taken to mitigate it. Figure Thirty Two shows the Governing Body Assurance Framework ‘Deep Dive’ topics delivered to and considered by the Governing Body throughout 2016-17.

Figure Thirty Two: Governing Body Assurance Framework Deep Dive Topics 2016-17

<table>
<thead>
<tr>
<th>Month</th>
<th>Governing Body Assurance Framework Deep Dive Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2016</td>
<td>GBAF14 Stroke Services compliance in Eastern Cheshire</td>
</tr>
<tr>
<td>May 2016</td>
<td>GBAF01 Mental Health Services Capacity</td>
</tr>
<tr>
<td>June 2016</td>
<td>GBAF09 Systems Resilience: Delayed Transfers of Care (DTOC)</td>
</tr>
<tr>
<td>July 2016</td>
<td>GBAF17 Diagnostic and Outpatient Access to Services</td>
</tr>
<tr>
<td>September 2016</td>
<td>GBAF22 NHS Eastern Cheshire CCG Planned Deficit 2016-17</td>
</tr>
<tr>
<td>October 2016</td>
<td>GBAF20 Delegated commissioning of Primary Care (GM) Services</td>
</tr>
<tr>
<td>November 2016</td>
<td>GBAF03 Non-delivery of CCG Quality Premium Priorities</td>
</tr>
<tr>
<td>January 2017</td>
<td>GBAF240 Caring Together Delivery Programme</td>
</tr>
<tr>
<td>February 2017</td>
<td>GBAF242 East Cheshire NHS Trust Underlying Financial Position</td>
</tr>
<tr>
<td>March 2017</td>
<td>GBAF244 Emergency Ambulance Performance in Eastern Cheshire</td>
</tr>
</tbody>
</table>

71 http://www.easterncheshireccg.nhs.uk/Meetings/25-may-2016.htm
74 https://www.easterncheshireccg.nhs.uk/Meetings/28-september-2016.htm
79 https://www.easterncheshireccg.nhs.uk/Downloads/Governing-Body/Meetings/2017-03-29/2.1%20Ambulance%20Risk%20Presentation%20Gov%20Body%20March%202017%20v0.3.pdf
Figure Thirty Three: NHS Eastern Cheshire CCG Governing Body Assurance Framework
Significant Risks as of 31 March 2017

<table>
<thead>
<tr>
<th>GBAF Risk No</th>
<th>GBAF Risk</th>
<th>Risk rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>247</td>
<td>NHS Eastern Cheshire CCG 2016-17 Financial Deficit</td>
<td>25</td>
</tr>
<tr>
<td>242</td>
<td>East Cheshire NHS Trust Underlying Financial Position</td>
<td>25</td>
</tr>
<tr>
<td>245</td>
<td>Non Delivery of the NHS constitutional standard for A&amp;E waiting time</td>
<td>20</td>
</tr>
<tr>
<td>244</td>
<td>Emergency Ambulance Performance in Eastern Cheshire</td>
<td>20</td>
</tr>
<tr>
<td>240</td>
<td>Caring Together Delivery Programme</td>
<td>20</td>
</tr>
<tr>
<td>248</td>
<td>Mental Health Services Capacity - Children and Adolescents Mental Health</td>
<td>16</td>
</tr>
<tr>
<td>249</td>
<td>Sustainability of Community Services</td>
<td>15</td>
</tr>
<tr>
<td>243</td>
<td>Elective, Diagnostic and Outpatient Access to Services</td>
<td>12</td>
</tr>
<tr>
<td>250</td>
<td>Mental Health Services Capacity - Increasing Access to Psychological Therapies in Adult Services</td>
<td>12</td>
</tr>
<tr>
<td>239</td>
<td>Non-Delivery of the CCG Quality Premium Priorities</td>
<td>9</td>
</tr>
<tr>
<td>241</td>
<td>Stroke Compliance in Eastern Cheshire</td>
<td></td>
</tr>
</tbody>
</table>

Throughout 2016-17 the following risks have been removed from the Governing Body Assurance Framework (Figure Thirty Four).

Figure Thirty Four: NHS Eastern Cheshire CCG Governing Body Assurance Framework Risks removed throughout 2016 - 2017

<table>
<thead>
<tr>
<th>GBAF Risk No</th>
<th>GBAF Risk</th>
<th>Month Removed</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Mental Health Services Capacity</td>
<td>Sept 2016</td>
</tr>
<tr>
<td>06</td>
<td>Co-commissioning Primary Care Services – Conflict of Interest</td>
<td>Sept 2016</td>
</tr>
</tbody>
</table>

In 2016 the CCG commissioned Mersey Internal Audit Agency (MIAA) to undertake a review of the Governing Body Assurance Framework. The overall objective was to receive an independent external opinion on the approach to which the CCG maintains and uses the Assurance Framework to support the overall assessment of governance, risk management and internal control. The review also included an assessment of the following sub objectives:

- **the structure of the Assurance Framework meets the requirements**
- **there is Governing Body engagement in the review and use of the Assurance Framework**

The Clinical Commissioning Group assesses risk on a continuous basis through its committee functions, which gather and review risk information submitted to them by staff, programme boards, providers and internal and external bodies involved in the work of the CCG. Risks that can be fully managed by the receiving committee or programme board are managed within that structure, those that may have an impact on achieving CCG objectives will be escalated to the Executive Committee. Where appropriate these risks will be added to the Governing Body Assurance Framework, ensuring that they receive adequate exposure, scrutiny and management at a Governing Body level.

In its February 2017 report MIAA gave the following opinion statement:

**The organisation’s Assurance Framework is structured to meet the NHS requirements, is visibly used by the Governing Body and clearly reflects the risks discussed by the Governing Body.**
The Clinical Commissioning Group Internal Control Framework

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

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.

NHS Eastern Cheshire CCG has established and maintains, via the Governance and Audit Committee, the Clinical Quality and Performance Committee and the Executive Committee, continual reporting, auditing and monitoring to ensure standards are being implemented, and therefore, risk is controlled to the lowest reasonably practicable levels.

Methods for identifying and managing levels of risk would include:

- **Internal methods**, such as; incidents, complaints, claims and audits, project risks based on the achievement of project objectives, patient satisfaction surveys, risk assessments, surveys including staff surveys, whistle-blowing and contract quality monitoring of commissioned services.

- **External methods**, such as; media, national reports, new legislation, NPSA surveys, reports from assessments/inspections by external bodies, reviews of partnership working.

All identified risks are recorded and managed through the organisational risk register and risks identified which could impact on the achievement of the CCG's strategic objectives are recorded and managed through the Governing Body Assurance Framework.

All groups reporting to the CCG Governing Body highlight risks for inclusion within the organisational risk register or assurance framework.

Risk identification is also obtained from member practices through practice visits, GP Members locality meetings, patient engagement forums, practice feedback forums and practice managers meetings.

**Information Governance**

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

The CCG completed and made its Information Governance Toolkit (v14) submission in March 2017, with a compliance score of 91% (Satisfactory). Mersey Internal Audit (MIAA) reported an overall “Significant Assurance” in their Information Governance Toolkit Assurance Review Assignment Report 2016-17 for NHS Eastern Cheshire CCG.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and receive a bi-monthly IG newsletter, highlighting current issues and areas of concern.

There are processes in place for incident reporting and investigation of serious incidents. We are continuously developing information risk assessment and management procedures to fully embed an information risk culture throughout the organisation against identified risks.

**Control Issues**

**Control issue**

NHS Eastern Cheshire CCG Financial Deficit 2016-17

**Mitigating actions**

The CCG has implemented a QIPP recovery process that is subject to external scrutiny from NHS England which has commissioned an independent assessment of our QIPP plans.

The CCG has created a number of QIPP schemes that are being implemented across Cheshire and Wirral CCGs and future work is now being delivered collectively in order to share workload. The CCG is focusing internal resources to support the implementation of schemes and has recruited additional temporary support in line with findings arising from NHS England’s Capacity and Capability review of ECCCG.

The CCG is engaging with key stakeholders around supporting the implementation of QIPP i.e. GPs. The CCG has participated in NHS England’s Deep Dive process to assess where there is further opportunity for efficiencies.

Right Care and Better Care tools have been used to identify additional activities. NHS England Right Care partner assigned from NHS England from December 2016.
Control issue
East Cheshire NHS Trust (ECT)
Underlying Financial Position

Mitigating actions
The CCG 2016-17 contract with ECT identified service development and improvement plans and service pressures and agreed joint mitigation actions.

ECT is responding to a recent request to supply information following the loss of circa 60% of its Community Services to a new provider following a procurement process for the services commissioned by NHS South Cheshire and NHS Vale Royal CCGs in the year. The response will include Quality Impact Assessments, Service sustainability, Financial implications etc.

Control issue
Non-delivery of the NHS Constitutional standard for A&E waiting times

Mitigating actions
A&E Delivery Board is meeting monthly. ‘Snow White’ provides system performance updates and forms the basis of local escalation during periods of high demand.

Control issue
Emergency Ambulance Performance in Eastern Cheshire

Mitigating actions
A change in the contracting arrangements for 2016-17 is being progressed to reduce the inequality. The CCG has assigned additional resources in the form of project support, improvement project facilitation, patient representative input and GP clinical input. Improvement plan priorities are inter hospital transfers (potential to ring fence vehicle) and expanding the community defibrillator programme. Discussions are underway with Cheshire Fire and rescue as an additional resource for first response.

Control issue
Mental Health Services Capacity - CAMHS

Mitigating actions
Continue to redesign services based on the ‘THRIVE’ model which supports lifelong strategies for health and wellbeing. The CCG works with commissioning partners (CEC and SCCCG) to integrate commissioning of services. Work with all providers including the voluntary sector to maximise return on investment. Following investment in services the neuro –developmental pathway implementation is on track to reduce waiting times to 12 weeks by April 2017 with significant reductions in current waiting times. Waiting List Initiatives being sought from NHSE to support transformation initiatives.

Control issue
Sustainability of Community Services

Mitigating actions
Highlighted the risk to NHSE/ NHSI. Directors of Finance and Quality met with ECT Finance and director of Nursing to discuss risk, clarify actions. Director of Quality has written formally to Director of Nursing to request further information i.e. documents outlining current and future cost, capacity, risks, mitigations, business continuity. Requested that ECT share historical activity data in relation to community services. Work with NHSI/CQC to ensure we have the information that is required to inform commissioning intentions for community services as a priority. Contracting Team informed of possible risks. Currently considering response from Trust and planning to act accordingly.

Control issue
Elective, diagnostic and Outpatient access to services

Mitigating actions
CCG has undertaken AQP processes to procure additional capacity in a number of specialties; Ophthalmology, Elective Surgery, Gastroenterology. Redesign of access criteria in order to direct patients to appropriate services. The Main Provider has been undertaking additional waiting list initiative work in relation to outpatients, diagnostics and routine surgery slots during the latter part of July and August 2016. The CCG representative continues to monitor the activity through attendance at the Operational Performance Group of the Main Provider. The contracting team continue to review all contracts in relation to the constitutional waiting times i.e. 18 weeks from all providers.

Control issue
Caring Together Delivery Programme

Mitigating actions
Detailed modelling work to identify what resources are required to implement the Caring Together programme. Establish workstreams with clarity of purpose and pace and scale of change. Integrated Community teams are being implemented within the limitations of existing resources. Caring Together Programme Board Meeting with NHSI and NHSE 17th October 2016 - agreement reached to model through system wide changes. Financial modelling work, now underway.
Review of Economy, Efficiency and Effectiveness of the Use of Resources

The CCG has had a challenging year and has incurred a deficit of £12.44M in its fourth year of operation. This was a significant deterioration from the 2015-16 surplus of £1.4m and was £8.6M more than our 2015-16 Financial Plan.

We have not delivered in full the business rules as set by NHS England. In particular, we should have delivered a surplus of 1% which would have been circa £2.7m. The planned deficit for 2016-17 agreed by the Governing Body of the CCG as part of the 2015-16 Financial Plan was supported by NHS England.

Progress against this plan has been routinely reported to the Governing Body through the Finance and Performance reports prepared by our Chief Finance Officer which have reported the continuing financial pressure from increased demand for services combined with price increases from commercial providers that have not been matched by increases in the CCG's spending allocation.

We continue on our Caring Together programme which aims to redesign the Health and Social Care system. Its objective is to deliver a long term sustainable future both in terms of quality and money within the next five years. This is one of the key Quality, Innovation, Productivity and Prevention (QIPP) schemes for the CCG. In addition, we had a number of other QIPP schemes which are aimed at ensuring services are being provided efficiently.

Feedback from delegation chains regarding business, use of resources and responses to risk

The CCG has a defined scheme of reservation and delegation, approved by its GP Membership and Governing Body. This identifies which functions are reserved for the Governing Body, its sub-committees, committees of the CCG and key individuals, and which are delegated for discharge across the CCG in line with effective use of resources and risk management processes. In support of this the CCG has financial procedures which identify how the standing orders should be applied by the CCG.

The Governing Body receives at each of its monthly meetings, held in public, assurance from financial reporting of current position versus budget and minutes of those committees with delegated functions are presented to members from the Chairs of the respective Committees.

Internal Audit provides independent assurance on the processes in place as part of the annual internal audit plan, approved by the Governance and Audit Committee in delegation from the Governing Body. External audit as part of their annual work plan also provide an oversight of assurance of the CCG’s value for money, economy, efficiency and effectiveness.

Counter Fraud

Our Counter Fraud Service is provided by the Anti-Fraud Service of the Mersey Internal Audit Agency (MIAA). An Accredited Counter Fraud Specialist is contracted to undertake counter fraud work proportionate to identified risks. We have in place an Anti-Fraud Plan for 2017/18 agreed and monitored by our Governance and Audit Committee.

Our Anti-Fraud Service provides an ongoing programme of prevention and detection exercises designed to protect staff and ensure that they are fully aware of the fraud risks we face, in line with NHS Protect Standards for Commissioners, Fraud, Bribery and Corruption.

Our Governance and Audit Committee receives regular progress updates on the delivery of the Anti-Fraud Plan and an annual report that summarises activity throughout the year, including reporting against each of the Standards for Commissioning as recommended by NHS Protect.

Our Chief Finance Officer has the responsibility for tackling fraud, bribery and corruption and maintains regular contact with our Anti-Fraud service to ensure any actions and recommendations are considered and executed promptly and effectively. They also report to the Governance and Audit Committee on a regular basis in conjunction with the Anti-Fraud Service and report to the Governing Body, where issues of sufficient moment arise.

Appropriate action is taken regarding any NHS Protect quality assurance recommendations as advised by our Accredited Counter Fraud Specialist.
Review of the Effectiveness of Governance, Risk Management and Internal Control

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within NHS Eastern Cheshire CCG.

Capacity to Handle Risk

The Governing Body is responsible for the overall governance of the organisation and is responsible for reviewing the effectiveness of the system of internal control, including systems and resources for managing all types of risk. The Governing Body has ratified the various risk based policies through the Governance and Audit Committee. These include Standards of Business Conduct, Safeguarding Adults and Children, Counter Fraud process and Information Governance policies as well as reviewing the Integrated Risk Management Strategy.

Mandatory staff training includes Safeguarding, Counter Fraud, Information Governance as well as Safety Awareness training. The CCG encourages it staff to seek, be mindful of and adopt best practice guidance to minimise and manage risk – both personal and corporate.

Review of Effectiveness

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

The Governing Body assurance framework provides me with evidence that the effectiveness of control that manage risks to the CCG achieving its principle objectives have been reviewed.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for NHS Eastern Cheshire CCG, the Director of Audit for MIAA issued an independent and objective opinion on the adequacy and effectiveness of the CCG’s system of risk management, governance and internal control. The MIAA Director of Audit concluded that:

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

During the year the Internal Audit issued six audit reports, five gave “Significant Assurance”, and one was categorised as limited assurance. The audit reports provide an overall level of assurance along with recommendations which range from critical to low, these are summarised below.

Significant Assurance

- Finance Systems Review - To provide an opinion on the effectiveness of the key financial systems which provided for compliance with NHS accounting requirements, the accuracy of accounts and reliability of management information. The review focussed solely on the key controls operating within the CCG. For controls operated by SBS the CCG should seek third party assurance around their existence and operation.

Recommendations: 0 Critical, 0 High, 5 Medium, 2 Low.

- Conflicts of Interest - To evaluate the arrangements in place to manage potential and actual conflicts of interest aligned to the assurances sought by NHS England.

Recommendations: N/A.

- Information Governance - To provide an opinion upon the policies and processes established by the CCG to develop and embed an Information Governance (IG) culture within the organisation, to collate and submit its IG Toolkit return and to provide an independent assessment of the validity and accuracy of the scores submitted.

Recommendations: N/A.

- Safeguarding - To assess the systems and processes in place across the organisation to ensure compliance with Safeguarding statutory requirements and guidance.

Recommendations: 0 Critical, 0 High, 4 Medium, 2 Low.

- Better Care Fund - To provide assurance that there is effective and robust governance built into the local integrated Better Care Fund processes including Section 75 joint Governance Agreements; and Risk Sharing and that these are sufficiently robust for the 15/16 BCF funding round.

Recommendations: 0 Critical, 0 High, 3 Medium, 0 Low.

Limited Assurance

- Productivity - To evaluate the governance arrangements, systems and processes in place within the CCG to manage Productivity plans in place for which the CCG is accountable.

Recommendations: 0 Critical, 1 High, 1 Medium, 0 Low.
Annual Audit of conflicts of interest management

As required by NHS England’s Managing Conflicts of Interest: Revised Statutory Guidance for CCGs (June 2016) an annual audit of conflicts of interest was completed by MIAA in February 2017 following the prescribed framework issued by NHS England. The following compliance levels, outlined in Figure Thirty Five, were assigned to each scope area.

The MIAA audit found that the CCG was partially compliant with legal requirements and statutory guidance in relation to the management of conflicts of interest and gifts and hospitality in three areas, however action was noted as being underway to address these issues. MIAA provided eight recommendations (Figure Thirty Six) that the CCG should implement to ensure full compliance with NHS England’s statutory guidance going forward.


Figure Thirty Five: NHS Eastern Cheshire CCG Conflicts of Interest Annual Audit Results 2016-17

<table>
<thead>
<tr>
<th>Scope Area</th>
<th>Compliance rating</th>
<th>Rag rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance Arrangements</td>
<td>Partially Compliant</td>
<td></td>
</tr>
<tr>
<td>Declarations of interests and hospitality</td>
<td>Fully Compliant</td>
<td></td>
</tr>
<tr>
<td>Register of interests, gifts and hospitality and procurement decisions</td>
<td>Partially Compliant</td>
<td></td>
</tr>
<tr>
<td>Decision making processes and contract monitoring</td>
<td>Partially Compliant</td>
<td></td>
</tr>
<tr>
<td>Reporting concerns, identifying and managing breaches</td>
<td>Fully Compliant</td>
<td></td>
</tr>
</tbody>
</table>

Figure Thirty Six: Internal Audit Recommendations around CCG Conflicts of Interest Management

<table>
<thead>
<tr>
<th>Area of scope</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| Governance Arrangements        | The CCG has a standards of business conduct policy in place. This policy is currently in draft status pending governance and audit committee approval. The policy should be updated to include:-  
  • Impact of non- compliance is not detailed in the policy.  
  • Reference BMA / other guidance.  
  • Require update of declarations following a change of role.                                                                                                                                             |
| Governance Arrangements        | The CCG should ensure a training programme is in place to ensure all staff / GP members received training. The CCG should include in the training programme, the NHS England package of training due out in April 2017. |
| Governance Arrangements        | The CCG should ensure all committee chairs have access to a conflict of interest checklist to reference key steps to be followed in covering the agenda item at meetings.                                         |
| Governance Arrangements        | The CCG should review the registers to ensure information reported is in accordance with NHS England requirements. MIAA has shared example formats of registers as part of this review which the CCG has agreed to adopt and report on their website. |
| Governance Arrangements        | A review of the CCG induction form confirmed that it includes a section on covering the conflict of interest policy. A Link to the policy and the declaration form should be embedded in the form. |
| Declaration of gifts and hospitality | MIAA noted that the current register required update to ensure compliance with requirements. The CCG has agreed to adopt a revised format to meet guidance requirements and will be updated following the next refresh of declarations. The CCG will ensure separate registers are published for declarations of interest and gifts and hospitality. |
| Decision Making Process        | Minutes where declarations of interest are made should provide for full explanation for the reason for the interest, and how the conflict has been agreed to be managed.                                |
| Fraud                          | The CCG should ensure that where an interest have been declared that there is clear narrative to report on how any risk will be mitigated / controlled.                                                                    |
Data Quality
Our Governing Body and Membership have received a variety of reports throughout the year which are based on good quality information that is both transparent and concise. This has been supported by a number of independent assurance checks via MIAA which looked at specific areas which support reporting through to the Governing Body and its Members.

Business Critical Models
Within the CCG we have a number of business models which are used to support the delivery of our statutory duties. In line with the Macpherson report these models have an underpinning framework that ensure each model has a responsible owner within the CCG who ensures the quality assurance process is compliant and appropriate, that model risks, limitations and major assumptions are understood by users of the model, and the use of the model outputs is appropriate.

Data Security
We have submitted a satisfactory level of compliance with the information governance toolkit assessment and there were no matters relating to Serious Untoward Incidents that were reported to the Information Commissioners Office in the year.

NHS computer systems were subject to a cyber attack in May 2017. This CCG and some of the primary care practices in the area were affected. Using well-tested contingency plans meant that this attack did not significantly disrupt services and access to IT systems was restored within five days.

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 reservation and delegation.

In light of the Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative 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. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG’s statutory duties.

Conclusion
I would like to thank the role of the Governance and Audit Committee and both Internal and External Audit in providing assurance and advice around our governance arrangements. In conclusion I am happy to confirm that no significant control issues have been identified in the preparation of the 2016-17 Annual Report and Accounts.

Signed
JERRY HAWKER
Chief Officer
(Accountable Officer)
30 May 2017
Remuneration and Staff Report

Remuneration Report

Introduction
Section 234B and Schedule 7A of the Companies Act, as interpreted for the public sector, requires NHS bodies to prepare a Remuneration Report containing information about directors’ remuneration. The report is in respect of the Senior Managers of the NHS body. ‘Senior Managers’ are defined as: ‘those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the clinical commissioning group as a whole, rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members.’

The Remuneration Committee determines remuneration for the CCG Governing Body members.

The Remuneration Committee
The terms of reference for the Remuneration Committee are approved by the Governing Body and contained within the CCG Constitution. The membership of the Remuneration Committee during the year and up to the date of this report is:

Chair:
Gerry Gray – Lay Member for Governance and Audit

Other members:
Gill Boston – Lay Member for Public and Patient Involvement
Duncan Matheson – Clinical Member - Secondary Care Doctor
Bill Swann – Lay Member for Public and Patient Involvement
Dr Jennifer Lawn – General Practice Locality Peer Group Lead

In the absence of the Chair of the committee a nominated Governing Body member acts as Chair. The Committee met on three occasions during the year, with attendance outlined in Figure Thirty Seven.

Biographies of the members
Biographies of the voting members of the Remuneration Committee can be seen on page 100. Details of the specific job titles and membership of committees is set out in the members report.

Policy on Remuneration of Senior Managers
Amendments to salary are determined annually by the Remuneration Committee. Senior Manager performance is monitored through the formal appraisal process, based on organisational and individual objectives.

As required the committee has access to professional advice from a professionally qualified HR manager from Midland and Lancashire Commissioning Support Unit and also the CCG legal advisers Hill Dickinson LLP.

In setting policy for current and future years, the committee has access to guidance, best practice and benchmarking information from NHS Employers, NHS England and comparative CCGs. Account is also taken of the pay and conditions of service that apply to other employees in the CCG.

Senior Managers performance related pay
Currently performance related pay is not an element of Senior Managers’ remuneration package. The Committee is considering options.

Senior Manager Contracts
Senior Manager (officer) contracts are subject to six months’ notice. Governing Body members have been appointed to varied fixed terms of office, details of which can be found in Figure Thirty Eight.

---

**Figure Thirty Seven: CCG Remuneration Committee member meeting attendance 2016-17**

<table>
<thead>
<tr>
<th>Member</th>
<th>April 2016</th>
<th>October 2016</th>
<th>January 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gerry Gray</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Gill Boston</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Bill Swann</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jenny Lawn</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Duncan Matheson</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

[ ] Member no longer in position
Past Senior Managers
No payments have been made to any past senior managers or for loss of office during 2016-17.

Pay Multiples
Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/Member in their organisation and the median remuneration of the organisation’s workforce.

The banded remuneration of the highest paid director/Member in the Clinical Commissioning Group on a full time equivalent basis in the financial year 2016-17 was £175k to £180k (2015-16, £170k to £175k). This was 5.1 times (2015-16, 5.5) the median remuneration of the workforce, which was banded £30k to £35k (2015-16, £30k to £35k).

In 2016-17, no employee (2015-16, no employee) received remuneration in excess of the highest-paid member. Remuneration ranged from £10-£15k to £175-£180k (2015-16, £10-£15k to £170-175k).

For these calculations, total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. It is pro rata the contracted hours and not the actual amounts paid. The workforce comprises executive directors and staff excluding non-executives.

There were no significant changes in remuneration for either the most highly paid individual or for staff.

Duration of contracts, notice periods and termination payments
The Accountable Officer and Chief Finance Officer are employed on contracts of service and are employees. Executive Governing Body members’ contracts can be terminated by either party with up to six months’ notice. Details of fixed term contracts are set out in the section below.

There are no special contractual compensation provisions for the early termination of Governing Body members’ contracts. Early termination by reason of redundancy or, ‘in the interests of the efficiency of the service’ is subject to the provisions of the Agenda for Change NHS Terms and Conditions Handbook.

Employees above the minimum retirement age who themselves request termination by reason of early retirement, are subject to the normal provisions of the NHS Pension Scheme.

Governing Body Members
The majority of members were appointed on fixed terms on dates prior to the existence of the CCG. For these members, the start date is shown as the first day of the CCG’s existence. Dates of contracts and unexpired terms of office for the Governing Body members are outlined in Figure Thirty Eight.

Figure Thirty Eight: CCG Governing Body member appointment start date

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Appointment Start Date</th>
<th>Appointment End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Paul Bowen Clinical Chair</td>
<td>1 April 2013</td>
<td>June 2018 (4 year tenure renewed)</td>
</tr>
<tr>
<td>Dr Mike Clark</td>
<td>1 April 2013</td>
<td>May 2017 (3 year tenure renewed)</td>
</tr>
<tr>
<td>Jerry Hawker Chief Officer</td>
<td>1 April 2013</td>
<td>Permanent Contract</td>
</tr>
<tr>
<td>Alex Mitchell Chief Finance Officer</td>
<td>1 April 2013</td>
<td>Permanent Contract</td>
</tr>
<tr>
<td>Duncan Matheson</td>
<td>1 May 2013</td>
<td>30 April 2017</td>
</tr>
<tr>
<td>Warren Tuite</td>
<td>1 December 2015</td>
<td>1 December 2018 (stood down 1 Aug 2016)</td>
</tr>
<tr>
<td>Julie Sercombe</td>
<td>17 May 2014</td>
<td>17 May 2017 (stood down 1 June 2016)</td>
</tr>
<tr>
<td>Bill Swann</td>
<td>1 April 2013</td>
<td>31 August 2016</td>
</tr>
<tr>
<td>Gerry Gray</td>
<td>1 April 2013</td>
<td>18 September 2017 (tenure extended)</td>
</tr>
<tr>
<td>Gill Boston</td>
<td>1 April 2013</td>
<td>28 February 2021 (4 year tenure renewed)</td>
</tr>
<tr>
<td>Jane Stephens</td>
<td>12 September 2016</td>
<td>12 September 2020</td>
</tr>
<tr>
<td>Jennifer Lawn</td>
<td>1 April 2013</td>
<td>1 November 2018 (3 year tenure renewed)</td>
</tr>
<tr>
<td>Dr Julie Sin</td>
<td>1 April 2013</td>
<td>Nominated member</td>
</tr>
<tr>
<td>Sally Rogers</td>
<td>1 April 2013</td>
<td>01 May 2017 (tenure extended)</td>
</tr>
<tr>
<td>Dr Alex Garvey</td>
<td>01 April 2016</td>
<td>01 April 2019</td>
</tr>
<tr>
<td>Dr Robert Thorburn</td>
<td>01 July 2016</td>
<td>01 July 2019</td>
</tr>
<tr>
<td>Laura Beresford</td>
<td>21 September 2016</td>
<td>21 September 2019</td>
</tr>
</tbody>
</table>
### Remuneration

**Figure Thirty Nine: Governing Body member remuneration 2016-17**

<table>
<thead>
<tr>
<th>Name</th>
<th>2016-17</th>
<th>2016-17</th>
<th>2016-17</th>
<th>2016-17</th>
<th>2016-17</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary and fees (bands of £5,000) £000</td>
<td>Taxable benefits (rounded to the nearest £100)*³</td>
<td>Annual performance related bonuses (bands of £5,000) £000</td>
<td>Long-term performance related bonuses (bands of £5,000) £000</td>
<td>Total All pension related benefits*¹ (bands of £2,500) £000</td>
<td>Total (Bands of £5,000) £000</td>
</tr>
<tr>
<td>Dr Paul Bowen*¹</td>
<td>85 - 90</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20 - 22.5</td>
<td>110 - 115</td>
</tr>
<tr>
<td>Dr Mike Clark</td>
<td>25 - 30</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25 - 30</td>
</tr>
<tr>
<td>Jerry Hawker<em>¹</em>³</td>
<td>120 - 125</td>
<td>43</td>
<td>-</td>
<td>-</td>
<td>17.5 – 20</td>
<td>145 - 150</td>
</tr>
<tr>
<td>Alex Mitchell<em>¹</em>³</td>
<td>90 - 95</td>
<td>23</td>
<td>-</td>
<td>-</td>
<td>25 - 27.5</td>
<td>120 - 125</td>
</tr>
<tr>
<td>Duncan Matheson</td>
<td>10 - 15</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Warren Tuite*²</td>
<td>0 - 5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0 - 5</td>
</tr>
<tr>
<td>Julie Sercombe*²</td>
<td>0 - 5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0 - 5</td>
</tr>
<tr>
<td>Bill Swann</td>
<td>0 - 5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0 - 5</td>
</tr>
<tr>
<td>Gerry Gray</td>
<td>10 - 15</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Gill Boston</td>
<td>15 - 20</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15 - 20</td>
</tr>
<tr>
<td>Jane Stephens</td>
<td>5 - 10</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Jennifer Lawn</td>
<td>25 - 30</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25 - 30</td>
</tr>
<tr>
<td>Dr Julie Sin<em>¹</em>²*⁴</td>
<td>Nil</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Nil</td>
</tr>
<tr>
<td>Sally Rogers*³</td>
<td>80 - 85</td>
<td>18</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>85 - 90</td>
</tr>
<tr>
<td>Dr Alex Garvey</td>
<td>25 - 30</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25 - 30</td>
</tr>
<tr>
<td>Dr Robert Thorburn</td>
<td>20 - 25</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>47.5 - 50.0</td>
<td>65 - 70</td>
</tr>
<tr>
<td>Laura Beresford</td>
<td>5 - 10</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5 - 10</td>
</tr>
</tbody>
</table>

*¹ All pension related benefits are calculated by a formula that calculates the increase in the year by deducting the sum of 20 times the member’s pension entitlement at age 60 plus lump sum entitlement at 31 March 2016 as adjusted for inflation from the sum of 20 times the member’s pension entitlement at age 60 plus lump sum entitlement at 31 March 2017. Employee contributions in the year towards these benefits are deducted. Pension related benefits for Dr Thorburn include benefits arising from contributions made by the GP Practice in which Dr Thorburn is a partner.

*² These amounts have been paid to third parties make available the services of the Governing Body member.

*³ Benefits relate to the taxable benefit on the provision of cars.

*⁴ Seconded from another body for £nil.
**Figure Forty: Governing Body member remuneration 2015-2016**

The equivalent figures for 2015 - 2016 were:

<table>
<thead>
<tr>
<th>Name</th>
<th>Salary and fees (bands of £5,000)</th>
<th>Taxable benefits (rounded to the nearest £100)</th>
<th>Annual performance related bonuses (bands of £5,000)</th>
<th>Long-term performance related bonuses (bands of £5,000)</th>
<th>All pension related benefits (bands of £2,500)</th>
<th>Total (Bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Paul Bowen</td>
<td>85 - 90</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>22.5 - 25</td>
<td>110 - 115</td>
</tr>
<tr>
<td>Dr Mike Clark*2</td>
<td>20 - 25</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20 - 25</td>
</tr>
<tr>
<td>Jerry Hawker</td>
<td>120 - 125</td>
<td>33</td>
<td>-</td>
<td>-</td>
<td>10 - 12.5</td>
<td>135 - 140</td>
</tr>
<tr>
<td>Alex Mitchell</td>
<td>90 - 95</td>
<td>20</td>
<td>-</td>
<td>-</td>
<td>20 - 22.5</td>
<td>115 - 120</td>
</tr>
<tr>
<td>Duncan Matheson</td>
<td>5 - 10</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Angela Wales*2</td>
<td>5 - 10</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Warren Tuite*2</td>
<td>0 - 5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0 - 5</td>
</tr>
<tr>
<td>Julie Sercombe*2</td>
<td>5 - 10</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Joanne Morton*2</td>
<td>5 - 10</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Bill Swann</td>
<td>5 - 10</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Gerry Gray</td>
<td>10 - 15</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Gill Boston</td>
<td>15 - 20</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15 - 20</td>
</tr>
<tr>
<td>Dr Jennifer Lawn*2</td>
<td>15 - 20</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15 - 20</td>
</tr>
<tr>
<td>Dr Julie Sin*4</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sally Rogers</td>
<td>75 - 80</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>75 - 80</td>
</tr>
</tbody>
</table>

*1 All pension related benefits are calculated by a formula that calculates the increase in the year by deducting the sum of 20 times the member’s pension entitlement at age 60 plus lump sum entitlement at 31 March 2015 as adjusted for inflation from the sum of 20 times the member’s pension entitlement at age 60 plus lump sum entitlement at 31 March 2016. Employee contributions in the year towards these benefits are deducted. The disclosure in previous years did not take account of employee contributions and therefore the figures in this table have been restated for those with pension related benefits.

*2 These amounts have been paid to third parties make available the services of the Governing Body member.

*3 Benefits relate to the taxable benefit on the provision of cars.

*4 Seconded from another body for £nil.
Pension disclosures

**Figure Forty One: Pension disclosure for 2016 - 2017**

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Real increase in pension at age 60 (bands of £2,500) £000</th>
<th>Real increase in pension lump sum at age 60 (bands of £2,500) £000</th>
<th>Total accrued pension at age 60 at 31 March 2017 (bands of £5,000) £000</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2017 (bands of £5,000) £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2016 £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2017 £000</th>
<th>Real increase in Cash Equivalent Transfer Value £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2016 £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2017 £000</th>
<th>Employer's contribution to partnership pension £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Paul Bowen Chairman</td>
<td>0 – 2.5</td>
<td>0 – 2.5</td>
<td>10 – 15</td>
<td>25 – 30</td>
<td>144</td>
<td>28</td>
<td>172</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Jerry Hawker Chief Officer</td>
<td>0 – 2.5</td>
<td>2.5 – 5</td>
<td>15 – 20</td>
<td>45 – 50</td>
<td>268</td>
<td>36</td>
<td>304</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Alex Mitchell Chief Finance Officer</td>
<td>0 – 2.5</td>
<td>0 – 2.5</td>
<td>30 – 35</td>
<td>80 – 85</td>
<td>448</td>
<td>35</td>
<td>483</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Dr Robert Thorburn</td>
<td>0 – 2.5</td>
<td>0 – 2.5</td>
<td>15 – 20</td>
<td>35 – 40</td>
<td>269</td>
<td>37</td>
<td>306</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
</tbody>
</table>

Pension disclosures for Dr Thorburn include amounts arising from contributions made by the GP Practice in which Dr Thorburn is a partner.

**Figure Forty Two: Pension disclosure for 2015 – 2016**

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Real increase in pension at age 60 (bands of £2,500) £000</th>
<th>Real increase in pension lump sum at age 60 (bands of £2,500) £000</th>
<th>Total accrued pension at age 60 at 31 March 2016 (bands of £5,000) £000</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000) £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2015 £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2016 £000</th>
<th>Real increase in Cash Equivalent Transfer Value £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2015 £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2016 £000</th>
<th>Employer's contribution to partnership pension £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Paul Bowen Chairman</td>
<td>0.5 – 2.5</td>
<td>0.5 – 2.5</td>
<td>10 – 15</td>
<td>25 – 30</td>
<td>128</td>
<td>16</td>
<td>144</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Jerry Hawker Chief Officer</td>
<td>0 – 2.5</td>
<td>2.5 – 5</td>
<td>10 – 15</td>
<td>40 – 50</td>
<td>241</td>
<td>27</td>
<td>268</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Alex Mitchell Chief Finance Officer</td>
<td>0 – 2.5</td>
<td>0 – 2.5</td>
<td>25 – 30</td>
<td>75 – 80</td>
<td>430</td>
<td>18</td>
<td>448</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Certain Members do not receive pensionable remuneration therefore there will be no entries in respect of pensions for these Members.

**Cash equivalent transfer values**

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s (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 effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

**Declared interests**

Declared interests are published on our website at https://www.easterncheshireccg.nhs.uk/.

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**Staff Report**

**Number of senior managers by band**

*Figure Forty Three* summarises the number of senior managers at 31 March 2017 by band. For the purpose of this disclosure, senior managers excludes executive board members whose remuneration is disclosed in *Figure Forty*.

**Figure Forty Three**

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very senior managers</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Band 8D</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Band 8C</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Band 8B</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Band 8A</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

**Staff Numbers**

The average number of staff employed by the CCG, excluding members of the Governing Body, during the year is outlined in *Figure Forty Four*.

**Figure Forty Four**

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration and estates</td>
<td>52</td>
<td>46</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>56</strong></td>
<td><strong>48</strong></td>
</tr>
</tbody>
</table>
Board and staff composition

The gender of the Governing Body and staff of the CCG at 31 March 2017 is outlined in Figure Forty Five.

Figure Forty Five

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board members</td>
<td>9</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Senior managers</td>
<td>5</td>
<td>16</td>
<td>21</td>
</tr>
<tr>
<td>Other employees</td>
<td>11</td>
<td>27</td>
<td>38</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td>50</td>
<td>75</td>
</tr>
</tbody>
</table>

Staff benefits

Figure Forty Six

<table>
<thead>
<tr>
<th>Employee benefits 2016-17</th>
<th>Total £'000</th>
<th>Permanent Employees £'000</th>
<th>Other £'000</th>
<th>Administration</th>
<th>Permanent Employees £'000</th>
<th>Other £'000</th>
<th>Programme</th>
<th>Permanent Employees £'000</th>
<th>Other £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and wages</td>
<td>2,763</td>
<td>2,678</td>
<td>85</td>
<td>2,111</td>
<td>2,102</td>
<td>9</td>
<td>652</td>
<td>576</td>
<td>76</td>
</tr>
<tr>
<td>Social security costs</td>
<td>313</td>
<td>313</td>
<td>-</td>
<td>296</td>
<td>296</td>
<td>-</td>
<td>17</td>
<td>17</td>
<td>-</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>342</td>
<td>342</td>
<td>-</td>
<td>324</td>
<td>324</td>
<td>-</td>
<td>18</td>
<td>18</td>
<td>-</td>
</tr>
<tr>
<td><strong>Employee benefits expenditure</strong></td>
<td><strong>3,418</strong></td>
<td><strong>3,333</strong></td>
<td><strong>85</strong></td>
<td><strong>2,731</strong></td>
<td><strong>2,722</strong></td>
<td><strong>9</strong></td>
<td><strong>687</strong></td>
<td><strong>611</strong></td>
<td><strong>76</strong></td>
</tr>
</tbody>
</table>

Figure Forty Seven

<table>
<thead>
<tr>
<th>Employee benefits 2015-16</th>
<th>Total £'000</th>
<th>Permanent Employees £'000</th>
<th>Other £'000</th>
<th>Administration</th>
<th>Permanent Employees £'000</th>
<th>Other £'000</th>
<th>Programme</th>
<th>Permanent Employees £'000</th>
<th>Other £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and wages</td>
<td>2,600</td>
<td>2,440</td>
<td>160</td>
<td>2,193</td>
<td>2,180</td>
<td>12</td>
<td>407</td>
<td>259</td>
<td>148</td>
</tr>
<tr>
<td>Social security costs</td>
<td>198</td>
<td>198</td>
<td>0</td>
<td>162</td>
<td>162</td>
<td>0</td>
<td>36</td>
<td>36</td>
<td>0</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>306</td>
<td>306</td>
<td>0</td>
<td>249</td>
<td>249</td>
<td>0</td>
<td>57</td>
<td>57</td>
<td>0</td>
</tr>
<tr>
<td><strong>Employee benefits expenditure</strong></td>
<td><strong>3,104</strong></td>
<td><strong>2,944</strong></td>
<td><strong>160</strong></td>
<td><strong>2,604</strong></td>
<td><strong>2,592</strong></td>
<td><strong>12</strong></td>
<td><strong>500</strong></td>
<td><strong>352</strong></td>
<td><strong>148</strong></td>
</tr>
</tbody>
</table>

Sickness absence data

Sickness absence data is set out in note 4.3 to the financial statements. The sickness absence data indicates that there has been a decrease in absence levels for 2016-17 when compared to 2015-16. In 2015-16, sickness levels increased disproportionately due to the impact of a small number of employees experiencing long term sickness. Incidents of long term sickness for 2016-17 have reduced in the reporting year and returned to within average levels. The overall annual sickness percentage rate for the CCG has reduced to 2.07% which is on a par with other CCGs in the North West region and with national rates. The number of whole time equivalent (wte) days absence in the 2016-17 twelve month period was 261, giving an average of 4.32 wte days absence per employee. The figures disclosed are based on the ESR Absence Time Line Analysis report.
Staff Policies applied in during the financial year

As an employer we are committed to ensuring that we have a diverse workforce by providing fair and equal access to all NHS Eastern Cheshire CCG jobs, including access to career development and training opportunities for existing and future staff. To do this we aim to recruit the best talent that we can and remove any barriers to ensure that we have the widest possible pool of talent to draw from.

The CCG has approved policies where reasonable adjustments to an employee’s working conditions due to an identified disability can be approved following agreement between employee and manager.

As an employer we are also committed to ensuring that our staff have access to and undertake training around our Public Sector Duty with regards equality and diversity. We have also ensured that we have robust arrangements in place for staff to report any occasions where they or their colleagues have been subject to any intentional or unintentional discrimination in the workplace or when undertaking their duties when representing the CCG.

Expenditure on consultancy

Note 5 to the accounts shows that expenditure on consultancy has reduced from £202,000 to £135,000. Consultancy services are used to provide professional insight into plans to improve services and to assist with shaping potential transformation of services in the future.

Off Payroll engagements (not subject to audit)

NHS Eastern Cheshire Clinical Commissioning Group did not have any off-payroll engagements as at 31 March 2017 for more than £220 per day and that last longer than six months are outlined.

There were no new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months.

There were no off-payroll engagements of Board members / senior officials with significant financial responsibility between 1 April 2016 and 31 March 2017.

Exit Packages

There were no exit packages, including special (non-contractual) payments between 1 April 2016 and 31 March 2017.

Parliamentary Accountability and Audit Report

NHS Eastern Cheshire CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at note 22. An audit certificate and report is also included in this Annual Report at pages 109-112.

Signed

JERRY HAWKER
Chief Officer
(Accountable Officer)
30 May 2017
Biographies

Biographies of the members of NHS Eastern Cheshire Clinical Commissioning Group’s Governing Body and its committees

Dr Paul Bowen
CCG Clinical Chair
Chair of Governing Body
Governing Body Member

Dr Paul Bowen trained at Nottingham University, and completed his hospital and general practice training in Lincolnshire. He moved to Cheshire in 2004 where he worked as a GP in Macclesfield, before becoming a partner at McIlvride Medical Practice in Poynton in 2006. His special interests are in diabetes, elderly care and mental health.

Paul became involved in commissioning in 2007 where he became chair of the local practice based commissioning group, and then a member and chair of the PCT’s commissioning executive (formally PEC). Paul has a passion for patient centred care, through integrated working across health and social sectors. His interests also lie in the use of technology and IT to bring patients and professionals closer together, through improved communication and collaboration.

Jerry Hawker
Chief Officer
(Accountable Officer)
Governing Body Member

Jerry joined the NHS in 2005 through the Department of Health Gateway to Leadership scheme and held a number of executive roles in Central & Eastern Cheshire PCT before joining the CCG. Prior to joining the NHS, he spent 15 years working in the specialty chemical industry and latterly running his own business consultancy company. He graduated as a Polymer Scientist and holds a corporate MBA from Babson College USA.

He is a strong advocate for using patients, carers and families’ experiences of the care system as a driver for change and helping create a culture of continuous improvement. Peoples experience of the care system also underpins his belief in the need for change and creation of new system leadership, shifting the focus from organisations to a high performing, high quality integrated care system.

Alex Mitchell
Chief Finance Officer
Governing Body Member

Alex started his finance career in 1988 with Marks and Spencer’s and having developed an interest in this area, applied for a role within the NHS in 1991. He has worked in Acute Hospitals, Community Providers, Primary Care Trusts as well as Clinical Commissioning Groups, all of which have provided him with a variety of experience and opportunities.

Alex is a member and fellow of the Association of Chartered Certified Accountants and feels that, by working within the NHS, he is applying his skills and energy on behalf of the public.
Gerry Gray
Lay Member for Governance and Audit, Governing Body Member – Lay Member Deputy Chair
Member of: Chair of Governance and Audit Committee, Chair of Remuneration Committee

Gerry is a graduate of Liverpool University and a Fellow of the Chartered Institute of Management Accountants. He has extensive experience of international business having spent more than 35 years in senior financial roles in blue chip multi-national organisations such as Ford Motor Company, Price Waterhouse Coopers, Courtaulds and Pilkington, including four years based in the USA.

Gerry is Chairman of the Regenda Housing Association, and Chairman of Community Catalysts, a national charity involved in the field of micro social enterprise.

Gill Boston
Lay Member for Public and Patient Involvement
Governing Body Member
Member of: Governance and Audit Committee, Remuneration Committee, Clinical and Quality Performance Committee and Chair of the Eastern Cheshire Primary (General Medical) Care Services Joint Commissioning Committee

Gill works as the programme manager for The National Care Forum and Voluntary Organisations Disability Group on the Department of Health funded Voluntary Sector Organisations Strategic Partnership Programme. She is a qualified social worker and holds an Honours degree in social studies and an MA in Community Care.

Gill has worked in various management and monitoring roles for the Local Authority before moving in to higher education where she spent the next 13 years as a senior lecturer in health and social care at the University of Salford before moving to her current role in October 2009. She is particularly interested in commissioning partnerships with the Voluntary and Community Sector and how CCGs can engage with and commission for people who are vulnerable, marginalised and whose voices are seldom heard.

As well as championing the views of the public and patients on the Governing Body and its sub-committees, Gill also takes the Governing Body lead on equality and diversity and is also the Chair of the Eastern Cheshire Primary (General Medical) Care Services Commissioning Committee.
Bill Swann
Lay Member for Public and Patient Involvement
Governing Body Member
Member of: Governance and Audit Committee, Remuneration Committee and Vice Chair of the Eastern Cheshire Primary (General Medical) Care Services Joint Commissioning Committee

Bill is a Chartered Mathematician having graduated from Nottingham, University, and holds a masters degree in Systems Engineering from Lancaster University. He worked with ICI in various roles, primarily concerned with applying computers to business, engineering, and production issues in different parts of the company, latterly as Information Services Supply Manager in the Pharmaceuticals business, now AstraZeneca.

When his wife developed mental and physical disabilities he took early retirement to become her carer, a role he undertook for sixteen years until her death in 2013. From his experiences as a carer, he realised that many of those with health and social issues, and their carers, find it very difficult to secure the services and help they need. He resolved to try to help improve the situation and became involved in numerous voluntary activities, including establishing and chairing the East Cheshire Carers Relevance Group. He also joined the board of Making Space, a national charity concerned with providing services to those with health and social care needs and their carers, a position he continues to hold.

Memories of his wife continue to provide the inspiration for his work with the CCG, where his main interest is in helping develop integrated care, both within health and between health and social care.

As well as championing the views of the public and patients on the Governing Body and its sub-committees, Bill is also a member of the Caring Together Leadership Forum.

Jane Stephens
Lay Member for Public and Patient Involvement
Governing Body Member
Member of: Vice Chair of the Eastern Cheshire Primary (General Medical) Care Services Commissioning Committee

Jane is a chartered engineer and has worked in both technical and project roles in ICI and AstraZeneca at various sites across the UK.

She now works part-time in business improvement. Jane is a member of the Association for Project Management and has experience of delivering sustainable change programmes; helping teams to work together to deliver cost-effective services that give customers what they need. She is also a LEAN Six Sigma Black Belt and this approach to continuous improvement is based on understanding what is important to the customer. Jane believes that this experience will help her to ensure that the needs of patients are heard and built in to new integrated healthcare services. Jane is also a trustee/director at East Cheshire Hospice (where she is the lay member on the Patient Care and Clinical Governance Committee) and as a school governor with 10 years’ experience at both primary and secondary level. She is currently one of two vice-chairs at Tytherington School, Macclesfield. Jane has huge respect for the NHS and all those who work in it to provide such good care and support. She is looking forward to playing her part in the CCG at this challenging and crucial time when clinicians, managers and social care staff are working hard to join up expert teams to create truly patient-centred services, which are greater than the sum of their parts, and are ultimately less frustrating and more satisfying for staff.
Sally Rogers
Registered Nurse
**Governing Body Member**
**Member of:** Clinical Quality and Performance Committee,
Eastern Cheshire Primary (General Medical) Care Services Commissioning Committee

Sally is a registered general nurse who completed return to practice nursing at Manchester University in March 2011. She worked for 13 years in industry before returning to the health service eight years ago leading a regional programme of work for The National Institute for Mental Health England. She remains passionate about the quality of care we deliver, particularly to older people.

Sally has been developing a bespoke ‘Leadership for Quality in General Practice Nursing’ course with local and National colleagues, which will be launched in May 2015 and academically evaluated and piloted in NHS Eastern and South Cheshire CCGs. Sally is also an Executive Board member of the National Association of Primary Care working in partnership with the NHS Confederation.

Duncan Matheson
Secondary Care Doctor
**Governing Body Member**
**Member of:** Governance and Audit Committee, Remuneration Committee, Clinical and Quality Performance Committee

Duncan trained as a medical student at Oxford and St Thomas’ Hospital, London and qualified as a doctor in 1970. Following posts in London his surgical training was mostly in Birmingham and the West Midlands and he was appointed Consultant Surgeon in Macclesfield in 1984.

Duncan set up a vascular surgical service in East Cheshire as well as working across the breadth of general surgery but as the nature of surgical services changed so did his focus and in his latter years was purely a breast surgeon. Duncan retired as a consultant in 2010.

Dr Alex Garvey
General Practice Locality Peer Group Lead - Alderley Edge, Chelford, Handforth and Wilmslow
**Governing Body Member**
**Member of:** Governance and Audit Committee

Dr Alex Garvey grew up in Altrincham, and graduated from the University of Manchester in 2007. He has worked across a wide range of hospital and community settings in the North West of England before moving to Alderley Edge Medical Practice in 2015 where he is now a partner. He has true appreciation of the health care needs of his patients and was delighted to have the opportunity to represent his locality by taking over the role of peer group lead for Chelford, Handforth, Alderley Edge and Wilmslow in April 2016.
Julie Sercombe
General Practice Locality Peer Group Lead Congleton and Holmes Chapel (until 1 June 2016)
Governing Body Member
Julie began her nursing career in 1983, qualifying as a Registered General Nurse three years later at Manchester Royal Infirmary. Since that time Julie has been in continuous NHS employment apart from a short maternity leave in 1989.

Her clinical experience has involved working in Secondary care, Primary Care and the Community, with the longest post being in a GP Practice in Northwich for 16 years, initially setting up a Practice Nurse Service in response to the 1990 GP Contract.

In 2005 Julie completed and was awarded a BSc Honours Nurse Practitioner degree (First Class) and also become an Independent Nurse Prescriber. Additionally, Julie has completed a Post Graduate Certificate in Managing Long Term Conditions at Masters Level, which supported her role whilst working as a Community Matron in Crewe. Julie has been a Governor at a local Primary school for the past 18 years (including Chair) and up until recently has also been a respite foster carer for a looked-after child with autism and attachment disorder – an experience she believes which has taught her a great deal about patience, perspective and resilience.

Dr Robert Thorburn
General Practice Locality Peer Group Lead Congleton and Holmes Chapel (from 1 June 2016)
Governing Body Member
Dr Robert Thorburn BM BCh MA MRCP did his pre-clinical training at Cambridge University and completed his clinical training at Oxford University graduating in 1990. He trained in general medicine and general practice at North Staffordshire Hospital and became GP Partner at Holmes Chapel Health Centre in 1997. He was a member of NHS Eastern Cheshire Primary Care Trusts Professional Executive Committee from 2002 – 2004 and was clinical lead for cardiovascular disease.

Dr Mike Clark
General Practice Locality Peer Group Lead Macclesfield
Governing Body Member, Assistant CCG Clinical Chair Member of: Eastern Cheshire Primary (General Medical) Care Services Commissioning Committee
Dr Mike Clark MB ChB MRCS MRCGP graduated from Manchester University in 1995. Mike has been a GP Partner at High Street Surgery, Macclesfield since 2005, and is the practice prescribing lead. Alongside his work in practice Mike is a GP with a specialist interest in Urology, vasectomy and minor surgery.

He is a strong advocate of shifting the focus of care towards the individual and facilitating patients being able to take responsibility for their own care.
Warren Tuite
General Practice Locality Peer Group Lead Bollington, Disley and Poynton (until 1 August 2016)

Governing Body Member
Member of: Governance and Audit Committee, Remuneration Committee and Eastern Cheshire Primary (General Medical) Care Services Commissioning Committee

Warren began working in the NHS in 2002 as a receptionist for an award-winning general practice in Marple, Stockport. He became operations manager in 2004, tasked with the day-to-day operational running of the practice. Warren graduated as a Bachelor of Arts (Hons) in healthcare management while at Marple. In 2009, he became a practice manager in Middleton before taking on the additional role of lead practice manager for the local CCG, representing 38 practices. He was appointed practice management director of the local GP federation and accepted advisory posts on project boards responsible for primary care improvement, development of a summary care record, electronic prescribing and locality commissioning.

Warren was named practice manager of the year in 2010 and 2011 by the North West Royal College of General Practitioners. He moved to Eastern Cheshire in March 2015 as practice manager for Priorsleigh Medical Centre, Poynton and joined NHS Eastern Cheshire CCG’s Governing Body in December 2015 as peer group lead for Bollington, Disley and Poynton.

Warren is passionate about ensuring that general practice operates efficiently and effectively while pushing boundaries to find new ways to improve patient service. His interests include service re-design, staff development and the intertwining of IT developments to improve efficiencies.

Laura Beresford
General Practice Locality Peer Group Lead Bollington, Disley and Poynton (from 21 September 2016)

Governing Body Member
Member of: Eastern Cheshire Primary (General Medical) Care Services Commissioning Committee

Laura joined the NHS in 2002 as a pharmacy technician and has special interests in medicines management and clinical research. She has since worked in a variety of roles including practice management and leadership development. She is currently the Systems & Research Manager at Bollington Medical Centre.

Dr Jennifer Lawn
General Practice Locality Peer Group Lead Knutsford

Governing Body Member
Member of: Governance and Audit Committee, Remuneration Committee,

Clinical Quality and Performance Committee and Eastern Cheshire Primary (General Medical) Care Services Commissioning Committee

Dr Jennifer Lawn MB ChB Manchester has over 20 years’ experience as a partner at Toft Road Surgery, Knutsford caring for a representative cross section of the local population.

She has been Practice Lead attending locality meetings for many years and has been involved in the evolution of the CCG. She is enthusiastic about improving healthcare in the local community whilst ensuring efficient use of limited resources.
Dr Julie Sin
Consultant in Public Health Medicine, Cheshire East Council
Governing Body Member
Julie first joined the NHS over twenty years ago. A graduate of Manchester University her early career spanned the breadth of hospital care, primary care and community health giving her invaluable insights into care across the NHS system.

After completing general practice training in 1994 and further work in reproductive healthcare she entered the field of public health medicine. In 2009 she joined Central and Eastern Cheshire Primary Care Trust to develop and lead its healthcare public health function and was key to the safe transition of the healthcare public health function locally during the 2013 reforms.

Combining her breadth of NHS experience and population medicine, Julie has worked with NHS Eastern Cheshire CCG since its inception, providing advice and support during its early development through to its current fully authorised function.

Julie’s Governing Body role around population healthcare ensures there is specific challenge to the CCG commissioning strategy so that it has due regard to health gain, evidence-based approaches, and population outcomes.

Neil Evans
Commissioning Director
Governing Body Member – no voting rights

Neil joined the NHS in 2008 having previously worked in a variety of operational, planning and change roles in Financial Services.

Neil was recruited to the NHS through a national leadership development programme and initially worked in the Acute Sector in both Operational and Project Management roles before moving to Central and Eastern Primary Care Trust in August 2009.

Neil has been involved in NHS Eastern Cheshire CCG since its inception.

Fleur Blakeman
Director of Strategy and Transformation
Governing Body Member – no voting rights
Member of: Eastern Cheshire Primary (General Medical) Care Services Commissioning Committee

Fleur qualified as a Registered General Nurse at Nottingham School of Nursing in 1991, completing a Return to Nursing Practice course at Chester University in 2013. Having qualified as a nurse, Fleur attended Leeds Metropolitan University to complete a degree in Health Sciences.

Fleur has gone on to obtain a number of post graduate qualifications including a Masters in Health Services Management at Manchester University and the Advanced Management Programme at Ashridge Business School.

Fleur has performed a number of roles in private healthcare and the NHS and has worked in commissioning organisations including North Staffordshire Health Authority, St Helens and Knowsley Health Authority, Kirby PCG, Ashton, Wigan and Leigh PCT and Warwickshire CCG. She has also worked in a number of hospitals including Nottingham University Hospitals NHS Trust, BUPA hospitals (various), Countess of Chester Hospital NHS Foundation Trust, Royal National Orthopaedic Hospital NHS Trust and Mersey Care NHS Trust.

Fleur was also a Trustee of Wirral CVS (a voluntary sector provider).

A wife and mother of two, Fleur is committed to improving health and social care services and individuals’ health and wellbeing. In her own time, she supports a number of charities and undertakes voluntary work.

Members of the Governing body without a vote

Member of: Clinical Quality and Performance Committee, and Eastern Cheshire Primary (General Medical) Care Services Commissioning Committee

Fleur qualified as a Registered General Nurse at Nottingham School of Nursing in 1991, completing a Return to Nursing Practice course at Chester University in 2013. Having qualified as a nurse, Fleur attended Leeds Metropolitan University to complete a degree in Health Sciences.

Fleur has gone on to obtain a number of post graduate qualifications including a Masters in Health Services Management at Manchester University and the Advanced Management Programme at Ashridge Business School.

Fleur has performed a number of roles in private healthcare and the NHS and has worked in commissioning organisations including North Staffordshire Health Authority, St Helens and Knowsley Health Authority, Kirby PCG, Ashton, Wigan and Leigh PCT and Warwickshire CCG. She has also worked in a number of hospitals including Nottingham University Hospitals NHS Trust, BUPA hospitals (various), Countess of Chester Hospital NHS Foundation Trust, Royal National Orthopaedic Hospital NHS Trust and Mersey Care NHS Trust.

Fleur was also a Trustee of Wirral CVS (a voluntary sector provider).

A wife and mother of two, Fleur is committed to improving health and social care services and individuals’ health and wellbeing. In her own time, she supports a number of charities and undertakes voluntary work.
Voting members of Governing Body subcommittees (Non-Governing Body Member)

Dr Victoria Buckley

Member of: Eastern Cheshire Primary (General Medical) Care Services Commissioning Committee

Dr Victoria Buckley graduated from Edinburgh University in 2004 where she completed her hospital and GP training. She has since worked in several different practices across Eastern Cheshire as a locum and salaried GP for 6 years and has been a GP partner for the last 3 years at Readesmoor Medical Centre in Congleton. She has specialist interests in Psychiatry and Family Planning and currently works with the Cheshire and Wirral Partnership to provide a General Practice service for patients in the Mental Health and Learning Disability Units. She is passionate about improving the well-being of patients and ensuring the most efficient and effective use of resources.

Joanne Morton

Governing Body Member
Member of: Eastern Cheshire Primary (General Medical) Care Services Commissioning Committee

Joanne has 30 years of management experience across both the Health and Private sectors. For the last 13 years she has worked as a practice manager, initially for a practice in Trafford Primary Care Trust area, and latterly for a practice within NHS Eastern Cheshire CCG’s area. In May 2014 she was appointed to serve as Peer Group Lead representing Chelford, Handforth, Alderley and Wilmslow.

Dr Julia Huddart

Executive GP for Clinical Leadership Team
Member of: Clinical Quality and Performance Committee

Dr Julia Huddart MB ChB DCH DRCOG MRCGP has been a GP in Wilmslow since 1983. She has been a trainer in General Practice for over 16 years and has had over 20 years’ experience in the position of Clinical Assistant Palliative Care at East Cheshire Hospice.

Dr James Milligan

Executive GP for Clinical Leadership Team
Member of: Clinical Quality and Performance Committee

Dr James Milligan BM BS graduated from Nottingham University in 1995 and undertook a variety of hospital posts before completing GP training in 2001. He has been partner at Handforth Health Centre since 2002.
Independent Auditor’s Report

to the members of the Governing Body of
NHS Eastern Cheshire CCG

Grant Thornton

We have audited the financial statements of NHS Eastern Cheshire Clinical Commissioning Group (the ‘CCG’) for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014 (the “Act”). The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers’ Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 (the “2016/17 GAM”) and the requirements of the Health and Social Care Act 2012.

This report is made solely to the members of the Governing Body of NHS Eastern Cheshire CCG, as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters in an auditor’s report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer’s Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and is also responsible for ensuring the regularity of expenditure and income. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the “Code of Audit Practice”) and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice as required by the Act.

As explained in the Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG’s resources. We are required under Section 21 (1) (c) of the Act to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report by exception where we are not satisfied.

We are not required to consider, nor have we considered, whether all aspects of the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an
assessment of: whether the accounting policies are appropriate to the CCG’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Performance Report and the Accountability Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit.

If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2016, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Opinion on financial statements

In our opinion:

• the financial statements give a true and fair view of the financial position of NHS Eastern Cheshire CCG as at 31 March 2017 and of its expenditure and income for the year then ended; and

• the financial statements have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the Health and Social Care Act 2012.

Basis for qualified opinion on regularity

The CCG reported a deficit of £12.4 million in its financial statements for the year ending 31 March 2017, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraph 223I of Section 27 of the Health and Social Care Act 2012, to break even on its commissioning budget.

Qualified Opinion on regularity

In our opinion, except for the effects of the matter described in the Basis for qualified opinion on regularity paragraph, 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.

Opinion on other matters

In our opinion:

• the parts of the Accountability Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the Health and Social Care Act 2012; and

• the other information published together with the audited financial statements in the Performance Report
and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the audited financial statements.

Matters on which we are required to report by exception

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Act 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.

On 17 January 2017 we referred a matter to the Secretary of State under section 30 of the Act in relation to NHS Eastern Cheshire CCG’s planned breach of its revenue resource limit for the year ending 31 March 2017.

We are required to report to you if we are not satisfied that the CCG has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for qualified value for money conclusion

The CCG reported a deficit of £12.4 million in its financial statements for the year ending 31 March 2017. In addition, the CCG has not yet succeeded in addressing the underlying financial position within the health economy and is forecasting a further deficit of £13.4 million for the year ending 31 March 2018.

The deterioration in the CCG’s financial position in 2016/17 was due to unanticipated increases in costs including Funded Nursing Care, Stroke transfer, Continuing Healthcare and the non-delivery of agreed savings (£3.7 million). The projected deficit of £13.4 million in 2017/18 will require the delivery of a further £17.9 million of savings not all of which are currently agreed. There is a considerable risk that further unanticipated costs and non-delivery of savings will mean the planned deficit could be exceeded.

This issue is evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified Value for Money Conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2016, except for the effects of the matter described in the Basis for qualified value for money conclusion paragraph, we are satisfied that, in all significant respects, NHS Eastern Cheshire CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in respect of the following matters where we are required to report by exception if:

- in our opinion the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board; or

- we have reported a matter in the public interest under section 24 of the Act in the course of, or at the conclusion of the audit; or

- we have made a written recommendation to the CCG under section 24 of the Act in the course of, or at the conclusion of the audit.

Certificate

We certify that we have completed the audit of the financial statements of NHS Eastern Cheshire CCG in accordance with the requirements of the Act and the Code of Audit Practice.

ROBIN BAKER
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Royal Liver Building
Liverpool
L3 1PS

30 May 2017
# NHS Eastern Cheshire Clinical Commissioning Group

## Financial Statements
for the year ended
31 March 2017

### Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement of Comprehensive Net Expenditure</td>
<td>94</td>
</tr>
<tr>
<td>Statement of Financial Position</td>
<td>95</td>
</tr>
<tr>
<td>Statement of Changes in Taxpayers’ Equity</td>
<td>96</td>
</tr>
<tr>
<td>Statement of Cash Flows</td>
<td>97</td>
</tr>
<tr>
<td>Notes to the financial statements</td>
<td>98 -116</td>
</tr>
</tbody>
</table>
## Statement of Comprehensive Net Expenditure
for the year ended 31 March 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>2016-17 £’000</th>
<th>2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Income from sale of goods and services</td>
<td>2</td>
<td>(20)</td>
</tr>
<tr>
<td>Other operating income</td>
<td>2</td>
<td>(46)</td>
</tr>
<tr>
<td><strong>Total operating income</strong></td>
<td></td>
<td>(66)</td>
</tr>
<tr>
<td>Staff costs</td>
<td>4</td>
<td>3,418</td>
</tr>
<tr>
<td>Purchase of goods and services</td>
<td>5</td>
<td>286,107</td>
</tr>
<tr>
<td>Depreciation and impairment charge</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Provision expense</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Other Operating Expenditure</td>
<td>5</td>
<td>258</td>
</tr>
<tr>
<td><strong>Total operating expenditure</strong></td>
<td></td>
<td>289,800</td>
</tr>
<tr>
<td><strong>Total Net Expenditure for the year</strong></td>
<td></td>
<td>289,734</td>
</tr>
<tr>
<td><strong>Comprehensive Expenditure for the year ended 31 March 2017</strong></td>
<td></td>
<td>289,734</td>
</tr>
</tbody>
</table>

The notes on pages 98 to 116 form part of these financial statements.
Statement of Financial Position
for the year ended 31 March 2017

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td><strong>Non-current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>11</td>
<td>251</td>
</tr>
<tr>
<td>Total non-current assets</td>
<td></td>
<td>251</td>
</tr>
<tr>
<td><strong>Current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>12</td>
<td>3,241</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>13</td>
<td>67</td>
</tr>
<tr>
<td>Total current assets</td>
<td></td>
<td>3,308</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td></td>
<td>3,559</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>14</td>
<td>(16,635)</td>
</tr>
<tr>
<td>Provisions</td>
<td>15</td>
<td>-</td>
</tr>
<tr>
<td>Total current liabilities</td>
<td></td>
<td>(16,635)</td>
</tr>
<tr>
<td><strong>Assets less Liabilities</strong></td>
<td></td>
<td>(13,076)</td>
</tr>
<tr>
<td><strong>Financed by Taxpayers’ Equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General fund</td>
<td></td>
<td>(13,076)</td>
</tr>
<tr>
<td>Total taxpayers’ equity:</td>
<td></td>
<td>(13,076)</td>
</tr>
</tbody>
</table>

The financial statements on pages 90 to 111 were approved and authorised for issue by the Governing Body on 30 May 2017 and signed on its behalf by:

**JERRY HAWKER**
Accountable Officer
30 May 2017

The notes on pages 98 to 116 form part of these financial statements.
## Statement of Changes in Taxpayers’ Equity for the year ended 31 March 2017

<table>
<thead>
<tr>
<th></th>
<th>General fund £’000</th>
<th>Total reserves £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Changes in taxpayers’ equity for 2016-17</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance at 1 April 2016</td>
<td>(10,338)</td>
<td>(10,338)</td>
</tr>
<tr>
<td>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2016-17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(289,734)</td>
<td>(289,734)</td>
</tr>
<tr>
<td>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</td>
<td>(289,734)</td>
<td>(289,734)</td>
</tr>
<tr>
<td>Net funding</td>
<td>286,996</td>
<td>286,996</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2017</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(13,076)</td>
<td>(13,076)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>General fund £’000</th>
<th>Total reserves £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Changes in taxpayers’ equity for 2015-16</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance at 1 April 2015</td>
<td>(10,530)</td>
<td>(10,530)</td>
</tr>
<tr>
<td>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2015-16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(242,420)</td>
<td>(242,420)</td>
</tr>
<tr>
<td>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</td>
<td>(242,420)</td>
<td>(242,420)</td>
</tr>
<tr>
<td>Net funding</td>
<td>242,612</td>
<td>242,612</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2016</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(10,338)</td>
<td>(10,338)</td>
</tr>
</tbody>
</table>

The notes on pages 98 to 116 form part of these financial statements.
Statement of Cashflows
for the year ended 31 March 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>2016-17 £’000</th>
<th>2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(289,734)</td>
<td>(242,420)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>(Increase) in trade &amp; other receivables</td>
<td>12</td>
<td>(696)</td>
</tr>
<tr>
<td>Increase in trade &amp; other payables</td>
<td>14</td>
<td>3,954</td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>15</td>
<td>(455)</td>
</tr>
<tr>
<td>Increase in provisions</td>
<td>15</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net Cash (Outflow) from Operating Activities</strong></td>
<td>(286,915)</td>
<td>(242,649)</td>
</tr>
</tbody>
</table>

| **Cash Flows from Investing Activities** |              |              |
| (Payments) for property, plant and equipment | (102) | (19) |
| **Net Cash (Outflow) from Investing Activities** | (102) | (19) |

| **Net Cash Inflow (Outflow) before Financing** | (287,017) | (242,668) |

| **Cash Flows from Financing Activities** |              |              |
| Grant in Aid Funding Received | 286,997 | 242,611 |
| **Net Cash Inflow from Financing Activities** | 286,997 | 242,611 |

| **Net (Decrease) in Cash & Cash Equivalents** | 13 | (20) | (57) |
| **Cash & Cash Equivalents at the Beginning of the Financial Year** | 87 | 144 |
| **Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year** | 67 | 87 |

The notes on pages 98 to 116 form part of these financial statements.
Notes to the financial statements for the year ended 31 March 2016

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014). This report was issued because the CCG exceeded its target revenue resources use (see note 23) and the accounts show that this spending target was exceeded by £12,439k. The CCG has forecast that it will continue to exceed its spending targets in 2017-18 and this has been built into the plans submitted to NHS England. The CCG continues to adopt the going concern basis for the reason outlined below.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

1.4 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

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

1.5 Pooled Budgets

Where the Clinical Commissioning Group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. If the Clinical Commissioning Group is in a “jointly controlled operation”, the
Clinical Commissioning Group recognises:

• The assets the Clinical Commissioning Group controls;
• The liabilities the Clinical Commissioning Group incurs;
• The expenses the Clinical Commissioning Group incurs; and,
• The Clinical Commissioning Group’s share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a “jointly controlled assets” arrangement, in addition to the above, the Clinical Commissioning Group recognises:

• The Clinical Commissioning Group’s share of the jointly controlled assets (classified according to the nature of the assets);
• The Clinical Commissioning Group’s share of any liabilities incurred jointly; and,
• The Clinical Commissioning Group’s share of the expenses jointly incurred.

1.6 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the Clinical Commissioning Group’s accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.6.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Clinical Commissioning Group’s accounting policies that have the most significant effect on the amounts recognised in the financial statements. Key judgements in the preparation of the financial statements are:

• ensuring that appropriate estimates are made for areas of estimation uncertainty as set out below,
• ensuring that appropriate policies are in place for recognising contractual liabilities,
• ensuring that appropriate policies are in place for considering any claims legal or for continuing health care.

1.6.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the Clinical Commissioning Group’s accounting policies that have the most significant effect on the amounts recognised in the financial statements:

• Claims for continuing health care from 1 April 2013 are provided to the extent that a reasonable estimate can be made for the amount of the claim and the potential success of any claim. As NHS England has assumed responsibility for claims received prior to 31 March 2013, the CCG is responsible only for claims received since that date. The estimated amount in respect of previously unassessed periods of care is of such claims at the year end is £Nil (2015/16 - £1,160,000).
• Data in respect of prescribing costs are usually received two months in arrears and it is necessary to estimate the amount that will be payable for the last two months of the year. This estimate is based on a prescribing spend profile issued by NHS England. The amount estimated at the year end is £5,018,000 (2015/16 - £5,184,000).
• Partially completed spells are periods of care for which the provider of those services has not billed their costs. The providers provide an estimate of the costs that need to be billed and this estimate is checked to ensure it is reasonable in the light of data in relation to stays. The amount is agreed between the provider and the CCG. The total amount accrued at the year end is £1,104,000 (2015/16 - £1,160,000).

1.7 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.8 Employee Benefits

1.8.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, 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. As leave is not carried forward, the estimate amounts to £Nil.

1.8.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the
NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the Clinical Commissioning Group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.9 Other Expenses

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

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

1.10 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.

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.

1.11 Depreciation, Amortisation & Impairments

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

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

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

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

1.12 Government Grants
The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

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

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

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

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

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

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Clinical Commissioning Group’s cash management.

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

- Timing of cash flows (0 to 5 years inclusive): Minus 2.70% (2015-16: minus 1.55%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.95% (2015-16: minus 1.00%)
- Timing of cash flows (over 10 years): Minus 0.80% (2015-16: plus 0.80%)

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

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

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

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

1.18 NHS Continuing Healthcare Risk Pooling

In 2015-16 a risk pool scheme was introduced by NHS England for NHS Continuing Healthcare claims, for claim periods prior to 31 March 2013. Under the scheme clinical commissioning groups contribute annually to a pooled fund, which is used to settle the claims.

1.19 Contingencies

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, contingencies are disclosed at their present value.

1.20 Financial Assets

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

Financial assets are classified into the following categories:

- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.20.1 Financial Assets at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Clinical Commissioning Group’s surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.20.2 Held to Maturity Assets

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity.

After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.20.3 Available For Sale Financial Assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on derecognition.

1.20.4 Loans & Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Clinical Commissioning Group assesses whether any financial assets, other than those held at ‘fair value through profit and loss’ are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of
the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.21 Financial Liabilities

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

1.21.1 Financial Guarantee Contract Liabilities

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

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

1.21.2 Financial Liabilities at Fair Value Through Profit and Loss

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

1.21.3 Other Financial Liabilities

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

1.22 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.

1.23 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 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).

1.24 Joint Operations

Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.25 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2016-17, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH group bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)

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

<table>
<thead>
<tr>
<th></th>
<th>2015-16 Total £’000</th>
<th>2016-17 Total £’000</th>
<th>2016-17 Admin £’000</th>
<th>2016-17 Programme £’000</th>
<th>2016-17 Total £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription fees and charges</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>20</td>
<td>-</td>
<td>20</td>
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<td>-</td>
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<tr>
<td>Charitable and other contributions to revenue expenditure: non-NHS</td>
<td>46</td>
<td>-</td>
<td>46</td>
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<tr>
<td>Non-patient care services to other bodies</td>
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<tr>
<td>Other revenue</td>
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<td>-</td>
<td>4</td>
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<tr>
<td><strong>Total other operating revenue</strong></td>
<td><strong>66</strong></td>
<td>-</td>
<td><strong>66</strong></td>
<td><strong>18</strong></td>
<td></td>
</tr>
</tbody>
</table>

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

## 3 Revenue

<table>
<thead>
<tr>
<th></th>
<th>2015-16 Total £’000</th>
<th>2016-17 Total £’000</th>
<th>2016-17 Admin £’000</th>
<th>2016-17 Programme £’000</th>
<th>2016-17 Total £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>From rendering of services</td>
<td>66</td>
<td>-</td>
<td>66</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>66</strong></td>
<td>-</td>
<td><strong>66</strong></td>
<td><strong>18</strong></td>
<td></td>
</tr>
</tbody>
</table>

Revenue is totally from the supply of services.

The Clinical Commissioning Group receives no revenue from the sale of goods.
## 4 Employee benefits and staff numbers

### 4.1.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2015-16</th>
<th></th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanent</td>
<td>Other</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>2,763</td>
<td>2,678</td>
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<tr>
<td>Social security costs</td>
<td>313</td>
<td>313</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>342</td>
<td>342</td>
<td>-</td>
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</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td><strong>3,418</strong></td>
<td><strong>3,333</strong></td>
<td><strong>85</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Less recoveries in respect of employee benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total - Net admin employee benefits including capitalised costs</strong></td>
<td><strong>3,418</strong></td>
<td><strong>3,333</strong></td>
<td><strong>85</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td><strong>3,418</strong></td>
<td><strong>3,333</strong></td>
<td><strong>85</strong></td>
<td></td>
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<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanent</td>
<td>Other</td>
<td></td>
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<td>£’000</td>
<td>£’000</td>
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<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Salaries and wages</td>
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<td>2,440</td>
<td>160</td>
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<tr>
<td>Social security costs</td>
<td>198</td>
<td>198</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>306</td>
<td>306</td>
<td>-</td>
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<td></td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td><strong>3,104</strong></td>
<td><strong>2,944</strong></td>
<td><strong>160</strong></td>
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</tr>
<tr>
<td>Less recoveries in respect of employee benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total - Net admin employee benefits including capitalised costs</strong></td>
<td><strong>3,104</strong></td>
<td><strong>2,944</strong></td>
<td><strong>160</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td><strong>3,104</strong></td>
<td><strong>2,944</strong></td>
<td><strong>160</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 4.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>Total Number</th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanently employed Number</td>
<td>Other Number</td>
<td>Total Number</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>56</td>
<td>2</td>
</tr>
<tr>
<td>Of the above:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of whole time equivalent people engaged on capital projects</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
4.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th></th>
<th>2016-17 Number</th>
<th>2015-16 Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Lost</td>
<td>261</td>
<td>408</td>
</tr>
<tr>
<td>Total Staff Years</td>
<td>60</td>
<td>50</td>
</tr>
<tr>
<td><strong>Average Working Days Lost</strong></td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2016-17 Number</th>
<th>2015-16 Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of persons retired early on ill health grounds</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£’000 Total additional Pensions liabilities accrued in the year</td>
<td>£’000</td>
<td>£’000</td>
</tr>
</tbody>
</table>

4.4 Exit packages agreed in the financial year

There were no exit packages in the financial year (2015-16 - None)

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

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

4.5.1 Accounting valuation

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

For 2016-17, employers’ contributions of £342,000 (2015-16: £306,000) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme’s actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS pension line of note 4.1.
### 5 Operating expenses

<table>
<thead>
<tr>
<th></th>
<th>2016-17 Total £'000</th>
<th>2016-17 Admin £'000</th>
<th>2016-17 Programme £'000</th>
<th>2015-16 Total £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>3,202</td>
<td>2,515</td>
<td>687</td>
<td>2,844</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>216</td>
<td>216</td>
<td>-</td>
<td>260</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td><strong>3,418</strong></td>
<td><strong>2,731</strong></td>
<td><strong>687</strong></td>
<td><strong>3,104</strong></td>
</tr>
<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>1,137</td>
<td>355</td>
<td>782</td>
<td>579</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>62,780</td>
<td>-</td>
<td>62,780</td>
<td>56,519</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>105,652</td>
<td>38</td>
<td>105,614</td>
<td>103,445</td>
</tr>
<tr>
<td>Services from other WGA bodies</td>
<td>4</td>
<td>-</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>53,083</td>
<td>-</td>
<td>53,083</td>
<td>37,940</td>
</tr>
<tr>
<td>Chair and Non Executive Members</td>
<td>252</td>
<td>252</td>
<td>-</td>
<td>184</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>3,570</td>
<td>25</td>
<td>3,545</td>
<td>3,439</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>93</td>
<td>34</td>
<td>59</td>
<td>202</td>
</tr>
<tr>
<td>Establishment</td>
<td>817</td>
<td>130</td>
<td>687</td>
<td>880</td>
</tr>
<tr>
<td>Transport</td>
<td>10</td>
<td>8</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Premises</td>
<td>699</td>
<td>233</td>
<td>466</td>
<td>635</td>
</tr>
<tr>
<td>Depreciation</td>
<td>17</td>
<td>4</td>
<td>13</td>
<td>-</td>
</tr>
<tr>
<td>Audit fees</td>
<td>49</td>
<td>49</td>
<td>-</td>
<td>54</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>32,318</td>
<td>-</td>
<td>32,318</td>
<td>32,494</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>25,319</td>
<td>-</td>
<td>25,319</td>
<td>1,138</td>
</tr>
<tr>
<td>Other professional fees excl. audit</td>
<td>245</td>
<td>220</td>
<td>25</td>
<td>375</td>
</tr>
<tr>
<td>Research and development (excluding staff costs)</td>
<td>6</td>
<td>-</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>Education and training</td>
<td>60</td>
<td>40</td>
<td>20</td>
<td>281</td>
</tr>
<tr>
<td>Provisions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>455</td>
</tr>
<tr>
<td>CHC Risk Pool contributions</td>
<td>271</td>
<td>-</td>
<td>271</td>
<td>677</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td><strong>286,382</strong></td>
<td><strong>1,388</strong></td>
<td><strong>284,995</strong></td>
<td><strong>239,336</strong></td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td><strong>289,800</strong></td>
<td><strong>4,119</strong></td>
<td><strong>285,681</strong></td>
<td><strong>242,440</strong></td>
</tr>
</tbody>
</table>

Audit fees for our auditors for the year were £54,000 (2015-16 - £54,000) inclusive of irrecoverable VAT. The amount included in the table above is net of a refund £5,400 received from Public Sector Audit Appointments in respect of fees incurred in previous years.
### 6.1 Better Payment Practice Code

<table>
<thead>
<tr>
<th>Measure of compliance</th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£’000</td>
</tr>
<tr>
<td><strong>Non-NHS Payables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade invoices paid in the Year</td>
<td>10,954</td>
<td>85,260</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>10,671</td>
<td>84,726</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>97.42%</td>
<td>99.37%</td>
</tr>
<tr>
<td><strong>NHS Payables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>2,752</td>
<td>172,380</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>2,648</td>
<td>172,142</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>96.22%</td>
<td>99.86%</td>
</tr>
</tbody>
</table>

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

### 6.2 The Late Payment of Commercial Debts (Interest) Act 1998

No payments were made under the Late Payment of Commercial Debts (Interest) Act 1998.

### 7 Income Generation Activities

The Clinical Commissioning Group does not undertake any income generation activities.

### 8. Finance costs

The Clinical Commissioning Group does not incur any finance costs in the year.

### 9. Net gain/(loss) on transfer by absorption

There were no gains or losses arising on transfer of assets by absorption.
10 Operating Leases

10.1 As lessee

10.1.1 Payments recognised as an Expense

<table>
<thead>
<tr>
<th></th>
<th>Buildings £’000</th>
<th>Other £’000</th>
<th>2016-17 Total £’000</th>
<th>Buildings £’000</th>
<th>Other £’000</th>
<th>2015-16 Total £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments</td>
<td>660</td>
<td>8</td>
<td>668</td>
<td>591</td>
<td>2</td>
<td>593</td>
</tr>
<tr>
<td>Total</td>
<td>660</td>
<td>8</td>
<td>668</td>
<td>591</td>
<td>2</td>
<td>593</td>
</tr>
</tbody>
</table>

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed. This note does not disclose future minimum lease payments in respect of this arrangement.

10.1.2 Future minimum lease payments

<table>
<thead>
<tr>
<th></th>
<th>Buildings £’000</th>
<th>Other £’000</th>
<th>2016-17 Total £’000</th>
<th>Buildings £’000</th>
<th>Other £’000</th>
<th>2015-16 Total £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payable:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No later than one year</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

11 Property, plant and equipment

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>Information technology £’000</th>
<th>Total £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost or valuation at 1 April 2016</td>
<td>268</td>
<td>268</td>
<td>268</td>
</tr>
<tr>
<td>Cost or valuation at 31 March 2017</td>
<td>268</td>
<td>268</td>
<td>268</td>
</tr>
<tr>
<td>Depreciation 1 April 2016</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charged during the year</td>
<td>17</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Depreciation at 31 March 2017</td>
<td>17</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2017</td>
<td>251</td>
<td>251</td>
<td>251</td>
</tr>
</tbody>
</table>

The net book value of assets comprises:

Purchased assets | 251 | 251
Total at 31 March 2017 | 251 | 251

Asset financing:

Owned | 251 | 251

Asset lives

Information technology: Minimum Life (years) | 3 | 5
## 12 Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>Current 2016-17 £’000</th>
<th>Non-current 2016-17 £’000</th>
<th>Current 2015-16 £’000</th>
<th>Non-current 2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>1,461</td>
<td>-</td>
<td>832</td>
<td>-</td>
</tr>
<tr>
<td>NHS prepayments</td>
<td>989</td>
<td>-</td>
<td>1,024</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA receivables: Revenue</td>
<td>138</td>
<td>-</td>
<td>312</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA prepayments</td>
<td>381</td>
<td>-</td>
<td>346</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accrued income</td>
<td>259</td>
<td>-</td>
<td>27</td>
<td>-</td>
</tr>
<tr>
<td>VAT</td>
<td>11</td>
<td>-</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Other receivables and accruals</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Trade &amp; other receivables</strong></td>
<td><strong>3,241</strong></td>
<td>-</td>
<td><strong>2,545</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

**Total current and non current**  
3,241 2,545

Included above:  
Prepaid pensions contributions —

### 12.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £’000</th>
<th>2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>203</td>
<td>-</td>
</tr>
<tr>
<td>By three to six months</td>
<td>12</td>
<td>-</td>
</tr>
<tr>
<td>By more than six months</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>215</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

Although there are some receivables shown as past due, these are with other entities within the NHS England group and therefore not considered impaired.

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to Clinical Commissioning Groups to commission services, no credit scoring of them is considered necessary.

## 13 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £’000</th>
<th>2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 1 April 2016</strong></td>
<td>87</td>
<td>144</td>
</tr>
<tr>
<td><strong>Net change in year</strong></td>
<td>(20)</td>
<td>(57)</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2017</strong></td>
<td><strong>67</strong></td>
<td><strong>87</strong></td>
</tr>
</tbody>
</table>

Made up of:  
Cash with the Government Banking Service 67 87

Cash and cash equivalents as in statement of financial position 67 87

**Balance at 31 March 2017**  
67 87

Patients’ money held by the clinical commissioning group, not included above —

-
**14 Trade and other payables**

<table>
<thead>
<tr>
<th></th>
<th>Current 2016-17 £’000</th>
<th>Non-current 2016-17 £’000</th>
<th>Current 2015-16 £’000</th>
<th>Non-current 2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: revenue</td>
<td>1,317</td>
<td>-</td>
<td>1,771</td>
<td>-</td>
</tr>
<tr>
<td>NHS accruals</td>
<td>1,866</td>
<td>-</td>
<td>1,718</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA payables: Revenue</td>
<td>2,760</td>
<td>-</td>
<td>1,711</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA payables: Capital</td>
<td>29</td>
<td>-</td>
<td>131</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accruals</td>
<td>9,858</td>
<td>-</td>
<td>6,933</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA deferred income</td>
<td>285</td>
<td>-</td>
<td>332</td>
<td>-</td>
</tr>
<tr>
<td>Social security costs</td>
<td>55</td>
<td>-</td>
<td>31</td>
<td>-</td>
</tr>
<tr>
<td>Tax</td>
<td>36</td>
<td>-</td>
<td>47</td>
<td>-</td>
</tr>
<tr>
<td>Payments received on account</td>
<td>24</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other payables and accruals</td>
<td>405</td>
<td>-</td>
<td>109</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Trade &amp; Other Payables</strong></td>
<td><strong>16,635</strong></td>
<td>-</td>
<td><strong>12,783</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>Total current and non-current</strong></td>
<td><strong>16,635</strong></td>
<td>-</td>
<td><strong>12,783</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

Other payables include £48k (2015/16 - £38k) for outstanding pension contributions.

**15 Provisions**

<table>
<thead>
<tr>
<th></th>
<th>Current 2016-17 £’000</th>
<th>Non-current 2016-17 £’000</th>
<th>Current 2015-16 £’000</th>
<th>Non-current 2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing care</td>
<td>-</td>
<td>455</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>455</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total current and non-current</strong></td>
<td>-</td>
<td>455</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Legal Claims £’000s</th>
<th>Continuing Care £’000s</th>
<th>Other £’000s</th>
<th>Total £’000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2016</td>
<td>-</td>
<td>455</td>
<td>-</td>
<td>455</td>
</tr>
<tr>
<td>Utilised during the year</td>
<td>-</td>
<td>(455)</td>
<td>-</td>
<td>(455)</td>
</tr>
<tr>
<td>Balance at 31 March 2017</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Continuing care provision relates to claims made by third parties for Continuing Healthcare Funding for unassessed periods of care. The provision is an estimate of the amount that is payable in respect of periods of care since 1 April 2013 as NHS England has accounted for provisions related to periods prior to that date (see note 16.2).
16 Commitments

16.1 Capital commitments
The Clinical Commissioning Group had no capital commitments at 31 March 2017.

16.2 Other financial commitments
The Clinical Commissioning Group has not entered into other non-cancellable contracts.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the Clinical Commissioning Group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2017 is £Nil (2015-16 £1,415k) and contingent liabilities amount to £620k (2015-16 - £Nil).

17 Financial instruments

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

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

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

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

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

17.1.3 Credit risk
Because the majority of the Clinical Commissioning Group’s revenue comes parliamentary funding, the Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

17.1.4 Liquidity risk
The Clinical Commissioning Group is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament. The Clinical Commissioning Group draws down cash to cover expenditure, from NHS England, as the need arises. The Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.
### 17.2 Financial assets

<table>
<thead>
<tr>
<th></th>
<th>At ‘fair value through profit and loss’</th>
<th>Loans and Receivables</th>
<th>Available for Sale</th>
<th>Total 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016-17 £’000</td>
<td>2016-17 £’000</td>
<td>2016-17 £’000</td>
<td>£’000</td>
</tr>
<tr>
<td><strong>Receivables:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>-</td>
<td>1,461</td>
<td>-</td>
<td>1,461</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>-</td>
<td>397</td>
<td>-</td>
<td>397</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>-</td>
<td>67</td>
<td>-</td>
<td>67</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total at 31 March 2017</strong></td>
<td>-</td>
<td><strong>1,927</strong></td>
<td>-</td>
<td><strong>1,927</strong></td>
</tr>
</tbody>
</table>

#### 2015-16 Financial assets

<table>
<thead>
<tr>
<th></th>
<th>At ‘fair value through profit and loss’</th>
<th>Loans and Receivables</th>
<th>Available for Sale</th>
<th>Total 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015-16 £’000</td>
<td>2015-16 £’000</td>
<td>2015-16 £’000</td>
<td>£’000</td>
</tr>
<tr>
<td><strong>Receivables:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>-</td>
<td>832</td>
<td>-</td>
<td>832</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>-</td>
<td>338</td>
<td>-</td>
<td>338</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>-</td>
<td>87</td>
<td>-</td>
<td>87</td>
</tr>
<tr>
<td><strong>Total at 31 March 2016</strong></td>
<td>-</td>
<td><strong>1,257</strong></td>
<td>-</td>
<td><strong>1,257</strong></td>
</tr>
</tbody>
</table>

### 17.3 Financial liabilities

<table>
<thead>
<tr>
<th></th>
<th>At ‘fair value through profit and loss’</th>
<th>Other 2016-17</th>
<th>Total 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016-17 £’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td><strong>Payables:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>-</td>
<td>3,184</td>
<td>3,184</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>-</td>
<td>13,051</td>
<td>13,051</td>
</tr>
<tr>
<td><strong>Total at 31 March 2017</strong></td>
<td>-</td>
<td><strong>16,235</strong></td>
<td><strong>16,235</strong></td>
</tr>
</tbody>
</table>

#### 2015-16 Financial liabilities

<table>
<thead>
<tr>
<th></th>
<th>At ‘fair value through profit and loss’</th>
<th>Other 2015-16</th>
<th>Total 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015-16 £’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td><strong>Payables:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>-</td>
<td>3,490</td>
<td>3,490</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>-</td>
<td>8,883</td>
<td>8,883</td>
</tr>
<tr>
<td><strong>Total at 31 March 2015</strong></td>
<td>-</td>
<td><strong>12,373</strong></td>
<td><strong>12,373</strong></td>
</tr>
</tbody>
</table>
18 Operating segments

The Clinical Commissioning Group considers it has only one segment: commissioning of healthcare services. All income, expenditure, assets and liability relate to that segment.

19 Pooled budgets

The Clinical Commissioning Group has entered into a pooled budget with Cheshire East Council. The pool is hosted by Cheshire East Council.

The Clinical Commissioning Group’s share of the income and expenditure handled by the pooled budget in the financial year was:

<table>
<thead>
<tr>
<th>Year</th>
<th>Expenditure £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016-17</td>
<td>337</td>
</tr>
<tr>
<td>2015-16</td>
<td>226</td>
</tr>
</tbody>
</table>

In addition, NHS Eastern Cheshire Clinical Commissioning Group was part of a Better Care Fund along with NHS South Cheshire CCG and Cheshire East Council. The memorandum account below shows expenditure for NHS Eastern Cheshire CCG:

<table>
<thead>
<tr>
<th>Year</th>
<th>Project funding £’000</th>
<th>Section 256 funding for projects £’000</th>
<th>Performance Fund £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016-17</td>
<td>8,939</td>
<td>3,552</td>
<td>-</td>
</tr>
<tr>
<td>2015-16</td>
<td>7,032</td>
<td>3,466</td>
<td>1,114</td>
</tr>
</tbody>
</table>

20 Related party transactions

The CCG makes payments to practices for services provided under clinical schemes agreed by the Governing Body. The following represents the gross costs of those services paid to practices and other organisations where a member of the Governing Body or a close family member exerts significant control over that practice or organisation:

<table>
<thead>
<tr>
<th>Related Party</th>
<th>Payments to Related Party £’000</th>
<th>Receipts from Related Party £’000</th>
<th>Amounts owed to Related Party £’000</th>
<th>Amounts due from Related Party £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>McIlvride Medical Practice - Dr Paul Bowen, Partner</td>
<td>825</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>High Street Surgery - Dr Mike Clark, Partner</td>
<td>1,115</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Toft Road Surgery - Dr Jennifer Lawn, Partner</td>
<td>1,303</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Holmes Chapel Health Centre, Dr Robert Thorburn Partner</td>
<td>2,461</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cumberland House - Spouse of Dr Bowen, Partner</td>
<td>2,147</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Annandale Medical Centre - Spouse of Dr Lawn, Partner</td>
<td>1,156</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Vernova Healthcare - Joint Venture of Member Practices</td>
<td>2,071</td>
<td>-</td>
<td>130</td>
<td>-</td>
</tr>
</tbody>
</table>

During the year the CCG was been approved under delegated commissioning arrangements which meant that the CCG assumed full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1st April 2016. This means that the payments to related parties in the year ended 31 March 2017 reflect these costs which were previously reported in the financial statements for NHS England.
For the year ended 31 March 2016, related party transactions were as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Payments to Related Party £’000</th>
<th>Receipts from Related Party £’000</th>
<th>Amounts owed to Related Party £’000</th>
<th>Amounts due from Related Party £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-16</td>
<td>McIlvride Medical Practice- Dr Paul Bowen, Partner 145</td>
<td>-</td>
<td>16</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>High Street Surgery - Dr Mike Clark, Partner 147</td>
<td>-</td>
<td>11</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Toft Road Surgery - Dr Jennifer Lawn, Partner 145</td>
<td>-</td>
<td>15</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Cumberland House - Spouse of Dr Bowen, Partner 219</td>
<td>-</td>
<td>22</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Vernova Health Care - Joint Venture of Member Practices 971</td>
<td>-</td>
<td>106</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>CLS Health Care - Chaired by Gill Boston until September 2015 347</td>
<td>-</td>
<td>32</td>
<td>-</td>
</tr>
</tbody>
</table>

Gill Boston had no beneficial interest in CLS Healthcare, a not for profit organisation, and did not benefit from payments made to that organisation which were in respect of clinical services.

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England;
- NHS Foundation Trusts;
- NHS Litigation Authority;
- NHS Business Services Authority;
- NHS Trusts;

In addition, the CCG works closely with other NHS Organisations such as NHS Midlands and Lancashire Clinical Commissioning Support Unit which provides many of our services and Vale Royal CCG which hosts our medicines management team.

NHS Organisations where the CCG has had significant transactions above £3m or where we worked closely with those organisations were:

<table>
<thead>
<tr>
<th>NHS England</th>
<th>-</th>
<th>277,295</th>
<th>-</th>
<th>430</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Cheshire NHS Trust</td>
<td>95,533</td>
<td>-</td>
<td>1,658</td>
<td>402</td>
</tr>
<tr>
<td>Cheshire and Wirral Partnership NHS Foundation Trust</td>
<td>16,496</td>
<td>-</td>
<td>-</td>
<td>159</td>
</tr>
<tr>
<td>University Hospitals of South Manchester NHS Foundation Trust</td>
<td>13,001</td>
<td>-</td>
<td>146</td>
<td>22</td>
</tr>
<tr>
<td>Stockport NHS Foundation Trust</td>
<td>13,418</td>
<td>-</td>
<td>-</td>
<td>65</td>
</tr>
<tr>
<td>Central Manchester Hospitals NHS Foundation Trust</td>
<td>6,338</td>
<td>-</td>
<td>31</td>
<td>94</td>
</tr>
<tr>
<td>North West Ambulance Service</td>
<td>6,701</td>
<td>-</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Mid Cheshire NHS Foundation Trust</td>
<td>7,302</td>
<td>-</td>
<td>267</td>
<td>-</td>
</tr>
<tr>
<td>NHS Midlands and Lancashire CSU</td>
<td>1,205</td>
<td>-</td>
<td>261</td>
<td>-</td>
</tr>
</tbody>
</table>
For the year ended 31 March 2016, NHS Organisations where the CCG has had significant transactions above £3m or where we worked closely with those organisations were:

<table>
<thead>
<tr>
<th>Payments to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS England</td>
<td>-</td>
<td>242,615</td>
<td>-</td>
</tr>
<tr>
<td>East Cheshire NHS Trust</td>
<td>93,645</td>
<td>-</td>
<td>141</td>
</tr>
<tr>
<td>Cheshire and Wirral Partnership NHS Foundation Trust</td>
<td>17,019</td>
<td>-</td>
<td>49</td>
</tr>
<tr>
<td>University Hospitals of South Manchester NHS Foundation Trust</td>
<td>11,903</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Stockport NHS Foundation Trust</td>
<td>11,441</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Central Manchester Hospitals NHS Foundation Trust</td>
<td>6,173</td>
<td>-</td>
<td>92</td>
</tr>
<tr>
<td>North West Ambulance Service</td>
<td>6,578</td>
<td>-</td>
<td>82</td>
</tr>
<tr>
<td>Mid Cheshire NHS Foundation Trust</td>
<td>4,467</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NHS Cheshire and Merseyside CSU</td>
<td>1,029</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

### 21 Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the Clinical Commissioning Group or consolidated group.

### 22 Losses and special payments

The Clinical Commissioning Group made no ex-gratia payments in the year (2015-16 - £Nil). There were no other losses or special payments in the year.

### 23 Financial performance targets

Clinical Commissioning Groups have a number of financial duties under the NHS Act 2006 (as amended). The Clinical Commissioning Group’s performance against those duties was as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016-17 Target</th>
<th>2016-17 Performance</th>
<th>Target met</th>
<th>2015-16 Target</th>
<th>2015-16 Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>277,361</td>
<td>289,800</td>
<td>No</td>
<td>243,837</td>
<td>242,420</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>150</td>
<td>150</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>277,295</td>
<td>289,734</td>
<td>No</td>
<td>243,837</td>
<td>242,420</td>
</tr>
<tr>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>25,564</td>
<td>24,886</td>
<td>Yes</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>4,383</td>
<td>4,119</td>
<td>Yes</td>
<td>4,747</td>
<td>4,250</td>
</tr>
</tbody>
</table>

Based on the above, the Clinical Commissioning Group did not meet its financial duties in the year.

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 received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).