NHS
East Lancashire
Clinical Commissioning Group

NHS East Lancashire CCG

Annual Report

2021/22

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This is the ninth Annual Report of the NHS East Lancashire Clinical Commissioning Group (CCG), and my fourth Annual Report.

The CCG was established formally in April 2013, and this report covers the activity of the CCG in the 12 months up to the end of March 2022.

Over the last year we have found ourselves both in, and gradually emerging from the COVID-19 public health emergency. Along with all of our partners and colleagues in the public sector, and in health and care, this was incredibly challenging, we continued to respond to the population needs that arose because of the virus, as well as the usual health needs that our population normally have and face. On top of this we supported a population scale vaccination programme, reaching and vaccinating significant numbers of people in East Lancashire through the hard work of our Primary Care Networks and communities across the area.

A year further on and we find ourselves locally, and nationally moving slowly and surely out of the pandemic and the measures that were introduced to control the spread of the virus. We are now collectively taking careful and cautious steps to a relative sense of normalcy and business as usual. The COVID-19 pandemic has been unprecedented in every way possible, and the population and NHS have been challenged far beyond our comfort levels. This has been a time of considerable achievement in response to this, as well as a time of insight and lessons learned. A positive take from this, is that the pandemic has definitely helped us to become stronger, more resilient and more effective and efficient.

Throughout 2021 our health services continued to experience exceptional pressure and demand. Our primary care (GP) and secondary care (hospitals) services were responding to what can only be described as a tidal wave of poorly people who had contracted COVID-19 and needed care and treatment. The infectivity of the virus meant that services had to operate in "COVID-19 safe" environments and healthcare environments had to transform rapidly to reduce the spread of infection while at the same time respond to the very many poorly people who were in need of treatment. We saw services rise to the challenge and surpass themselves. Last year the CCG and our partners in Pennine Lancashire won a national award – the prestigious Health Service Journal Award for partnership working for our development of the virtual COVID ward. This service offers patients pulse oximetry at home and helps people with COVID-19 and at risk of deterioration, monitoring and support in their own homes. Developing new services such as this, at pace and at scale, and in a partnership of many different organisations to meet the needs of our communities is an astonishing achievement in its own right and

during a pandemic was a real success story. I am absolutely delighted and proud that this service and the professionals, networks and communities involved achieved award winning national recognition.

Pennine Lancashire has significant and historical levels of social and economic deprivation, and unfortunately with this comes a multitude of long-term health problems. Demand and pressure on NHS services has always been disproportionately higher than other areas due to the poor health of the population in Pennine Lancashire. We learned that poor health is a real predictor of greater ill health from COVID-19, and consequently we sadly saw more hospital admissions, deaths and longer-term problems from COVID-19. Prime amongst these was the emergence of "long COVID", also known as post COVID-19 syndrome. While the emergence of "long COVID-19" began to put additional pressure on services, in Pennine Lancashire we rose to this challenge with the creation of local services to support those affected, particularly working in partnership with local authorities, and leisure trusts as well as primary and secondary care services.

The response to COVID-19 and the vaccination effort has been phenomenal. This is the best of our NHS and partners in action mobilising at speed and at scale. I am particularly grateful to our primary care networks, including our local GPs and their teams for their response to this crisis. I would like to pay testament to our clinical leadership which includes Dr Mark Dziobon, our Medical Director, his deputies Dr Qash Hussain and Dr Santhosh Davis, our Primary Care Network Clinical Directors, as well as our Governing Body GPs. The East Lancashire Alliance of Primary Care Networks, led by PCN Director Dr Fiona Ford, and supported by our eight other PCN Directors were at the forefront of the successful and well-received vaccination programme.

Our hospital services have responded admirably over the last year – and our hospital colleagues have been brave, compassionate and skilled in their response throughout. We are fortunate that in Pennine Lancashire we have such fine hospital services with such committed and skilled clinicians. I am very grateful to our hospital services and clinicians for the work they have done and continue to do. The regulated care sector which consists of care and nursing homes is an often under-recognised part of the health and care system but they play an important role in the care and support of our communities. They, their more vulnerable residents and families and carers bore the brunt of COVID-19 initially, and they responded to this compassionately and brilliantly. I would like to thank the leaders and staff of all our nursing and care homes in Pennine Lancashire.

As a CCG we have always recognised the value and importance of the voluntary, community, faith, and social enterprise sector (VCFSE) in Pennine Lancashire. We were one of the first CCGs in the country to see the value of, and invest in social prescribing. Social prescribing is where the voluntary sector and communities offer social support to people via a prescription from their GP. It offers "more than medicine" and has helped thousands in our area. Burnley Pendle and Rossendale CVS produce wonderful reports with data showing the benefits of this wonderful service. We continued this investment and support during the pandemic and in addition, we saw how the VCFSE stepped up to

really support and boost the vaccination programme and contribute towards its success. I mentioned earlier, the award winning virtual COVID ward development. A highlight of last year was to see one of the volunteer drivers for this service receive the HSJ award on behalf of the volunteer drivers across East Lancashire who supported this service so well. We were all so proud of the drivers and this was tangible recognition of their commitment and service.

This will be the last full Annual Report of the CCG as CCGs will be abolished from July 2022. Alongside the work I have described, over the last few years we have seen the evolution and maturing of NHS Lancashire and South Cumbria Integrated Care System (ICS), and the creation of the Lancashire and South Cumbria Integrated Care Board (ICB). This will replace the eight CCGs in Lancashire and South Cumbria and we will see the establishment of local place-based teams across the region. Primary Care Networks (PCNs) have really emerged as a force to be reckoned with and in turn in the new system we will see them working at neighbourhood level to ensure that services are high quality, integrated and successful.

I would like to finish by thanking everyone who has worked for the CCGs in Pennine Lancashire, as well as our partners, stakeholders, patients and the public. Pennine Lancashire is an amazing place: the “can do” mind set, and the good humour and compassion that I witness every day in Pennine Lancashire makes it a unique and special place. I wish everyone well for the future.

Dr Julie Higgins

Accountable Officer

20 June 2022

Performance Overview

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

Responding to the COVID-19 pandemic

Since March 2020, NHS East Lancashire, along with the other seven CCGs in Lancashire and South Cumbria has 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-19 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-19 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.

As a CCG our contribution to the effective availability and delivery of personal protective equipment (PPE) meant that services and front-line staff were well equipped. We were members of 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 which 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.

We worked to ensure that consistent and 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. Locally we used the highly effective communication methods and platforms that we have available to us to ensure we reached all professionals through professional briefings, and the public using traditional and social media.

As a CCG we ensured that antigen testing became firmly embedded in our commissioning and delivery of local services and in line with 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 CCG was represented on the Lancashire and South Cumbria NHS Testing Group, established in 2020, which 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.

The CCG as part of the Lancashire and South Cumbria Integrated Care System 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 and CCG websites 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, as well as throughout Pennine Lancashire via our communication team.

The COVID-19 vaccination programme – the largest in history – was well established by April 2021, both nationally and across Lancashire and South Cumbria. The CCG played our part in Pennine Lancashire, and as partners in lockstep with the national guidance 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, which included all areas of East Lancashire, 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.

Our 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 supported by the CCG, 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 launched across Lancashire and South Cumbria in 2020/21 to monitor vulnerable patients with COVID-19 in their own homes.

In Pennine Lancashire, we, along with our partner CCG, Blackburn with Darwen, and in partnership with local providers and GP practices continued to work together to provide an award-winning 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. The Pennine Lancashire Virtual COVID Ward service won the national Health Service Journal (HSJ) award for patient safety and partnership in 2021. This was national recognition of the speed, development and beneficial impact this service had for patients. The service is an example of true partnership working, where partners worked at speed, and at scale to offer a service at the heart of the COVID-19 response. Patients were given a pulse oximeter and had regular contact with the service so they could measure the oxygen levels in their blood several times a day. This allowed the early detection of a reduction in the oxygen levels, 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 enabled early treatment to be given, improving the patient's chances of recovery and preventing unnecessary admission to hospital.

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.

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.

Long COVID services have been developed and are being delivered to patients in Pennine Lancashire. An emerging challenge for the NHS has been those people who have suffered from continuing symptoms following infection with COVID-19. Called "long COVID" or post-COVID syndrome, this debilitating condition has affected many individuals and our knowledge about the syndrome is slowly

growing. In East Lancashire, in partnership with providers we established a post COVID service, which has been modelled on the effective virtual COVID ward service. This builds on the partnership between health, social, leisure and community and voluntary services to offer people a range of options to help them manage and live with long COVID. Many people who contract COVID-19 feel better in a few days or weeks and most will make a full recovery within 12 weeks. But for some people, symptoms can last much longer leading to a considerably reduced quality of life. Symptoms they experience can vary from extreme fatigue, shortness of breath, chest pain and difficulty sleeping amongst many others. A great number of people experiencing long COVID have had to come out of employment, some feel extremely lonely and isolated due to being removed from regular every day social routines which can lead to increased levels of anxiety and depression.

The treatment for long COVID varies from person to person and can depend greatly on the combination of symptoms the individual has. There is a waiting list to access the clinical long COVID service and work is now underway to focus on the discharge process for those people who are steadily improving and who can continue their recovery with the support of local initiatives, in particular connecting to the offer of the Active Lifestyles Hub. The Active Lifestyles Hub is a shared way of working across Pennine Lancashire's six community leisure providers, of whom five are based in East Lancashire. The model gives a more structured and consistent entry point into community for people across East Lancashire who need help to improve their health and mental wellbeing. The advantage for the health and care system is that the Active Lifestyles Hub is simple and easy to navigate for clinical health professionals and can connect people from across a large geographical footprint into a specialist, supported, local programme within their area. For individuals it provides opportunities to build upon the early work of the long COVID service within a supported environment, with the hope that some of the symptoms are further reduced, physical health improves, mental health improves and individuals who came out of work prematurely feel ready and able to return.

Along with the other seven CCGs in Lancashire and South Cumbria, we 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.

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 CCG has supported additional investment 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. The total across Lancashire and South Cumbria is 18, including in Pennine Lancashire, and this 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.

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. As a CCG, we worked with our partners 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.

Crisis alternatives such as crisis houses 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 been extended to cover East Lancashire. This provision offers 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. The Pennine Lancashire Homeless service, of which the CCG is a key partner, won the category of ‘Outstanding Contribution to Partnership Working’ for Pennine Lancashire at the Lancashire and South Cumbria Foundation Trust “Time to Shine” awards. The service identifies and supports the most vulnerable people facing multiple disadvantages and supports 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 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 – including East Lancashire.

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). In East Lancashire this investment has been well received by GP practices and the public, offering a greater range of support for people needed mental health support.

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 East Lancashire mirror the continuing work across Lancashire and South Cumbria 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 in East Lancashire and 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 for East Lancashire, reflects the trend across Lancashire and South Cumbria in that it 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. As of December, East Lancashire CCG achieved the recovery target.

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 and CCG 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.

Suicide prevention

Recognising the impact of the COVID-19 pandemic and lockdowns on people's mental health, the CCG in partnership with other CCGs and providers across 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. This has been heavily promoted in East Lancashire and continues to attract interest.

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).

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, including East Lancashire Hospitals NHS Trust, and we continue to work through plans to procure single electronic patient records (EPR) for acute and community services.

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.

East Lancashire CCG has been at the forefront of work supporting the regulated care sector to harness the power and utility of digital care. 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, the CCG has been a proponent of the GP TeamNet system and along with our partners 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.

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. East Lancashire CCG is a real advocate of this work and has seen significant progress throughout the year in uptake by practices in East Lancashire.

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.

The Healthier Lancashire and South Cumbria Digital Inclusion programme which we as a CCG, are a partner of, 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 our sister CCG, supported and influenced our 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.

Through partnership work in the digital programme the CCG 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.

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, of which the CCG is a member, and which had delegated authority, 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.

The CCG along with our partners across the system promoted 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. The course has been regularly promoted in East Lancashire and referrals from East Lancashire residents continued to be high.

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. In East Lancashire we promoted Your Diabetes, Your Way to the public and via GP practices. The engagement of patients from East Lancashire has been positive and the uptake has improved since 2020. Looking ahead we are reviewing the provision of structured 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. The CCG is a key partner of this alliance, and our lead GP for cancer services Dr Neil Smith (a Blackburn GP, but leading across both CCGs), is the lead GP for the Alliance. The Alliance's 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, through the clinical leadership of Dr Smith and colleagues, we have seen system-level leadership, as well as leadership to East Lancashire GPs to support cancer services and post-pandemic are the most restored Cancer Alliance nationally for urgent suspected cancer referrals. Our services in East Lancashire are seeing more patients every week for a cancer check than they saw before the pandemic and have worked hard to ensure that campaigns and messaging to promote public awareness have been amplified locally.

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.

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.

The CCG commissions East Lancashire Hospitals NHS Trust Pancreatic Cancer Rapid Diagnostic Service (RDS). We were delighted that the service kickstarted November's Pancreatic Cancer Awareness month with a win at the Macmillan Professionals Excellence Awards, as recognition of their outstanding contribution to cancer services. The service is part of a Lancashire and South Cumbria wide initiative designed to support earlier diagnosis in pancreatic cancer and came out top in the 'Integration Excellence' category. The award recognises teams who have improved the coordination of services and enabled integration across settings such as acute, primary, social, and voluntary services to provide a seamless experience for people living with cancer. The ELHT Cancer Services Team was nominated for their collaborative working with colleagues including diagnostic specialists, biomedical scientists, and clinicians. They also work closely with representatives from the Lancashire and South Cumbria Cancer Alliance, Primary Care Networks and 3rd sector organisations, Pancreatic Cancer Action and Pancreatic Cancer UK. The successful collaborative work has meant that an average wait time for a patient to be diagnosed with pancreatic cancer has reduced considerably following GP referral.

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, including East Lancashire Hospitals NHS Trust, 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 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 carbon monoxide monitoring during COVID-19 pandemic Standard Operating Procedure (SOP) and a Trauma Informed Care Training and Supervision package are 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 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.

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.

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.

As a CCG, we recognised that we, and the wider health and care system need a robust and overarching strategy for population health. In essence we along with our partners, commissioned a Health Equity Commission (HEC) to support this. Our Accountable Officer, Dr Julie Higgins led this work for the CCG, but equally across the whole Lancashire and South Cumbria health and care system. 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.

In East Lancashire we saw an innovative approach to Population Health Management when Dr Yas Naheed Clinical Director of Burnley East Primary Care Network ran a diabetes health programme which targeted healthy lifestyle including exercise and dietary advice to improve the health and wellbeing of individuals with diabetes at her practice. The result was a significant improvement in their health and wellbeing. Dr Naheed's approach is being considered across Pennine Lancashire and wider afield.

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
- 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 trend was mirrored locally in East Lancashire and reflects also, the national picture.

This year, the CCG and our partners across the ICS 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. In East Lancashire our GP lead for this Professor Umesh Chauhan has achieved national recognition for this undertaking a review to understanding the lived experience of people with learning disabilities and ensuring that locally, regionally and nationally we can learn more from these experiences and improve the care, health and wellbeing of people with a learning disability.

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 East Lancashire this has continued to be a real and growing demographic challenge.

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. East Lancashire along with the other seven 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, 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.

In Pennine Lancashire, the East Lancashire Alliance of Primary Care Networks which incorporates all GP practices in East Lancashire, has been integral to the delivery of the COVID-19 vaccination and booster programmes. The primary care response while at the same time delivery services as usual has been one of the major achievements for primary care over the last year.

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 pulse oximetry at home. As mentioned elsewhere, 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. In East Lancashire, the virtual COVID ward system which delivers pulse oximetry at home won the Health Service Journal Award for patient safety and partnership working last year. We are rightly proud of this achievement.

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 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.

Voluntary, Community, Faith and Social Enterprise (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.

In East Lancashire we have, over the years, invested considerable sums of money in the voluntary sector through our social prescribing scheme, which is run on our behalf by Burnley Pendle and Rossendale CVS. Social Prescribing helps patients with emotional, social and practical needs access a range of local, non-medical and non-clinical services, often provided by the community and voluntary sector. Services include, but are not limited to, local community support groups, bereavement support, financial support, exercise groups, social groups, and one-to-one peer mentoring. The BPRCVS Social Prescribing Team aims to reduce pressures on doctors' surgeries and hospitals by creating reductions in referrals to GPs for those suffering from anxiety, depression, low confidence, low self-esteem, and other social, emotional, and practical needs. People who are vulnerable and socially isolated who have been identified by GPs and other health and social care professionals, are matched with a Social

Prescribing Link Worker to improve confidence, inclusion, independence, and ultimately health and wellbeing. For more information go to: https://www.bprcvs.co.uk/index.php/services/social-prescribing-team.

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. East Lancashire CCG is a partner in this network. 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.

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 East Lancashire CCG and the other seven 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. East Lancashire CCG is a key member of the Pennine Lancashire A&E Delivery Board, and is represented on the UECN.

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, including the CCG, and locally East Lancashire providers and 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, including East Lancashire. 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 Summary

One of the CCG's responsibilities is to regularly monitor key performance indicators (KPIs) for the main services that it commissions and the population that it supports. The overall aim is to support the commissioning and provision of high-quality care for all people across East Lancashire - focusing on quality, performance, and outcomes. The CCG reports quality and performance monitoring progress regularly to its Governing Body meetings.

Improving the performance of services we commission

Monitoring of KPIs is an important way of making sure that the most critical services are functioning properly. It enables the CCG to take action with service providers to make improvements if targets are not met.

COVID-19-enforced changes to the nature of accessing health care, combined with clear and regular national and local communication of the health service response and restrictions during the pandemic, has seen a significant affect as to how patients interact with Primary and Secondary care. Despite the best efforts of staff, performance against the local and national constitutional metrics has been adversely impacted by the COVID-19 pandemic and response.

Key Performance Indicators

Throughout 2021/22 the CCG has monitored key performance indicators (KPIs). These KPIs are set nationally, with some scope for local performance in some areas. However, they reflect the targets that patients and the public (as well as GPs, and the CCG), consider important. These include ambulance and A&E metrics, cancer waiting times, referral to treatment and referral to diagnosis times, targets to reduce healthcare acquired infections (HCAIs) and indicators outlining mental health performance. The main Key Performance Indicators (KPI) are shown in full below.

(m = minutes; s = seconds; YTD (Year to Date)

Category	Specific KPI	Period	Actual	Target
Ambulance [Based on totality of NWAS Service Performance]	Category 1 (Mean average)	Apr21 - Mar22	00:08:42	7 minutes
	Category 1 (90th Centile)	Apr21 - Mar22	00:14:46	15 minutes
	Category 2 (Mean average)	Apr21 - Mar22	00:47:39	18 minutes
	Category 2 (90th Centile)	Apr21 - Mar22	01:44:46	40 minutes
	Category 3 (90th Centile)	Apr21 - Mar22	07:06:54	120 minutes
	Category 4 (90th Centile)	Apr21 – Mar22 (excl Jun-Nov21)	09:07:09	180 minutes

A&E (East Lancashire Hospital Trust)	Percentage of Patients who spent less than 4 hours in an A&E department	Apr21 - Mar22	72.95%	Formerly 95%
Cancer Waits	% of Patients seen within 2 weeks for an urgent GP referral for suspected cancer	YTD Apr 21 – Mar 22	88.07%	93%
	% of Patients seen within 2 weeks for an urgent referral for breast symptoms	YTD Apr 21 – Mar 22	78.31%	93%
	Maximum 31 day wait from diagnosis to first definitive treatment for all cancers	YTD Apr 21 – Mar 22	93.55%	96%
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	YTD Apr 21 – Mar 22	85.38%	94%
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	YTD Apr 21 – Mar 22	98.96%	98%
	Maximum 31 day wait for subsequent treatment where that treatment is a course of radiotherapy	YTD Apr 21 – Mar 22	97.64%	94%
	Maximum 62 day wait from urgent GP referral to first definitive treatment for cancer	YTD Apr 21 – Mar 22	67.11%	90%
	Maximum 62 day wait from referral from an NHS Screening Service to first definitive treatment for all cancers	YTD Apr 21 – Mar 22	67.31%	85%

	Maximum 62 day wait for first definitive treatment following a consultant's decision to upgrade the priority	YTD Apr 21 – Mar 22	84.29%	*
	Cancer: Percentage of patients meeting faster diagnosis standard.	YTD Apr 21 – Mar 22	73.68%	>75%
Referral to Treatment (RTT)	Patients on an incomplete pathway waiting no more than 18 weeks from referral	Mar 22	69.0%	92%
	Number of patients on an incomplete pathway waiting more than 52 weeks	Mar 22	895	0
Diagnostics	Percentage of Patients waiting 6 weeks or more for a diagnostic test	Apr 21 – Mar 22	20.85%	<1%
Healthcare Associated Infections (HCAI)	Methicillin-resistant *Staphylococcus aureus* (MRSA)	2021-22	3	0
	Clostridium difficile (C. dif)	2021-22	79	0
	Escherichia coli (E. coli)	2021-22	299	0
Mental Health	MH: IAPT recovery rate (%)	YTD Apr 21 – Feb22	57.0%	50%
	MH: Estimated diagnosis rate for people with dementia	Mar 22	67.6%	66.70%
	Maternity: Number of women accessing specialist community perinatal mental health services	Mar 21 – Feb 22	8.48%	
	CAMHS: Proportion of CYP (Children & Young People)	2021-22	58.62%	

	with eating disorders (Urgent referrals) that wait one week or less from referral to start NICE-approved treatment.			
	CAMHS: Proportion of CYP with eating disorders (Routine referrals) that wait four weeks or less from referral to start NICE-approved treatment.	2021-22	73.81%	
Learning Disability	Percentage of people aged 14+ years on the GP learning disability register receiving an annual health check	YTD (Q4) Apr 21 – Mar 22	62.0%	70%

*E * No identified target

LHT

–Lancashire Hospital

Performance Analysis

Urgent and Emergency Care

The number of patients attending East Lancashire Hospitals NHS Trust (ELHT) Accident and Emergency (A&E) began increasing from March 2021 following previously significant low attendance during 2020/21 (largely as a result of the impact from the COVID-19 pandemic and response of lockdowns and restrictions). However, A&E attendances during 2021-22 have been even higher than pre-pandemic levels and this has placed significant pressures on urgent care provision with a deterioration in performance against the associated targets.

Urgent & Emergency Care		Actual	Target
Ambulance: Category 1 (Mean average) [1]	Apr21 - Mar22	00:08:42	7 minutes
Ambulance: Category 1 (90th Centile) [1]	Apr21 - Mar22	00:14:46	15 minutes
Ambulance: Category 2 (Mean average) [1]	Apr21 - Mar22	00:47.39	18 minutes
Ambulance: Category 2 (90th Centile) [1]	Apr21 - Mar22	01:44:46	40 minutes
Ambulance: Category 3 (90th Centile) [1]	Apr21 - Mar22	07:06:54	120 minutes
Ambulance: Category 4 (90th Centile) [1]	Apr21 – Mar22 (excl Jun-Nov21)	09:07:09	180 minutes
A&E: Percentage of Patients who spent less than 4 hours in an A&E department [2]	Apr21 - Mar22	72.94%	95%

1. North West Ambulance Service (NWAS)
2. East Lancashire Hospital NHS Trust

Working with the wider Integrated Care System (ICS - incorporating both NHS and non-NHS organisations) NHS East Lancashire CCG has continued to support the ongoing transformation of urgent and emergency care. Transformational initiatives for the past year include:

- Emergency Department [ED] Streamer – this enables assessment at the front door of the Urgent Treatment Centres (UTC) followed by provision of a clinic appointment where appropriate.
- The continued provision of the local Clinical Assessment Service (CAS) to include paediatric patients.

- Expanding the capacity of the existing Acute Visiting Service (AVS) through the winter period, enabling GPs to refer patients who require urgent primary care to AVS for a home visit or advice consultation from a clinician.
- A comprehensive winter plan, with various initiatives, to support the Pennine Lancashire system (in and out of hospital) to deal with winter and COVID pandemic pressures.
- The commissioning of a Falls Lifting Service across Pennine (and Lancashire) that, working closely in partnership with the North West Ambulance Service (NWAS), has resulted in much improved response times for people who have fallen.
- Supporting the development of direct access pathways for NWAS to enable patients to get the right help and support that they need as quickly as possible.
- Continued partnership working with health system Providers to support the interoperability of Information Technology systems to enable patients to be booked into appropriate services.
- Ongoing development across the system of an urgent community response for patients.

Services to support patients after leaving hospital or to help avoid them attending acute services in the first place have also been attended to, developments in this 'Intermediate Tier' include:

- Development of 2 Hour Urgent Community Response service, where work has progressed to provide a Pennine Delivery Model which has been mobilised over the last 12 months to meet a national deadline of April 2022
- Partnered working with Primary Care, Community Services, Intermediate Tier Delivery Board and Care Sector boards on a 'Frailty Future State' service
- Navigation and support for Care Home choice - Transition into Care Allocation Service Team (CAST) during 2021-22
- The development of an Intermediate Tier dashboard which with further evolution will help shape future work
- Implementation of a comprehensive winter plan with various initiatives to support the Pennine Lancashire system (out of hospital) to deal with winter and COVID pressures
- Support for quicker hospital discharges with initiatives to increase the number of Home First appointments and a dedicated Home First transport service
- Optimising the 'Discharge to Assess' pathway, following the implementation of the National Discharge Policy in August 2020.

Figures published in March 2022 highlight that the North West Ambulance Service (NWAS) (which covers East Lancashire CCG) has seen underperformance across the ambulance service response time indicators with ambulances taking longer to reach patients than the expected standards. NWAS has reported more Category 1 incidents (where an immediate response to a life-threatening condition is required, e.g. a cardiac or respiratory arrest) during April 2021 to March 2022 compared to the equivalent period last year and the pre-COVID April 2019 to January 2020 period.

Just under half of all incidents (48%) were managed by NWAS without the need to transport the patient to A&E.

Planned Care

A consequence of the COVID-19 pandemic and its impact on both services and patient behaviour mean that nationally planned care appointments, diagnostic tests, inpatient surgery, and cancer services are facing significant backlogs and unmet need. Diagnosis at an early stage of a cancer's development for example leads to dramatically improved survival chances, so any delay can be of detriment.

Cancer Services

Across the East Lancashire CCG footprint there is a constant pressure due to capacity and demand with fluctuating monthly performance putting the achievement of Cancer waiting time targets at risk. NHS East Lancashire CCG monitors the waiting times for diagnosis and treatment for suspected cancer so that it can identify any potential problems and look to provide the right services to support patient outcomes.

It is being realised that there is pent up demand in the wider community following the COVID pandemic restrictions which is presenting itself now that patients slowly feel it is safe to access health services. This has created significant backlogs of patients both already in the system and as new referrals waiting to be seen. National performance analysis is showing all cancer targets remain challenged, but activity is now showing significant recovery.

Year to date (March 2022) East Lancashire CCG has shown underperformance against all of the cancer waiting time targets. Cancer 2 week referrals are currently higher than this time last year and generally higher than pre-COVID levels particularly for colorectal, breast and skin tumour sites. The percentage of patients seen within two weeks for an urgent cancer referral is at 88.07% (target 93%), 93.55% of patients have received their first treatment within one month (31 days) of a decision to treat (against a target of 96%) and 67.11% of patients have received treatment for cancer within two months (62 days) of an urgent referral (the target being 85%).

The Pennine Lancashire CCGs' Cancer Team have continued to work with all providers and primary care to ensure improvements to, and the optimisation of treatment pathways, focusing on the most challenged pathways (e.g., those with the highest volumes of patients).

For example, the Cancer Team have been working with Primary Care Networks to promote the three main national cancer screening programmes at every opportunity. In partnership with a national charity Target Ovarian Cancer, the team are piloting a small project to promote best practice for the primary care investigation and diagnosis of ovarian cancer. Ovarian cancer is often detected at a late stage, so the aim of this project is to provide support systems and learning for GPs to see more women in Pennine Lancashire diagnosed at an early stage.

A programme of work will shortly begin in NHS East Lancashire CCG that will invite anyone aged between 55 and 74 years of age, and who has ever smoked for an NHS Lung Health Check. The Targeted Lung Health Check programme is being successfully delivered within NHS Blackburn with Darwen and Blackpool CCG population, and the national programme has now been extended to the NHS East Lancashire CCG population.

All Cancer Alliances have been working to set up at least one Rapid Diagnostic Centre (RDC) Programme for patients with non-specific symptoms which could indicate cancer (as well as for a cohort of patients with site-specific symptoms who are currently served by an underperforming two week wait or 62-day pathway). Non-site-specific RDC and Pancreatic RDC pathways are now well established. In November 2021 the Pancreatic RDC team won a top Macmillan award at the Macmillan Professional Excellence Awards, as recognition of their outstanding contribution to cancer services. Lower Gastrointestinal pathway and Upper Gastrointestinal pathways have now both been implemented, and work has commenced on the Prostate pathway.

'Intelligent Buttons' to support laboratory test requests for each RDC pathway are being developed and implemented. These are unique sets of tests to support specific pathways with clinicians able to request required tests at the referral stage in a single step, saving time and ensuring all required tests are requested and available for effective triage to take place.

Faecal Immunochemical Testing (FIT) is a diagnostic test, run by the National Bowel Cancer Screening Programme but also which acts as a primary care triage tool to identify those low-risk patients that require further investigation via colonoscopy. The FIT test, as part of Lower Gastrointestinal two week wait referral is now well embedded across East Lancashire PCNs.

A fundamental re-design of the outpatient model of care is a key goal of the NHS Long Term Plan in order to improve patient convenience and access to services, helping avoid unnecessary travel to appointments and enable a more efficient use of outpatient clinics. The CCG Cancer Team continues to develop Personalised Stratified Follow-up (PSFU) pathways of care to deliver on this strategic goal. Breast, Colorectal and Prostate cancer PSFU pathways are all in place. This means that some patients will no longer have to attend face-to-face follow-up clinical appointments and have moved to a follow-up pathway that minimises the number of hospital visits. However, this still ensures that patients can get rapid access to clinical support when required. An element of the Gynaecology pathway will be the next specialism to introduce PSFU, patients with a diagnosis of endometrial cancer. Cervical and ovarian cancer are the next groups to be considered for PSFU.

Diagnostics

Diagnostic and surgical capacity is reduced overall due to COVID-19 Infection Prevention and Control measures and the downtime required between patient appointments and procedures. Several diagnostic tests have a high proportion of longer waiters which have built up over the course of the COVID-19 pandemic. The table below shows that average activity per month in 2021/22 is currently greater than

pre-COVID-19 levels. However, the CCG is underperforming in respect of the percentage of patients waiting six weeks or more for a diagnostic test: Across 2021-22, 20.85% of patients waited over six weeks for a diagnostic test (compared to 26.8% last year and 1.9% in 2019/20). The target being 1%.

Table (**) monthly average diagnostic activity count

EL CCG Diagnostic Activity Type	Average Monthly Average Activity Count		
	2019/20	**2020/21**	**2021/22**
Imaging	9,150	7,466	9,422
Endoscopy	1,261	966	1,411
Physiological measurement	1,414	850	1,369
TOTAL	**11,825**	**9,282**	**12,202**

Elective Care

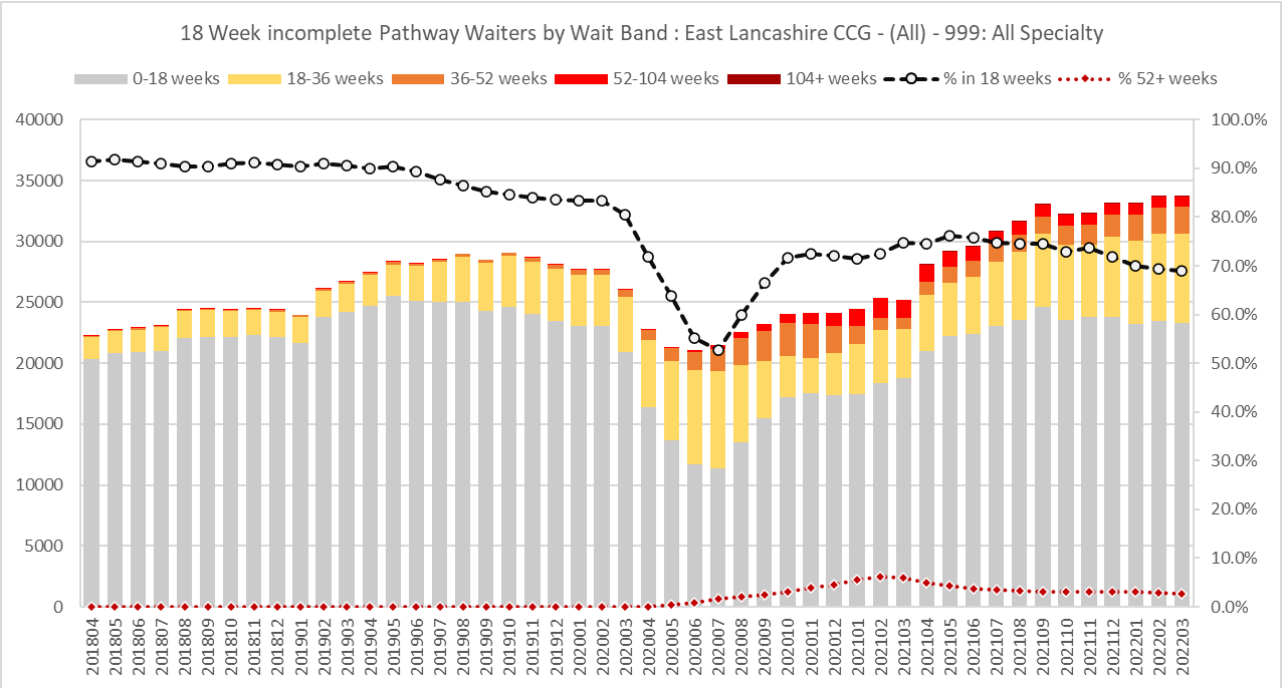
The consequence of restrictions, supporting the safety of the population during the COVID-19 pandemic, has been seen greatly within elective care. The impact on both services and patient behaviour mean that planned care appointments, diagnostic tests and inpatient surgery are facing significant backlogs and unmet need. Many medical conditions during this time will have unfortunately grown worse due to delays in treatment and care and there are likely to be patients who will present with a higher acuity.

A total of 64,211 GP referrals were made from EL CCG GPs into acute providers (during the period April 2021 to March 2022). This was an increase of 30.6%, when compared to the same period in the previous year (with 49,165 referrals in 2020/21), but remains lower than the same period pre-COVID in 2019/20 at 74,754.

After a sudden decrease in numbers at the beginning of the pandemic hospital waiting list sizes have been growing again from June 2020. Following national trends, the CCG is seeing increased numbers of longer waiting patients and is underperforming against the target (for patients to have achieved treatment in their pathway within 18 weeks following a referral varies by specialty).

As at the end of March 2022, 69.0% of East Lancashire CCG patients (23,285 from a total of 33,758) were on an incomplete pathway waiting for treatment within the target 18-week period. The percentage of patients waiting more than 52 weeks had dropped to 2.7% [895 patients] (with 0.2% waiting more than 104 weeks: 60 patients). The chart (**) below shows waiters, by wait band on a monthly basis, highlighting the increase in total waiters in 2021/22, the increased number of longer waiters compared to previous years and the underperformance against the ’18-week target’.

Chart *: 18-week Incomplete Pathway Waiters by Wait Band (All) - NHS East Lancs CCG



Source: NHS England : Statistics » Consultant-led Referral to Treatment Waiting Times (england.nhs.uk)

The overall position for patients waiting more than 52 weeks for treatment within Pennine Lancashire CCGs is slowly improving with numbers beginning to show a decrease following a strong focus on elective recovery by the Integrated Care Board (ICB) and affiliated organisations.

All hospital specialties have identified schemes to support outpatient redesign, looking to use staff skills more effectively and to move to digital technologies and patient initiated follow ups. East Lancashire Hospital Trust are ahead of their planned [Phase 3 restoration] trajectory for elective admissions and first outpatients, but down marginally on outpatient follow ups. An Outpatient Transformation Programme has been set up to look to embed best practice and digital solutions where appropriate (e.g., work in the Dermatology pathway has been implemented).

The CCG has supported the work of the local Elective Care Recovery Group and the establishment of contracts with the Independent Sector to deliver more capacity for the wider region Integrated Care System (ICS). A piece of work to undertake a transfer of patients from ELHT to BMI Beardwood to utilise IS capacity has been agreed and is being overseen by the Lancashire & South Cumbria IS Coordination Group. Further discussions are taking place with Independent Sector Providers and NHS Acute Providers to identify areas where collaboration on service delivery can provide better outcomes for our patients and support reduction waiting lists.

Healthcare Associated Infections (HCAI)

The CCG also monitors its providers, and is assessed upon, the rates of healthcare associated infections for MRSA (Methicillin-resistant *Staphylococcus aureus*), *Clostridium difficile* (C. dif) and *Escherichia coli* (E. coli) both in hospital and in community health settings.
The national target for patients with MRSA bacteraemia is zero; ELCCG has not been able to achieve this target in 20/21 with 3 recorded instances during the year. The CCG also strives to minimise patients acquiring C. diff; there have been 79 cases in East Lancashire. However, the CCG has worked hard to ensure that all organisations across Pennine Lancashire work together to share best practice, learn from their experiences and prevent and control such infections in future.

The national target for a reduction in Gram Negative Bacteraemia (including E. coli, *Pseudomonas* and *Klebsiella*) aims to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

Providers continue to report and review the nosocomial COVID-19 outbreaks that have occurred within the acute trusts. There have been a total of 33 nosocomial COVID-19 outbreaks within East Lancashire Hospital Trust involving staff and patients from both Pennine Lancashire CCGs. A nosocomial outbreak is defined as one where two or more staff or patients test positive and are linked by either time or place. Other outbreaks that have been managed include *Escherichia coli* (E. coli), *Klebsiella*, *Escherichia coloacae*.

Actions to control and prevent Healthcare Associated infections and outbreaks include screening admitted patients for MRSA and COVID-19. Targeted screening of other organisms is also carried out in the case of outbreak management. Weekly IPC (Infection Prevention and Control) audits are in place to look at hand hygiene, PPE (personal protective equipment) compliance, social distancing and the environment and there is also an increased and robust cleaning regime in place. Patients are continuing to be advised to wear masks when mobilising, on transfers to another department and when having direct clinical care with staff. Patients are also encouraged to inform members of staff when they have been to the bathroom to ensure cleaning is taking place promptly. Extra alcohol gel dispensers have also placed in lifts, strategically placed alcohol gel stations and the entrances to the hospital sites. Ventilation is also assessed and areas with inadequate ventilation are not used, windows and doors are opened where possible.

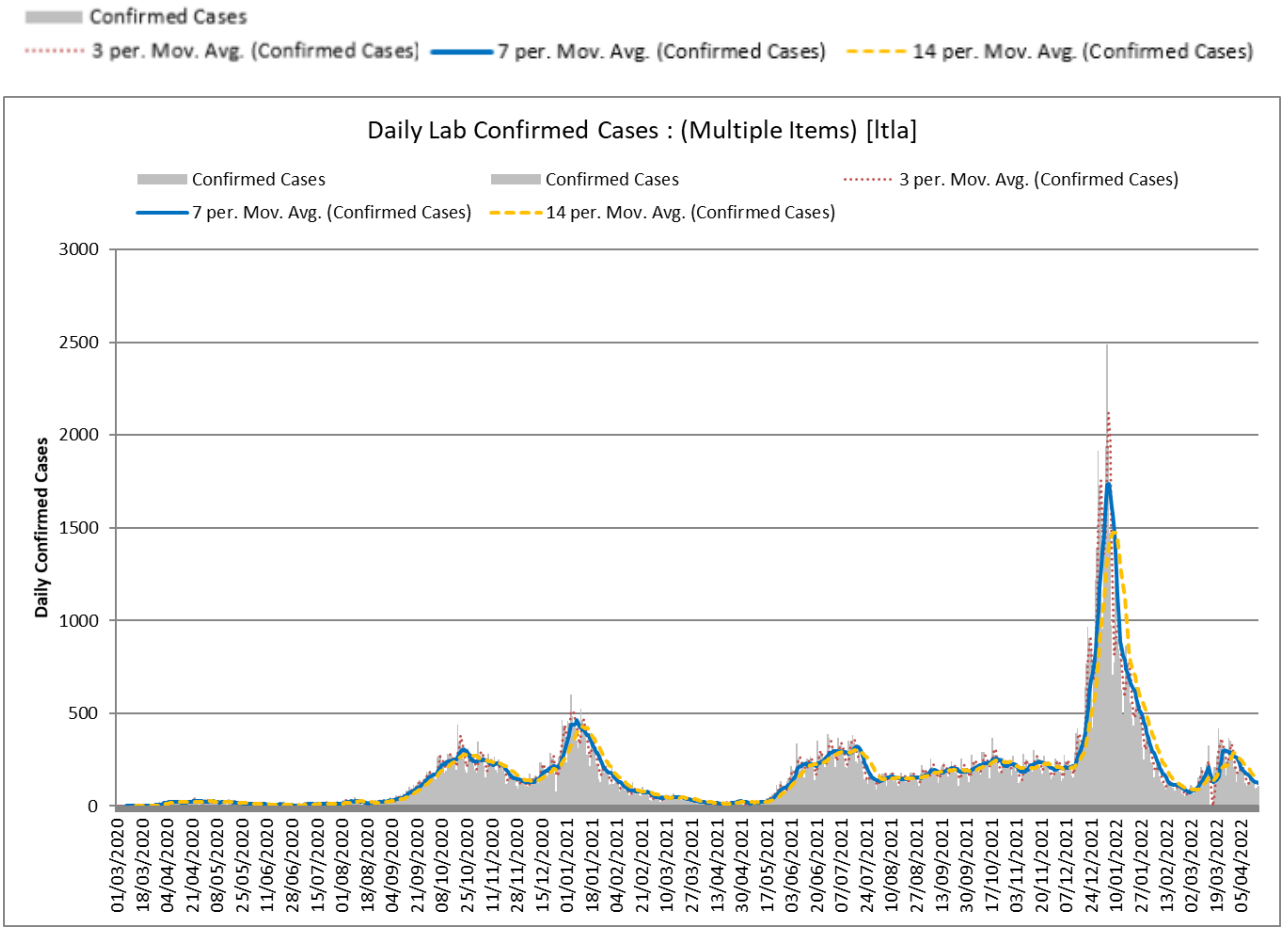
COVID-19 Reporting

To support decision making and monitoring of the ongoing COVID-19 pandemic across the CCG's population, national and local data has been collated, analysed and reported. The following trend chart (**) shows the daily laboratory-confirmed cases for the CCG.

All of the East Lancashire districts (Burnley, Hyndburn, Pendle, Ribble Valley, and Rossendale) have for significant periods reported greater positive case rates than the National or Northwest average during the course of the pandemic. The arrival of the Omicron variant of the SARS-CoV-2 [COVID-19] virus in December in particular tripled case rates, compared to the peak incidence in 2020/21. This recent spike

of cases can be seen in the chart below, that shows a rolling 7-day and 14-day trend across all East Lancashire areas. In line with national reporting confirmed Omicron COVID-19 cases have decreased significantly through February.

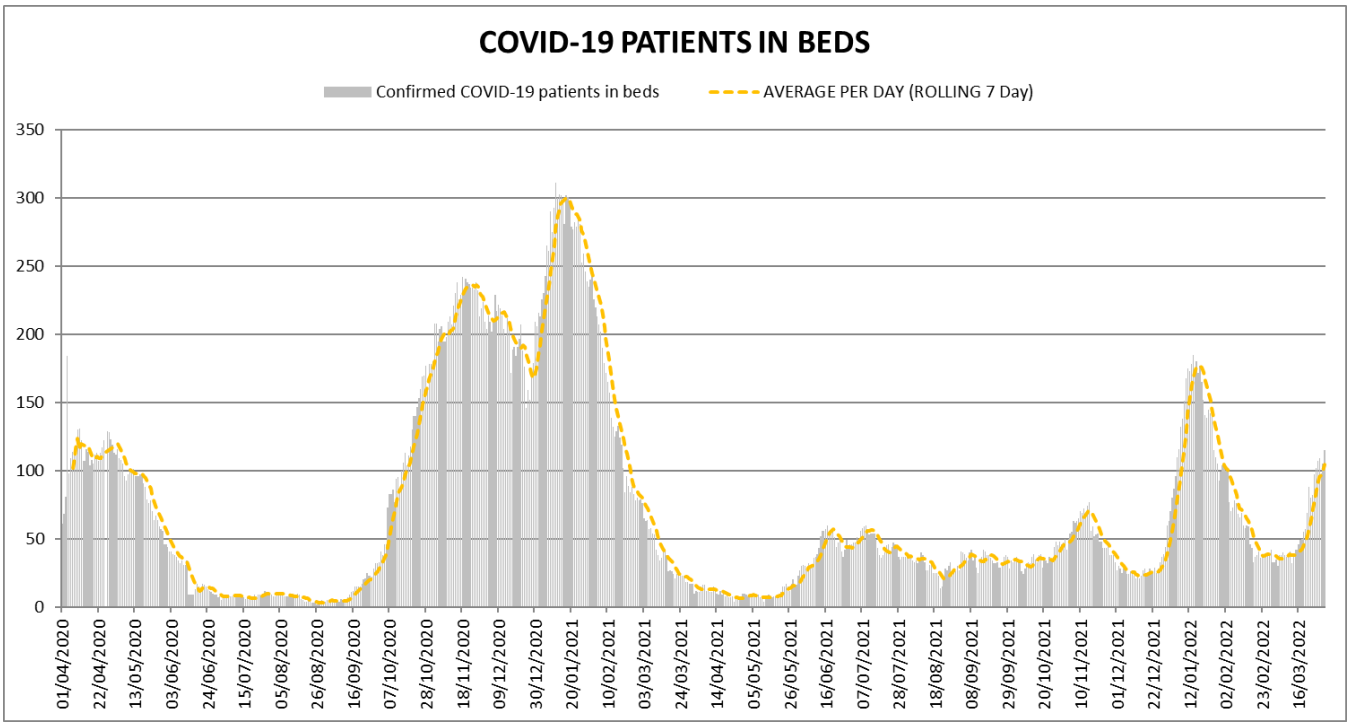
Chart *: Daily Laboratory Confirmed Cases (NHS East Lancashire CCG districts)



Source: National Dataset https://coronavirus.data.gov.uk/

COVID-19 related hospital activity has fluctuated at East Lancashire Hospital NHS Trust along with the pandemic waves since the start of the outbreak in the Spring of 2020. As shown in Chart ** below, in this last year there have been small peaks in the numbers of the beds occupied with COVID-19 patients around June and November 2021, then again significantly in January 2022 with the arrival of the highly transmissible Omicron variant.

Chart *: Admitted patients recorded with COVID-19 at East Lancashire Hospital Trust.



Source: National Dataset https://coronavirus.data.gov.uk/

In the last year, the CCG has been at the forefront of supporting its population in respect of the COVID-19 pandemic response, with regularly updated Pennine Lancashire community guidelines on the assessment and management of COVID-19, leading on the implementation of the vaccination programme and the continuing offer of the COVID-19 Management Service. In particular, the CCG, along with East Lancashire Hospitals NHS Trust and Lancashire and South Cumbria NHS Foundation Trust was an early implementor of a COVID-19 'virtual ward' (or 'pulse oximetry at home') programme.

The COVID-19 Virtual Ward (CVW) was set up in response to the significant challenges and impact that the pandemic had on local residents Doctors and Nurses were able to monitor the symptoms of COVID positive patients considered to be at risk of worsening illness and hospital admission, to safely managed them at home through remote online and telephone support and monitoring.

The CVW has been so successful that the partnership of care professionals from East Lancashire Hospitals NHS Trust, Lancashire and South Cumbria NHS Foundation Trust, East Lancashire Medical Services, and GP practices in the Blackburn with Darwen and East Lancashire areas, along with the Pennine Lancashire Clinical Commissioning Groups, and Council for Voluntary Services was shortlisted and won the HSJ award for *Best Use of Integrated Care and Partnership Working in Patient Safety Award* in September 2021.

The service has continued into 2021/22 and by 10 April 2022, 3,490 patients had been referred to the CVW (with over 3,452 discharges). The referrals include step down patients from East Lancashire Hospitals NHS Trust (ELHT) to support an early, safe discharge from the hospital setting.

The most significant response to the pandemic was the implementation of the national COVID-19 vaccination programme. The NHS has been at the forefront of organising the infrastructure, the clinical and non-clinical governance, and the operational implementation of the vaccination programme (over a short period of time).

Coronavirus Vaccinations		Actual	Target
Percentage of population having received a first vaccination for Coronavirus	As at 19/04/22	80.7%	*
Percentage of population having received a second vaccination for Coronavirus	As at 19/04/22	75.7%	*
Percentage of population having received a third or booster vaccination for Coronavirus	As at 19/04/22	54.7%	*

* No identified target

Significant engagement from Primary Care and CCG representatives within the local voluntary, community, faith and social enterprise (VCFSE) sector has supported the vaccination roll out into a wide diversity of population groups.

From 8 December 2020 to the present reporting time (19 April 2022), 273,466 first vaccine doses were provided to the NHS East Lancashire CCG population (80.7% of that population, aged 12 years and more); while 75.7% (256,552) of the CCG's population (over 12 years) were recorded as having received the second vaccine dose. Introduced later in 2021 the booster vaccination programme has provided 185,475 people in the CCG population with the third vaccine (54.7%).

COVID-19 Expenditure 2021/2022

Spend associated with the continued COVID-19 pandemic during 2021/22 is provided in the table below. Where additional funding over and above the CCG core allocation for the financial year has been provided, this is also indicated in the table.

Expenditure Classification	Source of Funding	Total Expenditure £
Hospital Discharge Programme	Allocation	700
Community Services		34
Mental Health Services		32

COVID Virtual Ward & post COVID syndrome service	Allocation	1,120
Primary Care – co commissioning		193
Other		36
Total		**2,115**

Mental Health Care

Mental Health services have continued to respond to system pressures and high demand alongside all NHS providers throughout 2021/22. The impact of the COVID-pandemic remains however, and the CCG has been instrumental in supporting Mental Health services retain access to all elements of care from the helpline to liaison in the emergency departments and to crisis support.

Community provision has been stretched throughout the year, despite a continued increase, and also flexibility to staff working patterns, access to in-patient provision remains a challenge with the continuing use of out of area beds and a limited ability to repatriate patients.

There were 1,510 inappropriate 'Out-of-Area Placement' bed days for adults (requiring non-specialist acute mental health inpatient care) attributed to NHS EL CCG during February 2022. OAP bed days have been higher during the second half of 2021-22 than in any of the previous 30 months.

There have been some key developments this year and locally Pennine Lancashire have been at the forefront of these. Such work is already reaping positive experience for patients and wider partners involved in supporting those experiencing mental health issues. The input and support from the voluntary sector (VCSFE) have increased at all stages of service development and delivery. They are key partners and a 'VCSFE framework' has enable an increased ability for this sector to deliver elements of mental health provision both locally and across the wider footprint.

Overall programmes of work being undertaken include the:

- increase of inpatient provision across Lancashire and South Cumbria (L&SC) with more beds available in Pennine Lancashire (at Whalley with an additional 24 beds and 6 PICU beds). ·
- Instant Response Service (IRS) which has been in progress for two years. A 'soft launch' for Pennine Lancashire went live in January 2022. The feedback from GPs; patients and partners were positive, and the data shows early positive outcomes.
- commencement in February 2022 of a Hyndburn practices/PCN pilot to introduce advice & guidance for GPs to allow access directly to a consultant psychiatrist. The intention is to roll this out across Pennine Lancashire in 2022/23.
- use of 'street triage', which was launched in Pennine Lancashire to focus on those patients in acute crisis particular where the police are usually involved. This service is a collaboration between nursing staff (at LSCFT) and the Lancashire Constabulary, working together to avert

the requirement for and reduce the need to utilise section 136 of the Mental Act helping ensure people are in a place of safety. Such circumstances traditionally led members of the public to the local Emergency Department, but early indicators suggest that such crises are being managed and deescalated more quickly.

- Primary Care elements of Mental Health being developed further with the TaPPs (Trainee Associate Psychological Practitioners) and ARRS (Additional Roles Reimbursement Scheme) roles. The Community MH Transformation Programme, which is a national expectation, and which has allocated resource for the implementation. It is anticipated this will align to neighbourhoods and hubs for a more cohesive local service offer for the populations of Pennine Lancashire.

From January to March 2021 targeted communications (at a L&SC and local provider level) promoted Improving Access to Psychological Therapies (IAPT) to small and medium [business] enterprises, larger employers, Local Authorities, the NHS workforce, and the public.

During the COVID-19 pandemic, the IAPT service offer has changed, with additional flexibility offered through online media: ‘Attend Anywhere’ web-based platforms has increased group activity. Demand for virtual appointments has remained high even as the COVID-19 restrictions have recently started to wane.

All provider IAPT webpages and self-referral forms have been reviewed, to ensure content is streamlined. Additionally, the ICB IAPT webpage has been improved, and used to support the roll-out of a national Help Campaign in January 2022.

Data from April 21 - Feb 22 showed that IAPT wait times were above target. The proportion of people waiting 6 weeks or less from referral to entering a course of IAPT treatment was 94.54% (against a target of 75%), and the proportion waiting 18 weeks was 99.71% (against a target of 95.0%).

The target of 50% for the (Improving Access to Psychological Therapies) IAPT Recovery Rate was being achieved for NHS East Lancs CCG patients as at the end of February 2022 with 57.0% of people who finished treatment after initially assessed as 'at caseness', (and attending at least two treatment contacts, coded as discharged, and who are assessed as moving to recovery). This is an improvement from 2020/21 where the percentage was below target at the end of the year, 46.3%.

Across Pennine Lancashire the CCGs are working together to update the EMIS system referral process into IAPT Services. As this service is primarily self-referral, there are some service users that will not undertake this action due to their current circumstances; therefore, this template can be completed by a Care Navigator or Social Prescribing colleagues in the community. This activity will be analysed by the CCGs’ Data Quality Team, so that trends can be reviewed and acted upon. etc. The plan is to implement this work across the ICB.

In addition to the new models described above, IAPT services for people with common mental health problems such as depression and anxiety will continue to be expanded. The providers of these services will be supported to integrate therapists within PCN's and alongside the neighbourhood care teams, to provide psychological therapy for people with long term conditions together with physical health interventions. There is a low access rate across the Lancashire and South Cumbria (which aligns with the national picture). Regular system meetings are in place with all Providers to address this with appropriate action plans.

In December 2021, following a successful bid to NHS England and NHS Digital, additional funding was secured to support the development of a digital platform that supports patient triage and/or access to Lancashire and South Cumbria NHS Foundation Trust (LCSFT). The bid has three strands, which will include a digital communications and social media campaign, which is currently (February 2022) in preparation for a launch in March 2022.

Haydock Medical Services were commissioned in 2021/22 as a new provider to support Children and Young People with ADHD (Attention-Deficit / Hyperactivity Disorder). The company inherited long patients waits from previously commissioned providers, so additional investment has been allocated in year and the system views this as a continuing priority into 2022/23.

Finally, there are Primary Care Network (PCN) 'Learning Sessions' planned between GPs and Primary Care staff and LSCFT Consultants and management leads to ensure all developments are clearly understood and also to keep abreast of clinical developments and support for primary care and patient management.

The work that has taken place throughout the pandemic means that Mental Health provision is less focused upon 'restoration' (as is the case in other clinically related disciplines), and more upon the 'recovery' of services. This is particularly true in managing the demand and surge in demand post-COVID-19. The full future impact of Post-COVID Syndrome ('long-COVID') amongst the population is unquantifiable at the moment (both for patients and for staff who have experienced the front-line health provision). LSCFT and commissioners are working together to plan resources as part of the priorities setting process to improve system working still further and allocate resources across the system to be focused on areas of greatest need, alongside national expectations.

Children and Young People

Expansion of the Mental Health Support Teams in Schools (MHSTs) has continued throughout 2021/22. Full coverage has been achieved in the following areas: Pennine Lancashire Pupil Referral Units and Special Schools, Burnley and Pendle primary schools and Hyndburn, Ribblesdale, and Rossendale secondary schools. Looking forward, 2023 will see the expansion of the MHSTs in Burnley and Pendle secondary schools and plans are being developed for expansion across primary schools in Hyndburn, Ribblesdale, and Rossendale. This would provide 100% coverage across all school settings.

Year One Transformation plans as part of the redesign have focussed on the implementation of risk support which includes a new responsive and intensive support team and an enhanced response team for self-harm and self-injury.

Access to Child and Adolescent Mental Health Services (CAMHS) continues to increase with a 37% increase in referrals to date for 2021/22 across Pennine Lancashire. East Lancashire is 38% above plan for the access target (of 35%).

Plans for 2022/23 include the implementation of an all-age single point of access increase in primary mental health workers, ensuring that every Primary Care Network has a link worker and expansion of the mental health support teams in schools.

As this last year progressed through the COVID-19 pandemic response and changes to restrictions, there was much anticipation of a significant increase in Respiratory Syncytial Virus (RSV) and other respiratory illnesses that mainly affect infants and small children. In preparation for such an outbreak the Pennine Children Families and Maternity Team have worked directly with GPs, Paediatricians, and the North West Ambulance Service (NWAS) colleagues to develop a clinical pathway for the assessment, treatment and care of acutely unwell children who typically present with a range of respiratory conditions (either in primary care or at hospital). Use of the pathway ensures that the child or young person will be treated in the right place by the right person as early as possible and is designed to ease pressures in a system which for many weeks was running at critical levels.

The pathway developed by the Pennine Paediatric Clinical Reference Group has also led to the development and implementation of an NWAS Paediatric Same Day Emergency Care (SDEC) pathway. This pathway allows NWAS to take eligible children directly to the Children's Observation and Assessment Unit (COAU) at Royal Blackburn Hospital, avoiding long handovers and waiting times in ED. Both pathways have since been requested for adaptation by CCGs across Lancashire and South Cumbria and ambulance services across the country.

An Individual Patient Activity pilot is launching across Lancashire and South Cumbria in March 2022 to jointly identify needs and agree support for children and young people with complex physical, emotional health and disabilities. The new way of working will improve the consistency of approach and governance across all areas, focusing on meeting the needs of children and young people, better outcomes, improving their lived experience and streamlining processes overall.

The Lancashire Local Area Special Educational Needs and/or Disabilities (SEND) revisit by Ofsted and the CQC (Care Quality Commission) in 2020 identified outstanding areas for improvement which have been taken forward through an accelerated progress plan over the last 18 months. In September 2021, evidence of progress was reviewed by inspection monitors who determined that sufficient progress had been made and monitoring was to be stepped down. In November 2021, Blackburn with Darwen local

area tested the new SEND Inspection Framework methodology, providing valuable feedback to the CQC and Ofsted about how the inspections may run in the future.

A recent assessment pilot for the autism spectrum disorder (ASD) service reduced waiting times for children and young people aged between 11 to 16 years from 18 months to an average of seven weeks (from triage to assessment). Building on this success, a sustainable, improved ASD pathway for children and young people aged 0-18 years is being developed as part of a three-year phased approach.

Work to improve the timeliness and quality of initial health assessments for looked-after children, has seen excellent results, with 100% of assessments offered within 20 days of referral in January 2022. East Lancashire Hospitals Trust's Community Paediatrics team have developed a nurse-led model and held capacity clinics to offer appointments to children at the earliest opportunity. Quality assurance monitoring is undertaken for all assessments, developed in conjunction with the CCG's Safeguarding Team, who also support by escalating delayed referrals from Local Authorities. Other Integrated Care Partnership areas have also commissioned East Lancashire Hospital Trust to deliver their assessments, owing to the reputation that has been developed.

A new [Parsek] digital solution is about to go live, starting in Rossendale, that will deliver a Clinical Coordinator-led virtual MDT (Multi-Disciplinary Team) service, alongside imaging and assessment videos. It will allow the MDT to have secure digital access to clinical reports, imagery, diagnostic assessments, both inpatient and outpatient notes and any other information from secondary and primary care services prior to the meeting. This will save time and avoid multiple visits by care professionals. This project is funded by the Lancashire & South Cumbria Integrated Care Board.

Learning Disability

The percentage number of annual health checks delivered by General Practitioners in East Lancashire CCG for persons on the GP Learning Disability Register aged 14 years or more was 62.0% at the end of quarter four in 2021/22 (well below the 70% target and the national value of 71.3%). 55.4% of patients on the LD register were recorded as having a completed health action plan which is below the national average of 61.5%.

Learning Disabilities is a key priority cohort for the CCG in the 2022-23 Neighbourhood Accelerator Programme. This Pennine Lancashire wide programme aims to initiate a health check (if not completed already) and to develop a clinically led care plan delivered by a Multi-disciplinary Team partnership with community and voluntary sector teams working to address personal and neighbourhood level inequalities which actively promotes prevention and better outcomes.

Safeguarding

There has been significant support provided to the COVID-19 pandemic response by the CCG Safeguarding Team. This has included supporting the system response to care homes and regulated

care, as well as specialist input and support in to various COVID-response workstreams. None-the-less over the last 12 months, the CCG has continued to deliver on its statutory duty to engage and commission services which safeguard our children and adults with care and support needs.
Key themes for note:

- Mandatory training levels have slipped in within the CCG and its Providers due to high levels of operational focus and reduced capacity as a result of the COVID-19 pandemic response. Work is underway to increase compliance.
- The lack of face-to-face contact with children and vulnerable adults during this time due to the COVID-19 pandemic has resulted in a decrease in the number of referrals across both Pennine Lancashire and the wider Integrated Care System (ICS). This performance aligns with a similar national trend and the safeguarding system in Pennine Lancashire is in preparation for the likely longer-term impact of this.
- The number of Safeguarding Adult Reviews and Child Safeguarding Practice Reviews across the CCG and the Pennine system as a whole, has increased. Work is underway to ensure learning from such reviews is more formally communicated and embedded into service redesign and commissioning decisions.
- The ongoing journey to working as an ICS has progressed significantly, including formal executive leadership and governance arrangements.
- The provision of assurance has been streamlined and more focussed on Key Lines of Enquiry (KLOE) in recognition of the challenges facing NHS Providers and Primary Care services.
- Looked After Children have been disproportionately impacted by the COVID-19 pandemic and access to health services, in particular mental health, and dental services, has been a significant challenge. This remains a key priority going forward.
- New legislation under the guise of the Domestic Abuse Act and the Mental Capacity Amendment Act both put new expectations on the CCG which have been incorporated into its working model arrangements.

The CCG has a continued responsibility and statutory duty to be active members of the local safeguarding arrangements. The safeguarding of children is delivered through a Pan-Lancashire approach, via the Children's Safeguarding Assurance Partnership (CSAP). The CSAP is attended, and now chaired, by Margaret Williams as the ICS Chief Nurse for Safeguarding, but there are also local 'Place Based' working sub-group in Pennine Lancashire known as the Tactical Group which the CCG is a member of. For adults there remains two Safeguarding Adult Boards on Local Authority footprints for Pennine Lancashire, both of which are attended and supported by CCG representatives.

The Health System across the ICS footprint operate a Safeguarding Health Executive meeting (SHE) which covers an 'all age' safeguarding agenda and is broad enough in scope to cover Acute and Mental Health Providers, CCG, and Public Health services. This is the vehicle for key decision making at a system level and where key partnership challenges to the health system can come for debate.

The COVID-19 outbreak and response has had a significant impact on safeguarding and more detail around this is available in the CCG Safeguarding Annual Report. This is both in terms of access to and the opportunity to assess safeguarding concerns during the pandemic, as well as the practical challenges as to how services have been able to operate during this time.

There is believed to be increased ‘hidden harm’ - abuse which may have increased due to the restrictions on individuals and families as well as abuse that may not have been identified by services due to that lack of face-to-face contact. There is also recognition that challenges such as an individuals’ mental health, sense of isolation, self-neglect and general well-being will all have been increased by the restrictions and the CCG must ensure the journey of recovery by the NHS takes this into account to enable the continued safeguarding of the population.

Performance Overview Summary

The purpose of this performance overview and review is to give the reader, a short summary that provides them with sufficient information to understand NHS East Lancashire: who we are and what we do as well as our objectives, the key risks to the achievement of our objectives and how we have performed in key and important areas of the business during the year.

About East Lancashire Clinical Commissioning Group (CCG)

The CCG was established without conditions by NHS England in 2013. We are responsible for planning, buying and monitoring the quality of hospital and community health services to meet the needs of patients in the five boroughs of East Lancashire – Burnley, Hyndburn, Pendle, Ribble Valley and Rossendale. The process of planning and buying health services is known as 'commissioning'. CCGs are led by GPs, who are clinicians, which is why it is called 'clinical commissioning'.
We serve a population of over 377,900 people, with urban areas such as Burnley, Nelson and Accrington, alongside market towns such as Clitheroe, villages and rural areas. We have 48 GP practices. In 2021/22 we received £735 million from the government in order to commission healthcare for local people. We are responsible for ensuring that the money is spent carefully and wisely, providing efficient and effective local services.

East Lancashire has a complex demographic picture. We have an ageing population, with the number of people over 75 years old increasing. Older people often have complex and long-term health problems, such as chronic illnesses, and more than one condition, which we call comorbidities. We also have a higher than average number of children and young people, meaning we also need to take their needs into account when commissioning services. Our population is predominantly white British, but there are a significant number of people of South Asian origin as well, making up approximately 11 per cent of the registered population. This group is younger than the white British group, particularly in Burnley. They also experience a relatively high risk of certain common diseases, such as cardiovascular disease and diabetes. A significant number of people from Eastern Europe also live in East Lancashire. We are home also to a notable Gypsy, Romany and Traveller (GRT) population, as well as Syrian refugees. Residents in four of our five boroughs (Burnley, Hyndburn, Pendle and Rossendale) experience notably high levels of deprivation and childhood poverty. Life expectancy and measures of the quality of people's lives and health are lower than elsewhere in the North West of England, and lower than the national average.

Smoking, alcohol and drug misuse, poor diet and lack of exercise contribute to the ill health of residents and this in turn creates extra pressure on NHS services. We believe that because of this complex demography, it is important to understand the circumstances of people's lives, recognise the importance of community and community assets, and engage and involve patients and residents. In doing this, we can ensure that we truly improve services, and the health and wellbeing of individuals.

Location, structure and commissioning activity of the CCG

Due to the COVID-19 pandemic, a level 4 national incident was declared on the 30 January 2020, resulting in NHS England introducing temporary measures in late March 2020 that impacted on our usual business model and the usual ways of working that we typically adopt in any given year. As a result of this, CCGs have had to adapt their normal practices, procedures and approaches to commissioning to accommodate the temporary measures brought about by being in a level 4 national incident.

Key to this was that much of our normal business operating model, and the external environment in which we operated shifted to a pandemic incident response which was managed across Lancashire and South Cumbria by the Integrated Care System (ICS) - Healthier Lancashire and South Cumbria. This is a partnership of all CCGs, health service providers and partners, such as local government. This enabled the entire health and care system across Lancashire and South Cumbria to respond to the COVID-19 pandemic in a coordinated, responsive and effective manner.

Much of the coordination was situated with the Lancashire Resilience Forum (LRF) and the Gold Command incident management system established by the ICS with NHS England. The CCG was an integral part of this and managed an incident room in Pennine Lancashire (based at the Blackburn with Darwen CCG Headquarters at Fusion House) throughout the duration of 2020/21. This enabled us to manage and support the health and care system response to the COVID-19 pandemic locally. This incident management model enabled us to ensure that our residents, patients, and our health service providers in primary, secondary and the regulated care sector were supported in their frontline response to COVID-19 in a consistent, coherent and responsive way. This included supporting and coordinating the local supply of personal protective equipment (PPE) for frontline staff, deployed CCG staff to support services in their response, and ensuring that services were adequately supported to deliver care to those suffering from COVID-19, as well as, where possible respond to the urgent health needs of the population. This also included supporting the delivery of online solutions for digital health care as the need for this arose, particularly for primary and secondary care consultations.

A major aspect of our response to the pandemic was to ensure that along with our partners in Pennine Lancashire we communicated clearly and consistently with our population about COVID-19, necessary prevention measures, COVID-19 testing arrangements, changes to the way services were delivered, and more recently, the roll out of the COVID-19 vaccination campaign. We sought, with our partners to issue clear, regular and consistent communication that was engaging and supportive. Finally, from January 2021 to the present time of writing, we worked with our Primary Care Networks and with each of our local authorities and partners to support the delivery of the vaccination campaign, as well as with the ICS in the delivery of the mass vaccination programme. The success of the vaccination programme has been a major milestone on the road to restoration and recovery of services.

Governing Body Membership

The composition of the Governing Body is provided in the Members Report.

Description of CCG's strategy

Our strategy is summed up by our mission statement: "We will use our local clinical expertise, the available evidence and patient experiences to ensure that the right services are commissioned for patients to be seen at the right time, in the right place, by the right professional. We will maintain a strong locality focus, with clinical expertise, patient experience and safety at the heart of all decision-making. We will harness efficiency and effectiveness in our work across our localities and we will seek to commission safe, stable, high quality services where best practice is the standard."

Priorities

The CCGs priorities throughout 2021/22 have been set in accordance with the NHS's response to the COVID-19 pandemic. This began on 30 January 2020, with the first phase of the NHS's preparation and response to COVID-19 triggered by the declaration of a level 4 national incident. In April 2020, organisations received a series of actions to support phase 2 of the response and then in July 2020, organisation moved into phase 3, with the priority for CCGs to continue operating in support of the ICS-system-wide response to accelerating the return and restoration of non-COVID health services and making full use of available capacity as we prepared for winter and responding to a second wave of COVID-19.

Throughout this year more than ever, the health, safety and physical health and wellbeing of our workforce has been a key priority. The NHS People Plan for 2020/21 was published and subsequently we have developed our local people plan in response to this.

Our principles

A core set of principles has been adopted to support our approach to clinical commissioning and transformation, and to underpin our organisational culture and the effectiveness of our decision making. These are:

- Patients are central to everything we do.
- The services we commission must be sustainable.
- We work in partnership to support the achievement of common goals.
- Patients experience truly integrated health and social care services.
- We commission high quality, safe and effective care. We will work with people and communities to help them to live happier and healthier lives.

How we contributed to sustainable development - improving environmental and social sustainability

The CCG has an obligation as a public sector organisation to work in a way that has a positive effect on the communities for which we commission healthcare services. Sustainability means spending public money well, using natural resources efficiently and building healthy, resilient communities.

In October 2020, the NHS committed to delivering a net zero national health system. This means improving healthcare while removing harmful carbon emissions and investing in efforts that remove greenhouse gases from the atmosphere.

There are two clear targets outlined in the “Delivering a Net Zero National Health Service” report:

- The NHS Carbon Footprint: for the emissions we control directly, net zero by 2040
- The NHS Carbon Footprint Plus: for the emissions we can influence, net zero by 2045.

The NHS Long Term Plan sets out these extended sustainability commitments which range from reducing single-use plastics and water consumption, through to improving air quality. There are many simple ways we contribute towards this such as:

- Using refillable bottles (glass)
- Turning off equipment and lighting when not in use and controlling temperature
- Locking in the benefits of agile working, such as saving on the number of car journeys
- Using the right bins and reducing the amount of waste sent to landfill
- Harnessing the use of digital technology to reduce unnecessary administrative processes

The CCG is currently developing and implementing its transitional plans for the “Future Ways of Working” which will take into consideration the vital role we play in helping this change take place with initiatives such as those above. During the pandemic and following it, the CCG has adopted an approach to agile working which supports staff to work remotely where they wish and prefer, and as a consequence of this, to reduce the number of car journeys. This shift will have a considerable impact on carbon emissions.

How the CCGs improved quality and safety in healthcare

NHS Blackburn with Darwen and East Lancashire CCGs are committed to working collaboratively with system partners to maintain high quality, safe, effective, compassionate care for the local population, while driving key quality improvements and championing patient experience across the system.

Improving quality

Following the challenges in 2020/21 of adapting quality assurance processes throughout the pandemic, the CCGs have supported local providers throughout 2021/22 in restoring existing reporting mechanisms against national and locally agreed quality contracts, whilst ensuring robust oversight. The CCGs continue to provide scrutiny and challenge of all contractual processes collectively with triangulation of other quality and experience reporting mechanisms such as complaints, compliments, soft intelligence, patient advice and liaison services (PALS), workforce, patient, family and carer surveys, and incidents. Due to our positive working relationships with system colleagues, we regularly attend provider clinical effectiveness meetings, and review effectiveness measures and outcomes, to support service improvements and development.

The CCGs continue to support the system through the pandemic with dedicated Infection Prevention and Control support, delivering widespread PPE support and simplifying access to tests and testing processes. We have worked collaboratively and supported Primary Care to ensure the COVID-19 vaccination programme continues to be effective for our most vulnerable population. Primary Care Quality Forums have been restarted and we are committed to working collaboratively with system partners in reducing variation and improving outcomes.

Hybrid ways of working have also been found to support some areas of assurance which remain impacted by pandemic guidelines with the CCGs accompanying system colleagues on 'virtual' quality visits where face-to-face restrictions remain in place.

Patient Safety

Patient Safety remains a key priority for the CCGs and system partners, who work collaboratively in an open and transparent way, to ensure there is a commitment to continuous quality and safety improvement.

The CCGs have a robust process for all serious incidents which meet the NHS England Serious Incident Framework criteria for reporting onto the Strategic Executive Information System (STEIS). Investigation reports from provider organisations are scrutinised by the CCG Serious Incident Review Group panels to collate themes and trends, whilst ensuring action plans and identified improvements are robust and effective in improving patient safety, care and experience.

We are proud to report that in preparation for the national implementation of the new Patient Safety Incident Response Framework (PSIRF), East Lancashire CCG and East Lancashire Hospitals Trust have worked collaboratively as Early Adopters of the PSIRF, representing the North-West region. The achievements to date are testament to the effective and positive working relationships between the CCG and Trust which will have a positive impact on patient safety and influence quality improvement with demonstrable outcomes. New assurance mechanisms have been implemented which will be continuously reviewed to ensure they remain effective.

The CCGs are dedicated to challenging standards of care and experience that do not meet expectation; we are committed to working with our colleagues in response to the findings from national high-profile cases, such as the most recent Ockenden review to prevent re-occurrence.

To ensure that quality and patient safety remains at the centre of the CCGs governance processes, quality and performance reports are presented for scrutiny at Quality Committee meetings, and then for robust challenge and escalation to the CCG Governing Body meetings.

The Pennine Lancashire Quality Committee (PLQC) has helped to shape the ICB Quality and Performance sub-committee through the production of reports and member attendance. The Chair of the PLQC has routinely attended the sub-committee meetings playing an active role whilst assisting the development of the committee.

How the CCGs have engaged and worked with their communities

As a CCG, we have engaged and worked with communities through the development of campaigns and initiatives. 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 CCG has worked in partnership with other CCGs and health service providers on shared campaigns across Lancashire and South Cumbria. These 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).

During 2021/22 the CCG has worked with partners across East Lancashire area to engage with people and communities to understand their experiences and perceptions of health and health services. This has in the main focused on the experiences of those with COVID-19, perceptions of the COVID-19 vaccination and vaccine hesitancy. In addition, we commissioned work with our VCFSE colleagues to understand the experience of those from more vulnerable communities and from wards where we have identified high use of services. We have undertaken surveys and engagement on access to and understanding of GP services and this has influenced the development of the new extended GP access service which was led by East Lancashire Alliance of Primary Care Networks and launched in March this year.

Our patient and public involvement networks in East Lancashire focused their volunteer work and input into supporting the response to COVID-19, working to support the vaccination hubs run by the Primary Care Networks but also helping to promote COVID aware practices and supporting GP practices in their efforts to promote access to primary care. Our Patient Partners Board, which was chaired historically by the Lay Member for Patient and Public Engagement, was suspended during the pandemic. This role has been undertaken in the interim by the Lay Member for Patient Engagement, and BwD CCG Chair.

Reducing health inequality

The NHS Constitution states that the NHS has a duty to '*…pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population*'. This is reflected in the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), which introduced for the first time, legal duties to reduce health inequalities, with specific duties on CCGs and NHS England.

The Health and Social Care Act 2012 introduced the first legal duties on health inequalities, with specific duties on NHS England and CCGs, as well as duties on the Secretary of State for Health (covering the

Department of Health and executive agencies Annex A) and NHS Improvement. These duties, which took effect from 1 April 2013, were:

- Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T).
- Exercise their functions with a view to securing that health services are provided in an integrated way and are integrated with health-related and social care services, where they consider that this would improve quality, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved (s.14Z1).
- Include in an annual commissioning plan an explanation of how they propose to discharge their duty to have regard to the need to reduce inequalities (s. 14Z11).
- Include in an annual report an assessment of how effectively they discharged their duty to have regard to the need to reduce inequalities (s. 14Z15).

Our Equality, Diversity and Inclusion Strategy 2021-2022 sets out the CCGs' objectives on reducing health inequalities across the Pennine CCGs' area. 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 Pennine CCGs' performance against a range of nationally determined 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 the Pennine CCGs' performance in relation to Goal 3 – a representative and supportive workforce. The CCGs scored '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

The health and wellbeing of our population

Health outcomes for people living in East Lancashire 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. 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.

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.

Across Lancashire and South Cumbria, 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.

Health and wellbeing – Improving outcomes

Dr Julie Higgins, our Accountable Officer recognised that the CCG, and our partners across Lancashire and South Cumbria needed an overarching strategy for population health as residents in East Lancashire experience exceptionally poor health, and considerable health inequalities. Dr Higgins recognised that such a strategy was not only needed but that we needed to have an independent review. Across Lancashire and South Cumbria health and social care leaders supported this view and as a result, Dr Higgins led the formation of a Health Equity Commission (HEC).

The HEC was launched by Professor Sir Michael Marmot in September 2021 and has also been chaired by him. In the Autumn of 2021, each local area submitted evidence to the Health Equity Commission. East Lancashire CCG and our partners in Pennine Lancashire gave a comprehensive presentation and

showed a powerful video to the Commission which highlighted the challenges and action required in Pennine Lancashire. Alongside the evidence from local places, the Commission saw evidence from each Health and Wellbeing Board, as well as undertaking focus groups across the region, focusing on issues such as economic development, leadership, older people, mental health and the needs of children and young people. Following this, the Institute for Health Equity, led by Professor Sir Michael Marmot for the Health Equity Commission, has been analysing the data and will be presenting draft recommendations for the region, including Pennine Lancashire, from April. We anticipate that there will be a summit later in the year where these are shared with the wider community.

Health and wellbeing strategy

The CCG contributes towards the delivery of the Health and Wellbeing Strategy through its involvement in the work of the Lancashire County Council Health and Wellbeing Board (H&WB). The H&WB is run by Lancashire County Council and has a strong focus on health and care needs of the local population. Information about the Board can be found here: Health and Wellbeing Board - Lancashire County Council

For more details of the Health and Wellbeing Strategy can be accessed here: lancashire-health-and-wellbeing-strategy.pdf

Respect for human rights

Our Equality and Inclusion Annual Report demonstrates how we are meeting our commitment to taking equality, diversity and human rights into account in everything that we do. The Equality and Inclusion Annual Report will be published on our website, once finalised, in June 2022. The latest Workforce Race Equality Standard (WRES) report can be accessed here: Workforce Race Equality Standard (WRES) (eastlancsccg.nhs.uk)

The CCG has published its Human Rights Policy here: Human Resources (eastlancsccg.nhs.uk)

Corporate Social Responsibility

As well as commissioning the provision of healthcare services in Blackburn with Darwen we are committed to our wider social responsibilities as a major local, public organisation. Our objective to contribute to our local community is evidenced in our vision to help people and communities to live happier and healthier lives. We do this by working with all organisations and members of each of our communities. Our work in each of our five localities is increasingly undertaken through the Health and Wellbeing Partnerships to ensure that the needs of our communities are met in a fair, sustainable and effective way. In addition, our investment in social prescribing, described elsewhere in this report, represents a significant commitment to corporate social responsibility in a real and tangible way.

We certify that the CCG has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

How we managed health and safety

The CCG fulfils its legal responsibility for health and safety under The Health and Safety and Work etc. Act 1974, and associated regulations by:

- Maintaining an Occupational Health and Safety Management System
- Using the services of the Midlands and Lancashire Commissioning Support Units (MLCSU) Health, Safety and Fire Team to act as the organisations 'competent person' who provide, advice, guidance and assistance in support to the CCG in its operations
- Measuring compliance with health and safety policies and procedures through Health and Safety Support visits and audit

The health and wellbeing of our staff, and our people

The CGG has ensured that all staff and the associated workforce have received a robust wellbeing offer since September 2020. As a starting point we have ensured that we ensured regular two-way opportunities for communication continued throughout the year via staff briefs, staff bulletins, directorate meetings and team meetings. In addition, we created a monthly staff wellbeing bulletin which was well received. Extensive support for agile working complemented this, including guidance, grants for home office equipment, equipment and furniture from the office. We rolled out Office 365 to further enhance remote and digital capabilities. We created online "wobble" rooms and established a process for wellbeing conversations. We also trained and supported staff to become mental wellbeing champions using the evidence based and well regarded, REACT model of supporting mental health conversations.

We established a group of health and wellbeing champions and staff representatives to support, signpost and guide staff, and we created a staff welfare group with wide ranging representation including our Wellbeing Guardian; an executive level role to ensure that staff wellbeing is considered throughout the organisation. In addition to this we have supported staff to access developmental activities and ran a staff appreciation and recognition day which was very well received. Finally, we were instrumental in the development of an ICS/ICB Health and Wellbeing Group and significant contribution to this group.

All our staff have access to the Lancashire and South Cumbria Foundation Trust (LSCFT) Resilience Hub, along with an external occupational health provider, as well as signposting and support from Health and Wellbeing champions. We have a named IPC nurse who has supported throughout the pandemic and continues to support CCG to ensure staff safety during the COVID-19 pandemic. Our workspace is COVID-19 secure, and staff only have access to offices if necessary. All staff have been supported to have flu and COVID-19 vaccinations. Flu vaccinations are reimbursed for staff who would need to pay.

Staff have been supported with equipment, furniture and guidance for agile/remote working. While we have been working remotely throughout the pandemic breaks and rest periods have been strongly encouraged to avoid burn out, as the boundaries between work and home were not so clear for those

focused on delivery. We monitored annual leave bookings throughout the year to ensure staff were not working long periods without a break. Senior leaders and managers have modelled this behaviour as to encourage their teams to do the same.

Our Wellbeing Guardian, HWB lead, staff representatives and HWB champions have signposted and supported staff in a supportive environment contributing to a culture of civility and respect.

All staff car parking is free. We continue to provide virtual wobble rooms to staff and have set up a wellbeing room in our reconfigured office space. Staff continue to be supported when they go on sick leave and when they return by accessing our HWB support, and support from occupational health or our employee assistance programme. We promoted and continue to promote physical health and wellbeing through our HWB offer. As well as our specific physical health related bulletins, colleagues have provided morning yoga sessions, and tips on fitness and physical exercise. Wellbeing is continually promoted, and initiatives are updated regularly.

Following a Tackling Racism exercise led by the North West Strategic Advisory Group for Black, Asian and minority ethnic colleagues (formerly BAME Assembly North West), the CCG setup a working group which has supported awareness and compiled an action plan to address inequalities. There has been significant progress in this area, including the formation of a Pennine Lancashire Equality Diversity and Inclusion (EDI) Partnership which has already identified several priorities to implement.

We responded to the need, and mobilised staff to each local and area of the health and care system to support testing, vaccination, Gold Command and latterly CCG closedown and ICB establishment work. Our system level HR Reference Group has compiled a recruitment protocol to support swift vacancy filling from within the system. Primary care related developments are led and provided by the Lancashire and South Cumbria Training Hub. Pennine Lancashire CCGs have contributed heavily to health and care system development with many staff redeployed to assist with ICB establishment for all or part of their roles. CCG staff clinical and non-clinical are representatives at place base partnerships and supporting the development of the partnership

Financial review

For the financial year 2021/2022, the NHS operated under continued emergency powers and the allocation of resources to CCGs based on the resource allocation formula was suspended. Core allocations to cover CCG historical expenditure on commissioning functions, primary care co-commissioning and running costs were issued in two six monthly tranches (referred to as half 1 (H1) and half 2 (H2)). These CCG specific allocations were then supplemented by additional resources which were allocated in aggregate to our Lancashire and South Cumbria healthcare system. These system level allocations were then devolved to individual organisations on a system agreed basis.
The breakdown of how the total allocation for 2021/22 is made up is shown in the table below:-

Allocation Source	Half 1 £'000	Half 2 £'000	TOTAL £'000
Commissioning Functions	298,608	306,656	**605,264**
Primary Care co-commissioning	29,816	29,816	**59,632**
Running Costs	3,427	3,427	**6,854**
COVID funding	4,500	0	**4,500**
Growth Funding	7,315	6,397	**13,712**
Share of system allocation	(1,764)	2,260	**496**
Draw down of retained surplus from previous years	1,100	0	**1,100**
Carry forward historic surplus	16,615	0	**16,615**
Other in-year allocations	9,632	16,672	**26,304**
TOTAL	**369,249**	**364,809**	**734,477**

Net expenditure is recorded against the CCG allocation and for the year 2021/22, NHS England set all CCGs a target to deliver and in-year break even position. For the year 2021/22, the CCG has recorded a deficit (overspend) against the in year, planned expenditure of £2,142k. However, the spend against the total allocated revenue resource limit reports a surplus of £14,473k. £2,109k of the in-year overspend against plan relates to the reversal of a technical pre-payment adjustment which has been highlighted as such by our External Audit provider, Grant Thornton, within the annual audit letter.

NHS England have given the CCG permission to record and overspend of this amount in order to write out this technical adjustment and to ensure a clean opening balance sheet position into the next financial year. This adjustment and position is common to all the CCGs within Lancashire and South Cumbria and NHS England have provided confirmation that it will not be offset in future years against any retained surpluses that the CCG carries forward

The following table highlights the annual financial performance, with comparative data for the previous year:

	2021/2022 £'000	2020/2021 £'000
Total notified allocation *of which* **In year Revenue Resource Limit**	734,477 717,862	711,277 693,562
Total Comprehensive Net Expenditure against in year Revenue Resource Limit	720,004	693,592
In year Surplus / (deficit)	(2,142)	0

Retained surplus brought forward	17,715	17,715
Retained surplus utilised during the year *(funded as part of in year revenue resource limit)*	1,100	0
Retained surplus carried forward	16,615	17,715
Percentage Cumulative surplus	2.3%	2.5%

From a balance sheet perspective, CCGs are limited to current assets and liabilities. CCGs do not own any premises, nor do they receive any capital resource limit that would enable them to bring long term assets onto their balance sheets.

The current and previous four years balance sheet summary is shown in the table below:

	2021/2022 £'000	**2020/2021 £'000**	**2019/2020 £'000**	**2018/2019 £'000**	**2017/2018 £'000**
Current Assets	5,439	5,781	8,499	5,195	3,618
Current Liabilities	(50,376)	(45,275)	(46,859)	(47,431)	(43,941)
Total Assets less liabilities	(44,937)	(39,494)	(38,361)	(42,236)	(40,323)

Although the level of liabilities may appear to be geared towards debt, in the ratio of 1:9.26 (1:6.8 in 2020/21), all liabilities are classed as current, ie that they will be cleared within a short period of time of the year end. CCGs are also a subset of a government department, and the risk of bankruptcy is considered to be negligible.

Current assets in the main, relate to money owed to the CCG and stock held as described in the notes to the accounts. The significant increase in 2019/2020 relates to the in-year technical adjustment for the prescribing pre-payment. This resulted in a one-off revenue benefit to the CCG in that financial year, but there was disagreement regarding the treatment between the CCG and our external audit providers. This technical adjustment has now been reversed to mitigate the disagreement and to deliver a clear balance sheet position moving into 2022/23.

The level of current liabilities have been fairly consistent of the previous five years and amounts relate to three general areas:

- Accrual for primary care prescribing costs for which there is a timing lag of two months
- Accrual for the costs of individual packages of care
- Money owed to NHS organisations based on invoices received

- Money owed to other providers based on invoices received

The trend in current liabilities has however seen an upturn in 2021/22 and this relates to an in-year provision relating to a potential legal claim in respect of continuing healthcare reparation costs.

ACCOUNTABILITY REPORT

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.

Dr Julie Higgins

Accountable Officer

20 June 2022

Corporate Governance Report

Member profiles

East Lancashire CCG has 48 member practices; each practice has a nominated lead representing the interests of the CCG as a whole. The members play a role in holding elected executive members to account and holding the CCG officers to account for the delivery of the strategic priorities.

As a clinically led organisation, we use the clinical expertise and insight of local GPs to drive the commissioning of health services locally. It is this clinical expertise and insight, combined with an in-depth knowledge of patient needs and experiences, which enables us to commission high quality healthcare for our residents and to make improvements where we know that healthcare is not as effective as it could be.

We ensure that performance and any issues that are important to our patients and members are addressed by the Governing Body, and improvements made where required. We also ensure the CCG is commissioning services that deliver best value for money.

Throughout 2021/22, we have continued to work within the government's COVID-19 guidelines on working safely, which has meant that we have not held meetings in public in the same way. Instead, we have used digital technology to hold "virtual meetings" to which members of the public have been invited to join.

The conduit between the Governing Body and our GP member practices are our Council of Members, the Clinical Chair, Medical Director, and our GP Clinical Advisors. They act to ensure that there is a two-way flow of information and insight between practices and the Governing Body. The CCG's performance is therefore monitored both formally and informally.

Throughout the year our member practices have been kept regularly informed of the work of the governing body and overall are satisfied with both progress and performance. They recognise the challenges within the local health economy and the work the CCG is doing to meet these challenges.

Member practices

Burnley Locality

Practice Name	Address
Burnley Group Practice	St Peters Centre, Church Street, Burnley BB11 2DL 187 Manchester Road, Burnley BB11 4HP The Health Centre, Kiddrow Lane, Burnley BB12 6LH
Briercliffe Surgery	Briercliffe Primary Care Centre, Briercliffe Road, Burnley BB10 2EZ
Burnley Wood Medical Centre	50 Parliament Street, Burnley BB11 3JX
Yorkshire Street Medical Practice	80 Yorkshire Street, Burnley BB11 3BT
Ightenhill Medical Centre	Tabor Street, Burnley BB12 0HL
Colne Road Surgery	36 Colne Road, Burnley BB10 1LG
Prestige Medical Group	Prestige Park, Colne Road, Burnley BB11 1PS 25 Oxford Road, Burnley BB11 3BB
Padiham Group Practice	Burnley Road, Padiham BB12 8BP
Thursby Surgery	2 Browhead Road, Burnley BB10 3BF
Rosegrove Surgery	225-227 Gannow Lane, Burnley BB12 6HY
Riverside Family Practice	St Peters Centre, Church Street, Burnley BB11 2DL

Hyndburn Locality

Practice Name	Address
Clayton Medical Centre	Wellington Street, Clayton Le Moors, Accrington BB5 5HU
Dill Hall Surgery	6-8 Church Street, Church Accrington BB5 4LF
Blackburn Road Medical Centre	257 Blackburn Road, Accrington BB5 OAL
Oswald Medical Centre	274 Union Road Oswaldtwistle BB5 3JB 387-391 Blackburn Road, Accrington, BB5 1RP
Peel House Medical Centre	Accrington Pals PHCC, 1 Paradise Street, Accrington, BB5 2EJ
Dr Bhat's Surgery	Heys Lane, Oswaldtwistle BB5 3BP
The Weavers Practice	High Street, Rishton, Blackburn BB1 4LA The Health Centre, Water Street, Great Harwood, Blackburn BB6 7QR
Rishton & Great Harwood Surgery	32 High Street, Rishton, Blackburn BB1 4LD
Great Harwood Medical Group	The Health Centre, Water Street, Great Harwood, Blackburn BB6 7QR
King Street Medical Centre	43 King Street, Accrington BB5 1QE
Richmond Medical	Acorn Primary Health Care Centre, 421 Blackburn Road, Accrington BB5 1RT
Dr Bello's Practice	6-8 Church Street, Church, Accrington BB5 4LF

PWE Accrington Victoria Practice	Accrington Victoria Community Hospital, Haywood Road, Accrington BB5 6AS

Pendle Locality

Practice Name	Address
Barrowford Surgery	Ridgeway, Barrowford BB9 8QP
Barnoldswick Medical Centre	1 Park Road, Barnoldswick, Colne BB18 5BF
PWE Pendle Valley Mill	Yarnspinners Primary Health Care Centre, Yarnspinners Wharf, Carr Road, Nelson BB9 7SR Brierfield Health Centre, Arthur Street, Brierfield, Nelson BB9 5SN
Richmond Hill Practice	Colne Health Centre, Craddock Road, Colne BB8 0JZ
Reedyford Health Care Group	Yarnspinners Primary Health Care Centre, Yarnspinners Wharf, Carr Road, Nelson BB9 7SR
Pendle View Medical Centre	47 Arthur Street, Brierfield, Nelson BB9 5RZ
Dr Jehangir's Practice	Yarnspinners Primary Health Care Centre, Yarnspinners Wharf, Carr Road, Nelson BB9 7SR
Whitefield Health Care	Yarnspinners Primary Health Care Centre, Yarnspinners Wharf, Carr Road, Nelson BB9 7SR
Nelson Medical Practice	Yarnspinners Primary Health Care Centre, Yarnspinners Wharf, Carr Road, Nelson BB9 7SR
Pendle Medical Partnership	Edward Street, Earby, Barnoldswick BB18 6QT Colne Health Centre, Craddock Road, Colne BB8 0JZ
Harambee Surgery	27 Skipton Road, Trawden, Colne BB8 8QU

Ribblesdale

Sabden & Whalley Medical Group	Whalley Surgery, 42 King Street, Whalley, BB7 9SL
Pendleside Medical Practice	Clitheroe Health Centre, Railway View Road, Clitheroe, BB7 2JG
The Castle Medical Group	Clitheroe Health Centre, Railway View Road, Clitheroe, BB7 2JG
Slaidburn Country Practice	Slaidburn Health Centre, Townend, Slaidburn, BB7 3EP

Rossendale Locality

Practice Name	**Address**
St James Medical Centre	Burnley Road, Rawtenstall, Rossendale BB4 8HH
Irwell Medical Practice	Bacup Primary Health Care Centre, Irwell Mill, Rochdale Road, Bacup OL13 9NR
Whitworth Medical Centre	Market Street, Whitworth, Nr Rochdale OL12 8QS
Haslingden Health Ltd	Haslingden Health Centre, Manchester Road, Haslingden, Rossendale, BB4 5SL
Ilex View Medical Practice	Rossendale Primary Health Care Centre, 161 Bacup Road, Rawtenstall, Rossendale BB4 7PL
Waterfoot Medical Practice	Waterfoot Health Centre, Cowpe Road, Waterfoot, Rossendale BB4 7DN
Hazelvalley Family Practice	7-9 Manchester Road, Haslingden, Rossendale BB4 5SL
Rossendale Valley Medical Practice	Haslingden Health Centre, Manchester Road, Haslingden, Rossendale BB4 5SL

PWE Fairmore Medical Practice	Rossendale Primary Health Care Centre, 161 Bacup Road, Rawtenstall, Rossendale BB4 7PL (Also Branch at Nelson)

Composition of Governing Body

Dr Richard Robinson - Chair
Dr Julie Higgins – Accountable Officer
Dr Mark Dziobon – Medical Director
Dr David White – GP Clinical Advisor
Dr Rakesh Sharma – GP Clinical Advisor
Dr Santhosh Davis – GP Clinical Advisor
Dr Tom Mackenzie – GP Clinical Advisor
Vacant – GP Clinical Advisor
Dr Paul Taylor – Secondary Care Doctor
Mrs Kirsty Hollis – Chief Finance Officer
Mr Alex Walker – Director of Performance and Delivery
Mrs Kathryn Lord – Director of Quality and Chief Nurse
Mr David Swift – Lay Member Governance
Vacant – Deputy Chair and Lay Member for Patient and Public Involvement (the EL CCG Governing Body nominated Mr Graham Burgess, the BwD CCG Chair and Lay Member for Engagement, to cover the vacant role for Public and Patient Involvement in EL CCG)
Vacant – Lay Member Equality and Inclusion (non-voting)

Committee(s), including Audit Committee

More detailed information about the Governing Body and related committees' membership is available in our Annual Governance Statement and Members Report.

Register of Interests

Managing potential conflicts of interest is essential for protecting the integrity of the overall NHS commissioning system and the Clinical Commissioning Group from any perceptions of wrongdoing.

The CCG Governing Body has approved and adopted the Managing Conflicts of Interest Policy (including Gifts and Hospitality) which adheres to the NHS England revised statutory guidance, published in June 2017.

All staff are required to declare any interests when joining the organisation, or if their circumstances (e.g. role or responsibilities) change, and thereafter on at least an annual basis. All Governing Body members review and declare their declarations of interest on a regular basis and the Chair of all committees receive and review member declarations prior to each

meeting. In addition, all members and non-members of the CCG Governing Body and its sub-committees declare any interests pertinent to the agenda at the start of each meeting and any interests declared are considered by the Chair and appropriate steps taken, where appropriate.

During 2021/22 NHS England's Corporate Data Collections for conflicts of interest were paused, including the requirement to submit Conflict of Interest quarterly and annual self-certifications. The CCG has continued to monitor and report progress against compliance on a quarterly basis to the Audit Committee. We have also encouraged all relevant staff to undertake the mandatory Level 1 Conflict of Interest training.

The CCG's policy and declarations of interest registers are available via our website at https://eastlancsccg.nhs.uk/about-us/registers-of-interests.

Personal data related incidents

There have been no reportable personal data related incidents during the reporting period.

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

East 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.
Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2022 is published on our website at Equality and Inclusion (eastlancsccg.nhs.uk)

Dr Julie Higgins

Accountable Officer

20 June 2022

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 the Chief Officer to be the Accountable Officer of NHS East 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 East Lancashire CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I also confirm that:

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

Dr Julie Higgins

Accountable Officer

20 June 2022

Governance Statement

Introduction and context

NHS East 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.

CCG Constitution

Our constitution sets out the arrangements that we have put in place to help us to deliver our vision and goals, to discharge all of our statutory obligations and to engage with our members, our patients and our community and other key stakeholders and partners to achieve this. It describes the CCG's governing principles – the rules and procedures that we have established to ensure probity and accountability in the day-to-day running of our organisation, to ensure that

decisions are taken in an open and transparent way and that patient and public interest always remain central to our goals.

The Constitution is published on the CCG's website at:
https://eastlancsccg.nhs.uk/about-us/our-constitution

The CCG, through the governance framework and its reporting structures, has communicated and embedded codes of conduct and defined standards of behaviour for CCG members and staff by having:

- A code of conduct for the Governing Body and sub-committee members showing mutual trust, respect and honesty (members of the Governing Body adhere to the seven principles of public life – Nolan Principles).
- All committees authorised by the Governing Body are responsible for keeping under review their terms of reference and membership; the Governing Body approves these and seeks regular assurance that their duties are discharged accordingly.

Governance Arrangements to support System Reform

In April 2021, a Strategic Commissioning Committee replaced the Joint Committee of CCGs; the committee has had a primary role in focusing on delivery and decision making for the Lancashire and South Cumbria population, with delegated authority on behalf of the governing body to make decisions at a Lancashire and South Cumbria level. The Committee members 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 disestablishment of the eight CCGs in Lancashire and South Cumbria and the establishment of the Integrated Care Board (ICB), a sub-committee structure (with working groups) was established to oversee the closedown programme of work 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, supported by a number of working groups (finance, contracts, HR and Governance).

COVID-19 Governance Arrangements

The CCG has operated throughout the year with robust governance arrangements in place to support the CCG's response to national incident levels and the associated national incident infrastructure. The regularity of the CCG's Incident Co-ordination Centre (ICC) and sub-cell meetings has also been reviewed and aligned accordingly. This has resulted in an agile approach, with meetings stepped up and down as required to enable the CCG to support the

COVID vaccination programme, whilst ensuring delivery against its strategic objectives and priorities.

CCG Committees and Sub-Committees

The CCG's Constitution has established the following committees/sub-committees:

- CCG Governing Body
- Audit Committee
- Primary Care Committee (meeting as a Committees in Common with Blackburn with Darwen CCG)
- Remuneration Committee (meeting as a Committees in Common with Blackburn with Darwen CCG)
- Pennine Lancashire Quality Committee
- Sustainability Committee
- Patient Partners Board)
- Strategic Commissioning Committee – formally the Lancashire and South Cumbria Joint Committee of Clinical Commissioning Groups

Council of Members

The Council of Members is the overarching membership body of the CCG, and each of its 48 practices has a nominated representative. Representing the interests of the CCG as a whole, the Council plays a role in holding elected executive members to account and holding CCG officers to account for the delivery of strategic priorities. The Council also approves the CCG's Constitution and proposed changes therein.

During 2021/22, due to the on-going response to the COVID-19 pandemic the Council of Members met virtually on 1 occasion. The members received updates on system reform aligned to the national proposals set out by the government, the transitional governance arrangements for 2021/22 and the planning and the implementation of provider collaboration at ICS level (including partnership working at local government level).

Throughout the reporting period the members received regular communications on national, regional and local issues, including updates on the decisions made by the CCGs Senior Directors (via the ICC) around the deployment of resources to support resilience within primary care. The membership was also consulted on the proposal to relocate the CCGs headquarters from Walshaw House to Fusion House in Blackburn with Darwen. Following an options appraisal, the members supported an agile model of working using Fusion House as a co-located staff base. Further regular communications from the Chair, Chief Officer and Medical Director were issued alongside practical support for operational issues throughout the reporting period.

Governing Body

The Governing Body is responsible for discharging the statutory duties and functions of the CCG. The Governing Body draws its membership from a broad range of clinicians, staff and lay members providing the appropriate balance of skills, experience, independence, and knowledge of the organisation to enable them to discharge their respective duties and accountabilities effectively.

In April 2021, the Governing Body received the 2021/22 Priorities and Operational Planning Guidance. This set out the six priorities for year ahead against a backdrop of the challenge to restore services, meet new care demands, and reduce the care backlogs as a direct consequence of the pandemic, and these formed the key focus of business for the governing body (outlined below).

To support the achievement of those priorities, the approval of a single commissioning function through the formal establishment of the Strategic Commissioning Committee across Lancashire and South Cumbria (as described above) was agreed. The SCC meetings were held in public with invitations open to members of the public to attend. This was to support the alignment of CCG resources, without affecting local clinical leadership. Assurance of the work undertaken, and the decisions made by the Strategic Commissioning Committee under the delegated authority from the Governing Body, is provided in a number of ways. The Strategic Commissioning Committee Workplan, and all papers and minutes from the SCC meetings are circulated to the Governing Body members. In addition, the CCG is represented in a decision-making capacity at the committee by the Accountable Officer and CCG Chair.

The Governing Body has met in public (virtually) as Committees in Common with Blackburn with Darwen CCG on five occasions with provision made for members of the public to join the meeting using digital technology.

Key areas of focus for the Governing Body during 2021/22:

- Refreshing commissioning work plans in line with the planning guidance with the ICS core purposes embedded within that will address health inequalities. Key specific areas for 21/22 included:
    - Restoring elective and cancer services to the highest possible level
    - Expanding mental health, learning disability and autism services
    - Continuing the development of Primary Care Networks, delivering an increase in the Primary Care workforce and access within Primary Care
    - Implementing a two-hour crisis community response at home and embedding Discharge to Assess
- Understanding, monitor and improve quality and safety post pandemic

- Developing focused work with partners to address health inequalities, including supporting the Health Inequalities Commission and Call to Action
- Transitioning the functions of the CCG into the ICS in a controlled manner closing-down the necessary duties and support the evolving ICS
- Supporting our staff in the transition to the ICS and shaping the structure of local and ICS teams
- Operating within the financial constraints and contribute to system improvement targets

In addition to this the CCG continued to support the ongoing response to the pandemic including:

- Supporting the vaccination programme
- Supporting the testing programme
- Ensuring readiness for outbreak management that might require standing up command structures again.

It is my view that the Governing Body has operated effectively in meeting its responsibilities throughout the period 1 April 2021 to 31 March 2022.

Strategic Commissioning Committee (formally known as the Lancashire and South Cumbria Joint Committee of Clinical Commissioning Groups)

The Strategic Commissioning Committee has 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. Under normal circumstances the meetings would be held in public, and members of the public invited to attend the formal meetings, however due to COVID-19 restrictions these meetings have been held virtually.
The committee has met (virtually) on five occasions during the reporting period; the agenda and formal papers are published on the Lancashire and South Cumbria ICS website here:

Lancashire and South Cumbria Health and Care Partnership: Strategic Commissioning Committee (healthierlsc.co.uk)

Throughout the COVID-19 pandemic, the CCGs in Lancashire and South Cumbria have worked effectively with local partners across the ICS to manage the local response, enabling joint decision making towards the operational management of services and ensuring consistency in partner, staff, patient and public communications

Audit Committee

The Audit Committee has met (virtually), on six occasions during the reporting period. The committee has been accountable to the Governing Body for providing an independent and objective view of our financial systems, financial information and compliance with laws,

regulations, and directions. The Committee is chaired by the Lay Member for Governance and includes membership from the Lay Member for Quality and Patient Engagement (this role has been vacant throughout the reporting period), the Secondary Care Consultant and a GP Clinical Advisor/member of the Governing Body.
The Governing Body receives the minutes of each Audit Committee which, in accordance with its Terms of Reference assures the organisation in the following areas:

- Governance, risk management and internal control – ensuring the establishment and maintenance of an effective system of governance and risk management across the CCG, including monitoring, and reviewing the organisation's assurance framework and risk register.
- Internal audit – ensuring the audit function established was effective and met the mandatory NHS Internal Audit Standards to provide appropriate assurance to the Governing Body. Ensuring internal audit reports finalised to date were providing a positive assurance overview.
- External audit – ensuring the work and findings of the appointed External Auditors and considering the implications of the management's responses to their work.
- Financial reporting – monitoring and delivery of the 2021/22 accounts timetable
- Other assurance functions including Counter Fraud arrangements and review of counter fraud work
- Reviewing the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about improprieties in financial, clinical or safety matters and ensure that any such complaints were investigated proportionately and effectively

The Audit Committee presents an annual report to the Governing Body which summarises its work during the year.

Committee members:

Mr David Swift	Lay Member – Governance and Chair of Audit Committee
Vacant	Lay Member – Quality and Patient Engagement
Dr Paul Taylor	Secondary Care Consultant
Dr Santhosh Davis	GP Clinical Advisor

In Attendance:

Mrs Kirsty Hollis	Chief Finance Officer
Mrs Debra Atkinson	Head of Corporate Business

The minutes and attendance at Audit Committee meetings are published on the CCG's website along with the Terms of Reference and Membership at:

https://eastlancsccg.nhs.uk/about-us/governing-body-meetings.

Remuneration Committee

The Remuneration Committee's primary role is to make recommendations of the appropriate remuneration and terms of service for the Accountable Officer, Lay members, Directors and other Very Senior Managers and Clinical Leads.
The members of the Remuneration Committee are the Clinical Chair, three Lay Members and the Secondary Care Doctor.

The Committee has operated effectively within its delegated levels of authority to make recommendations to the Governing Body on the remuneration of Governing Body members, Executive Managers and clinical leaders in the CCG. The committee has met on two occasions during the reporting period (as a committees in common meeting with Blackburn with Darwen CCG).

Committee membership:

Dr Richard Robinson	Clinical Chair
Mr David Swift	Lay Member – Governance
Vacant	Lay Member – Quality and Patient Engagement
Dr Paul Taylor	Secondary Care Consultant
Vacant	Lay Member – Equality and Inclusion

Primary Care Committee

NHS England has delegated the exercise of certain specific primary care functions to East Lancashire CCG and this committee is established as a sub-committee of the CCG's Governing Body. The functions of the committee are undertaken to promote increased co-commissioning to increase quality, efficiency, productivity, and value for money. Its role is to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act. This includes:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract).
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services").
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF).
- Decision making on whether to establish new GP practices in an area.
- Approving practice mergers.
- Making decisions on 'discretionary' payment (e.g. returner/retainer schemes).

In May 2021, the committee Terms of Reference were reviewed to ensure that both East Lancashire and Blackburn with Darwen CCGs were able to continue to exercise the primary care functions delegated to them from NHS England. It was agreed that the Primary Care Commissioning Committees of both CCGs would meet, under the provisions set out in legislation, as Committees in Common. To support these working arrangements and ensure both committees were able to maintain quoracy and decision making, the Chair of the Blackburn with Darwen CCG PCC was co-opted into the role of Chair of the EL CCG PCC.

The committee has met monthly, or as required from June 2021 onwards and the membership, attendance, agenda, and minutes are published on the CCG's website at:

https://eastlancsccg.nhs.uk/about-us/governing-body-meetings/primary-care-commissioning-committee

Pennine Lancashire Quality Committee (PLQC)

This joint committee is accountable to both East Lancashire and Blackburn with Darwen CCGs governing bodies. This committee has responsibility for all quality and safety issues for the two organisations and provides assurance to the governing bodies on all matters relating to the delivery of high-quality services by provider organisations to the residents of East Lancashire. This includes all aspects of performance management, service effectiveness, patient safety and experience and assurance of compliance with relevant regulatory standards.
The PLQC meetings were re-instated in April 2021 following a pause in 2020 as the CCGs responded to COVID-19. A revised Terms of Reference were approved by the Governing Body in July 2021, which supported the transitional arrangements including the formation of an ICS Quality and Performance Sub-Committee, to which all CCG quality committees report into. The ICS Quality and Performance Sub-Committee in turn, reports into the ICS Strategic Commissioning Committee.

The PLQC held its final meeting in March 2022 (with one further extraordinary meeting scheduled prior to disestablishment) to review the closedown due diligence requirements and provide an assurance overview of the handover arrangements for the quality agenda, in advance of the transition formally to the ICB.

Incident Coordination Centre (ICC)

Chaired by the CCGs Accountable Officer, with representation from the CCGs Senior Directors and Governing Body clinicians, the ICC has focused on the following areas during the reporting period:

- Supporting the deployment of the vaccinations programme
- Delivery against the Corporate Business Plan and Accountability Framework for 2021/22

- Ensuring continued oversight and management of the CCG's role in the COVID-19 response

The frequency of the ICC meetings was regularly reviewed during the reporting period and a summary of all ICC decisions taken have been presented on a quarterly basis to the CCGs Governing Bodies.

Sustainability Committee

The establishment of a Strategic Commissioning Committee on 1 April 2021 meant that delivery and decision making for the Lancashire and South Cumbria population was done across the Lancashire and South Cumbria footprint. The Sustainability Committee therefore did not meet during 2021/21; any decisions for local determination were made under the delegations of the CCG executive officers or via the governing body.

Patient Partners Board

Due to the ongoing response to the COVID-19 vaccination programme, the Patient Partners Board has not met during the reporting period.

UK Corporate Governance Code

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

Discharge of Statutory Functions

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

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's joint Risk Management Strategy and Policy sets out the responsibilities of individuals, the governing body and its sub-committees for managing risks associated with meeting the strategic objectives of the CCG. It aims to create a framework to achieve a culture that encourages staff to:

- Identify and control risks which may adversely affect the operational ability of the CCG.
- Compare risks using a grading system.
- Where possible, eliminate or transfer risks, or reduce them to an acceptable and cost-effective level (otherwise ensure the organisation openly accepts the remaining risks).
- Identify risks which are common risks across both Pennine Lancashire CCGs and manage this collectively.

Risks are identified from a number of sources, including the Governing Body, Senior Directors, staff, the Governing Body Assurance Framework, internal and external audit reports and risk assessments. Risk management is embedded within the organisation through delivery of the Risk Management Policy and Strategy and also through assessment of specific risks, including information governance, privacy impact assessments, equality impact assessments and business continuity.

Monitoring, evaluation and control have been further developed throughout the year and all identified risks are included on the operational risk register or Governing Body Assurance Framework.

Throughout 2021 we have ensured that the governance and oversight for operational risk management has remained a priority. A monthly cycle of risk management has remained in place throughout the reporting period to enable the timely escalation (and de-escalation) of risks to the Senior Directors and Governing Body.

Capacity to Handle Risk

The responsibility for risk management is clearly defined at all levels within the organisation. The CCGs Risk Management Strategy clearly outlines the roles and responsibilities of the governing body, the Audit Committee, the Pennine Lancashire Quality Committee, the Risk Management Group, the Accountable Officer, the Chief Finance Officer and other staff within the CCG.

The Audit Committee is responsible for reviewing the adequacy and effectiveness the CCG's Risk Management Arrangements and receives update reports on a quarterly basis.

Overall responsibility for the CCG's systems of internal control and preparation of the Annual Governance Statement is delegated to the Accountable Officer. The Chief Finance Officer has

delegated responsibility for ensuring the CCG has a system in place for checking and reporting breaches of financial policies, together with a proper procedure for checking the adequacy and effectiveness of the control environment.

The CCG uses an electronic system to record and monitor risks. This is a web-based application that is available to risk owners and managers and allows risk updates to be provided in a timely manner. The information is used to provide monthly reports for the Risk Management Group/Pennine Lancashire Quality Committee on all risks held on the CCG risk register, and quarterly updates to the Governing Body for those risks held on the Governing Body Assurance Framework.

Risk Management training has been provided via virtual training sessions delivered via the Midlands and Lancashire Commissioning Support Unit. Additional support has also been provided for risk owners via 1:1 risk update sessions.

Risk Assessment

Operational risks are identified in a number of ways e.g. when a new service development is planned the risks associated with the project are scoped out and included in the business case process.

During the reporting period risks have been identified through a variety of sources:

- Complaints and incidents
- Internal investigations
- Internal/external audit reports
- ICC and Cell Leads Meetings
- Data Security and Protection Toolkit
- Risk Assessments

All risks held on the CCGs risk registers are assigned to a named risk owner (the risk lead). Risk owners are the manager responsible for ensuring the implementation of the Risk Management Policy and Framework within their own areas of control and have key functions in relation to risk management which include:

- Ensuring risks are identified and managed and mitigating actions are implemented
- Ensuring action plans for risks are prepared and reviewed on a regular basis
- Reviewing risks on a monthly basis in readiness for updating the ICC and Governing Bodies

In addition, each risk also has a Senior Director (Senior Responsible Officer) lead to further strengthen the accountability, ownership and control of CCG risks.

We use two risk scores to provide an overall risk rating:

- Current risk score – this is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move toward the target risk score as action plans to mitigate the risks are developed and implemented.
- Target (appetite) risk score – this is the score that is expected after the action plan has been fully implemented.

Governing Body Assurance Framework (GBAF)

The GBAF identifies the principal risks to delivery of the CCG's strategic objectives and any gaps in assurance and control. Our shared Corporate Objectives with Blackburn with Darwen CCG are:

- To commission the best quality and effective services to deliver optimal healthcare outcomes for our local population
- Ensure the balance of our health investment reflects our population's needs and keeps the population well
- Deliver the 10-year strategy by engagement with the population we serve and ensure we commission services that meet local needs with a clear focus on population health management strategies
- We will focus on population health outcomes through helping to deliver successful Integrated Care Partnerships and ensure decisions, provision and access to local services is based on the needs of our population
- As local health leaders, we will focus on increasing life expectancy across Pennine Lancashire to be at, or above the national average in the next 10 years

The GBAF provides a structure and robust process to enable the organisation to focus on high level strategic and reputational risks with the potential to compromise the achievement of its strategic objectives. The framework is a dynamic tool that maps out key controls, highlights any gaps in control and assurance to mitigate the risks, and provides a mechanism to assure the Governing Body of the effectiveness of these controls. It is part of the wider governance and assurance framework to ensure the

CCG's performance across the full range of its commissioning activities is monitored and managed, resulting in targets being met, objectives achieved, and good outcomes realised for patients. Crucially, the GBAF provides the Governing Body with confidence that systems and processes in place are operating in a way that is safe and effective.

Overview of Strategic Risks

Over 2021/22 the risks held on the GBAF have been comprehensively reviewed to include the impact of COVID-19 and have fallen broadly into the following areas:

- The fragility of the regulated care sector
- The resilience and sustainability of general practice in Pennine Lancashire
- Achievement of the NHS Constitution performance indicators
- The widening of health inequalities across communities and/or between different groups due to the decline in economic circumstances across those groups, the unforeseen impact of health policy implementation and insufficient investment in anticipatory and preventative services
- Insufficient financial savings attributed to transformation of work programmes across the CCG
- Quality assurance of homecare and residential placements for children and young people with complex needs and/or continuing health needs
- That children would not be effectively safeguarded due to lack of routine contribution to safeguarding processes

During the year action plans and mitigations were put in place for any gaps identified in control and assurance, and all risks actively monitored.

There is a process in place for reporting, managing, investigating and learning from incidents. We have a Senior Information Risk Owner to support our arrangements for managing and controlling risks relating to information/data security.

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.

Control mechanisms are embedded within the system of risk management within the organisation; and there were no instances during the reporting period where the control environment was breached. The control mechanisms include:

- Compliance with legislative and regulatory requirements
- Scheme of Reservation and Delegation
- Prime Financial Policies
- Sub committees of the Governing Body
- The Governing Body Assurance Framework
- The Corporate Risk Register
- Internal performance management processes as outlined in the CCG Risk Management Strategy and Policy
- Organisational policies and procedures

Such controls reduce the likelihood of a risk occurring. We also have a statutory and mandatory training regime in place which is a significant aspect of control.

The Governing Body Assurance Framework also plays a key role in ensuring the effectiveness of internal control mechanisms. At the beginning of the financial year the CCG reviews the main risks to the delivery of the strategic and operational plans and these risks are reviewed by the Governing Body on a quarterly basis.

The Governing Body Assurance Framework and Corporate Register Risks have been reviewed bi-monthly throughout the reporting period via the Pennie Lancashire Quality Committee and the Governing Body Assurance Framework risks have been reviewed quarterly by the Governing Body. The full risk registers have been presented to the Audit Committee at each meeting.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2017) 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 carried out the annual internal audit of conflicts of interest audit which found that overall, the CCG has demonstrated that arrangements are in place to satisfy NHS England requirements with regard to Conflicts of Interest. Overall the review identified that controls were designed and operating effectively; individual levels of compliance were:

- Governance arrangements – partially compliant
- Declarations of interests and gifts and hospitality – fully compliant
- Register of interest, gifts, hospitality and procurement decisions – fully compliant
- Decision making processes and contract monitoring – fully compliant
- Reporting concerns and identifying breaches/non-compliance – fully compliant

Where areas for improvement were identified, those recommendations will be transferred to the successor statutory health organisation (Integrated Care Board) following the disestablishment of the CCG.

Data Quality

As described in the performance overview section, due to emergency measures introduced (nationally) in March 2020, normal contracting and performance management mechanisms continued to be paused in response to COVID-19. However, the CCG has continued to provide high level quality and performance data to the Governing Body.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. In May 2022, Mersey Internal Audit Agency published their review of the CCG's Data Security and Protection Toolkit – CCG to Integrated Care System (ICS) Handover arrangements. The report provided "Substantial Assurance" that "there is a good system of internal control designed to meet the system objectives, and the controls are generally being applied consistently".

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

There are processes in place for incident reporting and investigation of serious incidents. Information risk assessment and management procedures have been established to support an information risk culture throughout the organisation against identified risks.

Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, confirm that an appropriate framework and environment is in place to provide quality assurance of business critical models.

Third party assurances

NHS East Lancashire CCG receives third party assurance on the support services that it commissions and holds the contracts for directly and on nationally provided services the contracts for which are held for all CCGs by NHS England.

Directly commissioned support services

NHS Midlands and Lancashire Commissioning Support Unit

During 2021/22, NHS Midlands and Lancashire Commissioning Support Unit (the CSU) have maintained their annual service audit reporting (SAR) process. This process provides assurance to CSU customers and their auditors, that the CSU has internal controls and control procedures in place and that these are embedded into the working practices and continue to be of an excellent standard.

Deloitte UK are the independent assessors of the CSU control processes and test compliance against the agreed control standards with exceptions and subsequent mitigating actions reported to the CCG by way of the SAR.

The outcome of the SAR for the period 1 April 2021 – 31 March 2022 showed that out of the 74 controls that had been tested, there was just 1 exception which allowed the auditor to conclude that:

- All controls were described in a way that fairly presented the test activities
- Controls were designed in such a way as to reasonable assurance that controls objectives would be achieved during the period and
- All controls tested were operating with sufficient effectiveness to provide reasonal

East Lancashire Financial Services (ELFS)

East Lancashire Financial Services (ELFS) provide payroll services to the CCG. During 2021/22, ELFS took the decision to move to an ISAE3402 Type II report – services system for processing user entities transactions as part of their philosophy of continuous business improvement regarding the quality of service provided to clients. Grant Thornton LLP have provided a rigorous assessment of services provided.

Grant Thornton did not identify any adverse finding or fundamental process failures across the control standards tested. They did however identify a small number of exceptions which has resulted in a qualified opinion. The CCG are assured that the exceptions identified have been fully investigated and further controls put in place to remedy those weaknesses.

Mersey Internal Audit Agency (MIAA)

Mersey Internal Audit Agency (MIAA) provide the internal audit service to the CCG. MIAA has been assessed against the requirements of the Public Sector Internal Audit Standards, an external quality assessment process which is required to be undertaken every five years. The latest assessment was published on 14 November 2020 by an assessor from the Chartered Institute of Public Finance and Accountancy (CIPFA). It included a review of key documents and processes, alongside interviews with a range of staff and a sample of key stakeholders. MIAA were assessed as being fully compliant with all standards, with the overall conclusion from CIPFA that "**MIAA fully conforms to the requirements of the Public Sector Internal Audit Standards**"

Nationally Commissioned third-party services

The service auditor reports for the following, nationally procured, contracted and managed services for 2021/22 have been shared with NHS England who will fully comment on the assurances received as part of their annual report. A summary of the findings in relation to services where the CCG is an end user is shown here. Further details, if required, can be found in the NHS England annual report 2021/22.

Service Provider & Service	**Service Auditor / Type of report**	**Opinion**
NHS Shared Business Services (SBS) - Finance & Accounting Services	Price Waterhouse Coopers LLP ISAE 3402	Qualified – 1 exception identified
NHS Digital – General Practitioners Payment Services	Price Waterhouse Coopers LLP ISAE 3000	Qualified – 2 exceptions identified
NHS Business Services Authority – Prescription Payments Process	Price Waterhouse Coopers LLP ISAE 3402	Qualified – Control objective number 2 not met
Capital Business Services Ltd – Primary Care Support	Mazars ISAE 3402	Qualified – 4/17 control objectives not met
Electronic Staff Record Programme (ESR)	Price Waterhouse Coopers LLP ISAE 3000	Qualified – 1 exception identified

NHS Pension Scheme 2021/22

NHS East Lancashire CCG confirms that as an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations

contained within the scheme regulations are complied with. This includes and ensures that, deductions from salary in respect of employee contributions; employer contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in line with the timescales detailed within the Regulations.

Control Issues

There have been no significant control issues during the reporting period.

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

The draft accounts for 2021/22 are subject to external audit and demonstrate that:

- The CCG has delivered an in-year deficit of £2,142k against the planned level of expenditure, but maintained a surplus position against the total notified allocation for the financial year
- Has managed within the maximum cash draw down allocated to the CCG in year
- Managed to deliver our business within the running cost allowance

The CCG did not have a capital resource limit during the financial year.

In 2021/22 the CCG was eligible to draw down up to £3.5m of the retained historical surplus. The CCG opted to draw down only £1.1m resulting in the brought forward cumulative surplus reducing to £16.615m

Despite the in-year deficit reported for 2021/22, NHS England have confirmed that due to the technical nature of the transaction leading to the deficit position, this will not impact on the level of retained surplus available in future years.

Over the course of the year, the CCG has had an in-year QIPP target of £6,660k. Due to the nature of the financial regime adopted in 2021/22, it has been difficult for CCGs to identify recurrent QIPP savings and therefore the majority (£5,642k) of the in-year target has been delivered on a non-recurrent basis. This is mainly through slippage on planned investments, underspend against prescribing and independent sector activity and one-off benefits of commitments which have not materialised in year.

Despite the finance regime and the continued pandemic response including level 4 emergency response status, CCGs have been required to maintain and delivery the planning expectations set out in the long-term plan in relation to mental health services to ensure parity of esteem. For 2021/22, NHS East Lancashire CCG was set a target to deliver an additional 3.49% increased investment on mental health services. This target has been achieved with increased investment of, however as in previous years, this investment will be subject to independent

verification through a separate external audit review. This will be undertaken in the autumn months of 2022.

The Governing Body receive monthly reports on the CCG's financial position and forecast for the actual out-turn. Detailed scrutiny is undertaken through the CCG's Audit Committee, chaired by a lay member. Detailed monthly monitoring is also submitted to NHS England and challenge is received where in-month performance is not aligned to the annual plan.

The CCG has underspend against its in-year running cost allowance.

Delegation of functions

I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of these functions.

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

Services provided by the Midlands and Lancashire Commissioning Support Unit (MLCSU) are reviewed through monthly meetings with a dedicated service director and issues and risks are raised through the MLCSU customer forum.

Counter fraud arrangements

The NHS Counter Fraud Authority (CFA) require that providers and commissioners ensure that NHS resources are protected from fraud, bribery and corruption. The CCG is required to comply with all the standards sets out in the NHS CFA Standards for Commissioners to combat economic crime within the NHS.

We commission the services of assurance provider Mersey Internal Audit Agency to provide our Anti-Fraud Specialists.

We do not tolerate economic crime and we have an Anti-Fraud Bribery and Corruption Response Policy in place which is designed to make all staff aware of their responsibilities should they suspect offences being committed. When economic crime is suspected, it is fully investigated in line with legislation. Appropriate action is taken, which can result in criminal, disciplinary and civil sanctions being applied. This work is monitored by the Audit Committee as a standing agenda item at each meeting.

During 2021/22 due to the ongoing response to the COVID-19 pandemic, some of the planned activity was delayed e.g. face to face awareness sessions. However, alternative awareness activities were undertaken including the development of a Fraud, Bribery and Corruption Awareness Video with links shared via staff bulletins.

The Anti-Fraud Specialist completed a wide range of work across the main key areas of activity as outlined by NHS CFA and agreed within the workplan by the Audit Committee. The following has been achieved and (reported on to the CCG's Audit Committee) during the year:

- Attendance at each Audit Committee (virtual) and presentation of the 2021/22 work plans and annual report
- Regular meetings with key personnel including the Chief Finance Officer and Internal Audit
- Completion of baseline assessment of the Government Functional Standard 013 for Counter Fraud introduced in 2021/22
- Submission of the CCG's response to the Fraud Prevention Guidance Impact Assessment
- Provision of Anti-Fraud due diligence checklist to provide assurance regarding the pending transition to the ICB
- Review and update of the CCG's Anti-Fraud, Bribery and Corruption Policy
- Undertaken a risk assessment of the key risks (including closedown risks) to fraud across the CCG and associated mitigation actions.
- Continued response to COVID-19 fraud alerts and staff communication around the risks identified has been prioritised so appropriate action could be quickly taken
- Circulars covering various fraud and bribery related topics e.g. International Fraud Awareness, Fraud Newsflash, Recent Cases Articles as well as Fraud Awareness videos
- Provide support as required to undertake investigations into allegations
- Provision of evidence, and participation in, NHS CFA Quality and Compliance Team, Inspection of NHS East Lancashire CCG

A member of the executive team is proactively and demonstrably responsible for tackling fraud, bribery and corruption.

The CCG's Chief Finance Officer oversees the anti-fraud arrangements for the CCG.

Appropriate action is taken regarding any NHS Protect quality assurance recommendations.

The CCG has a "Freedom to Speak Up" policy to enable staff or members of the public to report any genuine non malicious concerns they have in confidence. This could be in relation to a possible fraud, crime, danger or other serious risk affecting patient safety, the welfare of staff or the reputation, or financial stability of the CCG or wider NHS.

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:

The overall opinion for the period 1 April 2021 to 31 March 2022 provides Substantial Assurance can be given that there is a good system of internal control designed to meet the organisation's objectives, and the controls are generally being applied consistently

During the year, Internal Audit issued the following audit reports:

Area of Audit	**Level of Assurance Given**
Assurance Framework	The organisation's Assurance Framework is structured to meet NHS England Requirements. The Assurance Framework is visibly used by the Governing Body The Assurance Framework clearly reflects the risks discussed by the Governing Body
Combined Financial Systems (Key Financial Controls)	Substantial Assurance
Conflicts of Interest	Governance arrangements – partially compliant Declarations of interests and gifts and hospitality – fully compliant Register of interest, gifts, hospitality and procurement decisions – fully compliant Decision making processes and contract monitoring – fully compliant Reporting concerns and identifying breaches/non-compliance – fully compliant

Data Protection and Security Toolkit – CCG to Integrated Care Systems (ICS) Handover Review Summary Report 2021/22	Substantial Assurance
CCG Transition Review	n/a Assurance can be provided that effective processes have been established for the completion and monitoring of the programme plan

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

Responsibility for risk management is brought together through the Senior Directors who work collectively to oversee the key risks to the organisation. Senior Managers take a pivotal role in the CCG reporting structure with a responsibility for co-ordinating, communicating and accelerating strategic and operational assurance issues, regularly reporting on core business activity.

Our Risk Register and Assurance Framework continues to be monitored and updated in line with the Risk Management Strategy and Policy supporting our systems of internal control throughout this year of operation.

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:

- Individual internal audit reports relating to the CCG
- External audit via their annual audit letter which provides a high-level summary of audit work carried out
- Regular Senior Directors, ICC and Cell leads meetings
- Reports to Audit Committee by the Local Anti-Fraud Specialists
- Information Governance Data Security and Protection Toolkit work plan.

- Review of the Corporate Risk Register by the ICC, Governing Body and Audit Committee
- scrutiny of the Governing Body Assurance Framework by the Audit Committee and Governing Body
- Regular meetings with NHS England

Conclusion

As Accountable Officer, my review concludes that NHS East Lancashire Clinical Commissioning Group has a generally sound system of internal control that supports the achievement of its policies, aims and objectives, and that no significant internal control issues have been identified.

Dr Julie Higgins

Accountable Officer

20 June 2022

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

Details of the remuneration committee, its roles, responsibilities, members and frequency can be found within the Annual Governance Statement section of this report at page 93.

Policy on the remuneration of senior managers

Remuneration of senior managers, up to and including Band 9, is undertaken in accordance with Agenda for Change, and guided as advised by NHS Midlands and Lancashire Commissioning Support Unit's Human Resources service.

Remuneration of very senior managers

We are obliged to review the remuneration of all our Senior Executives on an annual basis and in particular in accordance with Secretary of State Directions – those salaries which are in excess of the Prime Minister's ie £150,000 per annum. No individual received a salary which was in excess of the Prime Minister's salary of £150,000 per annum.

Policy on senior managers' contracts

Contracts are written in line with national terms and conditions with input and advice from the CSU HR commissioned service. The duration of the Chair and Lay Members to the CCG are written into the CCG constitution and run for a three year period. Governing Body clinical leads are re-elected as per the CCG constitution, every three years.

Senior managers' service contracts

There were no senior manager service contracts.

Senior manager remuneration – 2021/2022 (including salary and pension entitlements) – Information subject to audit

Table 4E: Single total figure table		2021/22			2021/22	2021/22			2021/22			2021/22			2021/22		
		Salary & fees (in bands of £5k)			All taxable benefits (total to the nearest £100)	Annual performance-related bonuses (in bands of £5k)			Long-term performance-related bonuses (in bands of £5k)			All pension-related benefits (in bands of £2.5k)			Total (bands of £5k)		
Name of senior manager	Job title (and period of office if relevant)	£000s (Band of £5k)			£s (nearest £100)	£000s (Band of £5k)			£000s (Band of £5k)			£000s (Band of £2.5k)			£000s (Band of £5k)		
Dr. J Higgins (i, viii)	Accountable Officer	90	-	95	0	0	-	0	0	-	0	0	-	-	90	-	95
K Hollis	Chief Finance Officer	110	-	115	0	0	-	0	0	-	0	32.5	-	35.0	145	-	150
K Lord (i)	Director of Quality & Chief Nurse	65	-	70	0	0	-	0	0	-	0	17.5	-	20.0	85	-	90
A Walker	Director of Performance & Delivery	100	-	105	0	0	-	0	0	-	0	27.5	-	30.0	130	-	135
Dr. M Dziobon (ii)	Medical Director	130	-	135	0	0	-	0	0	-	0	57.5	-	60.0	190	-	195
Dr. R J Robinson	GB GP Member - Chair	75	-	80	0	0	-	0	0	-	0	22.5	-	25.0	95	-	100
Dr. D White (iii)	GB GP Member - Clinical Advisor	75		80	0	0	-	0	0	-	0	5.0	-	7.5	80	-	85
Dr. R Sharma (iv)	GB GP Member - Clinical Advisor	55		60	0	0	-	0	0	-	0	22.5	-	25	80	-	85
Dr. S Davis (v)	GB GP Member - Clinical Advisor	75	-	80	0	0	-	0	0	-	0	0	-	0	75	-	80
Dr. T Mackenzie (vi, viii)	GB GP Member - Clinical Advisor	45	-	50	0	0	-	0	0	-	0	0	-	0	45	-	50
Dr. P Taylor (viii)	GB Member - Secondary Care Doctor	10	-	15	0	0	-	0	0	-	0	0	-	0	10	-	15
D Swift (vii)	Lay Member - Governance	15	-	20	0	0	-	0	0	-	0	0	-	0	15	-	20

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

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual.

The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Explanation of annotation in Senior manager remuneration – 2021/2022 comparative data

i) The Joint Accountable Officer and Director of Quality & Chief Nurse roles are joint posts with NHS Blackburn with Darwen CCG. 35% of costs are recharged to BwD CCG. The figures above include 65% of salary and pension. The total salary banding for Dr J Higgins is 140-145k and for K Lord is 100-105k.

ii) 15-20k salary relates to non-managerial work

iii) 35-40k salary relates to non-managerial work

iv) 15-20k salary relates to non-managerial work

v) 35-40k salary relates to non-managerial work

vi) 5-10k salary relates to non-managerial work

vii) Lay Members are not eligible for membership of the NHS Pension scheme

viii) Do not make contributions to the NHS Pension Scheme

Senior manager remuneration – 2020/2021 comparative data (including salary and pension entitlements) – information subject to audit

Table 4E: Single total figure table		2020/21			2020/21	2020/21			2020/21			2020/21			2020/21		
		Salary & fees (in bands of £5k)			All taxable benefits (total to the nearest £100)	Annual performance-related bonuses (in bands of £5k)			Long-term performance-related bonuses (in bands of £5k)			All pension-related benefits (in bands of £2.5k) (iv)			Total (bands of £5k)		
Name of senior manager	Job title (and period of office if relevant)	£000s (Band of £5k)			£s (nearest £100)	£000s (Band of £5k)			£000s (Band of £5k)			£000s (Band of £2.5k)			£000s (Band of £5k)		
Dr. J Higgins (i)	Accountable Officer	90	-	95	0	0	-	0	0	-	0	0	-	2.5	90	-	95
K Hollis	Chief Finance Officer	110	-	115	0	0	-	0	0	-	0	20.0	-	22.5	130	-	135
K Lord (i)	Director of Quality & Chief Nurse	65	-	70	0	0	-	0	0	-	0	15.0	-	17.5	80	-	85
A Walker	Director of Performance & Delivery	100	-	105	0	0	-	0	0	-	0	22.5	-	25.0	125	-	130
Dr. M Dziobon (ii)	Medical Director	95	-	100	0	0	-	0	0	-	0	47.5	-	50.0	145	-	150
Dr. R J Robinson	GB GP Member - Chair	75	-	80	0	0	-	0	0	-	0	20.0	-	22.5	95	-	100
Dr. D White (iii)	GB GP Member - Clinical Advisor	75	-	80	0	0	-	0	0	-	0	15.0	-	17.5	90	-	95
Dr. R Sharma (iv)	GB GP Member - Clinical Advisor	55	-	60	0	0	-	0	0	-	0	0	-	0	55	-	60
Dr. S Davis (v)	GB GP Member - Clinical Advisor	70	-	75	0	0	-	0	0	-	0	0	-	0	70	-	75
Dr. T Mackenzie (vi, viii)	GB GP Member - Clinical Advisor	45	-	50	0	0	-	0	0	-	0	0	-	0	45	-	50
M Pilling (vii)	Deputy Chair & Lay Member for Patient & Public Involvement (until November 2020)	10	-	15	0	0	-	0	0	-	0	0	-	0	10	-	15
Dr. P Taylor (viii)	GB Member - Secondary Care Doctor	10	-	15	0	0	-	0	0	-	0	0	-	0	10	-	15
D Swift (vii)	Lay Member - Governance	15	-	20	0	0	-	0	0	-	0	0	-	0	15	-	20

Explanation of annotation in Senior manager remuneration – 2020/2021 comparative data

i) The Joint Accountable Officer and Director of Quality & Chief Nurse roles are joint posts with NHS Blackburn with Darwen CCG. 35% of costs are recharged to BwD CCG. The figures above include 65% of salary and pension. The total salary banding for Dr J Higgins is 140-145k and for K Lord is 100-105k.

ii) 15-20k salary relates to non-managerial work

iii) 35-40k salary relates to non-managerial work

iv) 15-20k salary relates to non-managerial work

v) 35-40k salary relates to non-managerial work

vi) 5-10k salary relates to non-managerial work

vii) Lay Members are not eligible for membership of the NHS Pension scheme

viii) Do not make contributions to the NHS Pension Scheme

Pension benefits as at 31 March 2022 (information subject to audit)

		To 31 March 2022							
		Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2022	Lump sum at pension age related to accrued pension at 31 March 2022	Cash Equivalent Transfer Value at 01 April 2021	Real increase in Cash Equivalent Transfer Value (i)	Cash Equivalent Transfer Value at 31 March 2022	Employer's Contribution to partnership pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
Name		**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
K Hollis	Chief Finance Officer	0 - 2.5	0 - 2.5	45 - 50	90 - 95	797	36	852	0
Dr. D White	Clinical Advisor	0 - 2.5	0 - 2.5	15 - 20	45 - 50	399	12	425	0
Dr. R Sharma	Clinical Advisor	0 - 2.5	0 - 2.5	15 - 20	35 - 40	334	23	366	0
Dr. M Dziobon	Clinical Director	2.5 - 5.0	0 - 2.5	25 - 30	20 - 25	307	36	364	0
Dr. R Robinson	Governing Body Chair	0 - 2.5	0 - 2.5	20 - 25	45 - 50	357	18	387	0
K Lord (ii)	Director of Quality & Chief Nurse	0 - 2.5	0 - 2.5	25 - 30	50 - 55	424	19	455	0
A Walker	Director of Commissioning	0 - 2.5	0 - 2.5	40 - 45	115 - 120	953	43	1015	0

(i) The factors used by the NHS Business Authority to calculate Cash Equivalent Transfer Values; C.E.T.V.s; increased on the 29 of October 2018, affecting the calculation of the real increase of C.E.T.V.s. This together with adjustment for inflation and deduction of employee superannuation contributions gives the real increase shown.

(ii) Mrs K. Lord's post is a joint post with Blackburn with Darwen CCG. Mrs Lord's costs are shared 65% East Lancashire CCG and 35% Blackburn with Darwen CCG. The figures above reflect the East Lancashire percentage

(iii) Dr J. Higgins Chief Accountable Officer has no figures shown in this table for the 2021-22 financial year as she opted out of the NHS pension scheme in the 2020-21 financial year.

Values shown above are adjusted to reflect the number of days an employee was in post.

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

Pension benefits as at 31 March 2021 (information subject to audit) – prior year comparator data

		To 31 March 2021							
		Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2021	Lump sum at pension age related to accrued pension at 31 March 2021	Cash Equivalent Transfer Value at 01 April 2020	Real increase in Cash Equivalent Transfer Value (i)	Cash Equivalent Transfer Value at 31 March 2021	Employer's Contribution to partnership pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
Name		**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Dr. J Higgins (ii)	Accountable Officer	0 - 2.5	0 - 2.5	30 - 35	80 - 85	655	11	685	0
K Hollis	Chief Finance Officer	0 - 2.5	0 - 2.5	40 - 45	90 - 95	746	22	797	0
Dr. D White	Clinical Advisor	0 - 2.5	0 - 2.5	15 - 20	45 - 50	363	18	399	0
Dr. R Sharma	Clinical Advisor	0 - 2.5	0 - 2.5	15 - 20	35 - 40	318	2	334	0
Dr. M Dziobon	Clinical Director	2.5 - 5.0	0 - 2.5	20 - 25	20 - 25	259	29	307	0
Dr. R Robinson	Governing Body Chair	0 - 2.5	0 - 2.5	20 - 25	45 - 50	325	15	357	0
K Lord (ii)	Director of Quality & Chief Nurse	0 - 2.5	0 - 2.5	20 - 25	50 - 55	394	15	424	0
A Walker	Director of Commissioning	0 - 2.5	0 - 2.5	40 - 45	115 - 120	892	32	953	0

Losses and special payments

In 2021/22 no special payments were made or losses incurred.

Compensation on early retirement of for loss of office

There has been no incidence of compensation on early retirement for loss of office during 2021/2022 (nil return for 2020/2021).

Payments to past directors

There has been no incidence of payments to past directors during 2021/2022 (nil return for 2020/2021).

Fair Pay Disclosure

Percentage change in remuneration of highest paid director

	Salary and allowances	**Performance pay and bonuses**
The percentage change from the previous financial year in respect of the highest paid director	0%	N/A
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	1.64%	N/A

With the exception of those governing body members who hold very senior manager (VSM) contracts, employees of the CCG hold contracts and are paid in accordance with agenda for change. For 2021/22, the national agenda for change pay award was 3%. For VSM, there was national guidance published to state that those officers on such a contract, should not receive an in year pay award. This was accepted by the CCG's remuneration committee and no inflationary increase was awarded to those employees. This included the highest paid director.

The average percentage change is only showing as 1.64% as there has been a change to the composition of the staffing structure. A number of senior staff on higher agenda for change bandings have left the organisation and they have either not been replaced or, replaced by staff on lower grades, thus reducing the comparator figures.

Pay ratio information

As at 31 March 2022, remuneration ranged from £18.5k to £132.5k (+1.64% against 2020/21: £19.7k to £132.5k) 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.

Remuneration of NHS East Lancashire CCG staff is shown in the table below:

	25th percentile	**Median**	**75th percentile**
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£31,534	£45,839	£57,894
salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£31,534	£45,839	£55,683

The ratios of staff remuneration against the mid-point of the banded remuneration of the highest paid director, is illustrated in the table below.

Year	**25th percentile pay ratio**	**Median pay ratio**	**75th percentile pay ratio**
2021/22	4.20:1	2.89:1	2.29:1
2020/21	4.22:1	2.98:1	2.25:1

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 NHS East Lancashire CCG in the financial year 2021/22 was £130-135k (0%+/- against 2020/21: £130-135k) and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th percentile total remuneration ratio	25th percentile salary ratio	Median total remuneration ratio	Median salary ratio	75th percentile total remuneration ratio	75th percentile salary ratio
2021/22	4.20:1	4.20:1	2.89:1	2.89:1	2.29:1	2.38:1
2020/21	4.22:1	4.28:1	2.98:1	2.98:1	2.25:1	2.41:1

In 2021/22, 0 [zero] (2020/21, 0 [zero]) employees received remuneration in excess of the highest-paid director/member.

The general trend across all the percentiles is a slight reduction. All staff on agenda for change received a cost of living increase during the financial year 2021/22 whilst the senior directors on VSM pay scales did not in line with national guidance. Thus closing the gap.

Staff Report

As a CCG, we need to assure ourselves and our public that we have the capacity and capabilities needed to deliver our vision and strategy.

We want to ensure that our organisation is functioning at its best and that our employees are supported to develop themselves and others.

We want to be an organisation that people want to work for, and others want to work with.

Number of senior managers

The total number of senior managers, by head count is shown in the table below. A senior manager is anybody who is remunerated on Agenda for Change band 8A or above, very senior manager (VSM) payscale or an equivalent clinical grade.

Payscale	Headcount
VSM	4
Other Non-AFC	2
Clinical Non-AFC	14
Band 9	0
Band 8 - Range D	4
Band 8 - Range C	8
Band 8 - Range B	10
Band 8 - Range A	17

Staff numbers and costs

The average staff numbers for the year are shown in the table below:

	Total Number	Permanently Employed	Other
Total	78.34	76.09	2.25

The numbers above are based on the average whole-time equivalent number of employees and exclude staff on outward secondment.

These figures exclude those who hold a contract for services with the CCG, are lay members or who do not hold a contract of employment and are therefore not classed as “staff”.

Staff composition

Staff composition is shown in the table below and complies with the reporting requirements of the Department of Health and Social Care Group Accounting Manual for 2021/22.

	Headcount by Gender		
Staff Grouping	**Female**	**Male**	**Totals**
All Other Employees	67	13	**80**
Governing Body	3	9	**12**
Other Senior Management (Band 8C+)	14	6	**20**
Grand Total	**84**	**28**	**112**

The above analysis is based on “head count”.

Our management and staffing structure operates within fixed running costs and our staff have a wide range of local knowledge and professional expertise. We have five geographical localities all represented by a Primary Care Network (nine in total).

Employee Benefits (subject to Audit)

The following two tables show the split of employee expenditure costs between staff who hold a permanent contract with the CCG and those who are on a temporary contract. The second table is the comparator information from the financial year 2020/2021. The tables show very little change between the two financial years.

	2021/2022		
	Permanent Employees	**Other**	**Total**
	£'000	**£'000**	**£'000**
Employee Benefits			
Salaries and wages	**4,440**	**170**	**4,610**
Social security costs	**556**	**0**	**556**
Employer Contributions to NHS Pension scheme	**919**	**0**	**919**
Apprenticeship Levy	**11**	**0**	**11**
Gross employee benefits expenditure	5,926	170	6,096
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	5,926	170	6,096

Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	5,926	170	6,096

	2020/2021		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	**4,474**	**188**	4,663
Social security costs	**535**	**0**	535
Employer Contributions to NHS Pension scheme	**938**	**0**	938
Apprenticeship Levy	**10**	**0**	**10**
Gross employee benefits expenditure	5,957	188	6,145
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	5,957	188	6,145

Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	5,957	188	6,145

Sickness absence data

The following table details staff sickness and absence for the financial year 2021/22 and is consistent with that reported by NHS Digital and provided to the CCG.

Staff sickness absence 2022	2022	2021
Total FTE* Days Lost	493	317.56
Total FTE Days available	34,151	20,441.65
Average Annual Sick Days per FTE	3.2	3.5

(* FTE = Full Time Equivalent)

Staff absences were managed through the CCG's sickness absence policy.

Staff turnover percentages

The following table details staff turnover during the year 2021/2022

CCG Staff Turnover 2021-22	2021-22 Number
Average FTE Employed 2021-22	90.38
Total FTE Leavers 2021-22	8.68
Turnover Rate	9.60%

The CCG Staff Turnover Rate for 2021-22 has been calculated by dividing the total full time equivalent (FTE) Leavers in-year by the average FTE Staff in Post during the year. The CCG's Total FTE Leavers in year was 8.68. The CCG's Average FTE Staff in Post during the year was 90.38. The CCG Staff Turnover Rate for the year was 9.6%.

Staff Engagement

During the course of the year, staff from across all the CCGs in Lancashire and South Cumbria have been invited to participate in a quarterly health and wellbeing survey. The average response rate across all the CCGs was 21.5%. Themes and trends from the response have informed the health and wellbeing strategy and the support offers made to staff throughout the year.

Staff policies

All staff policies and procedures in force during the financial year are published on the CCG's website here: Policies (eastlancsccg.nhs.uk)

Details regarding diversity and inclusion policies, initiatives and longer term ambitions will be published with the Equality and Inclusion Annual Report for 2021/22 which will be published on the CCG website once approved. This will include:

- How policies and activities undertaken in the year have or will improve the diversity and inclusiveness of the workforce.

- Whether the entity has identified any barriers to improving the diversity of its workforce and if so, what actions the entity has or will put in place.
- Changes in staff composition impacting on the diversity and inclusiveness of the workforce, including appropriate trend data.
- Performance against internal targets set in relation to diversity and inclusiveness of the workforce if applicable.'

Trade Union Facility Time Reporting Requirements

East Lancashire CCG is an active participant in the Staff Partnership Forum facilitated by NHS Midlands and Lancashire Commissioning Support Unit. The CCG utilises this forum as a vehicle and mechanism to support proactive staff engagement, consultation and, where appropriate, negotiation. 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.

Other employee matters

Expenditure on consultancy

In 2021/22, the CCG spent £25,200 on consultancy.
The whole of this expenditure relates to the securing of services of an experienced senior nursing advisor in relation to investigation and reporting of quality issues with providers.

Off-payroll engagements

Off-payroll engagements longer than 6 months

The table below details 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	0
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	0

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

The CCG can confirm that there were no such engagements.

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

For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245[1] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	0
Of which:	
No. not subject to off-payroll legislation[2]	0
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	0
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	0
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

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

[2] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

The CCG can confirm that there were no such engagements.

Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year [1]	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements. [2]	12

[1]There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months.

[2]As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero.

Exit packages, including special (non-contractual) payments

Table 1: Exit Packages

There have been no exit packages or special non-contractual payments made to staff during the course of 2021/22 (nil return 2020/2021)

Exit package cost band (inc. 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	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0

£150,001 – £200,000	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
>£200,000	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTALS	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Table 2: Analysis of Other Departures

There have been no other departures agreed or paid during the course of 2021/2022. (nil return 2020/2021).

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

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

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

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

Dr Julie Higgins

Accountable Officer

20 June 2022

Parliamentary Accountability and Audit Report

NHS East Lancashire CCG is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report at page 118. An audit certificate and report is also included in this Annual Report at page 135.

External auditor's remuneration

Grant Thornton UK LLP are the CCG's appointed external auditors and we paid a total of £78.5k to them in 2021/2022.

The breakdown of this expenditure is as follows:

	2021/2022 £'000	**2020/2021 £'000**
External Audit Services	63.5	60.5
Further Assurance Work	0	0
Mental Health Investment Standard Assurance Work	15.0	10.0
Total Expenditure on external audit work	**78.5**	**70.5**

The work undertaken as part of the external audit service encompasses all the work carried out under the Code of Audit Practice, namely audit of the annual financial statements and the issue of a value for money conclusion on the CCG's use of resources.

Members of the appointed audit team have met with officers on a regular basis throughout the year to discuss and advise on matters ranging from technical accounting topics to discussing the audit process. They also attend Audit Committee meetings where they provide on-going audit updates, advice and discussion on any issues which are brought to their attention. This also ensure that they are formally sighted on CCG business throughout the year.

During the year, both Grant Thornton and those charged with governance of the CCG, have assessed potential conflicts of interest. Both were able to conclude that none were found.

Cost Allocation and charges for information

We certify that the CCG has complied with HM Treasury's guidance on cost allocation and the setting of charges for information.

Better Payment Practice Code / Prompt Payment Code

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. Details of our payment compliance can be found in note 6.1 of the annual accounts.

Dr Julie Higgins

Accountable Officer
20 June 2022

Independent auditor's report to the members of the Governing Body of NHS East Lancashire Clinical Commissioning Group

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of NHS East Lancashire Clinical Commissioning Group (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, the Health and Care Act received Royal Assent on 28 April 2022. The Act will allow for the establishment of Integrated Care Boards (ICB) , which are due to take on the commissioning functions of CCGs from 1 July 2022. On this date East Lancashire CCG's functions, assets and liabilities are due to transfer to NHS Lancashire and South Cumbria ICB.

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 £723.667 million against a target of £721.525 million and a deficit of £2.142 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.

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 20 June 2022 we referred a matter to the Sectary of State under Section 30 of the Local Audit and Accountability Act 2014 in relation to the CCG a breach of its breakeven duty and 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.

- 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/or expenditure recognition, and the significant accounting estimates related to the prescribing accrual. A section 30 referral to the Secetary of State in relation to the failure to achieve a breakeven duty.
- 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.

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.

Our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the CCG's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2022.

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 – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for the NHS East Lancashire Clinical Commissioning Group for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

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.

Sarah L Ironmonger

Sarah Ironmonger, Key Audit Partner

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

Manchester

20 June 2022

ANNUAL ACCOUNTS

The following pages detail the accounts submission for the financial year 1 April 2021 – 31 March 2022.

Dr Julie Higgins

Accountable Officer
20 June 2022

Entity name:	NHS East Lancashire Clinical Commissioning Group
This year	2021-22
Last year	2020-21
This year ended	31-March-2022
Last year ended	31-March-2021
This year commencing:	01-April-2021
Last year commencing:	01-April-2020

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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
Income from sale of goods and services	2	(3,663)	(838)
Other operating income	2	-	-
Total operating income		**(3,663)**	**(838)**
Staff costs	4	6,096	6,145
Purchase of goods and services	5	714,645	687,206
Provision expense	5	2,825	911
Other Operating Expenditure	5	101	137
Total operating expenditure		**723,667**	**694,399**
Net Operating Expenditure		**720,004**	**693,561**
Finance income		-	-
Finance expense		-	-
Net expenditure for the Year		**720,004**	**693,561**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**720,004**	**693,561**
Other Comprehensive Expenditure		-	-
Sub total		**-**	**-**
Comprehensive Expenditure for the year		**720,004**	**693,561**

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Property, plant and equipment		-	-
Intangible assets		-	-
Investment property		-	-
Trade and other receivables		-	-
Other financial assets		-	-
Total non-current assets		-	-
Current assets:			
Inventories	8	1,971	1,803
Trade and other receivables	9	4,102	3,933
Other financial assets		-	-
Other current assets		-	-
Cash and cash equivalents	10	41	45
Total current assets		**6,114**	5,781
Non-current assets held for sale		-	-
Total current assets		**6,114**	5,781
Total assets		**6,114**	5,781
Current liabilities			
Trade and other payables	11	(47,315)	(44,364)
Other financial liabilities		-	-
Other liabilities		-	-
Borrowings		-	-
Provisions	12	(3,736)	(911)
Total current liabilities		**(51,051)**	(45,275)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(44,937)**	(39,494)
Non-current liabilities		-	-
Total non-current liabilities		**-**	-
Assets less Liabilities		**(44,937)**	(39,494)
Financed by Taxpayers' Equity			
General fund		(44,937)	(39,494)
Total taxpayers' equity:		**(44,937)**	(39,494)

The notes on pages 5 to 28 form part of this statement

The financial statements on pages 1 to 28 were approved by the Audit Committee on the 14th of June and signed on it's behalf by:

Dr. J. Higgins
Chief Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22				
Balance at 01 April 2021	(39,494)	0	0	**(39,494)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	**(39,494)**	**0**	**0**	**(39,494)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22				
Net operating expenditure for the financial year	(720,004)			**(720,004)**
Other movements & net gain/(loss) on revaluations	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(720,004)**	**0**	**0**	**(720,004)**
Net funding	714,561	0	0	**714,561**
Balance at 31 March 2022	**(44,937)**	**0**	**0**	**(44,937)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21				
Balance at 01 April 2020	(38,361)	0	0	**(38,361)**
Transfer of assets and liabilities from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	**(38,361)**	**0**	**0**	**(38,361)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21				
Net operating costs for the financial year	(693,561)			(693,561)
Other movements & net gain/(loss) on revaluations	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(693,561)**	**0**	**0**	**(693,561)**
Net funding	692,428	0	0	692,428
Balance at 31 March 2021	**(39,494)**	**0**	**0**	**(39,494)**

The notes on pages 5 to 28 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		(720,004)	(693,561)
(Increase)/decrease in inventories	8	(168)	(119)
(Increase)/decrease in trade & other receivables	9	(168)	2,693
Increase/(decrease) in trade & other payables	11	2,950	(2,495)
Increase/(decrease) in provisions	12	2,825	911
Net Cash Inflow (Outflow) from Operating Activities		**(714,565)**	(692,571)
Cash Flows from Investing Activities		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(714,565)**	(692,571)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		714,561	692,428
Net Cash Inflow (Outflow) from Financing Activities		**714,561**	692,428
Net Increase (Decrease) in Cash & Cash Equivalents		**(4)**	(143)
Cash & Cash Equivalents at the Beginning of the Financial Year		**45**	188
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**41**	45

The notes on pages 5 to 28 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**

The Health and Care Act received Royal Assent on the 28th of April 2022. The Act will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs from the 1st of July 2022. On this date the CCG's functions, assets and liabilities will transfer to Lancashire & 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 31st of 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 **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 a range of activities and Note 17 provides details of the income and expenditure.

The pool is 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.

The Better Care Fund is accounted for net;Lancashire County Council invoices the CCG for the total amount of the Better Care Fund; the CCG in turn invoices Lancashire County Council for their share of the fund, the resulting net balance is accounted for in the CCG accounts.

1.5 **Operating Segments**

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

1.6 **Revenue**

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

• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

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

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

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

Payment terms are standard reflecting cross government principles.

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

1.7. **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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

1.7.2 **Retirement Benefit Costs**

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

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

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

Notes to the financial statements

Three employees are members of the NEST defined contribution scheme; the cost to the Clinical Commissioning Group regarding this scheme is limited to the contributions payable to the scheme for those employees within the relevant accounting period.

1.8 **Other Expenses**

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

1.9 **Grants Payable**

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

1.10. **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.

1.10.1 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

NHSE East Lancashire CCG ceased to be based in Walshaw House, Colne, Lancashire from April 2021. This has meant that there are no lease charges to be disclosed in the 2021-22 financial year. The CCG now shares premises with NHS Blackburn with Darwen CCG who account for all lease charges within it's accounts.

1.11 **Inventories**

The CCG has a stock of community equipment held at client premises. The inventory is valued at the figure shown in the service provider's register less write downs based on the age of the equipment. The total value of any single use items within the service provider's register is estimated to be immaterial.

1.12 **Cash & Cash Equivalents**

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

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

1.13 **Provisions**

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

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

1.14 **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.

1.15 **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.

Notes to the financial statements

1.16 **Carbon Reduction Commitment Scheme**

The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The clinical commissioning group is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

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.

1.19.1 **Financial Guarantee Contract Liabilities**

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

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

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

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Notes to the financial statements

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

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

1.21 **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 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.23 **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.

1.23.1 **Critical accounting judgements in applying accounting policies**
The following are the judgements, apart from those involving estimations, that management has made in the process of applying the clinical commissioning group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.
In line with the other clinical commissioning groups across Lancashire and South Cumbria, a decision has been made to write back a prescribing prepayment which had been set up to reflect prescription medications held by patients as at the 31st of March within each accounting year. This has had the effect of increasing in year prescribing expenditure by £2.109 million.

1.24 **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.

As noted above there has been no expenditure regarding leases within 2021-22 for NHS East Lancashire CCG, therefore there would have been no effect if IFRS 16 had been adopted.

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

2 Other Operating Revenue

	2021-22 Total	2020-21 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	**8**	8
Non-patient care services to other bodies	**-**	2
Other Contract income	**3,655**	828
Total Income from sale of goods and services	**3,663**	**838**
Other operating income	**-**	-
Total Operating Income	**3,663**	**838**

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

2021-22	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000
Source of Revenue			
NHS	8	-	2,847
Non NHS	-	-	808
Total	**8**	**-**	**3,655**

2021-22	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000
Timing of Revenue			
Point in time	8	-	3,655
Over time	-	-	-
Total	**8**	**-**	**3,655**

2020-21	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000
Source of Revenue			
NHS	8	2	162
Non NHS	-	-	666
Total	**8**	**2**	**828**

2020-21	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000
Timing of Revenue			
Point in time	8	2	828
Over time	-	-	-
Total	**8**	**2**	**828**

4. Employee benefits and staff numbers

4.1.1 Employee benefits	**Total**		**2021-22**
	Permanent Employees	**Other**	**Total**
	£'000	**£'000**	**£'000**
Employee Benefits			
Salaries and wages	**4,440**	**170**	**4,610**
Social security costs	**556**	**0**	**556**
Employer Contributions to NHS Pension scheme	**919**	**0**	**919**
Apprenticeship Levy	**11**	**0**	**11**
Gross employee benefits expenditure	5,926	170	6,096
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	5,926	170	6,096
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	5,926	170	6,096

4.1.1 Employee benefits	Total		2020-21
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	**4,474**	**188**	4,663
Social security costs	**535**	**0**	535
Employer Contributions to NHS Pension scheme	**938**	**0**	938
Apprenticeship Levy	**10**	**0**	**10**
Gross employee benefits expenditure	5,957	188	6,145
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	5,957	188	6,145
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	5,957	188	6,145

4.1.2 Recoveries in respect of employee benefits

There were no recoveries in respect of employee benefits in 2021-22 or 2020-21.

4.2 Average number of people employed

	2021-22			2020-21		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**76.09**	**2.25**	**78.34**	**77.25**	**3.34**	**80.59**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

There were no exit packages or other agreed departures within 2021-22 or 2020-21.

4.4 Pension costs

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

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

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

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

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

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

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

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

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to the 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 £657,759 were payable to the NHS Pension Scheme at the rate of 20.6% (2020-21 £654,960).

5. Operating expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	4,724	6,869
Services from foundation trusts	112,884	99,527
Services from other NHS trusts	351,278	350,454
Purchase of healthcare from non-NHS bodies	93,776	86,627
Purchase of social care	9,717	9,228
Prescribing costs	66,354	63,940
GPMS/APMS and PCTMS	63,949	61,565
Supplies and services – clinical	61	21
Supplies and services – general	5,774	195
Consultancy services	25	227
Establishment	1,131	1,988
Transport	6	1
Premises	4,549	6,351
Audit fees	80	73
Other non statutory audit expenditure	18	13
Other professional fees	92	3
Legal fees	164	85
Education, training and conferences	64	40
Total Purchase of goods and services	**714,645**	**687,206**
Provision expense		
Change in discount rate	-	-
Provisions	2,825	911
Total Provision expense	**2,825**	**911**
Other Operating Expenditure		
Chair and Non Executive Members	101	137
Total Other Operating Expenditure	**101**	**137**
Total operating expenditure	**717,571**	**688,254**

In accordance with S.I. 2008 No.489 the Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, where a CCG's contract with it's Auditors provides for a limitation of the Auditor's liability the principle term of this limitation must be disclosed. NHS East Lancashire CCG's Auditor is Grant Thornton U.K. L.L.P. and it's legal liability in regard to this audit is limited to £2 million.
The audit fee shown above is gross of Value Added Tax.

6 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	24,044	197,906	27,974	187,214
Total Non-NHS Trade Invoices paid within target	23,775	195,647	27,780	185,248
Percentage of Non-NHS Trade invoices paid within target	**98.88%**	**98.86%**	**99.31%**	**98.95%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	612	475,220	1,471	463,433
Total NHS Trade Invoices Paid within target	602	474,752	1,437	462,668
Percentage of NHS Trade Invoices paid within target	**98.37%**	**99.90%**	**97.69%**	**99.83%**

7. Operating Leases

7.1 As lessee

NHS East Lancashire Clinical Commissioning Group vacated it's headquarters in April 2021. Due to the Covid pandemic most staff have worked from home during 2021-22 and additional office space has been secured in NHS Blackburn with Darwen Clinical Commissioning Group headquarters for 2022-23 onwards. Thus no lease charges have been incurred in 2021-22.

7.1.1 Payments recognised as an Expense

	2021-22				2020-21			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payments recognised as an expense								
Minimum lease payments	-	-	-	**-**	-	386	9	**395**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**-**	**-**	**-**	**-**	**386**	**9**	**395**

7.1.2 Future minimum lease payments

	2021-22				2020-21			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payable:								
No later than one year	-	-	-	**-**	-	283	9	**292**
Between one and five years	-	-	-	**-**	-	746	-	**746**
After five years	-	-	-	**-**	-	-	-	**-**
Total	**-**	**-**	**-**	**-**	**-**	**1,029**	**9**	**1,038**

8 Inventories

	Loan Equipment £'000	Other £'000	Total £'000
Balance at 01 April 2021	1,803	-	**1,803**
Additions	168	-	**168**
Balance at 31 March 2022	**1,971**	**-**	**1,971**

	Loan Equipment £'000	Other £'000	Total £'000
Balance at 01 April 2020	1,684	-	1,684
Additions	119	-	119
Balance at 31 March 2021	**1,803**	**-**	**1,803**

9 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	1,441	-	1,343	-
Non-NHS and Other WGA receivables: Revenue	2,091	-	360	-
Non-NHS and Other WGA prepayments	529	-	2,118	-
Non-NHS and Other WGA accrued income	38	-	73	-
VAT	3	-	39	-
Total Trade & other receivables	**4,102**	**-**	**3,933**	**-**
Total current and non current	**4,102**		**3,933**	
Included above:				
Prepaid pensions contributions	-		-	

9.1 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	278	2,071	52	72
By three to six months	71	8	-	21
By more than six months	-	-	-	22
Total	**349**	**2,078**	**52**	**115**

10 Cash and cash equivalents

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	45	188
Net change in year	(4)	(143)
Balance at 31 March 2022	**41**	**45**
Made up of:		
Cash with the Government Banking Service	41	45
Balance at 31 March 2022	**41**	**45**

11 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	6,622	-	2,323	-
NHS accruals	596	-	1,680	-
Non-NHS and Other WGA payables: Revenue	6,413	-	5,209	-
Non-NHS and Other WGA accruals	32,307	-	33,992	-
Social security costs	78	-	75	-
Tax	74	-	65	-
Other payables and accruals	1,225	-	1,020	-
Total Trade & Other Payables	**47,315**	**-**	**44,365**	**-**
Total current and non-current	**47,315**		**44,365**	
Other payables include outstanding pension contributions	522		397	

The outstanding pension contributions for 2021-22 include an amount of £422,000 (2020-21 £301,000) for GP pensions re Co-commissioning responsibilities.

12 Provisions

	Current 2021-22 £'000	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
Continuing care	3,485	-	-	-
Other	251	-	911	-
Total	**3,736**	**-**	**911**	**-**
Total current and non-current	**3,736**		**911**	

	Continuing Care £'000	**Other £'000**	**Total £'000**
Balance at 01 April 2021	**-**	**911**	**911**
Arising during the year	3,485	-	**3,485**
Utilised during the year	-	-	**-**
Reversed unused	-	(660)	**(660)**
Balance at 31 March 2022	**3,485**	**251**	**3,736**
Expected timing of cash flows:			
Within one year	3,485	251	**3,736**
Between one and five years	-	-	**-**
After five years	-	-	**-**
Balance at 31 March 2022	**3,485**	**251**	**3,736**

13 Contingencies

NHS East Lancashire Clinical Commissioning Group has no contingent assets or liabilities as at the 31st of March 2022 (£NIL 2020-21).

14 Commitments

NHS East Lancashire Clinical Commissioning Group has no capital commitments relating to 2021-22, nor did it have any capital commitments for 2020-21.

15 Financial instruments

15.1 Financial risk management

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

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

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

15.1.1 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.

15.1.2 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.

15.1.3 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.

15.1.4 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.

15.1.5 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.

15 Financial instruments cont'd

15.2 Financial assets

	Financial Assets measured at amortised cost 2021-22 £'000	Equity Instruments designated at FVOCI 2021-22 £'000	Total 2021-22 £'000
Trade and other receivables with NHSE bodies	331	-	331
Trade and other receivables with other DHSC group bodies	1,112	-	1,112
Trade and other receivables with external bodies	2,126	-	2,126
Cash and cash equivalents	41	-	41
Total at 31 March 2022	**3,610**	**-**	**3,610**

	Financial Assets measured at amortised cost 2020-21 £'000	Equity Instruments designated at FVOCI 2020-21 £'000	Total 2020-21 £'000
Trade and other receivables with NHSE bodies	952	-	952
Trade and other receivables with other DHSC group bodies	393	-	393
Trade and other receivables with external bodies	430	-	430
Cash and cash equivalents	45	-	45
Total at 31 March 2021	**1,820**	**-**	**1,820**

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Trade and other payables with NHSE bodies	4,441	-	**4,441**
Trade and other payables with other DHSC group bodies	2,634	-	**2,634**
Trade and other payables with external bodies	39,412	-	**39,412**
Total at 31 March 2022	**46,487**	**-**	**46,487**

	Financial Liabilities measured at amortised cost 2020-21 £'000	Other 2020-21 £'000	Total 2020-21 £'000
Trade and other payables with NHSE bodies	1,714	-	**1,714**
Trade and other payables with other DHSC group bodies	17,771	-	**17,771**
Trade and other payables with external bodies	24,740	-	**24,740**
Total as at 31 March 2021	**44,225**	**-**	**44,225**

16 Operating segments

NHS East Lancashire Clinical Commissioning Group has one segment and this is how it is reported within the organisation.

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
NHS East Lancashire Clinical Commissioning Group	723,667	(3,663)	**720,004**	6,114	(51,051)	**(44,937)**
Total	**723,667**	**(3,663)**	**720,004**	**6,114**	**(51,051)**	**(44,937)**

16.1 Reconciliation between Operating Segments and SoCNE

	2021-22 £'000
Total net expenditure reported for operating segments	720,004
Total net expenditure per the Statement of Comprehensive Net Expenditure	720,004

16.2 Reconciliation between Operating Segments and SoFP

	2021-22 £'000
Total assets reported for operating segments	-
Total assets per Statement of Financial Position	**6,114**

	2021-22 £'000
Total liabilities reported for operating segments	(51,051)
Total liabilities per Statement of Financial Position	**(51,051)**

17 Joint arrangements - interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY 2021-22 Assets	Liabilities	Income	Expenditure	Amounts recognised in Entities books ONLY 2020-21 Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Learning Disability Pool	Lancashire County Council	Provision of Health & Social Care to adults with Learining Disabilities	0	-291	-2,221	2,221	0	0	-2,207	2,207
Better Care Fund	Lancashire County Council	LCC and ELCCG joint working re planning and implementation of integrated health and social care.	0	-3,396	-31,234	31,234	0	-585	-29,835	29,835

SUMMARY

Identified in BCF	'Control' of expenditure	Scheme Reference	Scheme summary narrative	EAST LANCASHIRE CCF BCF 2021/22 LCC £'000s	ELCCG £'000s	Total £'000s
ELCCG	ELCCG	BCF01	Transforming lives		£158.1	£158.1
ELCCG	ELCCG	BCF02	redesign of dementia services			£0.0
ELCCG	ELCCG	BCF03-05	redesign intermediate care etc		£18,411.2	£18,411.2
ELCCG	ELCCG	BCF03 - 06	Care home select			£0.0
Joint	ELCCG	BCF11	Carers		£309.1	£309.1
Joint	LCC	BCF11	LCC Carers support	£2,644.6		£2,644.6
Joint	ELCCG	BCF12	Reablement		£145.1	£145.1
Joint	LCC	BCF12	LCC residentail rehab	£1,968.5		£1,968.5
Joint	ELCCG	BCF13	Community equipment		£2,492.9	£2,492.9
Joint	LCC	BCF13	LCC community equipment	£2,185.2		£2,185.2
Joint	LCC	BCF14	Telecare services	£299.2		£299.2
Joint	LCC	BCF15	Care Act	£1,206.3		£1,206.3
Joint	LCC	BCF20	LCC reablement rehabilitation	£1,413.6		£1,413.6
				£9,717.4	£21,516.4	£31,233.8
			Learning Disabilities Pool			£2,221.4
			Grand Total			£33,455.2

The Lancashire BCF Steering Group has the decision making power with the members having joint control, however each party has commissioning responsibilities for it's share acting in line with the s75 agreement.
The Better Care Fund is accounted for net, Lancashire County Council invoices the CCG for the total amount of the Better Care Fund and the CCG in turn invoices Lancashire County Council for it's share of the fund. The resulting net balance is accounted for in the CCG's accounts.
The above table shows the CCG and Lancashire County Council contributions to the Better Care Fund. The risk share agreement incorporates the ability for parties to flex their contributions into the share of the section 75 agreement.

18 Related party transactions

The practices of GP members of the Governing Body have been reviewed and there are no sole practitioners controlling any of those practices.

In line with revised guidance the payments to those practices will not be disclosed as Related Party Transactions.

The Department of Health is regarded as a related party. During the year NHS East Lancashire Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department of Health is regarded as the parent Department, these entities are shown below.

- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority,
- NHS Property Services Ltd;
- Community Health Partnerships.

NHS Trusts and NHS FoundationTrusts where transactions in the 2020-21 financial year exceed £5 million are East Lancashire Hospitals NHS Trust, Lancashire & South Cumbria NHS Foundation Trust, Airedale NHS Foundation Trust, North West Ambulance Service NHS Trust and Lancashire Teaching Hospitals NHS Foundation Trust.

In addition, NHS East Lancashire 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.

19 Events after the end of the reporting period

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

There are no adjusting events after the end of the reporting period.

20 Financial performance targets

NHS East Lancashire Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS East Lancashire 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	721,525	723,667	694,400	694,400
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	717,862	720,004	693,562	693,562
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	7,146	7,085	7,143	6,778

Employee benefits and staff numbers

Employee benefits	**Admin**			**Programme**			**Total**		**2021-22**
	Permanent Employees £'000	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**
Employee Benefits									
Salaries and wages	3,133	122	**3,254**	1,308	48	**1,356**	4,440	170	**4,610**
Social security costs	402	-	**402**	154	-	**154**	556	-	**556**
Employer contributions to the NHS Pension Scheme	729	-	**729**	191	-	**191**	919	-	**919**
Other pension costs	-	-	**-**	-	-	**-**	-	-	**-**
Apprenticeship Levy	11	-	**11**	-	-	**-**	11	-	**11**
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	-	-	**-**	-	-	**-**	-	-	**-**
Gross employee benefits expenditure	**4,273**	**122**	**4,395**	**1,653**	**48**	**1,701**	**5,926**	**170**	**6,096**
Less recoveries in respect of employee benefits	-	-	**-**	-	-	**-**	-	-	**-**
Total - Net admin employee benefits including capitalised costs	**4,273**	**122**	**4,395**	**1,653**	**48**	**1,701**	**5,926**	**170**	**6,096**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**4,273**	**122**	**4,395**	**1,653**	**48**	**1,701**	**5,926**	**170**	**6,096**

Employee benefits	Admin			Programme			Total		2020-21
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits									
Salaries and wages	2,658	45	**2,704**	1,816	143	**1,959**	4,474	188	**4,663**
Social security costs	304	-	**304**	231	-	**231**	535	-	**535**
Employer contributions to the NHS Pension Scheme	653	-	**653**	285	-	**285**	938	-	**938**
Other pension costs	-	-	**-**	-	-	**-**	-	-	**-**
Apprenticeship Levy	10	-		-	-				
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	-	-	**-**	-	-	**-**	-	-	**-**
Gross employee benefits expenditure	**3,625**	**45**	**3,661**	**2,332**	**143**	**2,475**	**5,947**	**188**	**6,135**
Less recoveries in respect of employee benefits	-	-	**-**	-	-	**-**	-	-	**-**
Total - Net admin employee benefits including capitalised costs	**3,625**	**45**	**3,661**	**2,332**	**143**	**2,475**	**5,947**	**188**	**6,135**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**3,625**	**45**	**3,661**	**2,332**	**143**	**2,475**	**5,947**	**188**	**6,135**

Losses and Special Payments

NHS East Lancashire Clinical Commissioning Group had no losses or special payments in 2021-22 or in 2020-21.