NHS
Salford
Clinical Commissioning Group

# Annual Report and Accounts 2017/18

# Our approach to this report

This report is produced in response to the NHS England requirements, as published in the Department of Health Group Accounting Manual 2017/18. It aims to describe how we carry out our role as NHS Salford Clinical Commissioning Group (CCG). It summarises our responsibilities and tells the story of our achievements, our performance and the challenges we've faced during 01 April 2017 and 31 March 2018. It also cross-references other sections of the Annual Report for further details where relevant. It is split into three core sections:

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

## Contents

# Foreword

NHS Salford Clinical Commissioning Group (CCG) is the organisation that decides how to spend the NHS budget on the majority of health services for 270,000 people registered with a GP in Salford. This includes the care and treatment you receive in hospital, maternity services, community and mental health services. We also have delegated responsibility for commissioning general practice services.

Established under the Health and Social Care Act 2012 as a statutory body, every GP from the city's 45 practices is a Member of Salford CCG. As a CCG, we work hard to understand what is happening in Salford's communities in order to commission the right services for the public.

To do this, the vast majority of decisions about how we use the public's money is made by those clinicians who are closest to the people they look after – GPs and their practice staff. We work in partnership with health and social care partners (e.g. local hospitals, local authorities, the community and voluntary sector) and our Governing Body is made up of eight representatives of general practice from across Salford along with a chief accountable officer, chief finance officer, registered nurse, secondary care specialist and three lay members.

Salford is a growing city. Billions of pounds are being invested creating thousands of new jobs and homes. Yet Salford is a city of contrasts. Although there are diverse levels of affluence within the city, Salford is ranked as one of the most deprived local authority areas in England with life expectancy lower than the England average. Even within the city itself, people living in poorer areas live up to 14 years less than those in our richer neighbourhoods.

We're also an ageing city. As more people call Salford 'home', more of us are living longer and often with complicated health conditions. This means more people need more help and support to stay well.

Our vision is for Salford CCG to commission (buy) high quality services to enable our population to live longer, healthier lives, which aligns with the vision of the Salford Locality Plan:

*"Salford people will start, live and age well. People in Salford will get the best start in life, will go on to have a fulfilling and productive adulthood, will be able to manage their health well into their older age and die in a dignified manner in a setting of their choosing. People across Salford will experience health on a parallel with the current 'best' in Greater Manchester, and the gaps between communities will be narrower than they have ever been before."*

Our Annual Report tells the story of what Salford CCG did towards achieving this during 2017/18 and details all the information we are required to provide to the public. I hope you enjoy reading it and, if you have any comments or queries on the information within it, please do let us know using the contact details at the end of the report.

**Dr Tom Tasker**
**Chair**

# PERFORMANCE REPORT

**Anthony Hassall,**
**Chief Accountable Officer**
**23 May 2018**

## Performance Overview

## An overview from our Chief Accountable Officer

The last 12 months have been one of the most challenging periods for the NHS, both in Salford and nationally. “Winter pressures” is a term often dominating the media headlines, but winter pressures do not exist – the pressure on the health and social care system is all year round and we have seen unprecedented demand during 2017/18 across primary, community, social and hospital care.

Despite these challenges, the CCG, our member GP practices and our partners both in Salford and across Greater Manchester have been working hard to respond to this to help the sickest people in our community stay out of hospital wherever possible and continue to deliver high quality, safe, patient-centred care.

We are incredibly ambitious in Salford. Salford’s vision for joined up health and social care is outlined in the Salford Locality Plan and there have been a number of significant and exciting milestones during 2017/18 to turn this plan into a reality for the people of Salford.

For the second year running, Salford CCG was rated outstanding against NHS England’s CCG Assurance Framework for 2016/17. This makes Salford one of only six CCGs in the north of England to receive the highest national rating for performance, and one of 21 CCGs nationally.

Greater Manchester Health and Social Care Partnership (GMHSCP) also gave the CCG the highest rating, Green Star, for quality of leadership for 2016/17. We were shortlisted for HSJ Awards CCG of the Year 2017, recognising the CCGs in which clinicians are truly leading; organisations that are starting to build truly integrated care across their geographic patches; and commissioners with an unwavering focus on patients.

However, the most important rating from 2017/18 was being named one of the best CCGs for the way in which the people of Salford are given a voice over how health care is provided across the city. The assessment – conducted by the NHS National Public Participation team – rated Salford CCG as ‘outstanding’ scoring us 14 out of a possible 15 for our public engagement work. This demonstrates the effort and commitment of our staff – and those at Salford City Council, with whom we jointly carry out much engagement activity – to make sure that we build, foster and develop positive relationships with the people of Salford. By speaking to Salford residents about what they want from their local health services, we can better understand their needs and make the right improvements.

These ratings are, of course, very positive news for Salford but we are never complacent. The key challenge now for us all will be for us to continue to make real differences for the great people of Salford who we serve and whose health and wellbeing continues to be a challenge. This annual report gives a flavour of the work we are progressing, but it can only touch the surface of the work we continue to deliver in partnership across Salford.

Salford has a long and strong history of partnership working which has been built on sound foundations of joint working between the various public, private and community sector organisations in the city.

Throughout 2017/18 our GPs continued to work with local councillors, as well as other clinicians and key management leaders across the system, making decisions together about how to spend our significant funding for adult health and social care together. We also worked together on wider issues such as tackling poverty and responding to our city's changing population. We are determined to grasp opportunities to work together more to improve wellbeing and health and care services for our entire population in the future.

Once again we invested significantly in Salford's voluntary, community and social enterprise (VCSE) sector with £1 million to identify projects encouraging people to live healthier lifestyles and improve access to services. The VCSE sector makes a significant contribution to addressing local health and wellbeing needs, supporting individuals, families and communities. The main aim of our Third Sector Fund is to enable Salford Community and Voluntary Service (CVS) to use their position in the city to reach voluntary organisations, community groups and social enterprises across Salford. The fund provides access to investment opportunities, to support localised activity and help address some of the key health priorities in Salford supporting delivery of the Locality Plan.

To coincide with World Mental Health Day 2017, we launched a new suicide prevention strategy and action plan as a member of the Salford Suicide Prevention Partnership. We join a number of public sector organisations, including NHS, Salford City Council, Greater Manchester Police, HM Prison Forest Bank, Greater Manchester Fire and Rescue, local voluntary, community and social enterprises and Healthwatch Salford, working towards Salford being a city with no deaths by suicide. The strategy includes plans to help those affected by suicide by providing information, services, resources and training, which you can read more about here, www.salfordccg.nhs.uk/preventsuicide.

We have also further strengthened our partnership with neighbours in Salford and Wigan, with the progression of the Bolton, Salford and Wigan Partnership. Working together will mean that we can join up our resources and workforce to provide hospital care more safely and efficiently. Our hospitals are doing well but we know we can do even better together.

Our work as a maternity pioneer in partnership with Bolton and Wigan reached a milestone as Salford became home to the only freestanding midwifery-led unit in Greater Manchester for women who want to give birth in a home-from-home environment. With the addition of the new Ingleside Birth and Community Centre, women in Salford can choose from a full range of maternity services, along with a home birth or a hospital birth.

CCG leaders and staff continue to play an active role in leading on a range of Greater Manchester-wide transformational workstreams. For example, standardising acute care, breast services, bariatric surgery, neuro-rehabilitation, incentivising reform (new contracting and payment models), mental health, dementia, dermatology and hyper acute/community stroke. This Greater Manchester level work is fundamental and complementary to delivery of our Locality Plan within Salford.

The CCG was successful in gaining a place on the prestigious NHS Employers 2017/18 Annual Diversity and Inclusion Partners Programme. After 12 months we gained national accreditation with 'Partner Status', granted due to delivery of our robust action plan to develop and improve our overall equality performance.

Finally, Salford CCG received Living Wage accreditation. Accreditation as a living wage employer strengthens our position as a responsible employer and employer of choice, whereby we are able to recruit and retain the best talent. With the CCG's accreditation, over 50% of members of the Salford Health and Wellbeing Board are Living Wage employers. Being a real living wage employer recognises the value we place on our dedicated employees and the hard work that they do in making sure the people of Salford have access to the very best health care services.

While we continue to face difficult challenges as our health services come under increased pressure, we are excited about the many opportunities and developments ahead of us during 2018/19 and are extremely proud of what we have achieved so far towards our vision of the people of Salford living longer, healthier lives.

**Anthony Hassall,**
**Chief Accountable Officer**

## Our vision and aims

Our vision is to commission (buy) high quality services to enable our population to live longer, healthier lives. To achieve this, we have four aims to provide the best possible care for our patients.

These are:

1. Prevent ill health
2. Reduce health inequalities
3. Improve healthcare quality
4. Improve health and wellbeing outcomes

To achieve these four aims, Salford CCG had five strategic programmes in 2017/18:

- ✓ Quality of care
- ✓ Population health and prevention
- ✓ Integrated community based care and long term conditions
- ✓ Transforming and standardising acute and specialist hospital care
- ✓ Mental Health

This is supported by an additional internal work programme of Enabling Transformation.

Underpinning these is a set of values embedded through the way we work and carry out business: collaboration; innovation; and working with integrity.

## Our priorities for 2017/18

Ensure strong alignment and engagement with all our stakeholders – both locally and at Greater Manchester level - and in particular our members, local partners and population.

Deliver on our 2017/18 objectives and deliverables of the Salford CCG operational plan and associated outcomes, including all national requirement within the NHS Mandate and planning guidance – in particular, ensuring strong primary care in the further development of community based and integrated care.

Drive the further development of integrated commissioning with Salford City Council and, as appropriate, a North West sector approach to delivery of acute services where single service configuration meet the needs of the population and particularly in the context of planning for Healthier Together implementation.

Contribute in a leading way to the work of the Greater Manchester Health and Social Care Partnership (GMHSCP), ensuring all key stakeholders are involved and consulted on service transformation.

## Key risks

Our Governance Statement discloses strategic, commercial, operational and financial risks which may significantly affect the implementation of Salford CCG's strategies and objectives. Our policy for managing principal risks is available via www.salfordccg.nhs.uk/policies-and-procedures.

## Performance summary

## Quality

What are we aiming to achieve for Salford over the next three years?

Our goal is to be the UK's safest health and social care system by 2022 where the voice of our patient and their experiences of our services is captured and drives improvements. We are developing a culture where the potential for harm is actively considered, risks to quality are identified early and we have strategies to minimise any impact on someone using services.

What did Salford CCG achieve during 2017/18?

The CCG has been working on implementing a Quality and Safety strategy, available via www.salfordccg.nhs.uk/publications, with agreed action plans refreshed on an annual basis.

Scrutiny of the quality of care is written into provider contracts and provider quality assurance includes a number of processes to collate and triangulate information gathered from regular inspections and quality walk rounds, from within the system and by external bodies such as; CQC, NHS England and Monitor. Salford is one of three areas that took part in a new national CQC pilot, 'Quality of Care in a Place'. This is about increasing that level of openness by building a picture of what the whole quality of care is like for people living in a particular area – including how well services are co-ordinated and working together.

Safer Salford, the two-year programme which began in April 2016, builds on the learning from the successful Making Safety Visible programme. It focuses on reducing avoidable harm in health and care, emphasising communication handover between services and professionals and medication safety.

During 2017/18, Safer Salford achieved the following:

- More than 30 leaders from partner organisations in Salford have been involved in a development programme to understand the principles of the Measurement and Monitoring of Safety Framework and this has resulted in a range of safety improvements in different care settings across Salford
- Nine care homes completed the Safer Care Homes Collaborative and were able to make small changes in reducing falls for individual residents. Knowledge exchange visits have been implemented as part of this work to share learning
- Two Safer Handover events for GPs and hospitals consultants have been facilitated and a series of improvements are being implemented as a result

The programme is being evaluated and developed further for 2018/19 with a continued focus on care homes and handover. More information is available via www.safersalford.org

What else did we achieve in 2017/18?

- Implemented the Year 1 actions within our patient experience strategy, available via www.salfordccg.nhs.uk/publications, and agreed Year 2 actions making sure patient feedback and experience becomes an integral part of the commissioning processes and is used to influence and improve commissioned services
- Extended the use of our quality assurance framework so that the fundamental elements are incorporated into the processes to monitor the quality and safety of primary care services. The information gathered is used when planning and undertaking quality assurance visits to commissioned services, which now includes GP practices
- Working with Salford City Council, amended our Governance processes around quality to include oversight of information relating to adult social care services. An integrated quality and safety strategy is in development which will be implemented from April 2018
- Implemented a consistent and collaborative approach to supporting care homes in improvements, identified following CQC inspection ratings
- Produced a Medicines Optimisation Annual Report 2017 which was presented to the CCG's Governing Body in January 2018, available via www.salfordccg.nhs.uk/governing-body-minutes

## Salford CCG's Innovation Fund

Our Innovation Fund was created to test and evaluate products and services aiming to improve the experience and outcomes of patients in Salford. Each year we identify key gaps/areas by creating designated calls and use diverse and independent innovation panels to shortlist and award innovative bids. In 2017/18, we invested £2m into innovation bringing our total investment to more than £7m over the last five years. With more than 430 submitted bids, our Innovation Fund has led to 10 new commissioned services since 2013.

Some examples of projects we agreed to fund in 2017/18 include:

- GP Desensitisation Resource Box – conversations with people with learning disabilities at engagement events like Big Health Day suggested fears around medical equipment and not knowing what to expect at GP appointments was leading to Salford's low uptake of routine health tests. The box contains a selection of commonly used medical equipment so people with learning disabilities can learn about, touch and explore medical equipment reducing anxiety/fear
- Minor Illness Workshops – aimed at parents, carers and children to build parents' knowledge and confidence to manage children's minor illness at home without going to the GP or A&E unnecessarily
- Kafoodle Kare – a digital project to help care homes provide meals that are as nutritious as they can be based on complex needs. With 30-42% of patients admitted to care homes at risk of malnutrition, this trial will help care homes determine accurate nutritional information of meals so that residents can be as healthy as they can be via the food that they eat. This in turn will decrease malnutrition, reduce the need for supplements and ultimately improve the quality of life of elderly residents

Our Innovation and Research Strategy is available via www.salfordccg.nhs.uk/innovation-research

## Population Health and Prevention

What are we aiming to achieve for Salford over the next five years?

We want to improve the overall health outcomes of the population of Salford by preventing ill health and encouraging more people to look after themselves (i.e. self-care).

Work to encourage Salford people into changing their behaviour to prevent ill health and self-care more will play a significant part in reducing the demand and dependency on health and care services. In 2017/18, Salford was awarded £3.4 million from the Greater Manchester Health and Social Care Partnership to improve population health in line with Salford's Locality Plan. This is in addition to the £18 million received in 2016 from the Greater Manchester Transformation Fund. Areas for investment include training for frontline staff to identify mental health needs and early help for families with a focus on speech, language and communication, and providing support to the most vulnerable young people in the city.

What did Salford CCG achieve during 2017/18?

Salford's Health and Wellbeing Board, of which the CCG is a member, has overarching responsibility for the successful implementation of Salford's Locality Plan and, in 2016, created communications groups to work in partnership and lead on public awareness health improvement campaigns around the pillars of Start Well, Live Well and Age Well.

Examples of the campaigns carried out during 2017/18 include:

- Start Well – worked with the 1st Boothstown Brownies to tackle tooth decay by creating a new 'Sugar Smart' badge, which the Brownies earn by completing an activity book
- Live Well – worked with the Manchester and Salford Ramblers to arrange a Workforce Walking Challenge for employees from across the NHS, Salford City Council, Salford fire service and the voluntary sector, based on feedback from the public that we should "practice what we preach"
- Age Well – launched a falls prevention campaign promoting six simple exercises and advice on home hazards to tackle Salford having one of the highest rates of falls causing injuries requiring hospital admission amongst older people in Greater Manchester. More information on this campaign is available via www.salfordccg.nhs.uk/preventing-falls

**Third Sector Fund**

The Third Sector Fund is a voluntary, community and social enterprise (VCSE) grants programme developed in partnership, delivered by Salford CVS and funded by Salford CCG with the support of Salford City Council.

Established in 2014, the fund has awarded grants to over 174 voluntary organisations, community groups, social enterprises and schools to enable them, with a small investment, to address some of the key health priorities based on the Salford locality plan's Start Well, Live Well and Age Well.

In 2017/18, we announced a further £3m to be invested into the Third Sector Fund over the next three years. More information on the Third Sector Fund is available via www.salfordccg.nhs.uk/third-sector-fund

## Integrated Community Based Care and Long Term Conditions

What are we aiming to achieve for Salford over the next five years?


Salford Together is a partnership between Salford CCG, Salford City Council, Salford Royal NHS Foundation Trust, Salford Primary Care Together (SPCT) and Greater Manchester Mental Health NHS Foundation Trust.

The partnership is working to transform the commissioning and delivery of the health and social care system in Salford by integrating health and social care, bringing the commissioning budgets and services of GPs, nursing, social care, mental health, community based services and voluntary organisations into a more joined up system that focuses on a person's individual needs and provides them with the support to manage their own care.

We are working towards person-centred services through integrated pathways and an integrated workforce. Following the integration of adult services, we are now developing an agreed vision, objectives and deliverables to integrate care for children, young people and families. Key to an integrated care system is a neighbourhood population health model, something which our GP practices in Salford have been building the foundations towards for several years. This means we have a good basis to build on our neighbourhood capacity, develop the capability of our primary care workforce and deliver more specialist services in the community.

During 2017/18, Salford Together achieved the following:

- Co-located the Integrated Care Organisation and SPCT leadership teams to drive implementation of integrated care transformation
- Completed the Big Health and Social Care Conversation, a widespread public engagement exercise. More information available www.salfordtogether.com/survey-big-health-and-care-conversation
- Agreed four priority areas:
    1. Developing neighbourhood teams
    2. Providing more services that can help at home or in the community
    3. Improving access to GP and community services
    4. Improving care pathways
- Approved and launched transformation projects, including the Enhanced Care Team, and Salford Urgent Care Team
- Redesigned the falls pathway to increase the number of referrals to the Salford Falls Service and prevent falls in later life, which can result in serious injury and hospital admission
- Launched a Streaming Service within Salford Royal's Emergency Department to redirect patients coming to A&E with a primary care need to a more appropriate service

For more information on Salford Together, visit www.salfordtogether.com

What did Salford CCG achieve during 2017/18?

As we continue to commission in line with Salford's Primary Care Strategy, approved by our Governing Body in January 2016 and available via www.salfordccg.nhs.uk/publications, investment continues to scale up community-based services including GPs, community pharmacists, and community services so we can increase the care provided outside hospital.

- Continued to commission in line with the service and financial plan for the pooled budget for adult health and social care services through the Integrated Health and Care Commissioning Joint Committee (ICJC). The ICJC brings GPs and councillors together to make decisions with regards to health and social care matters for adults
- Rolled out Salford Wide Extended Access Pilot giving all residents registered with a Salford GP access to primary care evening/weekend appointments
- Commissioned SPCT to design a new approach to general practice to serve the increasing population in Ordsall South
- Launched an Acute Home Visiting service in Ordsall and Claremont and Walkden and Little Hulton to improve home visits and increase capacity within GP practices
- With Salford City Council and wider partners, we continued to implement the Child and Adolescent Mental Health (CAMHS Transformation Plan with key achievements including the launch of a community eating disorder service and the Single Point of Contact in CAMHS; and establishing an i-Thrive network. More information is available in the refreshed plan via www.salfordccg.nhs.uk/camhs
- Implemented the Better Births recommendations as part of the National Maternity Pioneer Programme in partnership with Bolton and Wigan, including developing the Ingleside Birth and Community Centre in Salford and trialling personal maternity care budgets in Wigan and Bolton
- Progressed our Primary Care Workforce Strategy, including upskilling the administrative workforce to be trained to review clinical correspondence estimated to save up to 40 minutes per day per GP. Available via www.salfordccg.nhs.uk/publications
- Commissioned the Practices Improving Processes in Salford (PIPS) programme providing eight practices with the training and tools to help them reduce waste and inefficiencies, reduce cost and improve productivity, such as increasing numbers of patients booking appointments or requesting repeat prescriptions online
- Commissioned CLAHRC (Collaborations for Leadership in Applied Health Research and Care) to undertake a two-year evaluation on the impact of new roles within primary care
- Following successful evaluation of innovation projects, funded the following schemes:
    - Go2Physio, a self-referral physiotherapy scheme
    - Impaired Glucose Regulation (IGR) Exercise Service, tackling physical activity and weight issues for those at risk of diabetes
    - Self-management in Inflammatory Bowel Disease, patient-access web-based support to help them manage the condition themselves
- Changed the GP x-ray service to improve 'drop in' access and reduce waiting times
- Continued to develop a CCG approach to Personalised Health Budgets, which will be finalised in 2018/19
- Approved plans for a new £4.6million health centre in Little Hulton

## Transforming and Standardising Acute and Specialist Hospital Care

What are we aiming to achieve for Salford over the next five years?

The main provider of acute health services in Salford, Salford Royal NHS Foundation Trust (SRFT), is an 'outstanding' organisation (CQC 2015/16) working with us towards Salford being the safest and most productive health and social care system in England.

As the Bolton, Salford and Wigan Partnership, Salford Royal, Bolton and Wrightington, Wigan and Leigh NHS Foundation Trusts are working together to create 'single shared services' for our combined populations for complex surgery and urgent care. Building on this, the partnership` – which includes the three CCGs - are exploring ways of joining up more surgical, medical and clinical support services – subject to public engagement.

What did Salford CCG achieve in 2017/18?

- Continued work on implementing the Healthier Together recommendations for general surgery and urgent, emergency and acute medicine through our partnership working with Bolton and Wigan
- Began work to ensure local services are meeting the quality standards for dermatology, paediatrics, breast services, elective orthopaedics and benign urology
- From April 2017, we became the responsible commissioner for bariatric surgery, a service which is performing well. Greater Manchester specialist medical weight management services have been reviewed, common standards agreed and implemented
- Continued to achieve national Referral to Treatment Times standards
- Achieved diagnostic waiting times standards for the majority of patients, however capacity issues for specific diagnostics (e.g. endoscopies and MRI scans) mean the overall standard has not been consistently achieved throughout the year and recovery plans have been agreed
- Agreed an Urgent Care Improvement Programme to improve performance as urgent care standards (i.e. A&E, ambulance) have proved very challenging, both locally and nationally
- Supported improvements such as GP streaming which has been operational in Salford Royal's A&E since October 2017. The aim is to replicate the primary care setting as a 'front-of-house' service, stream patients from A&E back into primary care, as well as educate and navigate where their care needs can be met in the community and primary care

## Mental Health

What are we aiming to achieve for Salford over the next five years?

Every year, one in four adults experience at least one diagnosable mental health problem. In Salford, this number is higher than other parts of the UK with around 24,500 people experiencing low levels of personal happiness and 20,700 people experiencing common mental health conditions.

Our integrated approach to mental health commissioning invests around £40million each year on mental health service provision. This mainly focuses on adult provision, in addition to the issues concerning the mental health of young people who are making the transition to adulthood and adult services. Sitting alongside this, the Children and Young People Emotional Health and Wellbeing Partnership oversees the work of the 0-25 programme, including Children and Adults Mental Health Services (CAMHS).

Despite ongoing financial constraints, mental health services are a key priority in Salford. A planned increase of around £1million each year for the next three years will ensure that we continue to meet national access and quality outcomes targets. We are also investing in specific areas, including children and young people's mental health, perinatal mental health and supporting early intervention teams and improving access to psychological therapies. We are committed to protecting effective services and developing new services with an increased focus on building resilience for communities and individuals, together with prevention and early intervention, to meet the rising demand within the resources available.

What did Salford CCG achieve in 2017/18?

- Reviewed delivery of the redesigned Community Engagement Recovery Team (CERT), which helps enhance and maintain service users' role in society, including supporting them in employment
- Our local Early Intervention in Psychosis service is achieving the national target of people experiencing first episode psychosis starting a NICE-recommended package of care within two weeks of referral (100% in December 2017 against a 50% target). However, the service is facing pressures to capacity. With Greater Manchester Mental Health NHS Foundation Trust (GMMH), we carried out a deep dive to understand why there was pressure and what could be done to address it and will be taking this work forward in 2018/19
- Continued to monitor Improved Access to Psychological Therapies and work towards increasing the number of people accessing psychological therapies for anxiety/depression to achieve access target of 25% by 2021. This includes focusing on people who have co-existing long-term physical health conditions
- Launched the Salford Suicide Prevention Strategy, available via www.salfordccg.nhs.uk/salford-suicide-prevention-strategy
- Invested in a Mental Health Police Interface Team, where a mental health practitioner is co-located with Greater Manchester Police to manage the high volume of calls
- Continued to work with GMMH to develop a specialist perinatal community service
- Approved plans to develop a two-year pilot with the VCSE sector to improve support for people with secondary care mental health problems to keep them in employment

## Enabling Transformation

What are we aiming to achieve for Salford over the next five years?

In 2016, the Greater Manchester Health and Social Care Partnership agreed to conduct an independent review of the commissioning arrangements in Greater Manchester, to explore if organisations are taking advantage of the benefits of working together, both locally and across Greater Manchester. The recommendations were:

- Local Authorities and CCGs must come together to form a Single Commissioning Function (SCF) delivering a significant pooled budget across health, social care and wider public services
- Commissioning decisions should be predominately taken at locality level but, for some services and functions, we should establish GM commissioning arrangements. For other services, GM should offer SCFs strategic support or develop common sets of standards.

During 2017/18, we agreed with Salford City Council (SCC) to build on the strong integration and partnership working arrangements already in place between the two organisations and, in principle, to create a new SCF for health and social care making it easier for councillors and local GPs to make decisions about health and social care in our city together.

The CCG has used shared posts in areas including commissioning, planning and performance and engagement to support an increasing move towards integrated commissioning and budgets across the CCG and Salford Council. Planning has been integrated for children and young people's services, both commissioned and those provided in house by SCC. Similarly, planning across all areas of adult health and social care including public health has been integrated providing a strong a stable foundation for the development of more integrated governance which has been emerging following an independently commissioning review undertaken by Deloitte across Greater Manchester.

What else did we achieve in 2017/18?

- Kept our 'outstanding' status improving performance, quality, safety, staff, stakeholder and patient insights
- Continued implementing our Engagement and Communication Strategy available via www.salfordccg.nhs.uk/publications, along with our Engagement Annual Report.
- Created a new Equality Impact Assessment framework for use when commissioning new services, reviewing/redesigning existing services or introducing new processes
- Achieved extremely positive feedback through the 2017 360 Stakeholder Survey, available via www.salfordccg.nhs.uk/publications, and 2017 Staff Satisfaction Survey
- Carried out a deep-dive midyear review of the CCG's financial position, which identified non-recurrent funding available for investment in 2017/18
- Refreshed the CCG's 5 year financial plan, presented to the CCG's Governing Body in May 2018 and available via www.salfordccg.nhs.uk/governing-body-minutes
- Made NHS public wifi available in all GP practices
- Completed our roll out of electronic prescribing in general practices
- Promoted the use of online access to records via our general practices so that all patients can book appointments or order repeat prescriptions online

Taking charge
of Health and Social Care

## Greater Manchester Health and Social Care Partnership – the devolution difference

In April 2016, Greater Manchester signed a devolution deal. Together we took control of our £6bn health and care budget and received £450m to transform services. Devolution gives us the freedom and flexibility to do things that benefit everyone in Greater Manchester. We are making our own decisions and it is starting to pay off, some changes are already making a difference.

- Strong partnerships built through devolution help us redesign and streamline services quickly so they work more effectively. For example, in 2017 the formation of the Northern Care Alliance NHS Group brought together five hospitals, 2,000 beds, specialist and acute services, a range of associated community services and over 17,000 staff across Salford Royal NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust
- Giving children a better start – we're spending an extra £1.5m on oral health to improve children's teeth and getting more children 'school ready'
- We're helping 115,000 smokers quit over the next three years
- We're fighting cancer with a mobile screening programme and community 'cancer champions'
- We're spending £74m on child and adolescent mental health and training teachers on mental health
- We're spending a further £50m on adult mental health services
- Our services are rapidly improving, for example our stroke centres are top-rated and we estimate that 200 lives have been saved because of the specialist care people have received
- We're creating more services closer to people's homes and making it easier to see medical professionals at convenient times through extended opening hours
- We're spotting and treating dementia quicker – seven more people a day are diagnosed with dementia and getting the help and support they need

More information is available via www.gmhsc.org.uk

## Performance Analysis

## Performance measures

The CCG's approach to performance monitoring, reporting and improvement incorporates a balanced view across patient access, quality, service performance, patient and staff insights, financial performance and risk elements. Performance dashboards have been developed to quantify both the outputs and outcomes of the CCG's annual plan and priorities which are aligned with the wider health and social care strategy in Salford - The Locality Plan. The performance reporting also aligns with all national planning requirements as well as those developed regionally in the devolved health and social care integrated care system of Greater Manchester. A full copy of the CCG annual plan and the key performance measures for 2018-19 can be found on the CCG website: http://www.salfordccg.nhs.uk/publications

The integrated reporting of performance includes progress against plans, performance, risks and their mitigation supported by a clear risk strategy and escalation process to ensure performance issues are clearly identified and owned at a level appropriate for their mitigation. At a strategic level these are overseen by the CCG Governing Body and delegated committees including those which the CCG operates in partnership with Salford Council through pooled budget arrangements. Beneath the strategic level there are contracts and finance, quality and outcome and a variety of strategy specific performance and delivery oversight groups in place. As with the strategic boards these mirror the governance arrangements and include a triangulation of performance, progress against plans and risks with clear ownership and accountability.

Monthly quality and outcome and performance and contract meetings with key providers ensure robust scrutiny of performance gaps and the development of effective recovery plans to address these. The CCG Executive Team and Governing Body reviews progress against the entirety of the Operational Plan on a bi-monthly basis and publishes these reports through the Salford CCG website. The Integrated Adult Health and Care Commissioning Joint Committee also meets bi-monthly to review the progress being made towards an integrated care system, with updates on decisions included within the published CCG Governing Body papers, www.salfordccg.nhs.uk/governing-body-minutes

### Performance Analysis

Detailed performance analysis for all key performance measures where the CCG is not on track is contained within the bi-monthly Governing Body organisational performance report. This year the CCG has sustained 'Outstanding' status (for 2016/17) and continued to work with primary care to improve the quality of services. The CCG has also led a city wide initiative to improve the quality of care homes across Salford which has begun to see some improvements with the majority of the focus coming in 2018-19 through the Care Homes Excellence programme.

Where performance is not on track, accountable commissioning leads and clinical leads work with the relevant providers to develop and agree recovery plans and a timetable – these are also included within the Governing Body reports. These recovery plans include any additional resources with any financial commitments approved through the appropriate commissioning governance groups.

Over 2017-18 performance highlights include:

- Sustained delivery of diagnosis rates for dementia in primary care amongst the highest in the UK with Salford taking the lead role in GM for the Dementia United programme
- Reduced the number of people falling aged over 65 through a system wide review of falls services and early interventions with wider partners
- Halved the % of delayed transfers of care year on year through integrated working with partners in social care, integrated care organisation and council
- Extended access to all Salford residents for GP led care – 7 days a week through neighbourhoods with the Salford Wide Extended Access Programme (SWEAP).
- Implemented GP streaming in the Emergency department and developed the arrangements for urgent treatment, rapid response and enhanced community care for delivery in 2018
- Sustained the delivery of national referral to treatment time performance (<18 weeks) in every month despite significant winter pressures
- Achieved urgent cancer 2 week wait times
- Continued to deliver high levels of access to psychological therapies following the development of a shared point of access service model across Salford with improved recovery rates year on year
- Significantly ahead of the national targets for Early Intervention in Psychosis for people experiencing a first episode treated within two weeks (~85%, national target = 50%)

Areas where performance remains challenging include:

- Ambulance response times. The lead commissioner for the North West Ambulance Service is Blackpool CCG. Ambulance response times are an issue across the Greater Manchester and the region and impacted by the ability of hospitals to admit patients and peaks in demand both seasonal and fluctuations each week.
- CAMHS treatment times due to provider capacity and high demand. A full recovery plan is being progressed.
- Cancer 62 day waits for first definitive treatment is slightly below target (82.5%, target =85%). These are often due to complex patients where cancer treatment is delayed due to other health factors and / or complex diagnostics. All cancer breaches are reviewed with providers through the cancer / scheduled care board.
- A and E 4 hour performance is comparable with last year at 85%. The key issue is length of stay and the CCG has been working together with the main provider to deliver a joint urgent and emergency care improvement plan.

Full recovery plans and the complete CCG performance dashboard covering each of the strategic programmes can be found here: www.salfordccg.nhs.uk/governing-body-minutes
The CCG is also subject to external assurance by NHS England. Salford CCG's 2017/18 year-end assessment will be available on www.nhs.uk/servicesearch/performance/search from July 2018. This assessment includes a full review of the quality of the CCG's leadership as well as the national improvement and assessment framework and local transformation improvement areas developed with the Greater Manchester Health and Social Care Partnership.

## Report of the Chief Finance Officer

### Summary Financial Performance 2017-18

The CCG has four statutory financial duties against which it is measured:

1. Revenue resource use does not exceed the amount specified in Directions
2. Revenue administration resource use does not exceed the amount specified in Directions
3. Capital resource use does not exceed the amount specified in Directions
4. Better Payments Practice Policy

In 2017-18, Salford CCG achieved all of its statutory financial duties and this reflects the strong financial management within the organisation. The financial statements of the CCG are detailed on the annual accounts pages 5 to 26. The performance against each of the statutory targets is summarised as follows:

- **Revenue resource use:** The CCG has a legal duty to maintain spending within its resource limit i.e. cannot overspend against its total budget. There are two separate limits against which the CCG is measured: revenue and cash. In 2017-18 the CCG met both requirements.

- The CCG reported an in year under spend (surplus) of £2.3m against its revenue budget (resource limit) of £440m. The CCG planned to achieve a breakeven position and therefore exceeded the planned surplus by £2.3m.

  As set out in the NHS Planning Guidance for 2017-18, CCGs were required to hold a 0.5% reserve uncommitted from the start of the year. NHS England requested CCGs did not spend this reserve and release this to the bottom line, to show this as an underspend, in order to offset the financial overspends elsewhere in the NHS. This accounted for £1.9m of Salford CCG's underspend in 2017-18. In addition, NHS England determined that savings from Category M drugs price reductions could not be spent in 2017-18 and accordingly this increased Salford CCG's surplus by a further £0.4m, to £2.3m in total.

  This additional surplus will be carried forward for drawdown in future years. Salford CCG has a historical cumulative surplus from previous years totalling £13.1m, so the amount carried forward to future years is now £15.4m.

  The cash book balance at the end of the year was £0.3m which was within the £0.5m limit approved by NHS England.

- **Revenue administration resource use:** Salford CCG has been allocated a running costs allowance of £5.56m. In 2017-18, the CCG's running cost expenditure was £5.51m and so has remained within its running cost target

- **Capital resource use:** The CCG received no capital allocation in 2017-18 and has incurred no capital expenditure

- **Better Payment Practice Code:** In line with other public sector bodies, NHS organisations are required to pay invoices within 30 days or within the agreed payment terms, whichever is the sooner. This is known as the Better Payment Practice Code

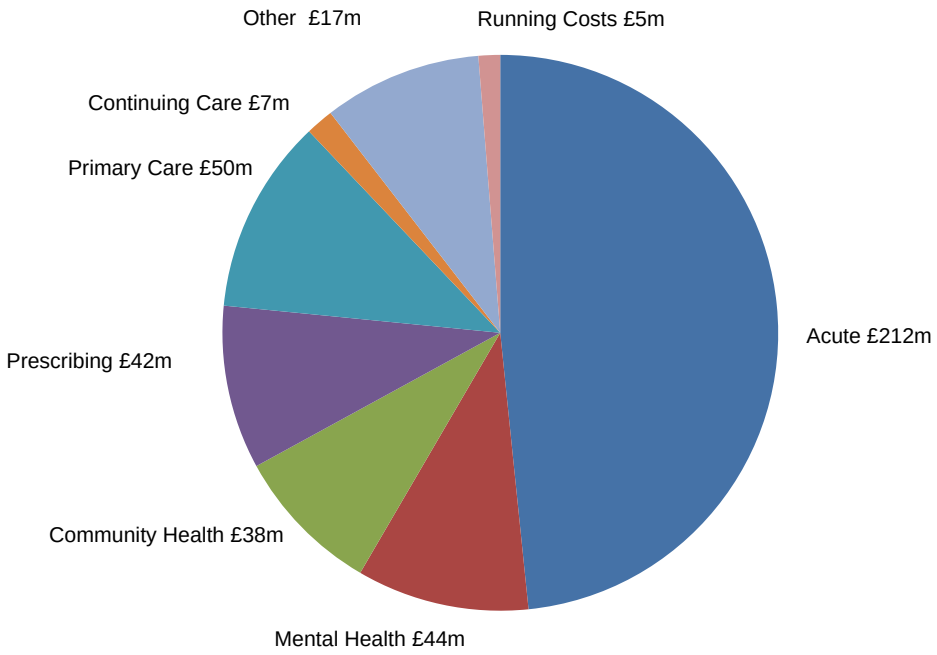
CCGs are required to ensure that at least 95% of invoices are dealt with in line with this code. In 2017-18 the CCG exceeded this target:

- NHS invoices: 100% by invoice value and 99.6% by invoice number
- Non NHS invoices: 99.1% by value and 99.3% by number
- Overall: 99.8% by value and 99.4% by number

**How did Salford CCG spend its allocation of £440m in 2017-18?**

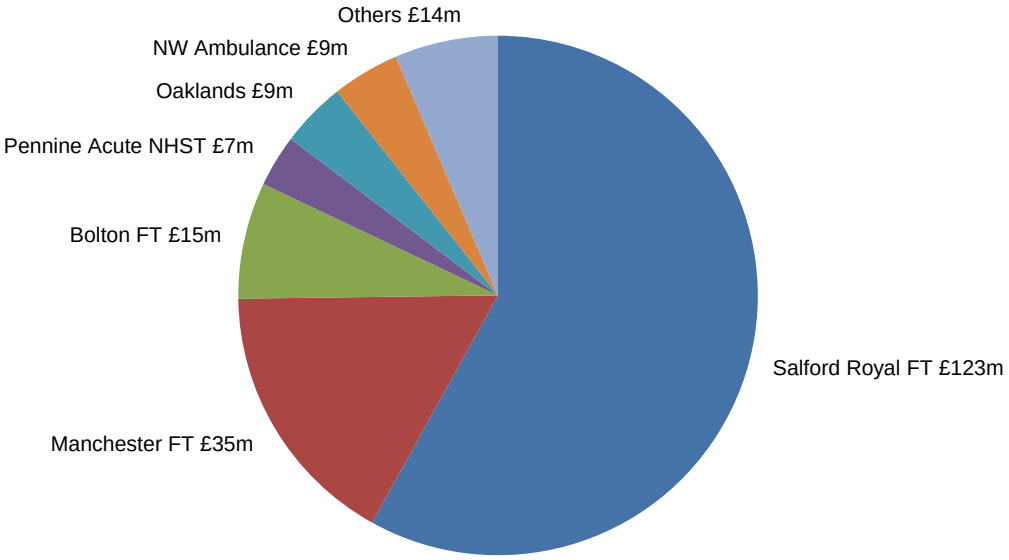
During 2017-18 the CCG achieved a surplus of £2.3m and spent £438m in delivering its objectives across a variety of services, as identified in figure one below:

**Salford CCG - Allocation of Total Expenditure 2017-18 - £438m**




By far the biggest area of spend relates to Acute services which equates to £212m, which is 48% of the total CCG spend. Acute services relate to hospital services (accident and emergency attendances, inpatient admissions, diagnostics and outpatients) as well as ambulance services. Whilst the majority of acute care is commissioned from Salford Royal NHS Foundation Trust (SRFT), other NHS and non NHS providers are also used. The services we buy from these providers are shown in figure two below:

**Salford CCG - Purchase of Acute Services 2017-18 - £212m**




## Looking forward into 2018-19

In January 2016, Salford CCG was notified of its financial allocations for the next 5 years (2016-17 to 2020-21). CCGs' allocations are based on a national funding formula, which includes weightings for the age profile of populations and the deprivation of localities, for example.

The November 2017 Budget allocated a further £1.6bn to the NHS and this means that Salford CCG will receive an additional recurrent uplift of 0.8% or £3.2m for 2018-19, over and above the previously announced uplift of £9.4m.

The CCG has been permitted to carry forward the cumulative surplus that was delivered in 2017-18 and previous years (£15.4m). There are rules set at a national level that determine the amount that can be used in any given year and the timescales that this funding can be drawn down. Salford CCG intends to use this surplus over the next 5 years to invest in service transformation. An amount of £2.6m will be used in 2018-19.

Salford CCG plans to make use of recurrent growth funding and the non-recurrent surplus over the next 5 years to achieve better outcomes for the population of Salford. Some of the investments planned for 2018-19 are as follows:

- ✓ An additional £350k has been set aside recurrently to implement the CCG's Quality Strategy. This funding will be used primarily in 2018-19 to continue the work on the Safer Salford initiatives (£250k) and £100k specifically for additional support to the Care Homes

- ✓ An additional £200k is set aside for Children and Young people's mental health to implement the children's elements of the Five Year Forward View for Mental Health, and a further £200k for maternal mental health pre and post birth.

- ✓ An investment of £1m recurrently in health and wellbeing services commissioned from the voluntary sector

- ✓ The CCG continues to invest £2m recurrently in the Innovation Fund, and this is planned to increase by £500k from 2019-20.

- ✓ Non recurrent funds have been set aside to increase the availability of lung health checks to improve early detection of cancer (£900k) and the refurbishment of Lance Burn Health Centre (£720k) so that antenatal services can relocate to the community from the Salford Royal site.

It is evident that Salford CCG will have funds available to invest over the next five years. The challenge for Salford CCG is to target this funding to make significant inroads into addressing those areas where there are poor health outcomes in Salford.

During 2018-19 the CCG will be exploring with Salford City Council as to how it can make effective joint decisions on health and social care budgets, to the advantage of the Salford population and ensure effective service delivery.

Steve Dixon
Chief Finance Officer

## Sustainable development

On 10 November 2017, the Social Value Alliance in Salford launched the 10% Better Campaign.

As part of this campaign we implemented the following principles:

- Optimising the social, environmental and economic well-being of Salford and its people in everything that we do
- Thinking long-term – turning investment into long-lasting outcomes
- Working together across sectors to provide social value outcomes
- Having values including inclusion, openness, honesty, social responsibility and caring for others
- Having a clear and current understanding of how social value can make Salford a better place to live
- Working together to measure, evaluate and understand social value, as well as reporting publicly to the people of Salford about the social value that we create

The CCG also committed to improving the following in Salford:

- ✓ **MORE** volunteering
- ✓ **MORE** young people who are in employment, education and training
- ✓ **MORE** Salford people saying that they have good wellbeing
- ✓ **LESS** waste – fuel, rubbish, energy, water, etc
- ✓ **MORE** recycling
- ✓ **MORE** green travel e.g. buses, trams, trains, bikes, lift shares, electric vehicles, walking
- ✓ **MORE** use of parks and green spaces
- ✓ **MORE** companies paying the Living Wage Foundation Living Wage
- ✓ **MORE** local people from vulnerable groups accessing new jobs, apprenticeships, training and work experience placements
- ✓ **LESS** fuel poverty
- ✓ **MORE** purchasing from Salford based companies

NHS Salford CCG pledged to continue to:

- Continue to work with the Salford Poverty Truth Commission to explore ways to reduce poverty and create local prosperity
- Play a leading role in encouraging the Salford health and social care system to implement the Living Wage
- Continuing to use social value in commissioning and contract evaluation to invest in health and wellbeing locally
- Explore the opportunities to develop high quality apprenticeships with partners
- Continue to improve staff health and wellbeing including through the second ‘One You’ health improvement programme
- Continue to explore further options to reduce the environmental impact of travel to meetings our meetings and continue to pursue paperless working

Other achievements in relation to social value over 2017/18 include:

- Maintained an active membership in the Locality Workforce Group
- Joined the Carbon Literacy Consortium, tested the training, rolled it out to senior leaders and applied for bronze Carbon Literacy accreditation – the first NHS organisation nationally to do so
- Managed the Third Sector Fund (innovation investment) through year two of a three year investment programme and continued to contribute to addressing the health priorities for Salford. Voluntary organisations, community groups, social enterprises and schools have continued to benefit from the Third Sector Fund. The programme is continuously developing to respond to local need and also provides a mechanism to lever additional funds into Salford and the VCSE sector
- Completed the Salford Poverty Truth Commission, www.salfordpovertytruth.org.uk, with Joseph Rowntree Foundation supported by CCG innovation funding and with CCG Chair representation as a public life commissioner
- Delivered a One You Fest with staff to help improve physical and emotional wellbeing of the workforce
- Included Social Value aims and monitoring within the service specification template and tender evaluation process
- Continued to default black and white and duplex printing, together with all committees remaining paperless
- Continued to sort the CCG's rubbish off site, so as much as possible is recycled

## Patient and public involvement

Salford CCG is committed to putting the voice of patients and the public at the heart of its commissioning. This was recognised in November 2017 when the NHS National Public Participation Team rated us as outstanding against the new Patient and Community Engagement Indicator, scoring 14 out of a possible 15 and describing Salford CCG as an "example of excellence".

We have continued to address the shift in the health and care landscape towards prevention and people living longer and healthier lives by strengthening our co-production style of engagement. Conversations with communities take an asset based approach, enabling us to develop solutions together and ask not just what we can do for citizens, but what citizens can do for themselves.

The integration of the health and social care engagement teams has been fundamental to co-production. It has enabled the CCG to have a wider reach into communities of interest and vulnerable groups bringing the existing forums together to create a 'wheel of engagement' (available via www.salfordccg.nhs.uk/publications) with a continuous cycle of discussion on key topics. This includes a Citizen Panel of over 2,500 citizens (1% of the population) and forums for mental health, learning difficulties, black and ethnic minorities, physical and sensory impairments, older people, people with dementia and young people.

During 2017/18 we have engaged with an estimated 6,000 citizens on a range of topics including suicide prevention; integrated care; maternity and community services; and safeguarding. Each year the CCG publishes an engagement report which outlines all our engagement work and the difference the feedback from patient and the public has made. This is available via www.salfordccg.nhs.uk/publications.

Examples include:

- Throughout the summer we attended a number of community events - such as Eccles Festival, Peel Park Pink Picnic and Broughton Community Day - speaking to 225 people about where and with whom suicide prevention information/training should be carried out. This information is integrated into the Salford Suicide Prevention Strategy, www.salfordccg.nhs.uk/salford-suicide-prevention-strategy
- Through our Innovation Fund project, Open Doors, we spoke with 300 individuals, statutory and non-statutory organisations on how to reduce barriers to engaging with and accessing health services within the black, Asian and minority ethnic (BAME) communities
- Our BAME ambassadors, i.e. representatives from BAME groups across Salford who meet monthly to learn about the latest developments in health and social care and to cascade it back to their respective communities and the groups they represent
- Recruited 45 volunteers to become Greater Manchester Cancer Champions, against a target of 14
- Our award-winning mental health drama workshop, A Spiralling Minds, once again toured all high schools in Salford, along with pupil referral units and secure units, reaching more than 2,500 young people
- We achieved a 52% response rate to our breast service satisfaction survey gaining feedback on people's experiences of the Nightingale Unit

- The Salford Dementia Champions are people living with mild to moderate dementia and their carers, who work with the CCG and Salford City Council to improve dementia services. They were presented with the Ceremonial Mayor's Citizen Award to recognise their outstanding contribution to turning Salford into a dementia-friendly city

We continue to seek new ways to improve our established methods to involve the local community in our work. Our bi-monthly Governing Body meetings are held in public and we maintain our long standing “public comments and questions” section at the beginning of all public Governing Body meetings, often receiving a range of queries from the public either in relation to general matters, or items on the meeting’s agenda. The formal part of our Governing Body always begins with a patient story, either shared directly by the people concerned, by way of a video or read by a member of staff.

It was the result of a workshop with members of our Citizen Panel that we took on the suggestion to combine our summer Citizen Panel event with our 2017 AGM and Governing Body meeting. To make our Annual Report 2016/17 more accessible, we presented a film to tell the story of the previous 12 months and live-streamed both the Citizen Panel and AGM, reaching a total 4,300 Facebook users. Our Annual Report film was split into several smaller films to share on social media and was watched a total 6,500 times.

At the locality level, our Start Well, Live Well, Age Well Plan (Locality Plan) is now firmly embedded across all key partners and continues to be delivered jointly with the City Council, Healthwatch, providers and the voluntary sector. Our Citizen Advisory Panel support us to communicate and engage with the community to achieve the aims of the plan. This year’s themes for engagement and discussion have been developed by the citizen members and include self-responsibility, people powered health and supporting others.

As a member of the Bolton, Salford and Wigan Partnership (BSWP), we are working with Healthwatch to make sure our transformation work is shaped and delivered with the patient voice at the very centre. We have established the Equalities and Experience Reference Group (EERG), which is a group of patients, service users and public representatives set up to help the BSWP improve patient experience and make sure that services are high quality, safe and accessible. The EERG meets every two months, with each meeting focusing on a subject linked to equalities and experience.

## Reducing inequality

It is a core requirement of Salford CCG to demonstrate how we embed equality, diversity and human rights across all work streams. This involves identifying, reporting and setting objectives on health inequality outcomes against each of the nine protected characteristic groups in our planning and decision making processes.

We achieve this by ensuring we engage with local community groups to identify key barriers to accessing services and on proposed key changes in healthcare to identify any potential adverse impacts for them. Through this consultation, we place the patient voice at the heart of this process which helps us to shape fair, accessible services that take account of individual needs and help reduce inequalities.

Our fifth Diversity and Inclusion Annual Report provides information on how we met our legal and mandated duties with regards to diversity and inclusion over the time period 01 September 2016 – 31 August 2017 and is available via www.salfordccg.nhs.uk/diversity-inclusion. It shows our commitment to promoting equality and reducing health inequalities and sets out the way we fulfil our responsibilities arising from the Equality Act 2010. The report sets out what we have done in key areas as well as the challenges we know we need to address to achieve our equality objectives:

1) Improve health and narrow the gaps in access, experience and outcomes
2) Improve collection and use of data/evidence for all protected groups
3) Communicate and engage with all protected groups
4) Develop equality and diversity competent and well supported staff
5) Develop leadership, corporate commitment and governance arrangements for equality and diversity

We are pleased with the progress in our equality assurance with health care providers and contract management, governance arrangements for reviewing equalities and, in particular, getting closer and engaging with our local communities.

The report also gives an overview of our current understanding of Salford's diverse population and health challenges. It recognises our legal responsibilities in demonstrating 'due regard' to the Public Sector Equality Duty and what we are doing to achieve it, as well as progress against our Equality Objectives and commissioning for inclusion.

We are increasingly assured that the organisations providing the services we commission can effectively collect and analyse data to improve service provision and achieve better health outcomes for vulnerable groups in Salford.

The report highlights examples of work we have undertaken to take account of the needs of our vulnerable communities, looks at our plans to improve the way we commission services and identifies future areas for development. It shows our approach to inclusion, with examples of work we have undertaken to take account of the needs of our vulnerable communities.

In 2017, we were successful in gaining a place on the prestigious NHS Employers 2017/18 Annual Diversity and Inclusion Partners Programme. After 12 months we gained national accreditation with 'Partner Status', granted due to delivery of our robust action plan to develop and improve our overall equality performance.

# ACCOUNTABILITY REPORT

**Anthony Hassall,**
**Chief Accountable Officer**
**23 May 2018**

## Corporate Governance Report

## Members Report

NHS Salford CCG's Constitution is available on our website: www.salfordccg.nhs.uk/salford-ccg-constitution. The Constitution was made between the Members of NHS Salford CCG and has been effective since 1 April 2013, when the organisation was established. All GPs in Salford have confirmed agreement to, and signed the NHS Salford CCG Constitution.

### Member profiles

Section 3.1 of NHS Salford CCG's Constitution provides full details of the Membership of the organisation. The Constitution has periodically been updated to reflect a number of national and local changes. The appropriate process has been followed to make these changes culminating in NHS England approval.

### Member practices

Information regarding the eligibility for Membership and arrangements for leaving the CCG is provided in Section 3 of the CCG's Constitution. In addition, Section 8.4 provides detail regarding the methods the CCG uses to engage with its Member Practices.

### Composition of Governing Body

Governing Body Members
Dr Tom Tasker, Chair
Anthony Hassall, Chief Accountable Officer Steve Dixon, Chief Finance Officer
Dr Jeremy Tankel, Medical Director
Dr Tom Regan, Clinical Director for Transformation
Dr Ben Williams, Neighbourhood Lead for Swinton
Dr David McKelvey, Neighbourhood Lead for Ordsall and Claremont
Dr Nick Browne, Neighbourhood Lead for Little Hulton and Walkden
David Flinn, Neighbourhood Lead for Broughton
Kate Jones, Neighbourhood Lead for Eccles, Irlam and Cadishead
Dr Chris Babbs, Governing Body Secondary Care Clinician
Alison Kelly, Governing Body Nurse
Edward Vitalis (Deputy Chair), Lay Member of Finance and Governance
Brian Wroe, Lay Member for Engagement
Paul Newman, Lay Member for Commercial

Ex Officio Governing Body Members (non voting)
Cllr Gina Reynolds, Salford City Council Executive Lead Member – Health and Wellbeing
Charlotte Ramsden, Salford City Council Strategic Director, People
David Herne, Salford City Council Director of Public Health

Executive Team Governing Body Attendees
Karen Proctor, Director of Commissioning
Francine Thorpe, Director of Quality and Safety
Hannah Dobrowolska, Director of Corporate Services

## Committee(s), including Audit Committee

Audit Committee

Edward Vitalis, Lay Member for Finance and Governance (Chair)
Dr Jeremy Tankel, Medical Director
Alison Kelly, Governing Body Nurse

Details of the membership of the Remuneration Committee are included in the Remuneration Report. Details of membership – including attendance - of all other Governing Body Prime Committees are included in the body of the Governance Statement below or at **Appendix A**.

## Register of Interests

NHS Salford CCG has a Conflicts of Interest policy which is in line with statutory guidance on managing conflicts of interest for CCGs. The register of interests is available at: www.salfordccg.nhs.uk/publications

There have been two personal data related incidents during 2017/18 formally reported to the information commissioner's office. These were closed by the Information Commissioner's Office with no further actions required.

## Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- So far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- The member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it

## Modern Slavery Act

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

The CCG was actively involved in developing Multi Agency Modern Day Slavery policies and procedures (now shared across Greater Manchester). Modern Day Slavery is included within relevant CCG Policies or appropriate links included to the multi- agency polices/procedures. This includes the GP Safeguarding Policy.

The CCG has supported the delivery of Multi Agency Complex Safeguarding Training across Salford on behalf of the Safeguarding Adult and Safeguarding Children's Boards, this has been inclusive of Multi Agency Modern Day Slavery training.

Assurance from providers is sought via the CCG Safeguarding Team using the Greater Manchester Safeguarding standards as part of contractual arrangements.

## Statement of Accountable Officer's Responsibilities

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

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

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year 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, 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.

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

**Anthony Hassall**
**Chief Accountable Officer**
**23 May 2018**

# Governance Statement

## Introduction and context

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

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

As at 1 April 2017, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

## Scope of responsibility

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

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

## Governance arrangements and effectiveness

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

## The Governing Body

NHS Salford CCG's Governing Body has approved the vision, values and overall strategic direction of the organisation and authorises any matters that amend the CCG's Constitution, including Terms of Reference for the Governing Body, its committees, the Membership of those committees, the overarching scheme of reservation and delegation and the standing orders and prime financial policies.

NHS Salford CCG's Constitution permits that the Governing Body must not comprise less than 6 Members and that the Chair will be a GP. In addition, five representatives of Member Practices (covering the various neighbourhoods) coupled with two other GPs or primary care

health professionals, one registered nurse (with a lead role on assurance for safeguarding and quality) and one secondary care specialist doctor (with a lead role on assurance associated with clinical matters including clinical systems and research and development) make up its clinical Membership.

Furthermore, three lay Members (one of whom will be the Deputy Chair) respectively lead on audit, remuneration and conflict of interest matters; patient and public participation matters; and commercial issues. Finally, the Accountable Officer and the Chief Finance Officer complete the composition of the Governing Body.

To add value to its work, NHS Salford CCG routinely extends an invitation to Salford City Council's Director of Public Health, its Strategic Director, People and its Lead Member for Adult Services, Health and Wellbeing.

Members of the CCG's Executive Team are also present at Governing Body meetings as non-voting members.

**Committees of the Governing Body**

To support the successful delivery of its functions and activities, NHS Salford CCG has several Prime Committees (outlined below), each accountable to the Governing Body. Improvements and amendments to the organisation's Constitution were made in 2017/18 to reflect the developing roles of these committees.

All Governing Body Members have undertaken an appraisal during 2017/18, and routine, informal Governing Body developmental sessions serve to facilitate the transfer of knowledge and aid aspects of each Member's personal development. The main body of the Annual Report provides comprehensive highlights of the work led by NHS Salford CCG's committees and sub-committees.

**Audit Committee**

The Audit Committee provides the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the group in so far as they relate to finance. In addition, NHS Salford CCG's Governing Body has conferred/delegated the following functions, connected with the Governing Body's main function to its Audit Committee:

- To review the implementation and ongoing quality of integrated governance, risk management and internal control, across the whole of NHS Salford CCG's activities (both clinical and non-clinical); and
- Act as the arbiter for any issues which may arise from conflicts of interest in relation of the awarding of contracts, in particular to primary care providers and/or primary care independent contractors.

The Committee directed that a number of reviews be undertaken, prioritised on a combination of risk rating and organisational impact. Assurance was obtained on the areas included in the Head of Internal Audit Opinion below.

**Remuneration Committee**

The Remuneration Committee makes decisions on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the organisation and on determinations about allowances under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme.

**Commissioning Committee**

The Commissioning Committee oversees commissioning activities including service developments, Quality, Innovation, Prevention and Productivity (QIPP) plans, investments/disinvestments, quality assurance and contract management.

**Primary Care Commissioning Committee**

The Primary Care Commissioning Committee oversees commissioning activities associated with the commissioning of Primary Care. These commissioning activities include GMS, PMS and APMS contracts, newly designed enhanced services; design of local incentive schemes; decision making on whether to establish new GP practices in an area; approving practice mergers; and making decisions on 'discretionary' payment.

**Executive Team**

The Executive Team is responsible for compliance with statutory and regulatory duties, operational delivery of all CCG functions and performance management of the objectives of the organisation. It is also specifically responsible for the functions of health, safety and risk, information management and technology (IM&T) including information governance, equality and diversity and health economy resilience.

**Integrated Adult Health and Care Commissioning Joint Committee** (joint commissioning arrangement with Salford City Council)

The Integrated Adult Health and Care Commissioning Joint Committee oversees commissioning activities associated with the Adult Health and Care Pool, including commissioning the Integrated Care Organisation and other providers. These commissioning activities include service strategy, service design and market management. The Integrated Adult Health and Care Commissioning Joint Committee also manages system performance and agrees the Commissioning Plan for the Integrated Care System.

**Appendix A** provides summary detail of attendance at meetings throughout 2017/18. Terms of Reference for each Prime Committee are available within the NHS Salford CCG's Constitution on our website www.salfordccg.nhs.uk/publications

**Joint Arrangements**

NHS Salford CCG is one of 10 member CCGs of the Greater Manchester Association of CCGs, a collaborative body which acts as a single commissioning voice within Greater Manchester and a vehicle for joint working. NHS Salford CCG's Clinical Chair and Chief Officer represent the CCG's interests at the Association Governing Group (AGG), the Association's most senior decision-making body. The CCG also has representatives on the

AGG's sub-committees, including Heads of Commissioning and Chief Finance Officers. Through the Greater Manchester Association of CCGs, Member CCGs are able to share best practice, access peer support and work collaboratively on a wider footprint to achieve the best possible health outcomes for their patients.

NHS Salford CCG has also entered into joint arrangements with Salford City Council and other Salford based organisations as follows:

- Salford Safeguarding Adults Board;
- Salford Safeguarding Children's Board;
- Salford Health and Wellbeing Board;
- Integrated Care Advisory Board; and the
- Greater Manchester Health and Social Care Partnership.

Terms of Reference for each committee highlighted above coupled with detailed attendance records are available upon request.

**UK Corporate Governance Code**

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, compliance is considered to be good practice. This Governance Statement is intended to demonstrate NHS Salford CCG's compliance with the principles set out in the code.

For the financial year ended 31 March 2018, and up to the date of signing this statement, the CCG has complied with the provisions set out in the Code, and equally applied the principles laid out therein.

**Discharge of Statutory Functions**

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

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

**Risk management arrangements and effectiveness**

NHS Salford CCG's Risk Management Strategy underpins a Risk Management Framework as part of its wider governance arrangements. The Framework illustrates how our strategic programmes, key work programmes and activities are aligned and explains the method by which risks are assessed, scored, monitored and reported.

Our strategic programmes and key deliverables (objectives) are the primary focus for risk identification and horizon scanning. Strategic risks are recorded in our strategic risk register

which is held in the integrated performance and risk system, Pentana (formerly known as Covalent). Operational risks are captured in specific programme/project risk registers across the organisation.

All risks across the organisation are aligned to objectives and so the CCG does not operate a process of escalation/de-escalation. If a risk is no longer considered to be relevant to a strategic objective, it can be moved to an operational risk register provided that the risk would have an impact on the achievement of objectives at that level i.e. for a programme/project. In turn, a programme/project risk could be moved to the strategic risk register provided that the assessment could demonstrate a risk to the achievement of one or more of our strategic objectives. This process is closely managed by the Senior Planning and Performance Manager, the CCG's risk practitioner.

Details on the CCG's Risk appetite, risk assessment process, risk ownership and accountability and training and reporting arrangements can be found in the CCG's latest Risk Management Strategy.

NHS Salford CCG reported one programme risk in relation to Information Governance in 2017/18 as follows:

A breach of Information Governance or data security processes may result in the release of Patient Confidential Data, Patient Identifiable Data, confidential corporate data or other highly sensitive information.

The risk was identified in 2015/16 and was carried over in to 2016/17 and subsequently in to 2017/18. The risk has strong existing controls and assurances with no gaps identified in the controls. The CCG is comfortable with the level of risk which has been rated as low (green) and therefore tolerates the risk.

The CCG did not identify any risks to compliance with the CCG's licence in 2017/18.

NHS Salford CCG reported one strategic risk to its internal controls in 2017/18 as follows:

Commissioning decisions are influenced by conflicts of interest and do not represent the best solutions for the people of Salford.

Existing controls are in place and assurances have been provided. Gaps in assurances were identified in 2015/16 and further controls were applied as part of the risk treatment plan. This risk was carried forward in to 2016/17 and again in to 2017/18 but remains low (green).

In 2017/18, NHS Salford CCG reported one strategic risk in relation to organisational performance as follows:

If pressures in the health and social care system are not effectively monitored and managed then we may fail to achieve national performance targets. This may result in patient harm, negative media attention (reputational damage), reduced patient confidence and could cause further pressures in the wider health system.

The risk was originally identified in 2015/16 and has been carried forward since then due to

ongoing pressures in the system. Existing controls and assurances are in place. There are currently no gaps in assurances but this risk remains high (red).

In addition to the risk above, the Governing Body receives an integrated planning, performance and risk report (Governing Body Assurance Framework (BAF) Report) at every meeting which details the latest performance breaches including plans for recovery.

All risks are subject to a bi-monthly review. This process is automated with system alerts being generated as risks reach their next scheduled risk assessment date. The process is overseen by the Senior Planning and Performance Manager, the CCG's risk practitioner.

**Other sources of assurance**

*Internal Control Framework*

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

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

The committee and reporting structures of NHS Salford CCG provide the basis of the framework and process that maintains, monitors and reviews the effectiveness of the system of internal control and risk management. The governance structure and sub committees comprise of a mix of senior managers, clinical professionals, independent contractors and internal audit representation to provide an effective balance between the Membership, executive and audit functions and furthermore to ensure that decision making is effectively triangulated.

The Governing Body's role is to provide active leadership of the CCG within a framework of prudent and effective controls that enable risk to be managed. Consequently, the Governing Body's Risk Assurance Framework itself provides the Governing Body with high level assurance of the progress of achievement of the CCG's aims, objectives and priorities within a robust risk based framework. In addition, the Governing Body also receives regular reports offering internal assurances on financial, organisational and quality performance.

For the 2017/18 financial year, Mersey Internal Audit (MIAA) have assessed the organisation's Assurance Framework as being structured to meet the NHS requirements, visibly used by the Governing Body and a clear reflection of the risks discussed by the Governing Body.

The Audit Committee specifically advises the Governing Body on the effectiveness of the system of internal control by the review of the internal audit report, external audit report and the Risk Assurance Framework. Any significant control issues are routinely reported to the Governing Body by the Audit Committee.

*Annual audit of conflicts of interest management*

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

On behalf of the CCG, MIAA has carried out our annual internal audit of conflicts of interest. Following the review, internal audit has assigned compliance levels to each area as follows:

| Scope Area | Compliance Level | RAG rating |
|---|---|---|
| Governance Arrangements | Partially Compliant | · |
| Declarations of interests and gifts and hospitality | Partially Compliant | · |
| Register of interests, gifts and hospitality and procurement decisions | Partially Compliant | · |
| Decision making processes and contract monitoring | Partially Compliant | · |
| Reporting concerns and identifying and managing breaches / non-compliance | Partially Compliant | · |

In the majority of cases (18 out of the 27 requirements set by NHS England for the 2017/18 year), the CCG is compliant with legal requirements and statutory guidance in relation to the management of conflicts of interest and gifts and hospitality and has a clear plan of action to address the areas identified for improvement in this audit.

*Data Quality*

Data provided to the Membership and the Governing Body to inform decision making has a high degree of provenance. It is obtained from trusted sources: NHS data sets; National Institute for Health and Care Excellence (NICE); the Joint Strategic Needs Assessment (JSNA); etc., and from trusted advisers: Greater Manchester Shared Services (GMSS); the National Health Service Litigation Authority (NHSLA); the National Health Service Business Services Authority (NHSBSA); etc.

The Audit Committee and internal audit team play pivotal roles in assuring and challenging, where relevant, the data and assumptions made from that data in reports destined for the Governing Body and other decision making committees or sub groups of the Governing Body.

*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 Framework is supported by an Information Governance Toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals, that personal information is dealt with legally, securely, efficiently and effectively. The CCG has submitted a satisfactory level of compliance with the Information Governance Toolkit. The full detail of our compliance with the assessment was presented to the Governing Body held in May 2018, and is available on our website.

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 have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We have developed formation risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

*Business Critical Models*

No significant internal control issues have been identified in this respect as the CCG uses only those quality assurance models prescribed by NHS England.

The CCG has received third party assurance from Greater Manchester Shared Services (GMSS), who provide a number of support services to NHS Salford CCG. GMSS have had a number of internal audits for which they have received significant assurance. These include key financial systems, people services and emergency preparedness, resilience and response. This confirms that significant assurance can be made in respect of governance, risk management and internal control arrangements operated by GMSS.

**Control Issues**

No significant control issues currently facing the CCG were identified via the Month 9 Governance Statement return.

**Review of economy, efficiency and effectiveness of the use of resources**

The Governing Body and its committees and sub committees receive proposals that are based upon evidence based commissioning intentions. A wide variety of data sources are used to inform the development of our commissioning intentions, but chief amongst these is the Joint Strategic Needs Assessment. Summary business cases are also provided for each commissioning intention that comprises an assessment of the cost benefit analysis of the proposal, equality assessment and an appropriate risk assessment.

The Audit Committee provides the assurance overview for the effective use of resources, and the internal audit team have an annual work programme that complements that role and focuses upon all work areas covered by the CCG.

While CCGs have a responsibility to promote comprehensive healthcare within the resources available, this does not mean an obligation to provide every treatment. As a commissioning organisation, NHS Salford CCG strives to take into account the resources available to it and the competing demands on those resources.

The Greater Manchester Shared Service (GMSS) Effective Use of Resources (EUR) team works closely with NHS Salford CCG to facilitate and support making those judgments at an individual patient level known as Individual Funding Requests (IFRs). GMSS's EUR team combines regional best practice and benchmarking with local knowledge gained from a strong client relationship and deep knowledge and expertise. A regional overview improves consistency across boundaries, leading to an improved patient experience.

Salford CCG was rated 'outstanding' in 2015/16 and 2016/17 by NHS England and commended in areas such as strong and robust leadership, involving and engaging patients and the public and getting best value for money. It is the only CCG in Greater Manchester rated 'outstanding' including Outstanding / Green Star for the Quality of its leadership. The CCG Quarter 4 assurance meeting for 2017/18 took place on 15th May 2018, the results of which will be published once available.

The CCG has submitted a Quality of Leadership assessment although no feedback has been received to date. It is anticipated that the indicator will be also be discussed at the Quarter 4 assurance meeting referred to above.

**Delegation of functions**

GMSS undertake a number of functions on behalf of the CCG including finance. There are no other significant delegated functions that are not already covered elsewhere in the governance statement.

**Counter fraud arrangements**

The CCG has made the following arrangements regarding its managing of counter fraud:

- An Accredited Counter Fraud Specialist is contracted from TIAA (Counter Fraud Services) to undertake counter fraud work proportionate to identified risks.
- The CCG's Audit Committee receives a report against each of the Standards for Commissioners at least annually. There is commitment to provide executive support and direction for a proportionate proactive work plan should this report identify any risks to the organisation.
- A member of the Executive Team is proactively and demonstrably responsible for tackling fraud, bribery, and corruption.

## Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded that, for the period 1 April 2017 – 31 March 2018:

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

During the year, internal audit issued the following audit reports:

| **Area of Audit** | **Level of Assurance Given** |
|---|---|
| Patient Access: Out of Hours and 7 Day | Significant |
| Key Finance Systems | Significant |
| Use of Research in Commissioning | Significant |
| Cyber Security – Organisational Controls | Significant |
| Information Governance Toolkit | Significant |
| Estates and Property Services | Limited |

## Review of the effectiveness of governance, risk management and internal control

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

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The Governing Body
- The Audit Committee
- Internal audit
- Other explicit review/assurance mechanisms.

The role and conclusions of each were that the committee and reporting structures of NHS Salford CCG provide the framework and processes that maintain, monitor and review the effectiveness of the system of internal control and risk management. The governance

structure and subcommittees comprise of a mix of senior managers, clinical professionals, independent contractors and internal audit representation.

The Governing Body's role is to provide active leadership of the CCG within a framework of prudent and effective controls that enable risk to be managed. High risks are reported to each meeting of the Governing Body where gaps in controls and assurances are identified and remedial actions agreed. The Governing Body also receives regular reports giving internal assurances on financial, organisational and quality performance.

The Audit Committee is pivotal in advising the Governing Body on the effectiveness of the system of internal control by the review of the internal audit report, external audit report and the Risk Assurance Framework. Any significant control issues are reported to the Governing Body by the Audit Committee.

**Conclusion**

No significant issues have occurred during 2017/18 which would have a significant impact upon the organisation. My review confirms that NHS Salford CCG has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

**Anthony Hassall**
**Chief Accountable Officer**
**23 May 2018**

## Appendix A
## Attendance at Governing Body Meetings and Prime Committees in 2017/18

| Members | Governing Body | Audit Committee | Primary Care Commissioning Committee | Remuneration Committee | Commissioning Committee | Executive Management Team | Integrated Adult Health and Social Care Commissioning Joint Committee |
|---|---|---|---|---|---|---|---|
| **Governing Body Members** | | | | | | | |
| Dr Tom Tasker, Chair | 6/6 | - | - | 3/3 | 9/14 | 26/38 | - |
| Anthony Hassall, Chief Accountable Officer | 5/6 | - | 5/7 | - | 3/14 | 29/38 | 3/6 |
| Steve Dixon, Chief Finance Officer & Deputy Chief Accountable Officer | 6/6 | 4/4 | 6/7 | - | 10/14 | 34/38 | 5/6 |
| Dr Chris Babbs, Governing Body Secondary Care | 5/6 | - | - | 2/3 | 1/14 | - | - |
| Dr Nick Browne, Neighbourhood Lead | 6/6 | - | - | - | 11/14 | - | 6/6 |
| David Flinn, Neighbourhood Lead | 6/6 | - | - | - | 10/14 | - | 5/6 |
| Kate Jones, Neighbourhood Lead | 6/6 | - | - | - | 11/14 | - | 3/6 |
| Alison Kelly, Governing Body Nurse | 4/6 | 0/4 | - | 2/3 | 1/14 | - | - |
| Dr David McKelvey, Neighbourhood Lead | 6/6 | - | - | - | 12/14 | - | 5/6 |
| Paul Newman, Lay Member – Innovation Matters | 6/6 | - | 6/7 | 3/3 | - | - | - |
| Dr Tom Regan, Clinical Director of Transformation | 5/6 | - | - | - | 10/14 | - | 4/6 |
| Dr Jeremy Tankel, Medical Director | 6/6 | 4/4 | 3/7 | - | 11/14 | - | 3/6 |
| Edward Vitalis, Lay Member, Audit, Remuneration & Conflicts of Interest | 5/6 | 4/4 | | 2/3 | - | - | - |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Dr Ben Williams, Neighbourhood Lead | 5/6 | - | - | - | 13/14 | - | 5/6 |
| Brian Wroe, Lay Member – Patient and Public Participation | 5/6 | - | 5/7 | 2/3 | - | - | - |
| **Executive Team** | | | | | | | |
| Hannah Dobrowolska, Director of Corporate Services | 6/6 | - | - | 3/3 | - | 28/38 | - |
| Karen Proctor, Director of Commissioning | 3/6 | - | 4/7 | - | 8/14 | 22/38 | 4/6 |
| Francine Thorpe, Director of Quality and Innovation | 6/6 | - | 5/7 | - | 11/14 | 31/38 | 5/6 |
| Jennifer McGovern (Left the CCG in Sept 2017) | - | - | - | - | - | 6/11 | - |
| Judd Skelton (replaced Jennifer McGovern) | - | - | - | - | - | 14/33 | 4/6 |

**NB**

The attendance information is only included for voting members and key supporting leads of each committee, and only formal meetings are included in the information provided. Many absences from the above meetings are a result of prioritisation of other meetings relevant to the CCG and, where appropriate, deputies provide cover.

- Indicates not applicable

# REMUNERATION AND STAFF REPORT

**Anthony Hassall,**
**Chief Accountable Officer**
**23 May 2018**

# Remuneration Report

## Remuneration Committee

For the period from 1 April 2017 to 31 March 2018, details of the membership of the Remuneration Committee were as follows:

- Edward Vitalis - Chair – Governance
- Dr Chris Babbs - Secondary Care Consultant
- Paul Newman - Lay Member – Commercial
- Brian Wroe - Lay Member – Engagement
- Alison Kelly - Governing Body Nurse

The Remuneration Committee follows national guidance issued by the Department of Health to determine the remuneration and terms and conditions of senior managers using the national Very Senior Managers pay framework (VSM). The Remuneration Committee is also responsible for the remuneration of the clinical members. Summary detail of attendance at meetings throughout 2017/18 is provided as an appendix to the Governance Statement.

The performance of VSMs is assessed through the CCG's Personal Development Review system in line with NHS policy. Remuneration is not performance related. Termination of contracts, and any relevant payments, are calculated on an individual basis, taking into account circumstances of termination, notice periods, length of service and salary. All calculations are in line with statutory and NHS terms and conditions.

## Policy on the remuneration of senior managers

The policy on the remuneration of directors for the current and future years is in line with the CCG's Approved Standing Orders. There are no senior managers earning in excess of £150,000.

## Senior manager remuneration (including salary and pension entitlements)

Senior managers for the purposes of the remuneration report are the members of the Governing Body plus the executive directors of the CCG.

| Name and Title | 2017/18 | | | | | |
|---|---|---|---|---|---|---|
| | (a) Salary (bands of £5,000) | (b) Expense payments (taxable) to nearest £100 | (c) Performance pay and bonuses (bands of £5,000) | (d) Long term performance pay and bonuses (bands of £5,000) | (e) All pension-related benefits (bands of £2,500) | (f) TOTAL (a to e) (bands of £5,000) |
| | £000 | £ | £000 | £000 | £000 | £000 |
| Tom Tasker Chair | 95-100 | | | | 25-27.5 | 120-125 |
| Anthony Hassall Chief Accountable Officer | 130-135 | | | | 112.5-115 | 245-250 |
| Steve Dixon Chief Finance Officer | 110-115 | | | | 42.5-45 | 155-160 |
| Karen Proctor Director of Commissioning | 85-90 | | | | 27.5-30 | 115-120 |
| Francine Thorpe Director of Quality & Innovation | 90-95 | | | | 12.5-15 | 100-105 |
| Hannah Dobrowolska Director of Corporate Services | 60-65 | | | | 62.5-65 | 125-130 |
| Harry Golby Acting Director of Commissioning | 5-10 | | | | | 5-10 |
| Tom Regan Clinical Lead for Transformation | 55-60 | | | | 15-17.5 | 70-75 |
| Jeremy Tankel Medical Director | 65-70 | | | | | 65-70 |
| Nick Browne Neighbourhood Lead | 25-30 | | | | 5-7.5 | 35-40 |
| David McKelvey Neighbourhood Lead | 25-30 | | | | 267.5-270 | 295-300 |
| Ben Williams Neighbourhood Lead | 25-30 | | | | 140-142.5 | 170-175 |

| Name and Title | 2017/18 | | | | | |
|---|---|---|---|---|---|---|
| | (a) Salary (bands of £5,000) | (b) Expense payments (taxable) to nearest £100 | (c) Performance pay and bonuses (bands of £5,000) | (d) Long term performance pay and bonuses (bands of £5,000) | (e) All pension-related benefits (bands of £2,500) | (f) TOTAL (a to e) (bands of £5,000) |
| | £000 | £ | £000 | £000 | £000 | £000 |
| Kate Jones Neighbourhood Lead | 25-30 | | | | 647.5-650** | 675-680** |
| David Flinn Neighbourhood Lead | 30-35 | | | | | 30-35 |
| Alison Kelly Governing Body Nurse | 5-10 | | | | | 5-10 |
| Chris Babbs Governing Body Secondary Care Clinician | 10-15 | | | | | 10-15 |
| Brian Wroe Lay Member | 5-10 | | | | | 5-10 |
| Edward Vitalis Lay Member | 10-15 | | | | | 10-15 |
| Paul Newman Lay Member | 5-10 | | | | | 5-10 |

** Note that the accuracy of the information provided by the NHS Business Services Authority – Pensions in respect of Kate Jones is under query

| Name and Title | 2016/17 | | | | | |
|---|---|---|---|---|---|---|
| | (a) Salary (bands of £5,000) | (b) Expense payments (taxable) to nearest £100 | (c) Performance pay and bonuses (bands of £5,000) | (d) Long term performance pay and bonuses (bands of £5,000) | (e) All pension-related benefits (bands of £2,500) | (f) TOTAL (a to e) (bands of £5,000) |
| | £000 | £ | £000 | £000 | £000 | £000 |
| Hamish Stedman, Chair | 45-50 | | | | | 45-50 |
| Anthony Hassall Chief Accountable Officer | 115-120 | | | | 50-52.5 | 165-170 |
| Steve Dixon Chief Finance Officer | 105-110 | | | | 62.5-65 | 170-175 |
| Karen Proctor Director of Commissioning | 80-85 | | | | 62.5-65 | 145-150 |
| Francine Thorpe Director of Quality and Innovation | 85-90 | | | | 112.5-115 | 200-205 |
| Hannah Dobrowolska Director of Corporate Services | 55-60 | | | | 32.5-35 | 90-95 |
| Paul Bishop Lead for Strategic Partnership and Planning | 85-90 | | | | | 85-90 |
| Jeremy Tankel Clinical Lead for Quality & Safety | 55-60 | | | | | 55-60 |
| Girish Patel Neighbourhood Lead | 25-30 | | | | | 25-30 |
| Owain Thomas Neighbourhood Lead | 40-45 | | | | 40-42.5 | 80-85 |
| Tom Tasker Neighbourhood Lead /Chair | 85-90 | | | | 35-37.5 | 120-125 |
| Jenny Walton Neighbourhood Lead | 75-80 | | | | | 75-80 |
| Aisha Awan Neighbourhood Lead | 20-25 | | | | | 20-25 |
| Nicholas Browne Neighbourhood Lead | 20-25 | | | | 167.5-170 | 190-195 |

| Name and Title | 2016/17 | | | | | |
|---|---|---|---|---|---|---|
| | (a) Salary (bands of £5,000) | (b) Expense payments (taxable) to nearest £100 | (c) Performance pay and bonuses (bands of £5,000) | (d) Long term performance pay and bonuses (bands of £5,000) | (e) All pension-related benefits (bands of £2,500) | (f) TOTAL (a to e) (bands of £5,000) |
| | £000 | £ | £000 | £000 | £000 | £000 |
| Alison Kelly Governing Body Nurse | 5-10 | | | | | 5-10 |
| David McKelvey Neighbourhood Lead | 5-10 | | | | 20-22.5 | 25-30 |
| Claire Gibbons Lead for Eccles, Irlam & Cadishead | 15-20 | | | | 37.5-40 | 55-60 |
| Mansel Haeney Secondary Care Clinician | 10-15 | | | | | 10-15 |
| Ben Williams | 0-5 | | | | | 0-5 |
| Brian Wroe Lay Member | 5-10 | | | | | 5-10 |
| Edward Vitalis Lay Member | 10-15 | | | | | 10-15 |
| Paul Newman Lay Member | 5-10 | | | | | 5-10 |

## Pension benefits as at 31 March 2018

| Name and Title | (a) Real increase in pension at pension age (bands of £2,500) | (b) Real increase in pension lump sum at pension age (bands of £2,500) | (c) Total accrued pension at pension age at 31 March 2018 (bands of £5,000) | (d) Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) | (e) Cash Equivalent Transfer Value at 1 April 2017 | (f) Real Increase in Cash Equivalent Transfer Value | (g) Cash Equivalent Transfer Value at 31 March 2018 | (h) Employers Contribution to partnership pension |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Anthony Hassall Chief Accountable Officer | 5-7.5 | 10-12.5 | 30-35 | 80-85 | 380 | 105 | 485 | |
| Steve Dixon Chief Finance Officer | 2.5-5 | 0-2.5 | 30-35 | 80-85 | 459 | 64 | 522 | |
| Karen Proctor Director of Commissioning | 0-2.5 | 0-2.5 | 25-30 | 65-70 | 407 | 49 | 456 | |
| Francine Thorpe Director of Quality & Innovation | 0-2.5 | 2.5-5 | 40-45 | 120-125 | 860 | 66 | 927 | |
| Hannah Dobrowolska Director of Corporate Services | 2.5-5 | 5-7.5 | 20-25 | 55-60 | 278 | 51 | 329 | |
| Harry Golby | 0-2.5 | 2.5-5 | 15-20 | 45-50 | 273 | 25 | 298 | |
| Tom Tasker | 0-2.5 | 0-2.5 | 20-25 | 55-60 | 315 | 67 | 381 | |
| Tom Regan | 0-2.5 | 0-2.5 | 0-5 | 0-5 | 7 | 8 | 15 | |
| Nicholas Browne | 0-2.5 | 0-2.5 | 10-15 | 35-40 | 204 | 11 | 215 | |
| David McKelvey | 10-12.5 | 35-37.5 | 20-25 | 60-65 | 185 | 269 | 454 | |
| Ben Williams | 5-7.5 | 17.5-20 | 5-10 | 20-25 | 26 | 103 | 129 | |
| Kate Jones | 27.5-30** | 82.5-85** | 50-55** | 155-160** | 406** | 633** | 1,166** | |

** Note that the accuracy of the information provided by the NHS Business Services Authority – Pensions in respect of Kate Jones is under query

**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.

**Compensation on early retirement of for loss of office**

None

**Payments to past members**

None

**Pay multiples**

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The annualised full-time equivalent remuneration of the highest paid member of the Salford Clinical Commissioning Group in the financial year 2017-18 was £155k-160k (2016-17 £155k-£160k) This is 3.6 times (2016-17, 3.8x) the median remuneration of the workforce, which was £42k (2016-17 £41k). In 2017-18, no employees (2016-17, nil) received remuneration in excess of the highest paid member of the governing body. Remuneration for 2017-18 ranged from £15k to £160k (2016-17, £15k - £158k). Total remuneration includes salary, non-consolidated performance related pay and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

## Staff Report

## Number of senior managers

Executive Team
As at 31 March 2018:

| Payscale Description | No. |
|---|---|
| Chief Operating Officer * | 1 |
| Chief Finance Officer * | 1 |
| Very Senior Manager | 2 |
| Chair * | 1 |
| Agenda for Change | 1 |
| Council payscale (joint appointment) | 1 |
| **Total** | **7** |

* Data is provided here only, although these individuals are also part of the CCG's Governing Body.

Governing Body
As at 31 March 2018:

| Payscale Description | No. |
|---|---|
| Governing Body Lay Member | 3 |
| Governing Body Clinical or Neighbourhood Leads | 8 |
| **Total** | **11** |

In addition, one Governing Body Member paid through a secondment agreement with their employing NHS Trust.

## Staff numbers and costs

| Employee Status | Number of Employees | Costs |
|---|---|---|
| Permanent | 124 | £4,944,849 |
| Fixed Term Temporary | 18 | £449,899 |
| **Total** | **142** | **£5,394,748** |

## Staff composition

At the end of the 2017/18 financial year, Salford CCG staff comprised:

| Employee Group* | Male | Female | Total |
|---|---|---|---|
| Executive Team ** | 3 | 3 | **6** |
| Governing Body | 9 | 2 | **11** |
| Senior Managers*** | 10 | 31 | **41** |
| Other Clinical Leads | 11 | 6 | **17** |
| All other employees | 16 | 56 | **72** |
| **Total** | **49** | **98** | **147** |

* Statistics drawn from NHS Electronic Staff Records (ESR) 2018, as such it includes information of staff members employed directly by the CCG only and not those on secondment to the CCG or in joint roles where the employer is not the CCG
** 3 members of the Executive Team are also Governing Body Members (Chair, Chief Accountable Officer and Chief Finance Officer), their data is only included in the Executive Team to avoid double counting
*** Staff at bands 8a – 8d, when not included in Executive Team above

Note: All Governing Body, other Clinical Leads and all but one female member of the Executive Team are paid at locally agreed pay rates, sometimes referred to as Very Senior Manager (VSM) pay grade.

## Sickness absence data

Salford CCG's average sickness absence rate over the year 2017/18 was 2.9% per cent (2.9% for 2016/17) compared with an average score of 3.03 per cent for all North West CCG's for the period Jan 2017 – Dec 2017 , as issued by the Health and Social Care Information Centre.

## Relevant union officials

The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires the CCG to report on trade union facility time in their organisation. Facility time is paid time off for union representatives to carry out trade union activities.

| Number of employees who were relevant union officials during the period 1 April 2017 – 31 March 2018 | Full-time equivalent employee number |
|---|---|
| Nil | Nil |

## Staff policies

Staff policies are available on the intranet and on request.

## Expenditure on consultancy

The CCG has incurred £38k in consultancy expenditure for 2017/18 (£197k in 2016/17). This was for Organisational Development support to review and further improve partnership relationships and approaches as part of the integration agenda across health and social care.

## Off-payroll engagements

### Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2018, for more than £220 per day and that last longer than six months:

| | Number |
|---|---|
| Number of existing engagements as of 31 March 2018 | 2 |
| | |
| for less than one year at the time of reporting | 1 |
| for between one and two years at the time of reporting | |
| for between 2 and 3 years at the time of reporting | |
| for between 3 and 4 years at the time of reporting | 1 |
| for 4 or more years at the time of reporting | |

The CCG confirms that all existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

**Table 2: New off-payroll engagements**

For all new off-payroll engagements between 01 April 2017 and 31 March 2018, for more than £220 per day and that last longer than six months:

| | **Number** |
|---|---|
| Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018 | 0 |
| Number of new engagements which include contractual clauses giving Salford CCG the right to request assurance in relation to income tax and National Insurance obligations | |
| Number for whom assurance has been requested | |
| *Of which:* | |
| assurance has been received | |
| assurance has not been received | |
| engagements terminated as a result of assurance not being received. | |

**Table 3: Off-payroll engagements / senior official engagements**

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2017 and 31 March 2018.

| | |
|---|---|
| Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year | 0 |
| Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements. | 0 |

## Exit packages, including special (non-contractual) payments

There have been three exit packages paid during 2017/18, totalling £17k (2016/17 Nil).

# Parliamentary Accountability and Audit Report

NHS Salford 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 Account Accounts pages 5 to 26. An audit certificate and report is also included in this Annual Report in **Appendix B**.

**Anthony Hassall**
**Chief Accountable Officer**
**23 May 2018**

NHS
Salford
Clinical Commissioning Group

# Annual Accounts 2017/18

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

## Report on the Audit of the Financial Statements

### Opinion

We have audited the financial statements of NHS Salford CCG (the 'CCG') for the year ended 31 March 2018 which 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 notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012.

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

### Basis for opinion

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

### Who we are reporting to

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them 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.

### Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the CCG's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

## Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of our work including that gained through work in relation to the CCG's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

## Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff 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 and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012[1]; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

## Opinion on regularity required by the Code of Audit Practice

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

## Matters on which we are required to report by exception

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

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or

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

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

### Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

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

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the CCG lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the CCG.

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

The Audit Committee is Those Charged with Governance.

### Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

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

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

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

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

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

### Responsibilities of the Accountable Officer

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

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

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. 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.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, 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 this criterion 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 2018, 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 to be satisfied that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

## Report on other legal and regulatory requirements – Certificate

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

***Mike Thomas***

Michael Thomas
Director
for and on behalf of Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester
M3 3EB
25 May 2018

# FOREWORD TO THE ACCOUNTS

## NHS Salford CCG

The clinical commissioning group was licence from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006

These accounts for the year ended 31 March 2018 have been prepared by Salford Clinical Commissioning Group under section 17 of schedule 1A of the National Health Service Act 2006 (as amended) in the form which the Secretary of State has, with the approval of the Treasury, directed.

The National Health Service Act 2006 (as amended) requires Clinical Commissioning Groups to prepare their Annual Report and Annual Accounts in accordance with Directions issued by NHS England.

**CONTENTS** **Page Number**

**The Primary Statements:**

**Statement of Comprehensive Net Expenditure for the year ended 31 March 2018**

| | Note | 2017-18 £'000 | 2016-17 £'000 |
|---|---|---|---|
| Income from sale of goods and services | 2 | (879) | (657) |
| Other operating income | 2 | (78) | (255) |
| **Total operating income** | | **(958)** | **(913)** |
| Staff costs | 4 | 6,715 | 6,798 |
| Purchase of goods and services | 5 | 431,399 | 416,473 |
| Depreciation and impairment charges | 5 | 0 | 0 |
| Provision expense | 5 | 228 | (202) |
| Other Operating Expenditure | 5 | 573 | 1,079 |
| **Total operating expenditure** | | **438,915** | **424,149** |
| **Net Operating Expenditure** | | **437,958** | **423,236** |
| Finance income | | | |
| Finance expense | | 0 | 0 |
| **Net expenditure for the year** | | **437,958** | **423,236** |
| Net Gain/(Loss) on Transfer by Absorption | | 0 | 0 |
| **Total Net Expenditure for the year** | | **437,958** | **423,236** |
| **Other Comprehensive Expenditure** | | | |
| **Items which will not be reclassified to net operating costs** | | | |
| Net (gain)/loss on revaluation of PPE | | 0 | 0 |
| Net (gain)/loss on revaluation of Intangibles | | 0 | (540) |
| Net (gain)/loss on revaluation of Financial Assets | | 0 | 0 |
| Actuarial (gain)/loss in pension schemes | | 0 | 0 |
| Impairments and reversals taken to Revaluation Reserve | | 0 | 0 |
| **Items that may be reclassified to Net Operating Costs** | | 0 | 0 |
| Net gain/loss on revaluation of available for sale financial assets | | 0 | 0 |
| Reclassification adjustment on disposal of available for sale financial assets | | 0 | 0 |
| **Sub total** | | 0 | (540) |
| **Comprehensive Expenditure for the year ended 31 March 2018** | | **437,958** | **422,696** |

**Statement of Financial Position as at 31 March 2018**

| | Note | 2017-18 £'000 | 2016-17 £'000 |
|---|---|---|---|
| **Non-current assets:** | | | |
| Property, plant and equipment | | 0 | 0 |
| Intangible assets | | 0 | 0 |
| Investment property | | 0 | 0 |
| Trade and other receivables | | 0 | 0 |
| Other financial assets | 9 | 554 | 540 |
| **Total non-current assets** | | 554 | 540 |
| **Current assets:** | | | |
| Inventories | | 0 | 0 |
| Trade and other receivables | 9 | 8,013 | 10,215 |
| Other financial assets | | 0 | 0 |
| Other current assets | | 0 | 0 |
| Cash and cash equivalents | 10 | 331 | 60 |
| **Total current assets** | | **8,344** | 10,275 |
| Non-current assets held for sale | | 0 | 0 |
| **Total current assets** | | **8,344** | 10,275 |
| **Total assets** | | **8,899** | 10,815 |
| **Current liabilities** | | | |
| Trade and other payables | 11 | (20,012) | (22,007) |
| Other financial liabilities | | 0 | 0 |
| Other liabilities | | 0 | 0 |
| Borrowings | | 0 | 0 |
| Provisions | 12 | (371) | (151) |
| **Total current liabilities** | | **(20,382)** | (22,158) |
| **Non-Current Assets plus/less Net Current Assets/Liabilities** | | **(11,484)** | (11,343) |
| **Non-current liabilities** | | | |
| Trade and other payables | | 0 | 0 |
| Other financial liabilities | | 0 | 0 |
| Other liabilities | | 0 | 0 |
| Borrowings | | 0 | 0 |
| Provisions | | 0 | 0 |
| **Total non-current liabilities** | | **0** | 0 |
| **Assets less Liabilities** | | **(11,484)** | (11,343) |
| **Financed by Taxpayers' Equity** | | | |
| General fund | | (11,484) | (11,343) |
| Revaluation reserve | | 0 | 0 |
| Other reserves | | 0 | 0 |
| Charitable Reserves | | 0 | 0 |
| **Total taxpayers' equity:** | | **(11,484)** | (11,343) |

The notes on pages 5 to 26 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 23 May 2018 and signed on its behalf by:

Anthony Hassall
Chief Accountable Officer

**Statement of Changes In Taxpayers Equity for the year ended 31 March 2018**

| | General fund £'000 | Revaluation reserve £'000 | Other reserves £'000 | Total reserves £'000 |
|---|---|---|---|---|
| **Changes in taxpayers' equity for 2017-18** | | | | |
| **Balance at 01 April 2017** | (11,343) | 0 | 0 | **(11,343)** |
| Transfer between reserves in respect of assets transferred from closed NHS bodies | 0 | 0 | 0 | **0** |
| **Adjusted NHS Clinical Commissioning Group balance at 31 March 2018** | **(11,343)** | **0** | **0** | **(11,343)** |
| **Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18** | | | | |
| Net operating expenditure for the financial year | (437,958) | | | (437,958) |
| Net gain/(loss) on revaluation of property, plant and equipment | | 0 | | 0 |
| Net gain/(loss) on revaluation of intangible assets | | 0 | | 0 |
| Net gain/(loss) on revaluation of financial assets | | 0 | | 0 |
| **Total revaluations against revaluation reserve** | **0** | **0** | **0** | **0** |
| Net gain (loss) on available for sale financial assets | 0 | 0 | 0 | 0 |
| Net gain (loss) on revaluation of assets held for sale | 0 | 0 | 0 | 0 |
| Impairments and reversals | 0 | 0 | 0 | 0 |
| Net actuarial gain (loss) on pensions | 0 | 0 | 0 | 0 |
| Movements in other reserves | 0 | 0 | 0 | 0 |
| Transfers between reserves | 0 | 0 | 0 | 0 |
| Release of reserves to the Statement of Comprehensive Net Expenditure | 14 | 0 | 0 | 14 |
| Reclassification adjustment on disposal of available for sale financial assets | 0 | 0 | 0 | 0 |
| Transfers by absorption to (from) other bodies | 0 | 0 | 0 | 0 |
| Reserves eliminated on dissolution | 0 | 0 | 0 | 0 |
| **Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year** | **(437,943)** | **0** | **0** | **(437,943)** |
| Net funding | 437,802 | 0 | 0 | 437,802 |
| **Balance at 31 March 2018** | **(11,484)** | **0** | **0** | **(11,484)** |

| | General fund £'000 | Revaluation reserve £'000 | Other reserves £'000 | Total reserves £'000 |
|---|---|---|---|---|
| **Changes in taxpayers' equity for 2016-17** | | | | |
| **Balance at 01 April 2016** | **(7,970)** | **0** | **0** | **(7,970)** |
| Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition | **0** | **0** | **0** | **0** |
| **Adjusted NHS Clinical Commissioning Group balance at 31 March 2017** | **(7,970)** | **0** | **0** | **(7,970)** |
| **Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17** | | | | |
| Net operating costs for the financial year | (423,236) | | | (423,236) |
| Net gain/(loss) on revaluation of property, plant and equipment | | 0 | | 0 |
| Net gain/(loss) on revaluation of intangible assets | | 540 | | 540 |
| Net gain/(loss) on revaluation of financial assets | | 0 | | 0 |
| **Total revaluations against revaluation reserve** | **0** | **540** | **0** | **540** |
| Net gain (loss) on available for sale financial assets | 0 | 0 | 0 | 0 |
| Net gain (loss) on revaluation of assets held for sale | 0 | 0 | 0 | 0 |
| Impairments and reversals | 0 | 0 | 0 | 0 |
| Net actuarial gain (loss) on pensions | 0 | 0 | 0 | 0 |
| Movements in other reserves | 0 | 0 | 0 | 0 |
| Transfers between reserves | 540 | (540) | 0 | 0 |
| Release of reserves to the Statement of Comprehensive Net Expenditure | 0 | 0 | 0 | 0 |
| Reclassification adjustment on disposal of available for sale financial assets | 0 | 0 | 0 | 0 |
| Transfers by absorption to (from) other bodies | 0 | 0 | 0 | 0 |
| Reserves eliminated on dissolution | 0 | 0 | 0 | 0 |
| **Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year** | **(422,696)** | **0** | **0** | **(422,696)** |
| Net funding | 419,324 | 0 | 0 | 419,324 |
| **Balance at 31 March 2017** | **(11,343)** | **0** | **0** | **(11,343)** |

The notes on pages 5 to 26 form part of this statement

**Statement of Cash Flows for the year ended 31 March 2018**

| | Note | **2017-18 £'000** | 2016-17 £'000 |
|---|---|---|---|
| **Cash Flows from Operating Activities** | | | |
| Net operating expenditure for the financial year | | (437,958) | (423,236) |
| Depreciation and amortisation | | 0 | 0 |
| Impairments and reversals | | 0 | 0 |
| Movement due to transfer by Modified Absorption | | 0 | 0 |
| Other gains (losses) on foreign exchange | | 0 | 0 |
| Donated assets received credited to revenue but non-cash | | 0 | 0 |
| Government granted assets received credited to revenue but non-cash | | 0 | 0 |
| Interest paid | | 0 | 0 |
| Release of PFI deferred credit | | 0 | 0 |
| Other Gains & Losses | | 0 | 0 |
| Finance Costs | | 0 | 0 |
| Unwinding of Discounts | | 0 | 0 |
| (Increase)/decrease in inventories | | 0 | 0 |
| (Increase)/decrease in trade & other receivables | 9 | 2,202 | (1,837) |
| (Increase)/decrease in other current assets | | 0 | 0 |
| Increase/(decrease) in trade & other payables | 11 | (1,996) | 6,134 |
| Increase/(decrease) in other current liabilities | | 0 | 0 |
| Provisions utilised | 12 | (8) | (219) |
| Increase/(decrease) in provisions | 12 | 228 | (202) |
| **Net Cash Inflow (Outflow) from Operating Activities** | | **(437,531)** | (419,360) |
| **Cash Flows from Investing Activities** | | | |
| Interest received | | 0 | 0 |
| (Payments) for property, plant and equipment | | 0 | 0 |
| (Payments) for intangible assets | | 0 | 0 |
| (Payments) for investments with the Department of Health | | 0 | 0 |
| (Payments) for other financial assets | | 0 | (541) |
| (Payments) for financial assets (LIFT) | | 0 | 0 |
| Proceeds from disposal of assets held for sale: property, plant and equipment | | 0 | 540 |
| Proceeds from disposal of assets held for sale: intangible assets | | 0 | 0 |
| Proceeds from disposal of investments with the Department of Health | | 0 | 0 |
| Proceeds from disposal of other financial assets | | 0 | 0 |
| Proceeds from disposal of financial assets (LIFT) | | 0 | 0 |
| Loans made in respect of LIFT | | 0 | 0 |
| Loans repaid in respect of LIFT | | 0 | 0 |
| Rental revenue | | 0 | 0 |
| **Net Cash Inflow (Outflow) from Investing Activities** | | **0** | (1) |
| **Net Cash Inflow (Outflow) before Financing** | | **(437,531)** | (419,361) |
| **Cash Flows from Financing Activities** | | | |
| Grant in Aid Funding Received | | 437,802 | 419,324 |
| Other loans received | | 0 | 0 |
| Other loans repaid | | 0 | 0 |
| Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT | | 0 | 0 |
| Capital grants and other capital receipts | | 0 | 0 |
| Capital receipts surrendered | | 0 | 0 |
| **Net Cash Inflow (Outflow) from Financing Activities** | | **437,802** | 419,324 |
| **Net Increase (Decrease) in Cash & Cash Equivalents** | 10 | **271** | (37) |
| **Cash & Cash Equivalents at the Beginning of the Financial Year** | | **60** | 96 |
| Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies | | 0 | 0 |
| **Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year** | | **331** | 60 |

The notes on pages 5 to 26 form part of this statement

**Notes to the financial statements**

## 1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2017-18 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

### 1.1 Going Concern

These accounts have been prepared on the going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
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 and Social Care 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 and Social Care 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:

The calculation of running costs has been undertaken in accordance with NHS England national guidance and definitions. However the application of the rules for each organisation involves an application of professional judgement to particular circumstances

The assessment of the pooled budget as a joint arrangement, resulting in accounting for the clinical commissioning group's share of transactions on a net basis.

#### 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:
Due to the NHS England deadline for the submission of the accounts, actual information is not available for the full 12 months for some material expenditure such as prescribing expenditure and secondary care incomplete spells of treatment. The CCG therefore estimates one or two months of expenditure in some areas using historical information, in year trends and any other available information sources.

Amounts included in provisions include an element of uncertainty around both the amount and timing of the likely liability occurring. They are also frequently, but not necessarily, one-off or unusual items for which there are fewer comparisons.

**Notes to the financial statements**

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.

1.8.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. 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.

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the clinical commissioning group's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

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.

**Notes to the financial statements**

1.10 **Intangible Assets**

1.10.1 **Recognition**

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

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

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

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

1.10.2 **Measurement**

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

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

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 **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.

**Notes to the financial statements**

1.12.1 **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.

1.12.2 **The Clinical Commissioning Group as Lessor**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.13 **Cash & Cash Equivalents**

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

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

1.14 **Provisions**

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

- Timing of cash flows (0 to 5 years inclusive): Minus 2.420% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 1.56% (previously: minus 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.

1.15 **Clinical Negligence Costs**

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

1.16 **Non-clinical Risk Pooling**

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

1.17 **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.

**Notes to the financial statements**

1.18 **Financial Assets**

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

Financial assets are classified into the following categories:

- Financial assets at 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.

1.18.1 **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.

1.18.2 **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.

1.18.3 **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 de-recognition.

1.18.4 **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.

1.19 **Financial Liabilities**

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

1.19.1 **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.

1.19.2 **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.

1.19.3 **Other Financial Liabilities**

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

1.20 **Value Added Tax**

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

1.21 **Losses & Special Payments**

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

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

1.22 **Subsidiaries**

**Notes to the financial statements**

Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.23 **Associates**

Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group from the entity.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.24 **Joint Ventures**

Material entities over which the clinical commissioning group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.25 **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.

1.26 **Research & Development**

Research and development expenditure is charged in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation.

1.27 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The DHSC Group accounting manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to FREM adoption and early adoption is not therefore permitted.

- IFRS 14: Regulatory Deferral Accounts ( not applicable to DH groups bodies)
- IFRS 16: Leases (application from 1 January 2019)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

The application of the Standards as revised would not have a material impacton the accounts for 2017-18, were they applied in that year.

**2 Other Operating Revenue**

| | 2017-18 Total | 2017-18 Admin | 2017-18 Programme | 2016-17 Total |
|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 |
| Education, training and research | 60 | 60 | 0 | 72 |
| Non-patient care services to other bodies | 819 | 491 | 328 | 585 |
| Other revenue | 78 | 0 | 78 | 255 |
| **Total other operating revenue** | **958** | **551** | **407** | **913** |

**3 Revenue**

| | 2017-18 Total | 2017-18 Admin | 2017-18 Programme | 2016-17 Total |
|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 |
| From rendering of services | 958 | 551 | 407 | 913 |
| From sale of goods | 0 | 0 | 0 | 0 |
| **Total** | **958** | **551** | **407** | **913** |

## 4. Employee benefits and staff numbers

### 4.1 Employee benefits 2017-18 Total

| | Total £'000 | Permanent Employees £'000 | Other £'000 |
|---|---|---|---|
| Employee Benefits | | | |
| Salaries and wages | 5,530 | 5,278 | 252 |
| Social security costs | 548 | 548 | 0 |
| Employer Contributions to NHS Pension scheme | 607 | 607 | 0 |
| Other pension costs | 1 | 1 | 0 |
| Apprenticeship Levy | 12 | 12 | 0 |
| Other post-employment benefits | 0 | 0 | 0 |
| Other employment benefits | 0 | 0 | 0 |
| Termination benefits | 17 | 17 | 0 |
| **Gross employee benefits expenditure** | **6,715** | **6,463** | **252** |
| Less recoveries in respect of employee benefits | 0 | 0 | 0 |
| **Total - Net admin employee benefits including capitalised costs** | **6,715** | **6,463** | **252** |
| Less: Employee costs capitalised | 0 | 0 | 0 |
| **Net employee benefits excluding capitalised costs** | **6,715** | **6,463** | **252** |

### 4.1 Employee benefits 2016-17 Total

| | Total £'000 | Permanent Employees £'000 | Other £'000 |
|---|---|---|---|
| Employee Benefits | | | |
| Salaries and wages | 5,656 | 5,386 | 270 |
| Social security costs | 533 | 533 | 0 |
| Employer Contributions to NHS Pension scheme | 609 | 609 | 0 |
| Other pension costs | 0 | 0 | 0 |
| Apprenticeship Levy | 0 | 0 | 0 |
| Other post-employment benefits | 0 | 0 | 0 |
| Other employment benefits | 0 | 0 | 0 |
| Termination benefits | 0 | 0 | 0 |
| **Gross employee benefits expenditure** | **6,798** | **6,528** | **270** |
| Less recoveries in respect of employee benefits | 0 | 0 | 0 |
| **Total - Net admin employee benefits including capitalised costs** | **6,798** | **6,528** | **270** |
| Less: Employee costs capitalised | 0 | 0 | 0 |
| **Net employee benefits excluding capitalised costs** | **6,798** | **6,528** | **270** |

**4.2 Average number of people employed**

| | 2017-18 | | | 2016-17 |
|---|---|---|---|---|
| | Total Number | Permanently employed Number | Other Number | Total Number |
| **Total** | **122** | **112** | **10** | **124** |
| Of the above: | | | | |
| **Number of whole time equivalent people engaged on capital projects** | **0** | **0** | **0** | **0** |

**4.3 Staff sickness absence and ill health retirements**

| | 2017-18 Number | 2016-17 Number |
|---|---|---|
| Total Days Lost | 622 | 818 |
| Total Staff Years | 117 | 119 |
| **Average working Days Lost** | 5 | 7 |

| | 2017-18 Number | 2016-17 Number |
|---|---|---|
| Number of persons retired early on ill health grounds | 0 | 0 |
| | **£'000** | **£'000** |
| Total additional Pensions liabilities accrued in the year | 0 | 0 |

**4.4 Pension costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

**4.4.1 Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

**4.4.2 Full actuarial (funding) valuation**

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

For 2017-18, employers' contributions of £607,000 were payable to the NHS Pensions Scheme (2016-17: £609,000) were payable to the NHS Pension Scheme at the rate of 14.38% 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 2012. These costs are included in the NHS pension line of note 4.1.1.

**5. Operating expenses**

| | 2017-18 Total £'000 | 2017-18 Admin £'000 | 2017-18 Programme £'000 | 2016-17 Total £'000 |
|---|---|---|---|---|
| **Gross employee benefits** | | | | |
| Employee benefits excluding governing body members | 6,071 | 3,468 | 2,603 | 6,202 |
| Executive governing body members | 628 | 628 | 0 | 596 |
| **Total gross employee benefits** | **6,699** | **4,096** | **2,603** | **6,798** |
| | | | | |
| **Other costs** | | | | |
| Services from other CCGs and NHS England | 911 | 589 | 322 | 1,111 |
| Services from foundation trusts | 254,780 | 88 | 254,692 | 250,194 |
| Services from other NHS trusts | 17,767 | 38 | 17,729 | 16,791 |
| Purchase of healthcare from non-NHS bodies | 67,968 | 0 | 67,968 | 58,579 |
| Chair and Non Executive Members | 496 | 496 | 0 | 424 |
| Supplies and services – clinical | 16 | 0 | 16 | 18 |
| Supplies and services – general | 906 | 36 | 869 | 652 |
| Consultancy services | 36 | 0 | 35 | 265 |
| Establishment | 767 | 189 | 578 | 1,015 |
| Transport | 35 | 0 | 35 | 211 |
| Premises | 2,838 | 341 | 2,497 | 2,835 |
| Audit fees | 50 | 50 | 0 | 68 |
| Prescribing costs | 41,768 | 0 | 41,768 | 41,950 |
| Pharmaceutical services | 91 | 0 | 91 | 150 |
| General ophthalmic services | 29 | 0 | 29 | 49 |
| GPMS/APMS and PCTMS | 42,979 | 0 | 42,979 | 42,031 |
| Other professional fees excl. audit | 10 | 7 | 4 | 114 |
| Legal fees | 172 | 40 | 133 | 0 |
| Grants to Other bodies | 0 | 0 | 0 | 124 |
| Research and development (excluding staff costs) | 72 | 0 | 72 | 333 |
| Education and training | 277 | 61 | 215 | 214 |
| Change in discount rate | 0 | 0 | 0 | 0 |
| Provisions | 228 | 32 | 195 | (202) |
| CHC Risk Pool contributions | 0 | 0 | 0 | 226 |
| Other expenditure | 5 | 0 | 5 | 197 |
| **Total other costs** | **432,200** | **1,968** | **430,232** | **417,351** |
| | | | | |
| **Total operating expenses** | **438,899** | **6,064** | **432,835** | **424,149** |

**Auditor liability limitation agreement**

In accordance with SI 2008 no.489, *The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008*, the CCG's contract with its auditors provides for a limitation of the auditor's liability to £2m. Audit fees are shown inclusive on non reclaimable VAT.

**6 Better Payment Practice Code**

| **Measure of compliance** | **2017-18 Number** | **2017-18 £'000** | 2016-17 **Number** | 2016-17 **£'000** |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total Non-NHS Trade invoices paid in the Year | 6,645 | 90,563 | 7,163 | 107,472 |
| Total Non-NHS Trade Invoices paid within target | 6,601 | 89,741 | 7,085 | 107,131 |
| **Percentage of Non-NHS Trade invoices paid within target** | **99.34%** | **99.09%** | **98.91%** | **99.68%** |
| | | | | |
| **NHS Payables** | | | | |
| Total NHS Trade Invoices Paid in the Year | 2,979 | 379,077 | 2,855 | 343,506 |
| Total NHS Trade Invoices Paid within target | 2,967 | 379,073 | 2,854 | 343,505 |
| **Percentage of NHS Trade Invoices paid within target** | **99.60%** | **100.00%** | **99.96%** | **100.00%** |

## 7. Operating Leases

### 7.1 As lessee

**7.1.1 Payments recognised as an Expense**

| | 2017-18 | | | | 2016-17 | |
|---|---|---|---|---|---|---|
| | Land £'000 | Buildings £'000 | Other £'000 | Total £'000 | Land £'000 | Buildings £'000 |
| **Payments recognised as an expense** | | | | | | |
| Minimum lease payments | 0 | 2,808 | 9 | **2,817** | 0 | 2,863 |
| Contingent rents | 0 | 0 | 0 | **0** | 0 | 0 |
| Sub-lease payments | 0 | 0 | 0 | **0** | 0 | 0 |
| **Total** | **0** | **2,808** | **9** | **2,817** | **0** | **2,863** |

Whilst our arrangements with Community Health Partnership's Limited and NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed . Consequently this note does not include future minimum lease payments for the arrangements only

**7.1.2 Future minimum lease payments**

| | 2017-18 | | | | 2016-17 | |
|---|---|---|---|---|---|---|
| | Land £'000 | Buildings £'000 | Other £'000 | Total £'000 | Land £'000 | Buildings £'000 |
| **Payable:** | | | | | | |
| No later than one year | 0 | 0 | 0 | **0** | 0 | 0 |
| Between one and five years | 0 | 0 | 0 | **0** | 0 | 0 |
| After five years | 0 | 0 | 0 | **0** | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** | **0** | **0** |

**8 Intangible non-current assets**

| 2017-18 | Computer Software: Purchased £'000 | Computer Software: Internally Generated £'000 | Licences & Trademarks £'000 | Patents £'000 | Development Expenditure (internally generated) £'000 | Total £'000 |
|---|---|---|---|---|---|---|
| **Cost or valuation at 01 April 2017** | 0 | 0 | 0 | 0 | 599 | 599 |
| Additions purchased | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions internally generated | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions donated | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions government granted | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions leased | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassified as held for sale and reversals | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals other than by sale | 0 | 0 | 0 | 0 | (599) | (599) |
| Upward revaluation gains | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments charged | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer (to)/from other public sector body | 0 | 0 | 0 | 0 | 0 | 0 |
| Cumulative amortisation adjustment following revaluation | 0 | 0 | 0 | 0 | 0 | 0 |
| **Cost / Valuation At 31 March 2018** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Amortisation 01 April 2017** | 0 | 0 | 0 | 0 | 599 | 599 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassified as held for sale and reversals | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals other than by sale | 0 | 0 | 0 | 0 | (599) | (599) |
| Upward revaluation gains | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments charged | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 |
| Charged during the year | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer (to) from other public sector body | 0 | 0 | 0 | 0 | 0 | 0 |
| Cumulative amortisation adjustment following revaluation | 0 | 0 | 0 | 0 | 0 | 0 |
| **Amortisation At 31 March 2018** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Net Book Value at 31 March 2018** | **0** | **0** | **0** | **0** | **0** | **0** |
| Purchased | 0 | 0 | 0 | 0 | 0 | 0 |
| Donated | 0 | 0 | 0 | 0 | 0 | 0 |
| Government Granted | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total at 31 March 2018** | **0** | **0** | **0** | **0** | **0** | **0** |

| 9 Trade and other receivables | Current 2017-18 £'000 | Non-current 2017-18 £'000 | Current 2016-17 £'000 | Non-current 2016-17 £'000 |
|---|---|---|---|---|
| NHS receivables: Revenue | 271 | 0 | 408 | 0 |
| NHS prepayments | 472 | 0 | 460 | 0 |
| NHS accrued income | 202 | 0 | 984 | 0 |
| Non-NHS and Other WGA receivables: Revenue | 6,699 | 0 | 7,305 | 0 |
| Non-NHS and Other WGA prepayments | 430 | 0 | 875 | 0 |
| Non-NHS and Other WGA accrued income | 15 | 0 | 217 | 0 |
| VAT | (76) | 0 | (36) | 0 |
| Other receivables and accruals | (0) | 0 | 2 | 0 |
| **Total Trade & other receivables** | **8,013** | **0** | **10,215** | **0** |
| **Total current and non current** | **8,013** | | **10,215** | |
| Included above: | | | | |
| Prepaid pensions contributions | 0 | | 0 | |

| 9.1 Receivables past their due date but not impaired | 2017-18 £'000 DH Group Bodies | 2017-18 £'000 Group Bodies | 2016-17 £'000 All receivables prior years |
|---|---|---|---|
| By up to three months | 110 | 379 | 589 |
| By three to six months | (11) | 55 | 3 |
| By more than six months | 39 | 10 | 0 |
| **Total** | **138** | **443** | **592** |

The great majority of trade is with bodies funded directly by 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.

**9.2 Non-current**

| | **2017-18 £'000** | 2016/17 £'000 |
|---|---|---|
| **Balance at 01 April 2017** | 540 | 0 |
| Additions | 14 | 540 |
| Revaluation | 0 | 0 |
| Impairments | 0 | 0 |
| Impairment reversals | 0 | 0 |
| Transferred from non-current financial assets | 0 | 0 |
| Disposals | 0 | 0 |
| Transfer (to)/from other public sector body | 0 | 0 |
| **Balance at 31 March 2018** | **554** | **540** |

North West eHealth was set up in 2008 to develop links between academia and the NHS in the area of health informatics and develop new research using anonymised patient records to support improving healthcare. Its customers are pharmaceutical companies and technology partners as well as the NHS and government. The original founders of this collaboration were the University of Manchester, Salford Royal Foundation Trust and Salford PCT. Salford PCT made annual contributions for research costs from 2008 until its demise on 31 March 2013. It accounted for these contributions as an intangible asset (development expenditure), and amortised these over its expected life. The net book value transferred to the CCG on 1 April 2013 was £599k and was amortised to nil value by 31 March 2015. The CCG has made no contributions since it was formed.

On 1 November 2016, the business of North West eHealth was transferred to a company limited by shares, North West eHealth Limited, the three shareholders being University of Manchester, Salford Royal FT and Salford CCG on a 40:40:20 basis. The share capital of the company will comprise both ordinary shares and preference shares.

The cumulative value of the intellectual property at 1 November 2016 was assessed by management as having a value of £2.7m based on a methodology approved by KPMG. This takes account of current cost plus the value of future income to be generated, discounted back to net present value. The company has issued preference shares to the three organisations to reflect the opening intellectual property value, and Salford CCG's shares have a value of £554k, being 20% of £2.7m. As the CCG's Chief Finance Officer is a director of North West eHealth Limited, under International Accounting Standard 28 - Investments in Associates and Joint Ventures (2011), the CCG has significant influence over its investment (but not control) and the company should be regarded as an associate of the CCG. The company's year end accounts show a loss of £458k for the 14 months to 31 December 2017. Management have recently reassessed the value of the interllectual property and confirmed that this has not reduced below the initial estimate of £2.7m. Accordingly, Salford CCG has not adjusted the value of the investment downwards for 2017 and it remains shown at a cost of £554k.

**10 Cash and cash equivalents**

| | **2017-18** | 2016-17 |
|---|---|---|
| | **£'000** | £'000 |
| **Balance at 01 April 2017** | 60 | 96 |
| Net change in year | 271 | (37) |
| **Balance at 31 March 2018** | **331** | **60** |
| | | |
| Made up of: | | |
| Cash with the Government Banking Service | 331 | 60 |
| Cash with Commercial banks | 0 | 0 |
| Cash in hand | 0 | 0 |
| Current investments | 0 | 0 |
| **Cash and cash equivalents as in statement of financial position** | **331** | **60** |
| | | |
| Bank overdraft: Government Banking Service | 0 | 0 |
| Bank overdraft: Commercial banks | 0 | 0 |
| **Total bank overdrafts** | **0** | **0** |
| | | |
| **Balance at 31 March 2018** | **331** | **60** |
| | | |
| Patients' money held by the clinical commissioning group, not included above | 0 | 0 |

| **11 Trade and other payables** | **Current 2017-18 £'000** | **Non-current 2017-18 £'000** | Current 2016-17 £'000 | Non-current 2016-17 £'000 |
|---|---|---|---|---|
| NHS payables: revenue | 3,685 | 0 | 1,031 | 0 |
| NHS accruals | 1,461 | 0 | 283 | 0 |
| Non-NHS and Other WGA payables: Revenue | 665 | 0 | 1,870 | 0 |
| Non-NHS and Other WGA accruals | 537 | 0 | 10,353 | 0 |
| Non-NHS and Other WGA deferred income | 6,281 | 0 | 5,783 | 0 |
| Social security costs | 87 | 0 | 83 | 0 |
| Tax | 81 | 0 | 78 | 0 |
| Other payables and accruals | 7,215 | 0 | 2,528 | 0 |
| **Total Trade & Other Payables** | **20,012** | **0** | **22,007** | **0** |
| Total current and non-current | **20,012** | | **22,007** | |

Other payables include £438k outstanding pension contributions at 31 March 2018 (£448k : 2016/17)

## 12 Provisions

| | **Current 2017-18 £'000** | **Non-current 2017-18 £'000** | Current 2016-17 £'000 | Non-current 2016-17 £'000 |
|---|---|---|---|---|
| Pensions relating to former directors | 0 | 0 | 0 | 0 |
| Pensions relating to other staff | 0 | 0 | 0 | 0 |
| Restructuring | 0 | 0 | 0 | 0 |
| Redundancy | 0 | 0 | 0 | 0 |
| Agenda for change | 0 | 0 | 0 | 0 |
| Equal pay | 0 | 0 | 0 | 0 |
| Legal claims | 0 | 0 | 0 | 0 |
| Continuing care | 0 | 0 | 0 | 0 |
| Other | 371 | 0 | 151 | 0 |
| **Total** | **371** | **0** | **151** | **0** |
| **Total current and non-current** | **371** | | **151** | |

| | **Pensions Relating to Former Directors £'000** | **Pensions Relating to Other Staff £'000** | **Restructuring £'000** | **Redundancy £'000** | **Agenda for Change £'000** | **Equal Pay £'000** | **Legal Claims £'000** | **Continuing Care £'000** | **Other £'000** | **Total £'000** |
|---|---|---|---|---|---|---|---|---|---|---|
| **Balance at 01 April 2017** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **151** | **151** |
| Arising during the year | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 228 | 228 |
| Utilised during the year | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (8) | (8) |
| Reversed unused | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Unwinding of discount | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Change in discount rate | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer (to) from other public sector body | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer (to) from other public sector body under absorption | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Balance at 31 March 2018** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **371** | **371** |
| **Expected timing of cash flows:** | | | | | | | | | | |
| Within one year | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 371 | 371 |
| Between one and five years | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| After five years | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Balance at 31 March 2018** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **371** | **371** |

Included in other provisions are amounts which may become due in respect of the cost of overseas visitors (£138k) and dilapidations costs for leased premises (£153k).

Pension payments are made quarterly and amounts are known. The pension provision is based on life expectancy.
Legal claims are calculated from the number of claims currently lodged with the NHS Resolution and the probabilities provided by them.

**13 Contingencies**

| | **2017-18 £'000** | 2016-17 £'000 |
|---|---|---|
| **Contingent liabilities** | | |
| Equal Pay | 0 | 0 |
| NHS Resolution Legal Claims | 0 | 0 |
| Employment Tribunal | 0 | 0 |
| NHS Resolution employee liability claim | 0 | 5 |
| Redundancy | 0 | 0 |
| Continuing Healthcare | 0 | 0 |
| Legal Claim | 0 | 0 |
| Dilapidations | 0 | 0 |
| Learning Disabilities Disputed Cases | 0 | 0 |
| Young peoples Mental health | 0 | 0 |
| UCLH Specialist Contract dispute | 0 | 0 |
| LTPS | 0 | 0 |
| Under-utilised property lease liabilities | 0 | 0 |
| NHS Prop Co | 0 | 0 |
| Retrospective Social Care claims | 0 | 0 |
| Other | 0 | 0 |
| **Net value of contingent liabilities** | **0** | **5** |

## 14 Financial instruments

### 14.1 Financial risk management

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

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

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

#### 14.1.1 Currency risk

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

#### 14.1.2 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.

#### 14.1.3 Credit risk

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

#### 14.1.3 Liquidity risk

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

**14 Financial instruments cont'd**

**14.2 Financial assets**

| | **At 'fair value through profit and loss' 2017-18 £'000** | **Loans and Receivables 2017-18 £'000** | **Available for Sale 2017-18 £'000** | **Total 2017-18 £'000** |
|---|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 | 0 |
| Receivables: | | | | |
| · NHS | 0 | 473 | 0 | 473 |
| · Non-NHS | 0 | 6,714 | 0 | 6,714 |
| Cash at bank and in hand | 0 | 331 | 0 | 331 |
| Other financial assets | 0 | 554 | 0 | 554 |
| **Total at 31 March 2018** | **0** | **8,072** | **0** | **8,072** |

| | At 'fair value through profit and loss' 2016-17 £'000 | Loans and Receivables 2016-17 £'000 | Available for Sale 2016-17 £'000 | Total 2016-17 £'000 |
|---|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 | 0 |
| Receivables: | | | | |
| · NHS | 0 | 1,392 | 0 | 1,392 |
| · Non-NHS | 0 | 7,522 | 0 | 7,522 |
| Cash at bank and in hand | 0 | 60 | 0 | 60 |
| Other financial assets | 0 | 543 | 0 | 543 |
| **Total at 31 March 2018** | **0** | **9,517** | **0** | **9,517** |

**14.3 Financial liabilities**

| | **At 'fair value through profit and loss' 2017-18 £'000** | **Other 2017-18 £'000** | **Total 2017-18 £'000** |
|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 |
| Payables: | | | |
| · NHS | 0 | 5,146 | 5,146 |
| · Non-NHS | 0 | 8,417 | 8,417 |
| Private finance initiative, LIFT and finance lease obligations | 0 | 0 | 0 |
| Other borrowings | 0 | 0 | 0 |
| Other financial liabilities | 0 | 0 | 0 |
| **Total at 31 March 2018** | **0** | **13,562** | **13,562** |

| | At 'fair value through profit and loss' 2016-17 £'000 | Other 2016-17 £'000 | Total 2016-17 £'000 |
|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 |
| Payables: | | | |
| · NHS | 0 | 1,313 | 1,313 |
| · Non-NHS | 0 | 14,750 | 14,750 |
| Private finance initiative, LIFT and finance lease obligations | 0 | 0 | 0 |
| Other borrowings | 0 | 0 | 0 |
| Other financial liabilities | 0 | 0 | 0 |
| **Total at 31 March 2018** | **0** | **16,064** | **16,064** |

**15 Operating Segments**
The Clinical Commissioning Group consider they have only one segment: commissioning of healthcare services.

**16 Pooled budgets**
The CCG and Salford City Council have a pooled budget for all adult services health and social care services in Salford. Salford CCG are the hosts of the pooled budget and the memorandum account for the Integrated Care Adult pooled budget is:

| | **2017-18** | 2016-17 |
|---|---|---|
| CCG % Contribution | 70% | 71% |

Salford CCG's shares of the income and expenditure handled by the pooled budget in the financial year were:

| | **2017-18** | 2016-17 |
|---|---|---|
| | **£'000** | £'000 |
| Income | 174,645 | 167,510 |
| Expenditure | (175,210) | (167,724) |

The total expenditure of the Integrated Care Adult Pool budget was £250.2m (2016-17 £237.4m) of which Salford City Council contributed £75m (2016-17 £69.7m)

**17 Related party transactions**

**2017/18**
**Details of related party transactions with individuals are as follows:**

Mr Steve Dixon is Chief Finance Officer and a Director of North West e-Health Limited.
All of the GP Governing Body members have GMS or PMS contracts with NHS England (Greater Manchester Health and Social Care Partnership).
The practices of Drs Ben Williams, Nicholas Browne, Tom Tasker, Tom Regan, David McKelvey and Ms Kate Jones are members of Salford Primary Care Together.
Kate Jones is a director of Salford Health Matters.
The partner of Mr Hassall is an employee of the Langworthy Cornerstone Association charity, a provider of services to Salford CCG.
Mrs Alison Kelly is a Nurse at at the Countess of Chester NHS Foundation Trust and a Nurse Lay Member at Salford CCG.

Payments have been made to the practices of Governing Body members in relation to Locally Commissioned Services, as follows:

| | | Payments to Related Party £'000 | Receipts from Related Party £'000 | Amounts owed to Related Party £'000 | Amounts due from Related Party £'000 |
|---|---|---|---|---|---|
| **Organisation** | **Governing Body Member** | | | | |
| SALFORD PRIMARY CARE TOGETHER | Dr Regan, Dr Browne, Dr Williams, Dr McKelvey, Ms Jones, Dr Tasker | 3,534 | (1) | 4 | 0 |
| ST ANDREWS MEDICAL CENTRE | Dr Tasker, Dr Regan | 166 | (26) | 0 | 0 |
| NORTH WEST E HEALTH LIMITED | Mr Dixon | 0 | 0 | 0 | (111) |
| LANGWORTHY CORNERSTONE ASSOCIATION | Mr Hassall | 493 | 0 | 0 | (1) |
| ORDSALL HEALTH SURGERY | Dr McKelvey | 235 | 0 | 89 | 0 |
| THE GILL MEDICAL PRACTICE | Dr Browne | 153 | 0 | 63 | 0 |
| NEWBURY GREEN MEDICAL PRACTICE | Mr Flinn | 280 | 0 | 128 | 0 |
| SALFORD HEALTH MATTERS | Ms Jones | 512 | (10) | 141 | 0 |
| THE POPLARS MEDICAL PRACTICE | Dr Williams | 271 | 0 | 143 | 0 |
| CLARENDON MEDICAL PRACTICE | Dr Tankel | 248 | (7) | 104 | 0 |

The Department of Health is regarded as a related party as it is the parent body of Salford CCG. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded a related party.

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies.

| | | | | | |
|---|---|---|---|---|---|
| SALFORD CITY COUNCIL | | 8,473 | (75,723) | 314 | (6,362) |

NHS ENGLAND
NHS PENSIONS
NORTH WEST AMBULANCE SERVICE NHS TRUST

BOLTON NHS FOUNDATION TRUST
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (until 30.09.2017)
MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (from 01.10.2017)
SALFORD ROYAL NHS FOUNDATION TRUST
COUNTESS OF CHESTER NHS FOUNDATION TRUST

**17 Related party transactions**

**2016/17**
**Details of related party transactions with individuals are as follows:**

The wife and sister in law of Dr Hamish Stedman, chair of Salford CCG until 31.07.2016, are employed by Salford Royal FT.
Dr Paul Bishop was the Clinical Lead for Strategic Partnerships and Planning until 01.11.2016. He is a Director of Salford Primary Care Together and Silverdale Medical Practice. His partner is a Nurse at University Hospitals South Manchester

Mr Steve Dixon is Chief Finance Officer and a Director of North West e-Health Limited.

David Herne is the Director of Public Health at Salford City Council
Dr Aisha Aiwan was Neighbourhood Clinical Lead from 01.06.2016 until 31.12.2016, whose brother is a partner at Gill Medical Centre, Swinton.
Mr Anthony Hassall and Dr Tom Tasker were Directors of Manchester Academic Health Science Centre until 31st March 2017.
The practice of Dr Tasker, St Andrew's Medical Centre, has a GMS contract with NHS England (Greater Manchester Area Team).
The practices of Drs Paul Bishop (until 01.11.2016), Ben Williams (from 01.02.2017), Nicholas Browne (from 1.6.16) and Tom Tasker (Chair from 01.08.2016) are all members of Salford Primary Care Together. Salford Primary Care Together is the GP provider company and was known as Salix Ltd until 1 November 2016.

Payments have been made to the practices of Governing Body members in relation to Locally Commissioned Services, as follows:

| | | Payments to Related Party £'000 | Receipts from Related Party £'000 | Amounts owed to Related Party £'000 | Amounts due from Related Party £'000 |
|---|---|---|---|---|---|
| **Organisation** | **Governing Body Member** | | | | |
| SALFORD PRIMARY CARE TOGETHER | Dr Bishop (until 01.11.2016), Dr Williams (from 01.02.2017), Dr Tasker. | 70 | 0 | 170 | 0 |
| SALIX LIMITED (until October 2016) | Dr Browne, Dr Tankel, Dr Tasker and Dr Choudry | 259 | 0 | 0 | 0 |
| SILVERDALE MEDICAL PRACTICE | Dr Bishop (unti | 378 | 0 | 1 | 0 |
| GILL MEDICAL CENTRE | Dr Aswan (from 01.06.2016 to 31.12.2016) | 174 | 0 | 0 | 0 |
| ST ANDREWS MEDICAL CENTRE | Dr Tasker | 98 | 0 | 0 | 0 |
| NORTH WEST E HEALTH LIMITED | Mr Dixon | 0 | 0 | 540 | (648) |
| MAHSC | Dr Tasker, Mr H | 0 | 0 | 188 | 0 |

The Department of Health is regarded as a related party as it is the parent body of Salford CCG. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded a related party.

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies.

| | | | | |
|---|---|---|---|---|
| SALFORD CITY COUNCIL | 27,518 | (76,536) | 11,060 | (6,256) |

NHS ENGLAND
NHS PENSIONS
NORTH WEST AMBULANCE SERVICE NHS TRUST

ROYAL BOLTON HOSPITAL NHS FOUNDATION TRUST
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST
SALFORD ROYAL NHS FOUNDATION TRUST

**18 Events after the end of the reporting period**

None to report

**19 Financial performance targets**

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

| | **2017-18 Target** | **2017-18 Performance** | 2016/17 Target | 2016/17 Performance |
|---|---|---|---|---|
| Expenditure not to exceed income | 441,232 | 438,916 | 439,764 | 424,149 |
| Capital resource use does not exceed the amount specified in Directions | 0 | 0 | 0 | 0 |
| Revenue resource use does not exceed the amount specified in Directions | 440,274 | 437,957 | 438,855 | 423,236 |
| Capital resource use on specified matter(s) does not exceed the amount specified in Directions | 0 | 0 | 0 | 0 |
| Revenue resource use on specified matter(s) does not exceed the amount specified in Directions | 0 | 0 | 0 | 0 |
| Revenue administration resource use does not exceed the amount specified in Directions | 5,560 | 5,513 | 5,520 | 5,493 |

## 20 Losses and special payments

### 20.1 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

| | **Total Number of Cases 2017-18 Number** | **Total Value of Cases 2017-18 £'000** | Total Number of Cases 2016-17 Number | Total Value of Cases 2016-17 £'000 |
|---|---|---|---|---|
| Administrative write-offs | 1 | 3 | 0 | 0 |
| Fruitless payments | 0 | 0 | 0 | 0 |
| Store losses | 0 | 0 | 0 | 0 |
| Book Keeping Losses | 0 | 0 | 0 | 0 |
| Constructive loss | 0 | 0 | 0 | 0 |
| Cash losses | 0 | 0 | 0 | 0 |
| Claims abandoned | 0 | 0 | 0 | 0 |
| **Total** | **1** | **3** | **0** | **0** |

### 20.2 Special payments

| | **Total Number of Cases 2017-18 Number** | **Total Value of Cases 2017-18 £'000** | Total Number of Cases 2016-17 Number | Total Value of Cases 2016-17 £'000 |
|---|---|---|---|---|
| Compensation payments | 0 | 0 | 0 | 0 |
| Extra contractual Payments | 0 | 0 | 0 | 0 |
| Ex gratia payments | 0 | 0 | 0 | 0 |
| Extra statutory extra regulatory payments | 0 | 0 | 0 | 0 |
| Special severance payments | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** |