NHS Greater Preston CCG Annual Report 2021/22

Contents

PERFORMANCE REPORT

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Accountable Officer

21 June 2022

Performance Overview

This section gives an overview of who we are and what we do, some of our highlight achievements during 2021-22, and the key risks we faced in meeting our objectives. If you want to find out more detail about our performance in the year, you will find this information in the performance analysis section.

Statement from Chief Officer on performance

2021-22 saw another year challenged by the ongoing effects of the Covid-19 pandemic. The NHS was placed back into a national incident level 4 (having been lowered to a level 3 in March 2021) as the effects of the Omicron Covid-19 variant and increased winter pressures took hold.

This meant that service priorities and working arrangements were managed at a national level and saw local systems prioritising Covid-19 vaccinations, access for patients to key services, the timely discharge of patients from services, and developing enhanced ‘surge planning’ to prepare for the predicted pressures.

These pressures have been evident across all services. Data gathered across the year clearly demonstrates the fluctuations in demand and subsequent performance as a consequence of the pandemic, and a range of additional challenges including the ongoing infection prevention control measures, workforce sickness and pausing and restarting of services have all led challenges in meeting a number of key targets.

A range of systemwide, and local arrangements have been developed from the early stages of the Covid-19 response to mitigate these pressures where possible, and the pandemic has shown how the NHS can deliver transformational change for patients when needed. Across Lancashire and South Cumbria there has been a continued focus on integrated working which has seen the leadership system across all partners come together to stabilise services and respond as a single system to the significant challenges faced. Greater Preston and Chorley & South Ribble CCGs have played a collegiate role within this enterprise. As Chief Officer I also lead (acting as Senior Responsible Officer) the Central Lancashire Elective Care Delivery Board which oversees the restoration of care systems, working alongside colleagues across Lancashire and South Cumbria.

Whilst colleagues in every part of the health and care system are working hard, activity and performance across urgent and emergency care has been under significant pressure throughout the year. This has been mitigated where possible through the commissioning of additional services and mutual aid arrangement between local acute Trusts and our colleagues in Local Authorities for example.

Work has continued across the year to recover elective services, however as the pandemic has created significant backlogs across different activities, many challenges remain across the country to restore elective care systems to pre-pandemic levels. Locally, both Chorley and South Ribble and Greater Preston CCGs are facing significant challenges to achieve restoration in elective services and quickly reduce the backlog in waiting time activity, this clearly has a bearing on meeting Referral to Treatment (RTT) targets in 2021-22. Once again, as with urgent

and emergency services, the trend shows performance falling over the winter period, in line with wider challenges across all health systems.

In Lancashire and South Cumbria, accelerator funding from NHS England has proved invaluable in helping the care system mitigate against some of these issues. Additional bed capacity in hospitals across the region has been provided, enabling improvements in pre- and post-operative patient assessments.

Primary Care continues to develop their ways of working, with a range of services offered via face-to-face, telephone and digital channels with members of GP practices multi-disciplinary teams. As with other areas of the NHS, challenges remain and the introduction of programmes through national directives such as the Winter Access Fund is enabling the CCGs to support our Primary Care colleagues in developing services for patients and supporting the workforce who have worked tirelessly throughout the Covid-19 challenges.

The Covid-19 vaccination programme has continued at pace with nearly half the vaccinations administered to people across central Lancashire in 2021-22 (315,425) taking place in Primary Care Network vaccination hubs. This work has been undertaken alongside the business as usual work that Primary Care has continued to provide. Primary Care within central Lancashire has continued to operate unabated during the various phases of Covid-19 despite its workforce being severely impacted by infections and staff isolation periods. This I feel is testament to the experience and clinical leadership within our many GP Practices.

The New Hospitals Programme, looking at the potential developments to hospital services across the country, continues to gather pace and the shortlist of options for development to services in Lancashire and South Cumbria was announced in March 2022. You can read more about the plans and work so far on page 45 of the report.

CCG staff continued to work remotely throughout the year, supporting both local CCGs and the Integrated Care System (ICS) work as we move into the final transition stages and closure of CCGs as part of the formal establishment of the Integrated Care Board (ICB). A national extension of the Integrated Care Board establishment timeline was announced in December 2021, with a new date for establishment of 1 July 2022 set. This has meant that the CCG will continue with its statutory arrangements until this point and work is continuing to establish shadow arrangements to be in place from April 2022 to support the transfer of formal responsibilities for commissioning services.

As Chief Officer for the two CCGs and part of a wider senior leadership team across the ICS, I was asked to lead the Lancashire and South Cumbria CCG closedown programme. Working with senior executive support within the CCG, we are successfully putting in place all the due diligence processes to see all the CCGs safely transition their statutory duties to the incoming ICB on 1st July 2022.

As we look towards the formal closedown of CCGs across the country, I would like to reflect on the achievements made by the CCG and its workforce throughout the years, not just in 2021-22. The dedication to supporting the local population of central Lancashire has been unwavering, and the successes of future organisations will be in no small part down to the achievements of CCG teams since the inception of the organisation in 2013.

On behalf of myself, the senior leadership team and CCG Governing Bodies, I wish to thank all staff, partners and members of our central Lancashire community.

Who we are and what we do

NHS Greater Preston CCG is a clinically-led, GP membership organisation, which plans, arranges and buys (commissions) a range of healthcare services on behalf of our local population.

We are a member organisation, made up of the 25 GP practices in Greater Preston, which serve a registered population of approximately 220,300.

We work very closely with NHS Chorley and South Ribble CCG, sharing a management team, staff body, operational and strategic plan, but are two separate statutory organisations.

The CCG's vision is to ensure equal and fair access to safe, effective and responsive health and social care for our communities that represent value – now and in the future.

This vision is underpinned by our organisational values, which are at the heart of everything we do:

- Be open and accountable to our patients, their carers and the local community
- Be professional and honest
- Work in partnership with others to achieve our goals
- Listen and learn, and be willing to change based on what we hear
- Respect and care for our staff, the people we work with and our local community

— Protect and invest the public funds that are given to us in a well-managed way

The CCG has a legal duty to make sure that the healthcare services we buy are safe, effective and of the highest quality, but also that these services provide value for money. In 2021-22 we had a budget of £370.1 million and £9.2 million Covid Support Funding which we used to commission the following services:

— Planned hospital treatment, diagnostic tests and appointments
— Urgent (emergency) care
— Community health services, such as specialist or district nurses, speech and language therapy or rehabilitation
— Mental health services
— Maternity and new-born services
— Children's healthcare services
— Services for people with learning disabilities

We have 'delegated responsibility' from NHS England for commissioning GP primary care services. Specifically, the CCG carries out the following activities:

— Planning, including needs assessment, of primary medical care services in Chorley, South Ribble and Greater Preston
— Undertaking reviews of primary medical care services in our area
— Coordinating a common approach to the commissioning of primary care services generally
— Managing the budget for commissioning of primary medical care services in Chorley, South Ribble and Greater Preston

NHS England still carries out functions relating to individual GP performance management (i.e. medical performers' list for GPs, appraisal and revalidation).

We commission services from a range of health and social care providers and work in close partnership with them to ensure our residents receive the highest quality care. Our main providers are:

— GP practices
— Lancashire Teaching Hospitals NHS Foundation Trust
— Lancashire and South Cumbria NHS Foundation Trust
— Ramsay Health Care Ltd

Our Population

It is important that we understand our population and their health needs to enable us to commission services that meet their needs. Lancashire County Council, produce and provide a

comprehensive analysis[1] of the current health and wellbeing needs of our population which we use to inform our planning so we can ensure we are addressing the needs of our population.

In Greater Preston, the population registered with GPs is evenly split between females (49.7%) and males (50.3%). In terms of age range, currently 16% of the population is aged 65 or over, but this is estimated to increase by 16% over the next 10 years, which has significant implications on health and care services.

The district of Preston is in the most deprived 20% of areas in England, with 91,759 persons living within neighbourhoods considered to be amongst some of the most deprived in England.

An analysis of the health and lifestyle of adults in the area shows that 18% of adults in Preston are smokers and 65% are estimated to be living with excess weight. Encouragingly, 67% of adults are believed to be physically active, which is slightly higher than the England average.

However, the life expectancy for both males and females in Preston is significantly lower than the national average, and Preston's suicide rate is significantly higher than the England average. A significantly higher level of recorded disease prevalence is also a contributory factor, with 53.8% of the population living with a long-standing health condition.

Prevalence of the conditions listed below is higher within our population than the England average:

- Atrial fibrillation
- Coronary heart disease
- Heart failure
- Hypertension
- Peripheral arterial disease
- Stroke and transient ischaemic attack
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Obesity (18+)
- Cancer
- Chronic kidney disease (18+)
- Depression (18+)
- Epilepsy (18+)
- Rheumatoid arthritis (16+)

Greater Preston also has a higher than the England average prevenance of people living with and being supported through a range of learning disability disorders.

How we spend your money

[1] https://www.lancashire.gov.uk/lancashire-insight/area-profiles/ccgs/

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The CCG has a legal duty to make sure that the healthcare services we buy are safe, effective and of the highest quality, but also that these services provide value for money. Due to the Coronavirus pandemic a level 4 national incident was declared on the 30th January 2020, the continued response coupled with elective recovery has significantly impacted on the usual ways of working, and in particular the NHS finance regime. As a result CCGs have had to adapt their normal practices, payment and reporting mechanisms to accommodate these temporary measures over the last two years.

The measures were primarily aimed at simplifying processes to reduce the number of intra-organisational transactions, thus facilitating the release of staff time to focus on the pandemic response whilst providing stability and certainty at the time.

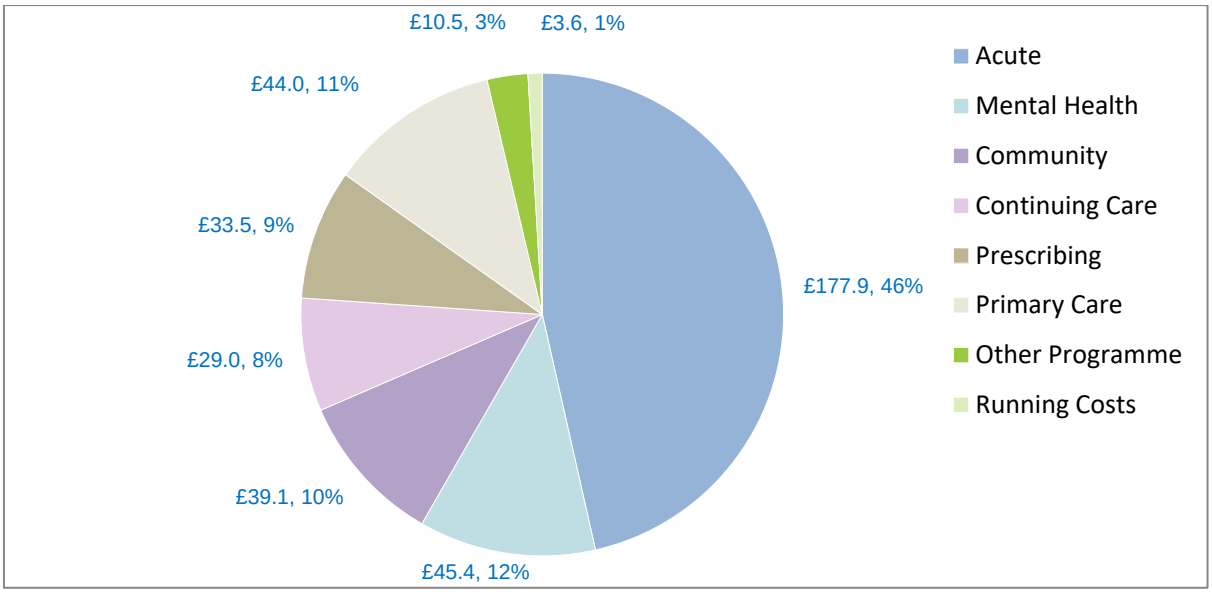
These measures included

- moving to a nationally determined monthly 'block' contract payment; subsidised with a top up payment where necessary.
- changes to cash management, to support faster payment to providers.
- changes to monthly revenue reporting
- suspension of the annual operational planning process for 2021/22.
- suspension of non-contract activity invoicing
- revisions to the resource allocation process

In 2021/22 we had an in-year budget allocation of £370.1 million and £9.2 million Covid Support Funding which we used to commission the following services:

- Planned hospital treatment, diagnostic tests and appointments
- Urgent (emergency) care
- Community health services, such as specialist or district nurses, speech and language therapy or rehabilitation
- Mental health services
- Maternity and new-born services
- Children's healthcare services
- Services for people with learning disabilities
- Hospital Discharge Programme

The chart below shows how our funding was allocated.



Performance against financial targets

NHS Greater Preston CCG three statutory financial targets to achieve for 2021/22, namely:

- Achieve operational financial balance – the CCG has reported an operational deficit for the 2021/22 financial year as a result of a technical accounting adjustment approved by NHSE/I. The reporting of a deficit position triggers the requirement of the CCGs external auditors to make a s30 referral to the Secretary of State for breach of statutory duties on failing to deliver a balanced financial position. Confirmation has been received from NHSE/I acknowledging that the CCG will post a deficit for the year-ending 21/22, however this position will not be considered financial failure and will not trigger any regulatory action.
- Remain within cash financing limits – this has been achieved in full.
- To pay 95% of all creditors within 30 days of receipt of invoice – this has been achieved in full.

Our system partnerships

Our Central Lancashire Place Based Partnership

Since the publication of the white paper "Health and Social Care integration" February 2022 the regional structures (system level) and local structures (place level) have continued to develop. The Integrated Care System (the ICS) will now be formed of the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP). To avoid confusion we are now the Central Lancashire Partnership (CLP). Our work is directed to the people of central Lancashire and our overarching aim remains *"to make Chorley, Preston and South Ribble a great place to live, work and grow".* We will do this through continuing to build on the success of our partnership, working with and listening to our communities, to improve health and wellbeing through a reduction in inequalities.

Over the past 12 months, we have progressed both development and delivery elements of the Central Lancashire Partnership. The delivery arm of our work is carried out by our System Delivery Boards through which we have agreed a number of partnership-level priorities for delivery, following a rigorous clinically and professionally-led priority setting process, led by our Clinical & Professional Forum.

The process was informed by disease profile data, specific to Central Lancashire, developed by the Determinants of Health SDB and resulted in a small number of bespoke priorities which have been our focus this year.

System Delivery Board	Priorities for delivery
Urgent and Emergency Care	System Flow and Discharge Winter Planning Admission Avoidance
Elective Care	Recovery and Restoration of services Outpatient Transformation Diagnostics Elective Pathway Transformation
Determinants of Health	We will improve health and wellbeing through the reduction in health inequalities
Primary and Community Care	Intermediate Care Neighbourhood development
Children's Young People and Maternity	Acute Paediatrics Neurodevelopmental (ND) Pathway Transition services

Key outcomes of this year's delivery functions are listed below and members have reported the benefits of the partnership approach.

System Delivery Board	Key Outcomes
Urgent and Emergency Care	• Delivered the 2021/22 winter plan as a number one priority in response to unprecedented challenges (winter, omicron, L4 national incident) – 17 key winter schemes to provide

	extra capacity and resilience for hospital and out of hospital services • Mobilised significant additional capacity • Secured and coordinated funding into priority service areas • Strengthened performance, monitoring and reporting arrangements
Elective Care	• Developed ICS-wide ophthalmology programme – implementing procurement for single community service • Mobilised the Community Diagnostic Centre (Preston Healthport) • Worked at local and system level to restore elective services including the use of the independent sector where applicable
Determinants of Health	• Preston health and engagement event • Direction of case finding activities to key areas of deprivation • Detailed ward profiles of our most challenged areas • Engaged and collaborative multiagency working groups • Extension of the COVID vulnerable project
Primary and Community Care	• The PCN and integrated care teams priorities have been merged and refocused on development of neighbourhoods • The development of mixed agency teams in neighbourhoods creates an infrastructure that also supports the population health agenda • The system wide plan for integrated care has been developed
Children's Young People and Maternity	• Plans are in place to roll out Patient Initiated follow up • A significant reduction in DNA rates (4%) has been seen. • Saturday clinics arranged to manage neuromuscular backlog with AHP support from Alder Hey • Review of Cystic Fibrosis, Epilepsy , Diabetes , SEND and Rheumatology, ENT surgery pathways • Clear identification of the ASD waiting list from all partners, with a standardised definition of wait times and regular contact with children and families

The development arm of our work is contained within the CLP Development Plan, and is the work of the core team whose role is to support and facilitate partnership working and delivery. This enables better collaboration through robust governance structures and supportive functions such as performance, finance and digital.

Partnership working has continued to be of vital importance as partners have responded to the ongoing pandemic and winter challenges. Partners have built on existing joined up practice and support services to extend and enhance support during the omicron wave and winter.

In terms of development of the Place-based Partnership itself, we have made great progress this year across the following domains:

- **Improving the quality of services**- the culture of the partnership has developed to enable issues or concerns to be escalated quickly and extraordinary meets have been called where required for the unique challenges of Omicron other pandemic related pressures.

- **Maximising the use of resources**- The partnership have mobilised a digital and operational and strategic estates group which ensures that we have support functions working in partnership.
- **Success measures**- The partnership delivery boards have shared dashboards to monitor their progress against agreed priorities
- **Population Health Management**- The determinants of health board has been mobilised and contains senior and operational staff from all partners. The board has shared in depth knowledge about our population and the support and services on offer. The group have also conducted a number of joined up interventions and thereby improved existing offers to the people who need it.
- **Listening to and communicating with our communities**- we have developed a place based plan for engagement
- **Valuing and developing the workforce**- we are working on a targeted people based plan to address the key workforce challenges that we face in Central Lancashire
- **Governance**- We hold ourselves to an agreed set of behaviours and value at place and we have continued to refine the governance structure to enable and integrated approach to the delivery of services and rapid escalation should it be required.
- **Collaboration with our partner places and the Lancashire & South Cumbria system** – this has seen each place taking the lead to develop and implement elements of the strategic narrative required to see our places and the overarching health and care system continue to mature.
- **Partnership Maturity** – we undertook two peer to peer reviews during 2021/22 with Board members scoring the partnerships progress against a number of domains. Our key areas of strength were around leadership, governance and decision making, place based leadership and collaboration and planning integrated services.

Next year as a partnership we will be focusing on the formal transition arrangements as required by the white paper and working towards an initial gateway process in June to ensure that the central Lancashire partnership is ready for the new challenges ahead.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Responding to the Covid-19 pandemic

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

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

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

The Hospital cell covered elective care, tertiary services, critical care, cancer, paediatrics, mutual aid and clinical prioritisation. The Out of Hospital cell co-ordinated the work of community services, mental health, learning disabilities and primary care. It also worked with social care, with a Care Sector sub-cell run jointly with the Lancashire LRF and with connections to Cumbria. A Joint Hospital and Out of Hospital cell chaired by Kevin McGee, Chief Executive of Lancashire Teaching Hospitals and the Provider Collaboration, was strengthened to enable collective system decision making with revised membership, which included the involvement of Directors of Adult Social Care from local authorities.

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

queueing ambulances. Data is looked at from a system perspective, and capacity is redistributed to where it is needed most.

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

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

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

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

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

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

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

The **Covid-19 vaccination programme** – the largest in history – was well established by April 2021, both nationally and across Lancashire and South Cumbria. The Covid-19 Vaccination Programme Board, established in November 2020, continued to provide oversight during

2021/22 as well as strategic direction to make sure the local offer met public need and was fit for purpose.

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

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

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

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

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

The ICS led clear communication of public messages, including materials in different languages and formats, about the importance of being vaccinated and how to attend appointments safely.

Pulse oximetry at home and Covid-19 virtual ward services were launched across Lancashire and South Cumbria in 2020/21 to monitor vulnerable patients with Covid-19 in their own homes.

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

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

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

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

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

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

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

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

Key issues and risks in 2021-22

The Governing Body is required to manage, monitor and own the key risks to the CCG achieving its strategic objectives. This is presented to the Governing Body as an Assurance Framework (GBAF), which sets out those key risks, the controls in place, where assurances are sought that these controls are effective, the gaps in controls and assurances, and associated action plans.

In 2021-22, the key issues and risks to achieving the CCG's objectives included**:**

- There is a risk that the CCGs fail to commission safe and effective services, which do not incorporate the patient voice and do not meet a minimum level of 'good' in the Improvement and Assessment Framework and therefore the CCGs fail to meet strategic objectives 1 and 4.
- There is a risk that the CCGs fail to effectively commission care that is integrated between in-hospital and out-of-hospital provision and therefore does not meet the whole population needs and does not achieve strategic objective 2.

- There is a risk that the CCGs fail to meet statutory financial duties and therefore fail to engineer a financially sustainable health and social care economy as defined in strategic objective 3.
- There is a risk that the CCG fails to sustain a rating of ‘green’ in the ‘leadership’ domain of the Improvement and Assessment Framework (IAF) and is therefore unable to evidence assurance of being a well run organisation and fails to meet strategic objective 5.
- There is a risk that the CCGs fail to reduce inequalities in access and outcomes across the health and care system which results in a failure to meet strategic objective 6.

At the end of 2021/22, there were 8 risks that had a high (red) risk rating of 15 or greater on the Corporate Risk Register.

More information on this risk and the actions being taken to mitigate it can be found in the annual governance statement on page 102.

Priorities and Achievements in 2021-22

Our priorities in 2021/22 were underpinned by the strategic objectives that were introduced in 2020. They are to:

- Improve quality through more effective, safer services, which meets a minimum level of ‘good’ in the Improvement and Assessment Framework
- Commission care so that it is integrated and ensures sustainability and meets whole population needs with an appropriate balance between in-hospital and out-of-hospital provision, which meets a minimum level of ‘good’ in the Improvement and Assessment Framework
- Engineer a financially sustainable health and social care economy which meets statutory financial duties
- Ensure people are at the centre of the planning and management of their own care, and that their voices are heard, enabling the CCG to meet a minimum level of ‘good’ in the Improvement and Assessment Framework
- Be a well-led clinical commissioning group, which meets a minimum level of ‘good’ in the Improvement and Assessment Framework
- Reduce inequalities in access and outcomes across the health and care system by achieving a minimum level of ‘good’ in the Improvement and Assessment Framework (Health and Care Partnership work programmes)

Health and Care Partnership work programmes

Mental health: children and young people

Child and Adolescent Mental Health Services (CAMHS) remained open and accessible during the Covid-19 pandemic – offering face-to-face, phone and digital solutions. Services have seen

a significant increase in the number of referrals since the start of the pandemic, along with an increased complexity of need, particularly for children and young people (CYP) returning to education.

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

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

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

Mental health: adults

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

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

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

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

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

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

In line with the national picture, the Lancashire and South Cumbria Eating Disorder service has seen a 64% increase in referrals for people of all ages. But there has been an 81% increase for adolescents aged 11 to 15; and a 41.4% increase for young people aged 15 to 20. An overall spike in referrals was seen in June 2020 and has been sustained throughout the remainder of

the year. To reduce waiting times, the voluntary sector has worked with us to help people requiring routine support. Additional capacity has also been put in place for urgent appointments – which has resulted in people now being seen in line with national expectations.

The Community Mental Health Transformation is a three-year programme of large-scale change that will be completed by March 2024. Plans are being developed to reconfigure community mental health services around primary care networks (PCNs) into community mental health hubs. Lancashire and South Cumbria NHS Foundation Trust (LSCFT) have set up a procurement framework for the VCFSE, which currently has 58 organisations listed. The framework will allow the trust to contract VCFSE organisations to provide peer support or lived experience and high-intensity user support into the community hubs by early 2022/23. Existing ICS asset maps have been further developed to include the services available within each PCN.

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

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

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

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

The recovery rate across all local CCGs has been above target (50%) for much of the year, with some fluctuations (Greater Preston and Fylde and Wyre who had four and two months below target). Any fluctuations have returned to target following action from the providers. At

the end of Q3 of 2021/22 all eight CCGs achieved their 50% minimum recovery target with the LSC position 56% overall.

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

January to March 2022 – targeted communications activity promoting IAPT to small and medium enterprises, local authorities, NHS workforce, further and higher education settings, large employers and the general public

Since Covid-19, the IAPT offer has changed, with additional flexibility offered via online offers, Attend Anywhere web-based platform, increased group activity. Demand for virtual appointments has remained high since the pandemic and will now form a core element of the IAPT service offer of additional sessions weekends and early evenings.

All provider IAPT webpages and self-referral forms have been reviewed, to ensure content is streamlined. The ICS webpage for IAPT has also been improved, and used to support the roll-out of a national campaign in January 2022.

All CCGs have formally agreed to system working in terms of shared workforce to ensure equity and reduce demand spikes in certain locations.

Long Term Conditions psychological support is being enhanced with integrated provision being re-introduced in secondary and primary care settings.

A pilot service offer working across West Lancashire with partner service providers has been evaluated and is being considered for further roll out due to increases in access as a result.

Following a successful bid to NHSE Digital, additional funding was secured to support the development of a digital product that could support triaging and/or access to IAPT services. This bid has three strands, which will include a digital communications/social media campaign, due for launch in Q1 of 2022, and the provision of additional digital capacity that commenced 1 April 2022 with a focus on 16-18 year old students.

Working with NHSEI, further High Impact Actions to increase access to IAPT services have been drawn together and an implementation plan is being worked up.

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

Psychoeducation empowers patients to understand their illnesses and improve their coping strategies. A typical length of stay is 12 to 18 months, but could be much shorter. Rehabilitation services are shown to successfully support two in three people progress to successful community living within 18 months of admission, whilst two in three do not require hospital admission within five years, and around one in ten go on to achieve independent living within

this period. People receiving rehabilitation support are eight times more likely to achieve or sustain community living, compared to those supported by usual community mental health services.

Suicide prevention

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

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

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

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

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

Digital

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

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

The Badgernet system has been deployed across all maternity services, and we continue to work through plans to procure single electronic patient records (EPR) for acute and community

services. We are currently supporting Blackpool Teaching Hospitals NHS Foundation Trust with an outline business case and, hope that once approved, the other three trusts will have the option to join the procurement exercise.

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

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

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

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

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

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

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

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

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

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

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

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

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

Stroke

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

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

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

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

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

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

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

Diabetes

More than 100,000 people aged 17+ in Lancashire and South Cumbria have type 2 diabetes, and it's estimated that more than 75,000 people are at a high risk of developing the condition.

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

Local people with type 2 diabetes have been able to access support to manage their condition through My Way Diabetes via Your Diabetes, Your Way. Again, all face-to-face learning sessions were temporarily suspended during the pandemic, but a lot of digital support and online resources were available. As people with diabetes are amongst those more vulnerable to Covid-19, local health and care organisations worked together to provide practical and emotional support – especially during the winter months. During 2021, there were 206 registrations of patients compared to 16 patients in 2020. There are 57 practices across Lancashire and South Cumbria with at least one or more patient registered with the platform. Looking ahead we are reviewing the provision of structured education for people with type 1 and 2 diabetes for 2022/23 and there will be additional sources of information from the national team available.

Pathology collaboration

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

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

Steps towards the formation of the future service have taken place during 2021/22, including the launch of a consultation of employees who currently work in pathology services. This process highlighted the need to do some more robust engagement and listen to staff to develop our vision for how the service will run in future. As such, the Pathology Collaboration Board agreed to pause the work to develop the single service by 1 July 2022 and the progression of the full business case. This pause will also allow the Board time to ensure that all options have been explored for securing the capital required to develop the future service. The Pathology Collaboration Board views this pause in the programme of work as a positive opportunity to do some further and more in-depth engagement with the pathology workforce. This will be done

with transparency and in partnership to ensure that all options have been explored before moving forwards together with this important work to determine how the future service will be delivered across Lancashire and South Cumbria. It is proposed that the engagement will be undertaken over the summer of 2022 and the feedback generated will be used to form options that will be taken to the Pathology Collaboration Board for approval and to agree the way forward.

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

Cancer Alliance

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

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

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

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

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

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

Maternity

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

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

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

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

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

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

From June 2021, the Perinatal Pelvic Health service project has developed training resources and a tool for risk assessments and screening, and physiotherapists have been recruited into specialist training posts. The programme now has strong service user involvement through the local Maternity Voices Partnerships, and a workplan is ready for delivery in 2022/23.

As part of our future statutory requirement in response to the Ockenden Report, a Maternity and Neonatal Quality Assurance panel has been established to understand the quality and

safety of local maternity services, and to ensure robust reporting mechanisms are in place to support governance and assurance processes. The focus for 2021/22 has been to further develop and establish the information flows and reporting structures with key partners including commissioners, providers, NHSEI, Clinical Networks and Maternity Voice Partnerships.

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

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

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

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

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

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

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

Paediatrics

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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%2). 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

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

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.

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 mirrors the national picture.

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

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

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

Cardiac

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

In July 2021, NHSEI provided the Cardiac Pathway Improvement Programme (CPIP) specification and funding for regional cardiac networks, to deliver the programme within their regions. In Lancashire and South Cumbria, significant opportunities have been identified for earlier diagnosis and better proactive management of CVD – particularly for people in the most deprived areas of England who are almost four times more likely to die prematurely from CVD compared with the least deprived areas. The network is working with the Integrated Stroke and

Neurorehabilitation Delivery Network (ISNDN) to prevent, detect and manage atrial fibrillation, high blood pressure (hypertension) and high cholesterol (hypercholesterolemia) to maximise resources and reduce duplication.

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

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

Funded care

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

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

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

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

Elective care

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

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

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

The plan sets out ambitions, guidance, and best practice to help systems address key issues, ensuring there is consistent focus on elective recovery for years to come. Supporting staff is also a key part of the recovery of elective services, recognising that staff need to be looked after so they can look after patients. Together, 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.3

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

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

(84%) that GP practices are facing significant challenges because of the pandemic, and 85% of patients would be happy to speak to another health professional other than their GP when appropriate.

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

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

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

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

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

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

As the NHS moves into a period of recovery and restoration, our future way of working will bring greater integration between GP practices, pharmacy, dentistry and optometry. The proposal to delegate commissioning responsibility for the full portfolio of primary care services to the Lancashire and South Cumbria Integrated Care Board is planned for implementation over the next 12 months. The appointment of our two Associate Clinical Directors Dr Lindsey Dickinson and Dr Peter Gregory will ensure that primary care services are at the heart of health and social care transformation and that the opportunity to work collaboratively with our partners at system, place and neighbourhoods is maximised.

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

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

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

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

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

VCFSE leadership programme

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

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

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

Respiratory

The Lancashire and South Cumbria Respiratory Network was formed in 2020 to reduce variation in delivery of care, and support the sharing of best practice across regions and across

the country. The network provides a strong foundation to manage the demand for respiratory services, reduce pressures on the healthcare system, and support the implementation of the NHS Long Term Plan objectives.

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

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

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

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

New Hospitals Programme

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

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

Members of the public have had the opportunity to have their say on proposals, and the shortlist reflects extensive feedback gathered from more than 12,000 local people, patients,

NHS staff, community representatives and stakeholders over the last year, using online workshops and surveys, public opinion research, focus groups, and in-person events and meetings. MPs and local authorities have also been kept up to date with progress.

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

Clinical policies

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

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

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

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

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

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

Urgent and emergency care

2021/22 priority setting and operational planning was undertaken against a backdrop of the challenge to restore services, meet new care demands and reduce the care back logs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes. Through the Urgent and

Emergency Care Network (UECN) in Lancashire and South Cumbria, the ICS along with each local A&E Delivery Board submitted responses in September and October 2021 to NHSEI for the system flow assurance process for Place Based Partnerships and ICSs.

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

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

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

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

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

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

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

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

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

Ageing well

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

Performance analysis

Elective Care

The delivery of elective care has continued to be challenged through the year mainly as a result of the impact of covid and the infection prevention control issues which continue to impact the recovery of these services. The recovery of services has been coordinated through the Integrated Care Partnership Elective Care Recovery Group, concentrating on improving performance at provider level.

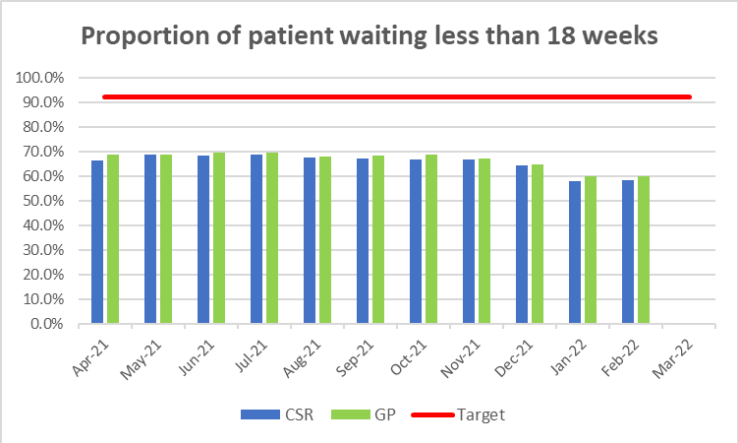
For Chorley South Ribble and Greater Preston CCGs the main provider is Lancashire Teaching Hospitals. The performance at Lancashire Teaching Hospitals (LTHTR) as the main impact on performance for the CCGs.

Elective Performance – main constitutional indicators.

	CSR (YTD)	GP (YTD)	Target
Referral to treatment (RTT) times for non-urgent consultant-led treatment - % patients on incomplete pathway waiting less than 18 weeks	67.0%	68.2%	92%
Cancer two-week wait - % patients with maximum two-week wait for first outpatient appointment when referred urgently with suspected cancer by a GP	85.2%	85.5%	93%
Cancer 62-day waits - % patients with a maximum 62-day wait from urgent GP referral to first definitive treatment for cancer.	64.7%	63.1%	85%
Diagnostic waiting times - % patients waiting less than six weeks for diagnostic test	39.6%	42.1%	1%

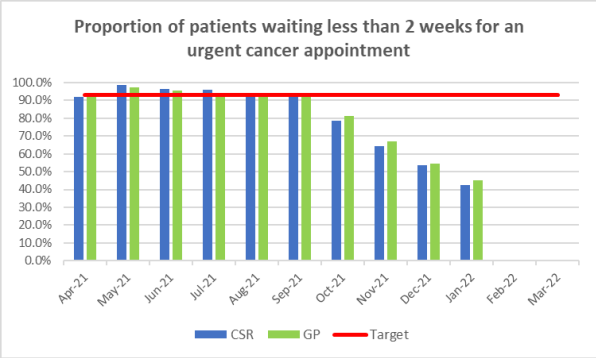
Referral to Treatment Times (RTT) Performance

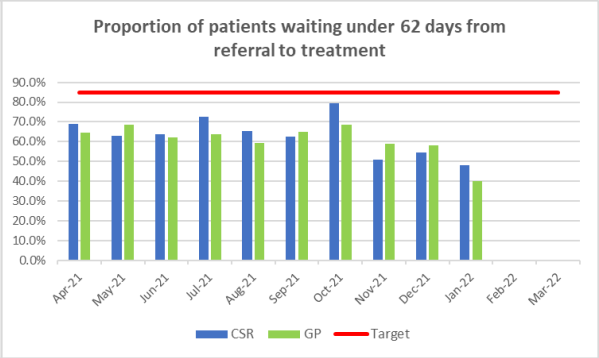
Neither Chorley & South Ribble or Greater Preston CCG met the target for open pathways for RTT in 2021-22, the trend shows performance falling over the winter period, a trend which matches that at LTHTR. The focus at present is reducing the significant number of patients waiting over 104 weeks and 52 weeks at LTHTR. There are several initiatives across outpatients to ensure that the resources available are used as efficiently as possible, including Advice and Guidance roll out, triaging GP referrals and Patient Initiated Follow Up (PIFU).



Cancer Performance

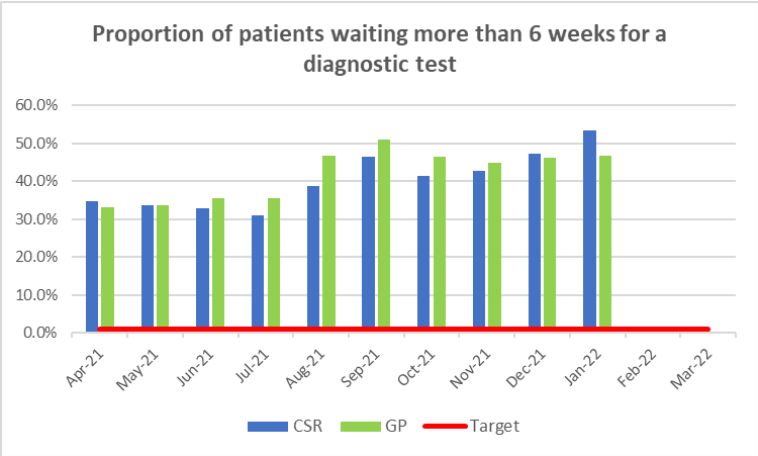
Both CCGs are not meeting performance for either the 2 weeks cancer pathway or the 62 days referral to treatment target. Cancer services continued throughout the pandemic, but like all other services capacity has been affected by adhering to IPC measures. There has been increased demand in this financial year across several tumour groups including Breast, Colorectal and Skin. Capacity in some of these pathways has also been affected by staffing issues which has required the CCG to look outside of the main provider for delivery of these services. There are a number of initiatives led by the Cancer Alliance aimed at improving the current performance.





Diagnostics Performance

The diagnostic target for both CCGs has not been met in any month in the financial year to date. The performance was challenged before the pandemic in Endoscopic and Non Endoscopic services, however this has been exacerbated by the constraints of IPC measures due the Covid restrictions. The CCG has developed the Community Diagnostic Centre in line with guidance to give extra capacity in diagnostics, as the number of services being offered expands this will ease the pressure on diagnostic services.



Mental Health

The performance in mental health services, as with other services has been impacted by the pandemic. The main indicator performance shows that most targets are still being met despite this impact.

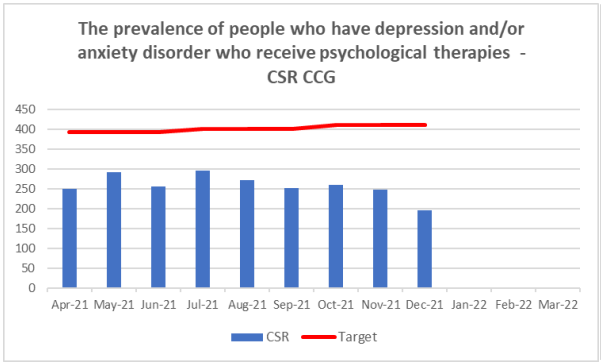
Mental Health Performance – main constitutional indicators

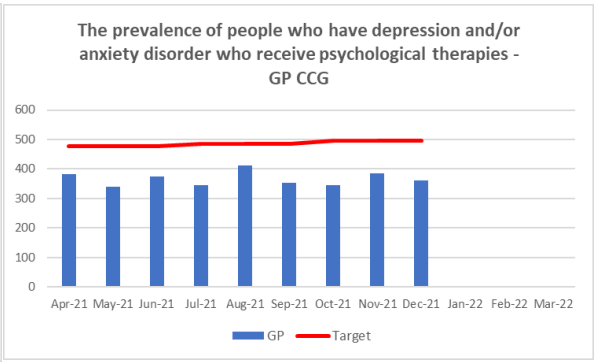
	CSR (YTD)	GP (YTD)	Target
IAPT Recovery - The proportion of people who complete treatment who are moving toward recovery.	53%	53.2%	50%
IAPT Prevalence - The prevalence of people who have depression and/or anxiety disorder who receive psychological therapies	2,319	3,298	CSR-3,612 GP – 4,368

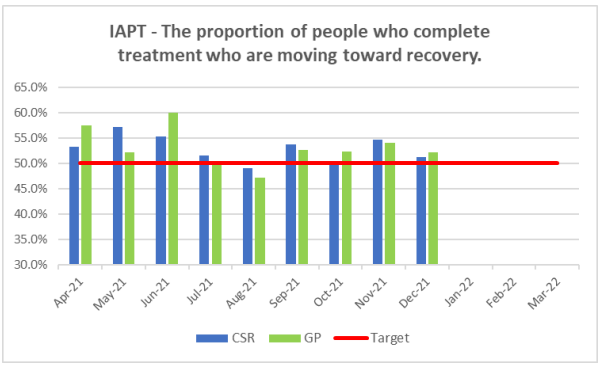
IAPT waits - The proportion of people that waited eighteen weeks or less from referral to entering a course of IAPT treatment against the number of those who started a course of treatment within the reporting period	98.7%	99.5%	95%
Dementia Diagnosis Rate	68.4%	71.6%%	66.7%

Improving Access to Psychological Therapies (IAPT) Performance

The expectation of a significant rise in demand for Improving Access to Psychological Therapies (IAPT) services has not materialised, instead there has been a steady rise. There have been several local and national initiatives to highlight the availability of the service and that patients can now self refer through the website at Lancashire and South Cumbria Foundation Trust (LSCFT). For those patients entering the service, both the time waiting to enter treatment and the recovery rate from treatment have met the target.

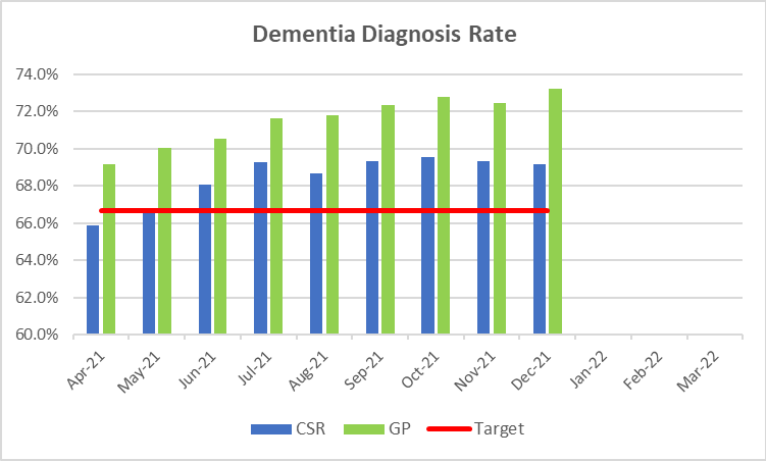






Dementia Diagnosis Rate Performance

The recording of the number of patients in Primary Care with dementia as a proportion of those expected to have dementia has met the target, with improving performance seen throughout the year.



Urgent and Emergency Care

Urgent and emergency care response: Central Lancashire high impact actions plan

Urgent and emergency care services have remained challenged throughout 2021-22. The ongoing response to the unprecedented nature of Covid-19, the changing needs of our local populations and increasing complexity of needs has led to high numbers of people attending our local emergency and urgent care centres.

In central Lancashire, we continue to address these issues through collaborative working and an agreed action plan of high impact services and schemes. Oversight and management of the plan is through the Urgent and Emergency Care Oversight Group, which meets weekly and is attended by all local partners.

To address operational pressures, there are robust governance arrangements in place in central Lancashire to respond on a daily basis, as required. Extraordinary central Lancashire Executive Command meetings are urgently convened when needed. Actions are agreed by partners in terms of prioritising provision, flexing the workforce across organisational boundaries and coordinating mutual aid locally.

To support the day to day flow through hospital from urgent and emergency care to discharge, the CCG has supported a number of response programmes including the commissioning and mobilisation of interim and general nursing care beds across multiple sites to provide additional community bed-based capacity.

We continue to work with LTHTR to improve access to and maximise utilisation of the beds and are continuing with commissioning a significant number of Home First slots and Crisis Hours to maximise discharges.

There are also a number of admission avoidance services in place - all community services working with LSCFT, such as the Rapid Response Service, District Nursing, Crisis Hours and Frailty Services.

111 First

The 111 First Project, designed to provide bookable appointments at local urgent and emergency department for suitable patients, has continued to build on the initial successes when 111 First was first launched in central Lancashire in November 2020. During 21/22 the project moved into phase 2 of the 111 First planned work focussing on further expanding Emergency Department (ED) bookable appointments from 111, further expansion of the Clinical Assessment Service (CAS) function and the development of community pathways. The project has also continued to work on the implementation of the ED IT System (Quadramed) digital solution to ensure the future interoperability with the 111 IT System.

Some of the main achievements over the last year include:

- The expansion of the ED bookable appointments via 111 which are now available to all adult patients. On average over 60% of patients referred by 111 to ED are now offered a bookable appointment and further work is being carried out to look at offering more slots to achieve the national 70% target.
- The CAS function has expanded to pick up 111 online category 3 and 4 cases to support system pressures and to specifically support NWAS and avoidance of ambulance deployment and potential conveyance. Further discussions are being held with NWAS colleagues to also expand the CAS function further to supporting NWAS with telephony category 3 and 4 cases.
- Currently the CAS function has over a 90% ED deflection rate which means that over 90% of patients that are referred to the CAS from 111 with an Emergency Treatment Centre (ETC) disposition are not then referred onto ED and instead receive alternative appropriate support.
- Work has been carried out to ensure 111 and the CAS can refer into the new 2 hour Crisis Response Service launched at the end March 22.

The 111 First Project Group are continuing to meet to continue with this work and the main focus over the next few months will be looking at implementing referrals from the CAS into Same Day Access to Emergency Care (SDEC), expanding ED bookable appointments further and further development and expansion of the CAS.

Additionally this year the central Lancashire CCGs have commenced leading on a new Integrated Urgent Care Programme and the development and delivery of a longer-term vision and strategy of the future Integrated Urgent Care (IUC) system in Central Lancashire. A project group and governance are in place to support the work and a collaborative approach working with key partners is being taken to develop a new IUC model.

As part of this programme of work an initial review of the current Integrated Urgent Care Service delivered by GTD Healthcare has been carried out to understand the existing provision in place. As a result, the contract with GTD has been extended up to January 2024 in line with the timeline for the development of a longer-term model. However if a new model is ready to be implemented sooner then this will replace the existing provision.

The next stage of this programme is to develop an evidence based Options Appraisal to identify potential new IUC models to then move to a position to develop and implement the chosen model. A long list of options are initially being developed and defined to then be evaluated against an agreed set of Critical Success Factors to result in a short list of options to take forward. The approach to the Options Appraisal was agreed by the Clinical Professional Forum

and dedicated clinical support for the project has been secured. A recent Task and Finish Group has been put in place to progress this work.

Performance data

Activity and performance across urgent and emergency care has been under significant pressure throughout the year. The Urgent and Emergency System Delivery Board (UEC SDB) had oversight on performance, supported by the Urgent and Emergency Oversight Group which reviewed operational detail on a weekly basis.

UEC SDB Key Performance Metrics – High Area of Interest

The UEC SDB was provided with a fortnightly update of the following specific key performance indicator. The following table is the last report of the financial year comparing performance for March 2022 against the previous month and the same period during 2021-2022.

			TARGET	Previous Month Feb-22	Current Month Mar-22	DOT Current vs. Previous	Last Year Mar-21	% Variance vs. Last Year	13 Month Trend	Apr-22 to Date	Daily Avg.	Apr-22 Forecast	Latest Day Reported
										As at 6th Apr-22			6th Apr-22
1	Ambulance Handovers	Breaches > 30 Minutes	0	523	710	▲	165	330%		149	25	770	24
		Breaches > 60 Minutes	0	199	322	▲	13	2377%		59	10	305	10
2	Corridor Care		0	0	0	▶	0		-				
3	Time in Department	Avg. Time to Initial Asessment	15 Mins.	22	24	▲	11	1					
		4 - 12 Hour Trolley Waits	-	1035	1377	▲	1336	3%		266	44	1374	43
		12 Hour Trolley Waits	0	45	128	▲	26	392%		18	3	93	0
		MH 12 Hour Breaches	0	14	13	▼	5	100%					
4	Stranded Patients	% Beds occupied by patients >=7 days	-	59.1%	59.6%	▲	50.0%	19%		57.9%			59.4%
		% Beds occupied by patients >=14 days	-	35.1%	35.6%	▲	27.3%	30%		32.5%			32.7%
		% Beds occupied by patients >=21 days	-	22.8%	23.7%	▲	16.3%	45%		22.2%			22.3%
5	Bed Occupancy	% G&A Beds Occupied	85%	96.1%	94.7%	▼	90.0%	5%		93.2%			93.0%
		% Critical Beds Occupied	-	81.3%	70.8%	▼	69.3%	2%		77.5%			76.5%
		% Community Bed Utilisation	85%	66.2%	72.5%	▲	56.2%	29%		65.5%			69.0% *

* Community Beds - Broadfield House, Meadowfield & Longridge
NOTE: Community Beds Utilisation is calculated based on days were beds are available for occupation or when information has been provided. There are inconsistencies in reporting when ther are closures.

KEY: Direction of Travel (DOT)

- ▲ Increasing position toward target
- ▼ Decreasing position toward target
- ▲ Inceasing position away from target
- ▼ Decreasing position away from target
- ▶ No change

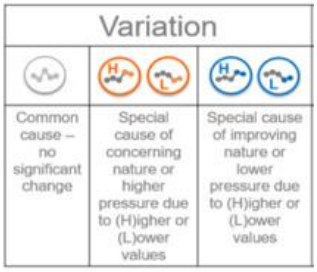
Target Not Met
Target Met

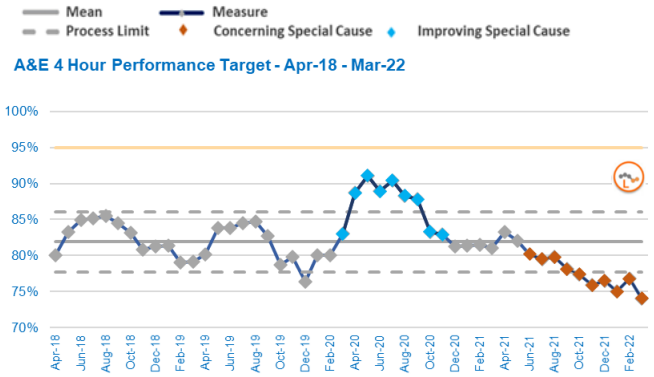
* Unvalidated Data

UEC SDB Performance Metrics

A more detailed set of metrics were reported on a monthly basis and can be seen below. Statistical Process Control (SPC) charts are used for each and utilise NHSI SPC icons within the tables to highlight any special cause variation.

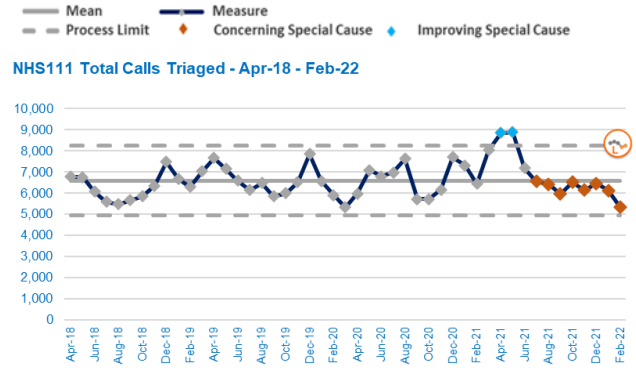
The charts include data from April 2018 to March 2022 to demonstrate the fluctuation in performance as a consequence of the pandemic.





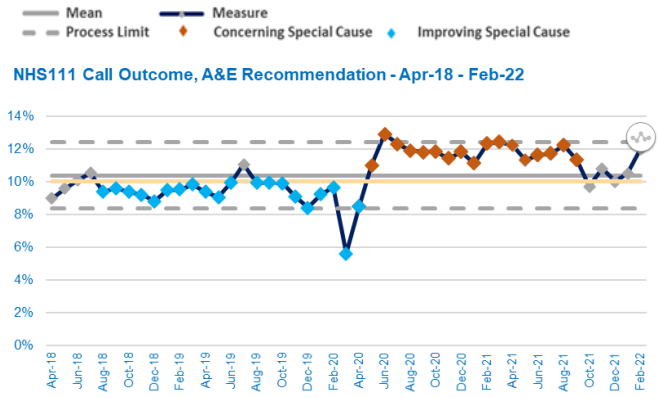
4 Hour A&E Performance (Target 95%)

Combined 4 hour performance across both A&E and UCC attendances at Lancashire Teaching Hospitals NHS Foundation Trust peaked at 83.3% in April 2021. The month of March 2022 was the lowest reported period of the year at 74.1%. There was a reducing trend in 4 hour performance falling below the mean average for the last ten months. Performance has fallen below the lower process limit for the last six months.



NHS 111 No of Calls Triaged

The average volume calls triaged across the year per month was 6,604. During the last reporting period (February 2022) 5,345 were triaged, a decrease of 794 triages from the previous month and a decrease of 1,111 triages compared to February 2021.

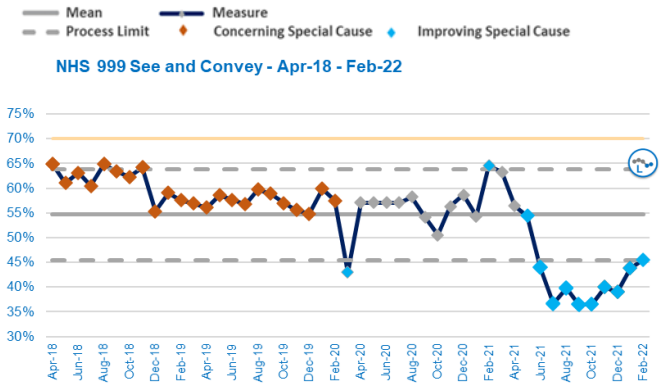


NHS 111 % A&E Recommendation

The proportion of NHS111 triages ending with a recommendation to attend A&E increased during February 2022 to 12%, similar levels as reported at the start of the COVID-19 outbreak.

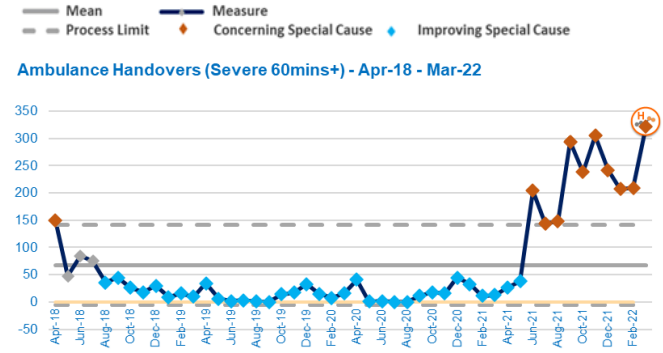
The actual number of patients with a recommendation in February 2022 was 641, compared to 646 in January. April 2021 saw the greatest number of recommendations at 1,080 for the month which only equated to

12.2% of calls due to the high number received during the month.



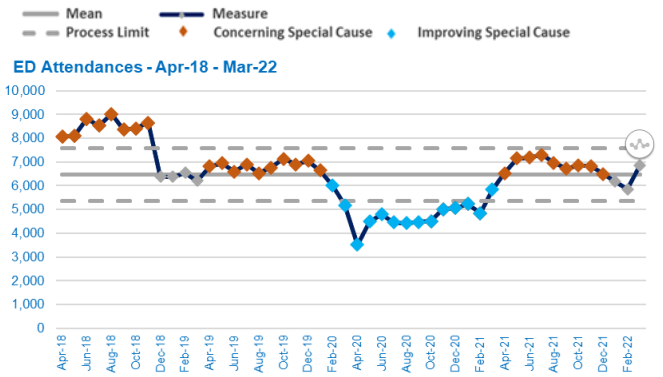
NHS 999 See and Convey

The proportion of NHS 999 calls with an outcome of See and Convey reduced significantly from the beginning of the year although there has been an increasing trend from January 2022.
In February 2022 there were 2,473 conveyances to hospital. This is a decrease of 54 compared to January 2022 (2,527) and an decrease of 256 conveyances compared to February 2021 (2,729).



Severe Ambulance Handovers (over 60 minutes (Target 0)

Handover delays have been significantly high throughout the year. In March 2022 322 patients waited over 60 minutes to be handed over with 710 patients waiting over 30 minutes.
Ambulance handover delays has been identified as a national priority due to the impact holding patients has on their outcomes. The expectation is that there will be no 60 minute breaches from the 1st April 2022.

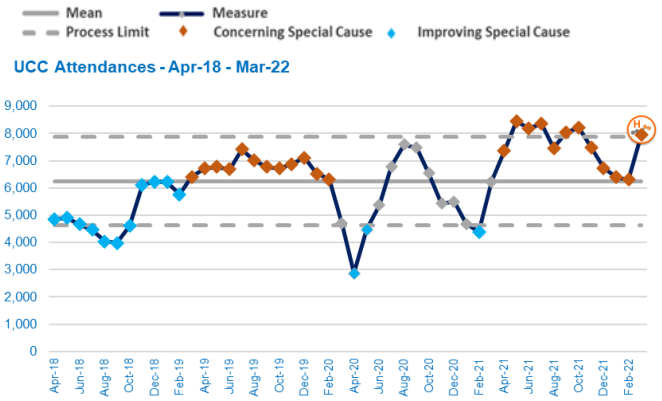


A&E (ED) Attendances

Total monthly volumes of ED attendances at Lancashire Teaching Hospitals NHS Foundation Trust increased at the start of year and levelled off to similar levels as reported at the start of the COVID-19 outbreak.

Following a reduction in attendance numbers from October 2021 and increase was recorded in March

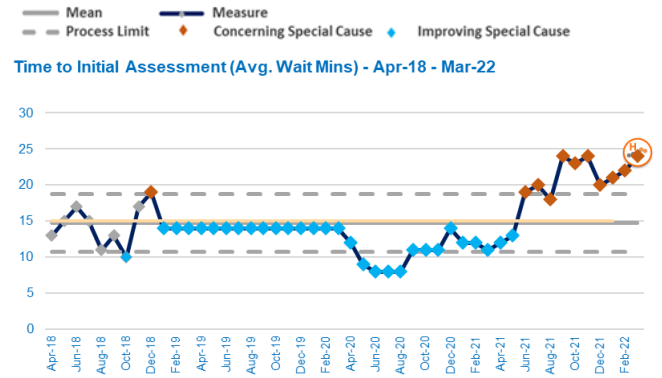
2022. On average the volumes of daily attends to ED was 221, an increase from the February 2022 average (209).



Urgent Care Centre (UCC) Attendances

A similar pattern has been recorded for Urgent Care Centre attendances as with ED attendances.

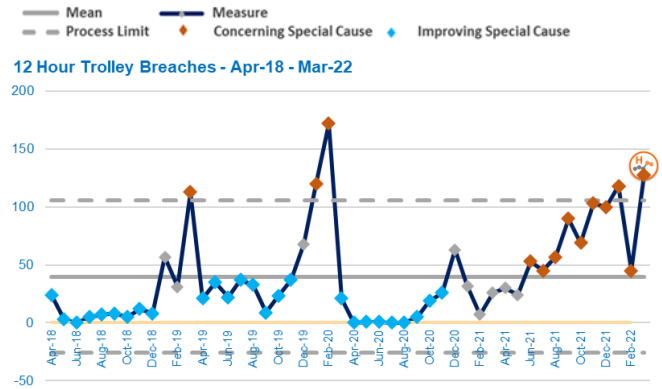
On average the daily volume of attends has increased to 256 during March compared to 226 during February 2022.



A&E Average Time to Initial Assessment (Target 15 mins)

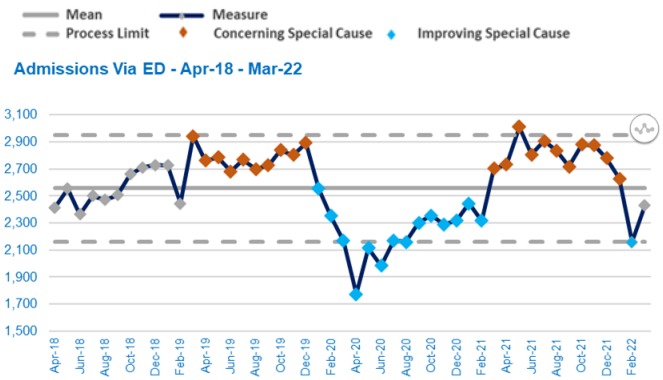
This target was achieved for the first few months of the year, but has failed from June 2021 onward.

Time to initial assessment during March 2022 is reported at 24 minutes. This is an increase of 2 minutes compared with February 2022.



12 Hour Trolley Breaches (Target 0)

There has been a significant increase in the volumes of 12 hour trolley breaches from the start of the year. There was improvement in February 2022 although during March 2022 there were 128 breaches reported.



Admissions via ED

For the first half of the year the number of admissions via ED was at similar levels as reported at the start of the COVID-19 outbreak.

A decrease was reported from October 2021 onwards until an increase in the volumes of admissions during March 2022 (2,428, avg. 78 per day) compared with the previous monthly position (February 2022, 2,158, avg. 77 per day).

The attend to admission conversion rate for March 2022 decreased further to 15.7%, the lowest rate reported.

Sustainable Development

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint. As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline.

The unprecedented challenges seen across the NHS as it responded to the needs of the Covid-19 pandemic response has meant that we have had to divert attentions away from our sustainability agenda to focus on countering the Covid-19 Pandemic. This response and its impact on service delivery models, alongside the changed model of working for our workforce has meant that it is not possible to measure the progress of our sustainability and carbon reduction targets in 2021/22 in comparison to previous years. That said, we have not lost our focus to reduce our carbon footprint and to become a more sustainable and environmentally friendly organisation.

Information on our activities during 2021-22 can be found in the following Public Sustainability Report: https://srp.digital/annual-public-sustainability-report-2020-21/

Improving quality for our local population

NHS Chorley & South Ribble and Greater Preston CCGs are committed to collaborating with our providers across the system in order to provide high quality care and service provision for all our citizens. Throughout 2021/22, the ongoing impact of the COVID-19 pandemic has continued to have a significant impact across the health and social care economy. The reconfiguration and temporary cessation of services in response to the infection prevention controls due to recurrent waves of the pandemic have led to surges in demand in emergency and unscheduled pathways and significantly increased waiting times for some elective surgery pathways. Staffing pressures due to COVID-19 sickness and isolation absence and the opening of additional escalation and surge areas to increase capacity and manage the flow of infected and potentially infected patients further stretched services well in excess of normal seasonal pressures.

In response to these unprecedented pressures, NHS England temporarily replaced normal contract management arrangements with a 'light touch' approach, which would support a level quality monitoring, whilst not being excessively burdensome on providers. Consequently, the quality team have continued to draw on longstanding collaborative working relationships with providers and to adopt innovative methods to gain assurance on patient safety, effectiveness and experience through the year.

Improving quality

Our citizens deserve consistently high-quality healthcare that is personal, effective, and safe; and care that respects their dignity and that is delivered with compassion. In the 2020-21 Annual Report NHS Chorley and South Ribble CCG repeated its commitment to continue to monitor and drive improvement in quality across all health care providers.

In order to fulfil this commitment, despite the challenges of having to use a 'light touch' approach, the CCGs have continued to monitor patient care in a variety of ways throughout 2021-22. This included monitoring provider activity and performance via a range of available information and indicators, which are reviewed on a continual basis and triangulated with information from numerous sources such as the national patient experience surveys, complaints, serious incidents and healthcare associated infections. In addition, regular contact has been maintained with all providers in order to understand any emergent risks or quality concerns that may affect our patients. The CCGs have continued to closely monitor safeguarding and quality issues that have arisen specifically in consequence of the pandemic, such as 52-week and 104-week waiting times. This helps to provide insights into the care that is actually being received by our patients.

Essential activity in relation to assurance of the quality and safety of commissioned services has also continued. This includes the CCG Serious Incident Review Panel; CCG C. difficile Infections Panel; CCG Quality & Performance Committee; Care Home monitoring /support; Learning Disability / Mental Health placement monitoring / support and CCG Safeguarding business.

The CCGs have also continued to receive assurance through their membership of provider quality assurance groups, such as Lancashire Teaching Hospitals' Safety & Quality Committee and their Infection Prevention Control Committee.

Quality visits

The CCGs planned programme of announced and unannounced quality assurance visits across our healthcare providers, in the majority of cases, continued to be suspended during 2021-22. The CCG Quality and Performance Directorate has used alternative methods to gain assurances from providers during this period with frequent contact with services.

Where visits have been required, for example as part of the due diligence approach to mobilisation of a new service, this has taken place.

During 21/22 the CCG undertook site visits to Buckshaw Hospital, part of the Ramsay Health Care group. The site opened in October 2021 and offers rapid access diagnostics, outpatient services and daycase across a number of specialities.

New services were also commissioned to provide additional general nursing beds to ensure patients who were medically fit and no longer required a hospital bed could come out to start their recovery sooner. Quality assurance visits were completed before and during the service delivery to ensure those general nursing beds were delivered with safe and compassionate care, resulting in a positive patient experience.

The CCG and Local Authority also undertook collaborative quality assurance visits to the regulated care sector to minimise the burden and reduce the number of staff attending a care home. These visits enabled assurances to be gained and actions taken and completed around a number of areas for improvement such as

- Care documentation
- Long and short term goals for patients
- Adverse discharges relating to inappropriate assessment and medication issues

The CCG has been pleased to support our acute provider Lancashire Teaching Hospitals NHS Foundation Trust to undertake STAR Short Observational Focussed Inspection (SOFI) walk-rounds. Visits to the Renal and Stroke Wards were undertaken as part of the internal preparation for CQC inspection. The collaborative feedback has allowed for developments for each of the wards and also highlighted the patient centred care from the staff.

The CCG will be guided by NHSE/I and CQC in the approach to undertaking quality visits in 2022-23.

The CCG has continued to meet with all health care providers throughout the pandemic to gain assurance of patient feedback being heard and listened to. In part this is done by meetings with

providers, reviewing contractual reporting and review of soft intelligence such as social media and patient feedback forums. Please see below some of the patient feedback obtained from monitoring online feedback from patients during 2021-22.

Acute Provider

"I would like to say thanks and well done to the two ladies who made my visit to the Xray department at the Royal Preston hospital yesterday (for a doppler of my carotid artery) a great experience. They made me feel totally at ease, talked me through the procedure checking that I was ok throughout. Two such lovely ladies who deserve a big THANK YOU.".

Community Provider

Diabetic Foot Dressings

"I started using the Clinic as I commenced working in Bamber Bridge - had previously used Chorley. Found all the Staff- Reception as well as Podiatrists-were excellent, friendly, and Welcoming. All in all, a much better experience".

Independent sector

"I had a back operation at Fulwood Hall last week and the standard of care and treatment was excellent. The nursing care was second to none and the food was very good when compared to other hospitals I have used previously. I would have no hesitation in recommending this Hospital to other patients who are considering using it.."

"I went into Fulwood Hall yesterday for a procedure and the staff and the care were excellent. This was my second visit in 12 months and the standards are amazing. Friendly warm staff and very informative and most importantly caring".

"I just wanted to say what a great experience I had recently at your cataract centre in Fulwood, Preston. The staff couldn't have been more accommodating, and my vision has improved immensely. You are all a credit to the NHS."

Serious incidents

Patient safety is the avoidance of unintended or unexpected harm to people during the provision of health care. We support providers to minimise patient safety incidents and drive improvements in safety and quality. Patients should be treated in a safe environment and protected from avoidable harm. Therefore, this remains a key priority for the CCG.

Patient safety is about maximising the things that go right and minimising the things that go wrong for people experiencing healthcare. It is human to make mistakes, so we need to

continuously reduce the potential for error by learning and acting when things go wrong. Each of the many organisations that make up the England healthcare system (both NHS and non-NHS) has its own remit and responsibility for improving safety. Hospitals, general practices and other providers are responsible for the safety of their patients. They should also share local information about risks and best practice.

The CCG holds providers to account for the quality of commissioned services. It seeks assurance that appropriate mechanisms are in place to prevent patient safety incidents from occurring and when they do occur, they are investigated appropriately.

All serious incidents which meet the NHS England Strategic Executive Information System (StEIS) reportable criteria are reviewed by the CCGs Serious Incident Panel. The investigatory report of all incidents are subject to scrutiny by panel members, which includes clinicians and subject matter experts. The panel ensures investigations are robust, with action plans addressing the pertinent issues to improve patient safety and care, including evidence of lessons learned and how any learning will be shared and disseminated across the organisation to reduce the risk of similar incidents occurring in the future.

Top 5/6 Incident Types			
March 2021 to March 2022			
Chorley & South Ribble CCG		Greater Preston CCG	
Apparent/actual/suspected self-inflicted harm meeting SI criteria	10	Apparent/actual/suspected self-inflicted harm meeting SI criteria	17
Slips/trips/falls meeting SI criteria	9	Slips/trips/falls meeting SI criteria	8
Treatment delay meeting SI criteria	4	Treatment delay meeting SI criteria	10
Diagnostic incident including delay meeting SI criteria	3	Diagnostic incident including delay meeting SI criteria	8
Pressure ulcer meeting SI criteria	3	Surgical/invasive procedure incident meeting SI criteria	8
Sub-optimal care of the deteriorating patient meeting SI criteria	7		

This year, the panel has introduced thematic reviews of incidents. Thematic reviews are a process by which the quality of care provided is reviewed in relation to a particular theme or aspect of care rather than an individual incident report. The aim of thematic review is to identify and analyse areas of good practice and areas for enhancement across key areas. The approach aims to take an overview of strategy, service provision and user experiences pursuant to a particular theme that cuts across many areas of care. It is intended that the process should be positive and constructive, supporting organisations. The scope of thematic review can be broad or narrow depending on the nature of particular theme. It evaluates the extent to which provision meets and supports the needs of patients and relevant stakeholders, including staff and evaluates the ways in which to monitor and improve the quality of care, share and disseminate examples of good practice, identify opportunities for enhancement and monitor action taken in response. To date, thematic reviews have been undertaken into the development of pressure ulcers and Maternity services.

Improvements undertaken this year also include:

- Collaborative working with the CCGs and the acute trust at round tables to review serious incidents.
- The local breech birth guideline at LTHFT has been amended to include a recommendation of consultant presence in the birth room for planned vaginal breech births.
- Learning to Improve Bulletin continues to be used at LTHFT.
- LTHFT introduced multi-disciplinary maternity specific Human Factors training.
- LTHFT implemented a Fall Prevention Collaborative involving 10 wards with a focus on risk assessment.
- Introduction of a brightly coloured wrist band for all patients identified to be at risk of falls to function as an instant visual sign to all staff that the patient is at risk.
- NHS Northwest Covid-19 Structured Judgement Review Guidance published in during 2021, has supported providers to develop an agreed framework for reviewing Covid-19 nosocomial deaths and this has become a regular standard agenda item at the Quality and Safety meeting at LTHFT.
- LTHFT. have continued to use the Perinatal Mortality Review Tool (PMRT) providing assurance that the Maternity service had fulfilled the requirements of safety action (one of NHS Resolution's schemes since 8 August 2021) and are working hard to support the Ockenden Review in relation to Maternity patients.
- LSCFT have established a Lesson Learned Forum and learning lessons workshops across the Trust to ensure staff.
- LSCFT launched a few collaboratives, namely Care Planning and Falls Reduction, involving both inpatient and community health teams.
- LSCFT have reduced the number of pressure ulcers, which has highlighted the impact of their improvement work.
- LSCFT have introduced a new protocol for the management of service users who are on the waiting list to be allocated a Care Co-ordinator.
- Ramsay have amended their Patient Journey Policy and the role of pre-assessment nurses in giving advice regarding medicines management pre-operatively.
- GTD provided promotional displays for learning disabilities in their facilities during National Adult Safeguarding Week (15 – 21 November 2021). They also launched leaflets and posters providing guidance for clinicians on how to communicate clearly during consultations; and made recommendations for improvements for patients with learning disabilities, including additional time for appointments, involving patients in consultations (as well as carers), taking time to explain things and avoiding the use of jargon.

This year and going forward, the CCG has been working towards the implementation of the new Patient Safety Incident Response Framework (PSIRF), a key part of the NHS Patient Safety Strategy, which aims to improve the NHS's understanding of patient safety by drawing insight from patient safety incidents. While recognising the importance of learning from what goes well, identifying incidents, recognising the needs of those affected, undertaking meaningful analysis and responding to reduce the risk of recurrence remain essential to improving safety. Doing this well requires the right skills, systems, processes and behaviours throughout the healthcare system. The PSIRF will support the NHS to operate systems,

underpinned by behaviours, decisions and actions, which will assist learning and improvement; and allow organisations to examine incidents openly without fear of inappropriate sanction, support those affected and improve services.

Health care associated infections

Clostridioides difficile

Clostridioides difficile (C.difficile) is a potentially severe bacterial infection that causes infective diarrhoea; and is commonly associated with people who have recently been treated with antibiotics, are elderly, have had a previous hospital admission, a weakened immune system or previous gastric surgery.

The COVID-19 pandemic continued to have a complex effect on social behaviour and the provision and delivery of healthcare throughout 2021/22. However, although this positively impacted on the C.difficile infection locally last year, with an overall reduction across Central Lancashire; by the end of February 2022, the cumulative number of infections had already exceeded the objectives set by NHS England for each CCG. This was also the case for Lancashire Teaching Hospitals in the same month.

The CCG have continued to lead the monthly Clostridioides difficile (C.difficile) Infection Panel, which reviews both community and acute attributed cases in order to highlight learning and discuss improvement actions in relation to any deviations from guidelines/ procedures (lapses in care); and to monitor the frequency of occurrences against NHS England and NHS Improvement's (NHSE/I) annual objectives. The panel's membership is taken from the wider health economy, including Lancashire Teaching Hospitals and Lancashire County Council. Membership includes infection prevention and control (IPC) specialists, a GP, a consultant microbiologist, a pharmacist, and a member of the CCG's Quality Team. The business of the panel has been conducted virtually since the start of the pandemic and GPs from affected practices have routinely invited to join the call and contribute to individual case reviews. However, due to competing priorities in response to the pandemic, Lancashire County Council's IPC Team have been unable to continue to provide the same level of support that they could previously.

Post-infection reviews focus on identifying areas of practice (including the location of care) that may have either contributed to the episode of infection, or increased the risk of further cases developing, due to 'lapses in care'. This learning approach supports staff development and informs plans to improve IPC arrangements and mitigate the risk of future infections. Analysis of post-infection reviews indicate that the majority of infections continue to be characterised in patients who are elderly, have multiple pre-existing health conditions and have received recent antimicrobial treatment, may of who had been hospitalised in the previous 3 month.

Common themes regarding 'lapses in care' highlighted in the post incident reviews of community attributed cases have included choice of antibiotics not compliant with NICE guidelines; delay in sending a loose stool sample for analysis; and delayed treatment. Learning is routinely fed back to affected practices and care homes to improve future practice. In addition. learning points are shared with primary care colleagues via the quarterly CCGs' HCAI

newsletter ‘Infection Insight’ and to care home colleagues via the ‘Time to Care’ newsletter. In addition, the CCGs’ Medicines Optimisation Team continues to work closely with primary care colleagues to share prescribing tips and provide feedback/ learning to individual practices, as appropriate, including encouraging GPs to seek advice from a Microbiologist for antimicrobial support, particularly for complex cases.

The CCGs’ Healthcare Associated Infections Reduction Group (HCAIRG) meets bimonthly to both monitor local prevalence rates and to share learning, guidance, and updates across the locality.

In November 2021, the CCGs participated in the virtual activities surrounding World Antimicrobial Awareness Week and European Antibiotic Awareness Day. This involved communications to improve antimicrobial awareness on use and increased resistance aimed for both staff and the public.

The CCGs continue to work closely with the Trust’s Infection Prevention & Control Team and via the Trust’s Infection Prevention & Control Committee to monitor progress and obtain assurance. This included a monthly review of the Trust’s CDI Action Plan, including:

- Development of an app to ease the identification, isolation and treatment of patients with loose stools; and software improvements to capture infection risks early.
- New point of care testing in the Emergency Department for suspected intestinal infections, ensuring more effective use of scarce isolation resources.
- Improvements to audit cycles to ensure learning is embedded in practice.
- Adoption of continuous improvement methodology involving 10 clinical areas.
- Programmes to identify key estates risks and proactive fogging/ decontamination of high risk clinical areas.

Common themes highlighted from the post incident reviews of acute attributed cases conducted by Lancashire Teaching Hospitals involving ‘lapses in care’ have included missing or insufficient documentation, especially around bowel habits and infectivity risk assessment, leading to delays in sampling and isolation; staff not adhering to IPC protocols; prescription errors / antimicrobial guidance not followed; IPC audit standards (including estate related) not met; delays in fogging affected bays, due to high demand and bed occupancy. In addition, the lack of side room capacity at the Trust, due to the ageing estate and continuing COVID-19 pressures throughout 2021/22, has at times delayed patients with loose stools, who would otherwise had been isolated in a timely manner.

Gram-Negative Blood Stream Infections (GNBSIs), including Escherichia coli (E. coli) bacteraemia

There are many different types of gram-negative bacteria. Some live in the intestine harmlessly, while others may cause a variety of diseases, particularly when they migrate or are introduced into another part of the body e.g. via the blood stream. Gram-negative bacteria can be resistant to antibiotics and in some cases are multi-resistant rendering most available antibiotic use ineffective. In 2017, it was estimated that almost three-quarters of GNBSIs consisted of E. coli (around 50%), Pseudomonas aeruginosa and Klebsiella spp. Most of these infections are

acquired in the community. The NHS Long Term Plan has supported a 50% reduction in GNBSIs by 2024/25.

Key infection risk factors include:

- Indwelling vascular access devices (insertion, in situ, or removal)
- Urinary catheterisation (insertion, in situ with or without manipulation, or removal)
- Invasive procedures (including, but not restricted to gastrointestinal tract surgery).

In July 2021, NHS England and Improvement introduced changes in the NHS Contract for 2021/22 to include quality requirements to minimise rates of the 3 main types of GNBSIs to new threshold levels, with a focus across health economies.

The CCGs locality-wide HCAI Reduction Group (which replaced the previous E. coli Reduction Group in 2020) involves representation from Lancashire Teaching Hospitals, Lancashire & South Cumbria Foundation Trust and Lancashire County Council. The group has a wider remit than the previous group, which includes an aim of reducing the number of HCAIs across the locality through the sharing of learning and greater collaboration on quality improvement initiatives. Although some of this work was affected and delayed by the impact of the pandemic and the competing priorities of partner organisations.

Improvement work undertaken this year includes:

- Forging links and building relationships within the wider integrated care system
- A review of the post-infection review template to enable the collection and collation of more reliable data
- Improved communication process with GP practices to improve quality and response rates
- Ongoing Antimicrobial Resistance (AMR) support to GP practices
- Developmental work with Lancashire Teaching Hospitals to link internal systems to automate entries e.g. catherisation into discharge letters for GPs
- Linking with Lancashire County Council in the provision of educational support for care homes
- Partnership development of a 2-year ‘Hydration Heroes’ project plan extending across care homes in Lancashire & South Cumbria to educate care givers and families on the importance of hydration in reducing urinary tract infections.

Nosocomial infections

Throughout 2021/22 surges in the community prevalence of new COVID-19 variants, including Omicrom have led similar surges in nosocomial infections across the health and social care system. Due to its geographical proximity and interconnectivity with centres of high prevalence, including East Lancashire, Greater Manchester and Merseyside, Central Lancashire at times experienced some of the highest prevalence rates in England, which also led to significant rates of nosocomial infections locally.

In collaboration with other health and social care partners across Lancashire & South Cumbria, the CCGs have worked to continually monitor and support nosocomial outbreaks across Central Lancashire, some of which, due to the cumulative effect of ongoing infections in large care homes have extended for several months.

In collaboration with Lancashire County Council, the CCGs helped to provide multi-disciplinary team support for care home providers providing educational and at times pastoral support to care home managers. The CCGs also supported the COVID-19 vaccination rollout programme and facilitated the secondment of staff to supporting roles in response to the pandemic. In addition, a system of mutual aid supported care homes, for example in the provision of testing kits when supplies were threatened due to demand.

The number of inpatients with COVID-19 and the number of nosocomial infections is closely monitored by the CCGs. NHS Northwest Covid-19 Structured Judgement Review Guidance, published in 2021 has supported providers in developing a framework for reviewing COVID-19 nosocomial deaths and this has become a regular agenda item at Lancashire Teaching Hospital's monthly Safety and Quality meetings.

The CCG is represented on Lancashire Teaching Hospitals' Infection Prevention & Control Committee (IPCC), which oversees the Trust's mitigations to contain and reduce outbreaks (2 or more co-located cases). Mitigating actions have included:

- Regular testing regimes for staff and patients, including point of care testing in the Emergency Department.
- The continuance of patient pathways and 'zones' in line with patient Covid status.
- Restrictions and controls (e.g. proof of testing) on visiting
- Reinforced messages for IPC practice and PPE use for staff/ patients/ visitors
- IPC team-led active investigations of incidents (single cases) and outbreaks (multiple cases) to identify and share learning and contain the spread
- Additional IPC education, promotion and audit of affected wards
- Fogging and deep cleaning of affected areas
- Review of staff break areas
- The use of temporary isolation facilities or Redi-Rooms and portable ventilation units in bays and break areas

Primary Care

The CCGs have continued to enhance the monitoring process with Primary Care with a real focus on patient safety and system-based learning across the Primary Care Networks (PCNs). Teleconferences continue with the Deputy Medical Director and Primary Care colleagues at NHSE/I in order to deal with pertinent issues. This provides an opportunity for intelligence sharing and the implementation of timely actions.

Across primary care technology and digital solutions have been embraced with practices offering virtual consultations, online booking and apps to support long term condition management. Whilst this has had a positive impact it is important to acknowledge the potential impact of reduced visibility of some patients. A comprehensive approach to triage has been needed to identify those patients who need a face to face appointment. This has enabled patients to be seen in practice to ensure there are no missed opportunities for intervention or care and where necessary safeguarded appropriately.

The CCG has continued to support the roll out and implementation of Personalised Care and Support Plans across primary care. Key staff have been trained to aid conversations to ensure co-production of care plans which are tailored to the individual needs and wishes. The

workforce across primary care has been expanded to include social prescribers and health coaches as well as care co-ordinators and clinical pharmacists. This is monitored and reported to NHS England with plans submitted on how this will be progressed over 2022/2023.

As part of the Enhanced Health in Care Homes programme primary care are supporting Multi-disciplinary Team (MDT) working Regular MDT meetings are undertaken with multi-professionals so care home staff have access to advice and input from specialist staff. This will further improve the quality of care and experience of residents.

Quality in care homes

The CCG commissions nursing care that is provided to patients within nursing and residential homes in our area, and we undertake regular work to improve the quality and safety of care provided in those places of residence. This has been extended to all care homes within the Lancashire footprint.

Our work includes monitoring the safety and effectiveness of care and working closely with the homes to look at different ways that patient experiences can be improved. In addition, we provide support and training opportunities to the regulated care sector workforce.

2021/22 saw a slightly less challenging year than the previous year for care homes in our area. However, Covid outbreak management, financial viability and staff shortages have continued to be an issue, especially recruitment into registered manager and nursing posts.

Fewer homes have required measures via the Quality Improvement Programme; however, a significant amount of Multi-Disciplinary Team (MDT) support has been provided within the sector in response to the Covid pandemic and outbreak management.

The area RADAR network has identified care homes requiring support at a stage where early intervention has been both offered and effective. Due to guidance issued in response to Covid pandemic, there has been a reduction in on site visibility within the care home sector, which in turn has impacted on the soft intelligence received into the RADAR networks, however the majority of the homes have received an on-site visit at some point over the last year with plans in place to visit all again in year. Whilst initially there was a decrease in the volume of safeguarding activity within the sector, the latter part of the year saw a marked increase as residents moved through services again and visiting was reinstated, this facilitating a targeted approach to CQC, CCG and Local authority inspection activity.

To drive improvements in quality and safety the CCG has led the following improvements:

- During 2020/21 the Care Home Collaborative held regular bi weekly teams meetings until December 2020, when a fortnightly forum delivered by LCC came into effect. This collaborative continues to develop standardised tools to promote best practice, support the workforce and improve residents' experience. Feedback from members in this group describe the invaluable opportunity to network, gain knowledge from the varied speakers presenting at the collaborative and to learn/share experience and knowledge for the care home residents.

- The web-based quality reporting system which was procured with local authority partners has been useful as one of the main sources of information to help identify the support needed for care homes within Preston and Chorley throughout the pandemic, it has been a source for information on vaccination uptake, for care home residents and staff as well as other registered settings ,along with bed occupancy, outbreak status, PPE, and testing to name a few and it will be continuing into the new financial year. From April 2021 providers have been able to access more views of data which will enable them to understand their own data against national, regional, and local data, to help see their own positions relative to others.
- The CCG is a member of the Aging Well programme board, the Local Resilience Forum care cell and Health and Social care Board. Additionally, the CCG chairs the ICS Regulated care group and Regulated sector quality sub-group, which includes workforce, quality improvement and digitisation.
- In response to the Covid pandemic, weekly calls have been put in place with leadership from the CCG, working in collaboration with Lancashire County Council, Public Health and safeguarding. These calls have covered care homes and home care providers within Preston, Chorley and South Ribble with Covid outbreaks and incidents. A team is in place to offer help and support to care homes dealing with outbreaks. Intelligence and information are collected and fed into the ICS regulated care outbreak meeting, where discussions take place on trends and themes identified across the region. This is then escalated to the ICP lead and the ICS Regulated Care Group for action and support.
- In light of the Covid pandemic and the need to move towards a more digital way of working, a Digital Readiness Group has been established with representatives from across the ICS to make sure that we are helping and giving the opportunities for our care homes to have access to digital technology along with supporting educational tools. This work is a continuation of that started by NHSE/I on the distribution of iPads and the continuing work regarding signing up care homes to NHS.net email and NECs capacity tracker accounts.
- A newsletter is produced and circulated monthly or as required (daily and weekly in 2020)-weekly to help the CCG share news, clinical updates, relevant information, and any provider celebrations along with details of available training for care home providers.
- The CCG have led on the development of the MCA Covid testing advice, and a safeguarding grab pack. These were developed to support both testing and the vaccination programme on behalf of the ICS. The CCG have also developed a communication strategy for sharing guidance updates and supporting materials, monthly bulletins along with hosting provider collaborative. The CCG has worked in partnership with local authority colleagues to produce a matrix and response strategy to support care homes who required enhanced/additional support.
- The CCG continues to work proactively with homes which are not performing as well as would be expected. We do this in partnership with health and social care partners in order to put action plans in place to support improvements. This ensures that quality services are provided for our population.
- The CCG has been working with partners to implement the nationally directed elements of NHS England Enhanced Health in Care Homes Framework, which was successfully

delivered and achieved. This will further improve the quality of care and experience for our care home residents.

- During 2021/22, the PPE training offer has been continued throughout the twelve month period to all care homes within Preston, Chorley and South Ribble. A targeted approach is still offered with regards to PPE training to all care homes within Preston, Chorley and South Ribble. The offer has been continuous through the twelve month period, Also taking opportunity to advertise training sessions through the LCC care home webinar and the CCG newsletters. The CCG also contributes updates on guidance, activity, swabbing, MCA, vaccination, and responses to challenges through both the webinars and newsletters.
- We have supported additional work within the Discharge to Assess pathways within the care homes which has resulted in assessments being undertaken in the right settings and allowing patients with a period of recovery by following and implementing NHS discharge guidance.
- We have worked in partnership with our providers to develop Trusted Assessor documentation, developed interim beds and support plans to promote timely and safe discharge of residents back to their home along with new admissions.

Our Chief Nurse also received the CNO Silver Award for her outstanding contribution and leadership to Regulated care during the pandemic.

Patients treated out of area in Acute Mental Health (Out of Area Patients OAP)

An ‘Out of Area placement (OAP) occurs when a person with acute mental health needs who require inpatient care is admitted to a unit that does not form part of the usual network of services. The CCGs continue to note a continuous increase in mental health acuity across the health economy impacting on both acute and community based mental health service. The CCG continue to work with the Lead Commissioner of Mental Health Services and system partners to understand why these placements continue to happen. A number of quality initiatives have been actioned in the past and continue .

- Participate in weekly bed flow meetings with LSCFT to support timely discharges and initiation of care planning needs
- Works in partnership with MLCSU to ensure funding is secured and not delayed
- The Mental Health Nurse within the CCG supports complex discharges and provides specialist advice as and when necessary
- Attends the daily Mental Health Hub call support system flow and pressures.
- LSCFT Rehabilitation now open on the Wesham site which should enable patients requiring this service across the ICS to be admitted with-out delays, and also prevent some individuals being transferred to out of area placements .
- Crisis House provision is now available in 3 areas of the ICS, which has a focus on admission prevention and facilitating earlier discharge for some patients.

Positive Lifestyle Team

One of the key priorities of the CCG is to address the physical health of patients with severe mental illness, as a result the CCG commissioned the Positive Lifestyle Team.

Role and function

- Provides an enhanced offer in supporting GP's/Primary Care Networks in managing complex patients with mental health needs.
- Supporting the discharge and transition of patients from secondary care to community services.
- Undertake mental health and medication reviews and liaise with psychiatry services as appropriate.
- Link with social prescribers and other teams.
- Undertake annual physical health screening for patients prescribed anti-psychotics within Primary care.
- Access to a dedicated clinical psychologist.
- Developed care pathways for seamless referral back into secondary MH service if needed.

Transforming Care

The Winterbourne View concordat was established in 2013 and is now referred to as Transforming Care for people with Learning Disabilities and/ or Autism.

The main principle remains that people with learning disabilities and/or autism should not be living in hospitals unless there is a clear rationale for assessment and treatment which needs to take place in a hospital setting.

It is widely acknowledged that the hospital model is not appropriate for many people with learning disabilities and/or autism, or whose behaviour is perceived as challenging. Hospital admissions must be sanctioned only as a last resort and once all other available treatment options have been considered and exhausted.

The expectation being that locally commissioned services have both the capacity and capabilities to provide local community' based care and support within robust and sustainable services designed to meet presenting needs and challenges.

Where hospital admissions are not deemed to be avoidable, the CCG continues to work with provider partners and the Local Authority to discharge individuals from hospital and ensures that:

- Local Area Emergency Protocol (LEAP) meetings / community care and treatment reviews are coordinated to prevent an admission.
- Individuals in a hospital setting have a care and treatment review within one month of admission, and every six months until they are discharged.
- 8 weekly quality review visits occur, to achieve assurance that people are safe and that discharge plans are being robustly progressed.

- A rapid transfer programme is in place to discharge individuals.

This year saw the introduction of Safe and Wellbeing reviews following the report of the very sad deaths of 3 people in their 30's with a learning disability and or autism in a Hospital in Norfolk. The report is highly critical about the use of independent and private sector providers for inpatient care, the lack of commissioner oversight.

As part of the Lancashire & South Cumbria Care Partnership, we were committed to ensuring that the recommendations detailed within the report are considered and actioned across our system.

As a result of the report, every person with a learning disability and or autism in a mental health/specialist bed has had a safe and well-being review completed. Reviews began at the end of October 2021.

The process is made up of two phases:

Phase 1 – Implement the undertaking of the reviews

Phase 2 – Assurance and Challenge of review findings
A review of the findings is under development to share key findings within ICS governance frameworks and shared across providers / system

The CCG continues to be an integral partner across the local economy, and we continue to work on initiatives to further develop the community infrastructure to support people with learning disabilities and autism safely in the community.

Learning disability and autism continues to be one of the work streams within the Commissioning Development Framework of the Integrated Care Service (ICS). Progress on the development of the priorities for the work stream are monitored on a monthly basis at the Lancashire and South Cumbria Strategic Commissioners Learning Disability and Autism meeting and reported through to the Transforming Care Steering Group. The focus remains on developing the infrastructure in relation to community specifications and models of care, development of pooled budgets across health and social care and workforce development.

The Covid-19 pandemic continued to impact upon our ability to conduct onsite visits and progress with discharges.

The table below summarises the number of admissions and discharges from 1 April 2021 where the commissioning responsibility rests with the CCG.

CCG In-patients

	No. of inpatients 1.4.2021	Admissions	Discharges	No. of inpatients 31.3.2022

GP	7	6	5	8
CSR	6	7	5	8

A ‘support’ register (Dynamic Support Database) continues to be used by the CCG at monthly Transforming Care meetings to track progress towards discharge for patients who are in hospital and to also support with hospital admission avoidance.

Commissioning for Quality and Innovation

Prior to the pandemic, the CCG utilised a Commissioning for Quality and Innovation (CQUIN) process to make a proportion of healthcare providers’ income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.

In order for all health care providers to respond to the pandemic, the NHS adopted special payment arrangements for 2020/21 and 2021/22, removed the requirement for trusts to sign formal contracts and disapplied financial sanctions for failure to achieve national standards. The Commissioning for Quality and Innovation (CQUIN) financial incentive scheme was suspended by NHSE/I for the entire period.

NHSEI have identified a small number of core clinical priority areas, where improvement is expected across 2022/23. In general, these are short-term clinical improvements that have been selected due to their ongoing importance in the context of COVID-19 recovery and where there is a clear need to support reductions in clinical variation between providers.

There are 9 schemes applicable to our acute provider, LTH.

- Flu vaccinations for frontline healthcare workers
- Compliance with timed diagnostic pathways for cancer services
- Appropriate antibiotic prescribing for UTI in adults aged 16+
- Recording of NEWS 2 score, escalation time and response time for critical care admissions
- Treatment of patients with confirmed Community Acquired Pneumonia in accordance with BTS Care bundle
- Screening and treatment of pre-operative anaemia for high blood loss surgeries
- Cirrhosis and fibrosis tests for alcohol dependent patients
- Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service
- Supporting patients to drink, eat and mobilise (DrEaMing) after surgery

Although LTH must report against all 9 applicable schemes, the CCG and LTH must agree which 5 should be earnable and provide the greatest opportunity to achieve the best outcomes for patients.

There are four schemes applicable to our community services provider, LSCFT.

These are

- Flu vaccinations for frontline healthcare workers
- Malnutrition screening in the community
- Assessment, diagnosis and treatment of lower leg wounds
- Assessment and documentation of pressure ulcer risk

The provider will undertake all four schemes.

All other health care providers commissioned by the CCG do not meet national criteria to partake in CQUIN this year.

Personalised Health Care Plans

A Personalised Care and Support Plan is a way of capturing and recording conversations, decisions and agreed outcomes in a way that makes sense to the person, they should be proportionate, flexible, and coordinated and adaptable to a person's health condition, situation and care and support needs.

One of the elements of the NHS Long Term Plan was to roll out the NHS Comprehensive model of Personalised Care, so that 2.5 million people can have choice and control over support for their mental and physical health. Unfortunately, this programme has remained paused due to the Covid response.

In 2021-22 the CCG had aimed to prioritise the training of staff in health coach training to aid conversations with patients and has reported an increase in the number of personalised care and support plans implemented and will ensure that personalised healthcare plans are embedded within the refreshed contracts with our health care providers, this unfortunately was also paused nationally due to Covid response. The CCG is awaiting refreshed guidance to relaunch the plan surrounding personalised health care plans.

Effectiveness

We also consider how effective our services are in delivering the level of quality and performance expected. Clinical effectiveness is about doing the right thing at the right time for the right patient and is a positive measure to establish a holistic view of improvements within quality and performance. Within the effectiveness agenda the CCGs work with NHS England/Improvement and the RightCare programme.

RightCare is a delivery methodology based around 3 simple principles of working with local systems.

During 2021-22 the RightCare programme remained suspended due to the Covid pandemic with the elective care programme focusing on recovery and maximising available capacity and NHSE/I redeployed to other workstreams.

The CCG remains committed to this programme of work and will be engaging closely with the NHSE/I team into 2022-23 to develop plans and move the programme forwards across the place base and ICB.

Effectiveness and service improvement work

Throughout the year the effectiveness team have worked in collaboration across a number of areas, supporting the Covid response and service developments/improvements where possible.

This has included:

- Evidence searches – expansions of mental health services and mental health service reviews, service specification development across a range of services and local policy reviews considering new evidence and the impact on effectiveness of interventions.
- Elective care programme – various support on ICS wide contracts, developing service specifications, quality schedules and service reviews.
- Bariatric services PROMs review

Safeguarding children and adults

The NHS Safeguarding Accountability and Assurance Framework sets out clearly the safeguarding roles, duties, and responsibilities for safeguarding in the NHS.

There is strong evidence that the CCGs undertakes their statute and regulatory requirements and have arrangements in place to safeguard and promote the welfare of children and adults in service delivery.

This is demonstrated by the following:

The CCGs were rated as receiving ‘significant assurance’ following a KPMG audit. An action includes the CCG regularly reporting compliance against the NHS Safeguarding Accountability and Assurance Framework. This demonstrates that the CCGs are delivering against their safeguarding responsibilities.

Policies and procedures are in place setting out a commitment to safeguarding children and adults including the Mental Capacity Act. To strengthen governance arrangements and support consistency in approach, a system policy and procedure review group is in place to ensure all Policies and Procedures are timely updated.

The arrangements for safeguarding assurance for the CCGs with Commissioned Services were adapted due to the COVID 19 pandemic; monitoring of safeguarding practice have been maintained. In recognition of the need to reduce footfall and burden, due to the Covid pandemic the CCGs adopted a lighter touch approach to audit work, with a stronger focus on supervision and risk sharing with partners.

Statutory functions have been sustained during COVID 19 with virtual approaches in some areas. A focus has been on safeguarding working across the Safeguarding Partnerships, and with regional / national networks.

The CCGs have continued their responsibility and statutory duty to be active members of the local Safeguarding Partnerships in a wide range of safeguarding arrangements and Boards. A significant part of this role is leading on the co-ordination and contribution to safeguarding reviews to support learning, generating actions to support continuous improvements. Learning is incorporated into training, awareness raising and communications.

Hidden harm and missed opportunities of not responding to abuse due to children, adults and families not being as visible has remained a concern. There has been significant support offered by the safeguarding team into the COVID 19 response. This has included supporting the system response to Regulated Care, as well as specialist input and support in to various COVID workstreams.

Several initiatives to influence safeguarding practice include:

- The CCGs’ Safeguarding Team has been instrumental in leading and supporting the Regulated Care market during the pandemic from both a safeguarding and quality perspective
- Preparatory work has commenced to implement and strengthen understanding of roles and responsibilities within the proposed changes within the Mental Capacity (Amendment) Act (2019) including the Liberty Protection Safeguards (LPS)
- Court of Protection backlog for Continuing Health Care patients continues to be tracked with risk mitigations and least restrictive care in place
- A Safeguarding Conference for Primary Care staff was held over a two-day period; to support safeguarding practice, the conference was well attended and very well evaluated
- A system approach to safeguarding adults and children has progressed significantly with the support of an Executive Safeguarding Lead role

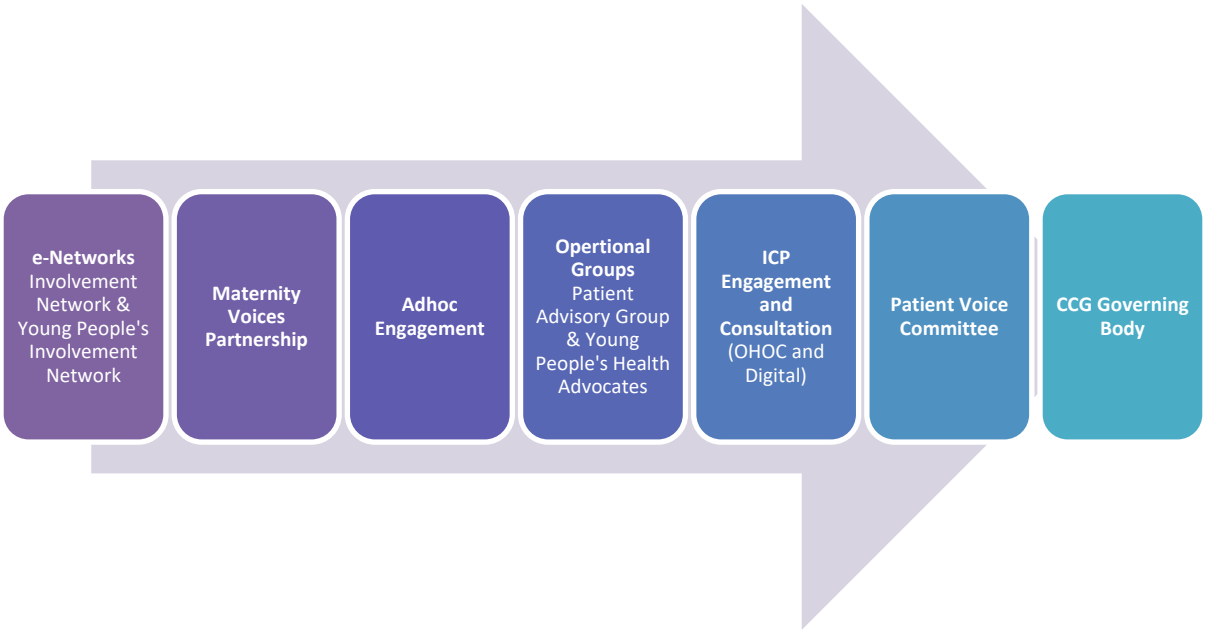
- The CCGs' Safeguarding Team have actively supported the development and facilitation of the Safeguarding System Learning Forum
- There remains a strong focus in relation to safer sleep with an increased multi-agency response to identifying and raising awareness of unsafe sleeping practices
- The SUDC Service commissioned Pan-Lancashire wide has been presented with a NHS England Safeguarding Star Award for their commitment in supporting families following a sudden loss of a child

There are plans to continue to strengthen safeguarding arrangements across Health and Social Care Partnerships. In addition to support the ongoing system and place-based development of safeguarding structures, priorities and workplans.

The Lancashire and South Cumbia CCGs report of April 2020 – January 2022 can be found here.

Engaging people and communities

The CCG's remains committed to involving patients and members of the public in the work we do. Our engagement framework illustrated below shows how the patient and public voice has been fed through to the Governing Body over the last year whilst being fully supportive of the NHS Constitution, for engaging with people and our communities.



NHS Chorley and South Ribble CCG and NHS Greater Preston CCG Engagement Framework 2020

The principles of the NHS Constitution

There are seven key principles within the NHS Constitution which also align to the public engagement and focuses on better health outcomes for patients, families and carers and our communities. The principles focus on:

The provision of a comprehensive service for all people within our communities that promotes respect, equality, and a reduction in health inequalities.

In line with the CCGs' specific value, 'to be professional and honest', the CCGs commission non-discriminatory services in compliance with SC13.1 NHS Standard Contract to meet the requirements of:

- Equality Act (2010) by ensuring the provider services we commission is available to all people in our local communities, specifically those with protected characteristics.
- Human Rights Act (1998) ensuring the human rights of the people in our communities are respected when accessing the services, we commission.
- Health and Social Care Act (2012) paying 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.

The CCG has been undertaking the equality delivery system (EDS) since 2013. This is a framework for monitoring equality compliance and reporting our professional approach to equality and diversity to gather inclusive patient feedback. The CCGs have an operational group, the patient advisory group (PAG) which enables the CCG to be open and honest about our business and receive appropriate feedback that we can use to make informed decisions.

Access to NHS services is based on clinical need, not an individual's ability to pay.

The NHS standard contract (SC13 Equity of Access, Equality and Non-Discrimination) ensures we commission provider services to deliver health services that are accessible for all local people, irrespective of any protected characteristic.

The highest standards of excellence and professionalism in the provision of high-quality, safe, effective, and focused care from people who are appropriately qualified and lead by people with commitment to improve the current and future health and care of the population.

The CCG has a specific value, 'to listen and learn, and be willing to change based on what we hear' to improve patient experience and their health outcomes. The Covid pandemic has prevented some engagement activity. However, digital training and alternative engagement, such as telephone, email, Zoom, Microsoft Teams, social media etc. has taken place to enable people to share their thoughts and concerns and identify solutions. The NHS standard contract (SC2 regulatory requirements, SC3 service standards) supports us to ensure our provider services demonstrate the delivery of a high-quality safe service that effectively focuses on patient experience.

The CCGs commission services that reflect the needs and preferences of their patients, their families, and their carers.

The CCG has a specific value, to ‘respect and care for our staff, the people we work with and our local community. We gather views through workshops, surveys and online meetings. Our operational patient groups support the CCG to make informed decisions about the care and treatment offered to patients. We also ensure that our provider services ensure individual people’s needs are assessed and met in appropriate and effective ways and people are informed and supported to be as involved as they wish to be in decisions about their care with the support of their families and carers.

The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities, and the wider population to provide and deliver improvements in health and well-being.

The CCG has a specific value, ‘to work in partnership with others to achieve our goals’, we work across the Lancashire and South Cumbia Integrated Care System (LSC - ICS) to improve the health and care of the local communities. We have recruited several partners from the local authority and third sector organisations as members of the PAG to ensure we align our services more effectively.

The CCG strives to provide the best value for taxpayers’ money and the most effective, fair, and sustainable use of finite resources.

The CCG has a specific value, the need to protect and invest the public funds that are given to us in a well-managed way. All decisions for funding on business cases / schemes include an in-depth analysis of the impact on patients by undertaking quality, privacy, and equality to ensure the best outcome for the sustainability of the NHS and health outcomes for the people in our communities.

The CCG is accountable to the public, communities, and patients that it serves. We ensure all decisions for the treatment of individuals are undertaken with their clinician, which we make clear to the public, patients and staff.

The CCG has a specific value, ‘to be open and accountable to our patients, their carers and the local community.’ We commission, procure and design and monitor services utilising the specialist skills of our workforce and our communities to ensure that we make informed decisions based on equality, quality, financial and privacy impact assessments.

Patient and public involvement and assurance

To promote the views and voices of patients and the public in the work of the CCGs.

The engagement framework highlights how the views and voices of patients and the public are promoted through the CCGs structure from public networks, operational groups to the Patient Voice Committee (PVC) which meets quarterly and provides the Governing Body with strategic leadership, assurance and scrutiny in relation to its duties to involve patients and the public in shaping NHS services (as outlined in section 242 (1b) of the National Health Service Act 2006,

the Equality Act 2010 and other relevant legislation). The Governing Body Lay Member for patient and public participation attends this meeting alongside the CCGs' Engagement and Patient Experience Lead, two representatives from the Patient Advisory Group (PAG) and the Equality and Diversity Lead.
The Chair from the PVC shares a report with the Governing Body to provide public and patient involvement assurance to Board members and highlight that the CCG is meeting our public involvement requirements within the NHS Constitution.

To ensure compliance with section 242 (1b) of the National Health Service Act 2006, the Equality Act 2010 and other relevant legislation.

The PVC assurance report enables the PVC to monitor arrangements relating to equality and diversity issues and compliance with statutory obligations, including the production of an equality annual report, equality strategy and an equality delivery system process. The CCGs have aligned the public involvement activities as evidence for our national requirements, such as the Equality Delivery System (EDS) framework, NHS Outcomes Framework, CCG annual report and Care Quality Commission inspections. The PVC assurance report specifies the membership of the public networks and operational groups and informs the gaps in protected characteristic representation for potential recruitment. PVC members are presented with formal consultation and pre-consultation patient activity plans, reports and strategies to review, scrutinise and evaluate to ensure the CCGs are meeting their legal duties in respect to the involvement of people who are associated with seldom heard groups and 'protected characteristic' groups as defined by the Equality Act 2010.

To provide assurance to the Governing Body on all matters concerning duties, obligations and responsibilities relating to the use of the patient voice in shaping local health services.

The PVC assurance report highlights the promotion of cross-system engagement by maintaining relationships with local authorities, provider organisations and the community, voluntary and faith sector. The PVC assurance report supports the PVC members to oversee and support the development and embedding of strategies, systems and processes in relation to using the patient voice and involving patients and the public in the work of the CCGs.

- Equality annual report, including equality delivery system (EDS) outcomes.
- Equality and diversity strategy
- Duty to Involve

The PVC assurance report enables the PVC chairs to provide challenges within the PVC meetings and assurances to the Governing Body that the patient voice is heard, and appropriate decisions and actions have been taken. The information within the PVC assurance report enables the Chairs to offer advice and support to other CCG Committees which meets their patient voice and involvement commitments. The PVC assurance reports highlights that the CCGs have considered beyond the nine characteristics to ensure that we are commissioning services for the wider communities.

To review and advise on the effectiveness and influence of systems and processes in place that enable patients and the public to be involved in CCG business.

Review, scrutinise and evaluate stakeholder engagement and consultation plans associated with CCG commissioning programmes and provide advice and support to ensure they are fit for purpose and allow patients and the public to have real influence in decision making.

To identify and share good practice in involving and empowering patients, and to challenge poor engagement practice.

PVC members provide advice and support for patient voice activity shared jointly with the local Healthwatch and the local Health and Wellbeing Board to explore and agree criteria for best practice 'effective engagement'. PVC members review stakeholder engagement plans associated with CCG commissioned providers and provide advice and support to ensure they are fit for purpose. The PVC members utilise the feedback from the operational groups and the networks to determine the best process to implement to get the most effective feedback. PVC endorses the promotion of the CCG as a learning organisation in terms of patient and public involvement and patient empowerment.

The PVC has a responsibility to manage conflicts or potential conflicts of interest when these are declared in the meeting by following the Managing Conflicts of Interest Policy.
The PAG members are asked to highlight any conflicts or provide declarations of interest before they become involved in any commissioning work.
If a member of PAG is identified as having a conflict of interest with any programme of work, another member will be asked to undertake the commissioning task.

How are we capturing patient and public voice during the pandemic?

The CCGs have had to adapt to working differently to maintain effective engagement with our local population and have used the following methods to capture people's views:

- Online surveys
- Workshops (on-line)
- Patient group meetings (on-line/ telephone)
- Telephone conversations
- Emails
- Social media
- Via the website on our 'contact us' form
- Socially distanced, covid secure meetings where possible

People are also able to feedback via the in-house Customer Care Team. Feedback gathered this way is shared with different teams within the CCG to ensure that it is acted upon where possible.

Our engagement framework groups

Our active **Patient Advisory Group (PAG)** is the CCGs core patient reference group who are representative of our local population and eight of the nine protected characteristics (age, disability, gender reassignment, marriage or civil partnership, race, religion or belief, sex and sexual orientation). Membership also includes carers and members of the VCFSE sector and Healthwatch Lancashire.
The group works with us on a regular basis to help shape and improve the services we commission. PAG members are involved in several commissioning activities, such as procurement processes for new services, service re-design and focus groups on how services can be improved. In addition, the PAG grade the CCG on the patient outcomes element of the annual Equality Delivery System (EDS) assessment that relates to access, experience, and health outcomes.
PAG meetings continue to be held via Zoom and MS Teams. Issues that occur are fed into the customer care system in "real time" so that they can be dealt with at source. Feedback is them provided back to the PAG once any necessary investigations have taken place.

The **Young People's Health Advocates** (YPHAs) are a sub-group of the PAG, consists of people aged 25 and under, who represent younger members of our population. The YPHAs have a regular high turnover, due to the age restriction, being under 25 years old and we have not been able to undertake public engagement to recruit to this group due to the restrictions of the Covid pandemic. However, we have managed to digitally engage with the members we have retain and provided up to date information and opportunities as they have arisen.

Recognising that some people may not want to join a physical group, the CCGs have two online forums. Our **Involvement Network** (over 25) and **Young People's Involvement Network** (under 25's) are virtual groups of people who receive regular updates on the CCG's work and activity and engagement opportunities; both with the CCGs and our partners, including voluntary sector events.

Currently there are almost 300 members of the online networks, communication is via email and some of the things the Networks have been involved with this year have included:

- Review of LCC's stop smoking service
- Review of clinical policies
- Vaccination roll out programme
- New carers Forum
- Lancashire Adult Learning Courses
- New health app
- New Hospitals Programme

The **Maternity Voices Partnership (MVP)** has maintained the involvement of service users and maternity services colleagues by upscaling the activity on the MVP social media platforms; Facebook, Twitter and Instagram and the continuation of virtual meetings via MS Teams.

The Virtual meetings have been held bi-monthly and have enabled service users to share their personal experiences with health professionals. Issues flagged by service users in the meetings have been dealt with at source and in real time.

The continued regular attendance and support by service users, maternity services staff together with wider partners such as the 0-19 health visiting service, the 0-19 infant feeding team, Families and Babies Peer Support, Team Dad, the Quit Squad, Homestart, Lancashire Women's Health, Healthier Lancashire and South Cumbria LMS, the CCG and Healthwatch Lancashire continues to validate the value and importance placed upon the bi-monthly meetings of the partnership.

The focus of the meetings this year has been in respect of pregnancy and maternity during covid. Providers of maternity services have been able to provide regular, real-time updates to service users and service users have been able to get their questions answered also in real-time.

MVP social media channels

MVPCentralLancs

@MVPCentralLancs

@MVPCentralLancs

You can read about the engagement activities this year in our Patient Involvement and assurance reports available on our website: https://centrallancashireccgs.nhs.uk/get-involved/patient-voice-committee
This year, the CCG has published details of patient and public involvement on our website. You can find information regarding the engagement activities and outcomes undertaken this year at: https://centrallancashireccgs.nhs.uk/get-involved/you-said-we-did

Engagement methods

We also use a wide variety of methods and data sets to ensure the patient voice is used to support commissioning decisions and is embedded in the commissioning cycle. These include:

- The Friends and Family Test (FFT)
- Customer care data (such as compliments, comments, concerns and complaints)
- Providers' quality reports
- Quality visits
- Healthwatch reports

Working with partners

Voluntary, community, faith, and social enterprise (VCFSE) sector
The CCG works with a wide range of partners from the voluntary, community, faith, and social enterprise (VCFSE) sector, which helps us to engage with and empower wider community groups. We involve local VCFSE networks when we are consulting on new, or changes to, services, opening opportunities to get involved to many smaller VCFSE organisations.

Healthwatch Lancashire
Healthwatch Lancashire is represented at our Governing Body, on our Patient Voice Committee and our operational patient groups which has opened routes for information exchange.

The Integrated Care System (ICS)
The CCG works in collaboration with Lancashire and South Cumbria ICS to deliver an Engagement Community of Practice and also supports the ICS digital collaboration, leading on a digital inclusion in primary care project.

The CCGs are working with colleagues across Lancashire and South Cumbria to establish a new engagement function for the soon to be established Integrated Care Board (ICB)

Digital

Central Lancashire CCG has been leading on an ICS wide programme of work for digital inclusion. Engaging with 14 voluntary, community, faith and social enterprise (VCFSE) organisations, representing Black Caribbean, Asian women, Young Asians, BAME communities needing safeguarding support, learning disability, autism, deaf / BSL users, age (+55 and 5 to 11 years) and social deprivation communities.

NHS England funded Digital Unite to provide digital training and resources to nominated representatives for all ICS organisations in England. LSC ICS worked with VCFSE organisations and developed digital sustainability by upskilling 53 members to become Digital Health Champions.

Lancashire and South Cumbria allocated £50k to this programme, from digital primary care funds, which enabled the Champions to provide digital training and support to their communities relating to access to primary care and what digital tasks mattered to them. For

some groups this included cyber safety to keep them secure online, social media to tackle isolation, use of apps specific to their needs to improve their health and wellbeing.

The VCFSE trained 2,224 people in their communities, improving knowledge, skills and confidence for the DHC and end users in five areas for each person they reached. They created 45 case studies and 180 minutes of bitesize videos to raise digital and or diverse awareness to health and care staff across the system.

This has positioned our ICS as system leaders for this national piece of work.

Place Based Partnerships

The CCGs continue to have a lead role on the central Lancashire Patients, Public and Carer Voice (PPCV) forum. The PPCV framework and Terms of Reference are currently being reviewed and updated to ensure that the work is aligned to the new ICB function.
Partners include the CCGs, the VCFSE, Lancashire Teaching Hospitals, Lancashire and South Cumbria Foundation Trust, Preston City Council, Chorley Council, South Ribble Borough Council, North West Ambulance Service, Healthwatch and Lancashire County Council.

Complaints

The CCG's in-house customer care team handles and manages complaints, queries or concerns in relation to CCG-commissioned services end to end. The team also handles other aspects of customer care which includes;

- Freedom of Information requests
- General enquiries
- Member of Parliament enquiries
- GP practice enquiries

The customer care team have dedicated telephone numbers and email addresses that make it much easier for members of the public to contact the CCG to make an enquiry or raise a complaint.

Robust customer care processes are in place, to ensure that we handle all complaints in a safe, timely and effective way.

The CCGs' policy is to acknowledge complaints within three working days and respond to within 28 working days. Occasionally, some complaints are more complicated and take longer to investigate.

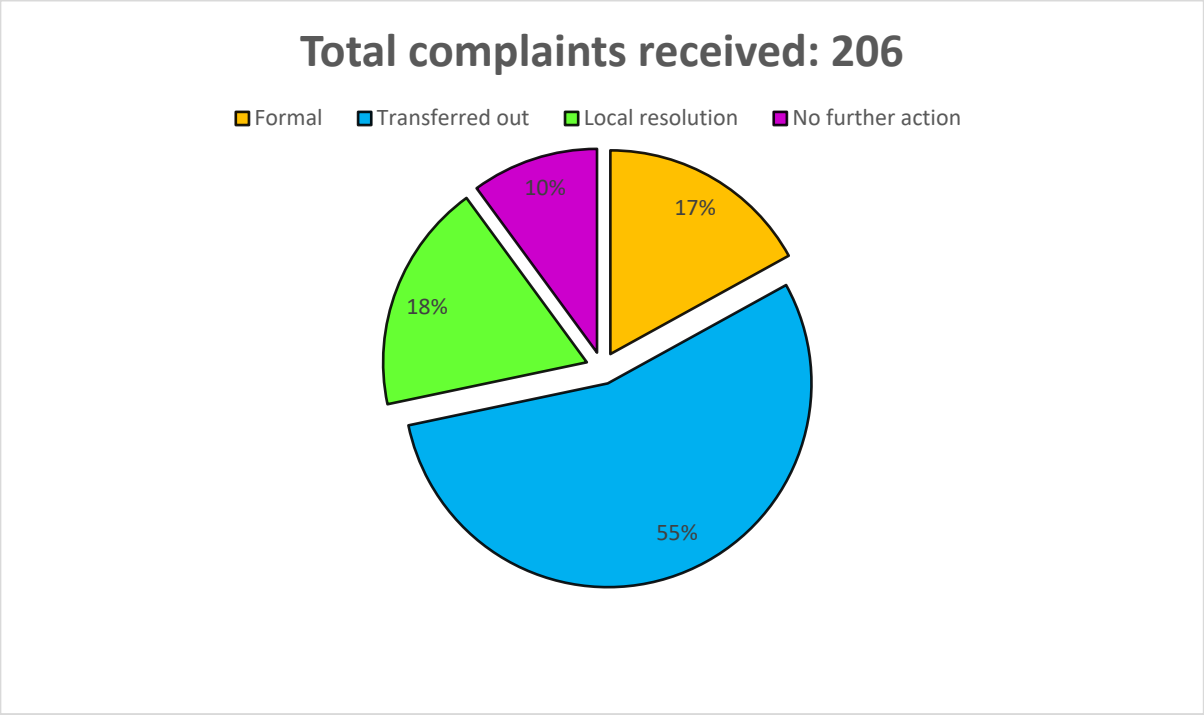
When this happens, the team negotiates a timescale with the complainant, and keeps them regularly informed of progress. Wherever possible, we encourage complainants to be involved in ongoing engagement with the CCG to help to continue to improve services

During 2021/211, 73% of all complaints were resolved within 28 working days.

During the pandemic, the CCGs have continued to maintain a fully staffed and personalised customer care service. This has been particularly valuable as many people have been worried and anxious during this time.

The team have continued to navigate people around the complex complaints system and have signposted patients to other organisations, agencies and advocacy help as appropriate.
Our customer care policy is available on the CCG website:
https://centrallancashireccgs.nhs.uk/contact-us

In 2021/22, the CCGs received 206 complaints. The chart below shows below how these were dealt with:



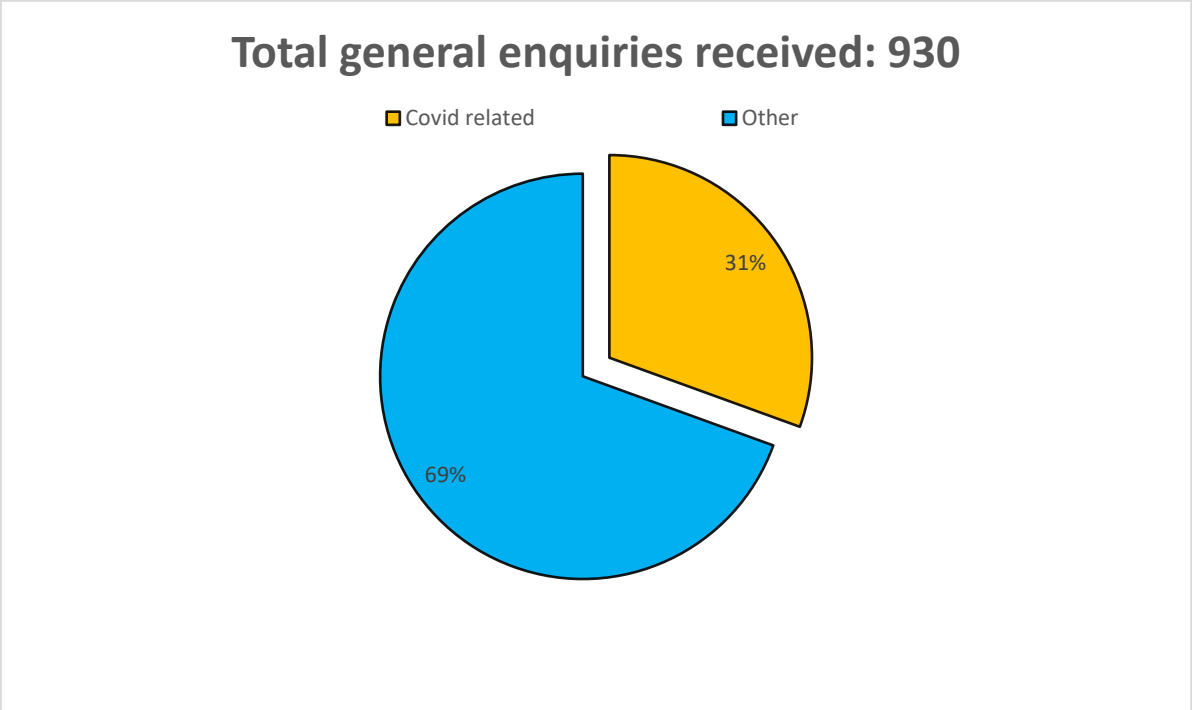
Of the complaints that came into the CCG, 55% were transferred out to other organisations. 28% of the complaints were resolved successfully by the customer care team without being escalated into a formal complaint.

Of the complaints dealt with by the CCG, the main themes were attributed to booking Covid-19 vaccinations, Covid-19 booster vaccination for housebound patients, Individual Funding Requests in relation to various CCG clinical policies including tonsillectomy, cosmetic criteria and IVF treatment, funding decisions and funding payment delays for Continuing Healthcare (CHC), delays with CHC assessments and decisions, and waiting times for ADHD services.

In the final quarter of the year (January 2021 – March 2022) the customer care team dealt with 176 queries in respect of covid-19. Fewer than ten of these escalated into a formal complaint

General Enquires (PALS)

In 2021/22, the CCGs received 930 general enquiries. Most of these were in relation to the Covid-19 pandemic:



Other themes included:

Continuing Health Care checklist and assessment delays, Individual Funding Requests for IVF, Diabetes, breast reduction, and tonsillectomy funding, Flu vaccination for housebound patients, funding for autism and waiting times for ADHD services, and Mental Health assessment queries.

How we use complaints data

The CCGs are committed to learning from complaints in order to improve the services we commission. We identify themes and trends and share them with other teams in the CCG responsible for monitoring those services. We also use the information when we buy in new services, or re-design the existing ones. In addition, we invite complainants to share their story with the CCGs.

Compliments

The CCGs are proud of the service delivered by the team across central Lancashire and is always looking at ways to improve people's experience of the complaints process.

Examples of what patients and members of the public have told us include:

Thank you from my heart

You have been a great help and support

Thank you for all your hard work

Thank you for being so caring and considerate

Thank you for your time and for all the useful information about Covid vaccinations

Your help is greatly appreciated

I appreciate that you took the time to explain the process and your position on the matter

We can't thank you enough, it's all down to you

You have been the only people who we have been able to rely on for help and the only people who offered to help

Thanks for your prompt and helpful reply

Thank you for your help, I prefer it when the CCG handles a complaint because you explain everything and accommodate reasonable adjustments

Thank you for persevering with my enquiry and for your tenacity and reassuring me, I am thrilled with the outcome

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

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

Reducing health inequality

Clinical Commissioning Groups (CCGs) have a key role to play in addressing equality and health inequalities, as commissioners, as employers and as local system leaders. We ensure that equality is embedded in our organisation by having five key equality and diversity leaders on our Governing Body and a dedicated Equality and Diversity Lead.

Having our Patient Advisory Group, which is representative of our local communities, involved in our commissioning work helps us to appropriately commission, buy, design, deliver and monitor services for the people in our communities to make sure they meet the needs of individual patients; their safety is prioritised and they are free from discrimination, harassment and victimisation under equality legislation.

When we are developing or redesigning services, we make sure all proposals include equality impact assessments (EIA) to consider the needs of the people within our local communities. This often includes asking patients from our operational groups to get involved in the whole process, including the scoring of tender applications, so that we have the best services for our communities.

Our Equality and Diversity Lead is currently leading on a national project to develop a citizen impact assessment framework (CIA) that pulls together the need to think about equality, digital and health inequalities when commissioning or providing services for our citizens.

We use the Equality Delivery System 2 (EDS2) every year to ensure that equalities and health inequalities are being effectively addressed through our work. While EDS2 is a mandatory process for providers, it is recommended for commissioners, and is also used throughout the year as evidence for the NHS England Improvement and Assessment Framework.

EDS2 is a national NHS England and NHS Improvement framework that we use to assess our delivery against a range of outcomes under four specific equality and diversity goals:

Goal 1: Better health outcomes
Goal 2: Improved patient access and experience
Goal 3: A representative and supported workforce
Goal 4: Inclusive leadership

This year, the eight CCGs across Lancashire and South Cumbria came together and completed a joint grading assessment that focused on EDS2 Goal 3. The Central Lancashire CCGs scored achieving for all outcomes.

Digital Inclusion

Central Lancashire CCGs have led on a Digital Inclusion in Primary Care project for Lancashire and South Cumbria Integrated Care System. Working in partnership with NHSEI, NHSX and Digital Unite we developed a project that commissioned voluntary, community, faith and social enterprise organisations (VCFSE) to undertake certified digital training to become digital health champions and then roll out the training to people in their communities. We provided some financial support to purchase equipment, or internet connectivity.

We targeted VCFSE organisations for people who have been disadvantaged throughout the Covid pandemic. These organisations included targeting people with learning disabilities, autism, older age (over 55), younger age (5 to 11), hearing loss / deaf, live in social deprived areas or from Black Caribbean, Asian women, wider BAME and young Asian communities.

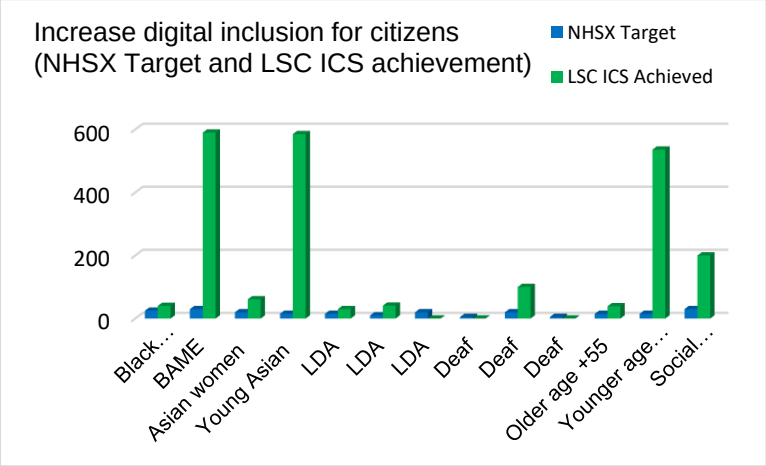
Lancashire and South Cumbria are the highest performers in England on this programme. The aims of the digital projects were to:

- Improve knowledge, skills and confidence to support our citizens to become digitally enabled.
- NHSX set England a target of 5 citizens per digital champion trained.

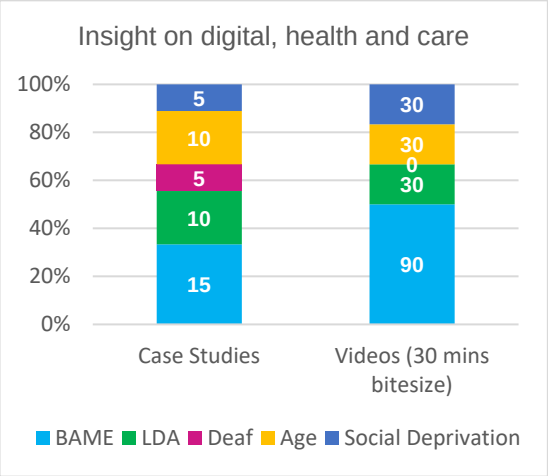
Our achievements

- We enabled 45 people to get a digital qualification to support their VCFSE organisation and enhance their job prospects

- Our NHSX target was to reach 225 people, we reached 2222 (to date). The table x shows an 887.5% increase on the targets set be NHSX.



- The table below highlights the VCFSE organisations who are providing us with case studies and / or videos relating to their target group and digital health or care. We have agreed 45 case studies and 180 minutes of videos in total.



This project has been so successful that we are planning to roll it out wider 2022/23. The case studies and videos will be used to gain insight into targeted communities that will enable us to make better decisions about how we design and deliver services.

Equality, Diversity and Inclusion Performance in 2021/22

Our Equality Annual Report supports the CCGs in demonstrating legislative compliance with the Equality Act (2010) and also its 2011 provision, the Public Sector Equality duty.

We publish our Equality Annual Report each year. Our report highlights a wide range of equality, diversity and inclusion work that we do to support our staff and our local communities. Our report also includes the CCGs' results of the annual Equality Delivery System 2 (EDS2) assessment of Goal 3.

Goal 3 – a representative and supportive workforce

- We undertake an annual workforce race equality standard (WRES) assessment and develop an action plan that is shared with NHS England.
- Throughout 2020/2021, we have used staff newsletters and team briefing sessions to regularly promote staff health and wellbeing surveys designed to help us understand the impact of COVID-19 and related changes to working arrangements upon our staff.
- As part of our EDS2 assessment, we undertake a workforce survey with our CCG staff, Board members and embedded staff employed by NHS Midlands and Lancashire Commissioning Support Unit to identify how people feel about working within our CCGs.

The overall grading for the Lancashire and South Cumbria CCGs for Goal 3 in 2021/22 is **Achieving**. Further information about the work we have undertaken this year to promote equality, diversity and inclusion will be available in our Equality Annual Report 2021/22, which is due for publication on our website in June 2022.

Equality Impact Assessments (EIA)

We have a robust EIA process that runs throughout all aspects of decision making. EIAs provide a foundation for ensuring that we meet our legal duties and give due regard to the Public Sector Equality Duty and NHS England and NHS Improvement's mandated equality standards. Risks that are identified in EIAs must be accepted, reduced, or eliminated completely.

We have implemented an EIA toolkit that provides a framework for undertaking EIAs and considers equality and human rights impacts upon equality protected group and other 'underserved groups' such as people experiencing homelessness, asylum seekers and carers.

Our EIA process enables us to evidence demonstrating 'due regard' to the Public Sector Equality Duty and ensures that consideration is given prior to any policy or commissioning decision made by the Governing Body (or other committees) that may affect equality and human rights. We have embedded equality impact and risk assessments into our policy development process and into our commissioning cycle.

Equality Impact and Risk Assessments conducted in 2021/22

- Ramsey Health Care contract for elective care
- Tier 4 bariatric surgery
- NHS 111 First phase two
- NHS Chorley and South Ribble CCG Board level staff Management of Change consultation
- NHS Greater Preston CCG Board level staff Management of Change consultation
- NHS Chorley and South Ribble CCG: Transferring of CCG staff to NHS Lancashire and South Cumbria Integrated Care Board (ICB) via a 'Transfer Scheme', 'in line with that required by the Transfer of Undertakings (Protection of Employment) Regulations 2006 otherwise known as (TUPE) and the Cabinet Office Statement of Practice on Staff Transfers in the Public Sector (COSOP)'
- NHS Greater Preston CCG: Transferring of CCG staff to NHS Lancashire and South Cumbria Integrated Care Board (ICB) via a 'Transfer Scheme', 'in line with that required by the Transfer of Undertakings (Protection of Employment) Regulations 2006 otherwise known as (TUPE) and the Cabinet Office Statement of Practice on Staff Transfers in the Public Sector (COSOP)'

Equality, Diversity and Inclusion in Staff Communications

Each month, the Equality and Inclusion Team at NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) produce equality awareness articles for use in our staff newsletter. The articles raise the profile of key equality related dates across the UK and allows us to draw attention to local awareness / celebration events.

In 2021/22, equality awareness articles considered a range of events that promote awareness and celebration of protected characteristics and other groups including:

- LGBT+ History Month
- International Women's Day
- Human Rights Day
- Black History Month
- Ramadan
- Young Carers Action Day

During 2021/22 we have also provided information for the CCGs monthly Wellness and Opportunities at Work (WOW) newsletter to raise the profile of national and local health and wellbeing events taking place that link in to protected characteristics, for example, Stress Awareness Month, Men's Health Week, Stroke Awareness Month, and World Diabetes Day.

The success of the WOW newsletter has led to the publication of a monthly health and wellbeing newsletter across the wider Lancashire and South Cumbria system, and we have continued to share information on local events taking place.

Health and wellbeing strategy

Lancashire Health and Wellbeing Board is responsible for the development and delivery of the health and wellbeing strategy for the area. Partners from across Lancashire's health and social care services are represented on the board, the CCG being an active member. The CCG is represented by Chief Officer, Denis Gizzi, who is the vice chair of the board.

The Board has overseen the creation of a Health and Wellbeing strategy (https://www.lancashire.gov.uk/media/907203/lancashire-health-and-wellbeing-strategy.pdf) that will enable local commissioners to plan and commission integrated services that meet the needs of the whole community.

The strategy aims to promote working together to:

- Achieve changes in the way that partners work; resulting in more effective collaboration and greater impact on health and wellbeing in Lancashire;
- Learn the lessons arising from this collaboration to strengthen future working together;

- Pursue the "Triple Aim" of improving outcomes, enhancing quality of care and reducing costs.

The strategy has been informed by and should be read alongside the Joint Strategic Needs Assessment (JSNA). For further information about the priorities identified by the JSNA, the Lancashire Insight website (www.lancashire.gov.uk/lancashire-insight) showcases assessments and provides a wealth of local data. Locally, the central Lancashire Health and Wellbeing Partnership has been developed to lead on the strategic coordination of health and wellbeing priorities and commissioning across the NHS, local authorities, social care, public health and the third sector.

Whilst the board did not meet between March 2021 and January 2022, during 2021/22 a number of CCG initiatives have continued to contribute towards the overall delivery of the strategy and identified priorities. For example:

- Continuing the development of the Central Lancashire Integrated Care Partnership and supporting the strengthening of the Integrated Care System, bringing together local NHS and council partner organisations, alongside local voluntary, community and faith sector to improve collaborative working, reduce duplication and make services sustainable for the future. This has included a number of key cross organisational communications and engagement campaigns as demonstrated on page 77 of the report.
- Supported local council engagement and in-reach teams to develop successful Covid-19 vaccination programmes, taking mobile vaccination clinics to areas highlighted as low uptake and those demonstrated to being at greater risk of underlying conditions.
- Our Digital Inclusion programme provided training to staff and volunteers within 14 voluntary, community, faith and social enterprise (VCFSE) organisations to develop **digital health champions** to enable targeted communities to become more digitally active and raise awareness of varying needs with health and care staff. Champions representing ethnic minority backgrounds, learning disabilities, autism, deaf, socially deprived, mental health, and military veteran communities were supported with access to the NHSX-funded Digital Unite platform.

ACCOUNTABILITY REPORT

Denis Gizzi

Accountable Officer

21 June 2022

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.

Corporate Governance Report

Members Report

Member Practices

- Avenham Lane Surgery
- Berry Lane Medical Centre
- Briarwood Medical Centre
- Dr CM Wilson and Partners
- Fishergate Hill Surgery
- Geoffrey Street Surgery
- Guttridge Medical Centre (Dr Ali)
- Guttridge Medical Centre (Dr Yerra)
- Issa Medical Centre - Dr Patel
- Lane Ends Surgery
- Longton Health Centre
- Lostock Hall Medical Centre
- Lytham Road Surgery
- North Preston Medical Practice
- Park View Surgery

- Penwortham St Mary's Medical Group
- Ribble Village Surgery
- Ribbleton Medical Centre
- Riverside Medical Centre
- St Fillan's Medical Centre
- Stonebridge Surgery
- The New Hall Lane Practice
- The Park Medical Practice

A range of channels are used to communicate and engage with members throughout the year. Members meet regularly at membership council meetings. In 2021/22, there were four membership council meetings and a range of network meetings.

In addition, members are sent a weekly newsletter from the CCG, and information is shared with them via an online member area, as well as ad-hoc or urgent communications as required.

Composition of Governing Body

The Governing Body ensures that the CCG has appropriate arrangements in place so it can exercise its functions effectively, efficiently and economically, with good governance and in accordance with the terms of the CCG constitution as agreed by its members.

The Governing Body leads on the setting of vision and strategy, approves commissioning plans, monitors performance against plan, and provides assurance on strategic risks.

The voting members of the Governing Body in 2021/22 were:

- Dr Sumantra Mukerji , Chair and clinical leader
- Dr Praphulla Methukunta, GP Director
- Dr Ewa Craven, GP Director
- Dr Anitha Rangaswamy, GP Director
- Dr Sandeep Prakash, GP Director
- Dr Hari Nair, GP Director
- Paul Richardson , Vice Chair and Lay Member for Governance
- Ian Cherry, Lay Member for Finance, Audit and Conflicts of Interest
- Debbie Corcoran, Lay Member for Patient and Public Involvement
- Tricia Hamilton, Governing Body Nurse
- Dr Eamonn McKiernan, Secondary Care Doctor

- Denis Gizzi, Chief (Accountable) Officer
- Katherine Disley, Chief Finance and Contracting Officer
- Helen Curtis, Director of Quality and Performance and Deputy Accountable Officer
- Jayne Mellor, Director of Transformation and Delivery

In addition, the Governing Body invites a number of other representatives to attend meetings to assist it in its decision making and in its discharge of its functions as it sees fit. These representatives may participate in debate but may not vote.

In 2021/22 these representatives were as follows:

- Jessica Tomlinson, Local Medical Committee (LMC) representative (Until September 2021)
- Ross McDuff, Local Medical Committee (LMC) representative (From September 2021)
- Marie Burnham, central Lancashire Integrated Care Partnership Chair
- Kerry Prescott – Healthwatch Representative Committees

The CCG Governing Body has a number of sub-groups, constituted as formal committees, which supports the Governing Body by making recommendations for action. Details of the scope of each committee can be found in the CCG's Constitution.

Audit Committee

The Audit Committee is responsible for scrutinising the CCG's arrangements for risk management and internal control and supporting the maintenance of an appropriate relationship between the CCG and its auditors.

The CCG's Constitution states that the Audit Committee shall consist of no less than three members, including:

- Ian Cherry – Lay Member for Finance and Audit (including conflicts of interest) - Audit Committee Chair
- Paul Richardson - Governing Body Vice Chair
- Debbie Corcoran – Lay Member for Patient and Public Involvement

Details of the responsibilities and members of the other CCG committees, including the Remuneration Committee and the Primary Care Commissioning Committee, can be found in the Governance Statement from page 102.

Register of Interests

The CCG holds details of all interests held by members of the Governing Body, membership and staff, which may conflict with their CCG responsibilities.

Personal data related incidents

The CCG recorded no incidents reportable to the Information Commissioner's Office during 2021/22.

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

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

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Officer to be the Accountable Officer of NHS Greater Preston 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 Greater Preston CCG auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Denis Gizzi – 21 June 2022

Governance Statement

Introduction and context

NHS Greater Preston 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.

The CCG's constitution also details those matters that were reserved to the Membership Council and those delegated to the Governing Body and its committees and sub-committees as follows:

- Audit Committee
- Remuneration Committee
- Quality and Performance Committee
- Clinical Effectiveness Committee
- Patient Voice Committee
- Primary Care Commissioning Committee
- Our Health Our Care Joint Committee (until the closure of the OHOC programme at the committee's final meeting on 26 May 2021)

The Governing Body has responsibility for:

- ensuring that the Group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the Group's principles of good governance;
- acting in accordance with its Statement of Policy for Compliance with General Financial and Public Sector Equality Duties that the Governing Body will adopt, keep under review and update for the Group;

- monitoring the performance of functions through the Group's reporting mechanisms; and
- securing sufficient commissioning and back office support to fulfil the Group's duties

The Membership Council has responsibility for, subject to the 2006 Act, performing all those functions of the Group that have not been delegated under the Constitution or otherwise to:

- the Governing Body;
- any other committee of the Group; or
- any employee or member;
- elected officer.

Membership Council

The Membership Council is made up of one member representative from each of the 22 practices, who are members of the CCG, and the CCG Chair, who is also the Chair of the Membership Council.

The Membership Council meets quarterly to ensure engagement, a seamless flow of information and instruction to and from the member practices of the CCG.

The functions of the Governing Body and its elected GP Directors are ultimately determined by consultation with the Membership Council. The Membership Council gives direction to those GP Directors elected to the Governing Body and receives assurance from them that the due processes outlined are being carried out in a faithful, honest, open and transparent fashion in the best interests of patients and the public.

During 2021/22 the Governing Body and the Membership Council have collaboratively worked on:

- The development of the New Hospitals Programme and primary care involvement within the programme.
- Continued development of a wider primary care at scale strategy for sustainable primary care within a shadow Integrated Care Partnership (ICP) and Integrated Care System (ICS)
- The Serve Asthma Project & restarting Spirometry.
- Highlighting how important the Primary Care voice is.
- Unifying the GP Quality Contract across the system.

Both the Membership Council and the Governing Body are committed to working with other stakeholders in the commissioning process, including:

- Collaborative Commissioning Board;
- Local primary care providers;
- Local acute, mental health and community providers;
- Healthwatch;
- the Central Lancashire Health and Wellbeing Board;
- the voluntary, community and faith sector;
- our public and patients;
- local authorities;
- Public Health England;
- NHS England;
- Integrated Care Partnership Shadow Board;
- Integrated Care Partnership Development meetings;
- Integrated Care System Board;
- NHS Transformation Unit

- Primary Care Networks

Evidence to show the communications and engagement undertaken with patients, the public, membership and key stakeholders is outlined in the performance report.

The following table overleaf outlines the membership attendance at Membership Council meetings throughout 2021/22:

GP Membership Council Attendance

List of Attendees **A = Attended** **N = No Attendance** **X = Not Required**	**Meeting date** **8.6.21**	**Meeting date** **7.9.21**	**Meeting date** **7.12.21**	**Meeting date** **1.3.22**
P81763 Guttridge Medical Centre 110 Deepdale Road 110 Deepdale Road, Preston, PR1 5AR	A	A	A	A
P81685 Guttridge Medical Centre 228-232 Deepdale Road, Preston, PR1 5AF	A	A	A	A
P81770 Avenham Lane Surgery Avenham Lane, Preston, PR1 3RG	N	A	A	N
P81055 Berry Lane Medical Centre Berry Lane, Longridge, PR3 3AP	A	A	A	A
P81748 Briarwood Medical Centre 514 Blackpool Road, Ashton, Preston, PR2 1HY	A	A	A	A

P80167 Dr Wilson and Partners, The Health Centre, Flintoff Way, Preston, PR1 5AF	N	A	A	A
P81169 Fishergate Hill Surgery 50 Fishergate Hill, Preston, PR1 8DN	A	A	A	A
P81093 Geoffrey Street Surgery Geoffrey Street, Preston, PR1 5NE	N	N	N	N
P81196 ISSA Medical Centre, 73 St Gregory Road, Deepdale, Preston PR1 6YA	A	A	A	N
P81119 Lane Ends Medical Centre Blanche Street, Preston, PR2 2RL	A	A	A	A
P81040 Longton Health Centre Liverpool Road, Longton, PR4 5HA	A	A	A	A
P81179 Lostock Hall Medical Centre 410 Leyland Road, Lostock Hall, Preston, PR5 5SA	A	A	A	A
P81015 Lytham Road Surgery 2a Lytham Road, Fulwood, Preston, PR2 8JB	A	A	A	A
P81071 The New Hall Lane Practice Geoffrey Street, Preston PR1 5NE	N	N	A	A
P81103 North Preston Medical Practice 2 Broadway, Fulwood, Preston, PR2 9TH	A	A	A	A

P81046 Park View Surgery 23 Ribblesdale Place, Preston, PR1 3NA	A	A	A	A
P81213 Penwortham St Mary's Health Centre Cop Lane, Penwortham, PR1 0SR	A	A	A	N
P81018 St Fillans Medical Centre, 2 Liverpool Rd, Penwortham, Preston PR1 0AD	A	A	A	A
P81107 Stonebridge Surgery, Preston Road, Longridge, Preston PR3 3AP	A	A	A	A
P81735 Ribble Village Surgery200 Miller Road, Preston, PR2 6NH	A	A	A	A
P81184 Ribbleton Medical Centre, 243 Ribbleton Avenue, Preston PR2 6RD	A	A	A	A
P81185 Riverside Medical Centre, 198 Victoria Rd, Walton-le-Dale, Preston PR5 4AY	A	A	X	A
P81664 The Park Medical Practice, 370 New Hall Ln, Preston PR1 4SX	A	A	A	A
Chair and Clinical Lead Dr Sumantra Mukerji	A	A	A	A

Governing Body

The Governing Body is, in the main, responsible for discharging the statutory duties and functions of the CCG.

The membership of the Governing Body consists of:

- CCG Chair (Chair)
- Lay Member for Governance (vice-chair)
- Five GP Directors
- Lay Member for Audit, Finance, and Conflicts of Interest
- Lay Member for Patient and Public Involvement
- Governing Body Nurse
- Secondary Care Doctor
- Accountable Officer
- Chief Finance and Contracting Officer (CFO)
- Director Quality and Performance (Deputy Accountable Officer)
- Director of Transformation and Delivery

The Governing Body invites the following individuals to attend any or all of its meetings:

- Chief Nurse*
- A member of HealthWatch Lancashire*
- A member of the Local Medical Committee *
- ICP Chair*

**Non voting*

The CCG's Governing Body has operated effectively throughout the reporting period, with the required level of attendance to achieve quoracy to facilitate effective decision making. Meetings have been taking place virtually via Microsoft Teams

throughout the year due to the Covid-19 pandemic, with members of the public offered the opportunity to join the meetings as an observer.

The Governing Body is quorate if the following are present:

- the Chair or Vice-Chair;
- either the Accountable Officer, the Chief Finance & Contracting Officer, or the Deputy Accountable Officer;
- two GP Directors;
- one Lay Member; and
- either the Secondary Care Doctor or the Governing Body Nurse.

Use of Emergency Powers

In response to the Covid-19 pandemic in 2020 the Governing Body agreed to use Section 3.9 of the CCG Constitution which refers to the use of 'emergency powers' as follows:

"The powers of the Governing Body may in an emergency or for an urgent decision be exercised by a group of at least five members of the Governing Body. This group must include at least:

i. the Accountable Officer or the Deputy Accountable Officer;
ii. the Chair or if not available the Vice-Chair of the Governing Body;
iii. the Chief Finance and Contracting Officer; and
iv. two Lay Members (inclusive of the roles of the Secondary Care Doctor and Governing Body Nurse)

The Governing Body formally met seven times during 2021/22 and has been quorate for each meeting.

There are no vacancies on the Governing Body.

In addition to public meetings, the Governing Body members have met four times throughout the year for the purpose of strategic development, education and discussion sessions.

These development sessions were held jointly with Chorley and South Ribble CCG. The sessions have covered the following topics; commissioning and system reforms, CCG closedown, transition arrangements and Information Governance Training.

In discharging its obligations the CCG Governing Body is responsible and accountable for delivering its financial duties, managing risk and for achieving national and local quality, constitutional and strategic objectives.

Minutes, executive summaries and annual reports of the Governing Body's established committees are submitted to the Governing Body throughout the year.

There is a shared commitment between Governing Body GP Directors and lay members together with the CCG's Management Executive (MET) to support an effective performance culture and promote good governance across the organisation. This is evidenced through the Governing Body's commitment to achieving the organisation's vision and values, and the successful implementation of a range of strategic objectives. These have been monitored through the on-going application of the CCG's performance management arrangements and the regular review of the GBAF, business plan and strategic objectives.

Key achievements for the Governing Body over the last financial year include; update reports with regard to the management of the pandemic response, new

hospitals programme, equality, diversity and inclusion annual report and strategy, the approval of operational planning priorities and financial framework; and development of the Governing Body Assurance Framework. The Governing Body have further approved Annual Accounts, Annual Report and the Annual Governance Statement for 2021/22, Financial Plan 2022/23, Emergency Preparedness, Resilience and Response, (EPRR) Core Standards Assessment 2021/22, and Safeguarding Annual Reports. The Governing Body received continued updates against CCG workforce and organisational development, governance updates and committee meetings, and reviewed and approved governance related policies as recommended by the Audit Committee.

The following table outlines the membership attendance at Governing Body meetings throughout 2021/22:

List of attendees EP = Use of Emergency Powers A = Attended N = No attendance	**Meeting date** **EP 28.4.21**	**Meeting date** **9.6.21**	**Meeting date** **22.9.21**	**Meeting date** **EP 14.10.21**	**Meeting date** **EP 22.12.21**	**Meeting date** **26.1.22**	**Meeting date** **23.3.22**
Dr Sumantra Mukerji, Chair	A	A	A	A	A	A	A
Denis Gizzi, Chief Officer	A	A	A	A	A	A	A
Katherine Disley, Chief Finance and Contracting Officer	A	A	A	A	A	A	A
Helen Curtis, Director of Quality and Performance	A	A	A	A	A	A	A
Jayne Mellor, Director of	A	A	A	A	N (apologies sent)	A	A

Transformation and Delivery							
Paul Richardson Lay Member for Governance	A	A	A	A	A	A	A
Ian Cherry, Lay Member for Audit, Finance and Conflicts of Interest	A	A	A	A	A	A (from item 9)	A
Debbie Corcoran, Lay Member for Patient and Public Involvement	A	A	N (apologies sent)	A	A	A	N (apologies sent)
Tricia Hamilton, Governing Body Nurse	A	A	A	A	A	A	A
Dr Eamonn McKiernan, Secondary Care Doctor	A	A	A	N (apologies sent)	A	A	A
Praphulla Methukunta, GP Director	A	A (from item 12)	A	A	N (apologies sent)	A	A
Hari Nair, GP Director	N (apologies sent)	A (until item 15)	A	A	A	A	N (apologies sent)
Anitha Rangaswamy, GP Director	A	A	A	A	A	A	A
Sandeep Prakash, GP Director	A	A	A	A	A	A	A
Ewa Craven GP Director	A	A	A	A	A	A	A

Audit Committee

The Audit Committee has operated throughout the financial year and has been accountable to the Governing Body for providing an independent and objective view

of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the CCG.

The Audit Committee meets as a 'committee in common' with Chorley and South Ribble CCG, and is chaired on an alternating basis by the Lay Member responsible for Audit, Finance, and Conflicts of Interest for each respective CCG. Matters of relevance to any one of the CCGs are reviewed in a separate meeting with decisions taken on those matters by the relevant representatives of the CCG.

The membership of the Audit Committee consists of:

- Ian Cherry, Lay Member for Audit, Finance, and Conflicts of Interest (Chair);
- Paul Richardson, Lay Member for Governance (Governing Body Vice Chair);
- Debbie Corcoran, Lay Member for Patient and Public Involvement.

The following colleagues and representatives will be expected to attend:

- The CFO who is responsible for supporting the chair in the management of the committee's business and for drawing the committee's attention to best practice, national guidance and other relevant documents as appropriate.
- Appropriate internal and external audit representatives.
- Other directors/managers may be invited to attend from time to time, with the agreement of the chair of the committee, to provide advice or present key reports in relation to risks or assurances in areas that are the responsibility of the directors/managers.
- An appropriate representative of the counter fraud service will attend a minimum of two meetings a year.
- Representatives from other organisations may be invited to attend on occasion.

The Governing Body receives an update report from the chair of the Audit Committee, which covers the proceedings of the meeting across the breadth of its responsibility for:

- Integrated governance, risk management and internal control
- Internal audit
- External audit
- Other assurance functions
- Anti-fraud
- Freedom to Speak Up
- Financial reporting
- Conflicts of interest

The Audit Committee meeting is quorate if a minimum of two voting members are present. The Audit Committee has been quorate at all of its meetings in 2021/22.

The Audit Committee terms of reference were submitted to the committee for review in May 2021, as per the requirement within the terms of reference to review these annually. Only one minor change was requested at that review. The Audit Committee reformatted its calendar of business in November to consider the close down of the business elements.

The Audit Committee has suspended its series of GBAF 'deep dives' throughout the year unless any concerns were raised for the Governing Body in order to allow the Audit Committee to focus on transition work for the closedown of the CCGs.

The Audit Committee has retained its duties for the management of conflicts of interest. The committee received and approved an updated Management of Conflicts of Interest Policy at its August 2021 meeting. The policy review was due

for its annual review and had minor changes to reflect points of clarification. There was no change to practice in the policy.

The Audit Committee has also produced an annual report of the 2021/22 year which was submitted to the committee in April 2022.

The Audit Committee conducted an effectiveness review of its own performance which was reported in August 2021. A series of statements were issued in a questionnaire to seek to understand how members of the Audit Committee and those who work with the Audit Committee are assured in terms of the effectiveness, efficiency and performance of the committee. Respondents were asked to use ratings from a range of 0 to 5 (0 being no opportunity to observe, 1 being strongly disagree, 3 being neither agree nor disagree and 5 being strongly agree). Overall the survey results show that respondents were either satisfied or very satisfied with the effectiveness of the Audit Committee and were 'in agreement' or 'strong agreement' with the statements provided in the survey, with 93.96% (311 out of a possible 331) questions receiving a score of 4 or greater.

Work continued during 2021/22 with the CCG Internal Audit Providers (KPMG). The committee focussed its attention on areas of limited assurance and identified recommendations to address these.

Key achievements for the Audit Committee over the last financial year include;

- Approval and monitoring the delivery of the internal audit plan for the year ahead with assurance sought where audits were at risk of not meeting agreed deadlines.

- Oversight of the development and progress on the GBAF and Corporate Risk Register (CRR).

- Oversight of the use of Emergency powers which were applied in response to the demands laced on the CCG by the impact of responding to the pandemic.

- Assurances received on progress in relation to information governance including the IG annual report and ensuring ongoing compliance with the DSTP toolkit.

- Receipt and assurances on the external audit findings report.

- Oversight of core internal audit reviews which inform the Head of Internal Audit Opinion for the CCG, and oversight of mandated and risk based internal audit reviews, overseeing any recommendations from those reviews are actioned by the CCG.

- Oversight of the anti-fraud work plan and receipt of the anti-fraud annual report.

- Recommendations made to the Governing Body for approval of policies in relation to governance and risk management.

- Assurances received on the work of the Audit Committee through effectiveness reviews of internal audit, external audit, and anti-fraud services.

The Audit Committee also reviewed the Risk Management Strategy at its meeting in March 2022, which it recommended to the Governing Body for approval, and it was subsequently agreed to rollover until the CCG closedown unless legislation requires that they are updated before that date, which is currently 30 June 2022.

The Audit Committee received updates to CCG corporate registers where indicated:

- Register for interests
- Hospitality
- Sponsorship and gifts
- Procurement decisions
- Tender waivers
- Standing orders
- Losses, write-offs and special payments

Governance related policies are submitted to Audit Committee for review and these will then be recommended to the Governing Body for formal ratification.

The following table outlines the membership attendance at Audit Committee meetings throughout 2021/22:

List of attendees A = Attended N = No attendance	**Meeting date** **7.5.21**	**Meeting date** **8.6.21 (annual accounts meeting)**	**Meeting date** **12.8.21**	**Meeting date** **5.11.21**	**Meeting date** **4.2.22**	**Meeting date** **4.3.22**
Ian Cherry, Lay Member for Finance, Audit & Conflicts of Interest (Chair)	Yes	Yes	Yes	Yes	Yes	Yes
Paul Richardson, Vice Chair	Yes	Yes	Yes	Yes	Yes	Yes
Debbie Corcoran,	Yes	Yes	N	Yes	Yes	Yes

Lay Member for Patient and Public Involvement			(apologies sent)			

Remuneration Committee

The Remuneration Committee is accountable to the Governing Body, and is responsible for recommending the remuneration, fees and other allowances for employees and for other persons providing services on behalf of the CCG to the Governing Body. The committee acts as a 'committee in common' with Chorley and South Ribble CCG.

The Remuneration Committee comprises the following members who are all members of the Governing Body:

- Lay Member for Governance (Chair)
- Lay Member for Patient and Public Involvement
- Lay Member for Audit, Finance, and Conflicts of Interest

Other non-voting attendees are invited to offer professional advice or services to the committee. For example the senior HR Business Partner is a regular attendee.

The Remuneration Committee met on five occasions in 2021/22. Another meeting was scheduled on 24 November 2021 which had one item only on the agenda which was regarding a policy update, therefore it was agreed to consider this item via e-governance. The health and safety policy was circulated to Remuneration Committee members and the Senior HR Business Partner on 18 November for comments by 24 November and recommendation to the Governing Body for approval.

The Remuneration Committee is quorate if a minimum of two members attend from each CCG (four members in total). The committee was quorate throughout 2021/22.

The Remuneration Committee approved the following policies:

- Flexible Working
- Disciplinary
- Job Matching and Re-banding
- Lone Worker
- Health and Safety

Recommendations have been agreed by the committee and presented to the Governing Body for approval on the remuneration for Very Senior Managers and other Governing Body members (excluding Remuneration Committee members).

The Committee agreed to seek additional assurance from external experts such as internal audit and anti-fraud where needed.

The committee reviewed its terms of reference in April 2021. As there have been no changes to national guidance since last reviewed and given that this would be the last year for the CCG due to commissioning reforms the committee agreed that there should be no changes to the current terms of reference. The committee therefore agreed to roll forward the terms of reference to 2021/22 and recommend them to the Governing Body for approval. The Terms of Reference were subsequently approved by the Governing Body.

The following table outlines the membership attendance at Remuneration Committee meetings throughout 2021/22:

List of attendees A = Attended N = No attendance	**Meeting date** **30.4.21**	**Meeting date** **28.7.21**	**Meeting date** **2.11.21**	**Meeting date** **14.12.21**	**Meeting date** **23.3.22**
Paul Richardson, Chair of the Remuneration Committee and Vice Chair, Lay Member for Governance	A	A	A	A	A
Ian Cherry, Lay Member for Audit, Finance and Conflicts of Interest	A	A	A	A	A
Debbie Corcoran, Lay Member for Patient and Public Involvement	A	A (from item 5)	N (apologies sent)	N (apologies sent)	N (apologies sent)

Quality and Performance Committee

The Quality and Performance Committee meets jointly (with NHS Greater Preston CCG) and met eight times during the period 2021/22.

Key achievements for the committee over the last financial year include:

- Maintained a focus on quality and safety throughout the COVID pandemic having regular updates on the plans in place and undertaking thematic reviews as necessary.

- Undertaken thematic reviews in the following areas: Elective Care Recovery, A&E Activity and SEND (Special Educational Needs and Disability).
- Reviewed the Quality Accounts for Ramsay Healthcare, Lancashire and South Cumbria Foundation Trust and Lancashire Teaching Hospitals. Quality Accounts.
- The committee has reviewed regularly progress under Transforming Care and approved as appropriate revised discharge dates on the recommendations from individuals' Multi-disciplinary Teams. In addition, the Committee has been kept informed on progress with the Learning Disabilities Mortality Review (LeDeR) and the significant work undertaken to ensure compliance with the process.

The Quality and Performance Committee is quorate if six members are present, which must include two clinicians and one lay member per CCG. The committee was quorate at all of its meetings.

The Quality and Performance Committee operates jointly between Chorley South Ribble and Greater Preston CCGs and comprises the following members:

- The GP Director with lead responsibility for quality from each CCG;
- The Lay Member for Governance (chair and vice chair);
- The Lay Member for Audit, Finance, and Conflicts of Interest for each of the CCGs;
- The Secondary Care Doctor, on behalf of both CCGs;
- The Governing Body Nurse, on behalf of both CCGs;
- The CFO, on behalf of both CCGs;
- The Director of Quality and Performance, on behalf of both CCGs;
- The Director of Transformation and Delivery, on behalf of both CCGs.

The following table outlines the membership attendance at Quality and Performance Committee meetings throughout 2021/22

List of attendees A = Attended N = No attendance	**Meeting date** **12/5/21**	**Meeting date** **9/6/21**	**Meeting date** **14/7/21**	**Meeting date** **8/9/21**	**Meeting date** **13/10/21**	**Meeting date** **10/11/21**	**Meeting date** **12/1/22**	**Meeting date** **9/3/22**
Mr Ian Cherry, Lay Member for Audit, Finance and Conflicts of Interest Greater Preston CCG	A	A	A	A	A	A	A	A
Mrs Linda Chivers, Lay Member for Audit, Finance and Conflicts of Interest Chorley and South Ribble CCG	A	A	A	A	A	N (apologies sent)	A	A
Dr Ewa Craven, GP Director Greater Preston CCG	A	A	A	A	A	A	A	A
Mrs Helen Curtis, Director of Quality and Performance	A	A	A	A	N	A	A	A

					(apologies sent)			
Mrs Katherine Disley, Chief Finance and Contracting Officer	A	A	N (apologies sent)	A	A	N (apologies sent)	A	A
Mrs Trisha Hamilton, Governing Body Nurse	A	A	A	A	A	A	N (apologies sent)	A
Dr Eamonn McKiernan, Secondary Care Doctor	A	A	A	A	A	A	A	A
Mrs Jayne Mellor, Director of Transformation and Delivery	A	A	A	A	A	A	A	A
Mr Paul Richardson, Vice Chair and Lay Member for Governance	A	A	A	A	A	A	A	A

Clinical Effectiveness Committee

The CCG's Clinical Effectiveness Committee meets in Common with NHS Chorley & South Ribble CCG. The committee has delegated responsibilities from the Governing Body in the following areas:

- Providing assurance that the CCG is developing clinical policies in line with the organisations strategic direction and in accordance with national / local priorities
- Overseeing effective use of resources for clinical purposes
- Providing oversight of the implementation of prescribing policies
- Advise the Governing Body on latest clinical evidence in decision making
- Prioritising clinical policy implementation
- Providing advice on evidence and effectiveness when setting quality standards including CQUIN
- Promoting research and innovation

The committee met in May 2021 and in April 2022 to review updates on Medicines Management, the development of Clinical Polices and the range / decisions made on of Individual Funding Requests received. Two meetings were stood down as a result of prioritisation for the response to the Covid-19 pandemic. However, the committee was assured through documented evidence that functions within remit such continued throughout the year, in some instances at system (Lancashire & South Cumbria) level.

To achieve quoracy at least four core members must be present, including at least one GP Director and one Lay member six members must be present, which must include two clinicians and one lay member. The committee comprises the following members:

- Lay member who leads on patient and public involvement from each CCG (chair)
- GP Director with lead responsibility for clinical policy from each CCG

- Director of Quality and Performance
- Public Health Consultant; on behalf of both CCGs;
- Lead Pharmacist; on behalf of both CCGs;
- Secondary care consultant; on behalf of both CCGs;
- Nurse member of the governing body; on behalf of both CCGs;
- Associate Director Performance and Analysis

The following table outlines the membership attendance at Clinical Effectiveness Committee meetings throughout 2021/22:

List of attendees A = Attended N = No attendance - = not in post	**Meeting date** **12.5.21**
Debbie Corcoran, Lay Member Patient & Public Involvement Greater Preston CCG	A
Helen Curtis, Director of Quality & Performance	N (apologies sent)
Tricia Hamilton, Governing Body Nurse	A
Glenn Mather, Associate Director Performance & Analysis	N (apologies sent)
Dr Eamonn McKiernan, Secondary Care Doctor	A
Claire Moss, Head of Medicines Optimisation	A
Geoffrey O'Donoghue, Chair of the Clinical Effectiveness	A

Committee Lay Member Patient & Public Involvement Chorley & South Ribble CCG	
John Cairns, GP Director Chorley and South Ribble CCG	N
Anne Robinson, GP Director Chorley & South Ribble CCG	A
Samantha Davis, Quality & Effectiveness Specialist (Clinical)	A

Patient Voice Committee

The Committee, which meets on a bi-monthly basis, is considered quorate if the meeting has an attendance of at least the chair or the vice chair, and four members are present.

The Committee met virtually via MS Teams four times during 2021/22 and was quorate on three occasions. The October 2021 meeting was not quorate, however, the decision-making items were circulated to all voting members for their information and approval. The January and February 2022 meetings had to be cancelled due to the pressures and demands of members responding to the Covid-19 pandemic.

Activity that demonstrates that the Committee has fulfilled the duties as defined within the Committee's Terms of Reference includes:

- A review of the Committee's Terms of Reference

- Robust oversight of the work of the patient-led reference groups, namely, the Patient Advisory Group, The Maternity Voices Partnership and the Young People's Health Advocates.
- Receipt and approval of the CCGs' Quarterly Customer Care Activity Report
- Receipt of the Patient involvement and assurance report detailing updates of the Patient Advisory Group, the Young People's Health Advocates and the Maternity Voices Partnership.
- Promotion of the work of the Committee internally and externally through a Committee Annual Report and a Committee Effectiveness survey.
- Receipt of the outcomes and results in relation to the annual equality delivery system (EDS) assessment for 2021.
- Receipt of updates in respect of the New Hospitals Programme
- Receipt of updates with regards to the development of the Central Lancashire Place Based Partnership Patients, Public and Carer Voice Committee
- Receipt of updates in respect of the emerging Lancashire and South Cumbria Communications and Engagement Function.

The following table outlines the membership attendance at Patient Voice Committee meetings throughout 2021/22:

List of attendees A = Attended N = No attendance	**Meeting date** **5.5.21**	**Meeting date** **7.7.21**	**Meeting date** **19.10.21**	**Meeting date** **28.3.22**

Debbie Corcoran, Chair of the Patient Voice Committee, Lay Member for Patient and Public Involvement	A	A	N (apologies sent)	A
Geoffrey O'Donoghue, Lay Member for Patient and Public Involvement	A	A	A	A
Glenis Tansey, Engagement and Patient Experience and Organisational Development Lead	A	A	A	A
Jonathan Bridge, Communications and Stakeholder Relations Manager	A	A	A	A
Dawn Clarke, Equality and Diversity Lead	A	A	A	A
Patient Advisory Group Co-Chair	A	A	A	A

Planning and Delivery Team representative	A	N (apologies sent)	N (apologies sent)	N (apologies sent)
Quality Team representative	A	A	A	A
Medicines Management representative	A	A	N (apologies sent)	A

Primary Care Commissioning Committee

The role of the committee is to discharge those duties delegated from NHS England in respect to the commissioning or primary [medical] care services. The committee functions as a corporate decision-making body for the management of delegated functions and the exercise of delegated powers.

The committee operates as a 'committee-in-common' with Chorley and South Ribble CCG. The committee meets in public and has met four times during 2020/21. Each meeting has been quorate.

The role of the committee is to ensure that any investments made in primary care are in accordance with the CCG's strategy and vision, and investments are in-line with the CCG's operational plan.

The Primary Care Commissioning Committee comprises the following members:

- Lay Member for Governance

- Lay Member for Audit, Finance, and Conflicts of Interest
- Lay Member for Patient and Public Involvement
- Governing Body Nurse
- Secondary Care Doctor
- Chief Officer;
- Chief Finance and Contracting Officer;
- Deputy Accountable Officer;
- CCG Chair; and *
- GP Director for Primary Care.*
- Director of Transformation and Delivery (CCG) *
- A representative from NHS England *

  *non- voting

The meeting will achieve quorum if a minimum of 4 members are present, and must include:

- The Chief Officer, or the Chief Finance and Contracting Officer, or Deputy Accountable Officer, Director of Quality & Performance, AND Secondary Care Doctor or Governing Body Nurse

Conflicts of interests are inherent at this Committee due to the nature of the content affecting primary care services. Previously conflicts have been managed by allowing the GP members to contribute to the discussion of the item as their clinical contribution would add value, however, the GPs have been removed from decision making and left the room at the time the decision was taken. The GP Chair and directors are non-voting members which also minimises this risk.

Examples of items presented to the committee are as follows:

- Approval of changes made to the Quality Contract 2021/22 for General Practice Population-based Health Improvement as a result of the impact from the COVID-19 pandemic
- Approval of the Local Enhanced Services for the role of Primary Care Network Health Inequalities lead
- Approval of contract for clinical waste collection
- Approval of Digital Maturity Scheme
- Approval of revised partnership arrangements following the dissolution of an existing partnership and subsequent consideration of long-term options (C&SR only)
- Approval of proposals for the Population Based Health Improvement (Quality Contract for General Practice) for 2022/2023
- Approval of Post Payment Verification template and process for use across Central Lancashire for 2021/22

The following table outlines the membership attendance at Primary Care Commissioning Committee meetings throughout 2021/22:

List of members A= attended N = non-attendance - = not in post	**Meeting date 7.4.1`**	**Meeting date 4.8.21**	**Meeting date 6.10.21**	**Meeting date 9.12.21 Part 2 only**	**Meeting date 2.3.22**
Paul Richardson, Vice Chair and Lay Member for Governance	A	A	A	A	A
Ian Cherry, Lay Member for Audit, Finance and Conflicts of	A	N (apologies sent)	A	A	A

Interest Chorley and South Ribble CCG					
Debbie Corcoran, Lay Member for Patient and Public Involvement Chorley and South Ribble CCG	A	A	A	A	A
Tricia Hamilton, Governing Body Nurse	A	A	A	A	A
Eamon Mc Kiernan, Secondary Care Doctor	A	A	A	A	A
Denis Gizzi, Chief Officer	A	A	A	A	A
Katherine Disley, Chief Finance and Contracting Officer	A	A	A	A	A
Helen Curtis, Director of Quality and Performance	N (apologies sent)	N (apologies sent)	A	A	A
Dr Sumantra Mukerji, Clinical Chair Chorley and South Ribble CCG	A	N (apologies sent)	A	A	A
GP Director Greater Preston CCG	A	A	A	A	A
Jayne Mellor, Director of Transformation and Delivery	A	A	A	A	A
Donna Roberts, Head	A	N	A	A	A

of Primary and Elective Care		(apologies sent)			
NHS England representative	N (apologies sent)	N (apologies sent)	A	N (apologies sent)	A

Our Health Our Care Joint Committee

The Our Health Our Care (OHOC) Joint Committee met once during 2021/22 to make a decision on the closure of the OHOC Programme following the instruction of the Secretary of State for Health and Social Care and the Minister for Health to close the programme. The CCGs released a statement on 26 February 2021 confirming the discontinuation of the Our Health Our Care programme in its current form. This action favoured the new opportunities available to Healthier Lancashire and South Cumbria to re-evaluate these matters via the New Hospitals Programme.

List of members A= attended N = non-attendance	**Meeting date** **26.5.21**
Denis Gizzi, Chief Officer and Chair of the committee	A
Dr Lindsey Dickinson, Chair, Chorley and South Ribble CCG	A
Dr Sumantra Mukerji, Chair, Greater Preston CCG	A

Dr John Cairns, GP Director, Chorley and South Ribble CCG	N (apologies sent)
Mr Ian Cherry, Lay Member for Finance and Audit, Greater Preston CCG	A
Mrs Linda Chivers, Lay Member for Finance and Audit, Chorley and South Ribble CCG	A
Mrs Helen Curtis, Director of Quality and Performance	N (apologies sent)
Mrs Debbie Corcoran, Lay Member for Patient and Public Involvement, Greater Preston CCG	A
Dr Ewa Craven, GP Director, Greater Preston CCG	A
Mrs Katherine Disley, Chief Finance and Contracting Officer	A
Dr Ravi Gokul, GP Director, Chorley and South Ribble CCG	N (apologies sent)

Mrs Tricia Hamilton, Governing Body Nurse, CCGs	A
Dr Eamonn McKiernan, Secondary Care Doctor, CCGs	A
Mrs Jayne Mellor, Director of Transformation and Delivery	A
Dr Praful Methukunta, GP Director Greater Preston CCG	A
Dr Hari Nair, GP Director, Greater Preston CCG	A
Mr Geoffrey O'Donoghue, Lay Member for Patient and Public Involvement, Chorley and South Ribble CCG	A
Dr Sandeep Prakash, GP Director Greater Preston CCG	A
Dr Anitha Rangaswamy, GP Director, Greater Preston CCG	A
Mr Paul Richardson,	A

Vice Chair and Lay Member for Governance, CCGs	
Dr Ann Robinson, GP Director, Chorley and South Ribble CCG	A
Dr Satyendra Singh, GP Director, Chorley and South Ribble CCG	A

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 Clinical Commissioning Group.

This can be found throughout this statement and in particular in the review of the CCG's committee terms of reference during 2021/22.

Discharge of Statutory Functions

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

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

Risk management arrangements and effectiveness

The CCG is committed to a risk strategy that minimises risks to all its stakeholders through a comprehensive system of internal control, whilst providing maximum potential for flexibility, innovation and best practice in delivery of its strategic objectives. The CCG's internal auditors have undertaken an audit into our risk management arrangements during 2021/22. In accordance with Public Sector Internal Audit Standards, it is a requirement to complete a review of risk management. In the NHS this includes a review of the design and operation of the Assurance Framework. A review was taken of the current arrangements in place to ensure that management have appropriate assurance that risks are managed effectively, escalated and de-escalated appropriately through the CCG and that there is sufficient overview and scrutiny of these risks. This year, the work focused on the processes for updating and reporting the Governing Body Assurance Framework (GBAF) in the 2021/22 year to date, including oversight from relevant CCG Committees. In addition, consideration to processes for how risks are escalated onto and also closed down and removed from the Corporate Risk Register (CRR).. The audit reported 'significant assurance'.

The CCG has reviewed and updated its Risk Management Strategy in March 2022 and subsequently ratified by the Governing Body. It was agreed that unless there was change in policy or good practice or if anything is identified through an internal audit, policies would be rolled over into the new financial year under new establishment of the ICB.

Examples of the types of risk that the CCG expected it may encounter and need to mitigate against include, but are not limited to; strategic, corporate, operational, financial, reputational, and environmental. One of two key sources of risk for the CCG this year has been the management of the continuation and recovery of the

covid-19 pandemic. This has featured as a high scoring risk on the corporate risk register and has directly impacted upon other risks such as the elective recovery programme, and has indirectly impacted upon other risks such as risk assessments being delayed in order to prioritise the response to the pandemic.

The other key risk to the organisation was the close down of the CCG by 1st April 2022, which was later extended to 30th June 2022. A detailed programme plan for CCG closedown was agreed system wide, with monitoring and management of the plan in place. Part of the CCG closedown work included a risk register of key risks associated. The key risk being due to the uncertainty of the staffing structure in the new NHS LSC system, that current CCG staff might leave to secure alternative employment, leaving insufficient staff to manage CCG closedown and transition, and to undertake the new responsibilities of the new system, resulting in a loss of system knowledge and expertise. This risk is scored at 16.

Once risks are identified, further evaluation is required to establish the exposure of the CCG to risk and uncertainty. The outcome of the risk analysis is used to rate its significance and prioritise its treatment. The CCG uses the National Patient Safety Agency (NPSA) 5x5 scoring matrix to ensure that once a risk is highlighted, that it is evaluated in a consistent way. Risks are scored in relation to the consequence they would have and the likelihood of them occurring, taking into account the controls and assurances in place. Using the scoring matrix, a score is established for each risk, which also determines the management, reporting and prioritisation of actions. All risks that score 15 or above populate the CRR and these risks are escalated to the Audit Committee for assurance on the process used to manage them, and to the Governing Body for overall responsibility. These such risks must have an executive lead owner who will report on progress with mitigation to the Governing Body.

All risks are given an initial rating reflecting the score of the risk at the time it was identified, a current rating reflecting the score of the risk to date, and a target rating.

The target rating reflects the level of risk appetite the organisation is willing to accept. Once a risk reaches its agreed target rating, the organisation can accept that this can be mitigated no further, unless the target is zero which means that the risk has been resolved.

All risks entered onto the CCG risk registers are assigned an action plan to outline how it can be further mitigated in the future. These action plans are reviewed with risk owners on a regular basis to assess the impact on the mitigation of the risk. As actions are completed these become controls and assurances which in turn should reduce the risk rating.

The CCG's risk appetite statement contained within the strategy is approved by the Governing Body via the Risk Management Strategy. The statement reflects that the CCG has no appetite for fraud and zero tolerance for regulatory breaches. The CCG also has zero tolerance for safeguarding, Information Governance, and reputational risk. Whilst the CCG is committed to reducing all risks to levels as low as reasonably practicable, it will, however, tolerate overall levels of risk where action is not cost effective or reasonably practicable. A risk appetite rating is assigned to each risk on the GBAF using the Good Governance Institute risk appetite matrix. These ratings were agreed for each GBAF risk based on feedback from all Governing Body members. This rating acts as a visual aid on the GBAF when it is reviewed by the Governing Body as a reminder of the level of tolerance that the CCG can safely accept.

Incident reporting is encouraged, and an associated policy is available on the CCG staff website. Furthermore the Constitution and the CCGs Freedom to Speak Up policy reflect the protection afforded by whistleblowing in line with national guidance. The CCG have assigned the role of the Freedom to Speak Up Guardian to the Vice Chair/Lay Member for Governance who is a member on both CCG Governing

Bodies. The Freedom to Speak Up policy is part of a suite of HR policies which are approved by the Remuneration Committee.

The GBAF reflects the risks to the CCG's strategic objectives. Each risk on the GBAF is assigned to a member of the Management Executive Team. Each risk is reviewed prior to submission to the Audit Committee, whereby the committee has the responsibility for gaining assurance on the processes used to manage the risks. The GBAF has also been submitted to the Quality and Performance Committee and Patient Voice Committee throughout the year whereby the committees have contributed to updates to those risks pertaining to its business. This helps the GBAF to remain as a 'live' document. The GBAF is then presented at each Governing Body meeting. The GBAF aims to drive the conversations of the Governing Body, and the Governing Body owns the strategic risks and action plans.

The Governing Body meetings whereby the GBAF and the CRR are discussed have been taking place virtually via Microsoft Teams throughout the year due to the Covid-19 pandemic, with members of the public offered the opportunity to join the meetings as an observer.

Capacity to Handle Risk

Leadership to the risk management process continues to be given a high profile within the CCG. All committees of the Governing Body are responsible for reporting and monitoring risks that arise from the remit of that committee, and each committee submits an update to the Governing Body to report on recent activity, and this would include any risks identified by that committee. The governance structure is effective with risks being escalated to the Audit Committee and the Governing Body throughout the year in accordance with the scoring as per the CCG's risk strategy. Committee responsibility for GBAF risks has been made more prominent, with a 'lead committee' assigned to each GBAF risk.

The Governing Body also has overall responsibility for the CCG's performance. The key tool to manage this is receipt of an Integrated Board Report, which provides an overview of CCG business and performance across a number of domains, covering areas such as; finance and activity, integrated business plan delivery, as well as constitutional standards, workforce, risk management and customer care performance.

The Chief Officer is accountable for having an effective risk management system in place within the CCG, for meeting all statutory requirements, and adhering to guidance issued by the Department of Health in respect of governance.

The Chief Finance and Contracting Officer (CFO) holds responsibility for ensuring that there are effective systems for the management of financial stewardship of the CCG's finances.

The Director of Quality and Performance / Deputy Accountable Officer holds the responsibility for ensuring that there are effective systems and processes in place for the management of risk, including a robust governance framework, GBAF, and CRR.

All members of the Management Executive Team are accountable for the management of risk within their area of responsibility. This is documented in the Risk Management Strategy as follows:

- ensuring that this strategy and associated policies, procedures and guidelines are implemented within their areas of responsibility;
- reviewing the GBAF and CRR relating to their team (transformation and delivery, quality and performance, finance and contracting)
- ensuring all risks are identified, assessed and included on the risk register;
- providing assurance to the committees overseeing each risk, as appropriate

The Head of Governance reviews all new risks prior to them being added to the risk register to ensure that they meet the standards of the Risk Management Strategy and are escalated, managed and monitored via this.

Risk Assessment

The CCG holds 3 risk registers; the GBAF which collates all threats to achieving the strategic objectives, the CRR which collates all operational risks which score 15 or above, and the operational risk register which covers all other risks with a score below 15. Within operational risk there are currently 2 further subcategories; Fraud risks and Integrated Business Plan risks. As at March 2022 there are five risks on the operational risk register; four of which have a rating of 12 and one with a rating of 8. On the Integrated Business Plan register there are two risks scoring 8 and 6. On the fraud risk register there are four risks; two scoring 4 and two scoring 6. All operational risks are reviewed on a quarterly basis to ensure that mitigation is progressing.

The CCG escalates the GBAF and CRR risks to every Audit Committee and Governing Body meeting. The Governing Body owns the GBAF and reviews and challenges each risk and action plan at each meeting. At the close of 2021/22, the GBAF contained five risks in the following areas:

- GBAF 01 Quality, Safe and Effective Services (closing risk rating 5x2=10)
- GBAF 02 Commissioning delivery and accountability (closing risk rating 5x2=10)
- GBAF03 Financial Sustainability (closing risk rating 4x1=4)
- GBAF04 Well Led (closing risk rating 4x2=8)
- GBAF05 Inequalities in the health and care system (closing risk rating 4x3=12)

Risk GBAF 01 on 2021/22 refresh of this risk, the impact score has increased from 3 to 5, because if the CCG doesn't mitigate this risk the impact could be catastrophic. The likelihood score has been reduced from 5 to 2, because despite the pressures in this area currently, much of this is outside of the CCGs ability to control due to being in a command and control structure as a result of the Covid-19 pandemic.

Risk GBAF02 on 2021/22 refresh of this risk, the likelihood score has been reduced from 5 to 2, because despite the pressures in this area currently, much of this is outside of the CCGs ability to control due to being in a command and control structure as a result of the Covid-19 pandemic. In February 2021 the Governing Body agreed the delegation of certain commissioning decisions to the new Strategic Commissioning Committee.

Risk GBAF03 CCG's have delivered against the financial plans for H1 & H2 in order to achieve a balanced year end position against the allocations provided. The full year forecast deficit resulting from a year end technical adjustment is considered to be an 'allowable deficit' with regulators.

Risks GBAF 04 The impact of not being well-run is significant as in the 2021/22 refresh of this risk, transition is reflected in more detail, however the risk rating remains at a similar position to last year. Most of what the CCG can influence is in place as a control or is making progress at pace such as the ICP governance structure and associated implications for the CCG.

Risks GBAF 05 On 2021/22 refresh of this risk, the rating remains at a similar position to last year. The likelihood of inequity being increased during the pandemic due to access to services being reduced and the format of delivery being changed. This remains the case, however it is anticipated that recovery throughout this year will reduce this risk in time.

The key aim for the GBAF this year was to ensure that the risks remained reflective of current position, which for all risks were significantly impacted upon due to the need to prioritise the pandemic response. Both the Audit Committee and the Governing Body have received regular reports, describing actions and progress to

mitigate risks, and gaps in controls and assurances, to provide assurance on the management of these risks.

At the close of 2021/22, the CRR contained eight risks in the following areas:

- Elective programme (closing risk rating 5x5=25)
- Quality contracts for domiciliary care (closing risk rating 4x4=16)
- Personal Health Budgets (PHB) (closing risk rating 4x4=16)
- Community Mental health Team (CMHT) Preston (closing risk rating 4x4=16)
- Suicide rates (closing risk rating 5x4=20)
- Out of area placements (closing risk rating 3x5=15)
- Covid-19 pandemic (closing risk rating 5x5=25)
- Initial Health Assessments IHA's 16-17 years (closing risk rating 3x5=15)

All papers submitted to the Governing Body include a covering executive summary, which highlights any specific risks, and the strategic objective which the paper relates to.

Other sources of assurance

Internal Control Framework

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

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

The system of internal control has been in place in the CCG for the year ending 31 March 2022 and up to the date of approval of the Annual Report and Accounts and has included:

- the CCG Constitution;
- the Risk Management Strategy;
- the Anti-Fraud annual plan;
- the Internal Auditor annual plan;
- the External Auditor annual plan;
- Data Protection and Security toolkit submission;
- Incident, Accident and Near Miss Reporting Policy and Procedure;
- quality and performance reporting;
- financial reporting;
- governance reporting between the Governing Body and its committees;
- Emergency Planning Resilience and Response assurance
- Equality Delivery System; and
- Safeguarding annual report.

Annual audit of conflicts of interest management

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

The CCG's internal auditors have carried out its annual internal audit of conflicts of interest. The audit report issued a compliance level of 'significant assurance'. This showed that the CCG has effective arrangements in place to manage conflicts of interest, hospitality, sponsorship and gifts which are in compliance with NHS England's statutory guidance on managing conflicts of interest.

Data Quality

The CCG utilises data provided from various information systems including NHS England, Secondary User Services, SLAM data and Open Exeter Systems to inform its performance and business reporting as well as Aristotle, the CSU reporting platform. This data forms a key part of the Integrated Business Plan which is approved by the Quality and Performance Committee and Governing Body and other committees as appropriate.

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.

All organisations that have access to NHS patient data and systems must use the DSP Toolkit to provide assurance that they are practicing good data security and that personal data is handled correctly.

Due to the extension to the establishment timeline for the transition of CCGs to ICB to the end of June 2022, NHS Digital made the completion of the DSPT toolkit non-compulsory for 2021/2022. For those CCGs who agreed to undertake the DSPT, an extended timeline for submission to 30th June 2022 was granted.

Further to the extension, authorisation for submission of the 2021/22 DSP Toolkit has not yet been sought. The CCG will ensure that submission is completed by the June 2022 deadline and ensure that all mandatory evidence items are available, accurate and have been fully met.

An information Governance Management Framework and Structure chart is in place to show lines of responsibility for Information Governance within the organisation. Due to Covid-19 it has not been possible for staff to attend face to face IG training, staff are required to undertake their mandatory annual IG training online via ESR. Specialist IG training is available for staff via webinars.

Serious data loss or data security incidents are managed via a Root Cause Analysis investigation process. As an organisation registered with the DSP Toolkit, we are required to report incidents that are categorised as 'reportable' through the IG Incident Reporting Tool. Incidents, where appropriate, may be escalated to organisations such as Care Quality Commission or NHS England/Improvement. The CCG has an Incident, Accident and Near Miss policy, which includes the process for the reporting of IG incidents to the Information Commissioners Office.

The CCG has recorded no IG incidents categorised as reportable outside the organisation during the period 2021/22.

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.

We are developing information risk assessment and management procedures and a programme is being established to fully embed an information risk culture throughout the organisation against identified risks. The CCG has in place an information risk work programme that has been agreed by the Senior Information Risk Officer (SIRO) to identify what information the CCG holds, stores, shares and receives from other organisations.

The CCG utilises the U-Assure system to log information assets, internal and external data flows and systems used within the organisation. Each team has nominated Information Asset Assistant (IAA) who will identify, log and review key information assets within their teams. A nominated Information Asset Owner (IAO) reviews the information and advises on the consequences should the assets be unavailable, damaged, destroyed or lost and its impact on the organisation.

The U-Assure system risk scores the asset dependent on the information recorded by both the IAA and IAO. Any asset which receives a score higher than 12 is categorised as a high-risk asset, for which an action plan is put in place to mitigate the risk. If an asset has a noticeable impact on the organisation, patients or legal obligation ability after being in-accessible after 3 days it is categorised as business critical.

Data flow maps are created for information that are distributed between internal teams and sent from or to external organisations, the method of transfer is also risk assessed. The information risk programme is an ongoing task throughout each year.

Business Critical Models

Over the course of the reporting period, the CCG has identified its business critical models and current arrangements for their quality assurance. Predominantly, these are provided by the Midlands and Lancashire CSU, however there are other external providers that are responsible for the administration of some business critical models and other internal systems that the CCG is reliant on to deliver its core functions.

All business critical models have been identified as part of the business continuity management arrangements and included on the CCG's information asset register, with a suitably qualified information asset owner.

Where business critical models are the responsibility of an external organisation, the CCG seeks assurance on the arrangements in place for managing these. In relation to those models provided by other NHS organisations, these are subject to regular

internal and external review, the outputs of which are reported to the CCG through management and service auditor reports.

Third party assurances

The contract management of all non-clinical providers is managed by the Procurement Manager for the CCG. As part of the requirement of Data Security Protection Toolkit the CCG must maintain a record of its suppliers that handle personal information and due diligence be undertaken against each supplier that handles personal information in accordance with ICO and NHS Digital guidance.

Healthcare organisations need assurance that they have robust systems, technology and processes in place to minimise the risk of incidents affecting day-to-day operations, and the ability to provide high quality patient care. As such, the CCG takes cyber security and privacy extremely seriously in order to protect patients and staff.

Control Issues

The month 9 Governance Statement return reported five control issues as follows:

1. Quality and Performance - RTT/52 week wait as follows:
   The position for both RTT and 52 week waits are updated weekly to the Management Executive Team as part of the performance report. There is also a monthly report delivered to the Elective Care Delivery Board which outlines the position of RTT and 52 week performance and trends.

   The delivery of improved performance in these indicators has been led by the Integrated Care Board since the start of the pandemic. There are numerous groups working through different elements of recovery through the Elective Care Recovery Group (ECRG), these groups are looking at, for example, diagnostic recovery, the utilisation of independent sector capacity, community diagnostic centres.

Waiting lists have been prioritised using P coding which allows for the treatment of those patients with the highest clinical priorities to be seen quicker.

The new operational guidance for 22/23 has emphasised the need to reduce waiting times with a zero tolerance of 104 weeks and reduction in 52 week waits.

2. Quality and Performance – Accident and Emergency as follows:

   Urgent and Emergency Care System Delivery Board is where in-depth discussions take place on performance and action plans, incorporating the Dashboard delivery to the Delivery Board and reporting to the CCG governing body through the Integrated Business Report (IBR).

   Daily 9am Bed meetings are held, with 10.30am system call over winter period, all of which is coordinated within the incident command structure for managing the pandemic.

   Robust on call system now incorporates OPEL level reporting as well as the introduction of the Escalation Management Solution (EMS) which uses algorithm based solution to reporting severity in the Urgent Care System.

   Senior execs meeting (SLT) weekly review system dashboard.

   Integrated Board Report which provides oversight of performance.

   Development of the Winter Plan to mitigate increased pressures in A&E over the Winter period. Effectiveness of winter plan is measured through performance monitoring of schemes within the plan.

   ECIST team working with Trust and CCG to improve flow and identify gaps and barriers

3. Quality and Performance - Other - as follows:

   Attendance at the Cancer Alliance continues and all associated sub-groups for Central Lancashire to monitor performance. In addition, a Cancer Performance Improvement Group has been established that meet weekly, to discuss all current operational issues.

   Virtual Central Lancashire cancer team meetings still take place monthly (Acute Trust; Macmillan GP Lead; CCGs) – receive weekly cancer performance update (real time update but data not yet validated) to highlight trends and risks and current performance and concerns.

   Continued support to the In-Hospital Cell/ICS/Cancer Alliance as part of all of the COVID responses and the expectations outlined within the planning guidance and Phase 3 COVID plans.

4. Quality and Performance – Continuing Healthcare - as follows:
   The CCG has restricted control over Continuing Health Care (CHC) patients in receipt of domiciliary healthcare as the contract framework for these patients is managed by Lancashire County Council (LCC). If there are safety and quality issues with these providers the CCG may not be fully aware, due to not having a direct contract in place for patients who receive care via spot purchase arrangements. Featured on CCG corporate risk register for mitigation with full action plan.

5. Quality and Performance – Personal Health Budgets - as follows:
   There is a risk that the CCG is not in a position to meet NHS England's requirement to be able to offer Personal Health Budgets (PHB) to all New Homecare packages from 1st April 2019. This poses a reputational risk to the CCGs that we will not meet this target. Currently this risk is featured on CCG corporate risk register for mitigation with full action plan. In liaison with

Blackpool Local Authority in relation to support being offered to Lancashire and South Cumbria to facilitate PHB's on the CCG.

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

The CCG continues to develop and strengthen the system of internal controls and has worked with the Internal and External Auditors to ensure that the CCG receives assurance in relation to the use of resources and that this is reported to the Governing Body.

There is a financial risk on the GBAF regarding the risk of failure to achieve financial statutory duties. Therefore the mitigation of this is overseen by the Governing Body.

Robust contract management is in place via formal contract performance meetings whereby the CCG has the opportunity to understand performance at a granular level and ensure appropriate challenge where indicated. An established joint contract review meeting has enabled all partners across the Central Lancashire Integrated Care Partnership to meet jointly.

The CCG's financial performance continues to receive scrutiny at Governing Body level. Financial performance continues to be monitored through monthly reporting to NHS England and at each Governing Body meeting; additional scrutiny and oversight of the processes is provided by the Audit Committee. In addition Governing Body Development Sessions have also taken place this year to discuss financial forecast against system envelopes and the financial impact of responding to the pandemic.

Throughout the year the CCG has continued to report on well-led in the Integrated Board Report which is submitted to the Governing Body at each meeting, the CCG has received a rating of green from the last return made to NHSE/I.

Delegation of functions

The CCG has applied our prime financial policies and scheme of delegation throughout the year, and taken into account the command and control structure in place as part of the emergency response to the pandemic. The CCG has also made decisions in line with its' committees terms of reference.

All committees which have met consistently throughout 2021/22 will submit an annual report to the Governing Body on the decisions they have taken in the last financial year. This is to assure the Governing Body that all business has been undertaken within the given delegated responsibility.

Five referrals were made to the Freedom to Speak up Guardian in 2021/22. All concerns have been investigated and feedback provided to the individuals who made the referrals as per the Freedom to Speak Up Policy.

NHS England requires the CCG to undertake an internal audit of the delegated commissioning arrangements. These requirements are set out in the NHSE publication "Primary Medical Care Commissioning and Contracting: Internal Audit Framework for delegated Clinical Commissioning Groups". The overall objective of the audit framework is to evaluate the effectiveness of the arrangements put in place by CCGs to exercise the primary medical care commissioning functions of NHS England as set out in the Delegation Agreement. Our Delegated Commissioning audit was graded as "substantial assurance" using the mandated NHS England assurance ratings. Overall it was found that the CCG's current arrangements around delegated

commissioning are clear and in line with both the NHSE's Policy and Guidance Manual and other CCGs. Controls around the procurement process are robustly designed to ensure compliance.

Anti-fraud arrangements

The CCG contracts anti-fraud service arrangements from Mersey Internal Audit Agency. This service includes the provision of an accredited anti-fraud specialist whose role is to undertake anti-fraud work proportionate to identified risks.

The Audit Committee receives an annual report against the Standards for Commissioners Self Review Tool. The Anti-Fraud Specialist will undertake a self-assessment against the Anti-fraud Functional Standards Return (CFFSR) for Commissioners and liaise with the CFO and Audit Committee Chair to agree the submission to NHS Anti-fraud Agency each year.

In line with the Audit Committee Handbook, Audit Committee's and their respective Chairs have a responsibility of oversight in respect of anti-fraud arrangements in addition to the CFO, and will have their own account to access the Self Review Tool (SRT). Both the CFO and the Audit Committee Chair are required to review the submission detail of the CFFSR before the CFFSR can be submitted and finalised on the national system.

The CCG's CFO is a voting member of the Governing Body and is responsible for overseeing and providing strategic management and support for all anti-fraud, bribery, and corruption work within the CCG. The fraud agenda is fully supported by the CFO and the Audit Committee, which actively encourages the anti-fraud specialist in the conduct of their activities. The anti-fraud specialist attends Audit Committee meetings throughout the year and presents regular anti-fraud progress reports for consideration and scrutiny. The anti-fraud specialist has meetings with the CFO to discuss fraud matters. In addition, the anti-fraud specialist meets privately with the Audit Committee chairs in year to discuss anti-fraud activity.

The CCG works to an annual pro-active anti-fraud work plan which reflects the four categories in relation to the self-assessment; Hold to Account, Prevent and Deter, Inform and Involve and Strategic Governance. Progress against the work plan is reported to the audit committee to ensure that the CCG is complaint the standards.

Head of Internal Audit Opinion

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

Head of Internal Audit Opinion 2021/22: Greater Preston CCG

Basis of opinion for the period 1 April 2021 to 31 March 2022

Our internal audit service has been performed in accordance with KPMG's internal audit methodology which conforms to Public Sector Internal Audit Standards (PSIAS). As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) or International Standard on Assurance Engagements (ISAE) 3000. PSIAS require that we comply with applicable ethical requirements, including independence requirements, and that we plan and perform our work to obtain sufficient, appropriate evidence on which to base our conclusion.

Roles and responsibilities

The Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The Assurance Framework should bring together all of the evidence required to support the AGS.

The Head of Internal Audit (HoIA) is required to provide an annual opinion in accordance with PSIAS, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the system of internal control). This is achieved through a risk-based programme of work, agreed with Management and approved by the Audit Committee, which can provide assurance, subject to the inherent limitations described below.

The purpose of our HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist the Governing Body in the completion of its AGS, and may also be taken into account by other regulators to inform their own conclusions.

The opinion does not imply that the HoIA has covered all risks and assurances relating to the CCGs. The opinion is derived from the conduct of risk-based plans generated from a robust and Management-led Assurance Framework. As such it is one component that the Governing Body takes into account in making its AGS.

Opinion

Our opinion is set out as follows:

- Basis for the opinion;
- Overall opinion; and
- Commentary.

Basis for the opinion

The basis for forming our opinion is as follows:

An assessment of the design and operation of the underpinning aspects of the risk and assurance framework and supporting processes; and
An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of these areas.

Overall opinion

Our overall opinion for the period 1 April 2021 to 31 March 2022 is that:

'Significant assurance with minor improvements required' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.'

Commentary

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety. Our opinion covers the period 1 April 2021 to 31 March 2022 inclusive, and is based on the nine audits that we completed in this period.

The design and operation of the Assurance Framework and associated processes

Our review of Risk Management and Governing Body Assurance Framework was graded as "significant assurance". The CCG's Governing Body Assurance Framework (GBAF) does reflect the organisation's key objectives and risks and is regularly reviewed by the Governing Body and Audit Committee. The CCG holds both the GBAF and the Corporate Risk Register (CRR) as live documents which are regularly updated to reflect changes in the listed risks and how they are being managed. This allows the CCG's Governing Body (GB) and relevant Committees to effectively manage risks including the impact of any dynamic risks. We have also found that the GB and relevant Committees have appropriate oversight, with the GB and Audit Committee receiving the GBAF and CRR at each meeting. The Governing Body has delegated responsibility to the Governing Body Audit Committee for reviewing and obtaining assurance on the effectiveness of the CCG's risk management processes overall and for the strategic risks in particular.

Our Core Financial Controls review this year was graded as "significant assurance with minor improvement opportunities". Through our sample testing we noted high levels of compliance in regards to the performance of bank reconciliations, CCG General Ledger user access reviews, contract and QIPP monitoring as well as adequate controls surrounding the supplier set up and amendments process in addition to other points of good practice.

Our Conflicts of Interest audit was graded as “significant assurance". This showed that the CCG has effective arrangements in place to manage conflicts of interest, gifts and hospitality which are in compliance with NHS England’s statutory guidance on managing conflicts of interest.

Our Delegated Commissioning audit was graded as “substantial assurance” using the mandated NHS England assurance ratings. Overall we found that the CCG’s current arrangements around delegated commissioning are clear and in line with both the NHSE’s Policy and Guidance Manual and other CCGs. Controls around the procurement process are robustly designed to ensure compliance.

Our Data Security Protection Toolkit (DSPT) review in 2021/22 was graded “partial assurance with improvements required". This reflects that whilst there are Data Security and Protection processes in place, there are additional actions which are required to meet the national standard mandatory assertions by the 30 June 2022 submission deadline. Given the time available before the submission deadline versus the date of our opinion (28 February 2022), there is scope for the CCG to remediate our observations prior to submission. Where remediation is not possible, the CCG should ensure a robust action plan has been developed, approved and implemented, which can also be evidenced to NHS Digital. We do not consider the detailed findings within our DSPT review, to impact on our overall audit opinion as they are not reflective of a pervasive deficiency in the overall control environment and there is time for management to address our findings prior to year end and submission of the toolkit.

The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year

We originally identified five risk-based reviewed within our 2021/22 plan, however the Contract Management and QIPP review was removed in agreement with management and AC Chairs to accommodate ICS-wide assurance work. For the remaining four risk-based reviews, two were graded as “significant assurance with minor improvement opportunities” and one as “significant assurance”.

Our final risk-based review, Referral Governance, Flow Management and Waiting List Prioritisation, received a “partial assurance with improvements required”. We found that the scope of the Elective Care System Delivery Board (ECSDB) was broad and members found it was not well defined. Further detail is required on exactly what actions the ECSDB will undertake in order to achieve the listed priorities. There are also interdependencies between the ICP-level ECSDB and the Elective Care Recovery Group (ECRG), an ICS-led Group with aligned priorities. Therefore, the ECSDB should ensure actions support existing work programmes in place.

We do not consider the detailed findings within our “partial assurance with improvements required” rated risk-based review, to impact on our overall audit opinion as they are not reflective of a pervasive deficiency in the overall control environment.

KPMG LLP

Chartered Accountants

Manchester

28 February 2022

KPMG as the Internal Auditors completed the agreed audit plan for the CCG and presented the findings to the Audit Committee on completion. Below is the statement in the year end report to summarise findings.

‘The commentary below provides the context for our opinion and together with the opinion should be read in its entirety. Our opinion covers the period 1 April 2021 to 31 March 2022 inclusive, and is based on the nine audits that we completed in this period.

The design and operation of the Assurance Framework and associated processes

Our review of **Risk Management and Governing Body Assurance Framework** was graded as “**significant assurance".** The CCG’s Governing Body Assurance Framework (GBAF) does reflect the organisation’s key objectives and risks and is regularly reviewed by the Governing Body and Audit Committee. The CCG holds both the GBAF and the Corporate Risk Register (CRR) as live documents which are regularly updated to reflect changes in the listed risks and how they are being managed. This allows the CCG’s Governing Body (GB) and relevant Committees to effectively manage risks including the impact of any dynamic risks. We have also found that the GB and relevant Committees have appropriate oversight, with the GB and Audit Committee receiving the GBAF and CRR at each meeting. The Governing Body has delegated responsibility to the Governing Body Audit Committee for reviewing and obtaining assurance on the effectiveness of the CCG’s risk management processes overall and for the strategic risks in particular.

Our **Core Financial Controls** review this year was graded as “**significant assurance with minor improvement opportunities”.** Through our sample testing we noted high levels of compliance in relation to’ the performance of bank reconciliations, CCG General Ledger user access reviews, contract and QIPP monitoring as well as adequate controls surrounding the supplier set up and amendments process in addition to other points of good practice.

Our **Conflicts of Interest audit** was graded as "**significant assurance".** This showed that the CCG has effective arrangements in place to manage conflicts of interest, gifts and hospitality which are in compliance with NHS England's statutory guidance on managing conflicts of interest. Our Delegated Commissioning audit was graded as "substantial assurance" using the mandated NHS England assurance ratings. Overall we found that the CCG's current arrangements around delegated commissioning are clear and in line with both the NHSE's Policy and Guidance Manual and other CCGs. Controls around the procurement process are robustly designed to ensure compliance.

Our **Data Security Protection Toolkit (DSPT)** review in 2021/22 was graded **"partial assurance with improvements required".** This reflects that whilst there are Data Security and Protection processes in place, there are additional actions which are required to meet the national standard mandatory assertions by the 30 June 2022 submission deadline. Given the time available before the submission deadline versus the date of our opinion (28 February 2022), there is scope for the CCG to remediate our observations prior to submission. Where remediation is not possible, the CCG should ensure a robust action plan has been developed, approved and implemented, which can also be evidenced to NHS Digital. We do not consider the detailed findings within our DSPT review, to impact on our overall audit opinion as they are not reflective of a pervasive deficiency in the overall control environment and there is time for management to address our findings prior to year end and submission of the toolkit.

The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year

We originally identified five risk-based reviewed within our 2021/22 plan, however the **Contract Management and QIPP review** was removed in agreement with management and AC Chairs to accommodate ICS-wide assurance work. For the remaining four risk-based reviews, two were graded as **"significant assurance with minor improvement opportunities**" and one as "**significant assurance".**

Our final risk-based review, **Referral Governance, Flow Management and Waiting List Prioritisation**, received a **"partial assurance with improvements required".** We found that the scope of the Elective Care System Delivery Board (ECSDB) was broad and members found it was not well defined. Further detail is required on exactly what actions the ECSDB will undertake in order to achieve the listed priorities. There are also interdependencies between the ICP-level ECSDB and the Elective Care Recovery Group (ECRG), an ICS-led Group with aligned priorities. Therefore, the ECSDB should ensure actions support existing work programmes in place. We do not consider the detailed findings within our "partial assurance with improvements required" rated risk-based review, to impact on our overall audit opinion as they are not reflective of a pervasive deficiency in the overall control environment'

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

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

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

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

- The Governing Body
- The Audit Committee

- Quality and Performance Committee
- Internal audit

The role of each of the four mechanisms above is referenced throughout this Statement, and have been reported against to the Governing Body throughout the year as described in this statement.

The CCG has agreed to top slice funding from its internal audit budget along with the other seven CCGs in Lancashire and South Cumbria to support system wide assurance work undertaken by Mersey Internal Audit Agency (MIAA).

Conclusion

This statement has identified that with the exception of the items referred to in section ‘Internal Control Framework’ and in the month 9 governance statement; all of which have been followed up, this statement concludes that there are no significant internal control issues which have been identified.

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The Committee, which is accountable to the Group's Governing Body, is responsible for making recommendation on the remuneration, fees and other allowances for employees and for other persons providing services on behalf of the Clinical Commissioning Group (CCG).

All recommendations will be submitted to the Governing Body for approval. Governing Body pay for board members and other senior staff was mainly on nationally determined pay rates. Where pay is determined locally this will be reviewed by the Committee who will agree on a recommendation for the Governing Body to agree.

Five meetings were held in 2021/22. Member attendance at the meeting can be found in the governance statement on page 102.

Policy on the remuneration of senior managers

The policy on senior managers' contracts was that they are permanent with a notice period of six months. The contracts have no end dates.

Remuneration of Very Senior Managers

No senior managers of the CCG were paid more than £150,000 per annum.

Senior manager remuneration (including salary and pension entitlements)

Salary and Pension disclosure tables (subject to audit):

Name	Title	Notes	2021/2022						2020/21					
			Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL
			(bands of £5,000)	(to the nearest £100)*	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(to the nearest £100)*	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
			£000	£	£000	£000	£000	£000	£000	£	£000	£000	£000	£000
Dr Sumantra Mukerji	Chair		115-120	0	0	0	652.5-655.0	770-775	120-125	0	0	0	12.5-15.0	135-140
Mr Paul Richardson	Vice Chair and Lay Member Governance	1	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Dr Ewa Craven	GP Director		35-40	0	0	0	0	35-40	35-40	0	0	0	0	35-40
Dr Praphulla Methukunta	GP Director		35-40	0	0	0	0	35-40	35-40	0	0	0	0	35-40
Dr Hari Nair	GP Director		55-60	0	0	0	0	55-60	50-55	0	0	0	0	50-55
Dr Sandeep Prakash	GP Director		55-60	0	0	0	0	55-60	50-55	0	0	0	0	50-55
Dr Anitha Rangaswamy	GP Director		35-40	0	0	0	0	35-40	35-40	0	0	0	0	35-40
Mr Ian Cherry	Lay Member Finance and Audit		20-25	0	0	0	0	20-25	20-25	0	0	0	0	20-25
Mrs Debbie Corcoran	Lay Member patient/Public Involvement		10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Mrs Patricia Hamilton	Nurse Member	2	5-10	0	0	0	0	5-10	15-20	0	0	0	0	15-20
Dr Eamonn McKiernan	Secondary Care Doctor	3	10-15	0	0	0	0	10-15	15-20	0	0	0	0	15-20
Mr Denis Gizzi	Chief Officer	4	80-85	0	0	0	15.0-17.5	95-100	80-85	0	0	0	247.5-250.0	330-335
Mrs Helen Curtis	Director of Quality and Performance	5	60-65	0	0	0	0	60-65	60-65	0	0	0	0	60-65
Mrs Katherine Disley	Chief Finance and Contracting Officer (from 1st April 2020)	6	65-70	0	0	0	12.5-15.0	75-80	60-65	0	0	0	37.5-40.0	100-105
Mrs Jayne Mellor	Director of Transformation and Delivery (from 19 February 2021)	7	55-60	0	0	0	0	55-60	5-10	0	0	0	0	5-10

Notes

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

All members have been in post for the whole year unless otherwise stated.

1. Mr Paul Richardson also served on NHS Chorley and South Ribble CCG. His remuneration during the year was in the range £15k-£20k; 50% of his remuneration is charged to NHS Greater Preston CCG
2. Mrs Patricia Hamilton also served on NHS Chorley and South Ribble CCG. Her remuneration during the year was in the range £15k-£20k; 50% of her remuneration is charged to NHS Greater Preston CCG
3. Dr Eamonn McKiernan also served on NHS Chorley and South Ribble CCG. His remuneration during the year was in the range £25k-£30k; 50% of his remuneration is charged to NHS Greater Preston CCG
4. Mr Denis Gizzi also served on NHS Chorley and South Ribble CCG. His remuneration during the year was in the range £145k-£150k; 55% of his remuneration is charged to NHS Greater Preston CCG
5. Mrs Helen Curtis also served on NHS Chorley and South Ribble CCG. Her remuneration during the year was in the range £110k-£115k; 55% of her remuneration is charged to NHS Greater Preston CCG
6. Mrs Katherine Disley also served on NHS Chorley and South Ribble CCG. Her remuneration during the year was in the range £115k-£120k; 55% of her remuneration is charged to NHS Greater Preston CCG
7. Mrs Jayne Mellor also served on NHS Chorley and South Ribble CCG. Her remuneration during the year was in the range £100k-£105k; 55% of her remuneration is charged to NHS Greater Preston CCG

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

	2021/22							
Name and Title	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 1 April 2021	Real increase in Cash Equivalent Transfer Value (CETV)	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
Mr Denis Gizzi - Chief Officer	2.5-5.0	(0.0)-(2.5)	60-65	130-135	1,171	49	1,238	0
Dr Sumantra Mukerji - Chair	27.5-30.0	85.0-87.5	50-55	150-155	0	0	0	0
Mrs Katherine Disley - Chief Finance and Contracting Officer (from 1st April 2021)	0.0-2.5	0.0	20-25	0	235	20	266	0

Notes

The pensions information disclosed above for Mr Denis Gizzi, Mrs Katherine Disley and Mrs Helen Curtis is the total pension entitlements and has not been split across the two CCGs which they are employed (Chorley and South Ribble CCG and Greater Preston CCG). The real increases in pension, lump sum and CETV reflect the proportion of time in the designated post. Mrs Helen Curtis and Mrs Jayne Mellor chose not to be covered by the NHS Pension Scheme arrangements during the reporting year.

The legal entity which employs Mr Sumantra Mukerji is NHS Greater Preston CCG. The legal entity which employs Mr Denis Gizzi, Mrs Katherine Disley, Mrs Helen Curtis and Mrs Jayne Mellor is NHS Chorley and South Ribble CCG.

The CETV figures do not incorporate any potential adjustment in respect of the McCloud judgement.

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).

Compensation on early retirement of for loss of office

There have been no payments of compensation on early retirement or for loss of office.

Payments to past members

There have been no payments made to past senior managers.

Pay multiples

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 Greater Preston CCG in the financial year 20221-22 was £115-£120k (2020-21, £120k - £125k), a 2.3% reduction on 2020/21's salary and allowances, there was no movement on performance pay and bonus. The relationship to the remuneration of the organisation's workforce is disclosed in the below tables.

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	3.54:1	3.64:1	2.21:1	2.21:1	1.39:1	1.44:1
2020-21	3.84:1	3.56:1	2.33:1	2.33:1	1.55:1	1.57:1

Year	25th percentile total remuneration	25th percentile salary	Median total remuneration	Median salary	75th percentile total remuneration	75th percentile salary
2021-22	£ 33,175	£ 32,306	£ 53,219	£ 53,194	£ 84,690	£ 81,494
2020-21	£ 31,365	£ 33,779	£ 51,668	£ 51,668	£ 77,432	£ 76,742

In 2021/22, no employees received remuneration in excess of the highest-paid member. Remuneration ranged from £7k to £76k (2020/21: £7k to £78k). 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. The average percentage change from 2020/21 to 2021/22 in respect of employees of the entity is 4.0% increase on salary and allowances, there was no movement on performance pay and bonuses.

The All Pensions Related Benefits section is a calculation based on figures supplied by NHS Business Services Authority. We are statutorily bound to use these figures however; a note of caution should be applied when interpreting them as:

a) The CCG has no way of interrogating or verifying the figures provided
b) They do not take into account any period of time where the individual may not have paid into the pension scheme due to a break in service as an officer
c) They are calculated on a notional full time basis when staff are in fact part time
d) The pensions related benefits note is based on an assumption as required in the Annual Reporting Guidance that individuals will be in receipt of their pension for 20 years after they have retired.

Staff Report

Number of senior managers

Senior management staff, which are shared with NHS Chorley and South Ribble CCG and excluding Governing Body members, are as detailed below.

Band	Number
VSM	0
9	1
8D	5
8C	6

8B 8A	8 8
Total	28

Staff numbers and costs (subject to audit)

Information on staff numbers and costs can be found in note 5 of the annual accounts.

Staff composition

NHS Greater Preston CCG directly employs 9 members of staff: 6 male and 3 female. The CCG shares a staff body with NHS Chorley and South Ribble CCG, which hosts the employment of 79 members of staff: 63 female and 16 males. The staff body is based at its Chorley House headquarters in Leyland.

The table below shows the analysis of staff number and composition by gender based on headcount of staff employed at NHS Greater Preston CCG as at 31 March 2022

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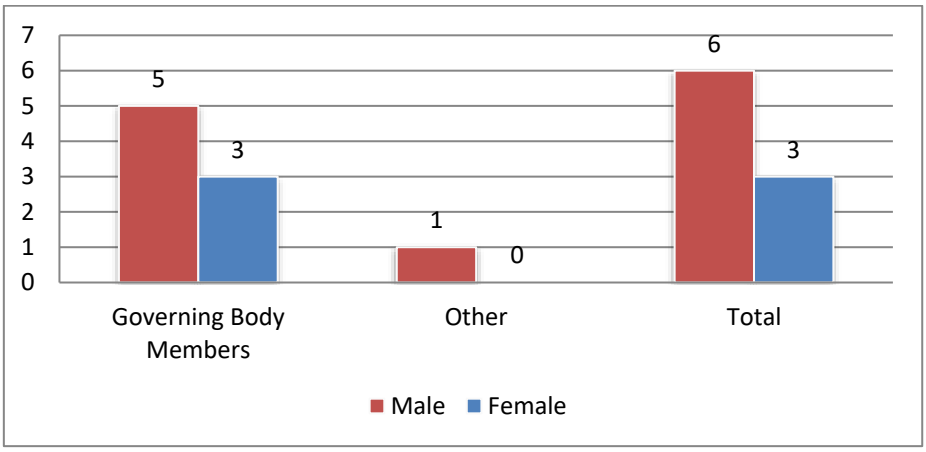

In addition, a number of staff from the Midlands and Lancashire Commissioning Support Unit are embedded with the CCG, meaning they are also based at Chorley House, but they are not employed by the CCG. These individuals work exclusively on activities for central Lancashire, generally covering functions such as clinical quality, medicines optimisation, contracting, and financial transactions.

Other employee matters

In accordance with The Trade Union (Facility Time Publication Requirements) Regulations 2017, the CCG is required to publish the following information:

The number of employees who were relevant union officials during the relevant period, and the number of full time equivalent employees	1
The percentage of time spent on facility time for each relevant union official	0%
The percentage of pay bill spent on facility time	0%
The number of hours spent by relevant union officials on paid trade union activities as a percentage of total paid facility time hours.	0%

NHS Chorley and South Ribble CCG hosts the employment of the union official; the information disclosed above is for both NHS Chorley and South Ribble and NHS Greater Preston CCGs and has not been split across the two CCGs. The trade union representative has declared a nil return for 2021/22.

Expenditure on consultancy

Details of expenditure on consultancy can be found in note 6 of the financial statements.

Off-payroll engagements

The CCG is required to report off-payroll arrangements as at 31 March 2022, for more than £245 per day and that last longer than six months. There are no existing or new off-payroll engagements requiring disclosure.

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	5

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)	

Exit packages, including special (non-contractual) payments
(subject to audit)

Details of exit packages can be found in note 5.3 of the financial statements.

Sickness absence data

This information relates to the twelve month period from January to December 2021 and is a joint figure for all staff that work for Chorley and South Ribble and Greater Preston CCGs.

CCGs with 12 months of Data

				c= a/b*225		
Org Code	Org Name	Org Code	Sum of FTE Days Sick	Sum of FTE Days Available	Average Annual Sick Days per FTE	Occurrences
			a	b	c	
00X	NHS Chorl	00X	542	27,671	4.4	12

Parliamentary accountability and audit report

NHS Greater Preston CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements.

The Financial Statements that follow page 179 of this report feature their own page numbering and contents. An audit report is also included in this Annual Report at page 179.

Staff policies

Our people

The CCG shares a workforce and executive team with its neighbouring CCG in central Lancashire. The workforce is employed by NHS Chorley and South Ribble CCG, and 'seconded' to NHS Greater Preston CCG.

This allows for robust collaborative working across the commissioning functions for the local health system in central Lancashire.

There are 9 CCG employees, with the teams enhanced by members of staff employed by Midlands and Lancashire Commissioning Support Unit and embedded into the head office at Chorley House in Leyland. The embedded staff teams primarily cover contracting, financial transactions, medicines optimisation and clinical quality.

The views of our workforce are always extremely important, and also vital to help us plan better ways of working, including collaboration and organisational development initiatives.

During the Covid-19 pandemic, the annual staff survey has been replaced with a monthly health and wellbeing survey. This was introduced as a way of checking in on our workforce as they continued to work from home and identifying any additional support needed.

The findings of the surveys initiated many staff initiatives such as:

- Weekly mindfulness session
- Well-being sessions
- Staff grant to purchase equipment to improve their working from home environment
- Introduction of wellbeing conversations
- Virtual staff fundraising events

All of this work was co-ordinated by the CCGs' operational Organisational Development (OD) staff working group. The OD group is representative of all the CCG business units and is overseen by the CCGs' OD Lead.

To celebrate all thing health and wellbeing, the CCGs worked with colleagues across Lancashire and South Cumbria to deliver a virtual Wellbeing Festival. The festival comprised of several wellbeing workshops covering a range of topics. All of the sessions were recorded so that staff can still access the support and resources post 31 March 2022.

Mandatory training compliance

The CCG has a mandatory training programme that all employees and office holders must complete so that they regularly learn and refresh core skills and gain knowledge on a wide range of essential topics. All new starters have to complete the full programme of training within the first month of them joining the CCG, and then to repeat modules using a set frequency, as detailed below.

The compliance against the training completion as at 31 March 2022 is outlined below. The rate covers staff and office holders for the CCG. A combined rate across both CCGs is also included.

Competency	Match	No Match
103|LOCAL|Managing Conflicts of Interest Module 1 - 1 Year|	100.00%	0.00%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	100.00%	0.00%
NHS|CSTF|Fire Safety - 1 Year|	77.78%	22.22%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	77.78%	22.22%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	88.89%	11.11%
NHS|CSTF|Moving and Handling - Level 1 - 3 Years|	88.89%	11.11%
NHS|CSTF|Preventing Radicalisation - Basic Prevent Awareness - 3 Years|	77.78%	22.22%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	100.00%	0.00%

NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	100.00%	0.00%
NHS|MAND|Fraud Awareness - 2 Years|	77.78%	22.22%
NHS|MAND|Information Governance - 1 Year|	100.00%	0.00%
Grand Total	89.90%	10.10%

Overall mandatory training compliance for the CCG was 89.90% as at 31 March 2022. Mandatory training is reported to the Governing Body bi-annually via a workforce report. The total combined compliance rate for both CCGs was 91.34%.

Development opportunities

To complement the mandatory training programme, the CCG also provides regular access to a range of non-mandatory training and development initiatives.

A schedule of online learning and development opportunities were provided during 2021/22. The courses offered to staff were:

- Unconscious Bias
- Project management
- Coaching
- Managing change
- Wellbeing
- Time management and time for rest and recovery
- Resilience
- Office 365

Diversity and inclusion

To reflect the NHS commitment to diversity and inclusion a number of policies, initiatives and longer-term ambitions have been developed in addition to the CCG work highlighted in this annual report. These will be described in the upcoming the joint Lancashire and South Cumbria EDI Annual Report due to be published in May 2022.

Parliamentary Accountability and Audit Report

FNHS Greater Preston CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at page 178. An audit certificate and report is also included in this Annual Report at page 157.

ANNUAL ACCOUNTS

Independent auditor's report to the members of the Governing Body of NHS Greater preston CCG

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of NHS Greater preston CCG (the 'CCG') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, the financial statements:

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

Basis for opinion

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

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to Note 1.2 to the financial statements, which indicates that, the CCG has prepared its accounts on the basis of a going concern recognising the Health and Care Act received Royal Assent on 28 April 2022. The Act will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities will transfer to Lancashire & 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 £378.151 million against income of £377.066 million and a deficit of £1.085 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. In addition, the CCG also received funding outside of the overall allocation of £1.051m.

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 8 June 2022 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to NHS Greater preston CCG's breach of its revenue resource limit for the year ending 31 March 2022.

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

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

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

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

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

Auditor's responsibilities for the audit of the financial statements

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

aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

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

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

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

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

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).
- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, Internal Audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls, expenditure recognition. We determined that the principal risks were in relation to:
  - journal entries that impacted expenditure or posted during the accounts production
  - The appropriateness of assumptions applied by management in determining significant accounting estimates, such as completeness and accuracy of provisions and prescribing accruals; and
  - transactions outside the normal course of business.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on manual journals including those postings with a net impact on expenditure;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the prescribing accrual**;**
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item

- assessing the revenue and expenditure recognition policies in accordance with the financial reporting framework.

- 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 statutory duty to breakeven, the potential for fraud in expenditure recognition, and the significant accounting estimates related to the prescribing accruals.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The CCG's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework**.**

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

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

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

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

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in 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 have documented our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

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

Use of our report

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG as a body, for our audit work, for this report, or for the opinions we have formed.

Gareth Kelly

Gareth Kelly, Key Audit Partner

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

Glasgow

21 June 2022

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The Primary Statements:

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	3	(648)	(549)
Total operating income		**(648)**	**(549)**
Staff costs	5	2,207	2,190
Purchase of goods and services	6	372,820	356,504
Provision expense	6	1,139	-
Other operating expenditure	6	1,985	2,116
Total operating expenditure		**378,151**	**360,810**
Net operating expenditure		**377,503**	**360,261**
Comprehensive expenditure for the year ended 31 March 2022		**377,503**	**360,261**

The notes on pages 5 to 23 form part of this statement.

Statement of Financial Position as at 31 March 2022

	Note	2021/22 £'000	2020/21 £'000
Current assets:			
Inventories	9	798	707
Trade and other receivables	10	3,516	4,105
Cash and cash equivalents	11	49	57
Total current assets		**4,363**	4,869
Total assets		**4,363**	4,869
Current liabilities			
Trade and other payables	12	(23,589)	(25,955)
Provisions	13	(1,139)	-
Total current liabilities		**(24,728)**	(25,955)
Non-current assets less net current liabilities		**(20,365)**	(21,086)
Assets less liabilities		**(20,365)**	(21,086)
Financed by taxpayers' equity			
General fund		(20,365)	(21,086)
Total taxpayers' equity:		**(20,365)**	(21,086)

The notes on pages 5 to 23 form part of this statement.

The financial statements on pages 1 to 23 were approved by the Governing Body on 16 June 22 and signed on its behalf by:

21-Jun-22

Katherine Disley
Chief Finance and Contracting Officer

21-Jun-22

Denis Gizzi
Accountable Officer

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

	General fund £'000	**Total reserves £'000**
Changes in taxpayers' equity for 2021/22		
Balance at 01 April 2021	(21,086)	**(21,086)**
Changes in NHS clinical commissioning group taxpayers' equity for 2021/22		
Net operating expenditure for the financial year	(377,503)	**(377,503)**
Net recognised NHS clinical commissioning group expenditure for the financial year	**(377,503)**	**(377,503)**
Net funding	378,224	**378,224**
Balance at 31 March 2022	**(20,365)**	**(20,365)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2020/21		
Balance at 01 April 2020	(10,837)	(10,837)
Changes in NHS clinical commissioning group taxpayers' equity for 2020/21		
Net operating costs for the financial year	(360,261)	(360,261)
Net recognised NHS clinical commissioning group expenditure for the financial year	(360,261)	(360,261)
Net funding	350,012	350,012
Balance at 31 March 2021	(21,086)	(21,086)

The notes on pages 5 to 23 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		(377,503)	(360,261)
Increase in inventories	9	(91)	(8)
Decrease in trade and other receivables	10	589	1,832
(Decrease)/increase in trade and other payables	12	(2,366)	8,451
Increase in provisions	13	1,139	0
Net cash outflow from operating activities		**(378,232)**	(349,985)
Net cash outflow before financing		**(378,232)**	(349,985)
Cash flows from financing activities			
Net funding received		378,224	350,012
Net cash inflow from financing activities		**378,224**	350,012
Net increase (decrease) in cash and cash equivalents	11	**(8)**	27
Cash and cash equivalents at the beginning of the financial year		**57**	30
Cash and cash equivalents (including bank overdrafts) at the end of the financial year		**49**	57

The notes on pages 5 to 23 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 Department of Health and Social Care Group Accounting Manual (GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the Department of Health and Social Care 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 CCGs, 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 (CCG) for the purpose of giving a true and fair view has been selected.

The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.2 **Going concern**

These accounts have been prepared on a going concern basis despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014.

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

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022, on a going concern basis.

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

In the application of the CCG's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.3.1 **Critical accounting judgements in applying accounting policies**

There are no critical judgements in applying accounting policies that management has made in the process of applying the CCG's accounting policies that have the most significant effect on the amounts recognised in the financial statements.

1.3.2 **Sources of estimation uncertainty**

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

The prescribing prepayment included in 2020/21 (£1.09 million) has been unwound and a further prepayment not included in the current year. Prescribing costs have been based on the latest information available which are the month 10 (January 2022) figures.

Provisions for additional continuing care costs (individual packages of care) reflect the current funding appeals where a financial remedy has not been possible to transact prior to end of the financial reporting period. The provision has been based on the latest case lists

1.4 **Pooled budgets**

Where the CCG has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the CCG accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the CCG is in a "jointly controlled operation", the CCG recognises:

- The assets the CCG controls;
- The liabilities the CCG incurs;
- The expenses the CCG incurs; and,
- The CCG's share of the income from the pooled budget activities.

If the CCG is involved in a "jointly controlled assets" arrangement, in addition to the above, the CCG recognises:

- The CCG's share of the jointly controlled assets (classified according to the nature of the assets);
- The CCG's share of any liabilities incurred jointly; and,
- The CCG's share of the expenses jointly incurred.

There have been no changes in the control of the CCG pooled arrangements in 2021/22. See note 17.

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 CCG.

1.6 **Revenue**

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

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

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

Payment terms are standard reflecting cross government principles.

1.7 **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.

1.7.2 **Retirement benefit costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. 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 defined contribution schemes: the cost to the CCG of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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

1.8 **Other expenses**

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

1.9 **Grants payable**

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

Notes to the financial statements

1.10 **Value Added Tax (VAT)**
Most of the activities of the CCG 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.

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

1.11.1 **The CCG as lessee**
The CCG had no finance leases.
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred. Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.12 **Inventories**
Inventories held are for the Community Equipment Loan Stock and are valued at the lower of cost and net realisable value.

1.13 **Cash and 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 CCG's cash management.

1.14 **Provisions**
Provisions are recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the CCG 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.

1.15 **Clinical negligence costs**
NHS Resolution operates a risk pooling scheme under which the CCG 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 the CCG.

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

1.17 **Contingent liabilities and contingent assets**
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG, 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 CCG. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingencies are disclosed at their present value.

1.18 **Financial assets**
Financial assets are recognised when the CCG 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.

Notes to the financial statements

1.18.2 **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 CCG recognises a loss allowance representing the expected credit losses on the financial asset.

The CCG 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 CCG therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the CCG 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 CCG 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.

1.20 **Third party assets**

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

1.21 **Losses and 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 CCG not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.22 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 **Accounting standards that have been issued but have not yet been adopted**

The DHSC 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.

1.23.1 **IFRS 16 Leases**

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 CCG will apply this definition to new leases only and will review legacy agreements made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the CCG 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 CCG's incremental borrowing rate. The CCG'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 CCG 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.

The CCG has undertaken an exercise to identify leases which are currently operating leases as well as a broader review of recurring expenditure streams where right of use assets (as defined by IFRS 16) may be embedded in contracting arrangements. This assessment has resulted in the CCG's existing operating lease with Lancashire County Developments Ltd being identified as a right of use asset which will be recognised on the Statement of Financial Position from 1 April 2022.

This lease is jointly held with NHS Chorley and South Ribble CCG and commenced in January 2018 for a period of three years which has subsequently expired.

IFRS16 requires the CCG to assess the expected length of occupation and where extensions remain, a plausible proposition to recognise the lease at that term. The CCG has assessed the current expected occupation to be five years from 1st April 2022.

Therefore the estimated impact of applying IFRS16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

Estimated impact on 1 April 2022 statement of financial position	**£000**
Additional right of use assets recognised for existing operating leases	258
Net impact on net assets on 1 April 2022	**258**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	53
Additional finance costs on lease liabilities	2
Estimated impact on surplus / deficit in 2022/23	**55**

1.23.2 **IFRS 17 Insurance Contracts**

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

The application of the standards as revised would not have a material impact on the accounts for 2021/22, were they to be applied in that year.

2. Financial performance targets

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

	2021/22	**2021/22**	**2021/22**	2020/21	2020/21	2020/21
	Target £'000	**Performance £'000**	**Duty achieved**	Target £'000	Performance £'000	Duty achieved
Expenditure not to exceed income	377,066	378,151	No*	360,811	360,810	Yes
Revenue resource use does not exceed the amount specified in Directions	376,418	377,503	No*	360,262	360,261	Yes
Revenue administration resource use does not exceed the amount specified in Directions	3,842	3,627	Yes	3,871	3,632	Yes

* See note 1.2

3. Other operating revenue

	2021/22 Admin £'000	**2021/22 Programme £'000**	**2021/22 Total £'000**	2020/21 Total £'000
Income from sale of goods and services (contracts)				
Non-patient care services to other bodies	-	523	**523**	523
Other contract income	-	125	**125**	26
Total income from sale of goods and services	**-**	**648**	**648**	**549**
Total operating income	**-**	**648**	**648**	**549**

4. Revenue - Disaggregation of income - income from sale of good and services (contracts)

2021/22

	Non-patient care services to other bodies	**Other contract income**
	£'000	**£'000**
Source of revenue		
NHS	-	-
Non NHS	523	125
Total	**523**	**125**

	Non-patient care services to other bodies	**Other contract income**
	£'000	**£'000**
Timing of revenue		
Point in time	-	-
Over time	523	125
Total	**523**	**125**

2020/21

	Non-patient care services to other bodies	Other contract income
	£'000	£'000
Source of revenue		
NHS	-	-
Non NHS	523	26
Total	523	26

	Non-patient care services to other bodies	Other contract income
	£'000	£'000
Timing of revenue		
Point in time	-	-
Over time	523	26
Total	523	26

5. Employee benefits and staff numbers

5.1.1 Employee benefits 2021/22

2021/22

	Permanent employees £'000	**Other £'000**	**Total £'000**
Employee benefits			
Salaries and wages	1,763	30	1,793
Social security costs	199	-	199
Employer contributions to NHS Pension scheme	215	-	215
Gross employee benefits expenditure	**2,177**	**30**	**2,207**

Employee benefits 2020/21

2020/21

	Permanent employees £'000	Other £'000	Total £'000
Employee benefits			
Salaries and wages	1,753	35	1,788
Social security costs	195	3	198
Employer contributions to NHS Pension scheme	204	-	204
Gross employee benefits expenditure	2,152	38	2,190

5.2 Average number of people employed

	2021/22			2020/21		
	Permanently employed number	**Other number**	**Total number**	Permanently employed number	Other number	Total number
Total	**27**	**2**	**29**	31	1	32

5.3 Exit packages agreed in the financial year

The CCG did not agree any departures where exit packages have been made in 2021/22 or 2020/21.

The CCG did not agree any departures where special payments have been made in 2021/22 or 2020/21

5.4 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/nhs-pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

5.4.1 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.

5.4.2 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%, and the Scheme Regulations were amended accordingly.

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

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

The staff body is shared with NHS Chorley and South Ribble CCG with NHS Chorley and South Ribble CCG hosting their employment on behalf of NHS Greater Preston CCG. Therefore, the employers' contributions' below relate to amounts paid for staff directly employed by NHS Greater Preston CCG but note 5.1.1 also includes the costs recharged from NHS Chorley and South Ribble CCG.

For 2021/22, employers' contributions of £474 were payable to the NHS Pensions Scheme (2020/21: £24,061) at the rate of 20.68% (2020/21:20.68%) of pensionable pay. These costs are included in the NHS pension line of note 5.1.1.

* Amending Directions 2021
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1023845/The_Public_Service_Pensions__Valuations_and_Employer_Cost_Cap___Amendment__Directions_2021.pdf

6. Operating expenses

	2021/22 Admin £'000	2021/22 Programme £'000	2021/22 Total £'000	2020/21 Total £'000
Purchase of goods and services				
Services from other CCGs and NHS England	1,462	2,469	**3,931**	4,159
Services from foundation trusts	-	194,042	**194,042**	189,072
Services from other NHS trusts	-	12,444	**12,444**	11,966
Purchase of healthcare from non-NHS bodies *	-	81,399	**81,399**	70,746
Purchase of social care	-	4,985	**4,985**	4,760
Prescribing costs	-	33,342	**33,342**	31,688
Pharmaceutical services	-	90	**90**	76
GMS/PMS and APMS	-	40,643	**40,643**	38,364
Supplies and services – clinical	-	263	**263**	279
Supplies and services – general	(22)	293	**271**	1,443
Consultancy services	-	-	**-**	68
Establishment	46	95	**141**	1,065
Transport	1	-	**1**	-
Premises	139	943	**1,082**	2,308
Audit fees	65	-	**65**	62
Other non statutory audit expenditure				
· Internal audit services	27	-	**27**	29
· Other services	-	12	**12**	10
Other professional fees	6	91	**97**	91
Legal fees	-	35	**35**	74
Education, training and conferences	7	(57)	**(50)**	244
Total purchase of goods and services	**1,731**	**371,089**	**372,820**	**356,504**
Provision expense				
Provisions	-	1,139	**1,139**	-
Total provision expense	**-**	**1,139**	**1,139**	**-**
Other operating expenditure				
Chair and non executive members	490	-	**490**	502
Grants to other bodies	-	927	**927**	841
Expected credit loss on receivables	-	-	**-**	310
Inventories consumed	-	414	**414**	463
Other expenditure	-	154	**154**	-
Total other operating expenditure	**490**	**1,495**	**1,985**	**2,116**
Total operating expenditure	**2,221**	**373,723**	**375,944**	**358,620**

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services

* Purchase of healthcare from non-NHS bodes includes the following;

- £9,191k of Hospital Discharge Programme expenditure (2020/21 £20,267k) of which £7,278k are claims from Lancashire County Council (2020/21 £12,707k)
- £0k of additional community based care support provided by Lancashire County Council in response to the pandemic (2020/21 £4,680k).
- £24,103k of Independent Sector (IS) expenditure (2020/21 £399k) of which £13,646k being on behalf of other Lancashire and South Cumbria CCGs. National arrangements / contracts were in place between NHS England and the main IS providers from March 2020 to March 2021 in response to the covid pandemic. From April 2021, commissioning responsibility returned to CCGs with NHS Greater Preston CCGs hosting the main IS contract on behalf of the Lancashire and South Cumbria CCGs.

In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, where a CCG contract with its auditors provides for a limitation of the auditor's liability, the principal terms of this limitation must be disclosed in a note to the accounts. The auditors liability cap is £2.0m.

7. Better Payment Practice Code (BPPC)

7.1 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	16,089	139,286	18,937	123,961
Total Non-NHS trade invoices paid within target	16,056	137,489	18,888	123,710
Percentage of Non-NHS trade invoices paid within target	**99.79%**	**98.71%**	99.74%	99.80%
NHS payables				
Total NHS trade invoices paid in the year	500	221,269	1,035	212,341
Total NHS trade invoices paid within target	485	221,140	1,022	212,044
Percentage of NHS trade invoices paid within target	**97.00%**	**99.94%**	98.74%	99.86%

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

The CCG made no payments in respect of this legislation.

8. Operating leases

8.1 As lessee

8.1.1 Payments recognised as an expense	**2021/22**			2020/21		
	Buildings	**Other**	**Total**	Buildings	Other	Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Payments recognised as an expense						
Minimum lease payments	90	1	**91**	138	1	139
Total	**90**	**1**	**91**	138	1	139

The CCG has signed a joint operating lease with NHS Chorley and South Ribble CCG for its headquarters building; Chorley House. The Lessor is Lancashire County Developments Limited. This commenced in January 2018 for a period of three years which has subsequently expired. The terms and conditions of the original contract are still operating where either party would be required to serve six months notice for the CCG to vacate the premises.

8.1.2 Future minimum lease payments	**2021/22**			2020/21		
	Buildings	**Other**	**Total**	Buildings	Other	Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Payable:						
No later than one year	44	-	**44**	45	-	45
Total	**44**	**-**	**44**	45	-	45

9. Inventories

	2021/22	
	Loan Equipment	**Total**
	£'000	**£'000**
Balance at 01 April 2021	707	**707**
Additions	505	505
Inventories recognised as an expense in the period	(414)	(414)
Balance at 31 March 2022	**798**	**798**

	2020/21	
	Loan Equipment	Total
	£'000	£'000
Balance at 01 April 2020	699	699
Additions	471	471
Inventories recognised as an expense in the period	(463)	(463)
Balance at 31 March 2021	707	707

10. Trade and other receivables	**Current 2021/22 £'000**	Current 2020/21 £'000
NHS receivables: revenue	50	505
NHS prepayments	37	195
NHS accrued income	2,327	785
Non-NHS and other WGA receivables: revenue	30	66
Non-NHS and other WGA prepayments	1,023	2,521
VAT	35	23
Other receivables and accruals	14	10
Total trade and other receivables	**3,516**	4,105
Total current and non current	**3,516**	4,105
Included above:		
Prepaid pensions contributions	-	-

10.1 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	-	4	60	45
By three to six months	-	22	-	-
By more than six months	-	2	342	2
Total	**-**	**28**	402	47

11. Cash and cash equivalents

	2021/22 £'000	2020/21 £'000
Balance at 01 April 2021	57	30
Net change in year	(8)	27
Balance at 31 March 2022	**49**	**57**
Made up of:		
Cash with the Government Banking Service	49	57
Cash and cash equivalents as in statement of financial position	**49**	**57**
Balance at 31 March 2022	**49**	**57**

12. Trade and other payables	**Current 2021/22 £'000**	Current 2020/21 £'000
NHS payables: Revenue	1,307	3,975
NHS accruals	1,164	1,276
Non-NHS and other WGA payables: revenue	3,836	972
Non-NHS and other WGA accruals	10,555	13,705
Social security costs	7	6
Tax	7	3
Payments received on account	-	-
Other payables and accruals	6,713	6,018
Total trade and other payables	**23,589**	25,955
Total current and non-current	**23,589**	25,955

Non-NHS and other WGA accruals and Other payables and accruals as at 31 March 2022 include assessments of outstanding healthcare costs for Individual Patient Activity of £4,806k (31 March 2021 £6,043k). It also includes £174k outstanding pension contributions at 31 March 2022 (31 March 2021 £161k)

13. Provisions and clinical negligence costs

13.1 Provisions 2021/22	Current 2021/22 £'000
Continuing care	1,139
Total	**1,139**
Total current and non-current	**1,139**

	Continuing Care £'000	Total £'000
Balance at 01 April 2021	**-**	**-**
Arising during the year	1,139	**1,139**
Balance at 31 March 2022	**1,139**	**1,139**
Expected timing of cash flows:		
Within one year	1,139	**1,139**
Balance at 31 March 2022	**1,139**	**1,139**

Under the accounts direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS continuing healthcare claims relating to periods of care before establishment of the CCG. However, the legal liability remains with the CCG.

The total value of legacy NHS continuing healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2022 is £0k (31 March 2021 £265k). The total value of legacy NHS continuing healthcare contingent liabilities accounted for by NHS England on behalf of this CCG at 31 March 2022 is £165k (31 March 2021 £350k).

13.2 Clinical negligence costs

NHS Resolution holds no provision as at 31 March 2022 (31 March 2021 £0k) in respect of clinical negligence liabilities of the CCG. Legal claims are calculated from the number of claims currently lodged with NHS Resolution and the probabilities provided by them.

14. Commitments

14.1 Capital commitments

The CCG had no capital commitments at 31 March 2022.

14.2 Other financial commitments

The CCG has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) for the provision of healthcare services which expire in future years as follows:

	2021/22 £'000	2020/21 £'000
In not more than one year	8,681	5,902
In more than one year but not more than five years	4,437	315
Total	**13,118**	6,217

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.

As the CCG 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 CCG 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 CCG in undertaking its activities.

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

15.1.1 Currency risk

The CCG is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The CCG has no overseas operations and therefore is not subject to any foreign exchange risk.

15.1.2 Interest rate risk

The CCG is not subject to any interest rate risk.

15.1.3 Credit risk

The majority of the CCG revenue is received from parliamentary funding, therefore the CCG 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

The CCG is required to operate within revenue and capital resource limits, which are financed from resources voted annually by parliament. The CCG draws down cash to cover expenditure, as the need arises. The CCG 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

	2021/22 £'000	2020/21 £'000
Financial assets measured at amortised cost		
Trade and other receivables with NHSE bodies	2,377	1,074
Trade and other receivables with other DHSC group bodies	-	215
Trade and other receivables with external bodies	44	76
Cash and cash equivalents	49	57
Total financial assets	**2,470**	1,422
Other current assets	1,893	3,447
Total current assets	**4,363**	4,869

15.3 Financial liabilities

	2021/22 £'000	2020/21 £'000
Financial liabilities measured at amortised cost		
Trade and other payables with NHSE bodies	1,370	790
Trade and other payables with other DHSC group bodies	1,092	5,789
Trade and other payables with external bodies	21,112	19,367
Total financial liabilities	**23,574**	25,946
Other current liabilities	15	9
Total current liabilities	**23,589**	25,955

16. Operating segments

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

The major suppliers of healthcare services were:	**2021/22 £'000**	2020/21 £'000
Lancashire Teaching Hospitals NHS Foundation Trust	131,941	131,309
Lancashire and South Cumbria NHS Foundation Trust	53,510	49,414

17. Pooled budgets

The Clinical Commissioning Group has entered into pooled budget arrangements for services for adults with learning disabilities and Better Care Fund, the details are as follows:

			Amounts recognised in Entities books ONLY 2021/22				Amounts recognised in Entities books ONLY 2020/21			
Name of arrangement	**Parties to the arrangement**	**Description of the principal activities**	**Assets £000's**	**Liabilities £000's**	**Income £000's**	**Expenditure £000's**	Assets £000's	Liabilities £000's	Income £000's	Expenditure £000's
Learning Disabilities Pool - North Lancashire	Lancashire County Council NHS Blackpool CCG NHS Fylde & Wyre CCG NHS Greater Preston CCG NHS Morecambe Bay CCG	Services for adults with learning disabilities hosted by Lancashire County Council	**-**	**-**	**-**	**50**	**-**	**-**	-	49
Learning Disabilities Pool - Central Lancashire	Lancashire County Council NHS Chorley and South Ribble CCG NHS Greater Preston CCG NHS West Lancashire CCG	Services for adults with learning disabilities hosted by Lancashire County Council	**-**	**-**	**(519)**	**1,518**	**-**	**-**	(519)	1,520
Better Care Fund	Lancashire County Council NHS Chorley and South Ribble CCG NHS East Lancashire CCG NHS Fylde & Wyre CCG NHS Greater Preston CCG NHS Morecambe Bay CCG NHS West Lancashire CCG	Services supporting the integration of Health and Social Care hosted by Lancashire County Council	**-**	**-**	**(10,484)**	**15,398**	**-**	**-**	(10,005)	14,694

The Lancashire Better Care Fund steering group has the decision making power with the members having joint control, however each party has delegated lead commissioning responsibilities for its share of the agreement and has control over expenditure.

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 their share of the fund. The resulting net balance is accounted for in the CCG accounts.

The above table shows the CCGs share of income and expenditure within 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

Details of related party transactions with individuals are as follows:

	2021-22		2020-21	
	Payments to related party £'000	**Amounts owed to related party £'000**	Payments to related party £'000	Amounts owed to related party £'000
Dr S Mukerji - GP Director NHS Greater Preston CCG				
Salaried General Practitioner - Stonebridge Surgery *	**1,117**	**38**	1,187	38
Dr E Craven - GP Director NHS Greater Preston CCG				
General Practitioner (Partner) - Lostock Hall Medical Centre	**764**	**31**	720	20
Dr P Methukunta - GP Director NHS Greater Preston CCG				
General Practitioner (Partner) - Briarwood Medical Centre	**795**	**45**	756	26
General Practitioner (Partner) - Lostock Hall Medical Centre	see above	see above	see above	see above
Dr H Nair - GP Director NHS Greater Preston CCG				
General Practitioner (Partner) - Lane Ends Surgery (formerly Doclands Medical Centre)	**1,160**	**67**	1,192	36
Beacon Medical Services Group *(applicable to 2020-21 only)*	**n/a**	**n/a**	548	-
Dr S Prakash - GP Director NHS Greater Preston CCG				
General Practitioner (Partner) Park Medical Practice	**2,478**	**71**	2,498	72
Dr A Rangaswamy - GP Director NHS Greater Preston CCG				
General Practitioner (Partner) - North Preston Medical Practice	**2,787**	**147**	2,016	93

The majority of the cost associated with most practices are for primary care medical services.

The Department of Health and Social Care is regarded as a related party. During the year the CCG has had a significant number of material transactions with entities for which the department is regarded as the parent department.

For example:
- NHS England
- NHS Foundation Trusts
- NHS Trusts
- NHS Resolution
- NHS Business Services Authority
- Other NHS Clinical Commissioning Groups.

19. Events after the end of the reporting period

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

There are no post balance sheet events which will have a material effect on the financial statements of the CCG.

20. Losses and special payments

20.1 Losses

The total number of CCG losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2021/22 Number	**Total Value of Cases 2021/22 £'000**	Total Number of Cases 2020/21 Number	Total Value of Cases 2020/21 £'000
Claims abandoned	93	154	254	334
Total	**93**	**154**	254	334

20.2 Special payments

The CCG had no special payments within the financial years 2021/22 and 2020/21.