NHS
West Lancashire
Clinical Commissioning Group

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Annual Report and Accounts

2021/22

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Foreword

Welcome to the CCG's Annual Report 2021/22

The COVID-19 pandemic has been one of the most significant challenges the NHS has faced in its history. The measures we have all endured have unequivocally been there to 'protect the lives and livelihoods of citizens across the United Kingdom. I would like to take this opportunity to thank all our workforce and our residents for playing their part from staff continuing to deliver excellent services to patients, people following self-isolation, social distance and infection control measures, through to those who have received your vaccinations and boosters when prompted.

Almost two years since the first national lockdown the government has published their latest response 'Living with COVID-19'. We still remain in a pandemic and because we are not able to fully predict the future of COVID-19 there is a level of uncertainty so we would like to encourage people to stay safe and help to protect the most vulnerable in our society. The next year signifies an exciting time for the NHS as we begin to move towards working with our partners in a more integrated way. We also look forward to continuing our journey to restore and develop excellent services.

Our annual report for 2021/22 provides us with the opportunity to share with you our most recent work and progress. Last year we were able to share details of the large scale COVID-19 vaccination programme. We reported that local health services such as GP practices, community and social care services, local authorities, the military and voluntary, community and faith sector and our patient groups had worked tirelessly together to vaccinate the eligible population of West Lancashire. This partnership way of working served us well when we were once again asked to mobilise the booster programme with the emergence of the Omicron variant, late in 2021 through to early 2022.

Staff have continued to work in new and innovative ways, continuing to work remotely or in other roles when required. The continued professionalism and commitment demonstrated is very encouraging and our teams are now preparing for the next steps in commissioning transformation with many teams already working collaboratively across Lancashire and South Cumbria for at least part of their roles.

NHS England and Improvement's white paper Integrating care: Next steps to building strong and effective integrated care systems across England (February 2021) details how ICSs, and the organisations within them, will work more effectively and more collaboratively in future. Working at system level has already demonstrated benefits locally, such as the response to COVID-19, the new hospitals programme and managing the system's financial deficit.

The white paper includes a move towards a 'system wide' organisation with the eight CCGs across Lancashire and South Cumbria cementing their partnership working. This means that we are now undertaking a process of CCG closedown and the development of a statutory Integrated Care Board (ICB) for Lancashire and South Cumbria.

As the Lancashire and South Cumbria Integrated Care Board development gathers pace, so too does the emergence of our place-based partnership. Much work had already taken place prior to the pandemic to shape some of our local priorities. Over the last year the place-based partnership has taken a strategic approach, laying the foundations for future partnership arrangements. In the coming months we will build stability to the leadership at 'place' through the recruitment of a programme director, identifying our governance arrangements and building the infrastructure to support this new way of working.

In West Lancashire it has long been recognised that there is a disparity in life expectancy between the most affluent areas and those areas which experience high levels of deprivation. Indeed, some areas of Skelmersdale for example are amongst the most deprived communities in

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England resulting in people experiencing a range of preventable diseases which affect quality of life and lead to increased morbidity. In West Lancashire we are strongly committed to reducing health inequalities through our population health management approach, identifying those most vulnerable and targeting help and support to them when they need it.

As part of our ambition to reduce health inequalities we have recently worked with other place-based partnerships across Lancashire and South Cumbria to participate in Professor Sir Michael Marmot's Health Equity Commission Review. With a summit of recommendations to be held in April 2022 we look forward to sharing ideas and approaches with our communities to co-produce services which will have a positive impact for some of our most disadvantaged residents.

Despite the challenges, these are also exciting times for the NHS. It only remains to again say a heartfelt thank you to everyone for their fortitude in pulling together through the pandemic. Everyone in West Lancashire has contributed and will, I am sure, continue to support their friends, neighbours, and those around them in the future.

We wish everyone an optimistic and determined 2022.

Andrew Bennett
Accountable Officer
21 June 2022

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Working with our partners – Lancashire and South Cumbria Health and Care Partnership

Responding to the Covid-19 pandemic

Since March 2020, CCGs in Lancashire and South Cumbria have continued to work together to respond to the Covid-19 (coronavirus) pandemic with local partners across the Integrated Care System (ICS) to manage the local response. Throughout 2021/22, the joint decision-making mechanisms continued to support the operational management of services and ensured consistency in partner, staff, patient and public communications.

NHS partners continued to work with Local Resilience Forums (LRFs) in Lancashire and Cumbria, which include partners from the NHS, local authorities, social care, education, police, fire and armed forces. Working together, these partnerships helped to manage the response to Covid-19, which this year focused on the changes to national guidance along with the rollout of the Covid vaccination and testing programmes, communicating key messages and continuing priority work programmes.

Hospital and Out of Hospital incident response cells in Lancashire and South Cumbria which were established in 2020/21 continued to operate under the North West Regional incident command structure.

The Hospital cell covered elective care, tertiary services, critical care, cancer, paediatrics, mutual aid and clinical prioritisation. The Out of Hospital cell co-ordinated the work of community services, mental health, learning disabilities and primary care. It also worked with social care, with a Care Sector sub-cell run jointly with the Lancashire LRF and with connections to Cumbria.

A Joint Hospital and Out of Hospital cell chaired by Kevin McGee, Chief Executive of Lancashire Teaching Hospitals and the Provider Collaboration, was strengthened to enable collective system decision making with revised membership, which included the involvement of Directors of Adult Social Care from local authorities.

The **Gold Command Winter Pressures Room** was established in preparation for the second wave of the pandemic in 2020 and continued to support local NHS operational activity and winter pressures. As a tactical support service, it monitors and analyses pressure on individual trusts and organisations – including A&E attendances, Covid-19 cases, people awaiting a Covid test result before admission, staff sickness, bed capacity, discharge delays, and queueing ambulances. Data is looked at from a system perspective, and capacity is redistributed to where it is needed most.

Work at the command room, as well as the System Vaccinations Operations Centre (SVOC), is ongoing seven days a week through collaboration between all CCGs and trusts, NHSEI leads and ICS executives. It has made a phenomenal difference in terms of collaborative working and system thinking for the benefit of patients.

The Lancashire and South Cumbria **Personal Protective Equipment** (PPE) and Consumables Policy Group has continued to operate throughout 2021/22, coordinating the usage and capacity planning for health services across the region. Access channels to PPE became firmly established and normalised towards the end of 2020, with the development of the PPE Portal and this remains the case. The PPE and Consumables Policy Group has worked effectively as a joint forum for debating, testing and implementing approaches to the use of PPE, including 'fit-testing' of equipment and clear facemasks.

System-wide staff notices and information have been circulated to inform the wearing of face coverings across all healthcare settings (hospital trusts, GP practices, dentists), including information for the wearing of face coverings by patients and visitors. These have been re-circulated as necessary in response to changes in the national guidance on the wearing of face coverings.

Antigen testing has become firmly embedded within the national response to Covid-19. Routine asymptomatic testing programmes, using rapid lateral flow testing, have been established across the health and care sectors, in education and in workplaces. They have also become universally available to members of the public, who can order free lateral flow tests via the national testing portal, their local pharmacy or by having them delivered by post to their home.

New variants and infection rates have required constant amendments and updates to testing guidance and testing regimes across all these sectors, along with self-isolation periods, which have changed regularly. The Lancashire and South Cumbria NHS Testing Group, established in 2020, reviews the Testing Strategy for the NHS across the region regularly and issues the strategy and other testing notices and information to the Hospital and Out of Hospital cells, the LRF and other groups.

Lancashire and South Cumbria is one of the few areas across the country to successfully embed the LAMP saliva testing regime across its hospital trusts and these tests have become the primary asymptomatic staff testing programme. This was achieved by a close working partnership with the University of Central Lancashire.

Guidance on all aspects of testing, including travel and testing, education, the Covid Pass, self-isolation and other related issues have been updated regularly on the ICS website for members of the public to access, and circulated via the testing matrix to Hospital and Out of Hospital cells, and across the Health and Care Partnership.

The **Covid-19 vaccination programme** – the largest in history – was well established by April 2021, both nationally and across Lancashire and South Cumbria. The Covid-19 Vaccination Programme Board, established in November 2020, continued to provide oversight during 2021/22 as well as strategic direction to make sure the local offer met public need and was fit for purpose.

In addition to many fixed sites in Lancashire and South Cumbria, NHS teams have gone to extraordinary lengths to take the vaccine to different communities, with pop-up and mobile services, including buses and street teams, often delivered through partnerships with religious and community groups as well as council services. This hyper-local approach has proved invaluable to increase uptake in many health inclusion groups.

NHS teams have been able to react quickly as the programme expanded to under-18s, vaccinating children in schools, and then the rollout of boosters and also third doses for those whose immune systems mean they need more protection.

In response to the emerging Omicron variant of the Covid-19 virus, the government announced the acceleration of the winter booster programme. Capacity doubled in the space of a week with daily vaccines moving from 10,000 a day to 20,000. A call out for support saw a reinvigoration of the vaccine response with many volunteers and retired clinicians returning to support the booster programme.

Between April 2021 and March 2022, more than 3.5 million vaccinations have been given to people in Lancashire and South Cumbria. This includes 1 million booster vaccinations.

Partners including local councils, the military, fire and rescue service, police, local businesses, volunteers, returning clinical staff and many more have supported the delivery of the vaccine. More than 1,600 local people offered their support following an appeal for volunteers, and since the vaccination programme began, volunteers have logged almost 140,000 hours through Lancashire Volunteer Partnership.

The ICS led clear communication of public messages, including materials in different languages and formats, about the importance of being vaccinated and how to attend appointments safely. **Pulse oximetry at home and Covid-19 virtual ward services** were

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launched across Lancashire and South Cumbria in 2020/21 to monitor vulnerable patients with Covid-19 in their own homes.

Local providers and GP practices continued to work together to provide the pulse oximetry at home or a Covid virtual ward service for eligible patients, identified as being particularly at-risk from the virus due to their age or a pre-existing condition. Patients were given a pulse oximeter and had regular contact from the service so they could measure the oxygen levels in their blood several times a day, which helps spot the early signs of silent hypoxia; when the body is starved of oxygen but without causing noticeable symptoms such as breathlessness.

This effective digital solution enables early treatment to be given – which both improves patients' chances of recovery and ensures that they only go to hospital if necessary.

In response to the successful vaccination programme and the Covid-19 variants that emerged during 2021/22, the services have continually adapted their patient criteria so that those most at risk from complications are offered the service.

The services have also expanded to include a lighter-touch pathway for lower-risk patients, where patients are contacted by text message and offered a pulse oximeter to self-monitor their oxygen saturation levels at home during the course of their illness. This allows them to easily self-refer into the service or contact NHS 111 if they have any concerns.

Covid-19 virtual wards remain in place and provide an enhanced level of virtual monitoring and care overseen by hospital clinicians, usually for those patients who are receiving treatment to help them recover from Covid-19 whilst in their own home. This enables people to be discharged earlier from hospital or can prevent a hospital admission altogether.

CCGs are considering how the remote monitoring offer and virtual ward concept could be extended for other conditions and using other monitoring devices.

CCGs are working closely together within a joint **Adult Social Care and Health Partnership** which was established under the joint cell. It has given a forum for senior NHS and the four upper tier local authority leaders to oversee integrated workstreams for Lancashire and South Cumbria. This includes key areas such as intermediate care and discharge, and strategic planning for the care sector that impact early intervention to avoid escalating needs and to facilitate system flow.

There have been extremely challenging pressures in the peaks experienced from Covid-19 during 2021/22, which has resulted in reduced capacity across the system from staff absences and outbreaks in care settings. The partnership has worked closely together to maintain capacity and support flow by commissioning additional capacity, keeping close contact with the sector to understand the daily position and flexing workforce. The excellent partnership working displayed and innovative approaches tested, such as the nationally recognised discretionary payments and support to informal carers as part of the discharge scheme, will now help to re-shape the intermediate system work as we go forward.

System reforms: how partners are working together and preparing for the future

This year has seen significant national developments in relation to health and care reorganisation and emerging guidance for delivering integrated care for the benefit of our population and staff.

Integrated care systems (ICSs) are partnerships of NHS organisations, councils and key partners from the voluntary, community and social enterprise sector, working together across a local area to meet health and care needs, coordinate services and improve population health. CCGs are a key partner, and in Lancashire and South Cumbria, all ICS partners are working together to improve health and care services and help the 1.8 million population to live longer, healthier lives.

In line with the NHS Long Term Plan (2019), all parts of England had to be served by an ICS from April 2021. In Lancashire and South Cumbria, the ICS had been developing for a number of years – meaning that the partnership was already relatively mature.

The NHS England and NHS Improvement White Paper Integrating care: Next steps to building strong and effective integrated care systems across England (February 2021) detailed how ICSs and the organisations within them will work more effectively and more collaboratively in future.

From April 2021, a Strategic Commissioning Committee replaced the Joint Committee of CCGs, with a primary role to focus on delivery and decision making for the Lancashire and South Cumbria population with the authority to make decisions at a Lancashire and South Cumbria level. The Committee brings the leadership of the eight Lancashire and South Cumbria CCGs together with ICS strategic commissioning leaders who have collectively committed to improve and transform health and care services across the area, delivering the highest quality of care possible within the resources available.

To support the closedown of eight CCGs and the establishment of the Integrated Care Board (ICB) in Lancashire and South Cumbria, a number of sub-committees and groups were established to oversee the progress and deal with any challenges across the system. This included the ICS Development Oversight Group, the Place-Based Partnerships Development Advisory Group, the CCG Transition Board, the CCG Closedown Group and the HR Reference Group.

In April 2021, the ICS Chief Officer wrote to the CCG chairs and accountable officers, the Managing Director and Director of Operations at MLCSU and the ICS executives to set out a number of expectations and asks regarding system resources during the 2021/22 transitional year.

As part of the first stages of developing resource proposals to build a consistent model for the system-level and place-based teams, four priority areas were identified as 'accelerator' functions:

- Primary and community services integration
- Population health management
- Quality and performance improvement
- Communications and engagement.

Each of the functions worked collaboratively with their teams to design both proposals for a future operating model and an approach to transition throughout the year to align more closely with the proposed target operating models.

The Place Based Partnership (PBP) Development Advisory Group (DAG) oversaw the creation of a Maturity Matrix, which allowed a self-assessment process to take place, to understand the progress already made and further actions required. The Maturity Matrix was revisited throughout the year to measure the progress. The PBP DAG is also overseeing a piece of work to assist in defining the scope of services at place and system, based on the PBP Strategic Narrative which was approved by the ICS Board last year.

In May 2021, a 'Delivering Integrated Care: Summary' document was produced locally and signed off at the ICS Board, which set out the national context, proposed changes and what the changes mean for staff.

A single internal communications process was established across the eight CCGs in May 2021 and staff affected by the transition to ICB were invited to attend colleague briefings to receive updates and raise concerns or ask questions in July, September, November, January and March.

A national ICS Design Framework was published in June 2021, setting out expectations of how NHS organisations were expected to respond in the next phase of system development, including the anticipated establishment of statutory ICS NHS bodies and an ICS Partnership, subject to legislation.

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Published in July, the Health and Care Bill (2021) defined the new NHS bodies as Integrated Care Boards (ICBs) which would replace CCGs, and the partnerships as Integrated Care Partnerships (ICPs).

Following a robust national recruitment process, David Flory CBE was confirmed as the Chair Designate of the NHS Lancashire and South Cumbria ICB in July 2021.

Following the ICS Design Framework, a number of national guidance documents were published, including a Readiness to Operate Checklist, HR Framework for Developing ICBs, CCG Close Down and ICB Establishment Due Diligence Checklist, Thriving places: Guidance on the development of PBPs, and ICS Implementation Guidance on Working with People and Communities.

A multi-agency Communications and Engagement Review Group was established in September 2021 to increase the efficiency of producing key communications materials to support developments in the ICS that require agreement by multiple partners.

Following a robust national recruitment process, Kevin Lavery was appointed as Chief Executive Designate of the NHS Lancashire and South Cumbria ICB in November 2021.

A national extension of the ICB establishment timeline was announced in December 2021, with a new date for establishment of 1 July 2022. Work continued through quarter four to reach a state of readiness for shadow arrangements to be in place from April 2022, whilst respecting the existing statutory arrangements. This mirrors the national approach, as the updated ICB Establishment Timeline confirmed ambitions to complete as many activities as possible by the end of March 2022, with exceptions related only to those actions that are dependent upon national guidance and/or legislation. For these, the intention is to have them completed by the end of May 2022.

Work continued with key workstreams to develop the leadership and governance arrangements and operating models for the Integrated Care Partnership, Place-Based Partnerships, Provider Collaboratives and the ICB. Work also continued to recruit to senior designate leadership teams for both the ICB and Place-Based Partnerships.

All NHS provider trusts are expected to be part of a provider collaborative in order to help set system priorities and allocate resources. In Lancashire and South Cumbria, a Provider Collaboration Board (PCB) was established with two provider collaboratives; an NHS Provider Collaborative and a Mental Health, Learning Disability and Autism Provider Collaborative. A wider range of provider collaboration board and strategic group colleagues helped develop a strategic narrative and supporting materials to support the PCB. These were approved in February 2022.

Throughout quarter four of 2021/22, an Engagement, Involvement and Coproduction Strategy for working with local people and communities has been in development for the Lancashire and South Cumbria ICS, through co-production with partners, stakeholders and public engagement. A strategy for implementing the partnership approach within the NHS ICB was also produced and both documents are scheduled to be taken to key decision-making boards in May 2022.

Health and Care Partnership work programmes

Mental health: children and young people

Child and Adolescent Mental Health Services (CAMHS) remained open and accessible during the Covid-19 pandemic – offering face-to-face, phone and digital solutions. Services have seen a significant increase in the number of referrals since the start of the pandemic, along with an increased complexity of need, particularly for children and young people (CYP) returning to education.

CAMHS services continue to be transformed in line with the evidence-based THRIVE model (developed with NHS organisations, local authorities, education, the police, and representatives from the voluntary, community, faith, and social enterprise sector, parents, carers and young people). As part of a government commitment, an additional £10.7 million has been invested over a three-year period to offer quality mental health services for children and young people. This will reduce waiting times, improve experience and quality of care, and ensure consistent levels of care are provided across the region. A focus will be on developing crisis care and making sure there is support 24/7, reducing the need for hospital admissions.

The funding will support the recruitment of more primary mental health workers who are trained and experienced in working within the community to promote positive mental health and wellbeing, giving advice and support at an early stage. The national ambition is for an increase in access to NHS-funded community services to meet the needs of at least 35% of those with diagnosable mental health conditions. Lancashire and South Cumbria are currently meeting the needs of 69% of children and young people with diagnosable mental health conditions.

The ICS has secured an additional eight **Mental Health Support Teams** (MHSTs) as part of the next phase of roll out. MHSTs provide specific extra capacity for early intervention and ongoing help within a school and college setting. Six of the eight teams have been allocated in 2021/22 and will be located in Blackpool, Wyre, Greater Preston, Chorley and South Ribble and West Lancashire. Two more will be located in Morecambe Bay and East Lancashire in 2022/23. This brings the total across Lancashire and South Cumbria to 18, and delivers against the NHS Long Term Plan ambition of MHSTs achieving 25% coverage by 2023/24. MHSTs will result in additional early intervention support to over 145,000 local children in schools. The Fylde Coast teams launched their MHST service on 7 February 2022, coinciding with the start of Children and Young People's Mental Health Week when Blackpool Tower was illuminated green to demonstrate the importance of children and young people's mental health.

Mental health: adults

Adult mental health services continued to provide treatment during the pandemic, following all updated guidance and using innovative ways of working. Many services rapidly adapted to be able to direct capacity and resource to where it was needed most. Partners worked across Lancashire and South Cumbria to implement digital solutions, seven-day working, a 24/7 mental health crisis line and the launch of mental health urgent assessment centres. Significant additional demand for services is anticipated in the wake of the pandemic. Continued additional investment and transformation work will allow the local system to meet these challenges.

Specialist Community Perinatal Mental Health (PMH) services have now been expanded to provide locality-based teams. This will allow new and expectant mothers with moderate to severe symptoms to access specialist care where they live. Additional investment has increased the availability to women who need ongoing support from 12 months to up to 24 months following childbirth. This service supported over 1,600 women between April 2021 and March 2022.

The NHS Long Term Plan set out the ambition to establish **Maternal Mental Health Services** (MMHSs) in all areas of England by 2023/24. This will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience. In 2020/21, Blackpool Teaching Hospitals NHS Foundation Trust bid successfully for Early Implementer and Fast Follower transformation funding from NHSEI to develop and test the service across the whole of Lancashire and South Cumbria. This much-needed service will provide evidence-based care for women who have post traumatic stress disorder following birth trauma or loss, neonatal admission, termination of pregnancy, separation, or severe fear of childbirth (tokophobia). The MMHS will reinforce the wider transformation programmes so that services are better integrated and provide appropriate access to psychological support for women and their families. The LSC model is based on national guidance and local needs – it will deliver a multi-disciplinary approach to care and treatment in a community setting. The Lancashire and South Cumbria Reproductive Trauma Service (MMHS) went live on 28 March 2022 and is now taking referrals.

Lancashire and South Cumbria NHS Foundation Trust is continuing at pace with the mobilisation of the newly-developed **Initial Response Service** (IRS) which will provide a single point of contact for all mental health urgent and routine referrals via one single number and a dedicated email address in each locality. The new service will be open 24/7, and includes an extended crisis mental health helpline and rapid response function where urgent, face-to-face assessments are needed. In the first four weeks since launching in Pennine Lancashire, the IRS has taken around 7,000 calls – averaging around 250 calls per day. The process will be gradual, initially launch being with the Police and North West Ambulance Service before being extended to GP practices. The Central Lancashire and West Lancashire model commenced in March 2022, and is based at the Avondale Unit on the Royal Preston Hospital Site. The Bay IRS is likely to soft launch in April 2022, and the Fylde Coast in May 2022.

Crisis alternatives such as The Central Lancashire Haven and Blackpool Light Lounge have been developed with our VCFSE (voluntary, community, faith and social enterprise) partners as an alternative to A&E. They aim to provide a welcoming and non-judgmental environment for individuals struggling socially and emotionally with life challenges or who are in crisis. Crisis house provision has also been extended to cover Pennine, Central and North areas. These offer short-term accommodation for people experiencing a mental health crisis – providing holistic therapeutic support and interventions to prevent hospital admissions.

More than half of everyone sleeping on the streets lives with a mental health problem, and nearly four in five have experienced childhood trauma. Blackpool was chosen to be a nationally-funded site for a Mental Health Rough Sleepers team to ensure those affected by homelessness have access to specialist NHS mental health support, joining up care with existing outreach, housing, drug and alcohol, and physical healthcare services. The teams will identify the most vulnerable people facing multiple disadvantages, and support them through an integrated holistic approach to understand the full scope of their needs.

In line with the national picture, the **Lancashire and South Cumbria Eating Disorder service** has seen a 64% increase in referrals for people of all ages. But there has been an 81% increase for adolescents aged 11 to 15; and a 41.4% increase for young people aged 15 to 20. An overall spike in referrals was seen in June 2020 and has been sustained throughout the remainder of the year. To reduce waiting times, the voluntary sector has worked with us to help people requiring routine support. Additional capacity has also been put in place for urgent appointments – which has resulted in people now being seen in line with national expectations.

The **Community Mental Health Transformation** is a three-year programme of large-scale change that will be completed by March 2024. Plans are being developed to

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reconfigure community mental health services around primary care networks (PCNs) into community mental health hubs. Lancashire and South Cumbria NHS Foundation Trust (LSCFT) have set up a procurement framework for the VCFSE, which currently has 58 organisations listed. The framework will allow the trust to contract VCFSE organisations to provide peer support or lived experience and high-intensity user support into the community hubs by early 2022/23. Existing ICS asset maps have been further developed to include the services available within each PCN.

The programme includes recruiting one primary care mental health worker per PCN each year from 2021/22 to 2023/24 – funded by the Additional Roles Reimbursement Scheme (ARRS). Across LSCFT, 14 workers have been successfully recruited this year, and rolling recruitment schemes are in place. A number of roles have been recruited for 2022/23 in conjunction with the Trainee Associate Psychological Practitioners scheme (TAPPs).

Personality disorder, eating disorder and rehabilitation specialists will also form part of the staffing model for the community hubs. An adult version of the First episode and Rapid Early intervention for Eating Disorders (FREED) service will be implemented, with plans to recruit staff early 2022/23. Rehabilitation staff will be recruited from quarter two 2022/23. Staff are reviewing their caseloads alongside the weighted population, and considering how the teams can be reconfigured into the new hub teams. They are also looking at patient flow to improve throughput in services and reduce waiting times.

The Individual Placement and Support (IPS) service will be extended into **Community Mental Health Teams** (CMHTs), where this is currently in early intervention teams. Initially, the areas covered by current practitioners will be expanded, then new practitioners will be recruited. To support the move away from Care Programme Approach (CPA) – DIALOG and DIALOG+ will be implemented. This has a full project team and includes new care plans and safety plans. Staff will be provided with tablets to allow patients to input their patient-reported outcome measures (PROMs), and to support patients and staff to build care plans together.

Improving Access to Psychological Therapy (IAPT) services across Lancashire and South Cumbria continue to work towards expanding access and maintaining the existing referral to treatment time and recovery standards in line with national targets. There has been significant investment during 2021/22 to grow and develop the IAPT workforce to support the achievement of these ambitions. Access rates across the ICS have increased from pre-Covid suppressed rates, but are lower than expected (35% below plan as of end of February 2022). Performance is at 92% of the five-year seasonal average.

The recovery rate across all local CCGs has been above target (50%) for much of the year, with some fluctuations (Greater Preston and Fylde and Wyre who had four and two months below target). Any fluctuations have returned to target following action from the providers. At the end of Q3 of 2021/22 all eight CCGs achieved their 50% minimum recovery target with the LSC position 56% overall.

Within 2021/22, the following actions have been undertaken both at an ICS level and provider level:

- January to March 2022 – targeted communications activity promoting IAPT to small and medium enterprises, local authorities, NHS workforce, further and higher education settings, large employers and the general public
- Since Covid-19, the IAPT offer has changed, with additional flexibility offered via online offers, Attend Anywhere web-based platform, increased group activity. Demand for virtual appointments has remained high since the pandemic and will now form a core element of the IAPT service offer of additional sessions weekends and early evenings.
- All provider IAPT webpages and self-referral forms have been reviewed, to ensure content is streamlined. The ICS webpage for IAPT has also been improved, and used to support the roll-out of a national campaign in January 2022.
- All CCGs have formally agreed to system working in terms of shared workforce to ensure equity and reduce demand spikes in certain locations.
- Long Term Conditions psychological support is being enhanced with integrated provision being re-introduced in secondary and primary care settings.
- A pilot service offer working across West Lancashire with partner service providers has been evaluated and is being considered for further roll out due to increases in access as a result.
- Following a successful bid to NHSE Digital, additional funding was secured to support the development of a digital product that could support triaging and/or access to IAPT services. This bid has three strands, which will include a digital communications/social media campaign, due for launch in Q1 of 2022, and the provision of additional digital capacity that commenced 1 April 2022 with a focus on 16-18 year old students.
- Working with NHSEI, further High Impact Actions to increase access to IAPT services have been drawn together and an implementation plan is being worked up.

In March 2022, **a new mental health rehabilitation inpatient unit opened in Wesham**, containing 28 beds for both men and women. Wesham is classed as a Community Rehabilitation Unit, and treats adults aged 18 to 65 with an impaired level of functioning due to complex psychosis – as defined by NICE. It helps patients to return to more independent living, reducing the need for supported accommodation. By improving activities of daily living (for example personal care, cooking and budgeting) and reintegrating patients into the community (for example through leisure and vocational activities), patients are helped to recover their independence.

Psychoeducation empowers patients to understand their illnesses and improve their coping strategies. A typical length of stay is 12 to 18 months, but could be much shorter. Rehabilitation services are shown to successfully support two in three people progress to successful community living within 18 months of admission, whilst two in three do not require hospital admission within five years, and around one in ten go on to achieve independent living within this period. People receiving rehabilitation support are eight times more likely to achieve or sustain community living, compared to those supported by usual community mental health services.

Suicide prevention

Recognising the impact of the Covid-19 pandemic and lockdowns on people's mental health, the Lancashire and South Cumbria ICS frequently campaigned on suicide prevention.

Through real-time surveillance of suspected and attempted suicides, drug-related deaths, and self-harm episodes, themes are being identified and intelligence-led interventions are being made. A multi-agency group reviews all data and risk factors to make sure the appropriate responses are made as and when they are needed.

Specialised suicide bereavement support services have been commissioned through the organisation AMPARO across the whole of Lancashire, enabling families bereaved by suicide to access timely bereavement support. Suicide prevention and real-time surveillance data are now key for safeguarding across the system.

The 'Let's keep talking' campaign encourages local organisations, businesses and community groups to access resources that promote people to open up about their mental health. Currently on phase 6, the campaign is focusing on debt support services and encouraging residents to reach out for help at the earliest opportunity. An online directory of suicide prevention and bereavement services across Lancashire and South Cumbria has had more than 20,000 hits since being published.

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More than 4,500 people have been trained in suicide prevention and self-harm. More than 1,270 people have signed up to be orange button wearers (local people who have undergone extensive suicide prevention training wear the button to signal that while they cannot counsel people, they are trained to direct them to relevant services). The scheme has now been rolled out across Cornwall, Devon, Somerset and Worcestershire.

Digital

The ongoing response to Covid-19 has further accelerated the spread and adoption of digital solutions during 2021/22. Our digital portfolio has expanded to support the Elective Recovery programme and to support care at home and in other settings with sharing of data, delivery of remote monitoring solutions, supporting virtual wards and virtual consultation, and supporting the self-management of health and wellbeing with digital tools.

The region has been the highest user of a **shared care record** (SCR) in the country. The Lancashire Patient Record Exchange Service (LPRES) has almost 7,000 registered users, and more than 8 million documents currently available to support patient care. A Centralised Viewer enables partners across the ICS to share documents, images and other media files. Plans are under development to use the SCR to support specific pathways such as end of life and palliative care records and unified medicines records.

The **Badgernet** system has been deployed across all maternity services, and we continue to work through plans to procure single **electronic patient records** (EPR) for acute and community services. We are currently supporting Blackpool Teaching Hospitals NHS Foundation Trust with an outline business case and, hope that once approved, the other three trusts will have the option to join the procurement exercise.

Partners across the system have developed a **Northern Star Digital Strategy**, which aims to deliver a wider set of benefits by managing digital convergence across all health care organisations towards a single way of doing things. To further enhance capabilities around data management for direct care and secondary uses such as business intelligence, population health management and research, a shared data warehouse is under development.

The **person-held record programme** (WelLPRES) has supported the delivery of patient-initiated follow-up (PIFU) pathways with the development of a secure clinical chat service, patient questionnaire capture and upload. A virtual multi-disciplinary team (MDT) platform has the facility for patients and carers to upload media such as video files to inform MDT meetings. This is currently supporting paediatric pathways, but we plan to roll out to other services in 2022/23. A virtual pre-operative assessment solution is also supporting patients to have pre-surgery checks performed remotely – reducing footfall and unnecessary exposure, and improving patient experience.

Work to support the **digitisation of regulated care** has seen the rollout of fully funded Social Care Record system licences for five care homes, with plans to expand the offer to 42 others. A total of 120 care homes have been supported to deliver video consultations, whilst other projects have supported recruitment to the sector, provided bursaries for digital pioneers, and supported the adoption and rollout of NHSmail and Data Security and Protection Toolkit (DSPT) compliance. A digital maturity roadmap has been developed for the regulated care sector.

The **Digital Diagnostics programme** has launched the HiPRES solution, and supported Covid-19 testing over the last 12 months – with 10,000 registered users as at March 2022 and with other use cases to follow. The Artificial Intelligence (AI) for Stroke programme is supporting patients around the region. University Hospitals of Morecambe Bay test picture archive and communication system (PACS) has been successfully connected to the centralised cloud-based imaging platform, and radiology images have been successfully sent across this network. This enables the transfer of patient imaging between all trust systems through a secure and cost-effective cloud environment. All SCR users will be able to see patient imaging in real time – eliminating the need for admin support, and improving our ability to provide quality care and timely decision making for patients wherever they are receiving treatment across the region.

In **primary care**, we have further developed the Agilio TeamNet solution, which supports with their management of information, HR and workforce processes, and evidence for the Care Quality Commission. Agilio also aids clinical decision making through a digital repository for clinical guidelines and pathways supporting demand management, a reduction in variation, and supporting patients to be seen by the right clinician at the right time in the right place. We have successfully rolled out the Health Education England online digital assessment tool across primary care, with the intention of building the digital skills, confidence and competence within the workforce. With the support of the training hub, more than 600 staff members have accessed the tool to date – the highest uptake in the country.

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Two elements of the **Primary Care Digital Maturity Scheme** have been completed: practices engaging with the digital front-door, online consultation and video consultation (DFOCVC) procurement have been reimbursed in accordance with the scheme; and practices and patients have completed questionnaires on existing functionality and future requirements.

The Fundamentals Practice Programme at the University of Central Lancashire supported an Action Learning Set (ALS) development programme with Redmoor Health for general practice nurses to develop their digital skills and support embedding digital into practice. This work has been further supported by the training hub and locality digital champion leads. One of the successes has been the implementation of video group consultations, with one of our nurses winning the 2021 National Practice Nurse of the Year Award for this work.

In a collaborative project between primary and secondary care, **robotic process automation** (RPA) uses artificial intelligence to introduce more efficient ways of working and address workforce challenges. The first process allows the allocation of groups of patients to their usual GP, and is now live in Morecambe Bay.

Our Digital Inclusion programme provided training to staff and volunteers within 14 voluntary, community, faith and social enterprise (VCFSE) organisations to develop **digital health champions** to enable targeted communities to become more digitally active and raise awareness of varying needs with health and care staff. Champions representing ethnic minority backgrounds, learning disabilities, autism, deaf, socially deprived, mental health, and military veteran communities were supported with access to the NHSX-funded Digital Unite platform. Our region saw the highest use of that platform and end-users reached nationally. The work with the learning disability and autism communities in Blackburn with Darwen supported delivery on six of the 10 key priorities of 'The Big Plan' for people with these conditions – focusing on reducing isolation, education and employment, workforce development, transforming care, commissioning and personalisation, advocacy, and being heard.

We also supported our workforce to enable **digital health literacy** among patients, in turn helping them to access suitable resources and become involved in the development or procurement of patient-facing digital tools. This included delivering an app prescribing scheme in primary care, providing access to the ORCHA Digital Health Academy platform, and using a user-centred approach to develop our person-held record to ensure our digital solutions are designed around the needs of the people using them.

To promote digital inclusion within the **elective recovery programme**, VCFSE-hosted digital health navigators are supporting patients on an elective care pathway with digital tools and the knowledge, skills and confidence to use them. Our work in the Digital Inclusion/ Health Inequalities space has also led to the development of a unified, regional 'Citizen Impact Assessment' that incorporates assessments of equality impact, health inequalities and digital impact.

We are currently engaging with stakeholders to support the writing of our three-year **Digital Transformation Investment Plans**, which will be submitted to NHSEI in June 2022. We are also providing digital expertise to the New Hospitals Programme planning.

Underpinning all this work, the Digital team developed a programme management function and commissioned a smartsheet control centre as a tool to compliment the ICS system and allow reports to be pulled at any time – without having to ask programme leads for information. We have embedded a robust governance structure which aligns with non-digital governance offering assurance to the system that all the required process and standards are met – for example clinical safety, information governance, and interoperability standards.

Stroke

The Covid-19 pandemic has continued to impact on stroke services – both in respect of people staying away from hospital and challenges in staffing and resources. Acute stroke centres have struggled to maintain the level of services achieved before the pandemic.

However, the Lancashire and South Cumbria Integrated Stroke and Neurorehabilitation Delivery Network (ISNDN) has worked tirelessly with the Stroke Patient and Carer Assurance Group, acute stroke service providers and others, to develop a business case for enhancing acute stroke centres across the region. The ICS Strategic Commissioning Committee ratified the business case in July 2021, which commits to invest millions of pounds in enhancing our acute stroke and rehabilitation centres over the next three years. The first steps of the implementation process are underway, alongside a public engagement exercise to understand any issues or concerns this process raises.

The business case for the development of the Lancashire Teaching Hospitals NHS Foundation Trust thrombectomy service was dependent on the enhancing stroke service business case, and has since been agreed by commissioners. Plans to extend the thrombectomy service in a phased approach over 2022/23 look to begin in March 2022.

The enhancement of the region's acute stroke centres dovetails with the development of Integrated Community Stroke teams, which is also well underway. This will ensure system-wide coverage of Community teams to provide intensive therapy services to stroke survivors in their homes following hospital discharge.

Implementation of artificial intelligence for stroke in each of the local acute trusts has enabled earlier identification of stroke patients that results in increased numbers of patients receiving thrombolysis and thrombectomy.

A case for change for the psychological support following a stroke was presented to and agreed by the ISNDN, and a new model of care for this support is in development. Stroke survivors and carers are keen to see these developments, and an options appraisal will shortly identify what may be achieved going forward.

World Stroke Day in October was promoted across Lancashire and South Cumbria, supporting the World Stroke Organisation's 'Precious Time' initiative and the Stroke Association's 'Hope After Stroke' campaign.

Diabetes

More than 100,000 people aged 17+ in Lancashire and South Cumbria have type 2 diabetes, and it's estimated that more than 75,000 people are at a high risk of developing the condition. It's essential to diagnose type 2 diabetes as early as possible, and to identify people at risk of the condition, so they can be supported to make healthier lifestyle choices to reduce their risk. In Lancashire and South Cumbria, people identified as being at risk are offered tailored support through the local Healthier You service. Normally the programme involves a series of face-to-face group sessions, but virtual meetings were established during the pandemic. These have continued with provider Ingeus receiving nearly 3,500 referrals across Lancashire and South Cumbria between April 2021 and February 2022.

Local people with type 2 diabetes have been able to access support to manage their condition through My Way Diabetes via Your Diabetes, Your Way. Again, all face-to-face learning sessions were temporarily suspended during the pandemic, but a lot of digital support and online resources were available. As people with diabetes are amongst those more vulnerable to Covid-19, local health and care organisations worked together to provide practical and emotional support – especially during the winter months. During 2021, there were 206 registrations of patients compared to 16 patients in 2020. There are 57 practices across Lancashire and South Cumbria with at least one or more patient registered with the platform. Looking ahead we are reviewing the provision of structured

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education for people with type 1 and 2 diabetes for 2022/23 and there will be additional sources of information from the national team available.

Pathology collaboration

A significant amount of progress has been made during 2021/22 on plans to transform pathology services across Lancashire and South Cumbria. This transformation work is critical as pathology touches everyone's life, from birth until after death and care pathways could not be provided without it.

Work progressed to form a single pathology service and the outline business case proposing how the future service will run was submitted to NHSE/I for approval and to request the required capital. All acute trust organisations involved in the collaboration are committed to achieving the benefits the formation of a single service will realise in relation to quality, resilience and improved outcomes for patients. There is also an expectation from NHSE/I that by 2024/25 all pathology networks will be at an agreed level of maturity with a future delivery model agreed.

Steps towards the formation of the future service have taken place during 2021/22, including the launch of a consultation of employees who currently work in pathology services. This process highlighted the need to do some more robust engagement and listen to staff to develop our vision for how the service will run in future. As such, the Pathology Collaboration Board agreed to pause the work to develop the single service by 1 July 2022 and the progression of the full business case. This pause will also allow the Board time to ensure that all options have been explored for securing the capital required to develop the future service. The Pathology Collaboration Board views this pause in the programme of work as a positive opportunity to do some further and more in-depth engagement with the pathology workforce. This will be done with transparency and in partnership to ensure that all options have been explored before moving forwards together with this important work to determine how the future service will be delivered across Lancashire and South Cumbria. It is proposed that the engagement will be undertaken over the summer of 2022 and the feedback generated will be used to form options that will be taken to the Pathology Collaboration Board for approval and to agree the way forward.

Other key programmes to support collaborative working and transformation have progressed and will continue to do so. For example, the business case for digital pathology, workforce re-design and the development of new roles. A significant development has been the procurement of a new Laboratory Information Management System that will be implemented across all laboratories. The contract has been awarded to the preferred supplier and the new system will provide a common platform across all pathology services, enabling the storing and communication of results, access to these results wherever a patient presents, and a more effective use of data that can inform future service developments. This is a significant service development and an example of what is possible through collaboration.

Cancer Alliance

The Lancashire and South Cumbria Cancer Alliance brings together decision makers and those who deliver cancer care to transform services and improve outcomes. Our aim is to raise general awareness of the signs and symptoms of cancer, identify those at high risk of cancer earlier, and continue to develop innovative treatments that improve survival and quality of life.

Throughout the pandemic, we have provided system-level leadership to support cancer services and are the most restored Cancer Alliance nationally for urgent suspected cancer referrals. We are seeing more patients every week for a cancer check than we saw before the pandemic and have worked hard to ensure that campaigns and messaging to promote public awareness have been amplified locally.

The number of cancer treatments delivered since the start of the pandemic have also continued at or around 100% of the baseline, and this is due to the hard work and dedication of all our health partners.

We are working across primary and secondary care to introduce innovative tests such as colon capsule endoscopy, cytosponge and the faecal immunochemical test (FIT) to identify those patients at greatest risk and target our resources toward those in greatest need. We are also one of the areas selected to work with Pinpoint, a new type of blood test designed to help GPs determine patients most likely to have cancer.

Exciting new programmes including genomics and targeted lung health checks are helping to detect cancers earlier. We have also been successful in becoming part of a North West Endoscopy Academy, with Lancashire and South Cumbria leading on training for endoscopists and supporting the whole training programme for these staff.

Our aims for 2022/23 are to continue to embed these innovations, ensure recovery and restoration, and move closer to operational targets for wait times.

Maternity

Much of the national Maternity Transformation Programme was paused during 2020/21, but has seen progress in many areas during 2021/22. However, some elements such as Continuity of Carer have not been able to progress due to the significant staffing pressures related to Covid-19.

In Lancashire and South Cumbria, all four maternity providers successfully submitted their evidence for the Ockenden immediate and essential actions. The second request for further required actions is currently awaited.

The roll out of the system-wide Maternity Information System – Badgernet – is now being actively used by Lancashire Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust and University Hospitals of Morecambe Bay NHS Foundation Trust. Blackpool Teaching Hospitals NHS Foundation Trust is due to go live in early summer 2022. Women across Lancashire and South Cumbria are able to access a personal care record digitally via an app or portal. This provides women with access to information in a secure, paperless format, and can be used to manage appointments, communicate with midwives, view clinical information, and receive notifications.

In December 2021, the Digital Maternity programme was also successful in a bid for NHSX Unified Tech funding. This money will be used to support improving interfaces, essential hardware purchases, and improving data quality and maternity innovations.

Our workforce and education transformation workstream has completed the implementation of the Maternity Support Worker (MSW) Competency Career and Education Framework and developed a system-wide midwifery preceptorship pack, which will be implemented in May 2022 and a system-wide Training Needs Analysis tool. Trusts have also received national monies to support staff retention for both midwives and MSWs. The regional maternity team is leading an international recruitment drive which will see 10 additional midwives entering the workforce in Lancashire and South Cumbria. In addition, a staff and student resource hub has been commissioned in partnership with the University of Central Lancashire and the University of Cumbria to host information, resources and training links for all maternity students and staff across Lancashire and South Cumbria. This will be formally launched early in the new financial year, and development will continue into 2022/23.

To support women's choice in maternity, a 'choices summary booklet' for women and families has been developed together with an informed consent poster.

From June 2021, the Perinatal Pelvic Health service project has developed training resources and a tool for risk assessments and screening, and physiotherapists have been recruited into specialist training posts. The programme now

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has strong service user involvement through the local Maternity Voices Partnerships, and a workplan is ready for delivery in 2022/23.

As part of our future statutory requirement in response to the Ockenden Report, a Maternity and Neonatal Quality Assurance panel has been established to understand the quality and safety of local maternity services, and to ensure robust reporting mechanisms are in place to support governance and assurance processes. The focus for 2021/22 has been to further develop and establish the information flows and reporting structures with key partners including commissioners, providers, NHSEI, Clinical Networks and Maternity Voice Partnerships.

Our Maternal Mental Health Service Holistic Approach to Reproductive Trauma service (HARTS) is ensuring a robust integrated psychology and maternity offer for women and their families needing specialist support and intervention due to birth trauma, loss and tokophobia and enduring moderate to severe mental health difficulties.

We have successfully launched pilots for an extended-hours breastfeeding helpline and the LatchAid Breastfeeding Support digital app. These were combined with extensive training across multiple disciplines for lactation and infant feeding.

The following services achieved gold accreditation in the Baby-Friendly Initiative Awards: East Lancashire Hospitals NHS Trust Maternity Services, Lancashire Children and Family Wellbeing Service and Virgin Care 0 to 19 Service, Blackburn with Darwen Children's Centres and LSCFT's 0 to 19 Service, University of Central Lancashire's Midwifery and Health Visiting Programmes.

System-wide, standardised Smoke-Free Pregnancy annual training, a CO2 monitoring during Covid-19 pandemic Standard Operating Procedure (SOP) and a Trauma Informed Care Training and Supervision package sre now in place for maternity services. These will be delivered by a commissioned provider from April 2022.

Strident efforts have been made to ensure that pregnant women are getting the necessary vaccinations against Covid-19 to maximise the positive outcomes for both mother and baby. Following workforce training, sharing of resources and leaflets, seven-minute briefings and social media campaigns – there has been an increase in uptake rates from 29% on 25 August 2021 to 58% by 8 February 2022.

The National Equity and Equality Guidance for local maternity systems was published in September 2021 which is currently being embedded into the existing work programme. Commissioning support unit colleagues have supported a population health needs analysis, and a community assets mapping exercise has been commissioned – both of which were submitted to the regional team in November 2021.

North West Coast Clinical Network colleagues have continued to develop standardised guidelines, pathways, SOPs and processes for use across the North West. These include pre-term birth, in-utero transfer, third trimester loss – stillbirth, homebirth (transfers from a community setting), outlier escalation process and Saving Babies' Lives 2 exemption process. The network also hosted two successful North West Coast Maternity Safety Summits in March and September 2021.

Paediatrics

We have now formed a whole-system board to deliver a national transformation programme to improve outcomes for children and young people across Lancashire and South Cumbria. A number of condition-specific clinical networks have been established:

The Asthma Network is working on several projects relating to education in schools and communities, standardisation of referral pathways, digital apps to promote self-management, ensuring early diagnosis, and giving carers access to approved training.

We are developing a Diabetes Network focussed on the national priorities which include ensuring children and young people have access to technology that helps them manage their condition, addressing the differences identified by the National Paediatric Diabetes Audit, supporting the transition to adult services, and preventing type 2 diabetes.

We are developing the focus of our Epilepsy Network to deliver on the national priorities, which include the transition to adult services, providing access to mental health assessment and psychological support, addressing the differences identified in the Epilepsy 12 audit, and standardising referral pathways.

We are part of a national pilot project to provide specialist clinics for children and young people with excess weight, ensuring that this care can be provided closer to home. Through a newly-developed Healthier Weight Healthier Futures network, we are working closely with the local authorities and voluntary sector to help children and young people achieve healthier lifestyles.

The Surgery in Children Network is working to address the requirements specified in the latest policy release. By July 2022, there will be no children waiting over two years for their surgery. A full workplan is currently being developed to consider seven key areas:

- elective care recovery and urgent care
- specialised commissioned surgery and paediatric intensive care
- alignment with paediatric critical care
- surgery in children and long-term ventilation operational delivery network
- facilities and estates
- governance
- workforce

The workplan will need to be agreed by the different boards.

The Palliative Care Network is working to improve the care for children with life-limiting illnesses, and funding has been agreed to appoint a new palliative care consultant for the area. We will work to ensure that staff have access to additional training, and that children and families benefit from a whole-team approach to care – personalised to meet their needs. We are also working to describe the bereavement support available for families when this is needed.

The Community Developmental Paediatrics Network will work together to support families and children with medical complexities and/or physical disabilities. We will work on pathways to prepare families for adult services and ensure that statutory duties are met.

In partnership with the local hospitals, we are implementing the Paediatric Early Warning Score – a national programme that aims to identify poorly and deteriorating children quickly.

Covid-19 pressures have continued to impact on children and young people's services, with the team supporting the wider system to plan for increased admissions over winter. We are working on new models of care including virtual wards.

The work to prepare children and young people's services for the creation of the Integrated Care Board (ICB) continues at pace with planning and discussions about the new commissioning arrangements. We are keen to ensure that their voice is loud and clear in discussions about the change.

In summer 2021, communications and engagement colleagues from CCGs across Lancashire and South Cumbria developed a campaign to highlight the rise of cases of respiratory syncytial virus (RSV) in young children and to advise and reassure parents and carers what they should do if they feel that their child has fallen ill with respiratory illnesses such as bronchiolitis.

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In December 2021, CCG communications colleagues developed an interactive digital campaign aimed at children and sharing key health and wellbeing messages. The campaign took the form of a digital advent calendar and featured the character Harry the Health Elf. Each day in December up to Christmas Day, a new calendar door opened featuring a new message on such topics as staying healthy over winter, cold and flu messages, and general winter wellbeing messages. The tone and language were aimed specifically at a younger audience.

This toolkit was only shared across each NHS and partner organisations digital channels, but was also shared with schools and other children focused settings across Lancashire and South Cumbria.

The creation of the ICB creates good opportunities to strengthen our links with the four local authorities. The team have been working closely with Lancashire County Council on a programme funded through the Department for Education to enable better and appropriate sharing of information across the system.

Personalised care

Personalised care is a key element in delivering Lancashire and South Cumbria's vision for future healthcare. We need to change the way we deliver health and wellbeing support, address health inequalities, work together with mutual respect and shared responsibility. We need to promote the prevention of illness, early identification of conditions, timely intervention, and enablement. We need people to be as active and independent as possible, living their best life.

We understand that health is both fluid and individual, and that the personal touch can make all the difference for patients. Successful communication between health professionals and their patients can lead to long-term positive health, reducing waiting lists and high costs by improving self-care in the process.

Despite the disruption caused by the Covid-19 pandemic, it has also shown the difference personalised approaches can make for the most vulnerable patients. After identifying these populations, we spoke with patients about what matters to them, involved them in shared decision making and helped them stay fit and active.

We have seen services innovating and adapting, identifying problems, finding solutions; embracing the key principles of personalised care, listening, and respecting the contribution that a patient can make; ensuring that the care provided helps that person live the best life they can. We have created partnerships across Lancashire and South Cumbria, piloting the Sir Muir Gray 'Living Longer Better' approach; supporting people and communities to be more active and involved.

A model of working and workforce training has been developed and put in place to help our practitioners and partners deliver this at-scale. Although face-to-face Patient Activation Measure (PAM) training was unable to take place, online workshops and resources have helped colleagues to support people's health and wellbeing, maximise self-management and reduce further unnecessary demand on services. We are also connecting colleagues with an online support platform to help practitioners use PAM. This system helps us measure a patient's knowledge, skills and confidence to manage their health conditions and helps them build these skills and live more independently.

Health coaching delivery has been adapted through the pandemic, and delivered through an online course. We are now reviewing how we offer this going forward and will move to a mix of online and e-learning resources for the majority of practitioners, but with face-to-face training available for specific roles directly involved in health coaching delivery.

Digital Unite assists our coaches to support and train end-users with technology, from creating an email to accessing NHS services, to support the five dimensions of health (physical, mental, emotional, spiritual, and social). The platform will also provide data on how many end-users have been reached and how many sessions were required to support them throughout the project.

Working with an ongoing Digital Inclusion project, our coaches will learn how applications are assessed and fit into health setting pathways; in addition, they will be able to review and recommend thousands of apps within the ORCHA library alongside other NHS-reviewed apps. This will help the patient receive the best app support to fit their individual needs and circumstances.

The pandemic has accelerated our need to make changes: providing choice, personalisation and embracing technology to help us deliver and use services in a different way. Our Co-Production in Action Conference was held online in March 2022 – providing an opportunity for us to share and learn from our successes in the North West; to better understand the real impact that effective co-production can have on our local communities. Those who attended were given the opportunity to attend a number of half-day workshops to generate a pipeline of micro-pilots to tackle high-priority issues and shape the future of health together.

Population health management

Health outcomes for people living in Lancashire and South Cumbria are significantly worse compared to the national average. There are also significant health inequalities between different areas, and the pace of improvement has slowed down – in many areas, life expectancy has fallen. Therefore, urgent action is required to reduce health inequalities and to tackle the major causes of ill-health and premature mortality.

Nearly one-third of people in Lancashire and South Cumbria live in some of the most deprived areas across England. More people are living in fuel poverty and unable to afford to heat their homes than the national average (13% compared to 10.6%[1]). We know that adverse living conditions (including child poverty) leads to significant variation in childhood development and school readiness. The percentage of children living in poverty ranges from 12% to 38% (the national average is 30%).

Access to health services has been cited as a barrier in several of our communities. Life expectancy is below the national average, but there is a significant level of unwarranted variation in the number of years people can expect to live a healthy life. Healthy life expectancy and disability-free life expectancy is predicted to be less than the expected state pension age of 68 years for children born today. In some neighbourhoods, healthy life expectancy is 46.5 years.

We know that the Covid-19 pandemic has exacerbated inequalities, and further challenges to outcomes are likely given the longer-term economic impacts. We have significant financial challenges to address over the coming years as we improve efficiency and productivity in the system.

Population health and population health management approaches can help us to intervene early and mobilise our workforce to improve outcomes and reduce costs. To make this work, all teams across health and social care must work in partnership with the community, voluntary and faith sectors, as well as other critical community stakeholders including our citizens, with governance structures that reflect the need for collaborative working and co-design.

Our goal is to improve the health and wellbeing of our population by reducing inequalities in the short, medium and long-term. Our aims align with those outlined at national level. We will achieve this through a systematic and appropriately scaled use of linked data and qualitative insight to inform interventions at every level.

[1] https://www.healthierlsc.co.uk/population

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We will use learning from our work before and during Covid-19, looking at elements that have blocked or enabled collaborative progress towards a consistent population health management way of working. We can only truly achieve our goals by working in partnership across all sectors. Our place-based partnerships are key to addressing the wider determinants of the health, behaviours and lifestyles of our communities.

We need to consider the role local Health and Wellbeing Boards will play in helping us to deliver our vision. Whilst broader partners have informed this model, it is predominantly about how NHS resources are used differently to play our part in population health. The NHS has further to go in its learning on how to do this and by working with partners, the model will continue to evolve.

Our population health operating model and development programme is designed to build robust foundations at every level to further develop our approach to population health. It will complement the broader programmes of work within our Clinical Networks, Health and Wellbeing Boards, respective organisations and more. It will grow local approaches for understanding and quantifying the impact of different disease combinations on service utilisation to enable place-based partnerships and their constituent partners to target resources more effectively.

As a system, an overarching strategy for population health is needed and will be shaped by the recommendations of the Health Equity Commission (HEC). The HEC was launched by Professor Sir Michael Marmot in September 2021, and is also chaired by him. We are looking forward to receiving his recommendations for the system, our partners and places in April 2022.

Workforce

The ICS developed a comprehensive plan to support our workforce planning and development, implement the requirements of the NHS People Plan, and look more widely at the future ICB workforce functions. The Workforce Function Plan is structured around delivery of the 10 people functions which were set out in the national guidance for ICBs/ICSs (August 2021). This approach will ensure the local and national people priorities and expectations are implemented, to develop and support the 'one workforce', and make Lancashire and South Cumbria a better place to work and live.

Throughout the pandemic, provider trusts and the ICS Workforce team have supported people to return to work in health and care through both national and local recruitment activity, and most recently the Landmark programme. Those staff have been integral to the success of the Covid-19 vaccination programme – and whilst that continues, we are now focusing on how we might best retain them. Other initiatives to support retention of staff include developing a system-level deployment HUB 'It's Your Move' (IYM) – building upon the concept initially launched in 2019 that has so far assisted more than 70 staff.

The ICS' Strategic Apprenticeship Group is developing the apprenticeship pipeline to create clear career pathways that will aid the recruitment and retention of staff, while also upskilling local communities. Significant work has been done on levy sharing, workforce and pipeline planning, shared cohorts, and rotational models. Their 'Grow our Own' Strategy highlights apprenticeship vacancies and aims to inspire people at every stage of their career journey. Work to date includes mapping the nursing apprenticeship pathways for social care, and analysing system data to forecast gaps in the future workforce.

The ICS has had a good track record of working with local voluntary services partners throughout the pandemic, particularly in mobilising volunteer support for the mass vaccination programme. A current programme of work has sparked the development of a new Volunteers Jobs Board on the Careers platform – creating one place for all volunteer vacancies across the system so they can be searched and promoted more easily.

A new range of employment programmes have been developed, targeting healthcare support worker (HCSW) vacancies across the system. These will be run at scale across the system in partnership with trusts, Lancashire Enterprise Partnership, the Department for Work and Pensions, and Lancashire Adult Learning. Work will focus on accessing certain groups within our local communities who may not traditionally consider roles in health and care. Programmes will be accelerated and will have guaranteed interviews at the end. They will work alongside current funding given to the trusts to develop a recruitment pipeline for HCSW, which includes supportive onboarding processes and pastoral support for those who are new to care.

The ICS' social care workforce programme works with the care sector, local authorities, health colleagues and wider regional and local key stakeholders. They have delivered a range of activities over the past year, including:

- Promoting a range of wellbeing support accessible to social care staff via a Health and Wellbeing Support Guide for Lancashire and South Cumbria
- Delivering multi-partner Social Care Workforce Forums to promote business and staff resilience
- Delivering a Registered Managers Retention Work Plan with Skills for Care and the North West Association of Directors of Adult Social Services (NWADASS)
- Succession planning model delivery with Skills for Care, the Institute of Health and Social Care Management (IHSCM), regional partners and local care providers.

Diagnostics and imaging

The diagnostic imaging programme aims to provide robust and sustainable integrated diagnostics services for local people, improving quality and efficiency and reducing unwarranted variations in standards of care. Although Covid-19 has continued to create pressures and challenges, a diagnostic imaging network has been established to enable local hospitals to work collaboratively to share best practice and support each other.

Additional capital investment secured during 2020/21 enabled the procurement of new CT scanners at some of the hospital sites, and to improve scanning capacity within community diagnostic centres. New mobile CT/MRI scanners will be delivered in summer 2022.

Artificial intelligence for stroke software was also implemented – enabling clinicians to make faster treatment decisions based on CT brain scans. Funding has been secured to increase training and development provision for radiographers, and a single tool has been agreed to enable a standardised approach for future clinical service planning decisions across Lancashire and South Cumbria.

Learning disabilities and autism

During 2021/22, Lancashire and South Cumbria Learning Disability and Autism teams continued to work together to ensure people received accessible, timely and relevant information relating to the pandemic and were able to access the health and care services they needed.

Separate all-age strategies for learning disabilities and autism have been in development and are due to be completed in April 2022. Stakeholders and individuals with lived experience have helped to guide service developments to meet identified needs and address gaps in provision.

We have continued to improve learning disability and autism services, increasing investment in several areas. We have:

- strengthened multi-disciplinary Community Learning Disability teams by increasing nursing and allied health professionals in the community
- established a learning disability intensive support service with a focus on supporting individuals in the community to prevent unnecessary admission to hospital

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- strengthened the specialist support provided by community forensic services; supporting individuals at risk and facilitating discharge from secure hospital provision
- established a health and social care Discharge Facilitation team focused on progressing discharges from specialist mental health or learning disability hospitals
- established a key working function for children and young people at risk of admission to inpatient service
- established an Autism Outreach team aimed at improving discharge and supporting autistic adults (age 16+) with complex needs in the community
- invested in pathway navigators in both the children and young people's and adult autism assessment pathways to improve communication and signposting for pre- and post-assessment support. This work includes the development of an all-age online support site
- implemented a successful waiting times initiative in the children and young people's autism pathway.

We have faced challenges relating to increasing numbers of referrals for children and young people autism assessments, increasing from an average of 80 referrals per month in 2020/21 to 120 per month in 2021/22. January 2022 saw a new peak of 127 referrals for LSCFT alone, with an upward trend. This mirrors the national picture.

This year, we have put a greater focus on assurance in the quality of care within inpatient settings with the establishment of Safe and Wellbeing reviews. Clinical colleagues have supported commissioners to visit and assure the system of individuals' safety, if physical health needs are being met, and if plans are in place for the person to return home.

We have also continued to focus on the completion of LeDeR – Learning from Deaths and plan to embed the learning as we develop the ICB and place-based partnerships to ensure the learning continues to be shared and actioned locally.

Although things are improving, the Lancashire and South Cumbria system remains challenged by the high number of individuals with a learning disability and autism in specialist inpatient care. Work continues to support the development of appropriate care and accommodation, to support the improvements needed to discharge and provide community support. Challenges also remain in the uptake and performance in completing learning disability annual health checks.

Cardiac

Heart disease remains the second highest cause of death in England, with an age-standardised mortality rate of 130 per 100,000 population. Furthermore, an estimated 6.1 million people in England currently live with cardiovascular disease (CVD).

In July 2021, NHSEI provided the Cardiac Pathway Improvement Programme (CPIP) specification and funding for regional cardiac networks, to deliver the programme within their regions. In Lancashire and South Cumbria, significant opportunities have been identified for earlier diagnosis and better proactive management of CVD – particularly for people in the most deprived areas of England who are almost four times more likely to die prematurely from CVD compared with the least deprived areas. The network is working with the Integrated Stroke and Neurorehabilitation Delivery Network (ISNDN) to prevent, detect and manage atrial fibrillation, high blood pressure (hypertension) and high cholesterol (hypercholesterolemia) to maximise resources and reduce duplication.

During Covid-19, there has been a reduction in the number of people with high blood pressure having regular checks and medication reviews, which increases the potential risk of a cardiac event or stroke. The ICS continues to support campaigns including 'Know Your Numbers' (which encourages people to get their blood pressure checked) via the Healthy Hearts website and our Twitter account @CardiacNwc (#improvinghearthealth #HealthyHearts).

Across England, the pandemic caused a rise in waiting times for echocardiograms (ECGs). In February 2022, our cardiac network, in collaboration with Lancashire and South Cumbria Community Diagnostic Centres team, successfully ran an 'echothon' – delivering ECGs at the weekend to reduce the wait times for local patients. This was a system-level approach through the collaborative working of skilled staff from all providers, using digital staff passporting to ensure that the needs of the population are met.

Funded care

During 2021/22, the funded care work programme has been working in partnership across the NHS and local authorities, meeting regularly to discuss the response to Covid-19 and the redesign of the whole NHS funded care service. Each element of the service is being redeveloped including system-wide data, reporting, finance, governance, quality assurance, communications and engagement and workforce modelling to create a service model that works across Lancashire and South Cumbria, and is designed to best meet the needs of the patients, families and carers it serves.

As part of this, patient and clinical feedback were gathered and fed into the Funded Care Group. CCGs supported the call-out for patients, carers and family members with lived-experience of the current processes to join the Funded Care Implementation Board (which oversees the programme of work) as representatives who can help the team shape the redesign work.

Workstreams and task and finish groups have been working to improve processes and services, including Standard Operating Procedures, forms and guidelines such as the Disputes Procedure and Non-Continuing Healthcare Joint Funding Procedure, and working together to look at areas like Personal Health Budgets, a Business Intelligence suite, joint training, community assessments, community equipment, the quality assurance process and a values and behaviours framework. A vast amount of work is ongoing on single sign-off processes for funding and eligibility that will continue into 2022/23.

The plan is to have a central Integrated Care Board (ICB) corporate model with four place-based partnership delivery models. The programme will operationalise to business as usual from April 2022 to deliver in shadow form at a place-based level during April to June 2022, before the ICB is established (currently due to be in July 2022).

Elective care

Recovering long waiting times is a priority for the NHS. The extraordinary achievements of staff over the last two years are a testament to their determination and resilience. NHS teams have provided expert care to more than 600,000 patients with Covid-19, but inevitably the capacity for delivering planned care has been impacted, resulting in longer waits for many.

The pandemic has shown how the NHS can deliver transformational change for patients when needed. Whilst colleagues in every part of the country are working hard to recover elective services, significant additional government funding for elective recovery presents opportunities to build on this success.

NHS England's delivery plan for tackling the Covid-19 backlog sets out plans to transform services for the better, focusing on increasing health service capacity, prioritising diagnosis and treatment, transforming the way we provide elective care, and providing better information and support to patients.

The plan sets out ambitions, guidance, and best practice to help systems address key issues, ensuring there is consistent focus on elective recovery for years to come. Supporting staff is also a key part of the recovery of elective services, recognising that staff need to be looked after so they can look after patients. Together,

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this plan will help the NHS deliver millions more tests, checks and procedures to patients in England.

In Lancashire and South Cumbria, the Accelerator funding from NHS England has proved critical in helping us mitigate against these issues, with elective activity scaled up to ensure we collectively see and treat as many people as we can as quickly as possible. It has helped by providing additional bed capacity in hospitals across the region, enabling improvements in pre- and post-operative patient assessments, and reducing the number of unnecessary admissions for treatments such as angiograms by monitoring patients remotely.

A total of 101 beds have been mobilised, utilising Accelerator funding to provide additional bed capacity. The ChatBot pilot (a waiting list validation programme using AI-automated and human operator calls) has helped us to contact long waiting patients. In Morecambe Bay, the Set for Surgery programme aims to optimise the health of all patients who are approaching surgery to help reduce cancellations and improve their post-operative outcomes.

We have also successfully bid against Targeted Investment Funds (TIF) to secure further funding to support elective recovery. Schemes include increasing elective and critical care capacity and additional digital solutions. A second round of TIF funding has recently been made available, and we are developing bids which will focus on building upon our existing elective infrastructure to further reduce the number of long waiting patients.

We are grateful to the efforts of every single one of our staff in achieving the gains we have to date, especially against the backdrop of the North West being one of the areas of the country hardest-hit by the pandemic, suffering the greatest losses and spending nearly two months longer in lockdown, and with, on average, 10% more hospital beds occupied by Covid-19 patients in the region than in the rest of England.

Staff have gone above and beyond the call of duty, time and again, putting their own lives on the line, to make sure patients who have needed us the most have been cared for during these unprecedented times, and despite funding coming to an end in February 2022, we will be working hard to maintain the programmes of work we have put in place in an effort to reduce the waiting lists and continue to provide the best possible care to our communities.

Primary care

Primary care covers a range of services for patients including GP practices, pharmacies, optometry and dentistry. For the purpose of this annual report, our update will focus primarily on GP practices as part of the delegated commissioning responsibility to CCGs.

The Covid-19 pandemic has been an extremely challenging time for the NHS, and this report provides an opportunity to thank all our staff working across primary care services for their remarkable contribution to the vaccination and booster programme and for their commitment, professionalism and resilience in continuing to provide support to our residents under very difficult circumstances whilst also themselves having to face the personal challenges we have all experienced during this period.

Throughout 2021/22, Covid-19 pressures have continued to impact the way in which primary care services were delivered. To ensure the most vulnerable patients are protected from infection and to ensure our staffing levels and capacity are maintained, the majority of appointments have been via telephone or video consultation where safe and appropriate and face-to-face appointments being offered to those with a clinical need. Demand for primary care services has also increased during this time. Data shows there were more patient appointments each month between September 2021 and February 2022 than in the comparable period in 2019/20 prior to the pandemic. The latest appointments data for NHS England shows that in comparison GP appointments overall in Lancashire and South Cumbria during this time have increased by 10%. Of the appointments between September 2021 and February 2022 an average of 63% were face to face appointments, 36% were telephone appointments and the remainder were home visits or video and online consultations[2].

GP practices are increasingly moving towards a more flexible approach to appointments, but we also want to acknowledge the convenience and benefits of telephone and remote consultations for some patients. We are pleased to report that GP practices now offer a range of options for patients to seek advice and support from a clinician; via traditional face-to-face appointments, telephone consultations and video consultations.

From October 2021, working closely with NHS England, we have implemented a programme of initiatives to support increased access for patients. Measures include an increase in the number of face-to-face appointments, an increase in extended access (appointments in the evenings and weekends), and support to the workforce through establishing additional administrative support to practices.

In December 2021 we conducted a survey to ask patients about their experience of accessing their GP services during Covid-19. Over 71% of patients reported a positive experience. 70% felt their GP practice was working hard to provide support to their patients, with 68% supporting telephone appointments where appropriate and 93% agreeing that GP practices should take measures in order to protect people from the risk of infection. There was an acknowledgement (84%) that GP practices are facing significant challenges because of the pandemic, and 85% of patients would be happy to speak to another health professional other than their GP when appropriate.

GP practices have also been integral to the delivery of the Covid-19 vaccination and booster programmes, administering 1.8m doses during 2021/22 (over half of the total doses administered across Lancashire and South Cumbria).

Colleagues have also contributed to system-wide discharge planning, shared patient advice and guidance, and prioritised procedures and appointments where necessary to ensure a focus on patients with urgent and same-day health care needs.

We are also supporting initiatives such as Covid-19 oximetry at home. This provides support to ensure patients who can remain at home are able to do so safely. Patients are provided with a pulse oximeter to measure blood oxygen levels and receive support from a healthcare professional.

Based on feedback from patients, we are developing a system-wide communications campaign fronted by key clinical staff to address patient access, the types of appointments available, and the role of different healthcare professionals to support patients and offer advice and guidance.

We also want to focus on supporting people to access the right service at the right time. Working closely with urgent and emergency care colleagues, we will build on the insight work of Healthwatch Together into patients attending urgent care facilities. Insight focus groups are planned for early in 2022 to understand ways we can support people in their access choices.

We are currently drafting a social media strategy to increase the social media presence of primary care at system level and local levels. This will support timely information to patients, increase knowledge and confidence in accessing services and encourage people to make the best use of the range of health professionals here to support them.

As the NHS moves into a period of recovery and restoration, our future way of working will bring greater integration between GP practices, pharmacy, dentistry and optometry. The proposal to delegate commissioning responsibility for the full portfolio of primary care services to the Lancashire and South Cumbria Integrated Care

[2] Reference source: Appointments in General Practice - NHS Digital

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Board is planned for implementation over the next 12 months. The appointment of our two Associate Clinical Directors Dr Lindsey Dickinson and Dr Peter Gregory will ensure that primary care services are at the heart of health and social care transformation and that the opportunity to work collaboratively with our partners at system, place and neighbourhoods is maximised.

To achieve this, we will take a strategic approach to future challenges and priorities by agreeing a strategy for primary and community care which will develop a delivery framework at neighbourhood, place and system level. Our workforce resilience is crucial and we have plans to increase the recruitment of GPs and healthcare professionals working in primary care as well as committing to the continued development of our existing workforce.

We have an ambition to improve access to primary care as outlined above and to help patients to access the best service for them. One example is the development of the Community Pharmacy Consultation Service which we intend to roll out over the next 12 months.

At neighbourhood level, the future development of Primary Care Networks will be supported by the findings from the Lancashire and South Cumbria 'PCN Futures' report, for example through leadership development. Recovery from the pandemic remains a primary focus whilst still maintaining the ability to respond to the uncertainty of any future Covid-19 impacts.

We intend to harness the benefits of robust digital solutions to support patients. We will achieve this by improving video consultations and triage software solutions. We know that at times patients find it hard to get through to their practice by telephone so we will agree a plan to roll out cloud telephony across our sites. We will also continue to promote the NHS App increasing usage year-on-year by 2024.

Finally, our focus must remain on driving down health inequalities. We know that for people born in the most deprived areas of Lancashire and South Cumbria, life expectancy is significantly lower than elsewhere. By listening to our communities and working in equal partnership with them, we will move increasingly to a co-production of services which will encourage people to have increased confidence in accessing healthcare and support them to maximise opportunities to live longer and healthier lives.

VCFSE leadership programme

The VCFSE (voluntary, community, faith and social enterprise) sector is a vital cornerstone of a progressive health and care system. Lancashire and South Cumbria ICS has been involved in the development of NHS England's ICS VCFSE system leadership programme since 2018/19.

In September 2021, Lancashire and South Cumbria VCFSE Alliance was successful in its bid for £10,000 funding, plus support from the NHS England Voluntary Partnerships team, gaining a mix of financial investment and facilitation to the VCFSE sector to develop alliances or leadership groups across the area. The programme will run throughout 2022, and will facilitate better partnership working, as well as enhancing the VCFSE sector's role in strategy development and the design and delivery of integrated care.

Lancashire and South Cumbria ICS will ensure their governance and decision-making arrangements support close working to shape, improve and deliver services, as well as to develop plans to tackle the wider determinants of health. VCFSE partnership will be embedded as an essential part of how the system operates at all levels, involved in governance structures and system workforce, population health management and service redesign work, and leadership and organisational development plans.

Respiratory

The Lancashire and South Cumbria Respiratory Network was formed in 2020 to reduce variation in delivery of care, and support the sharing of best practice across regions and across the country. The network provides a strong foundation to manage the demand for respiratory services, reduce pressures on the healthcare system, and support the implementation of the NHS Long Term Plan objectives.

In line with the NHS five-point plan, the first task was to facilitate the set-up of the Post Covid-19 Assessment Service (PCAS). The team came together in January 2021, starting with the placement of the lead provider, Lancashire and South Cumbria NHS Foundation Trust, creating an ICS admin hub to receive and process referrals, and setting up five Post Covid-19 Assessment Hubs to address the mental and physical symptoms of patients through holistic therapy.

The community model was designed around population needs such as transport, deprivation, and vulnerable groups. The referral pathway includes primary and secondary care, prisons, and children and young people. Further work is planned for the homelessness population. NHSEI declared this as the exemplary model for other regions to follow.

In May 2021, the need to address the backlog in respiratory disease (waiting lists for pulmonary rehabilitation and spirometry) was highlighted by the national team and place-based partnerships (PBPs). This prompted the focus on building the Integrated Respiratory Network Delivery Board (IRNDB). As the pulmonary rehabilitation programme cross-cuts with personalised care and Lung Health@HOME, stakeholder engagement has been a key network role.

We have started work to scope and map the relevant Respiratory teams and clinical leads across the ICS, and the planning behind addressing the six NHS Long Term Plan respiratory workstreams continues.

New Hospitals Programme

Following the publication of our Case for Change report in July 2021, the Lancashire and South Cumbria New Hospitals Programme has now entered an important phase. The programme team has collected information on everything from what future clinical and technological developments might need to be accommodated in new hospital facilities, to potential land availability and building specifications. Thousands of patients, staff and stakeholders have been involved in conversations to start to build a picture of how new hospital facilities should operate.

In March 2022, a list of shortlisted proposals was published to address some or all of the main challenges facing Royal Preston Hospital and Royal Lancaster Infirmary, with investment in Furness General Hospital (established as the priority for investment through the Case for Change). The shortlisted proposals are: to build a new Royal Lancaster Infirmary on a new site, with partial rebuild/refurbishment of Royal Preston Hospital; to build a new Royal Preston Hospital on a new site, with partial rebuild/refurbishment of Royal Lancaster Infirmary; investment at both Royal Lancaster Infirmary and Royal Preston Hospital, allowing partial rebuilding work on both existing sites; and two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital on new sites. Each of these proposals also includes investment in Furness General Hospital.

Members of the public have had the opportunity to have their say on proposals, and the shortlist reflects extensive feedback gathered from more than 12,000 local people, patients, NHS staff, community representatives and stakeholders over the last year, using online workshops and surveys, public opinion research, focus groups, and in-person events and meetings. MPs and local authorities have also been kept up to date with progress.

Following detailed analysis of each shortlisted option's feasibility, the programme will follow a clear process over the coming months, with scrutiny and approvals needed from decision makers within the NHS, the government and local authorities, and ongoing patient and public involvement, before the preferred option is agreed. The programme aims to complete the building of new hospital facilities by 2030.

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Clinical policies

The clinical commissioning policy development, review and harmonisation process was suspended for much of 2020/21 and only resumed at the beginning of 2021/22. Despite these challenges, several existing policies which had no amendments that impacted upon patient access have been reviewed, ratified and implemented.

In November 2020, NHS England identified a second wave of 31 evidence-based interventions (EBI2) to be implemented in 2021/22. These tests, treatments or procedures have been assessed on behalf of all eight CCGs in Lancashire and South Cumbria. Some relate to clinical policies (either existing or requiring a new policy if one does not exist), and others have been identified as needing clinical audit and implementation directly within provider trusts.

Although NHS England already consulted on these procedures, some clinical and public consultation on a local level was still required to understand any issues or concerns that their implementation may cause. Several EBI2 policies have gone through this process during the year, with more to follow.

Several new policies outside of the EBI2 range have also gone through the full commissioning policy development process, which includes clinical and public engagement. The Sensory Integration Therapy Policy received a significant level of feedback from those concerned with services for children with autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD).

The Assisted Conception Policy (IVF) continues to receive enquiries from the public, the media and MPs – most recently concerning access to IVF by same-sex female couples. Most clinical policies have a three-yearly review date, and this policy review is due next year.

2021/22 ended with an eclectic mix of policies completing the full policy development and review process. This includes three policies with a wider public and patient impact (Continuous and Flash Glucose Monitors for people with diabetes, the provision of wigs, and hernia surgery), two of which are expanding patient access, and other EBI2 policies.

Urgent and emergency care

2021/22 priority setting and operational planning was undertaken against a backdrop of the challenge to restore services, meet new care demands and reduce the care back logs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes. Through the Urgent and Emergency Care Network (UECN) in Lancashire and South Cumbria, the ICS along with each local A&E Delivery Board submitted responses in September and October 2021 to NHSEI for the system flow assurance process for Place Based Partnerships and ICSs.

This comprised of a template with a number of key priorities, outlining how we will:

- support 999 and NHS 111 services
- support primary care to help manage the demand for UEC services
- support greater use of Urgent Treatment Centres (UTCs)
- use communications to support the public to choose services wisely
- improve in-hospital flow and discharge
- support adult and children's mental health needs
- ensure a sustainable UEC workforce.

The responses were followed up by site visits and round table discussions with system partners in three of our Place Based Partnerships.

In response to the continuing demand on services, system partners have come together through the joint cell to develop and implement surge plans. These have increased capacity across hospital and out-of-hospital services, with a particular focus upon enhancing discharge arrangements and improving flow, with the most radical scheme being the building of additional beds on the Royal Preston Hospital site.

In addition, through the daily operation of the System Resilience Hub, we have run an 'LSC Together' process since January 2022 which focuses on the actions of partners and where the greatest improvements in the delivery of pathways can be made to reduce pressures in emergency departments, and to move more patients who no longer require hospital care into a more appropriate setting.

NHS partners have worked together to develop a shared and robust ICS communications and engagement plan for 2021/22 to support winter pressures and to support people to access the right services at the right time. The plan included campaign messages to alleviate pressures and demand across UEC services including a range of advice and self-care videos along with sharing flu and vaccine information. There has been a joined-up approach across the NHS Communications and Engagement teams and links to wider Local Resilience Forum partners for activity across a range of channels.

Advertising and media campaigns around winter messages such as mental health, respiratory, frailty, appropriate services, loneliness/isolation, self-care and hospital discharges have focused on how people can Keep Well This Winter and can help their communities. These have been run (paid-for and organic) on radio, Facebook, Twitter, Instagram and Spotify. Translated images and audio clips have formed part of a larger toolkit for voluntary sector partners. LSCFT led on a Resilience Hub 60-day social media campaign during December 2021 and January 2022 to promote mental health support to nursing and NHS staff across Lancashire and South Cumbria. A 'Thank You' campaign on radio and digital channels for health and care workers, vaccination volunteers and carers began in February 2022.

In November 2021, Healthwatch Together was commissioned to gather insight from face-to-face engagement around patients' reasons for use of services in accident and emergency departments, urgent treatment centres and walk-in centres. This was followed by further community engagement, phone calls and online focus groups to provide summary reports and recommendations. The findings are now contributing to the system planning underway for 2022/23.

In January 2022, the ICS put forward spokespeople for regional and local radio to increase the visibility of NHS voices and to provide public messages around increased system pressures. This included specific messages to support the Covid-19 booster campaign, discharges across trusts, uptake of Covid virtual wards and pulse oximetry at home services, encouragement for people to attend elective appointments and to demonstrate support of the care sector. There has also been a high level of support for the social care recruitment campaigns across NHS partners.

Ageing well

Despite the pressures on the system that have continued throughout 2021/22, we have maintained progress towards the delivery of two-hour Urgent Community Response services in each place-based area of Lancashire and South Cumbria. A check and challenge session held on 14 January 2022 tested the models being put in place locally within each system and identified good practice to share. The programme remains fully on track to meet the deadline of implementation by 31 March 2022.

Performance analysis for West Lancashire CCG

NHS West Lancashire CCG, is a clinically led organisation and is made up of 15 GP practices who care for around 113,000 patients, making this the smallest CCG in Lancashire. The majority of patients live within West Lancashire, with the remaining patients mainly living in Wigan and Chorley but being registered with West Lancashire GP practices.

West Lancashire incorporates the towns of Ormskirk, Skelmersdale, Burscough and surrounding communities; the CCG's footprint is aligned with that of West Lancashire Borough Council.

There is a diverse population in West Lancashire with a mix of rural, urban, affluent, and deprived areas, that require us to carefully target commissioned services to meet the needs of our population. Individual health outcomes can be adversely affected by lifestyle choices including smoking, alcohol and drug misuse, and factors such as diet and exercise.

"Our vision is to enable our population to be in control of their own health, commissioning the best possible care when needed."

We have further continued to develop the work we progressed last year in line with the NHS Long Term Plan to further develop our three Primary Care Networks (PCNs). The PCNs have continued to be key in how we have rolled out the COVID-19 mass vaccination programme and co-ordinating the GP Practices in responding to the COVID-19 pandemic in a unified way across West Lancashire. The structure of the PCNs is provided below:

Ormskirk & Aughton has roughly 33,000 residents and has been undertaking a structured medication review to ensure that their patients are getting the best medicines for their conditions.

Skelmersdale has approximately 47,000 residents and has been focussing on improving outcomes for patients with a respiratory disease and a social prescribing service which aims to support people with needs such as loneliness or financial worries.

Burscough and the Northern Parishes has a population of approximately 33,000. There is a higher percentage of older residents within this community with large rural areas; therefore, this PCN has developed the SHERIF scheme: **S**upporting **H**ousebound or **E**lderly patients affected by **R**urality, **I**solation or **F**railty.

The purpose of NHS CCGs is to work with local health and care partners to design services to meet the needs of the local population most appropriately and to use their allocated funding to buy the best services it can for the population. CCGs are structured to put local family doctors (GPs) in the driving seat, as they are best placed to understand the needs of their patients.

NHS West Lancashire CCG is set performance targets by the Department of Health and categorises these into those relating to improving health, transforming care, controlling costs, and enabling change, and managing operations. Within these it has identified five priority programmes, which are:

- Developing primary care.
- Transforming community care.
- Redesigning mental health services.
- Finance and strategic transformation plans, and
- Compliance, assurance, and planning.

Although we are now seeing restrictions ease, last year saw a continuation of the pressures put on the NHS due to COVID-19; but equally our NHS staff and also the brilliant health and social care staff, continued their immense efforts to care for local people and vaccinate our population.

In addition, within West Lancashire we face our own unique challenges due to our geographic position on the edges of Lancashire, Merseyside and Greater Manchester as well as the same significant challenges that confront any other NHS organisation – limits on NHS funding and a growing and ageing population, for example. We therefore fully recognise and acknowledge the need to change. The imminent transfer of CCGs to the Lancashire and South Cumbria Integrated Care Board will lead to strengthened health and care services, as they continue to evolve to fully support our community's needs now and in the future.

Examples of the CCG's achievements throughout 2021/22:

- The mental health support teams in schools service launched January 2022 across Skelmersdale and Upholland
- In the last 12 months the new Children's Community Nursing Outreach Team (CCNOT) has been recruited and started work to improve the health and wellbeing of families, children and young people in West Lancashire bringing care closer to home and supporting primary and secondary care in their work.
- An NHSE National Safeguarding Star Award was received during the year for the Sudden Unexpected Death in Childhood (SUDC) Nurse Led Service. The service co-ordinates a Joint Agency Response with the Police and works alongside the Local Authority in responding to child deaths and provides support to families at a critical time.
- An NHSE National Safeguarding star was awarded to the Specialist Safeguarding Practitioner for long term commitment and service to Safeguarding
- The eight CCGs were successful in winning the inaugural NHS Safeguarding Initiative Award from the HSJ in recognition of the work completed and shared nationally in relation to the System Safeguarding Development. This has included the development of portfolio-based leadership approach, strengthened governance arrangements and a collective health voice and system approach to safeguarding.

Key Performance Indicators

% Of all Incomplete Referral to Treatment (RTT) Pathways within 18 Weeks.

The COVID-19 pandemic has impacted the percentage of incomplete RTT pathways within 18 weeks significantly across the whole of the NHS. The principal issues have been Acute Trusts being required to prioritise Urgent Care to ensure appropriate resources were available for the Care of COVID-19 patients and with Independent Sector providers being required to suspend Service Level Agreements to enable support to be given to the Acute Sector.

Planned Care has been in a 'recovery' mode in 2021/22 with Independent Sector providers being allowed to recommence activity and Acute Sector providers trying to resume normal levels of activity, from an RTT perspective the significant backlog of cases who had already slipped beyond 18-weeks has meant that performance is significantly below the 92% target for this metric. Additionally, providers have indicated significant issues with staff absence and patients delaying treatment (and several COVID-19 spikes in year) which have impacted performance.

Prior to the COVID-19 pandemic NHS West Lancashire CCG were marginally above target for this metric, overall performance for financial year 2019-20 being 92.04%, significantly outperforming the Lancashire and South Cumbria Health and Care Partnership (a combined performance of 84.66% in 2019-20). Although performance for NHS West Lancashire CCG in 2021/22 has fallen significantly since 2019-20, year-end performance for 2021/22 at 74.91% is still significantly better than the ICS average of 68.30%.

Within the RTT figures for 2021/22 there have been issues raised regarding RTT activity figures submitted by Renacres Hospital (Ramsay Operations UK). It is understood that an error in the data for January-March 2022 may be responsible for a 3% understatement of the West Lancashire incomplete pathways data. This is a national issue and therefore the CCG continues to work with Ramsay Operations UK and other commissioners to rectify this data.

% Of all Incomplete RTT Pathways within 18 Weeks

As with the percentage of Incomplete RTT Pathways within 18 weeks, the number of pathways waiting 52 weeks or more has also been affected by COVID-19. In 2019-20 there were only three cases of an incomplete pathway where a patient was recorded as having been waiting 52 weeks or longer for West Lancashire CCG patients, these being related to two patient pathways.

During the COVID-19 pandemic patient waiting times were extended, and prioritisation was on a clinical need basis, resulting in increasing numbers of patients with incomplete pathways where the patient had been waiting 52 weeks or longer. The apogee of patients-waiting for NHS West Lancashire CCG was in March 2021 with 533 patients waiting longer than 52 weeks (6.6% of all incomplete Pathways), while for 2021-22 this number has remained below 400. Given the length of this waiting list, NHS West Lancashire CCG have co-ordinated with providers to ensure that patients are treated in a clinical priority order where appropriate rather than chronological to reduce the risk of harm. During 2021/22 the patients waiting 52 weeks and longer have represented 3.34% of the total number of Incomplete Pathways for NHS West Lancashire CCG patients, by comparison the ICS average has been 5.83%.

The majority of the patients on Incomplete Pathways exceeding 52 weeks duration for NHS West Lancashire CCG patients are at Liverpool University Hospitals NHSFT (1032 pathways in 2021/22 – 8.37% of all pathways); Wrightington, Wigan and Leigh Hospitals NHSFT (968 pathways, 6.79% of all pathways); Lancashire Teaching Hospitals NHSFT (658 pathways, 13.4% of all pathways) and St Helens and Knowsley Hospitals NHST (431 pathways, 4.8% of all pathways). Southport and Ormskirk Hospitals NHST were responsible for 566 pathways exceeding 52 weeks duration which is only 1.07% of all pathways for West Lancashire CCG patients at that provider. The CCG continues to work with Providers to ensure focus and capacity is given to reducing this level of 52-week waiters.

% Of patients waiting 6 weeks or more for a diagnostic test

This measure has been affected significantly by COVID-19 as the availability of testing has been affected by Infection Prevention and Control measures and also by staffing issues caused by COVID-19.

The majority of patients failing to be tested within 6 weeks are for endoscopy tests at Southport and Ormskirk Hospitals, where in addition to the issues mentioned above historic estates issues have demanded single sex clinics and further restricted throughput. Reconfiguration of the endoscopy suite at Southport Hospital during 2021/22 has alleviated these issues and from April 2022 increased throughput is being demonstrated. It will however require several months to reduce the outstanding waiting list, and it is unlikely that the 1% target for this metric will be achieved until late 2022-23.

Performance against this metric for NHS West Lancashire CCG compares unfavourably with the combined performance for the Lancashire and South Cumbria ICS. During 2021/22 NHS West Lancashire CCG achieved a year end performance of 30.44% whereas the ICS achieved 26.44%.

Again, the CCG is working with local providers to look to increase capacity for diagnostic tests in order to expedite diagnosis for those on the waiting lists.

Cancer Waiting Times

Cancer waiting times have been impacted significantly in 2021/22 due to a lack of outpatient capacity, additional Infection Control Protocols, staff absence for COVID-19 and patients choosing to delay the treatment. Fewer patients were referred by GPs into cancer services in 2020/21, and this appears to have caused additional demand on cancer services in 2021/22 with approximately 20% more patient pathways starting than 2019/20. This additional activity creates additional pressure on already strained services.

% Of patients seen within 2 weeks of an urgent referral for breast symptoms.

NHS West Lancashire CCG performance for 2021/22 of 74.91% significantly below the target of 92.00%, but better than the combined performance for Lancashire and South Cumbria ICS of 67.41%. The majority of NHS West Lancashire CCG breaches occurred at Liverpool University Hospitals NHSFT, with the main reason for delay being 'Insufficient Outpatient Capacity'.

% Of patients receiving 1st definitive treatment within 1 month of a cancer diagnosis.

NHS West Lancashire CCG performance for 2021/22 of 95.73% only marginally below the target of 96.00%. There were 31 breaches from 735 pathways, the target would have been met had 2 of the breaches been avoided. West Lancashire CCG performance against this target was better than the combined performance for Lancashire and South Cumbria ICS of 92.10%.

The largest number of NHS West Lancashire CCG breaches of this target occurred at Liverpool University Hospitals NHS Foundation Trust where achievement was 80.70%, activity at Southport and Ormskirk Hospitals NHS Trust exceeding the target with 98.92% of all patients meeting the requirement.

Key Performance Indicators

% Of all Incomplete Referral to Treatment (RTT) Pathways within 18 Weeks.

% Of patients receiving 1st definitive treatment within 2 months of a cancer referral.

NHS West Lancashire CCG performance for 2021-22 of 61.58% is significantly below the target of 85%. NHS West Lancashire CCG performance against this target is marginally worse than the combined performance for Lancashire and South Cumbria ICS of 64.01%.

The Cancer Network is working to ensure capacity planning within and across providers to help ameliorate the waiting times for cancer diagnosis and treatment.

Risks are assessed in accordance with the organisational risk management strategy. Risks are identified through analysis of performance data and soft intelligence, as well as through the reporting and assurance process. The way in which we have managed risks is described in the Annual Governance Statement (Risk Management Arrangements and Effectiveness) within this report.

West Lancashire Partnership

The partnership way of working has developed further still over the course of this year and as we to continue to build on the good work that has taken place across West Lancashire, we set out below some examples of our collaborative efforts:

- Delivery of the Science Summer School in Skelmersdale with over 400 young people in attendance. The event was the catalyst for a longer-term programme on raising aspiration as part of tackling inequalities, linked to the Place-based partnership aspiration as a teaching and learning Partnership. The work on this continues at pace, as we strive as a collective to further build pipelines into industry and healthcare – an example being the work alongside West Lancashire college which has resulted in an increase in the number of apprentices into work.
- Skelmersdale Health and Wellbeing Hub is now operational in the Skelmersdale Concourse. Currently, its main area of focus is to provide easier access to West Lancashire residents for vaccinations. However, plans are in train to potentially bring together some services relating to wellbeing and also NHS practitioners, such as the Trainee Associate Psychological practitioners (TAPPS), amongst others.
- The Winter Ready programme is to help encourage people to make changes to their lives to protect themselves from many common winter illnesses, such as colds, flu and Covid-19. West Lancashire Partnership worked collaboratively over the winter months to help mobilise and support the local communities to be prepared for winter.
- The Partnership has established a Health Inequalities Oversight Group whose remit is to consider the ways in which we strive as a collective group of partners on tackling the health inequalities which exist across West Lancashire.
- Linked to the above, in early 2021, health and care leaders from across Lancashire & Cumbria committed to form a Health Inequalities Commission to improve health inequalities and make a step change in people's health. This has now been renamed as the Health Equity Commission (HEC). The Health Equity Commission consists of a balanced panel comprising leaders/ influencers and independent experts from across Lancashire and Cumbria. It aims to provide local organisations, partners and place-based partnerships the support to make health inequalities and the 'prevention agenda' a shared priority and provide them with a clear voice in the region and across the Integrated Care System. Place-based partnerships across Lancashire and South Cumbria were invited to present to the panel in late 2021. West Lancashire chose to do this via a video produced by a local organisation, which conveyed the voice of lived experience of several local residents who shared their individual stories. This piece of work, which was commended, is a true testament to the absolute, fundamental importance of tackling inequalities. Something which is at the heart of the West Lancashire partnership.

Stroke

In 2021 NHS West Lancashire CCG commissioned an increased offer from the Stroke Association for a Stroke Recovery Service (SRS) with a full-time coordinator for West Lancashire. The SRS is designed to support stroke survivors, their families, and carers in the stroke pathway. The coordinator provides information, advice, emotional and rehabilitation support for stroke survivors and carers and helps to facilitate safe discharge from hospital and reduce the risk of readmissions.

The SRS personalised experience adapts to the individuals needs of stroke survivors offering shared decision making, personalised care and support planning, social prescribing, and community-based support. Through partnership working, liaising with local food banks or applying for grants, they have helped more people effected by stroke to get the best care and support possible.

Across West Lancashire the Stroke Association works closely with the Early Supported Discharge (ESD) and the Community Neuro Team to ensure that the SRS compliments the local system and that together they improve outcomes for people affected by stroke. The EDS for Stroke patients was also commissioned in 2021 and is provided by Southport and Ormskirk NHS Trust. ESD enables appropriate patients to be discharged from hospital earlier in the pathway, with therapy delivered in their home or place of residence. ESD is a nationally accepted model of delivering highly effective specialist stroke rehabilitation, achieving excellent outcomes for patients who have suffered a stroke.

Furthermore, to enable the best possible care for West Lancashire patients, the teams are also working with Cheshire and Merseyside Integrated Stroke Delivery Network (ISDN), supporting the upcoming stroke teams peer review visits at the local hospital for the reconfiguration of hyper acute services in C&M.

Diabetes

Within West Lancashire the Skelmersdale Primary Care Network (PCN) successfully obtained ICS funding to support targeted recovery of diabetes care pathways following the covid-19 pandemic. The funding enabled face to face clinics to be held for the completion of the Three Treatment Targets (HbA1c, Blood Pressure and Cholesterol) and Eight Care Processes (HbA1c, Blood Pressure, Cholesterol, Serum Creatinine, Urine albumin, Foot surveillance, BMI, Smoking). The project is ongoing; however, over 200 patients have been seen and had checks completed at extra diabetes specific clinics held across the PCN to date.

Sustainable Development

The pandemic thrust the CCG into significantly reducing our corporate carbon footprint by reducing printing, travel, and using digital solutions such as video conferencing for meetings. This has highlighted how significant the efficiencies through being more innovative and resourceful can be.

We are committed to creating an organisation that takes sustainable development and carbon reduction seriously. Our NHS property is owned or leased by NHS Property Services, who are responsible for providing appropriate property related information for annual sustainability reporting. We also benefit from our focus on commissioning sustainable quality services that provide not only value for money but ensure added value for the communities they serve.

The West Lancashire Partnership has taken further steps to work in an integrated and sustainable way with communities, commissioners, providers, and social partners to develop and enhance new ways of integrated working aimed at improving the health and well-being of the West Lancashire population. The West Lancashire Partnership, as an Executive and in groups, has continued to meet virtually during the pandemic in more co-ordinated and integrated ways that are now being embedded into business-as-usual practice.

2022/23 will see the West Lancashire Partnership agenda being driven forward at pace, building on the work programme already developed but also a priority will be to reflect on the new ways of working which have been so successful through the pandemic providing the perfect opportunity, with the commissioning reforms, to build a stronger, more resilient, and sustainable NHS.

Improve quality

West Lancashire CCG regularly reports information on its performance and quality indicators via its Integrated Business Report to its Clinical Executive Committee, Quality Committee, Primary Care Commissioning Committee, Transition & Transformation Board and its Governing Body.

Quality remains at the heart of everything we do. As described later in this report in relation to the CCG's Constitution, our Quality and Safety Committee is fundamental to how we discharge our duty under Section 14R of the NHS Act 2006 (as amended). Reports summarising the highlights, challenges, risks and progress for each area of health that we commission are considered by the committee, taking into account any actions required. We link into NHS England regionally via the Lancashire and South Cumbria Quality Surveillance Group where quality issues affecting the local area are discussed.

To continue our commitment to being transparent, we provide a quality update to our Governing Body so both our board and wider communities are aware of ongoing quality issues we are working to address. This information is in the public domain.

COVID-19 continues to have a huge impact on services. In line with Planning guidance from NHS England issued in March 2021 we have worked closely with primary care to support delivery of the NHS COVID vaccination programme and to improve access, local health outcomes and address health inequalities. The provider of our community health services and urgent care services, from December 2021, HCRG (Health Care Resourcing Group) previously known as Virgin Care, has worked collaboratively with ourselves and local health care providers to transform services with the aim of preventing inappropriate attendance at emergency departments and improve transfer into and out of hospital.

For those providers where we are not the lead commissioner, including Southport & Ormskirk Hospitals NHS Trust, any quality concerns can be raised directly with the lead commissioner such as Southport and Formby CCG in the case of the Trust. Quality of services provided by the Third Sector and any small providers are monitored in line with the requirements laid out in the contract.

During 2021/22 we continued to work with partners across the Lancashire and South Cumbria HCP to monitor the impact of COVID-19, support the restoration of elective and cancer care and manage the demand on mental health services to ensure our population continue to receive the quality care and support they need.

The CCG's Quality Team works alongside other providers such as Lancashire County Council's Infection Control team and supports Care Homes in the area.

The CCG has a Patient Experience framework in place that centres around the patients journey and draws upon information provided by users of commissioned services to identify learning and service improvement. Data is captured via the Patient Experience pathway from Complaints, MP Enquiries and other channels of general enquiries. Learning outcomes and patient activity is presented by Midlands and Lancashire Commissioning Support Unit via quarterly and annual reporting. Evidence of emerging trends, and early warning of weakness/failure in commissioned services is triangulated and used to integrate learning/service improvement with other mechanisms to monitor quality and contracting to support the Outcomes Framework.

In 2022/23, as we transition into the Lancashire & South Cumbria ICB our focus will be to ensure robust processes and governance systems are in place to optimise the quality of services locally and that quality assurance is addressed in all our service monitoring, procurement processes and service redesign.

Engaging people and communities

How CCGs have engaged and worked with their communities

As a CCG, we have contributed to a number of campaigns and initiatives across Lancashire and South Cumbria. The objectives of these campaigns have been to inform people about local services, and genuinely involve and co-produce new ways of working with our population and partners. Campaign materials and toolkits have been produced by the Communications teams supporting each of the initiatives and shared across the system.

The system-wide programmes that CCGs have been part of are detailed in the 'Working with our partners – Lancashire and South Cumbria Health and Care Partnership' section above, but include Covid-19 vaccinations, Healthy Hearts, 'Thank You' Care Workers, Keep Well This Winter, and Lung Health Checks. Mental health campaigns include Cards for Kindness, Healthy Young Minds, and the Resilience Hub, plus suicide prevention campaigns (Let's Keep Talking and the Orange Button community scheme).

We understand that codesigning services with patients, public, carers and stakeholders is of benefit to everyone by allowing us to use varied insight to improve and shape services. These conversations, for example, help us to further understand what our community wants and what our clinicians think.

We recognise that our stakeholders like to engage and communicate in different ways. We therefore rely on multiple ways in which to share our news, invite feedback and involve others. These would typically include for example, focus groups, online surveys, patient drop in sessions, 1-1 individual phone interviews and public events. And these would typically be advertised and promoted in a variety of ways including, media advertisements, press releases, social media, e-newsletters, social media and posters. However, it is important to note that due to the restrictions that were put in place as a result of the COVID-19 pandemic, how we have been able to engage with our community has been more restricted and has relied more on online and virtual settings as opposed to face-to-face engagement.

An example of this online engagement can be seen with the CCG's second virtual Annual General Meeting (AGM) which took place in September 2021. With restrictions meaning that we were unable to organise a face to face AGM as we had done in the years prior to the pandemic, we utilised technology that has allowed virtual meetings to take place and provided a virtual online AGM where members of the public were able to attend and observe. The agenda of the event not only included an update on the work of the CCG and the presentation of our annual figures for 2020/21 but also included an update on the West Lancashire COVID-19, the West Lancashire Prescription Ordering Direct Service (POD), developments around the creation of the Lancashire and South Cumbria Integrated Care Board (ICB) and the Shaping Care Together consultation (details of this are available below).

Other examples of engagement that took place in 2020/21 include:

North Mersey Hyper Acute Stroke Consultation

A 12-week public consultation was launched on 22 November 2021 and finished on 14 February 2022 for the people in Knowsley, Liverpool, Sefton, and West Lancashire to share their views on a proposal to establish a Comprehensive Stroke Centre at Aintree University Hospital. The proposal aims to improve hyper acute stroke care, which is the hospital care provided in the critical 72 hour period immediately after someone has a stroke

More information can be found here: www.liverpoolccg.nhs.uk/stroke

The public consultation is being managed by NHS Liverpool Clinical Commissioning Group (CCG), on behalf of five local CCGs – Knowsley, Liverpool, South Sefton, Southport and Formby and West Lancashire. Now that this consultation has finished, they will take all the feedback they've gathered and use it to write a report. They will publish this report when it is ready, and it will be used as part of the final decision-making process.

Shaping Care Together

Shaping Care Together is a programme run by NHS leaders across West Lancashire and Sefton, including Southport and Ormskirk Hospital Trust, which seeks to 'futureproof' services by looking at new ways of working and new ways of delivering care.

Since January 2021, patients, public, staff and stakeholders have been invited to share their views about local health and care services through questionnaires and online discussion groups. The events were supported by Sefton CVS to make sure we had involvement from the local voluntary, community, faith and social enterprise (VCFSE) organisations and some of our hardest to reach communities.

At the end of March 2022 the programme has seen the following:

- 18.8k visits to its dedicated website
- 2,402 survey responses
- 352 staff completing the survey
- 1,788 patients, public and stakeholders completing the survey
- More than 30 online discussion groups

Early review of the feedback from questionnaires includes:

- 85 per cent of respondents favour treatment at a specialist centre for a 'once-in-a-lifetime operation'
- 94 per cent agree that healthcare should be 'local where possible and specialist where necessary'
- 87 per cent feel that the NHS should deliver more care closer to home where appropriate
- 69 per cent agree that the NHS should combine adult's and children's A&E with clinical support services
- 3,685 responses to three open-ended (qualitative) questions to provide richer views and experiences

In March 2022, Shaping Care Together released the 'Our Challenges and Opportunities' paper which outlines the case for change, some of the main challenges we have heard, and some opportunities for providing better care to patients. The document was informed by the results of early engagement with our public, staff and stakeholders throughout 2021 and distributed to more than 1,200 stakeholders via email and from the Shaping Care Together website. People were then asked to share their views about 'Our Challenges and Opportunities'.

We are currently in the process of analysing the responses and we will share the results of the engagement in 2022-2023 which will inform how we progress Shaping Care Together and our next steps into the year ahead.

We have seen a number of themes emerge from our engagement with local patients, staff, political stakeholders and members of the public, including:

- Concerns around the accessibility of primary care services
- Need to use community services to improve social prescribing initiatives
- Issues around public transport in certain areas
- Concerns around staffing levels and retention issues
- Improving patient journeys and support for patients to navigate their own care

Visit www.yoursayshapingcaretogether.co.uk for more information about the programme and to sign up for regular updates.

Engaging people and communities

Healthwatch Lancashire Emergency Department and Urgent Treatment Centres engagement

In winter 2021 Healthwatch Lancashire were asked to engage with patients presenting at Emergency Departments (ED) and Urgent Treatment Centres (UTC) across Lancashire and South Cumbria to explore the reasons for attendance and to understand experience and highlight themes to support NHS communications.

Within the West Lancashire remit this engagement took place at Southport Hospital Emergency Department, Skelmersdale Walk-in Centre and the Ormskirk Urgent Treatment Centre.

Across the three sites Healthwatch spoke to more than 60 patients and some of the findings and recommendations identified include raising awareness of NHS 111 online, an increase in education around when best to attend an ED and a UTC and increase awareness of how to increase awareness of the services that pharmacies can provide.

The learnings that emerged from the engagement have helped to shape some of the communications that were shared over the festive period and beyond.

NHS England's statutory guidance which is published for CCGs entitled 'Patient and public participation in commissioning health and care: Statutory guidance for CCGs and NHS England', sets out ten principles of participation which are listed below:

1. Reach out to people rather than expecting them to come to you and ask them how they want to be involved, avoiding assumptions.
2. Promote equality and diversity and encourage and respect different beliefs and opinions.
3. Proactively seek participation from people who experience health inequalities and poor health outcomes.
4. Value people's lived experience and use all the strengths and talents that people bring to the table, working towards shared goals and aiming for constructive and productive conversations.
5. Provide clear and easy to understand information and seek to facilitate involvement by all, recognising that everyone has different needs. This includes working with advocacy services and other partners where necessary.
6. Take time to plan and budget for participation and start involving people as early as possible.
7. Be open, honest and transparent in the way you work; tell people about the evidence base for decisions, and be clear about resource limitations and other relevant constraints. Where information has to be kept confidential, explain why.
8. Invest in partnerships, have an ongoing dialogue and avoid tokenism; provide information, support, training and the right kind of leadership so everyone can work, learn and improve together.
9. Review experience (positive and negative) and learn from it to continuously improve how people are involved.
10. Recognise, record and celebrate people's contributions and give feedback on the results of involvement; show people how they are valued.

Reducing health inequality

There is clear evidence that reducing health inequalities improves life expectancy and reduces disability across the social gradient. Our duty under Section 14T of the National Health Service Act 2006 (as amended) to have regard to the need to reduce inequalities is central to everything we are working towards as we look to transition into the ICB from July 2022 and develop the West Lancashire Partnership. The WLP is central to driving forward the development, transformation, and redesign of services within primary care and the community to make them more accessible and personalised for our communities and the neighbourhoods we serve.

During 2021/ 22 NHS West Lancashire has worked closely with West Lancashire Borough Council, GP Practices, Community Health Service providers and Social Prescribing teams to proactively support our residents who were most vulnerable to COVID-19 in preparation for a challenging winter and severe COVID-19 complications. This was called the 'Winter Ready Programme'. This initiative was set up in response to COVID-19 and as a direct consequence of the work from the West Lancashire Partnership. The aim was to address the health inequalities that were, and continue to be, amplified as a direct result of COVID-19. An integrated partnership approach was used to mitigate the risks, deliver physical activity and weight management interventions supporting residents to get fitter and healthier.

In quarter 3 and 4 of this reporting year, the CCG has really progressed with the Population Health programme of work that seeks to reduce Health inequalities across West Lancashire. This programme is ultimately accountable to Lancashire and South Cumbria Health and Care Partnership who are taking a programme led approach.

West Lancashire CCG are leading a population health programme of work across West Lancashire Partnership aimed at tackling health inequalities by focusing on disadvantaged groups using CORE20 PLUS5 methodology. This is an approach set up by NHS England and NHS Improvement to tackle health inequalities and identifies the **Core20** – the 20% most deprived population, **Plus** – other inclusion groups as identified by local population health data, and target **5** clinical areas of health inequalities.

The programme of work will ultimately seek to improve health outcomes and life expectancy in these groups. WLCCG are taking a system wide approach to enable the following:

1. Readiness – by April 2022 we will:
   - Have data insights, profiling and precision data at ward level
   - Continue to build on existing consultation, participation and listen to what people say
   - Use PHE maturity matrix to assess system wide readiness to address health inequalities and priority wards
   - Have created the structures and the governance to take a system wide health inequality driven approach
2. Agree the Priorities – by July 2022 we will have:
   - System-wide collaboration to agree shared priorities and focus
   - Agreed system accountability
   - Be using quantitative and qualitative evidence to underpin
3. System wide planning – by September 2022 we will have:
   - Developed a system wide shared health inequalities strategy & action plan
   - Context data in strategy form using a 'village of 100 people' framework
   - Developed a shared accountability health inequalities performance dashboard

West Lancashire CCG sets high standards of performance and behaviour from the people it employs and aims to ensure that no potential

Reducing health inequality

or actual employee receives less favourable treatment on the grounds of their race (or any other protected characteristic or under-served group). We recognise the need to work alongside our partner organisations in Lancashire and South Cumbria, to ensure that race equality remains a key priority as we move to one commissioning organisation from July 2022.

In light of learning around the impact of COVID-19, the CCG (in partnership with all Lancashire and South Cumbria CCGs) is committed to improving the support available for all staff. This includes the system-wide implementation of actions and recommendations contained in the NHS People Plan and aligning this with existing NHS mandated standards such as the Workforce Race Equality Standard and the Equality Delivery System (more detail can be found under the Staff Policies section of this report page 94).

As an employer the CCG is highly committed to Equality, Diversity, and Inclusion. This commitment is detailed within the joint Lancashire and South Cumbria CCGs Equality, Diversity and Inclusion Strategy approved during 2021/22; and is also reflected throughout the CCG's wider policies and procedures. The joint strategy has provided an aligned approach across the system to support the period of system reform leading up to transition. This strategy includes a clear and firm commitment to progressing the aims of the NHS People Plan and working with our employees to ensure that our workforce is fully representative and supported. This will also help to ensure that Equality and Inclusion remains at the forefront as the Lancashire and South Cumbria CCGs make the transition to system-wide working. The strategy is available on the CCG website - https://www.westlancashireccg.nhs.uk/wp-content/uploads/WLCCG-EDI-Strategy-2021-22.pdf.

Health and wellbeing strategy

The Lancashire Health and Wellbeing Board is a statutory committee of Lancashire County Council for key leaders from the health and care system in Lancashire to build strong and effective partnerships, which improve the commissioning and delivery of services across NHS and local government, leading in turn to improving the health and wellbeing of local people.

Board members work together to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services from the NHS and their local council in the future.

During 2021/22 the Board's membership was streamlined to make it more efficient and focused, the CCG is now represented on the Board by Dennis Gizzi (Accountable Officer for Chorley & South Ribble CCG) who acts as a representative on behalf of the CCGs across the ICS.

More detail on the Lancashire Health and Wellbeing Board including the Strategy, Joint Strategic Needs Assessment and minutes can be found using the link below: https://www.lancashire.gov.uk/practitioners/health-and-social-care/health-and-wellbeing-board/

Locally we are committed towards the actions that will lead to achieving improvement in health and wellbeing. During 2021/22 the CCG has progressed a number of initiatives to support the implementation of the Health and Wellbeing priorities at a local level:

- The West Lancashire Partnership has continued to develop, and objectives have been set which work to reduce Health Inequalities across our area (more detail on this can be found in the section of the report titled Reducing Health Inequalities).
- The Health Inequalities Oversight Group is chaired by Dr Peter Gregory who is also the Chair of the CCG and WLP and is a group that acts in a quasi-oversight and scrutiny role to challenge commissioners and providers to demonstrate how new and improved ways of integrated working will target and tackle deepening and widening health inequalities, including those linked to the Covid-19 pandemic.
- As part of the ICB programme, we have driven forward with our Population Health agenda, employing a new Senior System Population Health Lead and a joint appointment with West Lancashire Borough Council for a Population Health Intelligence Advisor. There are also two new projects underway relating to priority wards and the trauma informed agenda.
- The Lancashire Health and Wellbeing Board received this update in May 2022 and noted the commitment to continue to work with partners to address health inequalities and deliver the health and wellbeing strategy.

Financial review

	£m 2021-22	£m 2020-21	£m 2019-20	£m 2018-19	£m 2017-18	Total
Acute	96.4	90.6	95.6	87.4	82.2	452.1
Ambulance	3.8	3.7	3.6	3.3	3.2	17.5
Community	21.6	21.2	17.3	16.0	15.7	91.8
Individual Care Packages	12.9	14.0	8.8	9.0	8.6	53.4
Mental Health	21.3	19.8	17.1	16.7	15.1	90.0
Other	7.5	10.1	7.7	6.4	6.0	37.7
Prescribing	19.9	18.8	16.9	17.0	18.0	90.5
Primary Care	17.3	15.4	14.0	13.7	13.1	73.5
Running Costs	2.2	2.2	2.5	2.4	2.2	11.4
Totals	**202.8**	**195.7**	**183.5**	**171.7**	**164.1**	**906.5**

The CCG's net expenditure has increased year on year over a 5 year timeline. This increase is to be expected due to inflation.

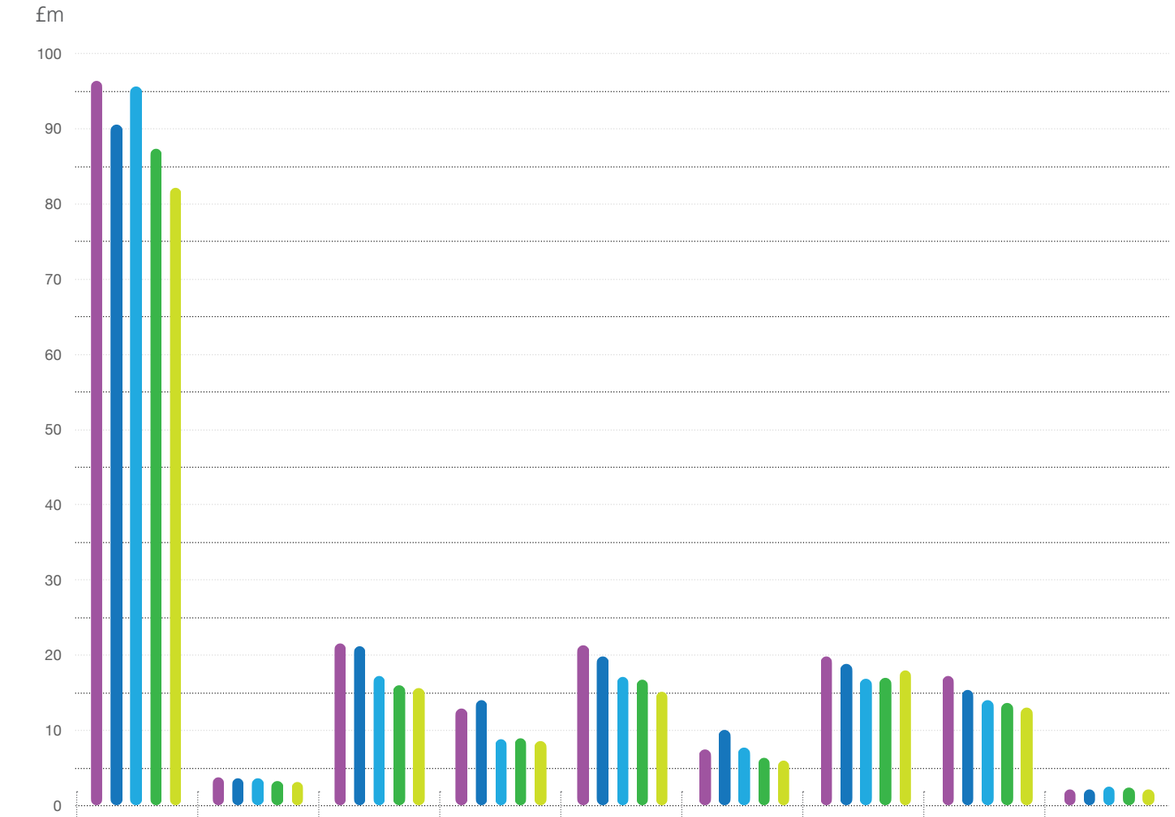
The CCGs acute expenditure shows a decline in 2020-21 due to a change in the way providers were paid as a result of the pandemic. NHSE&I directly commisioned Independent Sector contracts, and the payments of small/medium contracts were paid by other NHS commissioners on WLCCG behalf.

Individual Care Packages increased in 2020-21 due to the CCG funding care for the first 4 weeks post discharge, consistent with national guidance in response to the Covid pandemic.

Mental Health expenditure has increased inline with the Mental Health Investment Standard (MHIS).

The CCG has invested in a number of services such as:

- IAPT Single Point of Access helping to improve access, enhance care and reduce waiting times.
- CAMHS Thrive Model which places an emphasis on prevention and early intervention to provide an integrated, person-centred and needs-led approach to delivering Mental Health services for children and young people.
- Initial response service providing 24 hour access to mental health care, advice, support and treatment.
- Expansion of specialist Perinatal Community Service supporting women with severe and/or complex mental health issues in the perinatal period



	Acute	Ambulance	Community	Individual Care Packages	Mental Health	Other	Prescribing	Primary Care	Running Costs
2021-22	96.4	3.8	21.6	12.9	21.3	7.5	19.9	17.3	2.2
2020-21	90.6	3.7	21.2	14	19.8	10.1	18.8	15.4	2.2
2019-20	95.6	3.6	17.3	8.8	17.1	7.7	16.9	14	2.5
2018-19	87.4	3.3	16	9	16.7	6.4	17	13.7	2.4
2017-18	82.2	3.2	15.7	8.6	15.1	6	18	13.1	2.2

Accountability Report

Signature

Andrew Bennett
Accountable Officer
21 June 2022

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during 2021/22, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

Members Report

NHS West Lancashire CCG is a membership organisation working on behalf of all GP practices within the boundaries of West Lancashire. A Membership Council was formed when the CCG was established in 2013, it includes a member of every GP practice, it is responsible for the major decisions affecting the Group e.g. approving the constitution or holding the governing body to account. Clinical leadership is fundamental to everything the CCG does and this is reflected in the way it is set up and run.

Dr Amanda Doyle, OBE was our Chief Clinical Officer and Accountable Officer 1st April 2021 through to 31st July 2021. On the 1st August 2021, Andrew Bennett became our Chief Officer and Accountable Officer. As Andrew is also the Chief Officer for the Fylde Coast CCGs, his appointment with NHS West Lancashire CCG is as the Interim Shared Accountable Officer. For the remainder of this report Amanda and/or Andrew will be referenced in their role as our Accountable Officer. Below are the Senior Officers within the CCG for 2021/22. Membership and attendance at meetings can be found on page 58-62.

Dr Peter Gregory,
CCG Chair

Dr Amanda Doyle,
Accountable Officer (01/04/21 – 31/07/21)

Andrew Bennett
Accountable Officer (01/08/21 – to date)

Claire Heneghan
Chief Nurse

Paul Kingan
Chief Finance Officer and Deputy Accountable Officer

Jackie Moran
Director of Integration and Transformation

Member profiles

A list of the GP membership council members and attendance is set out on page 58-59.

Member practices

All GP practices within the boundaries of West Lancashire are members of the CCG. All practices can be viewed by following the link below: https://www.westlancashireccg.nhs.uk/about-us/gp-practices/

Composition of Governing Body

The membership council delegates responsibility to the governing body to manage CCG affairs.

The Governing Body ensures that the CCG has appropriate arrangements in place so it can exercise its functions effectively, efficiently, and economically, with good governance and in accordance with the terms of the CCG constitution as agreed by its members. The Governing Body leads on the setting of vision and strategy, approves commissioning plans, monitors performance, and provides assurance on strategic risks.

The Governing Body has 10 members. These include three local GPs (one is the CCG Chair), a hospital consultant, a Chief Nurse, three lay members, a Chief Finance Officer, and a Chief Officer (prior to 1st August 2021 Chief Clinical Officer) who is also our Accountable Officer. A full list of Governing Body members is in this report on page 60.

Committee(s), including Audit Committee

Committees continue to support the role of the governing body as follows:

- the **Audit Committee** is responsible for providing assurance to the Governing Body that there is a sound system of integrated governance, risk management and internal control across the CCG's activities including financial compliance and regulation,
- the **Remuneration Committee** determines arrangements for pay and conditions for the most senior CCG employees,
- the **Quality and Safety Committee** strives to ensure that services commissioned by the CCG meet quality standards in terms of being safe, clinically effective, and providing a good patient experience,
- the **Clinical Executive Committee** ensures that items going to the governing body have had thorough clinical input,
- the **Primary Care Commissioning Committee** commissions appropriate quality GP services,
- the **Finance and QIPP Committee** oversee the financial position of the CCG and the achievement of schemes designed to improve efficiency.

Membership and Attendance of Meetings

Membership Council Membership Council Membership and Attendance – April 2021-March 2022

One meeting took place in May 2021

Member	Practice	Attendance
Dr S Sur	Aughton Surgery	
Dr D Harris*		1/1
Dr S Saxena	Ashurst Primary Care	
Dr I Saxena		1/1
Dr A Bisarya	Dr A Bisarya	
Dr D Bisarya		1/1
Dr B Biswas	Beacon Primary Care	
Dr R Bonsor		1/1
Dr A Kazich		
Dr G Henry		
Dr R Lewis		
Dr K Pollard		
Dr A Oyeyele		
Dr R Parish		
Dr B Biswas	Burscough Family Practice	
Dr W Parkar		1/1
Dr S Panniker		
Dr A Krishnamurthy	The Elms	1/1
Dr S Sur		
Dr Duddukuri		1/1
Dr D Bisarya	Excel Primary Care	1/1
Dr S Dontula		
Dr R Jaidka		1/1
Dr S Panniker		
Dr M Musadaidzwa		
Dr S Hussain		
Dr S Barnes	Hall Green Surgery	
Dr L Roby		
Dr D Chang		
Dr M Rutherford		

Member	Practice	Attendance
Dr I Saxena	Lathom House Surgery	1/1
Dr H Sharma	Manor Primary Care	
Dr A Sharma		1/1
Dr C Milton		
Dr A Bishop-Cornet	Ormskirk Medical Practice	1/1
Dr S Frampton		
Dr L Dean		
Dr S Taylor		
Dr D Mullen	Parbold Surgery	
Dr S Gullick		
Dr J Kinsey		1/1
Dr R Mason		
Dr C Dongre		
Dr H Saunders	Parkgate Surgery	
Dr P Gregory		1/1
Dr J Hooson		
Dr S Roper		
Dr H Billington		
Dr R Tilley	Stanley Court Surgery	1/1
Dr I Yuzgina		1/1
Dr J Graham		
Dr T S Poon	Tarleton Practice	
Dr F Pilkington		
Dr A Sears		
Dr V Mittal		1/1
Dr A Roberts *		
Dr P Batra		
Dr S Kershaw		1/1

Membership and Attendance of Meetings

Governing Body Membership and Attendance – April 2021-March 2022

Member	Attendance
Dr Peter Gregory, Chair	5/6
Dr Dheraj Bisarya, GP Executive Lead	6/6
Dr John (Jack) Kinsey, GP Executive Lead	5/6
Doug Soper, Lay Member	6/6
Greg Mitten, Lay Member	6/6
Steve Gross, Lay Member	6/6
Dr Adam Robinson, Secondary Care Doctor	6/6
Dr Amanda Doyle, Chief Clinical Officer (Left 31 July 2021)	0/2
Andrew Bennett, Interim Chief Officer (Commenced 1 August 2021)	4/4
Paul Kingan, Chief Finance Officer	5/6
Claire Heneghan, Chief Nurse	6/6

Governing Body Part II Attendance – April 2021-March 2022

Member	Attendance
Dr Peter Gregory, Chair	7/7
Dr Dheraj Bisarya, GP Executive Lead	7/7
Dr John (Jack) Kinsey, GP Executive Lead	6/7
Doug Soper, Lay Member	7/7
Greg Mitten, Lay Member	5/7
Steve Gross, Lay Member	7/7
Dr Adam Robinson, Secondary Care Doctor	7/7
Dr Amanda Doyle, Chief Clinical Officer (Left 31 July 2021)	1/2
Andrew Bennett, Interim Chief Officer (Commenced 1 August 2021)	4/5
Paul Kingan, Chief Finance Officer	7/7
Claire Heneghan, Chief Nurse	7/7

Audit Committee Membership and Attendance – April 2021-March 2022

Member	Attendance
Doug Soper, Lay Member (Chair)	5/5
Greg Mitten, Lay Member	5/5
Dr John (Jack) Kinsey, GP Executive Lead	5/5
Dr Adam Robinson, Secondary Care Doctor	4/5
Claire Heneghan, Chief Nurse	3/5

Clinical Executive Committee Membership and Attendance – April 2021-March 2022

Member	Attendance
Dr Peter Gregory, Chair	11/17
Dr Dheraj Bisarya, GP Executive Lead	15/17
Dr John (Jack) Kinsey, GP Executive Lead	16/17
Jo DeBacker, Practice Manager (Left 8 February 2022)	8/17
Dr Amanda Doyle, Chief Clinical Officer (Left 31 July 2021)	0/17
Paul Kingan, Chief Finance Officer	16/17

Remuneration Committee Membership and Attendance – April 2021-March 2022

Member	Attendance
Doug Soper, Lay Member (Chair)	1/1 meetings held
Greg Mitten, Lay Member	1/1
Steve Gross, Lay Member	1/1
Dr Adam Robinson, Secondary Care Doctor	0/1
Claire Heneghan, Chief Nurse	0/1

Membership and Attendance of Meetings

Primary Care Commissioning Committee Membership and Attendance – April 2021-March 2022

Member	Attendance
Steve Gross, Lay Member (Chair)	5/5
Doug Soper, Lay Member	5/5
Claire Heneghan, Chief Nurse	2/5
Paul Kingan, Chief Finance Officer	4/5
Dr Adam Robinson, Secondary Care Doctor	2/5

Primary Care Commissioning Committee Part II - Membership and Attendance – April 2021 – March 2022

Member	Attendance
Steve Gross, Lay Member (Chair)	4/4
Doug Soper, Lay Member	4/4
Claire Heneghan, Chief Nurse	3/4
Paul Kingan, Chief Finance Officer	4/4
Dr Adam Robinson, Secondary Care Doctor	4/4

Register of Interests

Statutory guidance on managing conflicts of Interest is available for CCGs at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-revised-statutory-guidance-for-ccgs-2017/

To ensure that our business is conducted in an open and fair way, all governing body members declare any conflicts of interest they may have. Our conflict of interest policy was updated and approved in April 2021 by Audit Committee with ratification by Governing Body in July 2021 and can be found at: https://www.westlancashireccg.nhs.uk/wp-content/uploads/Conflict-of-Interest-Policy-1.pdf

The CCG's Register of Interests as at 31st January 2022 can be viewed through the following link: Register-of-interests-Governing-Body-members-January-2022.pdf (westlancashireccg.nhs.uk)

Personal data related incidents

No Information Commissioner reportable data security breaches have occurred during this financial year.

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

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

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 Andrew Bennett to be the Accountable Officer of NHS West Lancashire CCG.

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

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

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

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

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

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS West Lancashire CCG auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance Statement

Introduction and context

NHS West Lancashire CCG is a body corporate 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 2021, 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.

This has been achieved by operating within the CCG constitution as signed by all GP practices in West Lancashire. The constitution outlines the principles of good governance which must always be adhered to in the way the CCG conducts its business. These include observing the highest standards of propriety, impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business. In September 2020, the constitution was due for review; however, the Governing Body decided to postpone this as it is a significant process whilst the organisation is in the midst of a continued emergency response. Furthermore, as the commissioning reforms are imminent, it would be more pragmatic to delay this work.

The CCG remains accountable for all of its functions, including those that it has delegated, and all business is conducted in the name of the group. The constitution (available at: https://www.westlancashireccg.nhs.uk/resources/corporate-documents) set outs a scheme of reservation and delegation which details the powers designated to its Membership Council, Governing Body and those decisions that are the responsibility of individual members and employees.

Details of all the Group's Governing Body and Committees membership, attendance and responsibilities can be found under the Members Report, page 56 - 62.

As part of the CCG's response to the COVID-19 pandemic, the Governing Body implemented an Interim Decision Making Framework (IDMF). The purpose of the framework was to ensure that critical decisions and actions to tackle the pandemic could be taken in an effective and transparent manner whilst at the same time reducing the burden on clinicians to attend a multitude of meetings at a time of national crisis. The IDMF provides a clear structure and process for how the CCG could continue to conduct urgent Covid-19 business outside the formal meeting structure. The IDMF is available using the link below: https://www.westlancashireccg.nhs.uk/wp-content/uploads/Covid-19-Pandemic-Interim-Decision-Making-Framework-Version-4.pdf

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. Our corporate governance arrangements have been reported on by drawing upon best practice available, including those aspects of the UK Corporate Governance Code considered to be relevant to the CCG and best practice.

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

The CCG acknowledges that good awareness and understanding of risks associated with managing healthcare commissioning is critical to the successful delivery of improved outcomes and experience of the population of West Lancashire.

The Governing Body has ultimate responsibility for risk management, delegated from Membership Council, as identified in the risk management strategy, which was ratified in February 2021, this document can be found at: https://www.westlancashireccg.nhs.uk/wp-content/uploads/West-Lancs-CCG-Risk-Management-Strategy.pdf.

When the risk management strategy was approved, an updated process was also agreed with a view to improving the risk management culture within the CCG and the assurance cycle. The primary change was clarifying the role of the CCG's committees in the risk management and assurance process.

The aims and objectives of our risk management strategy are:

- An integrated approach is taken to manage all risks (clinical, financial, and organisational), ensuring that all are identified, assessed and managed appropriately.
- Commitment to ensuring the principles of risk management are embedded throughout our organisation and formulate a key element of our systems and processes.
- Maintain a risk management framework, which includes providing assurance to the Governing Body that strategic and operational risks are being managed effectively, as well as ensuring we are meeting all our statutory obligations.
- Our system ensures that risk becomes 'everyone's business'. Our approach to risk must therefore be easily understood by our staff, those contracted to us and our members, to enable our population to understand that commissioning decisions have been based upon a detailed and sensible understanding of the risks involved. We encourage an open culture, in which everyone is encouraged to identify risks and report incidents.
- We also use risk management as a tool to support achievement of – and continuous improvement against – all externally and internally set performance measures.

The risk management strategy sets out the CCG's appetite for risk, attitude towards risk and the culture that will underpin its successful management and delivery. The CCG has an approved integrated assurance framework, which is utilised alongside the risk strategy; together ensuring that a systematic and consistent approach to managing risk is adopted through the organisation. The strategy further details a model for implementing risk management, which is to identify, quantify, manage and mitigate each presented risk, thus making it a routine process for all staff. To facilitate this all risks are recorded on a corporate risk register which is saved on the network and is available to all staff to access.

The corporate risk register is a management tool that enables the CCG to understand its comprehensive risk profile. It is a repository of information detailing the totality of risks evident through the organisation's activities at both a strategic and operational level, including quality, clinical, financial, and business risks. This repository is the hub of the internal control system.

The CCG has an automated risk module, which includes an electronic form to identify and assess new risks. Once the form has been completed and approved by an Executive Officer, the risk is added to the register and monitored on a monthly basis. The quantification of all risks is undertaken utilising a five by five matrix (see section of this report on Risk Assessment) along with appropriate descriptors to assist in determining the consequence and likelihood of the impact of the risk (appendix c in the risk management strategy link supplied on page 68).

All risks are monitored by an appropriate Committee regardless of risk score. In the case of a risk graded as 'high' (score of 12 or above) there is an obvious potential impact to the organisation, and they are reported to the Clinical Executive Committee and to Audit Committees and Governing Body Meetings via the assurance framework. During the COVID-19 pandemic, new governance structures and arrangements were agreed which supported the management of risks during this time. More detail is provided on this under the next section of the report 'Capacity to Handle Risk'.

The assurance framework provides the CCG with a comprehensive method for the effective and focused management of the significant risks that may impact on the delivery of the CCG's strategic objectives. Executive officers have oversight of all risks, this is to ensure there is robust management and awareness of principal risks to business objectives or achievement of priorities at a strategic level within the organisation. Some operational risks will be at a corporate level and will be reported into the Governing Body through the assurance framework, while others may not be, as they are being managed at project level and mitigated accordingly.

The Governing Body is responsible for assuring itself that the CCG identifies and effectively manages any risks which could affect the achievement of the strategic objectives or priorities. The Governing Body provides leadership, scrutiny, challenge, and support for risk management. The Accountable Officer has overall responsibility for corporate governance within the organisation, which includes risk management activities.

Risk owners are responsible for ensuring that their risks are under review at appropriate intervals, and the risk register is updated under the co-ordination of the Corporate Business Manager at the agreed frequency in line with the risk matrix. Executive Officers are responsible for ensuring that:

- the risk strategy and associated policies, procedures and guidelines are adhered to within their areas of expertise,
- the risk register is reviewed relating to their Service areas such as clinical, planning and delivery, quality and performance, corporate services, finance and contracting,
- all risks are identified, assessed, and included on the risk register,
- assurance is provided to the committees overseeing each risk,

All the Committees receive risk reports via 'live' dashboards, specific to their areas of business and provide on-going assurance to the Governing Body over the management of risk which is reflected in the assurance framework. Specific detail on individual committee responsibility can be found in the risk management strategy. When linked, the risk register, risk reporting mechanisms into committees and the assurance framework all formalise the process of securing assurance and scrutinising risk, which is inherent in any effective risk management and accountability process.

The Governing Body and Audit Committee review the assurance framework and gain assurance that risks are being appropriately managed throughout the organisation. Assurance is further gained by minutes from Committees and Executive Officers in attendance at board meetings (which are held in public). The assurance framework and 'live' risk reporting is also considered by the Clinical Executive Committee on a regular basis.

Risk management is embedded in the activity of the organisation through the above measures and also through assessments of specific risks – for example, the Project Management Office (PMO) has a set of consistent project initiation documentation which must be completed

Risk management arrangements and effectiveness

for any internal project, which includes data protection impact assessments, equality impact assessments and quality impact assessments.

There are other policies supporting the management of risk such as the information governance policies, safeguarding frameworks, the serious untoward incident (SUI) policy and procedure, the health and safety policies and the equality strategy. All of these are available on the CCG website.

Incident reporting is encouraged in the CCG and the constitution positively encourages whistleblowing as a means of gaining awareness of potential fraud, bribery and corruption. The CCG has linked policies for whistleblowing, bribery and corruption with alignment to safeguarding policies.

Capacity to Handle Risk

The CCG's risk management process has evolved throughout the pandemic to reflect the emergency situation as the national incident response level has been increased or decreased.

The CCG established an Internal Incident Command Team (IICT) at the beginning of March 2020, to enable appropriate management oversight in directing the emergency response locally, but also to feed responsively into the Command and Control structures of the ICS, NHS England and the Lancashire Resilience Forum (LRF).

As previously mentioned in this report the CCG implemented an IDMF which clearly identifies when under an incident response who has emergency powers (via delegated authority) and the process for these to be exercised, to enable urgent decisions to be made and urgent business to continue; moreover, it mitigates against the risk of business as usual processes and governance causing inappropriate delays when responding to an emergency situation. The IDMF has been extended throughout the year to ensure the CCG is able to respond promptly to the emergency situation, it has recently been extended to provide stability during the transition period of closing down the CCG.

To support efficiency and speed of decision making during the pandemic, approval of risks could be granted through the IICT as well as through Executive Officers. COVID specific updates were regularly circulated to IICT members and there were weekly risk discussions, with customary risk reports submitted to Committees and Governing Body in line with the revised meeting schedules according to the national emergency response level.

The CCG has been in incident response throughout 2021/22 and so the process and governance structures described above have been utilised; however, during times when the national response was stepped down and recovery & restoration became more of a priority the following structures were be adhered to:

Governing Body approves the assurance framework at the start of the financial year and receives bi-monthly reports on progress.

Clinical Executive Committee ensures that there is continuous engagement with the CCG membership, and that membership views are reflected in the work of the CCG; it reviews all planning documents and recommends them to the Governing Body after checking that they are patient focused, effective, economic and efficient. It also oversees the delivery of these plans and ensures compliance with governance requirements and legal duties.

Audit Committee is responsible for providing assurance to the governing body that there is a sound system of integrated governance, risk management and internal control across the CCG's activities.

Quality and Safety Committee provides assurance that commissioned services are clinically safe, effective and provide good patient experience.

Remuneration Committee monitors, reviews and reduces risks relating to conflicts of interest and financial remuneration.

Primary Care Commissioning Committee manage risks related to the commissioning of primary care services.

Finance and QIPP manages risks related to achievement of financial targets on behalf of the Governing Body.

The Accountable Officer is responsible for ensuring robust systems are in place regarding corporate governance within the CCG, including risk management activities. The Chief Finance Officer has delegated responsibility from the Accountable Officer for progressing organisational risk management and governance activity.

All CCG employees and representatives are responsible for identifying, assessing and managing risks of all types in their work area, following any codes of conduct issued by their professional bodies. Appraisal processes ensure that all staff have the training and other resources required to equip them for their roles with regards to risk management.

Risk Assessment

Risks are assessed by scoring them according to a matrix which scores the impact if they happened (score of between 1 and 5) and the likelihood that they will happen (score of between 1 and 5). The likelihood and impact scores are then multiplied to give an overall risk score of between 1 (1 multiplied by 1) and 25 (5 multiplied by 5).

Scores of 12 or more are reported to Governing Body which is held in public. This is to enable the Governing Body to focus on the higher risks, and for the lower risks to be managed by Committees and responsible officers under delegated authority.

At the time of writing this report in March 2021, the CCG was recording 24 risks, of which 5 were assessed as extreme (risk score 15 and above). At the start of the financial year the CCG was reporting 11 extreme risks, the reduced number of extreme risks at the end of the reporting year reflects the hard work of the CCG to mitigate the risks but also the move nationally to learning to 'live with COVID'. The risk profile of the organisation has changed throughout the year from being primarily urgent incident response type risks with staff fatigue, burn out and resilience being a ongoing significant risk throughout the year. The impact of COVID in terms of increased waiting lists has also increased throughout the year. These risks are not unique to West Lancashire and are seen across Lancashire and South Cumbria; they are reflective of the sustained unparalleled system pressures being experienced nationally within the NHS.

The extreme risks were:

- Long term impact of COVID-19 on Health Inequalities. This is an area which the CCG has been working significantly with partners to address, utilising population health management techniques and this is a priority for the West Lancashire Partnership. For further detail on this work please see the section title "Reducing Health Inequalities" within the performance overview section of this report.

- Failure to deliver financial balance has remained a risk for the CCG this year. It has been complicated by the pandemic and the majority of services operating under block contracts with reduced contract monitoring meetings to allow commissioners and providers to focus on the response to the pandemic. WL CCG has been working closely with the other Lancashire and South Cumbria CCGs to mitigation this risk in a united way, in readiness for the transition to the ICB.

- There is a risk that due to the uncertainty of the staffing structure in the new ICS organisation current CCG staff will leave to secure alternative employment, leaving insufficient staff to manage CCG closedown and transition, and to undertake the new responsibilities of the new system. This would result in a loss of system knowledge and expertise. As well as the CCG governance structures monitoring this risk, this has also been monitored by the ICS structures as well. In attempt to understand how staff are feeling the LSC CCGs have utilised health and wellbeing questionnaires, setting aside time for informal conversations and making available opportunities for colleagues to process the challenges being faced through virtual team chats.

- There is a risk the CCG will not be sufficiently resourced to deliver its priorities. This is very closely aligned to the risk above but relates specifically to CCG continuing to have statutory duties and having the appropriate level of resource to deliver those duties. The pandemic has been a significant factor in this, but as our resilience as an organisation has reduced there is a risk further departures will impact on our delivery.

- Unmanageable levels of customer enquiries and information requests. The CCG continues to receive a high number of customer enquiries through all channels and statutory timescales for responses were not relaxed during the height of the pandemic. All enquiries are triangulated for consistency of response and to attempt to reduce any duplication. The FOI process changed as of 1st March 2021 with the Corporate Team coordinating requests to relevant departments within the CCG to improve efficiency.

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 sections entitled 'governance arrangements and effectiveness' and 'delegation of functions' describe how the internal control arrangements operate. There is a clear process for reporting, management, investigation and learning from incidents. There is a Senior Information Risk Owner (SIRO) to support the arrangements for managing and controlling risks relating to information/data security, with information asset owners being nominated and trained across functions. Our CCG Chair, who is a practising GP, has been nominated as Caldicott Guardian to ensure that patient confidentiality is protected.

There is a scheme of reservation and delegation, standing financial instructions and standing orders. The CCG receives assurance in relation to the internal control framework of Midlands and Lancashire Commissioning Support Unit (MLCSU) via update reports presented to the Audit Committee. The Chief Finance Officer meets regularly with MLCSU representatives to discuss controls and the CCG also gains assurance through service auditor reports, shared with MLCSU customers and their Audit Committees.

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.

The CCG has completed the annual audit of conflicts of interest, demonstrating that arrangements are in place to satisfy NHS England requirements. The compliance rating given to each scope area can be seen in the figure below.

Scope Area	RAG Rating	Level
1. Governance Arrangements	●	Fully Compliant
2. Declarations of interests and gifts and hospitality	●	Partially Compliant
3. Register of interests, gifts and hospitality and procurement decisions	●	Fully Compliant
4. Decision making processes and contract monitoring	●	Fully Compliant
5. Reporting concerns and identifying and managing breaches / non compliance	●	Fully Compliant

Figure 1, Conflicts of interest audit compliance levels concluded (as per NHSE guidelines) for each scope area

The area of partial compliance related to two instances where declarations of interest had not been made in the 28 day timeframe. A recommendation was made that staff should be reminded at intervals during the year that any changes in circumstances should be notified within the 28 day timeframe and all staff commencing contractual employment with the CCG should complete a declaration within the 28 day timeframe.

The CCG accepted this recommendation. A request has been made to the ICB Comms & Engagement Team for a standard reminder to be added to the monthly staff newsletter. The New Starters checklist for managers also includes a prompt to remind line managers to ensure declarations are completed in a timely manner.

More detail on all audits undertaken this year are provided within the Head of Internal Audit Opinion section of this Annual Report on page 82.

Data Quality

The Governing Body receive data relating to the performance of the CCG. This includes activity and financial data. The quality of data received from providers we commission services from is routinely validated to ensure accuracy. If any anomalies or unexpected trends occur, they are investigated. The integrated business report is a regular item on the Governing Body agenda and can be found on the website.

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 data security and protection toolkit (DSPT) 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 submitted the 2020-2021 DSPT and achieved 'standards met'. For 2021-2022 NHS Digital have set the submission deadline as 30th June 2022; therefore, authorisation for submission of the 2021-2022 DSPT has not yet been sought. The CCG will ensure that submission is completed by the June 2022 deadline and ensure that all mandatory evidence items are available, accurate and have been fully met.

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 DSPT. 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 are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

Other sources of assurance

Business Critical Models

These are largely provided by MLCSU. They are subject to regular external review, the outputs of which are submitted to their client CCGs through service auditor reports.

Within the CCG, business critical models are mostly spreadsheet-based. These have all been identified and form part of the CCG's information asset register, each with a suitably qualified information asset owner.

Third party assurances

The CCG relies on a number of third party providers with contracts being agreed with the relevant organisations together with monitoring arrangements to ensure contract compliance. Furthermore, the CCG receives independent reports produced by external auditors providing assurance in relation to the functions provided by third party organisations.

The providers include:

- Midlands and Lancashire CSU (MLCSU) – MLCSU provides a number of commissioning support services to the CCG including procurement, continuing healthcare and IT. During 2021/22 NHS Midlands and Lancashire CSU continued with the annual service auditor reporting (SARS) process supported by the CCG. In order to deliver assurance over the internal controls and control procedures operated by a service organisation to its customers and their auditors, many organisations engage a reporting accountant to prepare a report on internal controls (known as a Service Auditor Report).

  Throughout the year Deloitte UK undertook independent testing of all processes against the control standards documented in the SARS and their final report identified just 1 exception out of the 74 controls tested.

- NHS Business Services Authority (NHSBSA) – NHSBSA provides a range of services to NHS organisations, NHS contractors, patients and the public. They have a responsibility to calculate the remuneration and reimbursement due to prescribing contractors across England. Prescription services also provide the NHS with a range of drug, financial and prescribing information.

  PricewaterhouseCoopers were engaged to report on NHSBSA's description of its Prescription Payments Services throughout 2021/22. The audit identified one control with an exception related to assurance that access to its systems is appropriately restricted.

  The CCG has noted the report and acknowledges the proposed changes by the management of NHSBSA to address this exception.

- NHS Shared Business Services – NHS Shared Business Services (NHS SBS) provides finance and accounting services to a number of NHS organisations. PricewaterhouseCoopers were engaged to review the controls NHS SBS takes responsibility for with an overall aim of providing an independent third party opinion of their design and operating effectiveness.

  The 2021/22 review identified one exception in relation to assurance that equipment and facilities are protected from damage by fire, flood and other similar environmental hazards and that physical security is adequate. The CCG acknowledges the management response to this exception and accepts that data back-ups are in place, which safeguards client data at all times.

- NHS Digital – NHS Digital is the national information and technology partner to the health and social care system. PricewaterhouseCoopers were engaged to review the controls NHS Digital takes responsibility for in the end to end processing of payments to general practices in England, with an overall aim of providing an independent third party opinion over their design and operating effectiveness.

  The review of system controls during 2021/22 identified exceptions in relation to assurance that access to systems is controlled. Specifically, controls were not in place to provide appropriate timely removal of leavers to GP Data Collection. This is a national report and within the auditors report there is a management response as a remedial action. The points raised are issues with system controls/access within NHS Digital which do not have an impact on calculations.

  The CCG notes the management response to these exceptions and does not consider that they pose a significant risk to it.

- Capita – Capita provide a range of payment and pension administration services under the Primary Care Support England (PCSE) contract. Mazars were engaged to report on Capita's service controls system throughout 2021/22 and on the design and operation of controls. Although the review covered all primary care service sectors the CCG exposure is limited to the controls relating to GP payments and pension administration services. They identified a qualification on four out of seventeen control objectives.

  The CCG note these qualifications and have internal controls to mitigate their risk such as reviewing the monthly management accounts to ascertain if there are any unusual expenditure trends/items.

Control Issues

There are no significant control issues facing the CCG.

Review of economy, efficiency & effectiveness of the use of resources

The Audit Committee oversees these elements on behalf of the governing body, raises any key issues and reports its minutes to the Governing Body in meetings held in public.

The Accountable Officer is responsible for ensuring that the CCG operates economically, efficiently, and effectively on a day-to-day basis. She is supported in this role by a senior team and a management structure. Key functions are performed by the Chief Nurse (providing assurance from a clinical perspective) and the Chief Finance Officer (ensuring overall economy, efficiency and effectiveness).

Internal audit services provide an independent review of CCG functions, according to an annual plan which reflects relative risk. Internal audit links with the Chief Finance Officer on a day-to-day basis and reports to the Audit Committee as a standing item on each agenda. Internal audit have access to whatever officers and documents (electronic or hard copy) they need to do their job.

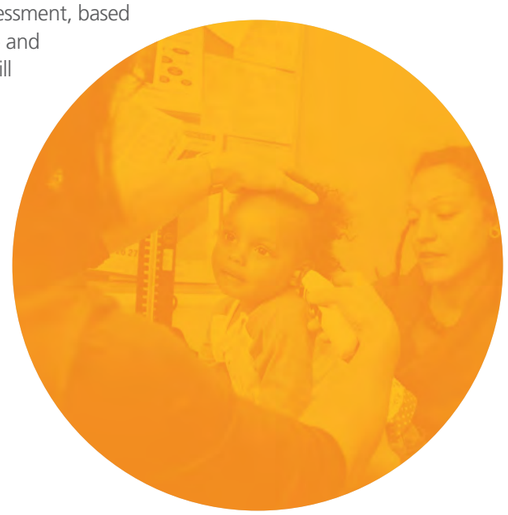
The CCG reports to NHS England, which monitors its performance, again providing assurance as to its economy, efficiency and effectiveness. A financial budget is prepared annually and is approved by the Governing Body. This highlights how the CCG will spend the sums allocated to it by the Department of Health, and also demonstrates how it will comply with Department of Health business rules. Monthly integrated business reports are produced, comparing performance to date with expected performance at that point in the year, for both financial and other performance targets (being a combination of national requirements and locally determined targets). In the case of financial performance, a forecast to the financial year end is also included.

As public bodies, CCGs are expected to keep their running (management) costs as low as possible, consistent with delivering their functions to a high standard. This is to ensure that as much resource as possible is available to support services to patients, carers and the wider public.

The NHS Oversight Framework replaced the CCG Improvement and Assessment Framework in 2019/20. The framework is intended as a focal point for joint work, support and dialogue between NHS England, NHS Improvement, CCGs, providers and sustainability and transformation partnerships and integrated care systems.

Consistent with the national policy direction to move to system oversight, discussions throughout 2020/21 were at a system level, rather than solely with individual CCGs. A simplified approach was taken to the annual performance review, taking account of the different circumstances and challenges CCGs have faced in managing the different phases of the NHS response to Covid-19. It was concluded in June 2021 that the CCG has maintained focus and energy throughout a challenging year. The leadership team and the entire CCG workforce were acknowledged for having worked extremely hard, at pace, and under difficult conditions. NHSE/I recognised that people have shown a high degree of flexibility and resilience over the past year, with significant efforts made to support staff through a professionally and personally challenging time whilst also preparing for the future.

The simplified narrative assessment, based on performance, leadership and finance, described above will also be used for 2021/22, to provide greater flexibility to reflect both the continued uncertainty faced by the NHS in light of COVID-19 and the NHS System Oversight Framework 2021/22. The assessment will be completed by the 30th June 2022.



Delegation of functions

For business as usual processes, the governing body has an approved scheme of delegation, identifying which functions it retains, and which are delegated to its committees and senior officers.

Committees reporting to the governing body operate under terms of reference approved by the governing body, which reflect their delegated roles. Committees submit their minutes to governing body meetings. A management structure, various communication mechanisms, and a system of regular line manager supervision meetings ensure that delegated functions are followed up.

Internal audit provide independent assurance to inform management and the audit committee should there be failures in this regard. External auditors provide an opinion on value for money secured from the CCG's commissioning activities and also give an opinion on the true and fair view presented to readers of the CCG's annual accounts. This gives assurance and assists the Audit Committee in recommending to Governing Body that the CCG's annual accounts are adopted.

Auditors have regular progress meetings with the Chief Finance Officer and have access to other officers as required. Where functions are delegated to external organisations, such as MLCSU (for various management functions provided on a large scale to provide greater economy and resilience to client CCGs) and the Mersey Internal Audit Agency (providing internal audit services to a wide range of organisations again to achieve greater economy, concentration of specialist expertise, and improved organisational resilience) contracts are agreed with the relevant organisations together with monitoring arrangements to ensure contract compliance.

For externally delegated functions, the CCG also receives service auditor reports from the external auditors of those organisations. These are independent reports to inform clients of the organisations concerned.

As mentioned earlier in this report, as part of the CCG's response to the COVID-19 pandemic, the Governing Body implemented an IDMF.

The purpose of the framework was to ensure that critical decisions and actions to tackle the pandemic could be taken in an effective and transparent manner whilst at the same time reducing the burden on clinicians to attend a multitude of meetings at a time of national crisis. The IDMF provides a clear structure and process for how the CCG could continue to conduct urgent Covid-19 business outside the formal meeting structure. Moreover, all Chairman's decisions made using the IDMF are reported to the next scheduled Governing Body for completeness and transparency. The IDMF is available using the link below: https://www.westlancashireccg.nhs.uk/wp-content/uploads/Covid-19-Pandemic-Interim-Decision-Making-Framework-Version-4.pdf

The CCG has also been required to provide significant operational guidance and support to our providers in all settings (care homes, community and acute). Operational oversight throughout the pandemic has been through specialist leads with escalation through to Senior and Executive Managers when required, with situational reports received by senior management on a daily basis during peaks in the pandemic.

The response to the pandemic has seen effective and streamlined ways of working through the ICS; escalation from a local, place level, was through the ICS and NHS England command and control structures utilising our Internal Incident Command Team, External Incident Command Team, and implementation of the CCG Business Continuity Plans with specialist management oversight through the Emergency Preparedness Resilience and Response Lead. These structures and plans ensured services and providers supported each other through mutual aid processes ensuring our patients received a continuity of service that met the quality standards the CCG requires.

Counter fraud arrangements

The Local Counter Fraud Specialist (LCFS) reports to the Audit Committee. Their reports update the committee on proactive (preventing, deterring, creating and maintaining a culture of honesty) and reactive work (responding to whistleblowing, conducting investigations, pursuing available sanction and recovering amounts due) that is being undertaken.

The Audit Committee approves the annual plan for anti-fraud, bribery and corruption activities to ensure that a significant proportion of time is devoted to proactive work.

The LCFS is employed by Mersey Internal Audit Agency, with which the CCG holds a contract for the provision of anti-fraud services.

The LCFS is visible within the organisation and liaises regularly with the Chief Finance Officer, who is accountable for tackling fraud, bribery and corruption, for support and direction.

The Audit Committee ensures that appropriate action is taken with regard to LCFS recommendations and NHS Counter Fraud Authority quality assurance recommendations. The NHS Counter Fraud Authority (NHSCFA) is a national organisation charged with making sure that a high level of professionalism exists in anti-fraud work and with undertaking investigations when they are needed across a larger area.

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:

Key area	Summary
Head of Internal Audit Opinion	The overall opinion for the period 1st April 2021 to 31st March 2022 provides Substantial Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
Planned Audit Coverage and Outputs	The 2021/22 Internal Audit Plan has been delivered with the focus on the provision of your Head of Internal Audit Opinion. This position has been reported within the progress reports across the financial year. Review coverage has been focused on: • The organisation's Assurance Framework • Core and mandated reviews, including follow up; • A range of individual risk based assurance reviews; and • CCG Closedown/ICB Transition support
MIAA Quality of Service Indicators	MIAA operate systems to ISO Quality Standards. The External Quality Assessment, undertaken by CIPFA (2020), provides assurance of MIAA's full compliance with the Public Sector Internal Audit Standards.

Of the reviews completed in the year, assurance ratings were given in four cases. Assurance rating were not applicable to four reviews, due to the nature of this work. The audit assignment element of the Opinion is limited to the scope and objectives of each of the individual reviews. Detailed information on the limitations (including scope and coverage) to the reviews has been provided within the individual audit reports and through the Audit Committee Progress Reports throughout the year.

A summary of the reviews performed in the year is provided below:

	Review	Assurance Opinion	Recommendations Raised				
			Critical	High	Medium	Low	Total
1	Assurance Framework	Meets Requirements	Not applicable				
2	Conflicts of Interest	Full/Partially Compliant	0	0	1	1	2
3	Primary Care Commissioning and Contracting: Commissioning and Procurement of Primary Medical Services	High	0	0	0	1	1
4	Local Transition Group Attendance and Reporting Briefing Note	Not applicable	Not applicable				
5	Key Financial Controls Third Party Assurance Briefing Note	Not applicable	Not applicable				
6	2020/21 Data Protection and Security Toolkit Assessment Summary Report	Substantial / Moderate	Not applicable				
7	2020/21 Data Protection Security Toolkit: CCG to Integrated Care Systems Handover Review Summary Report	Substantial	Not applicable				
		Total	**0**	**0**	**1**	**2**	**3**

All recommendations raised were accepted by management.

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 board
- The audit committee
- If relevant, the risk / clinical governance / quality committee
- Internal audit
- Other explicit review/assurance mechanisms.

Conclusion

No significant internal control issues have been identified.

NHS West Lancashire CCG - Remuneration Report 2021-22

Remuneration Committee

The Committee was established by NHS West Lancashire CCG to approve the remuneration and terms of service for the Chief Officer, other staff on very senior manager (VSM) pay terms and conditions, and GP Governing Body members.

In the first year of operation the Committee set baseline salaries in accordance with national and local guidance, and the performance elements required of Bands 8c and above under Agenda for Change.

Pay for board members and other senior staff is mainly in accordance with nationally determined pay rates. Where pay is determined locally this is agreed by the Committee.

The Committee met once in 2021-22.

It is the responsibility of the Committee in its discussions to:

- include all aspects of salary (including any performance related element, bonuses and any other allowances), provisions for other benefits including pensions and car allowance, and arrangements for termination of employment and other contractual issues in decision making
- approve any non-contractual payments at any level that may be regarded as novel and/or contentious and which required Treasury approval.

Policy on the remuneration of senior managers

No bonus payments were awarded by the Remuneration Committee during 2021-22

Remuneration of very senior managers

No senior managers received remuneration in excess of £150,000 per annum (pro rata). For the purposes of this note GP Governing Body members have not been classed as very senior managers.

Senior manager remuneration (including salary and pension entitlements)

Salaries and allowances - SUBJECT TO AUDIT

Single total figure table

2021-22							
Name	Title	Salary (Bands of £5,000)	Expense Payments (Taxable) (Rounded to nearest £100)	Performance pay and bonuses (Bands of £5,000)	Long-term Performance Pay and Bonuses (Bands of £5,000)	All Pension Related Benefits (Bands of £2,500)	Total (Bands of £5,000)
		£'000	£	£'000	£'000	£'000	£'000
Amanda Doyle	Chief Clinical Officer	10-15	0			0	10-15
Andrew Bennett	Accountable Officer	10-15	0			0	10-15
Paul Kingan	Chief Finance Officer	105-110	5,100			42.5-45	155-160
Jackie Moran	Director of Integration and Transformation	90-95	0			37.5-40	130-135
Claire Heneghan	Chief Nurse	75-80	9,600			0	85-90
Dr Peter Gregory	GP Executive Lead	85-90	0			25-27.5	115-120
Dr John (Jack) Kinsey	GP Executive Lead	35-40	0			0	35-40
Greg Mitten	Lay Member	5-10	0			0	5-10
Douglas Soper	Lay Member	10-15	0			0	10-15
Dr Adam Robinson	Secondary Care Consultant	0	0			0	0
Steve Gross	Lay Member	5-10	0			0	5-10
Dr Dheraj Bisarya	GP Executive Lead	35-40	0			10-12.5	45-50

2020/21							
Name	Title	Salary (Bands of £5,000)	Expense Payments (Taxable) (Rounded to nearest £100)	Performance pay and bonuses (Bands of £5,000)	Long-term Performance Pay and Bonuses (Bands of £5,000)	All Pension Related Benefits (Bands of £2,500)	Total (Bands of £5,000)
		£'000	£	£'000	£'000	£'000	£'000
Dr Amanda Doyle OBE	Chief Clinical Officer	30-35				0	30-35
Paul Kingan	Chief Finance Officer	105-110	5,200			22.5-25	135-140
Jackie Moran	Director of Integration and Transformation	90-95				37.5-40	130-135
Claire Heneghan	Chief Nurse	80-85	9,700			0	90-95
Dr Peter Gregory	GP Executive Lead	75-80				62.5-65	135-140
Dr John Caine	Former Chair	50-55				0	50-55
Dr John (Jack) Kinsey	GP Executive Lead	35-40				27.5-30	60-65
Dr Dheraj Bisarya	GP Executive Lead	35-40				7.5-10	45-50
Douglas Soper	Lay Member	10-15				0	10-15
Greg Mitten	Lay Member	5-10				0	5-10
Steve Gross	Lay Member	5-10				0	5-10
Dr Adam Robinson	Secondary Care Consultant	0				0	0
Mike Maguire	Former Chief Officer	0-5				0	0-5
Dr Rakesh Jaidka	GP Executive Lead	0-5				0	0-5
Dr Vikul Mittal	GP Executive Lead	0-5				0	0-5

Notes

1. 2020-21 figures are disclosed to enable comparison with the current year.
2. The figures shown for Dr Amanda Doyle OBE represent the proportion of Dr Doyle's remuneration relating to West Lancashire CCG only, for the time in post 01/04/2021 to 31/07/2021.
   Dr Doyle's total salary for the period of office (excluding taxable benefits) is £75-80K which is split as follows:
   £15-20k to Blackpool CCG in respect of Accountable Officer duties;
   £30-35k to the Integrated Care System for work as the ICS Lead;
   £15-20k to Fylde and Wyre CCG in respect of Accountable Officer duties; and
   £10-15k charged to West Lancashire CCG in respect of Accountable Officer duties.
   The recharges from Blackpool CCG to West Lancashire CCG and Fylde and Wyre CCG are based on the population split between the three CCGs.
   The pension and taxable benefits disclosure has not been apportioned and is showing in full in Blackpool CCG's Annual Report only.
3. The figures shown above for Mr Andrew Bennett represent the proportion of Mr Bennett's remuneration relating to West Lancashire CCG only, for the time in post (from 01/08/2021).
   Mr Bennett's total salary for the period of office (excluding taxable benefits) is £90-95K which is split as follows:
   £15-20K to Blackpool CCG in respect of Accountable Officer duties;
   £45-50K to the Integrated Care System for work as the ICS Lead;
   £15-20K to Fylde and Wyre CCG in respect of Accountable Officer duties; and
   £10-15K charged to West Lancashire CCG in respect of Accountable Officer duties.
   The recharges from Morecambe Bay CCG to West Lancashire CCG and Fylde and Wyre CCG are based on the population split between the three CCGs.
   The pension and taxable benefits disclosure has not been apportioned and is showing in full in Blackpool CCG's Annual Report only.
4. Adam Robinson is an employee of Salford Royal NHS Foundation Trust. Due to a change in NHS payment processes as a result of Covid-19, no charges were directly incurred by the CCG in 2020-21 for Adam Robinson.
5. The taxable benefits listed above relate to lease cars.

Pension benefits as at 31st March 2022 - SUBJECT TO AUDIT

Name	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 2022 (Bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2022 (Bands of £5,000)	(e) Cash equivalent transfer value at 1 April 2021 (nearest £1,000)	(f) Real increase in cash equivalent transfer value	(g) Cash equivalent transfer value at 31 March 2022 (nearest £1,000)	(h) Employer's contribution to stakeholder pension
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Paul Kingan	Chief Finance Officer	2.5-5	0-2.5	40-45	75-80	652	40	710	0
Jackie Moran	Director of Integration and Transformation	2.5-5	0-2.5	35-40	75-80	665	42	723	0
Dr John (Jack) Kinsey	GP Executive Lead	0	0	15-20	30-35	322	(35)	294	0
Dr Peter Gregory	Chair	0-2.5	0-2.5	20-25	35-40	299	15	328	0
Dr Dheraj Bisarya	GP Executive Lead	0-2.5	0-2.5	10-15	25-30	168	6	182	0

Notes

1. Figures in brackets represent negative values.
2. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive directors.
3. The Pension Benefits and Benefits in Kind for Dr Amanda Doyle and Andrew Bennett whose salary costs are currently being recharged from Blackpool CCG and Morecambe Bay CCG have not been apportioned and are showing in full in Blackpool CCG Annual Reports only

Cash equivalent transfer values (CETV)

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members' accrued benefits and any contingent spouse'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 schemes or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in their former scheme. The pensions 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. No CETV will be shown for members over 60 (1995 Section).

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pensions due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangment).

The method used to calculate CETVs changed, to remove the adjustment for the Guaranteed Minimum Pension (GMP) on 8 August 2019.

Payments to past members

The CCG has not made any payments to past members during the year 2021-22

Compensation on early retirement or for loss of office

The CCG has not made any payments for retirement or loss of office is 2021-22

Pay multiples - SUBJECT TO AUDIT

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce.
The banded remuneration of the highest paid director / member in West Lancashire CCG in the financial year 2021-22 was £182,500 (2020-21, £182,500) the median remuneration of the workforce, which was £47,126 (2020-21 £45,753).

The relationship to the remuneration of the organisations workforce is disclosed in the below table.

Year	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
2021-22	5.15:1	3.87:1	2.41:1
2020-21	5.71:1	3.99:1	2.59:1

Pay Ratio Information

As at 31 March 22, remuneration ranged from £7,882 to £182,500 (0% against 2020-21: £7,882 - £182,500) based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff).

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

A number of factors contribute to the increase in the median salary. These include annual pay awards, staff receiving incremental increases in line with Agenda for Change Terms & Conditions and reflect additional responsibilities undertaken by certain members of staff. As a consequence the pay multiple has decreased.

Remuneration of West Lancashire CCG's staff is shown in the table below:

	25th percentile	Median	75th percentile
All Staff' remuneration based on annualisation, full-time equivalent remuneration of all staff (including temporary and agency staff)	£35,435	£47,126	£75,874
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (invluding temprary and agency staff)	£35,435	£47,126	£75,874

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director / member in West Lancashire CCG in the financial year 2021-22 was £182,500 (2020-21, £182,500). The relationship to the remuneration of the organisations workforce is disclosed in the below table.

Year	25th Percentile total remuneration ratio	25th percentile Salary ratio	Median total Remuneration ratio	Median Salary Ratio	75th percentile total remuneration ratio	75th percentile salary ratio
2021/22	5.15:1	5.15:1	3.87:1	3.87:1	2.41:1	2.41:1
2020/21	5.71:1	5.71:1	3.99:1	3.99:1	2.59:1	2.59:1

In 2021-22, 0 (2020-21, 0) employees received remuneration in excess of the highest-paid director / member. Actual remuneration ranged from £7,882 to £113,133 (2020-21 £7,882 to £111,209).

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

Staff Report

The CCG's performance regarding this is regulated by NHS England. We are a small CCG, so we buy in support services from NHS Midlands and Lancashire Commissioning Support Unit (MLCSU). We also receive support from public health colleagues from Lancashire County Council.

The member makeup of the governing body is 1 female and 9 males. 1 of the 10 members is on the very senior manager pay scale.

Number of senior managers

We have 4 Senior Managers (excluding Governing body and Directors) at band 8c and above, of whom 1 is male and 3 are female. The bandings are listed below:

Table of senior managers by band	
Band	**Number**
8c	3
8d	1
Total	**4**

Staff numbers and costs (Subject to Audit)

We have a support team of 31 staff (excluding the directors, lay members and senior managers). Of these 31 staff, 25 are female and 6 are male. An analysis of staff numbers (full time equivalent) and costs can be found in the financial statements note 3.1 and 3.2.

Staff composition

The staff composition excludes the lay members.

	Female	Male
Directors	2	5
Senior managers	3	1
Other employees of the CCG	25	6

The average number of staff employed during 2021/22 is 40.

The 7 directors in the table above include:

The CCG Chair, Peter Gregory, and 2 other local family doctors as referred to in the Corporate Governance section of this report.

The Chief Nurse, Claire Heneghan

The Chief Officer, Andrew Bennett

The Chief Financial Officer, Paul Kingan

The Director of Integration and Transformation, Jackie Moran

Staff Report

Sickness absence data

	2021-22
Total Days Lost	367
Total Staff Years	41
Average working days lost	9

The CCG manages staff sickness in line with the agreed Staff Sickness Policy.

The clinical commissioning group has not agreed any early retirements due to ill health grounds as at 31 March 2022 or the prior year ending 31 March 2021.

Staff turnover percentages

CCG Staff Turnover 2020/21	
Average FTE employed	39.7
Total FTE Leavers	2.40
Turnover Rate	6.05%

Staff policies

The CCG recognises one of its greatest assets is our employees, and it has never been more important to understand our team, in terms of what inspires and drives them but also how they are feeling physically and mentally. To ensure we have received this feedback from colleagues the CCG has maintained appraisals and one-to-one protected time, albeit in using video conferencing tools. The CCG has representation on the Lancashire and South Cumbria CCGs Health and Wellbeing Group, which recently oversaw a system wide Health and Wellbeing Festival open to all West Lancashire CCG colleagues, as well as continuing to utilise:

- Virtual team chats for all colleagues to come together and keep abreast of any ongoing developments nationally or locally
- Briefing and development sessions
- Staff health and wellbeing survey – linking in with the Lancashire and South Cumbria ICS approach
- Health and wellbeing conversations in one-to-one protected time
- Our Board Level Health and Wellbeing Champion to oversee the implementation of the People Plan
- Risk assessments of those particularly vulnerable to COVID-19 infection more frequently where their roles in pandemic management were more public facing
- Worked with the NW BAME Assembly to engage with West Lancashire CCG staff to protect, support, develop and understand the needs of staff within these groups

The staff policies updated throughout 2021/22 financial year are:

- Bomb Threat Policy
- Conflict of Interest Policy
- Display Screen Equipment
- Fire Safety
- Health & Safety
- Incident Reporting Policy
- Office Safety
- Petitions Policy
- Smoking at Work Policy
- Non-Medical Prescriber Registration Policy
- Disciplinary Policy
- Job Matching & Re-banding Policy (supersedes Job Evaluation Policy)
- Lone Worker Policy

Our Equality, Diversity and Inclusion Strategy 2021-2022 sets out the CCG's objectives on reducing health inequalities across the NHS West Lancashire CCG as well as Lancashire and South Cumbria. Our strategy is based on the requirements of the NHS Equality Delivery System (EDS), which supports the aims to embed equality into all policies and practices while moving forward with performance and going beyond the legislation.

The EDS provides a robust framework against which we can assess and grade the CCG's performance against a range of nationally determined equality indicators grouped under the four goals:

- Better health outcomes.
- Improved patient access and experience.
- A representative and supported workforce.
- Inclusive leadership.

The EDS grading event for 2021-22 assessed NHS West Lancashire CCG's performance in relation to Goal 3 – a representative and supportive workforce. The CCG scored an EDS grade of **'Achieving'** in each of the following outcomes:

3.1: Fair NHS recruitment and selection processes lead to a more representative workforce at all levels

3.2: The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations

3.3: Training and development opportunities are taken up and positively evaluated by all staff

3.4: When at work, staff are free from abuse, harassment, bullying and violence from any source

3.5: Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives

3.6: Staff report positive experiences of their membership of the workforce

Further information about the work we have undertaken this year to promote equality, diversity and inclusion will be available in our Equality Annual Report 2021/22, which is due for publication on our website in June 2022.

Trade Union Facility Time Reporting Requirements

The CCG does not employ anyone who undertakes relevant union official duties as outlined in the Trade Union (Facility Time Publication Requirements) Regulations 2017 and therefore no time is released from this employer in relation to official duties. The CCG liaises and works with CSU TU representatives and area/ regional representatives from those recognised unions whose time will be recorded with their employing authority.

Expenditure on consultancy

Total expenditure on consultancy for 2021/22 was £163k (2020/21 £379k).

Off-payroll engagements

The CCG is required to report on certain off-payroll arrangements.

All off-payroll engagements as of 31st March 2022, for more than £245 per day and that last longer than 6 months:

	Number
Number of existing engagements as of 31 March 2022	2
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	2

All existing off-payroll engagements as at 31st March 2022 have 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 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2022 for more than £245* per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2022	
Of which, the number that have existed:	
for less than one year at the time of reporting	
for between one and two years at the time of reporting	
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	
for 4 or more years at the time of reporting	

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Exit packages, including special (non-contractual) payments - SUBJECT TO AUDIT

Table 1: Exit packages

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£	WHOLE NUMBERS ONLY	£	WHOLE NUMBERS ONLY	£	WHOLE NUMBERS ONLY	£
Less than £10,000					-	-	-	-
£10,000 - £25,000					-	-	-	-
£25,001 - £50,000					-	-	-	-
£50,001 - £100,000					-	-	-	-
£100,001 - £150,000					-	-	-	-
£150,001 - £200,000					-	-	-	-
>£200,000					-	-	-	-
Totals				**Agrees to A below**	**0**	**0**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme. Exit costs in this note are the full costs of departures agreed in the year. Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Table 2: Analysis of Other Departures

	Agreements	Total Value
	Number	£'000s
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice*	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval**	-	-
Total	**0**	**£0**

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 3 which will be the number of individuals.

* any non-contractual payments in lieu of notice are disclosed under "non-contractual payments requiring HMT approval" below.

**includes any non-contractual severance payment made following judicial mediation, and list amounts relating to non-contractual payments in lieu of notice.

No non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Independent auditor's report

to the members of the Governing Body of NHS West Lancashire CCG

Report on the Audit of the Financial Statements

Opinion on financial statements

- We have audited the financial statements of NHS West Lancashire CCG (the 'CCG') for the year ended 31 March 2022, 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 international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

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

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 1.1 to the financial statements, which indicates that under the Health and Care Act 2022 the commissioning functions, assets and liabilities of West Lancashire CCG are due to transfer to NHS Lancashire and South Cumbria Integrated Care Board on 1 July 2022.

Conclusions relating to going concern

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

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

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

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

The responsibilities of the Accountable Officer with respect to going concern are described in the 'Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements' section of this report.

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 audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements 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 in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG, 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.

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

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity section of our report, 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.

Basis for qualified opinion on regularity

The CCG reported expenditure of £204.126 million against income of £203.485 million and a deficit of £0.641 million in its financial statements for the year ending 31 March 2022. The CCG thereby breached two of its duties under the National Health Service Act 2006, as amended by paragraphs 223H and 223I of Section 27 of the Health and Social Care Act 2012, to ensure that annual expenditure does not exceed income and revenue resource use does not exceed the amount specified by direction of NHS England.

Independent auditor's report

to the members of the Governing Body of NHS West Lancashire CCG

Matters on which we are required to report by exception

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

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

We have nothing to report in respect of the above matters except on 19 May 2022, we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to NHS West Lancashire CCG's breach of its revenue resource limit for the year ending 31 March 2022.

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 they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

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

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).
- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and income and expenditure recognition. We determined that the principal risks were in relation to:
  - material year end journals and manual journals posted during the year with high risk characteristics
  - potential management bias in determining estimates for year end prescribing accrual.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on the material year end transactions and manual journals posted during the year with high risk characteristics;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of prescribing accruals;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and expenditure recognition, the deficit overspend and the significant accounting estimates related to prescribing accruals.

Independent auditor's report

to the members of the Governing Body of NHS West Lancashire CCG

- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG including:
  - the provisions of the applicable legislation
  - NHS England's rules and related guidance
  - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the CCG's operations, including the nature of its operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.

– the CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework.

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

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

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

Responsibilities of the Accountable Officer

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

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

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

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

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

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

Report on other legal and regulatory requirements – Certificate

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

Use of our report

This report is made solely to the members of the 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.

Alex Walling

Alex Walling, Key Audit Partner
for and on behalf of Grant Thornton UK LLP,
Local Auditor
Bristol
21 June 2022

Parliamentary Accountability and Audit Report

NHS West Lancashire CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report at page 103.

ANNUAL ACCOUNTS

Andrew Bennett
Accountable Officer

21st June 2022

Financial statements

The Primary Statements::

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Other operating income	2	(1,279)	(1,450)
Total operating income		(1,279)	(1,450)
Staff costs	3	2,930	3,154
Purchase of goods and services	4	201,093	193,912
Depreciation and impairment charges	4	0	9
Provision expense	4	74	28
Other Operating Expenditure	4	29	34
Total operating expenditure		**204,126**	**197,137**
Total Net Expenditure for the Financial Year		**202,847**	**195,687**
Comprehensive Expenditure for the year		**202,847**	**195,687**

The notes on pages 113-137 form part of this statement

The financial statements on pages 107-113 were approved by the Governing Body on 14th June 2022 and signed on its behalf by:

Paul Kingan
Chief Finance Officer

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Current assets:			
Inventories	7	489	438
Trade and other receivables	8	701	1,623
Cash and cash equivalents	9	47	47
Total current assets		**1,237**	2,108
Total assets		**1,237**	2,108
Current liabilities			
Trade and other payables	10	(11,320)	(14,166)
Provisions	11	(145)	0
Total current liabilities		**(11,465)**	(14,166)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(10,228)**	(12,058)
Non-current liabilities			
Provisions	11	0	(71)
Total non-current liabilities		**0**	(71)
Assets less Liabilities		**(10,228)**	(12,129)
Financed by Taxpayers' Equity			
General fund		(10,228)	(12,129)
Total taxpayers' equity:		**(10,228)**	(12,129)

Statement of Changes In Taxpayers Equity for the year ended 31 March 2021

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(12,129)	**(12,129)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	(12,129)	(12,129)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22		
Net operating expenditure for the financial year	(202,847)	(202,847)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	(202,847)	(202,847)
Net funding	204,748	204,748
Balance at 31 March 2022	(10,228)	(10,228)

The notes on pages 113-137 form part of this statement

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21		
Balance at 01 April 2020	(10,834)	**(10,834)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	(10,834)	(10,834)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21		
Net operating costs for the financial year	(195,687)	(195,687)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	(195,687)	(195,687)
Net funding	194,392	194,392
Balance at 31 March 2021	**(12,129)**	**(12,129)**

The notes on pages 113-137 form part of this statement

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(202,847)	(195,687)
Depreciation and amortisation	4	0	9
(Increase)/decrease in inventories	7	(51)	31
(Increase)/decrease in trade & other receivables	8	922	1,568
Increase/(decrease) in trade & other payables	10	(2,846)	(428)
Increase/(decrease) in provisions	11	74	28
Net Cash Inflow (Outflow) from Operating Activities		**(204,748)**	(194,479)
Net Cash Inflow (Outflow) before Financing		**(204,748)**	(194,479)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		204,748	194,392
Net Cash Inflow (Outflow) from Financing Activities		**204,748**	194,392
Net Increase (Decrease) in Cash & Cash Equivalents	9	**0**	(87)
Cash & Cash Equivalents at the Beginning of the Financial Year		**47**	134
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**47**	47

The notes on pages 113-137 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

The Health and Care Act received Royal Assent on 28 April 2022. The Act will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs are due to take on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities are due to transfer to NHS Lancashire and South Cumbria ICB.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. 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. The statement of financial position has therefore been drawn up at 31 March 2022, on a going concern basis.

1.2 Accounting Convention

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

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

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

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

1.4 Joint arrangements

Arrangements over which the clinical commissioning group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the clinical commissioning group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.5 Pooled Budgets

The clinical commissioning group has entered into a pooled budget arrangement with Lancashire County Council (in accordance with section 75 of the NHS Act 2006). Under the arrangement, funds are pooled for Learning Difficulties and Social Care. Note 14 provides details of the income and expenditure.

The pools are hosted by Lancashire County Council. 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

1.6 Operating Segments

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

1.7 Revenue

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

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

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

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

1.8 Employee Benefits

1.8.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees.

1.8.2 Retirement Benefit Costs

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

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

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

1.9 Other Expenses

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

1.10 Grants Payable

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

1.11 Leases

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

1.11.1 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.

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 Inventories

Inventories are valued at the lower of cost and net realisable value. The CCG classes community equipment within individuals' homes as an inventory and has employed a methodology that considers the age of the equipment to determine its net realisable value.

1.13 Cash

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

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.

1.15 Clinical Negligence Costs

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

1.16 Non-clinical Risk Pooling

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

1.17 Contingent liabilities and contingent assets

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

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

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

1.18 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.18.1 Financial Assets at Amortised cost

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

1.18.2 Financial assets at fair value through other comprehensive income

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

1.18.3 Financial assets at fair value through profit and loss

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

1.18.4 Impairment

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

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

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

commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

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

1.19 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.

1.19.1Financial 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 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 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

1.22 Critical accounting judgements and key sources of estimation uncertainty

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

1.22.1 Sources of estimation uncertainty

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

Timing differences. There are a number of accruals and prepayments (totalling a net £6.817m) within the Statement of Financial Position where estimation techniques have been applied. This is because the outturn information is not available at the time of preparation of the financial statements

Prescribing. The CCG has included an accrual of £3.183m which relate to the estimated charges to the CCG for medicines in February and March 2021. The estimates are based on recent expenditure trends and seasonal profiles.

1.23 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – IFRS 16 Leases has been deferred until 1 April 2022, but CCGs will still need to provide adequate disclosure on the impact of the new standard. HM Treasury have issued application guidance which will assist entities in assessing the impact and this can be found at IFRS_16_Application_Guidance_December_2020.pdf (publishing.service.gov.uk).

  IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged

  IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The clinical commissioning group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

  On transition to IFRS 16 on 1 April 2022, the clinical commissioning group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the clinical commissioning group's incremental borrowing rate. The clinical commissioning group's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

  For leases commencing in 2022/23, the clinical commissioning group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

The CCG has undertaken an initial assessment of the above standards which indicates that their impact on its financial position will be immaterial

2. Other Operating Revenue

	2021-22 Total £'000	2020-21 Total £'000
Other operating income		
Other non contract revenue	1,279	1,450
Total Other operating income	**1,279**	**1,450**

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the clinical commissioning group and credited to the General Fund.

Revenue is totally from the supply of services. The clinical commissioning group received no revenue from the sale of goods for the year ending 31st March 2022 or for the prior year ending 31 March 2021.

3. Employee benefits and staff numbers

3.1 Employee benefits

	2021-22		
	Total		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	2,282	39	2,321
Social security costs	232	0	232
Employer Contributions to NHS Pension scheme	377	0	377
Gross employee benefits expenditure	**2,891**	**39**	**2,930**
Less recoveries in respect of employee benefits	0	0	0
Total - Net admin employee benefits including capitalised costs	**2,891**	**39**	**2,930**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**2,891**	**39**	**2,930**

3.1 Employee benefits

	2020-21		
	Total		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	2,493	8	2,501
Social security costs	246	0	246
Employer Contributions to NHS Pension scheme	407	0	407
Gross employee benefits expenditure	**3,146**	**8**	**3,154**
Less recoveries in respect of employee benefits	0	0	0
Total - Net admin employee benefits including capitalised costs	**3,146**	**8**	**3,154**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**3,146**	**8**	**3,154**

3.2 Average number of people employed

	2021-22			2020-21		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	45.16	1.00	46.16	51.58	0.03	51.61

3.3 Exit packages agreed in the financial year

	2021-22					
	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	2021-22					
	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
£50,001 to £100,000	0	0	1	54,750	1	54,750
Total	**0**	**0**	**1**	**54,750**	**1**	**54,750**

	2021-22		2020-21	
	Departures where special payments have been made		Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

Analysis of Other Agreed Departures

	2021-22		2020-21	
	Other agreed departures		Other agreed departures	
	Number	£	Number	£
Contractual payments in lieu of notice	0	0	1	54,750
Total	**0**	**0**	**1**	**54,750**

* As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with contractual terms.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

3.4 Staff sickness absence and ill health retirements

	2021-22 Number
Total Days Lost	367
Total Staff Years	41
Average working Days Lost	**9**

3.5 Pension costs

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

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

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

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

3.5.1 Accounting valuation

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

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

3.5.2 Full actuarial (funding) valuation

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

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

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

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

For 2021-22, employers' contributions of £376,762 (2020-21: £407,476) were payable to the NHS Pensions Scheme at the rate of 20.68% of pensionable pay. These costs are included in the NHS pension line of note 3.1.

The NHS Pensions data for benefits and related CETVs does not allow for any potential adjustment arising from the McCloud judgement.

4. Operating expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	2,908	1,572
Services from foundation trusts	46,499	46,174
Services from other NHS trusts	60,171	58,901
Purchase of healthcare from non-NHS bodies	47,794	44,188
Prescribing costs	20,668	19,442
GPMS/APMS and PCTMS	18,133	16,374
Supplies and services – clinical	1,001	931
Supplies and services – general	1,716	2,531
Consultancy services	163	379
Establishment	299	486
Transport	794	751
Premises	768	2,086
Audit fees	73	65
Other non statutory audit expenditure		
- Other services	0	12
Other professional fees	8	1
Legal fees	80	10
Education, training and conferences	18	9
Total Purchase of goods and services	**201,093**	**193,912**
Depreciation and impairment charges		
Amortisation	0	9
Total Depreciation and impairment charges	**0**	**9**
Provision expense		
Provisions	74	28
Total Provision expense	**74**	**28**
Other Operating Expenditure		
Chair and Non Executive Members	29	29
Grants to Other bodies	0	5
Total Other Operating Expenditure	**29**	**34**
Total operating expenditure	**201,196**	**193,983**

In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, where a CCG contract with its auditors provides for a limitation of the auditor's liability, the principal terms of this limitation must be disclosed in a note to the accounts.

The Auditors liability cap amount is £2m.

5.1 Better Payment Practice Code

Measure of compliance	2021-22 Number	2021-22 £'000	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,405	76,944	9,671	68,726
Total Non-NHS Trade Invoices paid within target	9,373	76,758	9,609	68,197
Percentage of Non-NHS Trade invoices paid within target	**99.66%**	**99.76%**	**99.36%**	**99.23%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	475	112,288	966	111,395
Total NHS Trade Invoices Paid within target	466	112,222	957	110,959
Percentage of NHS Trade Invoices paid within target	**98.11%**	**99.94%**	**99.07%**	**99.61%**

The Better Payment Practice Code required the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

5.2 The Late Payment of Commercial Debts (Interest) Act 1998

The clinical commissioning group has not made any such payments in the year ending 31 March 2022 or for the prior year ending 31 March 2021.

6. Operating Leases

6.1 As lessee

The clinical commissioning group occupies property owned and managed by NHS Property Services Limited. Included within these charges are amounts relating to subsidies and void spaces whereby the income generated by NHS Property Services Ltd from tenants is insufficient to cover costs and the clinical commissioning group covers the shortfall.

6.1.1 Payments recognised as an Expense

	2021-22			2020-21		
	Buildings £'000	**Other £'000**	**Total £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payments recognised as an expense						
Minimum lease payments	290	1	291	1,511	1	1,512
Total	**290**	**1**	**291**	**1,511**	**1**	**1,512**

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

The implementation of IFRS 16 was due to be introduced from April 2020. Due to the coronavirus outbreak in Spring 2020, IFRS16 will now be implemented 1st of April 2022.

Under IFRS16, it is the intention of the CCG to re-classify one operating leases as finance lease.

7 Inventories

	Loan Equipment £'000	**Total £'000**
Balance at 01 April 2021	**438**	**438**
Additions	51	**51**
Balance at 31 March 2022	**489**	**489**

8.1 Trade and other receivables

	Current 2021-22 £'000	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS receivables: Revenue	89	0	280	0
NHS accrued income	148	0	166	0
Non-NHS and Other WGA receivables: Revenue	269	0	377	0
Non-NHS and Other WGA prepayments	68	0	741	0
Non-NHS and Other WGA accrued income	131	0	47	0
VAT	(4)	0	12	0
Total Trade & other receivables	**701**	**0**	**1,623**	**0**
Total current and non current	**701**		**1,623**	

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2022 or for the prior year ending 31 March 2021.

8.2 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	**2021-22 Non DHSC Group Bodies £'000**	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000
By up to three months	88	78	280	381
By three to six months	0	1	0	0
By more than six months	0	174	0	66
Total	**88**	**253**	**280**	**447**

8.3 Provision for impairment of receivables

The clinical commissioning group had no provision for impairment of receivables in the year ending 31 March 2022 or for the prior year ending 31 March 2021.

The clinical commissioning group's aged debt report is reviewed in order to determine the recovery status of the debtor balances. Each item is considered on a case by case basis.

9 Cash

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	47	134
Net change in year	0	(87)
Balance at 31 March 2022	**47**	**47**
Made up of:		
Cash with the Government Banking Service	47	47
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	**47**	**47**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2022	**47**	**47**
Patients' money held by the clinical commissioning group, not included above	0	0

10 Trade and other payables

	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS payables: Revenue	1,148	0	1,550	0
NHS accruals	582	0	331	0
Non-NHS and Other WGA payables: Revenue	922	0	4,834	0
Non-NHS and Other WGA accruals	3,565	0	3,833	0
Non-NHS and Other WGA deferred income	135	0	0	0
Social security costs	32	0	28	0
Tax	30	0	29	0
Other payables and accruals	4,906	0	3,561	0
Total Trade & Other Payables	**11,320**	**0**	**14,166**	**0**
Total current and non-current	**11,320**		**14,166**	

11 Provisions

	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
Continuing care	145	0	0	71
Total	**145**	**0**	**0**	**71**
Total current and non-current	**145**		**71**	

	Continuing Care £'000	Total £'000
Balance at 01 April 2021	**71**	**71**
Arising during the year	74	**74**
Balance at 31 March 2022	**145**	**145**
Expected timing of cash flows:		
Within one year	145	**145**
Balance at 31 March 2022	**145**	**145**

The provision pertains to Continuing Care claims relating to the period up to, and including, 2021/22 that may be settled in future years. It is calculated by reference to claims received and currently being processed, their probability of success and an estimate of their weekly care package cost.

12 Financial instruments

12.1 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.

12.1.1 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.

12.1.2 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.

12.1.3 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.

12.1.4 Liquidity risk

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

12.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

12 Financial instruments cont'd

12.2 Financial assets

	Financial Assets measured at amortised cost 2021-22 £'000	Total 2021-22 £'000	Total 2020-21 £'000
Trade and other receivables with NHSE bodies	140	140	**205**
Trade and other receivables with other DHSC group bodies	109	109	**171**
Trade and other receivables with external bodies	388	388	**494**
Cash and cash equivalents	47	47	**47**
Total at 31 March 2022	**684**	**684**	**917**
Items not classed as financial instruments	64	64	**753**
Total trade and other receivables + cash and cash equivalents	**748**	**748**	**1,670**

12.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	Total 2021-22 £'000	Total 2020-21 £'000
Trade and other payables with NHSE bodies	499	499	**334**
Trade and other payables with other DHSC group bodies	1,421	1,421	**9,545**
Trade and other payables with external bodies	9,204	9,204	**4,231**
Total at 31 March 2022	**11,124**	**11,124**	**14,110**
Items not classed as financial instruments	196	196	**56**
Total trade and other payables	**11,320**	**11,320**	**14,166**

The carrying value of financial assets and liabilities is a reasonable approximation of fair value.

13 Operating segments

The clinical commissioning group consider they have only one segment: commissioning of healthcare services.

14 Joint arrangements - interests in joint operations

CCGs should disclose information in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

14.1 Interests in joint operations

			Amounts recognised in Entities books ONLY 2021-22				Amounts recognised in Entities books ONLY 2020-21			
Name of arrangement	Parties to the arrangement	Description of principal activities	Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000	Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
LD Pool	LCC, Chorley & South Ribble CCG, Greater Preston CCG	Services for Adults with Learning Disabilities - Central Pooled Fund	0	0	(405)	1,473	0	0	(379)	1,478
Better Care Fund	Lancashire County Council	Better Care Fund Social Care	0	0	(5,886)	8,787	0	0	(5,615)	8,382

14.2 Services for Adult Learning Difficulties

The clinical commissioning group has a pooled budget arrangement with Lancashire County Council. The pool is hosted by Lancashire County Council.

Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for Services for Adults with Learning Disabilities.

14.3 Better Care Fund

The clinical commissioning group has a pooled budget arrangement with Lancashire County Council, NHS Morecambe Bay CCG, NHS Fylde and Wyre CCG, NHS Greater Preston CCG, NHS Chorley and South Ribble CCG and NHS East Lancashire CCG. The pool is hosted by Lancashire County Council.

15 Related party transactions

Details of related party transactions with individuals are as follows:

	2021/22			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts owed to Related Party £'000
Parkgate Surgery (Chair - Dr Peter Gregory)	1,032	0	0	0
Parbold Surgery (GP Exec Lead - Dr John Kinsey)	852	0	0	0
Dr A Bisarya (GP Exec Lead - Dr Dheraj Bisarya)	372	0	0	0
Excel Primary Care (GP Exec Lead - Dr Dheraj Bisarya)	2,163	0	0	0
Lancashire Teaching Hospitals NHS FT	2,462	0	0	0
Liverpool University Hospitals NHST FT	9,587	0	0	0
OWLS	3,137	0	0	0
CVS West Lancashire Ltd	95	0	0	0
Twinkle House Ltd	78	0	8	0

The transactions above to Practices are in relation to Enhanced Services and Tier 2 services (such as Anti-Coagulation, Minor Surgery and Phlebotomy) provided by the above mentioned GP Practices and also for Primary Care Co-Commissioning.

OWLS CIC Ltd provide urgent care services to the West Lancashire population including out of hours provision and an acute visiting service.

The Department of Health and Social Care is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department of Health and Social Care is regarded as the parent Department. For example:

- NHS England
- NHS Foundation Trusts
- NHS Trusts
- NHS Litigation Authority
- NHS Business Services Authority
- NHS Property Services
- Community Health Partnerships

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Lancashire County Council in respect of joint enterprises.

	2020/21			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts owed to Related Party £'000
NHS Fylde & Wyre CCG	1	0	0	(6)
Parkgate Surgery (Chair - Dr Peter Gregory)	1,012	0	0	0
Parbold Surgery (GP Exec Lead - Dr John Kinsey)	826	0	0	0
Dr A Bisarya (GP Exec Lead - Dr Dheraj Bisarya)	382	0	0	0
Excel Primary Care (GP Exec Lead - Dr Dheraj Bisarya)	2,157	0	18	0
Liverpool University Hospitals NHST FT	9,397	0	95	(158)
OWLS	1,316	0	0	0
NHSE/I	1	0	0	(16)
CVS West Lancashire Ltd	138	0	0	0
Twinkle House Ltd	12	0	0	0

16 Events after the end of the reporting period

The Health and Care Act received Royal Assent on 28 April 2022. Subject to the issue of an establishment order by NHS England the CCG is due to be dissolved on 30 June 2022. On 1 July the assets, liabilities and operations are due to transfer to NHS Lancashire and South Cumbria ICB.

17 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:

	2021-22 Target	2021-22 Performance	2020-21 Target	2020-21 Performance
Expenditure not to exceed income	203,485	204,126	197,289	197,137
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	202,206	202,847	195,839	195,687
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	2,204	2,157	2,218	2,173

The CCG is reporting a forecast deficit of £641,000 for the 2021/22 financial year. This relates to the unwinding of a prescribing prepayment initially entered in the accounts in 2019/20. This treatment is consistent with that adopted by the other Lancashire and South Cumbria CCGs and will be considered 'allowable' by NHS England when considering the CCG's financial performance. Aside from this technical matter, the CCG has broken even against its allocated resources for 2021/22.

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For you.

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To get involved in your local CCG, please visit
www.westlancashireccg.nhs.uk

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