NHS CHORLEY AND SOUTH RIBBLE CCG ANNUAL REPORT QUARTER 1 2022-23

Contents

WELCOME

Welcome to the Quarter 1 2022-2023 Annual Report for NHS Chorley and South Ribble Clinical Commissioning Group (CCG).

The national extension of the Integrated Care Board establishment meant that the CCG continued with its statutory arrangements until 31 June 2022 and established shadow arrangements from April 2022 to support the transfer of formal responsibilities for commissioning services.

The following information provides an update on the activities undertaken to achieve both the required statutory responsibilities of CCGs and the appropriate due diligence to ensure a smooth transition to the newly established Integrated Care Board (ICB) during the period of 1 April 2022 – 30 June 2022.

PERFORMANCE REPORT

This section gives an overview of who we are and what we do, some of our highlight achievements during Quarter 1 2022-23, 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 Executive on performance

This period, referred to as Quarter 1, has seen continued challenges to service delivery and planning alongside the significant national developments in the reorganisation of health and care and emerging guidance for delivering integrated care for the benefit of our population and staff.

In line with the Health and Care Act (2022), which completed the Parliamentary processes in April, the eight CCGs in Lancashire and South Cumbria were closed on 30 June 2022. The statutory responsibilities of the CCGs were transferred to the new organisation, Lancashire and South Cumbria Integrated Care Board (ICB), which was established on 1 July.

As part of the preparations for establishing the new ICB, due diligence was given to the closedown of the CCGs and set up for the new organisation. The Lancashire and South Cumbria ICB constitution was signed off and the Readiness to Operate 'ROS' checklist was given approval from the regional team. The hard work and dedication of all colleagues who worked on the closedown of CCGs and establishment of the ICB must be recognised here.

The final meeting of the Strategic Commissioning Committee (SCC), which brought together the leadership of the eight Lancashire and South Cumbria CCGs with ICS strategic commissioning leaders, took place on 9 June. Several documents were prepared for the first meeting of the Integrated Care Board on 1 July 2022:

- ICB Constitution and Standing Orders
- Committees of the Board, including Terms of Reference for:
    - Audit Committee
    - Renumeration Committee and Panel
    - Quality Committee
    - People Board
    - Public Involvement and Engagement Advisory Committee
    - Primary Care Contracting Group
- Governance handbook
- Lancashire and South Cumbria CCG policies for consideration and adoption
- Special lead roles on the Integrated Care Board
- Appointment of ICB Founder Member of the Integrated Care Partnership
- ICB budget summary.

CCG staff continued to work in an agile way throughout the period with the support of the 'our ways of working' framework, supporting both local CCGs and the Integrated Care System (ICS) work as we moved into the final transition stages and closure of CCGs as part of the formal establishment of the ICB.

Information previously contained on CCG websites is now available via lancashireandsouthcumbria.ICB.NHs.uk/legacyccgs

I look forward to developing local relationships with partners, patients and local communities as the role of the ICB develops and I would like to take this opportunity to formally recognise and thank our local teams across each CCG area for their dedication to supporting the local populations in Lancashire and South Cumbria as they continue to address the challenges that we have outlined in this work through the new and emerging structures.

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board (on behalf of the former Chorley and South Ribble CCG)

28 June 2023

Who we are and what we do

NHS Chorley and south Ribble 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 30 GP practices in Chorley and South Ribble, which serve a registered population of approximately 188,000.

We work very closely with NHS Greater Preston 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 £318.4 million and a Covid Support Fund of £3.2 million, 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.

Chorley and South Ribble are two of the more affluent districts within Lancashire, with both falling within the 45% least deprived districts in England. Despite this, 28% of the registered population live within areas that fall among the 40% most deprived areas in England. An analysis of the health and lifestyle of adults in the area shows that 13% of adults in Chorley and 8% in South Ribble are smokers. While over two thirds of the population in both areas are believed to be physically active, South Ribble has a significantly higher proportion of adults living with excess weight compared to England, with over two thirds believed to be obese or overweight.

Chorley and South Ribble CCG has significantly higher levels of recorded disease prevalence for the following conditions:

- 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+)

Chorley and South Ribble also have 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

As described above, the total allocations to NHS Chorley and South Ribble CCG for 2022/23 relate to the first quarter of the year only and were as follows:

- We received allocations totalling £71.4m for commissioning NHS services for the local community
- We received a further allocation of £7.1m for delegated commissioning of primary care medical services
- We received a further allocation of £0.9m for the CCG running costs

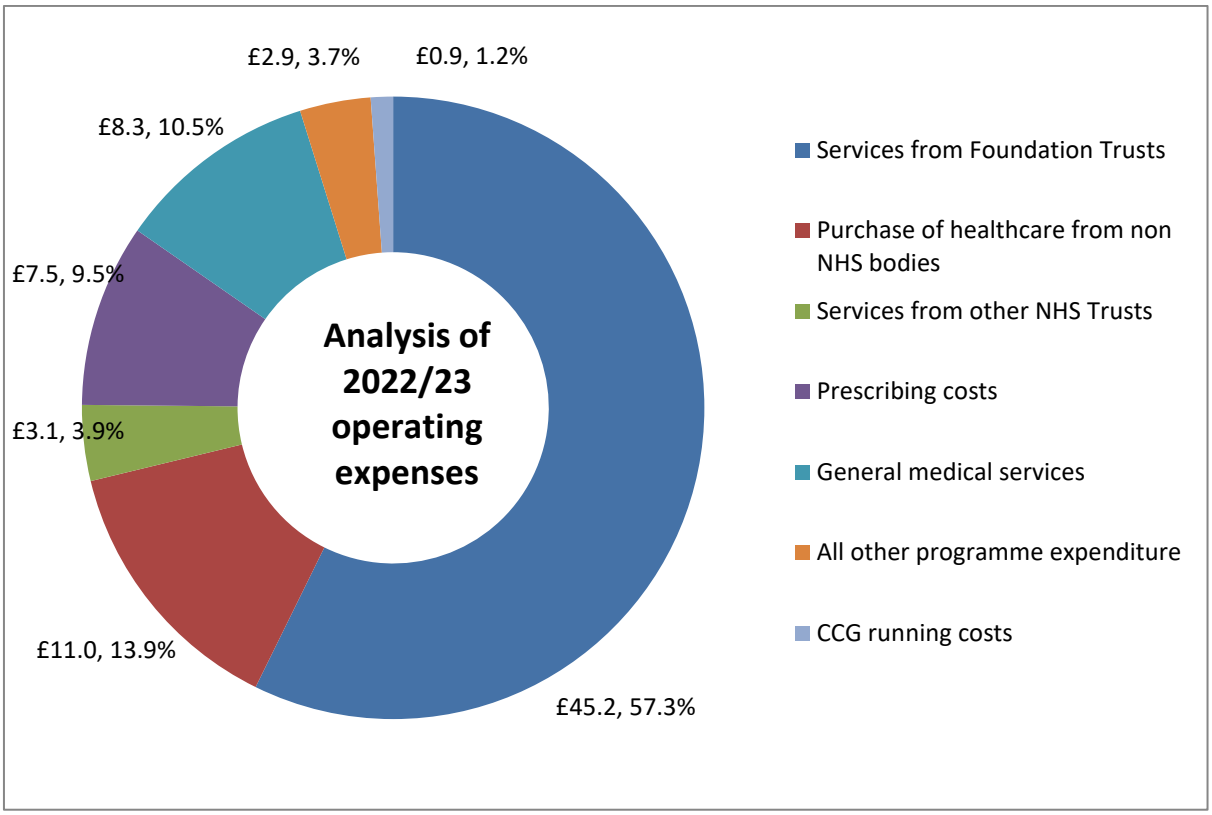
In order to enable the CCG to report a breakeven position at the end of quarter 1, we also received the following allocation adjustments:

- A reduction to allocations of £0.8m for commissioning NHS services for the local community

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

- A reduction to allocations of £0.2m for delegated commissioning of primary care medical services

Analysis of 2022/23 operating expenses (£m)



Performance against financial targets

The CCG's performance against each of its financial duties, as reported in Note 2 to the Accounts, for the first quarter of the 2022/23 financial year was as follows:

- The CCG achieved its in year control total of a breakeven, but this was only achieved with the reduction to allocations of £1.1m as described above
- The CCG did not remain within the cash limit, but the shortfall will be recovered by the Lancashire and South Cumbria Integrated Care Board during the remainder of the financial year
- The CCG maintained its administration expenditure within its Running Costs Allowance.

Our system performance

In response to the priorities set by NHS England nationally during period of 2021-22, local systems continued to priorities Covid-19 vaccinations, access for patients to key services, the timely discharge of patients from services, and developing enhanced 'surge planning' to prepare for 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.

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. You can read more in this report on how the development of the ICB and the continuation of Integrated Care System relationships have supported mitigating the pressures felt across the system.

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 we saw in 2021-22, the pandemic has created significant backlogs across different activities, creating challenges that remain across the country to restore elective care systems to pre-pandemic levels. Locally we are facing significant challenges to achieve restoration in elective services and quickly reduce the backlog in waiting time activity, which has continued to have an effect on meeting Referral to Treatment (RTT) targets moving into Q1 2022.

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 work has been undertaken during this period to ensure that planning and development of services across Lancashire and South Cumbria primary care is robust and effective for our primary care colleagues, patients and local populations.

The focus at present across central Lancashire is reducing the significant number of patients waiting over 104 weeks and 52 weeks at LTHTR. At the end of quarter 1 there were 43 patients waiting over 104 weeks for patients in the CCG area. 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).

Additionally, activity and performance across urgent and emergency care continued to be under significant pressure throughout the first quarter of 2022-23. You can read more on this in the performance analysis section within this report.

Working with our partners

Lancashire and South Cumbria Health and Care Partnership

The **Covid-19 vaccination programme** – the largest in history – was well established by April 2022, both nationally and across Lancashire and South Cumbria. The Covid-19 Vaccination Programme

Board, established in November 2020, continued to provide oversight during quarter one of 2022/23 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.

Up to June 2022, more than 3.7 million vaccinations have been given to people in Lancashire and South Cumbria.

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 144,000 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.

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.

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.

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.

Moving forwards, 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.

PERFORMANCE ANALYSIS

Some of the data within this section of the report refers to NHS Chorley and South Ribble CCG and NHS Greater Preston CCG collectively, where this is the case, it is specified.

Elective Care

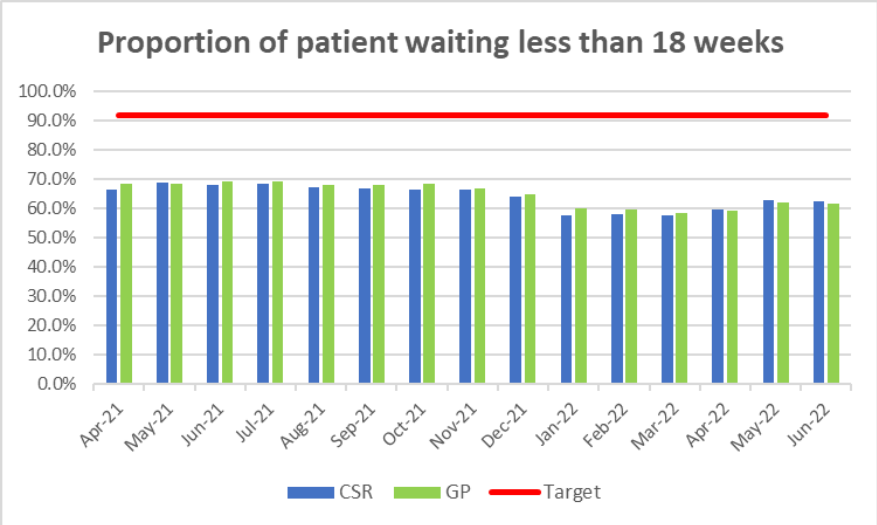
The impact of covid has continued to make performance in Elective and Cancer services challenged going into the first quarter of 2022/23. The recovery of services continues to coordinated through the Integrated Care Partnership Elective Care Recovery Group, concentrating on improving performance at provider 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.

Referral to Treatment Times (RTT) Performance

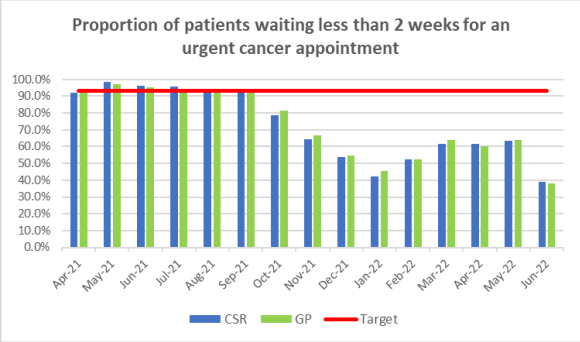
Neither Chorley & South Ribble or Greater Preston CCG met the target for open pathways for RTT in 2021-22, which continued into the first quarters of 22/23. The trend shows performance falling over the winter period, a trend which matches that at LTHTR, however there has been some improvement in performance at both CCGs in the first quarter of 22/23. The focus at present is reducing the significant number of patients waiting over 104 weeks and 52 weeks at LTHTR. At the end of quarter 1 there were 43 patients waiting over 104 weeks for patients in the CCG area. 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).

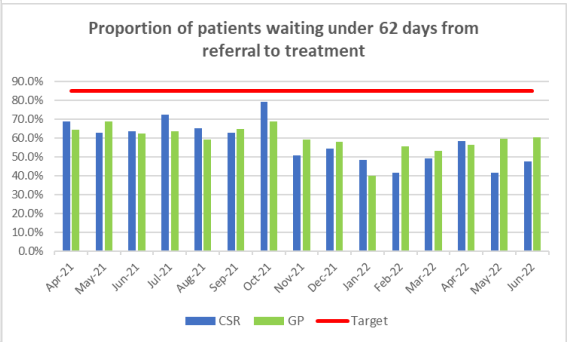


Cancer Performance

Both CCGs are not meeting performance for either the 2 weeks cancer pathway or the 62 days referral to treatment target, a position which has deteriorated over the first quarter of 22/23. 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

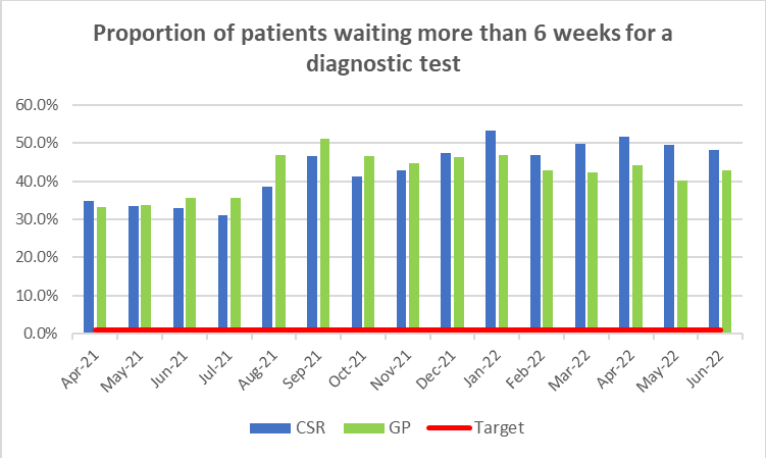
staffing issues which has required the CCG to look outside of the main provider for delivery of these services. There are a number of initiatives led by the Cancer Alliance aimed at improving the current performance.





Diagnostics Performance

The diagnostic target for both CCGs has not been met in any month in the financial year 21/22 and has continued into the calendar year 22/23. 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.

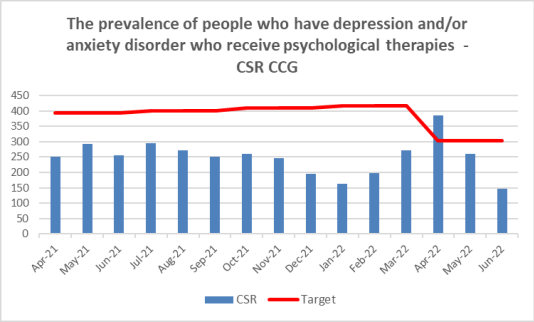


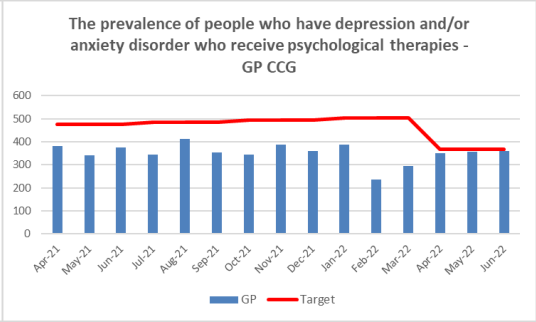
Mental Health

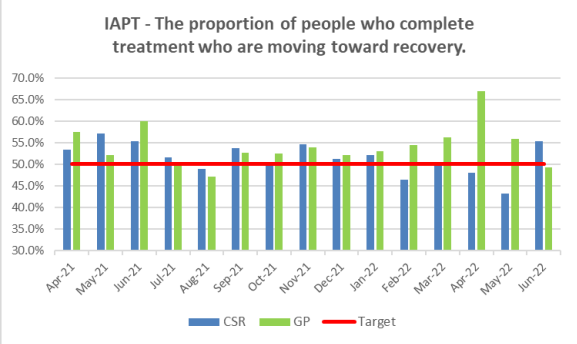
The performance in mental health services, as with other services has been impacted by the pandemic. The main indicator performance shows that most targets are still being met despite this impact.
Mental Health Performance – main constitutional indicators

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. In the first quarter of 22/23 there has been good performance in prevalence, especially in Greater Preston CCG. 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.

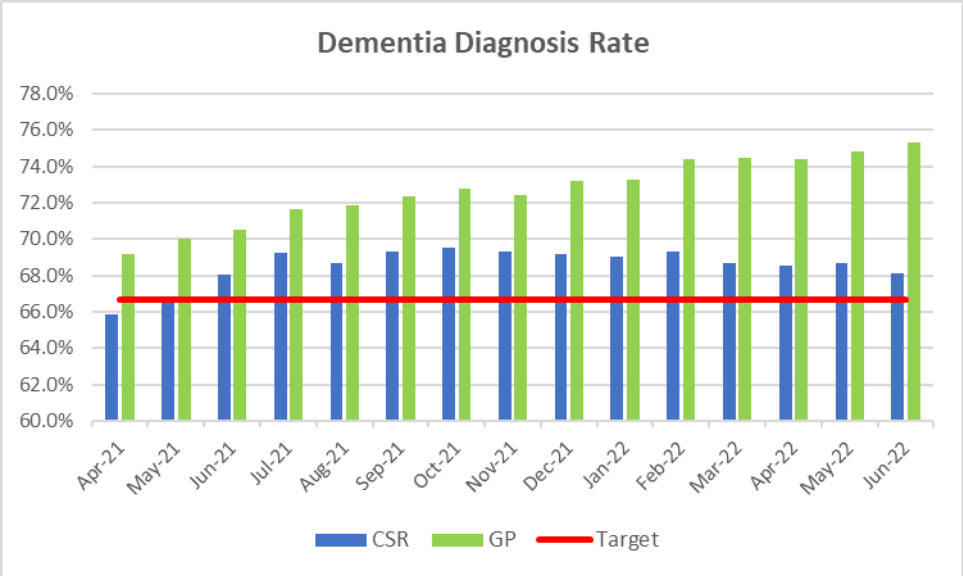






Dementia Diagnosis Rate Performance

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, the performance continued to improve in the first quarter of 22/23.



Urgent and Emergency Care

Activity and performance across urgent and emergency care continued to be under significant pressure throughout the first quarter of 2022-2023. 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 regular updates of the following specific key performance indicators. The following table compares the month of June 2022 against the month of July 2022, with a comparison against the same period during 2021-2022.

			TARGET	Previous Month	Current Month	DOT Current vs. Previous	Last Year	% Variance vs. Last Year	13 Month Trend	Aug-22 to Date	Daily Avg.	Aug-22 Forecast	Latest Day Reported
				Jun-22	Jul-22		Jul-21			As at 4th Aug-22			4th Aug-22
1	NWAS Response Metrics	Category 1 Calls % < 15 Minutes	90%	87.3%	87.4%	▲	83.0%	5%					
		Category 2 Calls % < 40 Minutes	90%	64.0%	53.0%	▼	44.5%	19%					
		> 30 Min. Lost Unit Hours - Chorley Hospital	-	28.7	30.7	▲	19.5	57%					
		> 30 Min. Lost Unit Hours - Royal Preston	-	687.9	771.9	▲	480.1	61%					
	Ambulance Handovers LTHTR	Breaches > 30 Minutes	0	565	673	▲	427	58%		104	26	806	25
		Breaches > 60 Minutes	0	228	284	▲	144	97%		52	13	403	11
2	Corridor Care		0	0	0	▶	0		-				
3	Time in Department	Avg. Time to Initial Assessment	15 Mins.	18	19	▲	20	-5%					
		4 - 12 Hour Trolley Waits	-	1538	1466	▼	1909	-23%		156	39	1209	39
		12 Hour Trolley Waits	0	74	114	▲	45	153%		0	0	0	0
		MH 12 Hour Breaches	0	24	19	▼	11	73%					
4	Stranded Patients	% Beds occupied by patients >=7 days	-	56.6%	56.3%	▼	50.9%	11%		57.1%			56.8%
		% Beds occupied by patients >=14 days	-	32.3%	34.5%	▲	29.5%	17%		32.9%			31.1%
		% Beds occupied by patients >=21 days	-	20.4%	21.9%	▲	17.7%	24%		21.0%			20.8%
5	Bed Occupancy	% G&A Beds Occupied	85%	95.4%	98.1%	▲	94.0%	4%		95.5%			95.3%
		% Critical Beds Occupied	-	77.9%	67.0%	▼	76.7%	-13%		63.2%			50.0%
		% Community Bed Utilisation	85%	94.0%	92.1%	▼	76.6%	20%		59.6%			79.3% *

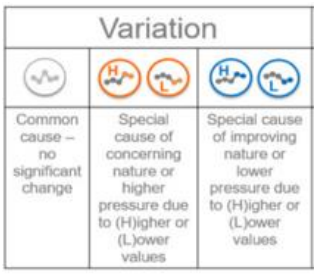
KEY: Direction of Travel (DOT)
▲ Increasing position toward target
▼ Decreasing position toward target
▲ Inceasing position away from target
▼ Decreasing position away from target
▶ No change

Target Not Met
Target Met

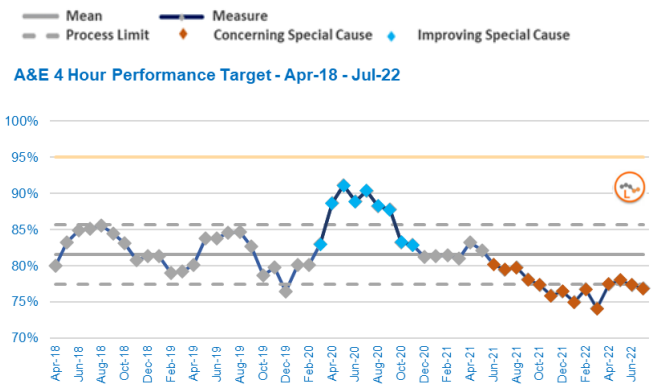
* Unvalidated Data

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.

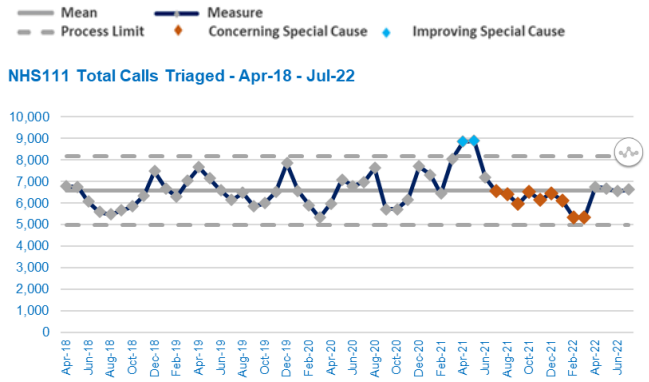


The charts include data from April 2018 to June / July 2022 to demonstrate the fluctuation in performance as a consequence of the pandemic.



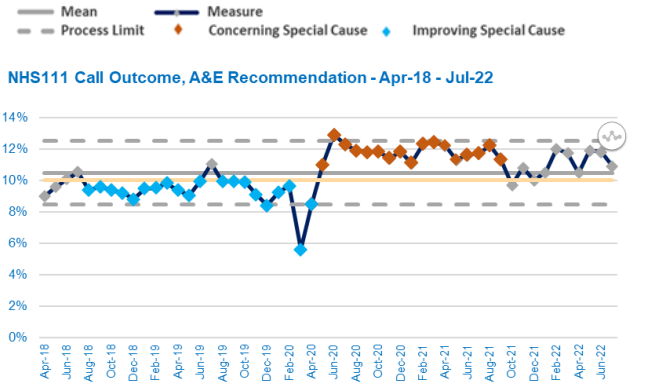
4 Hour A&E Performance (Target 95%)

Combined 4 hour performance across both A&E and UCC attendances at LTHTR during July 2022 is reported at 76.9%. This is a deteriorated position compared with the previous three months and is below the SPC charts lower process limit.



NHS 111 No of Calls Triaged

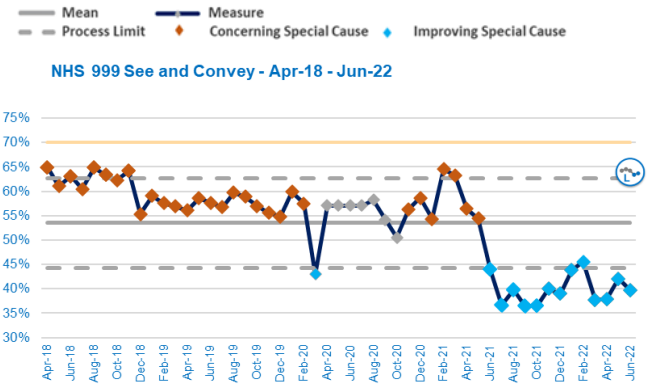
The total volume of calls triaged during July 2022 was 6,627 an increase of 75 triages compared with June 2022. Triage volumes compared to July 2021 show a 1% increase (6,562).



NHS 111 % A&E Recommendation

The proportion of NHS111 triages ending with a recommendation to attend A&E decreased during July 2022 to 10.9% (June 2022, 11.8%).

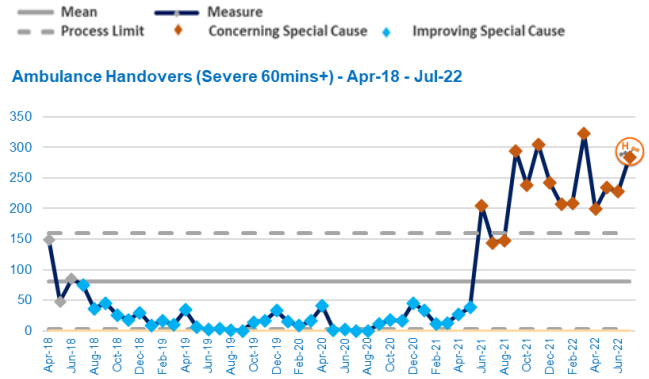
The actual number of patients with a recommendation to attend A&E in July 2022 was 723 this was reported at 770 referrals during June 2022.



NHS 999 See and Convey

The proportion of NHS 999 calls with an outcome of See and Convey during June 2022 was 39.7%, a decrease from 42.1% reported in May 2022.

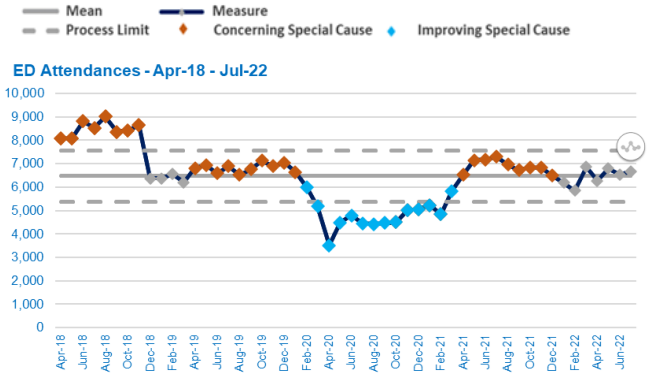
In June 2022 there were 2,557 conveyances to hospital an average of 85 per day. This is a decrease of 128 compared to May 2022 (2,685, 87 per day) and a decrease of 624 conveyances when compared to June 2021 (3,181).



Severe Ambulance Handovers (over 60 minutes (Target 0)

Handover delays remained significantly high. In July 2022, 284 patients waited over 60 minutes to be handed over with 673 patients waiting over 30 minutes.

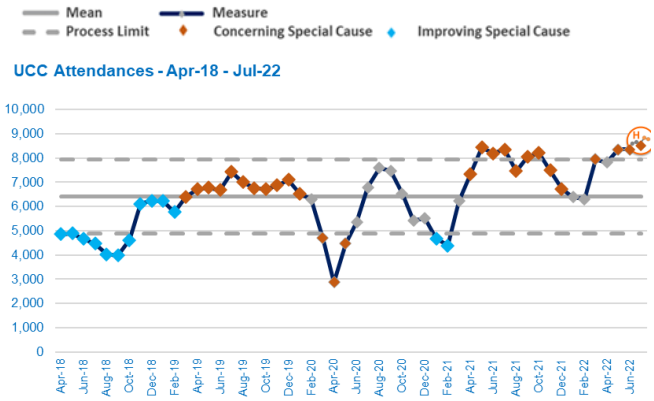
Ambulance handover delays has been identified as a national priority due to the impact holding patients has on their outcomes. The expectation was that there would be no 60 minute breaches from the 1st April 2022.



A&E (ED) Attendances

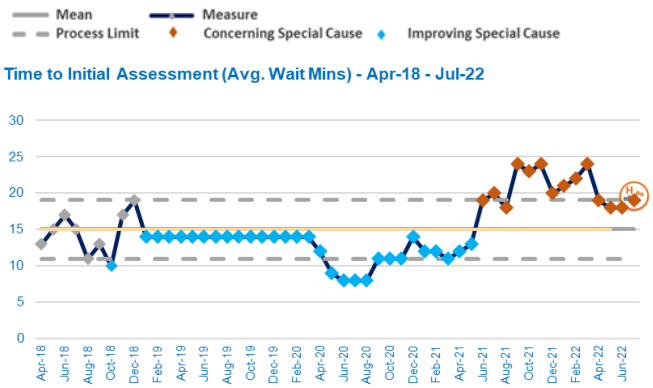
Total monthly volumes of ED attendances at LTHTR sites remained relatively stable over the last 5 months reported March - July 2022. During July 2022 the average volumes of daily attends to ED was 215, a slight decrease from previous month (June 2022, 218).

Average daily attendances at Chorley ED is reported at 68 during July 2022, an increase of 3 attendances per day compared with June 2022 (65).



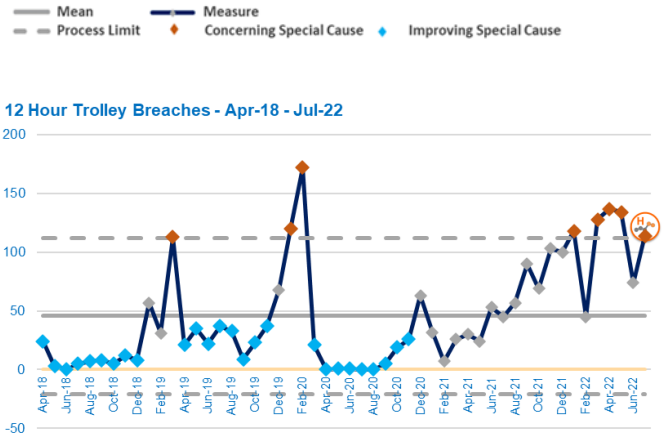
Urgent Care Centre (UCC) Attendances

Total volumes of Urgent Care Centre attendances increased during the month July 2022 however on average, the daily volume of attends has decreased to 275 compared to 279 during June 2022.



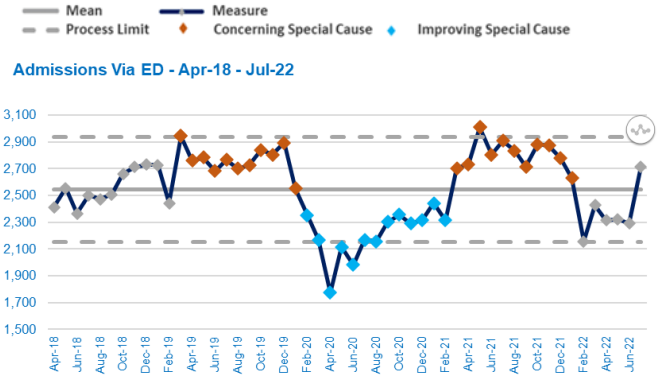
A&E Average Time to Initial Assessment (Target 15 mins)

Time to initial assessment during July 2022 is reported at 19 minutes. This is an increase of 1 minute compared with June 2022. This position remains above the 15 minute target.



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.



Admissions via ED

During July 2022 volumes of admissions via ED increased to 2,715 compared to 2,290 reported in June 2022.

Average admissions per day during July 2022 is reported at 88 (Jun-22, 76). Compared with July 2021 this is a slight decrease (Jul-21, 90).

Mental health: children and young people

Child and Adolescent Mental Health Services (CAMHS) have continued to see an increase in referrals, and an increased complexity of needs which has caused children and young people (CYP) to remain in services for longer. Services continue to be transformed in line with the evidence-based THRIVE model, which was developed with NHS organisations, local

authorities, education, the Police, representatives from the voluntary, community, faith and social enterprise (VCFSE) sector, parents, carers and young people.

An additional £10.7 million of government funding has been awarded over a three-year period to help reduce waiting times, improve experience and quality of care, and ensure consistent levels of care are provided across the region. Priorities include increasing access to services and enhancing support for CYP who need more help and risk support through further development of crisis care, and making sure there is support 24/7 – reducing hospital admissions.

The funding has contributed to an increase in staff who are trained and experienced in working within the community to promote positive mental health and wellbeing – providing advice and support when required. Response and Intensive Support teams also have been recruited, supporting CYP requiring an urgent or crisis response (up to four hours) through assessment and brief response within A&E and community settings. New Risk Support Liaison Workers (RSLWs) have been created to support CYP who are unable to access an evidenced-based intervention. They provide consultation, advice, support and training to the local workforce, parents and carers to enable delivery of an AMBIT (Adaptive Mentalisation-Based Integrative Treatment) approach.

Mental Health Support Teams (MHSTs) provide specific extra capacity for early intervention and ongoing help within a school and college setting. Following the establishment of six new teams in 2021/22, two more will begin working within allocated schools and colleges in Morecambe Bay and East Lancashire during 2022/23. This brings the region's total to 18 and delivers against the NHS Long Term Plan ambition of 25% coverage by 2023/24.

Mental health: adults

From April to July 2022, the eight CCGs continued to work collaboratively with providers and stakeholders as part of the Integrated Care System to increase and transform mental health services for the Lancashire and South Cumbria population:

Specialist Community Perinatal Mental Health (PMH) services continue to expand in line with the NHS Long Term Plan ambitions, providing specialist care to new and expectant mothers with moderate to severe needs up to 24 months following birth. For 2022/23, the growth is focused on developing support in terms of psychological therapies. This includes parent-infant therapy and systemic family therapy. As of May 2022, the service has supported 272 women – slightly above the national trajectory. Peer support and partner assessments are also now provided as part of the service.

In response to the NHS Long Term Plan ambition to establish **Maternal Mental Health Services (MMHSs)** in all areas of England by 2023/24, the Lancashire and South Cumbria Reproductive Trauma Service went live on 28 March 2022 with an official launch on 8 June. The service, provided by Blackpool Teaching Hospitals NHS Foundation Trust, works collaboratively with the maternity services at every trust in the region to serve the whole population.

A total of 139 referrals were accepted in quarter one, and 61 women have started treatment. Most referrals are made by the Specialist Perinatal Community Mental Health team and the

specialist perinatal midwives. The service offers support and therapies to those who have experienced birth trauma, fear of childbirth (tokophobia) or perinatal loss (including early miscarriage, stillbirth, neonatal death, termination of pregnancy, and separation at birth). Fathers, birthing partners or co-parents of mothers accessing the service will be offered an assessment and signposted as appropriate.

The specialist team includes maternal mental health midwives, psychological therapists, mental health practitioners, peer support coordinators and volunteers with lived experience. The service is being co-produced with people with experience of reproductive trauma and/or loss to gain a better understanding of their needs. To help explain the services on offer, a film was produced in collaboration with four mothers. Please note that contents may trigger unsettling feelings for individuals affected by birth trauma and/or loss. The film is also available with subtitles.

Lancashire and South Cumbria NHS Foundation Trust (LSCFT) is continuing to mobilise the **Initial Response Service (IRS)** which will provide a single point of contact for all mental health urgent and routine referrals via one 24/7 phone number and a dedicated email address in each locality. The new service 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 – an average of 250 per day.

The process will be gradual, initially launching with the Police and North West Ambulance Service before being extended to GP practices. The Central Lancashire and West Lancashire model is based at the Avondale Unit on the Royal Preston Hospital site, and commenced in May 2022. The Bay and Fylde Coast IRS plan to soft launch in winter 2022. Work is underway to enable appropriate NHS 111 calls to be transferred to the IRS.

Crisis alternatives such as The Central Lancashire Haven and Blackpool Light Lounge have been developed with our VCFSE 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. A re-procurement process for a crisis housing provision across Lancashire and South Cumbria is underway, with an additional crisis house for the Morecambe Bay area. Crisis houses offer short-term accommodation for people experiencing a mental health crisis and provide holistic therapeutic support and interventions to prevent hospital admissions.

In line with a national rise in referrals, Lancashire and South Cumbria **Eating Disorder service** has seen a significant increase in referrals in all age groups. The increased demand on the service, experienced during covid, has continued into 2022/23. To reduce waiting times, the service has now partnered formally with BEAT eating disorder charity to deliver assessment and treatment to adults and young people with routine needs. The service has undertaken a full review of all pathways and an external review of the clinical model, which has resulted in exceeding the waiting time target for urgent assessment and treatment of people with an urgent need for eating disorder support.

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 have set up a procurement framework for the VCFSE, which currently has 58 organisations listed. The framework has been used to procure peer support services for East Lancashire, Central and West Lancashire, and Lancaster – a peer support service is currently being procured for South Cumbria.

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). Building on the 26 appointments made during 2021/2022, roles for the 2022/23 cohort are currently being confirmed with the PCNs before recruitment can commence. Several additional 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** was implemented, between April and June 2022 an additional 22 whole time equivalents were recruited into these pathways. Additional VCFSE services for low complexity eating disorders will also be offered as part of the hubs' VCSFE signposting – and will be procured in quarter two of 2022/23. Rehabilitation staff will be recruited from quarter two of 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 ICS has developed an information dashboard to support primary care in delivering **physical health checks for patients on the serious mental illness (SMI) registers**. A steering group has been established to help support and drive the delivery of the health checks. A new digital remote monitoring project works across the system with a range of stakeholders assisting in delivering the checks. An improved offer for physical health monitoring and medication monitoring for SMI patients has been developed, including additional staff, improved electronic patient record keeping, and increased access to devices like echocardiograms. ECG rollout and recruitment will commence in quarter two of 2022/23.

The Individual Placement and Support (IPS) service has been extended into Community Mental Health Teams (CMHTs), with a phased rollout as additional employment specialists are recruited. The full project team includes new care plans and safety plans. Staff will be provided with tablet devices in order to use DIALOG+ – an app that guides mental health staff in their conversations with patients about the different issues affecting their quality of life. Through 'solution-focused therapy', they work together to solve the issues and build care plans.

As this can be used as both a patient-reported outcome measure (PROM) and to support interventions, DIALOG and DIALOG+ will be implemented from October 2022 to support the move away from Care Programme Approach (CPA). The care coordinator role will be replaced with a new key worker role that can apply to all members of a multi-disciplinary team (MDT).

Improving Access to Psychological Therapy services across Lancashire and South Cumbria continue to work towards expanding access while improving in-treatment waits and maintaining

the existing positive performance with regards to referral-to-treatment times and recovery standards, in line with national targets.

Figures for April and May 2022 project IAPT performance for 2022/23 at 31% below the NHS Long Term Plan ambition (9,175) and 17% below the recovery trajectory (7,630) – a reduced target which was agreed with NHS England. Lancashire and South Cumbria IAPT access was 36% below plan for 2021/22. Several actions are in place to improve performance for 2022/23:

The national IAPT Lead is to undertake a review, in collaboration with LSCFT and the ICB, and provide ongoing support with several high-impact actions

Creative World has been commissioned to deliver a package of promotional activity and market research

A digital triage pilot is being scoped

Investment into IAPT trainees for 2022/23 has been prioritised

Trajectories have been developed by each provider to support the delivery of the NHS Long Term Plan ambition over the next two years.

The other national standards for recovery and referral to treatment times were all met during the reporting period.

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. Our combined and collaborative responses to intelligence reporting have contributed to a 16% reduction in suicides across our area over the past 12 months.

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 10, the campaign is focusing on the cost of living and providing support services and encouraging residents to reach out for help at the earliest opportunity.

More than 6,000 people have been trained in suicide prevention and self-harm. More than 1,800 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 also been rolled out across Cornwall, Devon, Somerset and Worcestershire.

Digital - Our vision for digital and data transformation

Digital and data will enable the transformation of care and care pathways improving the outcomes for the population of Lancashire and South Cumbria.

Our citizens will become empowered take control of their own health and wellbeing. We will support our population to stay healthy and live well through insights and innovative technology.

We will empower our workforce with digital skills to become fully agile and digitally connected to the wider health and social care environment and to make timely intelligence-driven decisions.

Digital Transformation

The way we manage our lives is changing. More and more households now have internet access, go online every day, and use a smartphone.

It is now time to embrace this rapidly increasing digitalised world and manage our own well-being, health and social care needs. With two-thirds of visits to the nhs.uk website being on smartphones, there are clear indications that a majority of people are ready to go online to understand and manage their health and care needs.

Lancashire and South Cumbria is home to a growing population. More of us are getting older and experiencing long-term health problems. Some of this disease could be avoided or the ill-effects slowed down if we took positive action. Using digital is one approach to help address the challenges we all face.

In 2018, Lancashire and South Cumbria published its ‘Our Digital Future’ and set out partnership working as a system. This strategy outlines a set of principles aligned to inter-connected themes. Read more here https://www.lancashireandsouthcumbria.icb.nhs.uk/our-work/digital-transformation

Stroke

The Covid-19 pandemic continues to impact on stroke services. This is due to people staying away from hospital, the backlog of stroke reviews and check-ups and challenges in staffing and resources. It is possible that these issues are also contributing to the rise in strokes across the region, as admissions are rising across all trusts. As a consequence, acute stroke centres have not yet returned to the level of services achieved before the pandemic.

In response, Lancashire and South Cumbria Integrated Stroke and Neurorehabilitation Delivery Network (ISNDN) has set up an Operational Implementation Group to oversee the implementation and delivery of improvements to acute stroke centres. Progress is being made in several areas of development. Ambulatory care is now operational in most trusts, although some challenges in recruitment remain and a seven-day service has not yet been achieved across the region.

The public engagement on the implementation process has now closed. Although the response overall was disappointing, sufficient feedback has been received to identify a range of issues and concerns from patients and members of the public. A report of findings has been produced, which is now under consideration.

Plans to extend the thrombectomy service in a phased approach over 2022/23 have been put in place, but recruitment to key roles is proving challenging.

Improvements to 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.

The use of artificial intelligence for stroke in each of the local acute trusts has enabled earlier identification of stroke patients – resulting in increased numbers of patients receiving thrombolysis and thrombectomy treatment.

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.

Diabetes

More than 100,000 people aged 17 and above 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 is crucial to diagnose the condition as early as possible and identify those at risk so they can be supported in making healthier lifestyle choices.

In Lancashire and South Cumbria people identified as being at risk are offered tailored support through the local Healthier You service. Healthier You is a nationally-commissioned diabetes prevention programme aimed at reducing the risk of developing or delaying the onset of Type 2 diabetes. The latest evidence shows the programme can have a major impact on people's lives, and almost one million people have been referred to the programme since it was first launched in 2016 with participants who complete the programme achieving an average weight loss of 3.3kg. During April and May 2022, there were 856 referrals to the programme.

In April, commissioners awarded a new contract to continue the NDPP service across the region. Reed Wellbeing will take over from 1 August 2022, and work is underway to support the transition. Patients who have already started a programme with the outgoing provider will see the programme through to completion.

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 suspended during the pandemic, although a number of digital support resources were available online. 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 We are reviewing the provision of structured education for all diabetes patients for 2022/23 and additional sources of information will be available from the national team.

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. We aim 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.

We have completed detailed pathway analysis identifying demand and capacity to target our resources for those at greatest risk and deliver improved outcomes for patients. Our innovative approach to screening with the faecal immunochemical test (FIT) and the 'double FIT' initiative received recognition in the British Medical Journal and we continue to work with health partners to deliver innovation for our patients.

Funding from the Small Business Research Initiative (SBRI) has enabled us to rollout the 'sponge on a string' cytosponge test within primary care. Sites have been selected that will provide patients with access to diagnostics in a community setting and our priority is to shorten waiting times between referral and diagnosis to ease pressure on secondary care endoscopy services which are significantly stretched.

A joint bid with our innovation partner, Cyted, has also been submitted for further SBRI funding to deliver CYTOPRIME2 which will continue innovation in cancer diagnosis. Targeted Lung Health Checks continue with eligible patients in Blackpool, Blackburn with Darwen and now Rossendale benefitting from improved outcomes through earlier detection.

Maternity

The Lancashire and South Cumbria **Maternity and New Born Alliance (MNBA)** has continued to work with partners to deliver the requirements of the National Maternity Transformation Programme to make sure all women, their babies and their families experience safe, kind, compassionate and personalised care.

The Covid-19 pandemic has enforced unprecedented staffing pressures across the system, but all providers have continued to maintain safe services whilst also responding to national demands, such as those laid out in the Ockenden Report's Immediate and Essential Actions (IEAs). Services which were forced to close during 2020/21 have all been reinstated and wherever possible (by monitoring staffing levels daily), women have been able to give birth in their chosen setting.

All four maternity providers successfully submitted their evidence for the **Ockenden IEAs** against the interim report, which was published in December 2020. The full report was published in March 2022.

The system-wide rollout of the **Maternity Information System (MIS), Badgernet** is now fully into the implementation phase with Lancashire Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, University Hospitals Morecambe Bay NHS Foundation Trust, and Blackpool Teaching Hospitals NHS Foundation Trust actively using the new system.

Women can use the service to access a personal care record securely and digitally via an app/portal, where they can manage appointments, communicate with midwives, view clinical information, receive notifications and have instant access to their pregnancy information. Following a successful in a bid for funding from the NHSx Unified Tech Fund, the Digital

Maternity programme can support improving interfaces, essential hardware purchases, 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 – agreeing on standardised job descriptions and delivering a bridging training programme to upskill the workforce. Apprenticeship pathways will now be explored to 'grow our own midwives' during these times of significant national staff shortages.

In May 2022, a system-wide preceptorship pack was implemented in readiness for the next intake of newly-qualified midwives. This work has been recognised regionally and nationally with other trusts and Local Maternity Systems (LMSs) also looking to adopt this package.

Training Needs Analysis has been completed for **system-wide Essential Maternity Training** – accurately detailing the training that all midwives must complete to be fully compliant. This is set to continue as new, mandated training arises from reports such as Ockenden, and work continues with the trusts to support them to achieve compliance.

Trusts have also received national funding to support staff retention for both midwives and MSWs and 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, the development of a staff and student resource hub has been commissioned in partnership with the University of Central Lancashire (UCLan) and the University of Cumbria. The hub will host information, provide resources and training links for all students and staff working within maternity services across Lancashire and South Cumbria. This formally launched early in 2022/23 and continues to be developed.

The **Choice and Personalisation workstream** recently launched two new resources – a choices summary booklet for women and families and an informed consent poster.

The **Perinatal Pelvic Health Service** commenced in June 2021 in accordance with the NHS Long Term Plan. Training resources and a risk assessment/screening tool have been developed and physiotherapists recruited into specialist training posts. The programme now has strong service user involvement through the local Maternity Voices Partnerships (MVP) and delivery of the work plan is now underway.

The main aims of the LMS Quality function are to understand all relevant information for Lancashire and South Cumbria in relation to quality and safety in maternity services, and to ensure robust reporting mechanisms are in place to support governance and **quality assurance** processes. The 2021/22 focus was to further develop and establish the information flows and reporting structures with key partners across the region, including commissioners, providers, NHSE/I, Clinical Networks and MVPs.

A defined process and governance reporting structure have been signed off by the MNBA Board. These detail what information will be gathered and analysed, to allow any key themes, risks and good practices to be identified. A Quality and Performance Manager commenced their role in January 2022 to drive the quality assurance agenda. A system-wide intelligence base and a baseline quality standard were developed for the LMS and collated before April 2022.

The LMS Maternity Assurance Panel was formed in response to the Ockenden Report as part of a revised perinatal quality surveillance model (December 2020). The Panel is Chaired by a Non-Executive Director who is responsible for discharging the quality responsibilities, and has continued to meet regularly. The essential actions arising from Ockenden identified that serious incident reports must still be shared with the LMS. A standard operating procedure for StEIS Reportable Incidents is now in place between providers, commissioners and the LMS so that timely notification of reports and investigations are shared. A member of the LMS assurance panel now attends the individual CCG Serious Incident Panels to review and discuss each incident. Bi-monthly incident reports are collated across the region, with six monthly thematic reviews undertaken, to allow any key learning and improvements to be promptly shared and enacted.

At present, the LMS does not hold statutory responsibilities for quality issues, so CCG Quality Leads and providers continue to support the LMS to safely discharge their duties.

Lancashire and South Cumbria Maternal Mental Health Service: The Reproductive Trauma service is being standardised across the system – incorporating both the Early Implementor and Fast Follower services. This will ensure a robust integrated psychology/maternity offer for women and their families needing specialist support and intervention due to birth trauma/loss and tokophobia (during their maternity, neonatal or perinatal experiences) and enduring moderate to severe mental health difficulties.

Consultation and co-production are at the heart of the service, with the voices of women, fathers, partners and co-parents informing future work. Collaboration with key partners has enabled the development of tools and resources which enhance the service. Connections are being made with relevant VCFSE organisations to explore collaborative opportunities to create wrap-around support at a local level for women and their families. UCLan is evaluating service development, by sharing excellent practice from a national/international perspective which should give clear evidence of the impact across the system. Laying strong foundations has been key to establishing a clear training plan, robust systems, documents, policies, processes and a clear governance structure, which were all fundamental in supporting ‘go live’ in March 2022.

The perinatal mental health workstream, led by colleagues within the North-West Coast Clinical Network is part of the ICS Mental Health programme. This work continues to improve access rates for women to specialist perinatal mental health services and to develop specialist pathways – including parent and infant and Perinatal Psychiatric Emergency.

Prevention and infant feeding: The extended-hours breastfeeding helpline and the LatchAid Breastfeeding Support digital app pilot schemes that launched last year were combined with extensive training across multiple disciplines.

System level working has continued the Baby Friendly Initiative awards and the following services now have gold accreditation: East Lancashire Hospitals NHS Trust (ELHT) Maternity Services, Lancashire Children and Family Wellbeing Service and Virgin Care 0-19 Service, Blackburn with Darwen Children’s Centres and LSCFT’s 0-19 Service, UCLan’s Midwifery and Health Visiting Programmes.

As per the NHS Long Term Plan, an in-house standardised Tobacco Dependency Service in Pregnancy model is now fully implemented at Blackpool Teaching Hospitals NHS Foundation Trust and at the University Hospitals of Morecambe Bay NHS Foundation Trust. It will be implemented at ELHT by September 2023, and at Lancashire Teaching Hospitals NHS Foundation Trust by March 2024. This includes standardised Smoke Free Pregnancy annual training for staff and a CO (carbon monoxide) Monitoring service, which has continued throughout the pandemic.

A Trauma Informed Care Training package is also in place for maternity services. The training commenced in 2022 and the audience has been widened to cover maternity, perinatal mental health services, neonatology, early pregnancy gynaecology and Women's Aid services.

Strident efforts have been made to ensure uptake of **Covid-19 vaccinations in women during pregnancy** to maximise positive outcomes for expectant mothers and their babies. Following workforce training, a display of resources, printed materials, briefings and social media campaigns, there has been an increase in second dose uptake rates in pregnant women from 29% on 25 May 2021 to 69% on 6 July 2022. The regional target for the second dose is 70%.

The National **Equity and Equality Guidance** for local maternity systems was published in September 2021 and is currently being embedded into the existing work programme. Colleagues at NHS Midlands and Lancashire Commissioning Support Unit 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. There has been a delay in the next phase of the work due to the nationally-recognised pressures across all LMSs, but planned developments remain for 2022/23.

Our colleagues at **North West Coast Clinical Network** have continued to develop standardised guidelines, pathways, standard operating procedures (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 NWC), outlier escalation process and Saving Babies Lives 2 exemption process. The network also hosted two successful Northwest Coast Maternity Safety Summits in March and September 2021.

Paediatrics

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

The **Asthma Network** has worked on several projects relating to improving asthma care. We are taking part in a national pilot which aims to identify those children who are most at risk of an asthma attack to ensure they are on the most appropriate treatment. The asthma digital passport will be introduced in September as part of another national pilot. The Communications and Engagement team has supported the development of essential resources to enable the Asthma-friendly Schools programme to commence.

The **Diabetes Network** has been developed focussing on national priorities. We have refreshed our commissioning guidance for children who request a continuous glucose monitor and are now looking at any areas of inequality in the National Paediatric Diabetes Audit. A bid

has been submitted for national funding to support the transition to adult services, working with the VCFSE sector and local authority to design projects to provide support for children with Type 2 diabetes and help to prevent this in school-age children.

The **Epilepsy Network** has been established 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.

Specialist clinics for children and young people with excess weight have been established in Preston, ensuring that this care can be provided closer to home. This is part of a national pilot in partnership with Royal Manchester Children's Hospital and Alder Hey Children's Hospital. We are also working closely with the local authorities and VCFSE sector through the recently-developed **Healthier Weight, Healthier Futures network** to help children and young people achieve healthier lifestyles.

The focus of work in the **Surgery in Children Network** has been to address the backlog due to Covid-19. By July 2022, there is a requirement for no children to be waiting more than two years for their surgery, with further work being undertaken to reduce waits over 78 weeks.

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. Joint working with Together for Short Lives and The Kentown Wizard Foundation will introduce five specialist palliative care nurses across Lancashire and South Cumbria (as a national pilot), to further improve the care for children with life-limiting illnesses.

Other achievements include:

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

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 throughout the year. We are working on new models of care including virtual wards

The Integrated Care Board has ensured that children's and maternity services will have prominence in the new structures which will ensure that the voice of children and young people remain at the heart of new developments

The new ICB also creates opportunities to strengthen our links with the four local authorities. The team has 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 and 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 groups, 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 and finding solutions. Services have embraced the key principles of personalised care, which is listening, and respecting the contribution that a patient can make and 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 in 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 involving primary care, community and acute service colleagues. We provide a range of personalised care workforce training, including Make Every Contact Count (MECC), Patient Activation Measure (PAM) and Health Coaching. We have developed resources to help 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 so both online and face-to-face training can now be offered. We are now supporting colleagues in all our services to provide more choice and a personalised service to better meet patients' needs.

Digital Unite and ORCHA assist our coaches to support and train end-users with technology, from creating an email to accessing NHS services and utilise applications in a safe way, to support the five dimensions of health (physical, mental, emotional, spiritual, and social). The knock-on impact of Covid-19 has reduced availability of some NHS staff to attend sessions, however the recent Confed event in Liverpool discussed plans for new Health Coaching and Care Coordinator roles, with these skills of importance to their growing toolkit of support.

Following our Coproduction in Action (#CPiA) event in March 2022, we co-produced three workshops on project planning, bid writing, and pitching, and invited organisations from around the region to attend. From those workshops, more than 12 organisations have co-produced four unique pilot projects based on the CORE20PLUS5 health inequalities model.

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

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

further to go in its learning on how to do this and by working with partners, the model will continue to evolve.

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

As a system, an overarching strategy for population health is needed and will be shaped by the recommendations of the Health Equity Commission (HEC). The HEC was launched by Professor Sir Michael Marmot in September 2021, and is also chaired by him.

Workforce

The ICS developed a comprehensive plan to support and shape our workforce planning and development, to implement the requirements of the NHS People Plan, and to look more widely at the future ICB workforce functions and delivery of these. 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 has been taken in order to ensure we implement the local and national people priorities and expectations to develop and support the 'one workforce' and make the health and care system a better place to work and live.

Throughout the Covid-19 pandemic, provider trusts and the ICS workforce team have worked to support staff seeking to return to work through both national and local recruitment activities and most recently through the Landmark programme. Those staff have been integral to the success of the vaccination programme and whilst that continues, we are now focusing on how we might best retain them. We continue to develop a system-level deployment hub referred to as 'It's Your Move' (IYM) – building on the 2019 concept that has so far assisted more than 70 staff.

The ICS' Strategic Apprenticeship Group aims to create clear career pathways that will aid the recruitment and retention of staff, while also upskilling local communities. The group is focused on creating apprenticeships which are directly responsive to the population needs and workforce challenges in Lancashire and South Cumbria. Significant work has been done on levy sharing, workforce and pipeline planning, shared cohorts and rotational models. The group's 'Grow our Own' strategy highlights apprenticeship vacancies, but also aims to inspire people at every stage of their career journey. Its work to date has included mapping the nursing apprenticeship pathways for social care, and analysing system data to forecast and map gaps in the future workforce.

We celebrated the work of apprentices from across Lancashire and South Cumbria at the region's first NHS Health and Care Apprenticeship Awards. More than 250 people attended the ceremony, which was held at Stanley House in Blackburn and hosted by The Apprentice's Aaron Willis. The ceremony recognised the hard work, commitment and skill of the many apprentices working in health and care across the region.

The ICS has had a good track record of working with local voluntary services partners during the pandemic – particularly in mobilising volunteer support for the mass vaccination programme. There is also a current programme of work supporting and developing our approach to volunteering. This includes development and launch of a new Volunteers Jobs Board on the Careers platform. Alongside the Volunteers information pages, the Jobs Board will enable all Volunteer vacancies across the system to be displayed in one place for ease of searching and promotion.

Building on the success of our current employability programmes, we have now developed a range of programmes targeting Healthcare Support Worker (HCSW) vacancies. The employment programmes will be run across the system in partnership with trusts, Lancashire Enterprise Partnership (LEP), the Department for Work and Pensions, and Lancashire Adult Learning. An important aspect of our approach will be to work with partners focusing on how we access different 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. The programmes 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 in partnership with the care sector, local authorities, health colleagues and wider regional and local key stakeholders. A range of activities have been delivered including developments over the past year have been:

A health and wellbeing support guide for social care staff across the region

Promoting business and staff resilience through multi-partner Social Care Workforce Forums

A registered managers retention work plan with Skills for Care and NWADASS.

The ICS also has a social care workforce programme, which works in partnership with the care sector, local authorities, health colleagues and wider regional and local key stakeholders. Recently we have been working on succession planning model delivery with Skills for Care, IHSCM, regional partners and local care providers.

Most recently, the Social Care Workforce Forum received fantastic feedback as attendees heard from key speakers from the panels discussing workforce challenges and strategies targeting recruitment, retention and grow your career opportunities. Louise Taylor's opening remarks set the context for the journey ahead and the changes needed across health and care to move towards a partnership approach.

Diagnostic Imaging

The Diagnostic Imaging Network aims to achieve a high-quality, effective and accessible network of services throughout Lancashire and South Cumbria through collaboration, innovation, efficiency, patient and staff focus, along with a focus on quality.

The Network was established to enable local hospitals to work collaboratively to share best practice, secure additional funding and support each other. Capital investment secured during 2020/21 enabled the procurement of new CT scanners at some of the hospital sites and

enabled an increase in scanning capacity within community diagnostic centres. Further additional investment has funded new mobile CT and MRI scanners which will be delivered in September 2022.

Funding has been secured to increase training and development provision for radiographers and sonographers, and further increase the number of apprentices. Additional capital has been secured to upgrade the radiologist training facility in Preston ensuring capacity for additional trainees in the future.

Five-year recruitment plans have been developed in order to increase the number of radiographers and radiologists, which will ensure we have adequate workforce numbers to meet increasing demand. A single demand and capacity analysis tool has been developed and rolled out to enable a standardised approach for future clinical service planning decisions across Lancashire and South Cumbria.

Learning disabilities and autism

Our separate all-age strategies for learning disabilities and autism were completed in April 2022. These were developed alongside stakeholders and individuals with lived experience. We have continued to improve learning disability and autism services and have increased investment in several areas:

We have commenced recruitment to a Health Facilitation team as part of a three-year Annual Health Check programme that will support GP practices to increase the number of health checks undertaken for people with a learning disability aged 14 and over. Additional investment has been secured to specifically target people who did not receive a health check in 2021/22.

Undertaking a system-wide review of care and accommodation vacancies has enabled us to forward plan against effective discharge activity and developed strategic relationships with housing providers to understand current and future provision.

We have developed and launched a complex case-supported living framework that will significantly increase our ability to meet the bespoke needs of individuals and enable better matching with providers. We have also recommissioned and mobilised our Community Forensic Service.

A 12-month Autism Diagnostic Validation pilot has commenced for mental health admissions where autism spectrum disorder (ASD) is queried or unvalidated. A system-wide review of all-age autism capacity and demand has commenced, and we have implemented a statistically-analysed case for required system investment in autism services to meet demand. We have recommissioned an adult diagnostic provider (to commence in July), that will focus on backlog activity until September 2022, with a service provision from October 2022.

We have established and embedded a children and young people (CYP) digital autism referral system-wide process to support consistency and streamlining the process across the ICB. A system-wide autism support hub has launched. This will bring clinicians and autistic people together to share knowledge, ideas, best practice and communications with additional content being developed throughout the year.

We have commenced recruitment to our Senior LeDeR (learning from lives and deaths of people with a learning disability or autism) Reviewer post, who will also have an ICB focus on health inequalities, to ensure learning continues to be shared and encouraged locally and across the system.

Improvements have been made to the number of adults with a learning disability and autism who are in specialist inpatient care. This will continue to be a challenge and remains a focus of the ICB. Our CYP inpatient performance remains below trajectory.

We are still facing challenges relating to increased numbers of referrals for children and young people ASD assessments, along with significant waits. This remains a continued focus of the ICB team. The outcome of the Niche evaluation will hopefully support an investment profile for future funding.

The number of people with a learning disability who are accessing annual health checks remains a challenge across the system. However, targeted activity to support this represents a key opportunity to increase the number of health checks undertaken. Delivery of health checks for those who were outstanding from 2021/22 has already commenced in quarter one of 2022/23.

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, there are an estimated 6.1 million people in England currently living with cardiovascular disease (CVD).

In August 2021, a Cardiac Network was formed in Lancashire and South Cumbria to facilitate the nationally-mandated Cardiac Pathways Improvement Programme (CPIP).

The Cardiac Pathways Improvement Programme in Lancashire and South Cumbria has helped identify significant opportunities for earlier diagnosis and better proactive management of CVD with particular focus on 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 Population Health team and 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. Together these teams will work on the CORE20PLUS5 requirements for CVD.

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. In February 2022, our cardiac network, in collaboration with Lancashire and South Cumbria Community Diagnostic Centres team, successfully ran an ‘echothon’ – delivering echocardiograms 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. The initiative reduced the waiting list by 12%

in just two months and reassured those who have been waiting longer than necessary for a scan.

The Cardiac Network was successful in a bid to develop face-to-face cardiac rehabilitation services in Morecambe Bay to help level-up services across the system. We also working on an end-to-end Heart Failure Pathway engaging with stakeholders from across the system, including community services, patients and their carers. We will be developing several specialist end-to-end pathways over the next two years.

Funded care

During Q1 of 2022/23, the funded care work programme continued to work in partnership across the NHS and local authorities, meeting regularly to discuss the redesign of the whole NHS funded care service. Each element of the service is still 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 is gathered and fed into the Funded Care Group. Patients, carers and family members with lived-experience of the current processes joined the Funded Care Implementation Board (which oversees the programme of work) in 2021/22 as representatives who can help the team shape the redesign work and continue to sit on the FCIB and be part of the workstreams that they have a particular interest in.

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 throughout 2022/23.

Elective care

Recovering long waiting times that were impacted by the Covid-19 pandemic is a priority for the NHS. The extraordinary achievements of staff over the last two years are a testament to their determination and resilience. 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 a consistent focus on elective recovery in the future. Supporting staff is also a

key part of the recovery of elective services, recognising that staff need to be looked after so they can provide optimal care for patients. Together, this plan will help the NHS deliver millions more tests, checks and procedures to patients in England.

During 2021/22, the Accelerator funding from NHS England proved fundamental in helping us in Lancashire and South Cumbria to 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 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. Targeted Investment Funds (TIF) were also secured to further support elective recovery – schemes included increasing elective capacity, critical care capacity and digital solutions.

Additional TIF funding for providers in 2022/23 further supported elective recovery. Bids have been submitted by all four acute provider trusts and include expansion of theatre capacity, additional endoscopy capacity and beds to help ringfence elective activity. This will support faster treatment of cancer patients and help further reduce long waits.

Key priorities for 2022/23 include outpatient transformation, which focuses on reducing the number of follow-up appointments by increasing the use of Patient-Initiated Follow Up (PIFU) pathway and increasing the use of Virtual Consultations and Advice and Guidance. The ChatBot pilot (a waiting list validation programme using artificial intelligence (AI)-automated and human operator calls) has helped us to contact long waiting patients and is now being rolled out across all providers. Likewise, the Morecambe Bay, the Set for Surgery programme which aims to optimise the health of all patients who are approaching surgery to help reduce cancellations and improve their post-operative outcomes is also being rolled out system-wide.

Work on theatre productivity and utilisation will continue with a refreshed focus on the Theatre Right work and our Clinical Networks will look to reduce variation and improve performance against High Volume Low Complexity (HVLC) standards. We are on course to have no patients waiting longer than 104 weeks by the end of July 2022 and have committed to reducing the number of patients waiting over 78 weeks to zero by March 2023.

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 and suffering the greatest losses. Covid-19 patients in the region occupied an average of 10% more hospital beds than the rest of England. Added to this, the North West spent almost two months longer in lockdown compared with the length of lockdowns in the rest of the country.

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. 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 and Integrated Neighbourhood Care covers a range of services for patients including GP practices, pharmacies, optometry and dentistry. This annual report 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 despite some of the intensity of the early days now easing with successful vaccine programmes and milder variants, the impact of covid has created pressures for all health and care organisations. We are seeing sustained rises in demand on primary care services as well as witnessing significant workforce challenges. Despite these challenges and the continued uncertainty of the COVID-19 pandemic where rates are once again rising, our primary care staff continue to demonstrate their commitment and professionalism. In our annual report for 2021/22 we took the opportunity to thank our staff for their remarkable contribution to delivering their day-to-day services and in supporting the vaccination and booster programme. That recognition of their continued dedication is also integral to our final CCG report for quarter one.

Our future way of working will bring greater integration between GP practices, pharmacy, dentistry and optometry with the delegation of commissioning responsibility for GP Practices and pharmacy taking place on 01 July 2022 and for dentistry and optometry the 31 March 2023. We have worked closely with our two Associate Clinical Directors Dr Lindsey Dickinson and Dr Peter Gregory to offer assurance to NHS England that we meet the criteria required for such an important responsibility. At the time of writing, the first phase of delegation has been successfully completed and we are now commencing preparations for further delegation next year. During this time there has been a greater emphasis on partnership working particularly with our NHS E colleagues and our focus will be to continue this very successful collaborative approach in the future.

GP practices continue to provide a more flexible approach to appointments. We 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. The latest GP Patient Survey data shows that, in line with the national average, 59% of patients were offered a choice of time, place and type of appointment as well as being offered a choice of healthcare professional. 73% of patients were satisfied with the appointment they were offered and 84% of patients agreed that reception staff were helpful2.

In the three months covered by this report (April – June 2022) data from NHS Digital demonstrates that GP services continued to increase the number of appointments available. In our last annual report, we presented data that showed 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. We are delighted to note that the most recent data available shows that in April and May 2022 the number of available appointments continues to rise with more than 1.5 million appointments across Lancashire and South Cumbria in just those two months[3].

[3] Appointments in General Practice, May 2022 - NHS Digital

As part of the valued contribution to commissioning decisions and service improvement our clinical colleagues contribute at both place and across Lancashire and South Cumbria, offering their expertise and knowledge. To ensure this continues we have supported the development of an interim GP framework to so that decisions and programmes of work remain clinically led. Interim GP sessions are now in place to cover a number of priorities including mental health, cancer, population health and safeguarding.

In May 2022 we held our first GP Improvement week. The initiative brought together a number of partners who manned a control room at one of our practices for one week in order to identify any issues, barriers and good practice which could improve patient experience. The Thornton Practice, led by Dr Tony Naughton and part of the Torentum PCN was our pilot site. Supported by colleagues from NHS England we identified a number of key issues and implemented solution-based measures in real time. The results of the week are still being analysed but look very promising and we intend to rollout the programme across a selection of practices in Lancashire and South Cumbria.

In our last annual report we spoke about our ambition to improve access to primary care and to help patients to access the best service for them. One way in which we intend to do this is to increase the workforce with more GPs and more staff providing additional roles which support patients to access high quality care in a timely way. To date we have achieved a 10% increase in GPs against our target which means we have another 18 doctors in post and we have recruited almost 500 additional support roles.

As always our patients come first and in order to understand their needs we have made a strong commitment to patient involvement. We have commenced an audit of our patient participation groups and will strengthen the support to practices to recruit more patient voice members and continue to bring these groups together to share good practice and support each other.

We have also held a number of focus groups with patients to understand barriers to accessing services. With this information we intend to work closely with our urgent and emergency care colleagues to ensure clear and consistent messaging, particularly during the winter when demand is higher, to enable patients to get the right care when they need it.

We recognise that not everyone wishes to engage with primary care through digital solutions, but for many this offers quick, convenient and accessible ways in which to experience a range of services. Our work continues to improve video consultations and triage software solutions, telephony and the use of the NHS App[4].

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.

Finally, we remain committed to tackling health inequalities. The disparities in life expectancy for people born in the most deprived areas of Lancashire and South Cumbria represent one of our biggest priorities and also one of our most significant challenges. As we move from Clinical

[4] https://www.gp-patient.co.uk/

commissioning groups to an Integrated Care Board, there is an opportunity for primary care, often the front door of the NHS, to be at the heart of integrated working to improve not just life expectancy but the quality of everyday life for our residents.

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 ICB 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 funding and 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 ran throughout 2022 and the first quarter of 2022/23, and facilitated better partnership working, as well as enhanced the VCFSE sector's role in strategy development and the design and delivery of integrated care. Lancashire and South Cumbria VCFSE Alliance have held several workshops with wider sector partners to focus on strategy and partnership development.

Lancashire and South Cumbria ICB 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 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.

Initially the network was asked to facilitate the setup of the Post-Covid Service with stakeholders from across the region. However, 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 which prompted the formation of the Integrated Respiratory Network Delivery Board (IRNDB).

Since then the six NHSE/I respiratory workstreams have active programs, which include quality improvement and quality assurance. As part of the network's role to enable service transformation and standardise care for patients across the region, we are leading in pulmonary rehabilitation, early and accurate diagnosis and breathlessness.

Many of our respiratory programmes are interdependent on other Integrated Care System programmes and we are making sure that all our stakeholders and ICS colleagues are aligned and collaborating.

Three new Clinical Leads are in post in addition to our pulmonary rehabilitation lead Catherine Edwards to ensure representation from across all disciplines which assists identification of system needs, the adoption of new projects, programme implementation and governance.

Sharing the Respiratory Clinical Lead roles will be Dr Sharada Gudur, Acute Clinical Lead (Lancashire Teaching Hospitals NHS Foundation Trust) and Dr Stuart Berry, Primary and Digital Clinical Lead (East Lancashire GP). The Diagnostic Lead is Dr Kathryn Prior (LTHT).

New Hospitals Programme

Following the publication of our Case for Change report in July 2021, the Lancashire and South Cumbria New Hospitals Programme is now in 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 has progressed; however, it continues to have a backlog of policies (both existing and proposed) created by the Covid-19 pandemic. In recent months, the departure of a few key members of the Policy Review team has also had an impact on the capacity to get the review process back on track.

Many of the second wave of 31 evidence-based interventions (EBI2) developed by NHS England have been implemented, but some lower priority procedures still remain. These tests, treatments or procedures have been assessed on behalf of 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.

Five policies have recently completed public engagement. These include Continuous and Flash Glucose Monitoring (CGMs) for people with diabetes, the provision of wigs, hernia surgery and chronic rhinosinusitis (an EBI2 policy). The engagement feedback for each policy has been analysed and reports of findings produced. Due to the release of updated NICE guidance on CGMs during the engagement period, amendments to the policy in line with NICE guidance and with patient feedback has been fast-tracked and this policy has now been ratified.

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 this year.

Urgent and emergency care

2022 priority setting and operational planning was undertaken against a backdrop of the challenge to restore services, meet new care demands and reduce the care backlogs that are a direct consequence of the Covid-19 pandemic. This was delivered whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes. The Urgent and Emergency Care Network (UECN) in Lancashire and South Cumbria, the ICS, along with each local A&E Delivery Boards, developed the ICS Operational Plan for Urgent and Emergency Care for 2022/23.

This detailed plan describes several programmes of work to be undertaken across the whole system during the year:

Transforming access to urgent and emergency care services (NHS 111 First)

999 Ambulance Services and Patient Transport Services (optimising performance and reducing wider service pressures)

Developing capacity in community settings (two-hour urgent community response, virtual wards and urgent treatment centres)

Improving flow through hospitals (Emergency Departments and Same Day Emergency Care)

Managing hospital occupancy

Measuring and improving performance against the proposed new Urgent and Emergency Care Standards

Resilience and surge planning.

In response to the continuing demand for 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 on enhancing discharge

arrangements and improving flow, with the most radical scheme being the creation 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 can be made to reduce pressures in emergency departments. In addition to this, more patients who no longer require hospital care have been moved into a more appropriate setting.

NHS partners have worked together to develop a shared and robust ICS communications and engagement plans 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.

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 contributed to the system planning for 2022/23.

Ageing well

All Place Based Partnerships (PBPs) within Lancashire and South Cumbria delivered the minimum standard and had two-hour Urgent Community Response services operational by the deadline of 31 March 2022. This includes full geographic coverage and working 8am to 8pm, seven days a week.

All PBPs have been consistently submitting records of activity into the Community Services Dataset (CSDS) and achieving the 70% response standard. However, work is required to ensure there is a consistently accurate picture on the national dataset. The programme remains on track and has formed the foundations for the ICB Virtual Ward programme implementation plan in 2022/23.

We have been piloting direct access-to-community services for care settings in Pennine Lancashire, which initially showed good outcomes on A&E attendances and a significant reduction in falls. This work has been shared at the Ageing Well seminar for the North West and is under consideration for broader rollout across the ICB. This builds on the weekly Enhanced Health in Care Homes rounds which are in place across the region.

The Morecambe Bay area is participating in the regional Anticipatory care Community of Practice work which will help inform next steps around this work, which is scheduled to be progressed nationally in 2023.

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 during the first three months of 2022/23 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.

Improving quality

CQUIN Update

During 2022/23, the agreed block payment arrangement between the CCG/ICB and providers across Lancashire and South Cumbria was deemed to include CQUIN payment. During 2022/23 no financial transactions relating to achievement or non-achievement of the CQUIN scheme goals will take place. Each NHS Trust Provider is still required to report against all relevant CQUIN indicators. These nationally identified indicators relate to important quality, safety and experience improvements which the CCGs/ICB want to deliver for our Lancashire and South Cumbria citizens. CCG/ICB quality representatives will monitor and report on the progress made and reported by NHS Trust Providers during 2022/23. Quality representatives will also work with each Trust to identify any areas where Place or System support may be needed to progress. As the duration of certain CQUIN schemes rolls into the following contractual year (2023/24), it is important that the opportunity is not lost to commence development of these transformational improvements this year, prior to any financial incentive/penalty being aligned to achievement in 2023/24.

Continuing with planning for PSERF

The CCG has begun engaging with the Providers in relation to PSRIF and staff at ELHT have kindly provided advice to help LTHTR in particular and across the system to raise awareness of what is required, as ELHT have successfully implemented this new patient safety model.

As part of the system working for the development of the Acutes Quality Schedule (4 and 6), there has been agreement to sign up to working together to implement the new patient safety agenda.

Working is ongoing with LSCFT to gain approval for a new indicator. Nationally, the new guidance has not been released but it is anticipated this will be during Quarter Two and all providers will have 12 months to implement this.

The Quality team are planning to work with Primary Care to support the way forward during Quarter Two.

PSRIF level 1 and 2 training has been undertaken by the Quality team.

Support with fragile services

LTHTR

The Quality team are supporting Elective recovery across multiple workstreams, including Ophthalmology, ENT, Dermatology, Trauma/MSK, Referral optimisation and clinical triage, waiting list validation and Patient Tracking List (PTL) with Independent Sector services.

Referral to Treatment times remain challenged at Lancashire Teaching, more patients are now waiting over 18 weeks than under 18 weeks. The work continues to be managed through the Elective Care Recovery Group. The team is also undertaking reviews of packs of data released by the SERG team to identify any further opportunities or options to support Elective recovery locally.

Quality has been working closely with Ramsay sites as they undertake IPT work with LTHTR. This will include learning trends/themes and opportunities for the future. Ramsay are being supported in undertaking clinical triage of PTL's within LTHTR, taking the opportunity to move patients (longest waiters) into the IS for their procedures.

Dermatology continues to be under pressure and routine and urgent slots in Dermatology have been reinstated. However, there has been an increase in 2ww Cancer waits and this continues to be monitored by the Quality team. This has been recorded on the CCGs risk Register.

Gynaecology services remained suspended until 31 August 2022, due to a temporary consultant staffing shortfall, which has resulted in the service prioritising urgent and emergency care. The closure is starting to have an impact on the 2ww cancer waits and the Quality team in conjunction with commissioners are working closely with LTHTR to understand the risks to patient safety.

Quality has also been working closely with LTHTR in relation to the services which are considered as vulnerable, and the CCG have formally written to LTHTR to request an update as to how these services will be brought back on line. It has been agreed as part of the assurance process, weekly meetings will take place with Quality, commissioners and the LTHTR to ensure collaborative working continues.

LTHTR has suspended Oral surgery and Maxilliofacial Services (OMFS) (which are managed by NHSEI) as it is no longer safe for them to accept new patient referrals onto a waiting list that they cannot maintain, or clear. The Chief Operating Officers across Lancashire and South Cumbria have agreed to operate a mutual aid model, where new patient referrals will be directed to one of the other 3 Trusts.

Clinical Harm Reviews

Support has been given to the provider around Clinical Harm Reviews and in Q1 an agreement was made as to how they would be undertaken and how harms will be reviewed. This has been shared with the Chief Nurse of the Integrated Care Board

LSCFT

Several services with staffing issues have seen an increase in referrals/contacts, including Adult and Children's Speech and Language Therapies (SALT) services, District Nursing services and Children's Therapies. There are a number of 52ww breaches in the Children's SALT team, but no reports of harm for these children. LSCFT are currently formulating a business case to request a return to non-mask wearing to improve the offer to these families and make interventions more efficient.

The Trust are using a number of safety measures, such as using PRAG rating, and Critical Service Framework employed to determine priority service delivery to manage assessments within the DN service and a risk matrix framework to assess children's needs to identify those children that can effectively be seen by in different settings. They are also working through caseload validation to support staff with this.

The development of a business case for Adult Speech & Language Therapies has been escalated to the Lead AHP within the ICS, who is due to present a paper on SALT workforce challenges across the ICS.

The challenges in Children's Therapy Services, especially Speech and Language Therapy is being co-ordination through the ICB. The development of the Marie Gascoigne model is being developed in Pennine Lancs to define the service offer.

There are continuing pressures on the waiting times for other services particularly Falls team and Domiciliary Physiotherapy. There is work continuing to redefine the offer for Phlebotomy and Treatment Rooms.

Closedown for the Clinical Commissioning Groups

During Quarter 1 we have been working closely with the incoming ICB to ensure that there was a smooth transition, The work was monitored by Mersey Internal Audit and was positively received.

Engaging people and communities

How CCGs have engaged and worked with their communities

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

The system-wide programmes the CCGs have been part of are detailed in the Working with our Partners: Lancashire and South Cumbria Health and Care Partnership section above. These include Covid-19 vaccinations, Healthy Hearts, 'Thank You' volunteers and Lung Health Checks. Mental health campaigns include Healthy Young Minds, the Resilience Hub, and Let's Keep Talking.

Reducing Health Inequalities

Avoidable health inequalities are, by definition, unfair and socially unjust. A person's chance of enjoying good health and a longer life is determined by the social and economic conditions in which they are born, grow, work, live and age. These conditions also affect the way in which people look after their own health and use services throughout their life. Addressing such avoidable inequalities and moving towards a fairer distribution of good health requires a life course approach and action to be taken across the whole of society.

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. Each of the Lancashire and South Cumbria CCGs ensure that equality is embedded in their organisations by having named equality and diversity leaders on their Governing Bodies and strong Equality, Diversity and Inclusion (EDI) processes built into day-to-day operations.

Each of the CCGs have patient and patient involvement mechanisms, that are representative of our local communities, which help 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 are subject to robust Equality and Health Inequalities Impact and Risk Assessment (EHIIRA) processes to consider the needs of the people within our local communities. This enables the CCGs to show '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 decision-making

committees) that may affect equality and human rights. Furthermore, this enables to us to design our services and policies in the most inclusive ways possible.

The Lancashire and South Cumbria CCGs report annually on each of the EDI-related mandated standards set out by NHS England and Improvement. In 2021-22, the CCGs took a joint approach to report upon the following:

Equality Delivery System 2 (EDS2)

Workforce Race Equality Standard (WRES)

Detailed information about the CCGs' performance on these standards for 2021-22 can be found in the joint Lancashire and South Cumbria CCGs' Equality and Inclusion Annual Report 2021-22 which has recently been published on each of the CCGs' websites and the new Lancashire and South Cumbria ICB website.

In 2022-23, the newly established Lancashire and South Cumbria Integrated Care Board (ICB) will assumed responsibility for reporting upon EDI-related NHS mandated standards. NHS England and Improvement are expected to provide clarification upon the reporting processes for ICBs on these standards imminently.

Equality, Diversity and Inclusion Activity in Q1 2022-23

Equality and Inclusion Annual Report 2021-22

In Q1 2022-23, the LSC CCGs produced a joint Equality and Inclusion Annual Report for 2021-22 which demonstrates legislative compliance with the Equality Act (2010) and the Public Sector Equality Duty and sets out how the CCGs have delivered upon their commitment to taking EDI and Human Rights into account in everything they do; from commissioning services, employing their workforce, developing their policies, and engaging with their local populations.

This marked the first time that the CCGs had produced a joint formal report on annual EDI activities. This report provided progress updates on the LSC-aligned Equality, Diversity and Inclusion Strategy and Action Plan agreed in 2021-22 and designed to prepare for the closedown of the CCGs and the transfer of EDI-related statutory duties and responsibilities to the new Lancashire and South Cumbria ICB.

The report was approved by each CCG in Q1 2022-23 and has since been published on each CCG's website and the new Lancashire and South Cumbria ICB website.

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.

Interim Equality, Diversity and Inclusion Strategy for 2022-23

In Q1 2022-23, MLCSU's Equality and Inclusion Team continued to work in partnership with the ICS Director of Transformation and Non-Exec Directors to prepare for the transfer of EDI-related statutory responsibilities to the ICB by developing a draft interim EDI Strategy for adoption by the ICB in 2022-23.

This strategy covers the core EDI responsibilities required of any NHS organisation as well as setting the scene for the ICB to develop some more ambitious objectives that recognise the need to address and reduce the health inequalities affecting residents in Lancashire and South Cumbria.

As part of the development work for this strategy, engagement took place with health and care organisations and patient representative groups across Lancashire and South Cumbria including the delivery of a stakeholder workshop in May 2022 which was aimed at seeking the views of organisations on the strategic vision and the identification of strategic priorities.

The draft strategy is currently being reviewed by the ICB and should be finalised and adopted by the ICB in Q2 2022-23.

Equality and Health Inequalities Impact and Risk Assessments (EHIIRA)

The CCGs utilise the Equality and Health Inequalities Impact and Risk Assessment (EHIIRA) toolkit from the Equality and Inclusion Team at NHS MLCSU. The EHIIRA toolkit provides a framework for undertaking Equality Impact and Risk Assessments. This tool combines two assessments consisting of Equality and Human Rights. This enable the CCGs to show '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. The CCGs have continued to embed EHIIRAs into policy development and the commissioning cycle.

In Q1 2022-23, **12** EHIIRAs relating to service design or workforce decisions were supporting across the Lancashire and South Cumbria CCGs.

Equality and Health Inequalities Impact and Risk Assessments conducted in Q1 2022-23

- Fylde Coast CCGs – Clinical Assessment Services
- Fylde Coast CCGs – FCMS Contract (ongoing)
- Fylde Coast CCGs – Data Sharing Agreement: Blackpool CCG and Blackpool Council
- CSRGP CCGs – Central Lancashire Community Diagnostics Centre (ongoing)
- Morecambe Bay CCG – Community Lymphoedema Service (ongoing)
- LSC ICB – Communications and Engagement Strategy (ongoing)
- LSC ICB – LSC Autism Intensive Support Service
- Pennine CCGs – Local Quality Contract: Cervical Screening (ongoing)
- Pennine CCGs – Safeguarding Specification within the East Lancs GP Quality Contract
- Pennine CCGs – Local Quality Contract: Osteoporosis Service
- Pennine CCGs – COVID Virtual Ward – Enhanced Local Service (ongoing)
- West Lancashire CCG – Medicines Optimisation Service – Service Specification

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.

During Q1 2022-23, we have also provided information for the LSC CCGs' monthly Health and Wellbeing 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.

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.

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.

Financial review

Financial Key Performance Indicators

The CCG's performance is measured against a number of financial key performance indicators as outlined below:

Key performance indicator	Target	Actual	Result
Revenue resource use does not exceed the amount specified in Directions	Maintain expenditure within the allocated resource of £78.4m	Total expenditure £78.4m	Achieved
Delivery of a control total of breakeven	Deliver a control total of breakeven	Total position breakeven	Achieved
Maintain expenditure within the Annual Cash Drawdown Requirement	Annual (quarter 1) Cash Drawdown Requirement total £79.3m	Total cash outflow £83.6m	Not achieved (shortfall recovered by Lancashire and South Cumbria Integrated Care Board during the remainder of the financial year)
Revenue administration resource use does not exceed the amount specified in Directions	Maintain administration (running costs) expenditure within the allocated resource of £0.9m	Total administration (running costs) expenditure £0.9m	Achieved
QIPP savings targets identified and savings achieved	Overall QIPP savings target £1.0m	Total QIPP savings £0.3m	Not achieved (shortfall covered by additional growth allocations and underspends in other areas)
Comply with the Better Payment Practice Code (BPPC)	Ensure 95% (by number and volume) of all valid invoices are paid by the due date or within 30 days of receipt of a valid invoice, whichever is later	Non-NHS payables 98.88% by number, 99.42% by value NHS payables 98.02% by number, 99.88% by value	Achieved

Financial review

As a result of the dissolution of the CCG on 30 June 2022, this report only covers the first quarter of the 2022/2023 financial year. In order to ensure all CCGs could report a breakeven position as at 30 June 2022, NHS England made adjustments to individual CCG allocations in month 3 to cover any surplus/deficit incurred in quarter 1. As such, the CCG allocations reduced by £1.0m to ensure that overall allocation and expenditure were matched.

In order to ensure financial balance across the whole financial year under this arrangement, NHS England will adjust the allocation for quarters 2 to 4 for the Lancashire and South Cumbria Integrated Care Board by the aggregate amount of allocation adjusted for all eight constituent CCGs.

During the first quarter, the previous arrangement under which NHS providers were paid a nationally determined monthly 'block' contract payment was continued, to enable a measure of financial stability for all parties.

The following section provides a brief overview of the CCG's financial performance in the first quarter of 2022/23. The financial accounts have been prepared under a Direction issued by NHSEI under the National Health Service Act 2006 (as amended). A full set of accounts, including associated certificates, is included later in this report.

Financial Performance

We have faced a number of financial pressures during the first quarter of 2022/23. The revised financial regime first introduced in 2020/21 to assist organisations in dealing with the Covid-19 pandemic, was largely replaced by a return to business as usual arrangements, with restricted additional funding for the Hospital Discharge Programme and the majority of other Covid-19 related expenditure being funded from within CCG allocations. The block contract arrangements in place with NHS providers for the previous two financial years have been maintained and adapted to cover payments to providers outside of the Integrated Care Board boundary, such that any contract values above £0.5m with individual providers are subject to a formal contract, with any below that value covered by Low Value Activity (LVA) arrangements, both of which are determined at an aggregated Integrated Care Board level.

As part of the planning process, CCGs were expected to make Quality, Improvement, Productivity and Prevention (QIPP) savings during the year, based on an ICS system agreed percentage of allocation. The CCG's overall target for the first quarter was £1.0m but, due to the constraints imposed by the introduction of the block payments to providers as part of the revised financial regime, the only schemes able to deliver significant savings were in medicines management. Overall, the CCG realised savings of £0.3m, with the shortfall having been covered by unplanned underspends in some areas and the additional allocations received to secure the breakeven position reported, as described above.

Analysis of Covid-19 expenditure

The CCG received no additional allocations to cover expenditure incurred as a result of the Covid-19 pandemic during the first quarter of the financial year.

Analysis of EU exit related expenditure

The CCG has not incurred any additional costs in relation to the UK exit from the EU and has not been in receipt of any additional funding.

Accounting policies

The CCG's accounting policies are shown in full in Note 1 to the Annual Accounts. Following the Health and Care Act receiving Royal Assent on 28 April 2022, which allowed for the establishment of Integrated Care Boards across England and the abolition of CCGs, Integrated Care Boards took on the commissioning functions of CCGs. As a result, the functions, assets and liabilities of the CCG transferred to the Lancashire and South Cumbria Integrated Care Board on 1 July 2022. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. Where a CCG 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. As NHS Chorley and South Ribble CCG's functions will continue to be delivered by the Lancashire and South Cumbria Integrated Care Board, the CCG has therefore assessed that it remains a going concern as at 30 June 2022 (Note 1.2 to the Accounts provides further detail on the adoption of the going concern assumption). The accounting policies follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury.

We have made no changes to accounting estimates during quarter 1 of the 2022/23 financial year, however, as described above, the CCG has continued to contract with NHS providers on a block basis and payments have therefore, in general, been fixed irrespective of levels of activity undertaken.

Further details of accounting estimates made are reported in Note 1.3 to the Accounts, "Critical accounting judgements and key sources of estimation uncertainty".

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board (on behalf of the former Chorley and South Ribble CCG)

28 June 2023

Corporate Governance Report

Members Report

A list of the GP membership council members and attendance for the period 1st April - 30th June 2022 is set out on pages 59-62

Details of the Group's Governing Body and Committees membership, attendance and responsibilities can be found under the section titled: Governance arrangements and effectiveness, commencing at page 56.

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 quarter 1 of the 2022/23 financial year.

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

NHS Chorley and South Ribble 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.

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board (on behalf of the former Chorley and South Ribble CCG)

28 June 2023

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 Chorley and South Ribble 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 Section14Rof 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 confirm that there was adequate and sufficient handover from the previous Accounting Officer to provide me with the assurances required to make these statements, 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 Chorley and South Ribble 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.

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board (on behalf of the former Chorley and South Ribble CCG)

28 June 2023

Governance Statement

Introduction and context

NHS Chorley and South Ribble CCG was 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 were set out under the National Health Service Act 2006 (as amended). The CCG's general function was arranging the provision of services for persons for the purposes of the health service in England. The CCG was, in particular, required to arrange for the provision of certain health services to such extent as it considered necessary to meet the reasonable requirements of its local population.

Between 1 April 2022 and 30 June 2022, the clinical commissioning group was 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 NHS Chorley and South Ribble CCG's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NHS Chorley and South Ribble CCG's Accountable Officer Appointment Letter.

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

Governance arrangements and effectiveness

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

The CCG's constitution also detailed 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

The Governing Body had responsibility for:

- ensuring that the Group had 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 would 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 had 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 was made up of one member representative from each of the 30 practices, who were members of the CCG, and the CCG Chair, who was also the Chair of the Membership Council.

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

During the first quarter of 2022/23, prior to the closedown of CCGs on 30 June 2022 the Governing Body and the Membership Council have collaboratively worked on:

- The urgent care phone line which is now live and accepting referrals where GPs feel a rapid response will support patients in their own home and avoid admission to hospital.
- Work with Lancashire Teaching Hospitals with regard to service changes to support primary care.

Both the Membership Council and the Governing Body have continued to commit 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 outlines the membership attendance at Membership Council meetings throughout the first quarter of 2022/23:

CSR Membership Council Attendance

List of Attendees A = Attended N = No Attendance	**Meeting date 15.6.22**
P81740 Adlington Medical Centre, Babylon Lane, Anderton, PR6 9NW	A
P81692 Beeches Medical Centre, Liverpool Road, Longton, PR4 5AB	N (apologies sent)
Y02466 Buckshaw Village Surgery, The Lodge, Oakbridge Drive, Buckshaw, PR7 7EP	A
P81117 Central Park Surgery Balfour Street, Leyland, PR25 2TD	N (apologies sent)
Y00347 Chorley Health Centre (Dr Baghdjian & Partners), Collison Avenue, Chorley, PR7 2TH	N
P81127 The Surgery Chorley Collison Avenue, Chorley, PR7 2TH	A

List of Attendees A = Attended N = No Attendance	**Meeting date 15.6.22**
P81180 Clayton Brook Surgery, Tunley Holme, Clayton Brook, PR5 8ES	A
P81033 Coppull Medical Practice, 5 Acreswood Close, Coppull, PR7 5EN	N
P81173 Croston Medical Centre, 30 Brookfield, Croston, PR26 9HY	N
P81655 Croston Village Surgery, Out Lane, Croston, PR26 9HJ	A
P81701 Dr Dawoud's Surgery, 652 Preston Road, Clayton-le-Woods, PR6 7EH	A
P81689 Eaves Lane Surgery, 311 Eaves Lane, Chorley, PR6 0DR	N
P81171 Euxton Medical Centre, St. Mary's Gate, Euxton, PR7 6AH	N (apologies sent)
P81154 Granville House Medical Centre Granville Street, Adlington, PR6 9PY	A
P81181 Kingsfold Medical Centre, Woodcroft Close, Penwortham, PR1 9BX	A

List of Attendees A = Attended N = No Attendance	**Meeting date 15.6.22**
Y03656 The Leyland Surgery, West Paddock, Leyland, Lancashire, PR25 1HR	A
P81687 New Longton Surgery 2 Churchside, New Longton, PR4 4LU	A
P81044 Library House Surgery, Avondale Road, Chorley, PR7 2AD	A
P81642 Medicare Unit, 1 Croston Road, Lostock Hall, PR5 5RS	N
P81186 Moss Side Medical Centre, 16 Moss Side way, Leyland, PR25 7XL	A
P81062 Regent House Surgery, 21 Regent Road, Chorley, PR7 2DH	A
P81083 Roslea Surgery, 51 Station Road, Bamber Bridge, PR5 6PE	N
P81076 Sandy Lane Surgery, Sandy Lane, Leyland, PR25 2EB	A
P81741 Station Surgery, 8 Golden Hill Lane, Leyland, PR25 3NP	A

List of Attendees A = Attended N = No Attendance	Meeting date 15.6.22
P81038 The Chorley Surgery, 24-26 Gillibrand Street, Chorley, PR7 2EJ	A
P81082 The Ryan Medical Centre, St Mary's Road, Bamber Bridge, PR5 6TE	A
P81769 Village Surgery – Lostock Hall William Street, Lostock Hall, PR5 5RZ	N
P81010 Withnell Health Centre Railway Road, Withnell, PR6 8UA	A
P81143 Whittle Surgery 199 Preston Road, Whittle-le-Woods, PR6 7PS	N
P81057 Worden Medical Centre West Paddock, Leyland, PR25 1HR	A
Chair and Clinical lead Dr Lindsey Dickinson	A

Governing Body

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

The membership of the Governing Body consisted 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 invited 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 taken 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 was quorate if the following were 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 referred 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)

There has been a GP Director vacancy on the Governing Body throughout the first quarter of 2022/23.

The Governing Body formally met twice during the first quarter of 2022/23 and has been quorate for each meeting. None of those meetings were held using Emergency Powers as described above due to the Covid-19 pandemic.

In addition to public meetings, the Governing Body members have met once throughout first quarter of the year for the purpose of seeking assurances with regard to the CCG/ICB Transition Programme Plan and any actions against the Due Diligence Checklist as part of the CCG closure arrangements.

This development session was held jointly with Greater Preston CCG.
The session covered the overall plan for CCG closure.

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

There has been a continued 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 has been evidenced through the Governing Body’s commitment to achieving the organisation’s vision and values, and the continued successful implementation of the CCG’s 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 first quarter of 2022/23 prior to closedown include; noted the CCG's month 12 financial position for 2021/22; approved the Operational Planning Priorities and Financial Framework Arrangements for 2022/23; noted updates on performance within the Integrated Board Report and approved a minor change to the CCG Safeguarding Policy; approval of final CCG Annual Report for 2021/22; approval of CCG Annual Accounts and Financial Statements for 2021/22 and Management Letters of Representation; approval of CCG Closedown Transition Plan; noted the final Governing Body Assurance Framework and Corporate Risk Register; and noted the use of the Corporate Seal for a Section 75 Agreement.

The following table outlines the membership attendance at Governing Body meetings throughout the first quarter of 2022/23:

A = Attended N = No attendance - = not in post **List of attendees**	**Meeting Date** **25.5.22**	**Meeting Date** **16.6.22**
Dr Lindsey Dickinson, Chair	A	A
Denis Gizzi, Chief Officer	A	A
Katherine Disley, Chief Finance and Contracting Officer	A	A
Helen Curtis, Director of Quality and Performance	A	A
Jayne Mellor, Director of Transformation and Delivery	A	N (apologies sent)
Paul Richardson Lay Member for Governance	A	A
Linda Chivers, Lay Member for Audit, Finance	A	A

and Conflicts of Interest		
Geoffrey O'Donoghue, Lay Member for Patient and Public Involvement	A	A
Tricia Hamilton, Governing Body Nurse	A	A
Dr Eamonn McKiernan, Secondary Care Doctor	A	A
John Cairns, GP Director	A	N (apologies sent)
Satyendra Singh, GP Director	A	A
Ravi Gokul, GP Director	A	A
Ann Robinson, GP Director	N (apologies sent)	A
GP Director Vacancy	-	-

Audit Committee

The Audit Committee has operated throughout the first quarter of the financial year prior to CCG closedown 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 met as a 'committee in common' with Greater Preston CCG, and was 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:

- Linda Chivers, Lay Member for Audit, Finance, and Conflicts of Interest (Chair);
- Paul Richardson, Lay Member for Governance (Governing Body Vice Chair);
- Geoffrey O'Donoghue, Lay Member for Patient and Public Involvement.

The following colleagues and representatives will be expected to attend:

- The CFO who was 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 were the responsibility of the directors/managers.
- An appropriate representative of the anti-fraud service would attend a minimum of two meetings a year.
- Representatives from other organisations may be invited to attend on occasion.

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 2022/2023.

The Audit Committee continued to suspend its series of GBAF 'deep dives' throughout the first quarter of 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 recommended to the Governing Body that the Management of Conflicts of Interest Policy be rolled over until the CCG closedown unless legislation required that they are updated before 30 June 2022, as approved by the Governing Body at its meeting in March 2022.

Work continued during 2022/23 with the CCG Internal Audit Providers (KPMG). The committee focussed its attention on the draft 2022/23 Internal Audit Plan and Lancashire and South Cumbria System Briefing, setting out how Mersey Internal Audit Agency (MIAA) would be providing assurance with regard to the effectiveness of the CCG closedown arrangements both at a system and local level.

Key achievements for the Audit Committee over the first quarter of 2022/23 financial year include;

- Noted the Audit Committee Annual Report for 2021/22;
- Noted arrangements for CCG closedown and transition arrangements;
- Noted updates on External Audit Progress Reports
- Noted updates on Internal Audit Progress Reports and support provided by MIAA to the LSC transition;
- Reviewed and noted updates against the Governing Body Assurance Framework and Corporate Risk Registers;
- Noted the Information Governance Annual Report and completion and sign-off of the IG Toolkit submission;
- Reviewed the contents of the CCG Annual Accounts and Financial Statements for 2021/22 and Management Letter of Representation and recommended them to Governing Body for approval;
- Reviewed the contents of the CCG Annual Report including Annual Governance Statement for 2021/22 and recommended them to Governing Body for approval;
- Noted an update on the External Audit accounts audit;
- Noted the External Audit Findings Report;
- Noted updates on Anti-Fraud Progress and Investigations;
- Noted updates against Whistleblowing arrangements;

Following the Audit Committee's review of the Risk Management Strategy at its meeting in March 2022, which it recommended to the Governing Body for approval, it was subsequently agreed to rollover the policy until the CCG closedown unless legislation required that they are updated before 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 were submitted to Audit Committee for approval to recommend to Governing Body for rollover until the CCG closedown unless legislation required that they are updated before 30 June 2022. Those policies were subsequently approved by the Governing Body at its meeting in March 2022.

The following table outlines the membership attendance at Audit Committee meetings throughout the first quarter of 2022/23:

List of attendees A = Attended N = No attendance	**Meeting date** **1.4.22**	**Meeting date** **6.5.22**	**Meeting date** **16.6.22** **(annual accounts meeting)**
Linda Chivers, Lay Member for Finance, Audit & Conflicts of Interest (Chair)	A	A	A
Paul Richardson, Vice Chair	A	A	A
Geoff O' Donoghue, Lay Member for Patient and Public Involvement	A	A	A

Remuneration Committee

The Remuneration Committee was accountable to the Governing Body, and was 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 acted as a 'committee in common' with Greater Preston CCG.

The Remuneration Committee comprised the following members who were 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 were invited to offer professional advice or services to the committee. For example the senior HR Business Partner was a regular attendee.

The Remuneration Committee was quorate if a minimum of two members attend from each CCG (four members in total). The Remuneration Committee has not met during the first quarter of 2022/23.

Quality and Performance Committee

The Quality and Performance Committee met jointly with NHS Greater Preston CCG once during the first quarter of 2022/23.

Key achievements for the committee over the first quarter of the financial year include:

- Assurances received on actions completed and one remaining recommendation to be picked up with regard to a Chorley and South Ribble CCG practice (Station Surgery) by the ICB following transition.
- Assurances received in relation to a Freedom To Speak Up referral and a complaint forwarded by a whistleblower to the CQC which subsequently conducted an investigation. All actions arising from the CQC report have been recorded and support mechanisms put in place to ensure that patient safety is maintained.

- Considered quality accounts from Lancashire Teaching Hospitals NHS Foundation Trust, Lancashire and South Cumbria NHS Foundation Trust and Ramsay Healthcare along with draft responses on behalf of the CCGs.
- Acknowledged that regarding CCG closedown national guidance has been followed and actions taken to provide assurance regarding quality governance, including the use of internal and external auditors and subject matter experts.
- Considered the current Governing Body Assurance Framework, particularly in the context of the imminent transition to the ICB and agreed changes to likelihood risk scores due to the time remaining as CCGs prior to submission of a final GBAF to the Governing Body.

The Quality and Performance Committee was quorate if six members were present, and which included two clinicians and one lay member per CCG. The committee was quorate at its meeting on 8 June 2022.

The Quality and Performance Committee operated jointly between Chorley South Ribble and Greater Preston CCGs and comprised 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 the first quarter of 2022/23.

List of attendees A = Attended N = No attendance	**Meeting Date** **8/6/22**
Mr Ian Cherry, Lay Member for Audit, Finance and Conflicts of	A

Interest Greater Preston CCG	
Mrs Linda Chivers, Lay Member for Audit, Finance and Conflicts of Interest Chorley and South Ribble CCG	A
Dr Ewa Craven, GP Director Greater Preston CCG	A
Mrs Helen Curtis, Director of Quality and Performance	A
Mrs Katherine Disley, Chief Finance and Contracting Officer	A
Mrs Trisha Hamilton, Governing Body Nurse	A
Dr Eamonn McKiernan, Secondary Care Doctor	A
Mrs Jayne Mellor, Director of Transformation and Delivery	A
Mr Paul Richardson, Vice Chair and Lay Member for Governance	A

Clinical Effectiveness Committee

The CCG's Clinical Effectiveness Committee met in Common with NHS Greater Preston CCG. The committee had 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 once on 13 April 2022 to receive updates on Clinical Policies, Individual Funding Requests, CQUIN Scheme, Medicines Management and the ongoing work towards a single QIPP Programme across the ICB to ensure we can achieve economies of scale with the resources we have and to support medicines optimisation across the ICB. The committee was assured with regard to the transition and how the work of the committee would link into the ICS through the Elective Recovery Group and Strategic Commissioning Committee.

To achieve quoracy at least four core members were required to 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 comprised 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 the one Clinical Effectiveness Committee meeting held throughout the first quarter of 2022/23:

List of attendees A = Attended N = No attendance - = not in post	**Meeting** **Date** **13.4.22**
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	A
Dr Eamonn McKiernan, Secondary Care Doctor	A
Claire Moss, Head of Medicines Optimisation	A
Geoffrey O'Donoghue, Chair of the Clinical Effectiveness Committee Lay Member Patient & Public Involvement Chorley & South Ribble CCG	N (apologies sent)
John Cairns, GP Director Chorley and South Ribble CCG	N (apologies sent)
Ann Robinson, GP Director Chorley & South Ribble CCG	N (apologies sent)
Samantha Davis, Quality & Effectiveness Specialist (Clinical)	N (apologies sent)

Patient Voice Committee

The Committee, which met on a bi-monthly basis, was considered quorate if the meeting had an attendance of at least the chair or the vice chair, and four members were present.
The Committee met once face to face during the first quarter of 2022/23 and was quorate.

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

- Assurances received from the Customer Care Activity Report for Quarter 4 2021/22, and on how the system would work from 1 July 2022.
- Assurances received on patient and public involvement for the period 29 March to 16 June 2022 with updates noted from the Patient Advisory Group, Maternity Voice Partnership and on staff and public engagement.
- Review of GBAF 05 which relates to the risk that the CCG fails to reduce inequalities in the health and care system which would result in a failure to meet the CCG's Strategic Objective in achieving a minimum level of 'good' in the Improvement and Assessment Framework. The committee was assured that any risks and areas of progress were captured and that there was nothing to add to GBAF 05.
- Received assurances on the effectiveness of the committee from the Patient Voice Committee Effectiveness Report for 2021/22.
- Received updates on Commissioning Reforms and the ICS in relation to the New Hospitals Programme and on Communications and Engagement.
- Received updates on the ICP which included Patient, Public and Carers Voice Committee and a Covid-19 Vaccination Programme update.
- Received assurances that Healthwatch will work with the ICB to develop and facilitate the establishment of a Citizen Panel model and a role on the IC Board.

The following table outlines the membership attendance at Patient Voice Committee meeting on 23 June 2022:

List of attendees A = Attended N = No attendance	**Meeting Date** **23.6.22**

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

Primary Care Commissioning Committee

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

The committee operated as a 'committee-in-common' with Greater Preston 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 committee meets in public and has met three times during the first quarter of 2022/23. Each meeting was quorate.

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

The Primary Care Commissioning Committee comprised 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 Director of Quality & Performance
- CCG Chair; and *
- GP Director for Primary Care *
- Director of Transformation and Delivery (CCG)*

  A representative from NHS England*

  *non- voting

The meeting achieved quorum if a minimum of 4 members were present, and included:

- 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 were 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 were non-voting members which also minimised this risk.

Examples of items presented to the committee are as follows:

- A summary of Quarterly Contractual Changes that were enacted during the previous quarter January to March 2022.
- Approval to undertake a full procurement to award a 10 + 5 year APMS contract in respect of Withnell Heath Centre to ensure continued access to General Medical Services for patients following termination of contract for one of the GPs at the health centre.
- Commented on proposed new Population Based Health Improvement (Quality Contract for General Practice) for 2022/23.
- Received an update on Chorley East Primary Care Network (PCN) and supported the creation of a new PCN to ensure continuity of care for the population.
- Noted proposals for the GP QC Quality Improvement Framework for 2022/23 and how this would be implemented in Central Lancashire.
- Supported proposals with regard to removing eligible elements from the Population Based Health Improvement (Quality Contract for General Practice) prior to the new ICB improvement framework being implemented in July 2022. This was in support of the development of a single quality contract approach for implementation across Lancashire and South Cumbria. The committee supported the removal of the Medicines Co-ordinator Specification and relevant finances from the GP quality Contract.

The following table outlines the membership attendance at Primary Care Commissioning Committee meetings during the first quarter of 2022/23:

List of members A= attended N = non-attendance - = not in post	**Meeting Date 6.4.22**	**Meeting Date 20.4.22**	**Meeting Date 15.6.22**
Paul Richardson, Vice Chair and	A	A	A

Lay Member for Governance			
Linda Chivers, Lay Member for Audit, Finance and Conflicts of Interest Chorley and South Ribble CCG	A	N (apologies sent)	N (apologies sent)
Geoff O Donoghue, Lay Member for Patient and Public Involvement Chorley and South Ribble CCG	N (apologies sent)	N (apologies sent)	A
Tricia Hamilton, Governing Body Nurse	A	A	A
Eamon Mc Kiernan, Secondary Care Doctor	A	N	A
Denis Gizzi, Chief Officer	A	A	N (apologies sent)
Katherine Disley, Chief Finance and Contracting Officer	A	A	N (apologies sent)
Helen Curtis, Director of Quality and Performance	N (apologies sent)	A	A
Dr Lindsey Dickinson, Clinical Chair Chorley and South Ribble CCG	A	A	A
GP Director Chorley and South Ribble CCG	A	A	A
Jayne Mellor, Director of Transformation and Delivery	A	A	A
Donna Roberts, Head of Primary and Elective Care	A	A	A
NHS England representative	A	A	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 the review of the CCG's committee terms of reference during Quarter 1 of 2022/23.

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, 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 provided the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

Risk management arrangements and effectiveness

The CCG was 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. In accordance with Public Sector Internal Audit Standards, it was a requirement to complete a review of risk management. In December 2021, the CCG's internal auditors undertook an audit into our risk management arrangements during 2021/22 which resulted in significant assurance given.

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 has been the 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.

Another key risk to the organisation was the close down of the CCG by 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 was due to the uncertainty of the staffing structure in the new NHS LSC Integrated Care Board at that time, in that CCG staff may have left 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 was scored at 16.

Once risks were identified, further evaluation was required to establish the exposure of the CCG to risk and uncertainty. The outcome of the risk analysis was used to rate its significance and prioritise its treatment. The CCG used 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 were 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 was 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 were 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 had an executive lead owner who reported on progress with mitigation to the Governing Body.

All risks were 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 reflected the level of risk appetite the organisation was willing to accept. Once a risk reached its agreed target rating, the organisation could accept that this could 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 were assigned an action plan to outline how it could have been mitigated in the future. These action plans were reviewed with risk owners on a regular basis to assess the impact on the mitigation of the risk. As actions were completed these became controls and assurances which in turn should reduce result in the reduction of rating.

The CCG's risk appetite statement contained within the strategy was approved by the Governing Body via the Risk Management Strategy. The statement reflects that the CCG had no appetite for fraud and zero tolerance for regulatory breaches. The CCG also had zero tolerance for safeguarding, Information Governance, and reputational risk. Whilst the CCG was committed to reducing all risks to levels as low as reasonably practicable, it was, however, tolerant of overall levels of risk where action was not cost effective or reasonably practicable. A risk appetite rating was 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. The rating acted as a visual aid on the GBAF when it was reviewed by the Governing Body as a reminder of the level of tolerance that the CCG could safely accept.

Incident reporting was encouraged, and an associated policy was available on the CCG staff website. Furthermore the Constitution and the CCGs Freedom to Speak Up policy reflected the protection afforded by whistleblowing in line with national guidance. The CCG had assigned the role of the Freedom to Speak Up Guardian to the Vice Chair/Lay Member for Governance who was a member on both CCG Governing Bodies. The Freedom to Speak Up policy was part of a suite of HR policies which were approved by the Remuneration Committee.

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

The Governing Body meetings whereby the GBAF and the CRR were discussed had 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 continued to be given a high profile within the CCG. All committees of the Governing Body were responsible for reporting and monitoring

risks that arose from the remit of that committee, and each committee submitted an update to the Governing Body to report on activity, and this would have included any risks identified by that committee. The governance structure was 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 had been made more prominent, with a 'lead committee' assigned to each GBAF risk.

The Governing Body also had overall responsibility for the CCG's performance. The key tool to manage that was the receipt of an Integrated Board Report, which provided 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 was accountable for having had 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) held responsibility for ensuring that there were effective systems for the management of financial stewardship of the CCG's finances.

The Director of Quality and Performance / Deputy Accountable Officer held the responsibility for ensuring that there were 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 were accountable for the management of risk within their area of responsibility. This was documented in the Risk Management Strategy as follows:

- ensuring that the strategy and associated policies, procedures and guidelines were 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 were identified, assessed and included on the risk register;
- providing assurance to the committees overseeing each risk, as appropriate

The Head of Governance reviewed 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 were escalated, managed and monitored via this.

Risk Assessment

The CCG held 3 risk registers; the GBAF which collated all threats to achieving the strategic objectives, the CRR which collated all operational risks which score 15 or above, and the operational risk register which covered all other risks with a score below 15. Within operational risk there were 2 further subcategories; Fraud risks and Integrated Business Plan risks.

The CCG escalated the GBAF and CRR risks to every Audit Committee and Governing Body meeting. The Governing Body owned the GBAF and reviews and challenges each risk and action plan at each meeting. At the close of June 2022, the GBAF contained five risks in the following areas:

GBAF Definition	Risk Score	Rationale
GBAF 1 Quality, Safe and Effective Services	risk score reduced from 5 x 2 to 5 x 1 = 5	as likelihood is minimal to occur within the final weeks of the CCG
GBAF 2 Commissioning delivery and accountability	risk score reduced from 5 x 2 to 5 x 1 = 5	as likelihood is minimal to occur within the final weeks of the CCG
GBAF 3 Financial Sustainability	risk score previously reduced to 4 x 1 = 4	The 2022/23 plan has been submitted with all CCGs planning a break even position as at 30 June 2022, therefore the risk of failing to meet statutory financial duties is considered to be low.
GBAF 4 Well Led	risk score reduced from 4 x 2 to 4 x 1 = 4	as actions have been managed as part of the CCG closedown management process
GBAF 5 Inequalities in the health and care system	risk score increased from 4 x 3 to 4 x 4 = 16	due to the increase of inequalities during the pandemic

All papers submitted to the Governing Body included a covering executive summary, which highlighted any specific risks, and the strategic objective which the paper related 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 allowed risks to be managed to a reasonable level rather than eliminating all risk; it could therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control had been in place in the CCG until the end of June 2022 and up to the date of approval of the Annual Report and Accounts and had 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) required CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England had published a template audit framework.

Due to the closure of CCGs on 30 June and subsequent transition to the Integrated Care System on 1 July 2022, it has been agreed that the annual internal audit of conflicts of interest would be carried out later in the year during 2022/23.

Data Quality

The CCG utilised 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 formed 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 set out the processes and procedures by which the NHS handled information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework was supported by an information governance toolkit and the annual submission process provided assurance to the CCG, other organisations and to individuals that personal information was dealt with legally, securely, efficiently and effectively.

All organisations that had access to NHS patient data and systems used the DSP Toolkit to provide assurance that they were practicing good data security and that personal data was 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.

The CCG submitted their submission of the DSPT in May 2022 ahead of the June 2022 deadline and ensured that all mandatory evidence items were available, accurate and had been fully met.

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

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

The CCG had recorded no IG incidents categorised as reportable outside the organisation during the period Quarter 1 2022/2023.

The CCG placed high importance on ensuring there was robust information governance systems and processes in place to help protect patient and corporate information. We had established an information governance management framework and developed information governance processes and procedures in line with the information governance toolkit. We had ensured all staff undertook annual information governance training and had implemented a staff information governance handbook to ensure staff were aware of their information governance roles and responsibilities.

We developed information risk assessment and management procedures and a programme was established to fully embed an information risk culture throughout the organisation against identified risks. The CCG had in place an information risk work programme that had been agreed by the Senior Information Risk Officer (SIRO) to identify what information the CCG held, stored shared and received from other organisations.

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

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

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

Business Critical Models

Over the course of the reporting period, the CCG had identified its business critical models and current arrangements for their quality assurance. Predominantly, these were provided by the Midlands and Lancashire CSU, however there were other external providers that were 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

There were no significant control issues facing the CCG

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

The CCG continued to develop and strengthen the system of internal controls and had worked with the Internal and External Auditors to ensure that the CCG received assurance in relation to the use of resources and that this was reported to the Governing Body.

Robust contract management were in place via formal contract performance meetings whereby the CCG had the opportunity to understand performance at a granular level and ensure appropriate challenge where indicated. An established joint contract review meeting had enabled all partners across the Central Lancashire Integrated Care Partnership to meet jointly.

The CCG's financial performance continued to receive scrutiny at Governing Body level. Financial performance continued 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 had also taken place this year to discuss financial forecast against system enveloped and the financial impact of responding to the pandemic.

Throughout the year the CCG had continued to report on well-led in the Integrated Board Report which was submitted to the Governing Body at each meeting, the CCG had 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.

There had been no referrals were made to the Freedom to Speak up Guardian in 2022/23 Qtr1 .

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 contracted anti-fraud service arrangements from Mersey Internal Audit Agency. This service included the provision of an accredited anti-fraud specialist whose role was to undertake anti-fraud work proportionate to identified risks.

The Audit Committee received an annual report against the Standards for Commissioners Self Review Tool. The Anti-Fraud Specialist undertook 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 had a responsibility of oversight in respect of anti-fraud arrangements in addition to the CFO, and would have their own account to access the Self Review Tool (SRT). Both the CFO and the Audit Committee Chair were required to review the submission detail of the CFFSR before the CFFSR could be submitted and finalised on the national system.

The CCG's CFO was a voting member of the Governing Body and was responsible for overseeing and providing strategic management and support for all anti-fraud, bribery, and corruption work within the CCG. The fraud agenda was fully supported by the CFO and the Audit Committee, which actively encouraged the anti-fraud specialist in the conduct of their activities. The anti-fraud specialist attended Audit Committee meetings throughout the first quarter of year and presented regular anti-fraud progress reported for consideration and scrutiny. The anti-fraud specialist had meetings with the CFO to discuss fraud matters. In addition, the anti-fraud specialist met privately with the Audit Committee chairs in year to discuss anti-fraud activity.

The CCG worked to an annual pro-active anti-fraud work plan which reflected 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 was reported to the audit committee to ensure that the CCG was compliant with 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 2022/23 Quarter 1: Chorley and South Ribble CCG

1 Introduction

The purpose of this Head of Internal Audit 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 organisation's system of internal control.

This Opinion will assist the Integrated Care Board's (ICB) Governing Body in the completion of the CCG's Governance Statement (AGS) for the 22/23 Quarter 1 accounting period, along with considerations of organisational performance, regulatory compliance, the wider operating environment and health and social care transformation.

This opinion is provided in the context that the CCG was in the process of transition to an ICB and relates the internal audit work undertaken in Quarter 1 of 2022/23 only.

2 2021/22 Internal Audit Service Delivery

2.1 CCG Closedown

• Throughout 21/22 and into 22/23 MIAA has looked at ways we can continue to provide an internal audit service that both supports the delivery of statutory objectives and manage the transition whilst also providing a degree of flexibility to support in meeting these challenges. On this basis in 21/22, each of the Lancashire CCGs agreed to ring fence approximately 10% of their 21/22 internal audit plan days for pan system transition support. This support has continued into 22/23 and the outcomes from this work support the Head of Internal Audit Opinion (HoIAO) and is summarised in section 4.3.3.2.

• To support CCGs in their transition to Integrated Care Boards (ICBs), NHSE/I has and continues to issue a range of guidance. Documentation published includes a CCG Closedown & ICB Establishment Due Diligence Checklist, which outlines a number of activities and tasks that need to be completed by CCGs and ICBs as part of the transition process. The checklist

includes 10 specific elements relating to Internal Audit and Anti-Fraud. MIAA has been undertaking a number of activities in response to the guidance and this is summarised in section 4.3.3.3.

We would like to take this opportunity to thank the Audit Committee and all the staff at the CCG for their ongoing support during Quarter 1 of 22/23.

3 Executive Summary

This report provides the Quarter 1 2022/2023 Head of Internal Audit Opinion for NHS Chorley & South Ribble CCG, together with the planned internal audit coverage and outputs during Quarter 1 of 2022/23 and MIAA Quality of Service Indicators.

Key Area Summary Head of Internal Audit Opinion The overall opinion for the period 1st April 2022 to 30th June 2022 provides Substantial Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

4 Planned Audit Coverage and Outputs

The Quarter 1 2022/23 Internal Audit Plan has been delivered with the focus on transition support and the provision of your Head of Internal Audit Opinion. This position has been reported within the progress reports across the quarter. Review coverage has been focused on:

• CCG Closedown/ICB Transition reviews and support;

• CCG compliance with statutory functions; and

• Follow up of outstanding internal audit recommendations.

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.

Conclusion

This statement has identified that with the exception of the items referred to in section 'Internal Control Framework' and in the governance statement; all of which have been followed up, this statement concludes that there are no significant internal control issues which have been identified.

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board (on behalf of the former Chorley and South Ribble CCG)

28 June 2023

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.

No meetings were held in the period April to June 2022. Member attendance at the meeting can be found in the governance statement on page 70.

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):

			2022/23 (for the period ended 30 June 2022)						2021/22 (for the year ended 31 March 2022)					
Name	**Title**	**Notes**	**Salary** (bands of £5,000) £000	**Expense payments (taxable)** (to the nearest £100)* £	**Performance pay and bonuses** (bands of £5,000) £000	**Long term performance pay and bonuses** (bands of £5,000) £000	**All pension related benefits** (bands of £2,500) £000	**TOTAL** (bands of £5,000) £000	**Salary** (bands of £5,000) £000	**Expense payments (taxable)** (to the nearest £100)* £	**Performance pay and bonuses** (bands of £5,000) £000	**Long term performance pay and bonuses** (bands of £5,000) £000	**All pension related benefits** (bands of £2,500) £000	**TOTAL** (bands of £5,000) £000
Dr Lindsey Dickinson	Chair (up to 30 June 2022)		30-35	0	0	0	0	30-35	125-130	0	0	0	32.5-35.0	155-160
Mr Paul Richardson	Vice Chair and Lay Member Governance (up to 30 June 2022)	1	0-5	0	0	0	0	0-5	5-10	0	0	0	0	5-10
Dr John Cairns	GP Director (up to 30 June 2022)		5-10	0	0	0	0	5-10	35-40	0	0	0	0	35-40
Dr Ann Robinson	GP Director (up to 30 June 2022)		5-10	0	0	0	0	5-10	25-30	0	0	0	0	25-30
Dr Satyendra Singh	GP Director (up to 30 June 2022)		5-10	0	0	0	0	5-10	35-40	0	0	0	0	35-40
Mr Ravi Gokul	GP Director (up to 30 June 2022)		10-15	0	0	0	0	10-15	35-40	0	0	0	0	35-40
Mrs Linda Chivers	Lay Member Finance and Audit (up to 30 June 2022)		0-5	0	0	0	0	0-5	20-25	0	0	0	0	20-25
Mr Geoffrey O'Donoghue	Lay Member Patient/Public Involvement (up to 30 June 2022)		0-5	0	0	0	0	0-5	10-15	0	0	0	0	10-15
Mrs Patricia Hamilton	Nurse Member (up to 30 June 2022)	2	0-5	0	0	0	0	0-5	5-10	0	0	0	0	5-10
Dr Eamonn McKiernan	Secondary Care Doctor (up to 30 June 2022)	3	0-5	0	0	0	0	0-5	10-15	0	0	0	0	10-15
Mr Denis Gizzi	Chief Officer (up to 30 June 2022)	4	15-20	0	0	0	7.5-10.0	20-25	65-70	0	0	0	12.5-15.0	75-80
Mrs Helen Curtis	Director of Quality and Performance (up to 30 June 2022)	5	10-15	0	0	0	0	10-15	50-55	0	0	0	0	50-55
Mrs Katherine Disley	Chief Finance and Contracting Officer (up to 30 June 2022)	6	10-15	0	0	0	7.5-10.0	20-25	50-55	0	0	0	10.0-12.5	65-70
Mrs Jayne Mellor	Director of Transformation and Delivery (up to 30 June 2022)	7	10-15	0	0	0	0	10-15	45-50	0	0	0	0	45-50

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 Greater Preston CCG. His remuneration during the period was in the range £0k-£5k; 50% of his remuneration is charged to NHS Chorley and South Ribble CCG.
2. Mrs Patricia Hamilton also served on NHS Greater Preston CCG. Her remuneration during the period was in the range £0k-£5k; 50% of her remuneration is charged to NHS Chorley and South Ribble CCG.
3. Dr Eamonn McKiernan also served on NHS Greater Preston CCG. His remuneration during the period was in the range £5k-£10k; 50% of his remuneration is charged to NHS Chorley and South Ribble CCG.
4. Mr Denis Gizzi also served on NHS Greater Preston CCG. His remuneration during the period was in the range £35k-£40k; 45% of his remuneration is charged to NHS Chorley and South Ribble CCG.
5. Mrs Helen Curtis also served on NHS Greater Preston CCG. Her remuneration during the period was in the range £25k-£30k; 45% of her remuneration is charged to NHS Chorley and South Ribble CCG.
6. Mrs Katherine Disley also served on NHS Greater Preston CCG. Her remuneration during the period was in the range £25k-£30k; 45% of her remuneration is charged to NHS Chorley and South Ribble CCG.
7. Mrs Jayne Mellor also served on NHS Greater Preston CCG. Her remuneration during the period was in the range £25k-£30k; 45% of her remuneration is charged to NHS Chorley and South Ribble CCG.

Pension benefits as at 30 June 2022 (subject to audit)

	2022/23 (for the period ended 30 June 2022)							
Name and Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 30 June 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 30 June 2022 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2022 £000	Real increase in Cash Equivalent Transfer Value (CETV) £000	Cash Equivalent Transfer Value at 30 June 2022 £000	Employer's contribution to stakeholder pension £000
Mr Denis Gizzi - Chief Officer	0.0-2.5	0.0-2.5	60-65	130-135	1,238	20	1,273	0
Dr Lindsey Dickinson - Chair	0	0	10-15	20-25	348	0	186	0
Mrs Katherine Disley - Chief Finance and Contracting Officer	0.0-2.5	0.0	20-25	0	266	10	282	0

Notes

The pensions information disclosed above for Mr Denis Gizzi and Mrs Katherine Disley 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 Dr Lindsey Dickinson, Mr Denis Gizzi and Mrs Katherine Disley is NHS Chorley and South Ribble CCG.

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023 to 24 CETV figures.

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 in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

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.

Fair Pay Disclosure (subject to audit)
Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. 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 Chorley and South Ribble CCG in the period April to June 2022 was £125k-£130k (2021/22: £125k-£130k), a 0% increase on 2021/22 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 table.

Period	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
April 2022 to June 2022	3.73:1	3.73:1	2.33:1	2.33:1	1.58:1	1.61:1
April 2021 to March 2022	3.99:1	4.04:1	2.40:1	2.71:1	1.60:1	1.63:1

Period	25th percentile total remuneration	25th percentile salary	Median total remuneration	Median salary	75th percentile total remuneration	75th percentile salary

April 2022 to June 2022	£34,225	£34,225	£54,619	£54,619	£80,593	£79,013
April 2021 to March 2022	£31,920	£31,534	£53,168	£47,126	£79,756	£78,192

In the period April to June 2022, no employees received remuneration in excess of the highest-paid member. The full year equivalent remuneration ranged from £3k to £64k (2021/22: £6k to £63k). 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 2021/22 in respect of employees of the entity is 3.01% increase on salary and allowances due to staffing changes. 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 Greater Preston CCG and excluding Governing Body members, are as detailed below.

Band	Number
VSM	0
9	1
8D	5
8C	9
8B	8
8A	10
Total	33

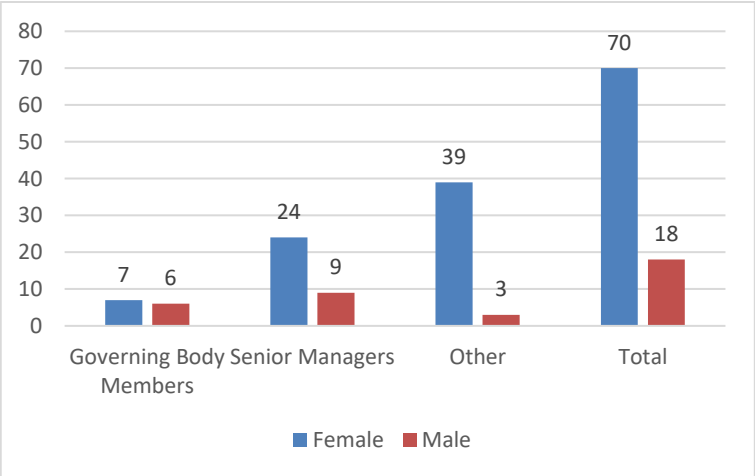
Staff numbers and costs (subject to audit)

Information on staff numbers and costs can be found in note 5 of the annual accounts.

Staff composition

Chorley and South Ribble CCG directly employs 88 members of staff: 70 female and 18 males, who are based at the Chorley House headquarters in Leyland. The staff body is shared with NHS Greater Preston CCG, with Chorley and South Ribble CCG hosting their employment on behalf of Greater Preston CCG.

The table below shows the analysis of staff number and composition by gender based on headcount of staff employed at NHS Chorley and South Ribble as at 30
June 2022.



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 April – June 2022.

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 30 June 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 2022 and 30 June 2022:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements. (2)	5

Exit packages, including special (non-contractual) payments **(subject to audit)**

Details of exit packages can be found in notes of the financial statements.

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board (on behalf of the former Chorley and South Ribble CCG)

28 June 2023

Parliamentary accountability and audit report

NHS Chorley and South Ribble 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 in this report feature their own page numbering and contents. An audit report is also included in this Annual Report at page 103.

Independent auditor's report to the members of the Board of NHS Lancashire and South Cumbria Integrated Care Board in respect of NHS Chorley and South Ribble Clinical Commissioning Group

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Chorley and South Ribble Clinical Commissioning Group (the 'CCG') for the period ended 30 June 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the 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 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 and of its expenditure and income for the period 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 2022-23; 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 to the financial statements, which indicates that the Health and Care Bill allowed for the establishment of Integrated Care Boards (ICBs) and abolished Clinical Commissioning Groups (CCGs). The functions, assets, and liabilities of NHS Chorley and South Ribble CCG transferred to NHS Lancashire and South Cumbria ICB on 1 July 2022. When NHS Chorley and South Ribble CCG ceased to exist on 30 June 2022, its services continued to be provided by NHS Lancashire and South Cumbria ICB from 1 July 2022.

Conclusions relating to going concern

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

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 2022-23 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 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 2022) 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.

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.

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.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. 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.

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 themselves. 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:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements the other information published together with the financial statements in the annual report for the financial period for which the financial statements are prepared is consistent with the financial statements.

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

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

Matters on which we are required to report by exception

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

- we 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.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 28 to 29, 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.

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.

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.

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. Irregularities, including fraud, are instances of non-compliance with laws and regulations. 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 2022-23).
- 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. We determined that the principal risks were in relation to closing journal entries around expenditure in order to possibly manipulate the year-end financial performance.
- 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 unusual closing journal entries around expenditure that could manipulate the year-end financial performance;
  - 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.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not

detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to the prescribing accrual.
- 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**.**

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.

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 made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 30 June 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 were operating effectively during the three month period ended 30 June 2022.

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 January 2023. 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 were 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 Chorley and South Ribble 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 Board of NHS Lancashire and South Cumbria ICB, as a body, in respect of NHS Chorley and South Ribble CCG, 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 Board of NHS Lancashire and South Cumbria ICB those matters we are required to state to them in an auditor's report in respect of the CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NHS Lancashire and South Cumbria ICB and the CCG and the members of the Governing Bodies of the both entities, as bodies, for our audit work, for this report, or for the opinions we have formed.

Matthew Dean

Matthew Dean, Key Audit Partner

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

London

29 June 2023

NHS Chorley and South Ribble Clinical Commissioning Group - 3 month accounts to 30 June 2022

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The Primary Statements:

Notes to the financial statements

Statement of Comprehensive Net Expenditure for the period ending 30 June 2022

	Note	3 month period end to 30 June 2022 £'000	Full year accounts 2021/2022 £'000
Income from sale of goods and services	3	(192)	(977)
Other operating income	3	(304)	-
Total operating income		**(496)**	**(977)**
Staff costs	5	773	2,460
Purchase of goods and services	6	77,560	315,999
Provision expense	6	-	492
Other operating expenditure	6	604	1,633
Total operating expenditure		**78,937**	**320,584**
Net operating expenditure		**78,441**	**319,607**
Comprehensive expenditure for the period ending 30 June 2022		**78,441**	**319,607**

The notes on pages 5 to 24 form part of this statement.

Statement of Financial Position as at 30 June 2022

	Note	3 month period end to 30 June 2022	Full year accounts 2021/2022
		£'000	£'000
Current assets:			
Inventories	9	627	785
Trade and other receivables	10	1,759	2,364
Cash and cash equivalents	11	24	39
Total current assets		**2,410**	3,188
Total assets		**2,410**	3,188
Current liabilities			
Trade and other payables	12	**(13,772)**	(19,696)
Provisions	13	**(492)**	(492)
Total current liabilities		**(14,264)**	(20,188)
Non-current assets less net current liabilities		**(11,854)**	(17,000)
Assets less liabilities		**(11,854)**	(17,000)
Financed by taxpayers' equity			
General fund		(11,854)	(17,000)
Total taxpayers' equity:		**(11,854)**	(17,000)

The notes on pages 5 to 24 form part of this statement.

The financial statements on pages 1 to 24 were approved in line with delegated authority granted by the Board of Lancashire and South Cumbria Integrated Care Board (as successor organisation to NHS Chorley and South Ribble CCG) on 21 June 2023 and are signed on its behalf by:

Kevin Lavery
Chief Executive

Samantha Proffitt
Chief Finance Officer

Statement of Changes In Taxpayers Equity for the period ended 30 June 2022

	General fund £'000	**Total reserves £'000**
Changes in taxpayers' equity for the 3 month period end to 30 June 2022		
Balance at 01 April 2022	(17,000)	(17,000)
Changes in NHS clinical commissioning group taxpayers' equity for the 3 month period end to 30 June 2022		
Net operating expenditure for the financial period	(78,441)	**(78,441)**
Net recognised NHS clinical commissioning group expenditure for the financial period	**(78,441)**	**(78,441)**
Net funding	83,587	**83,587**
Balance at 30 June 2022	**(11,854)**	**(11,854)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for the Full year accounts 2021/2022		
Balance at 01 April 2021	(16,649)	(16,649)
Changes in NHS clinical commissioning group taxpayers' equity for the Full year accounts 2021/2022		
Net operating costs for the financial year	(319,607)	(319,607)
Net recognised NHS clinical commissioning group expenditure for the financial year	(319,607)	(319,607)
Net funding	319,256	319,256
Balance at 31 March 2022	(17,000)	(17,000)

The notes on pages 5 to 24 form part of this statement.

Statement of Cash Flows for the period ended 30 June 2022

	Note	**3 month period end to 30 June 2022 £'000**	Full year accounts 2021/2022 £'000
Cash flows from operating activities			
Net operating expenditure for the financial period		(78,441)	(319,607)
(Increase)/decrease in inventories	9	158	(121)
(Increase)/decrease in trade and other receivables	10	604	(49)
Increase/(decrease) in trade and other payables	12	(5,923)	30
Increase in provisions	13	0	492
Net cash outflow from operating activities		**(83,602)**	(319,255)
Net cash outflow before financing		**(83,602)**	(319,255)
Cash flows from financing activities			
Net funding received		83,587	319,256
Net cash inflow from financing activities		**83,587**	319,256
Net increase (decrease) in cash and cash equivalents	11	**(15)**	1
Cash and cash equivalents at the beginning of the financial period		**39**	38
Cash and cash equivalents (including bank overdrafts) at the end of the financial period		**24**	39

The notes on pages 5 to 24 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 2022-23 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.

The Health and Care Act received Royal Assent on 28 April 2022. The Act allowed for the establishment of Integrated Care Boards (ICB) across England and abolishment of clinical commissioning groups (CCG). ICBs took on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities transfered 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 30 June 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.

Prescribing costs have been based on the latest information available which are the month 1 (April 2022) figures. The CCG makes an estimate of costs for the final two months of the year based on trends in previous years. The estimated costs for May and June 2022 total £5.0m.

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. See note 13.

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 the period to 30 June 2022. 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**

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.
IFRS 16 Leases is effective across public sector from 1 April 2022. The transition to IFRS16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the Standard have been employed. These are as follows;
- The CCG has applied the practical expedient offered in the Standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 Leases and IFRIC 4 Determining whether an Arrangement contains a Lease and not to those that were identified as not containing a lease under previous leasing standards.
- On initial application the CCG has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.
- No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the Standard.
- The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application, employed per paragraph C10 (c) of IFRS 16.
- Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1st April 2022 will be assessed under the requirements of IFRS 16.
There are further expedients or election that have been employed by the CCG in applying IFRS 16. These include;
- The measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16.
- The measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16.
- The CCG will not apply IFRS 16 to any new leases of intangible assets.

HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.
The CCG is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 the CCG has assessed that in all other respects these arrangements meet the definition of a lease under the Standard.
The CCG is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.
The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.
For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.11.1 **The CCG as lessee**

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability.
The CCG has not recognised any right of use assets in the period to 30 June 2022.

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. Please note that the discount rates to be used by NHS organisations are published once a year, therefore the ones in effect at 30 June 2022 are consistent with those published at 31 March 2022.

• A nominal short-term rate of 0.47% (2021/22: 0.47%) 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% (2021/22: 0.70%) 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% (2021/22 0.95%) 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% (2021/22: 0.66%) 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.

Notes to the financial statements

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.

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 Standard and Interpretation to be applied in the period to 30 June 2022.

1.23.1 **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 this standard as revised would not have a material impact on the accounts for the period to 30 June 2022, were they to be applied in that period.

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:

	3 month period end to 30 June 2022 Target £'000	**3 month period end to 30 June 2022 Performance £'000**	**3 month period end to 30 June 2022 Duty achieved**	Full year accounts 2021/2022 Target £'000	Full year accounts 2021/2022 Performance £'000	Full year accounts 2021/2022 Duty achieved
Expenditure not to exceed income	78,938	78,938	Yes	319,579	320,584	No
Revenue resource use does not exceed the amount specified in Directions	78,441	78,441	Yes	318,602	319,607	No
Revenue administration resource use does not exceed the amount specified in Directions	911	911	Yes	3,626	3,413	Yes

3. Other operating revenue

	3 month period end to 30 June 2022 Admin £'000	**3 month period end to 30 June 2022 Programme £'000**	**3 month period end to 30 June 2022 Total £'000**	Full year accounts 2021/2022 Total £'000
Income from sale of goods and services (contracts)				
Non-patient care services to other bodies	-	192	**192**	769
Other contract income	-	-	**-**	208
Total income from sale of goods and services	**-**	**192**	**192**	**977**
Other non contract revenue	-	304	**304**	-
Total other operating income	**-**	**304**	**304**	**-**
Total operating income	**-**	**496**	**496**	**977**

4. Revenue - Disaggregation of income - income from sale of good and services (contracts)

3 month period end to 30 June 2022

	Non-patient care services to other bodies	**Other contract income**	**Total**
	£'000	**£'000**	**£'000**
Source of revenue			
NHS	-	-	**-**
Non NHS	192	-	**192**
Total	**192**	**-**	**192**

	Non-patient care services to other bodies	**Other contract income**	**Total**
	£'000	**£'000**	**£'000**
Timing of revenue			
Point in time	-	-	**-**
Over time	192	-	**192**
Total	**192**	**-**	**192**

Full year accounts 2021/2022

	Non-patient care services to other bodies	Other contract income	Total
	£'000	£'000	£'000
Source of revenue			
NHS	-	74	74
Non NHS	769	134	903
Total	769	208	977

	Non-patient care services to other bodies	Other contract income	Total
	£'000	£'000	£'000
Timing of revenue			
Point in time	-	-	-
Over time	769	208	977
Total	769	208	977

5. Employee benefits and staff numbers

5.1.1 Employee benefits 3 month period end to 30 June 2022

3 month period end to 30 June 2022

	Permanent employees £'000	**Other £'000**	**Total £'000**
Employee benefits			
Salaries and wages	513	108	621
Social security costs	58	3	61
Employer contributions to NHS Pension scheme	86	4	90
Apprenticeship levy	1	-	1
Gross employee benefits expenditure	**658**	**115**	**773**
Less recoveries in respect of employee benefits (note 5.1.2)	-	-	-
Total - net employee benefits	**658**	**115**	**773**

Employee benefits Full year accounts 2021/2022

Full year accounts 2021/2022

	Permanent employees £'000	Other £'000	Total £'000
Employee benefits			
Salaries and wages	1,631	163	1,794
Social security costs	213	7	220
Employer contributions to NHS Pension scheme	430	10	440
Apprenticeship levy	6	-	6
Gross employee benefits expenditure	2,280	180	2,460
Less recoveries in respect of employee benefits (note 5.1.2)	-	-	-
Total - net employee benefits	2,280	180	2,460

5.1.2 Recoveries in respect of employee benefits

3 month period end to 30 June 2022

Full year accounts 2021/2022

	Permanent employees £'000	**Other £'000**	**Total £'000**	Total £'000
Employee benefits - revenue				
Salaries and wages	**-**	**-**	**-**	-
Total recoveries in respect of employee benefits	-	-	-	-

5.2 Average number of people employed

	3 month period end to 30 June 2022			Full year accounts 2021/2022		
	Permanently employed number	**Other number**	**Total number**	Permanently employed number	Other number	Total number
Total	**35**	**1**	**36**	34	2	36

5.3 Exit packages agreed in the financial year

The CCG did not agree any departures where exit packages have been made in the 3 month period to 30 June 2022 or 2021/22.

The CCG did not agree any departures where special payments have been made in the 3 month period to 30 June 2022 or 2021/22.

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 30 June 2022, is based on valuation data as 31 March 2021, updated to 30 June 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 Greater Preston CCG, with NHS Chorley and South Ribble CCG hosting their employment on behalf of NHS Greater Preston CCG. Therefore, a proportion of the employers contributions' below are recharged to NHS Greater Preston CCG and the figures included within note 5.1.1 reflect NHS Chorley and South Ribble CCGs share of the costs.

For the 3 month period to 30 June 2022, employers' contributions of £111,541 were payable to the NHS Pensions Scheme (2021/22: £658,459) at the rate of 20.68% (2021/22: 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

	3 month period end to 30 June 2022 Admin £'000	3 month period end to 30 June 2022 Programme £'000	3 month period end to 30 June 2022 Total £'000	Full year accounts 2021/2022 Total £'000
Purchase of goods and services				
Services from other CCGs and NHS England	338	742	1,080	3,489
Services from foundation trusts	-	45,218	45,218	178,227
Services from other NHS trusts	-	3,105	3,105	12,831
Purchase of healthcare from non-NHS bodies	-	10,998	10,998	52,099
Purchase of social care	-	1,108	1,108	4,189
Prescribing costs	-	7,498	7,498	30,901
Pharmaceutical services	-	13	13	49
GMS/PMS and APMS	-	8,302	8,302	32,289
Supplies and services – clinical	-	107	107	132
Supplies and services – general	(84)	44	(39)	899
Consultancy services	-	-	-	7
Establishment	5	49	54	226
Transport	-	-	-	(2)
Premises	43	(13)	29	364
Audit fees	49	-	49	65
Other non statutory audit expenditure				
· Internal audit services	-	-	-	27
· Other services	-	-	-	12
Other professional fees	1	17	18	83
Legal fees	-	12	12	100
Education, training and conferences	8	-	8	13
Total purchase of goods and services	**360**	**77,200**	**77,560**	**315,999**
Provision expense				
Provisions	-	-	-	492
Total provision expense	**-**	**-**	**-**	**492**
Other operating expenditure				
Chair and non executive members	92	-	92	372
Grants to other bodies	-	176	176	856
Inventories consumed	-	336	336	405
Total other operating expenditure	**92**	**512**	**604**	**1,634**
Total operating expenditure	**452**	**77,712**	**78,164**	**318,125**

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services

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	3 month period end to 30 June 2022 Number	3 month period end to 30 June 2022 £'000	Full year accounts 2021/2022 Number	Full year accounts 2021/2022 £'000
Non-NHS payables				
Total Non-NHS trade invoices paid in the period	3,936	26,643	14,951	95,276
Total Non-NHS trade invoices paid within target	3,892	26,488	14,902	94,840
Percentage of Non-NHS trade invoices paid within target	**98.88%**	**99.42%**	99.67%	99.54%
NHS payables				
Total NHS trade invoices paid in the period	202	53,298	500	203,418
Total NHS trade invoices paid within target	198	53,236	491	203,322
Percentage of NHS trade invoices paid within target	**98.02%**	**99.88%**	98.20%	99.95%

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

The CCG made no payments in respect of this legislation.

8. Leases - Right-of-use assets

The CCG recognised no right of use assets in the period to 30 June 2022.

9. Inventories

	3 month period end to 30 June 2022	
	Loan Equipment	**Total**
	£'000	**£'000**
Balance at 01 April 2022	785	785
Additions	178	178
Inventories recognised as an expense in the period	(336)	(336)
Balance at 30 June 2022	**627**	**627**

	Full year accounts 2021/2022	
	Loan Equipment	Total
	£'000	£'000
Balance at 01 April 2021	663	663
Additions	527	527
Inventories recognised as an expense in the period	(405)	(405)
Balance at 31 March 2022	785	785

10. Trade and other receivables	**Current 3 month period end to 30 June 2022 £'000**	Current Full year accounts 2021/2022 £'000
NHS receivables: revenue	583	903
NHS accrued income	-	833
Non-NHS and other WGA receivables: revenue	328	159
Non-NHS and other WGA prepayments	805	227
VAT	18	13
Other receivables and accruals	25	229
Total trade and other receivables	**1,759**	2,364
Total current and non current	**1,759**	2,364
Included above:		
Prepaid pensions contributions	-	-

10.1 Receivables past their due date but not impaired

	3 month period end to 30 June 2022 DHSC group bodies £'000	**3 month period end to 30 June 2022 Non DHSC group bodies £'000**	Full year accounts 2021/2022 DHSC group bodies £'000	Full year accounts 2021/2022 Non DHSC group bodies £'000
By up to three months	162	4	194	24
By three to six months	21	-	-	-
By more than six months	-	19	-	19
Total	**183**	**23**	194	43

11. Cash and cash equivalents

	3 month period end to 30 June 2022 £'000	Full year accounts 2021/2022 £'000
Balance at 01 April 2022	39	38
Net change in the period	(15)	1
Balance at 30 June 2022	**24**	**39**
Made up of:		
Cash with the Government Banking Service	24	39
Cash and cash equivalents as in statement of financial position	**24**	**39**
Balance at 30 June 2022	**24**	**39**

12. Trade and other payables	**Current 3 month period end to 30 June 2022 £'000**	Current Full year accounts 2021/2022 £'000
NHS payables: Revenue	1,419	1,189
NHS accruals	1,483	2,643
Non-NHS and other WGA payables: revenue	1,085	1,361
Non-NHS and other WGA accruals	6,500	7,940
Social security costs	72	64
Tax	61	65
Other payables and accruals	3,152	6,434
Total trade and other payables	**13,772**	19,696
Total current and non-current	**13,772**	19,696

Non-NHS and other WGA accruals and Other payables and accruals as at 30 June 2022 include assessments of outstanding healthcare costs for Individual Patient Activity of £1,666k (31 March 2022 £5,199k). It also includes £316k outstanding pension contributions at 30 June 2022 (31 March 2022 £242k).

13. Provisions and clinical negligence costs

13.1 Provisions 2022/23

	Current 3 month period end to 30 June 2022 £'000
Continuing care	492
Total	**492**
Total current and non-current	**492**

	Continuing Care £'000	Total £'000
Balance at 01 April 2022	**492**	**492**
Arising during the period	-	-
Balance at 30 June 2022	**492**	**492**
Expected timing of cash flows:		
Within one year	492	**492**
Balance at 30 June 2022	**492**	**492**

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 the 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 30 June 2022 is £0k (31 March 2022 £0k). The total value of legacy NHS continuing healthcare contingent liabilities accounted for by NHS England on behalf of this CCG at 30 June 2022 is £0k (31 March 2022 £0k).

13.2 Clinical negligence costs

NHS Resolution holds no provision as at 30 June 2022 (31 March 2022 £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 30 June 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:

	3 month period end to 30 June 2022 £'000	Full year accounts 2021/2022 £'000
In not more than one year	7,565	8,348
In more than one year but not more than five years	5,146	5,510
In more than five years	206	826
Total	**12,917**	14,684

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

	3 month period end to 30 June 2022	Full year accounts 2021/2022
	£'000	£'000
Financial assets measured at amortised cost		
Trade and other receivables with NHSE bodies	503	1,217
Trade and other receivables with other DHSC group bodies	196	640
Trade and other receivables with external bodies	238	268
Cash and cash equivalents	24	39
Total financial assets	**961**	2,164
Other current assets	1,449	1,024
Total current assets	**2,410**	3,188

15.3 Financial liabilities

	3 month period end to 30 June 2022	Full year accounts 2021/2022
	£'000	£'000
Financial liabilities measured at amortised cost		
Trade and other payables with NHSE bodies	307	1,570
Trade and other payables with other DHSC group bodies	2,595	2,312
Trade and other payables with external bodies	10,738	15,685
Total financial liabilities	**13,640**	19,567
Other current liabilities	132	129
Total current liabilities	**13,772**	19,696

16. Operating segments

The Clinical Commissioning Group had one segment and this is how it was reported within the organisation:

	Gross expenditure £'000	Income £'000	**Net expenditure £'000**	Total assets £'000	Total liabilities £'000	**Net assets £'000**
NHS Chorley and South Ribble Clinical Commissioning Group	78,938	(497)	**78,441**	2,410	(14,264)	**(11,854)**
Total	78,938	(497)	**78,441**	2,410	(14,264)	**(11,854)**

16.1 Reconciliation between Operating Segments and SoCNE

	3 month period end to 30 June 2022
	£'000
Total net expenditure reported for operating segments	78,441
Total net expenditure per the Statement of Comprehensive Net Expenditure	78,441

16.2 Reconciliation between Operating Segments and SoFP

	3 month period end to 30 June 2022
	£'000
Total assets reported for operating segments	2,410
Total assets per Statement of Financial Position	2,410
Total liabilities reported for operating segments	(14,264)
Total liabilities per Statement of Financial Position	(14,264)

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 for the 3 month period end to 30 June 2022				Amounts recognised in Entities books ONLY for the Full year accounts 2021/2022			
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 - 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	**-**	**-**	**(189)**	**649**	-	-	(756)	2,843
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	**-**	**-**	**(2,621)**	**3,714**	-	-	(9,902)	14,033

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:

	3 month period end to 30 June 2022		Full year accounts 2021/2022	
	Payments to related party £'000	**Amounts owed to related party £'000**	Payments to related party £'000	Amounts owed to related party £'000
Dr L Dickinson - GP Director				
NHS Chorley and South Ribble CCG				
General Practitioner (Partner) - The Chorley Surgery	**674**	**158**	2,485	103
Shareholder of Chorley Collaborative Group - Limited Company	**-**	**-**	109	-
Dr J Cairns - GP Director NHS Chorley and South Ribble CCG				
General Practitioner (Partner) - The Library House Surgery	**424**	**161**	2,280	139
Dr Ravi Gokul - GP Director NHS Chorley and South Ribble CCG				
Kingsfold Medical Centre	**170**	**19**	685	27
Shareholder and Director Ribble Medical Group ltd - Current				
Dr A Robinson - GP Director NHS Chorley and South Ribble CCG				
General Practitioner (Partner) - Withnell Health Centre	**165**	**30**	758	29
Dr S Singh - GP Director NHS Chorley and South Ribble CCG				
General Practitioner (Partner) - Clayton Brook Surgery	**50**	**63**	869	57

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 period 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.
The Act allowed for the establishment of Integrated Care Boards (ICB) across England and abolishment of clinical commissioning groups (CCG). ICBs took on the commissioning functions of CCGs from 1 July 2022.
On this date NHS Chorley and South Ribble CCG ceased to exist; its services continued to be provided by NHS Lancashire and South Cumbria ICB. The functions, assets and liabilities of the CCG transferred to Lancashire and South Cumbria ICB.

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 3 month period end to 30 June 2022 Number	**Total Value of Cases 3 month period end to 30 June 2022 £'000**	Total Number of Cases Full year accounts 2021/2022 Number	Total Value of Cases Full year accounts 2021/2022 £'000
Administrative write-offs	**-**	**-**	3	1
Total	**-**	**-**	3	1

20.2 Special payments

The CCG had no special payments for the period to 30 June 2022 or for the financial year 2021/22.