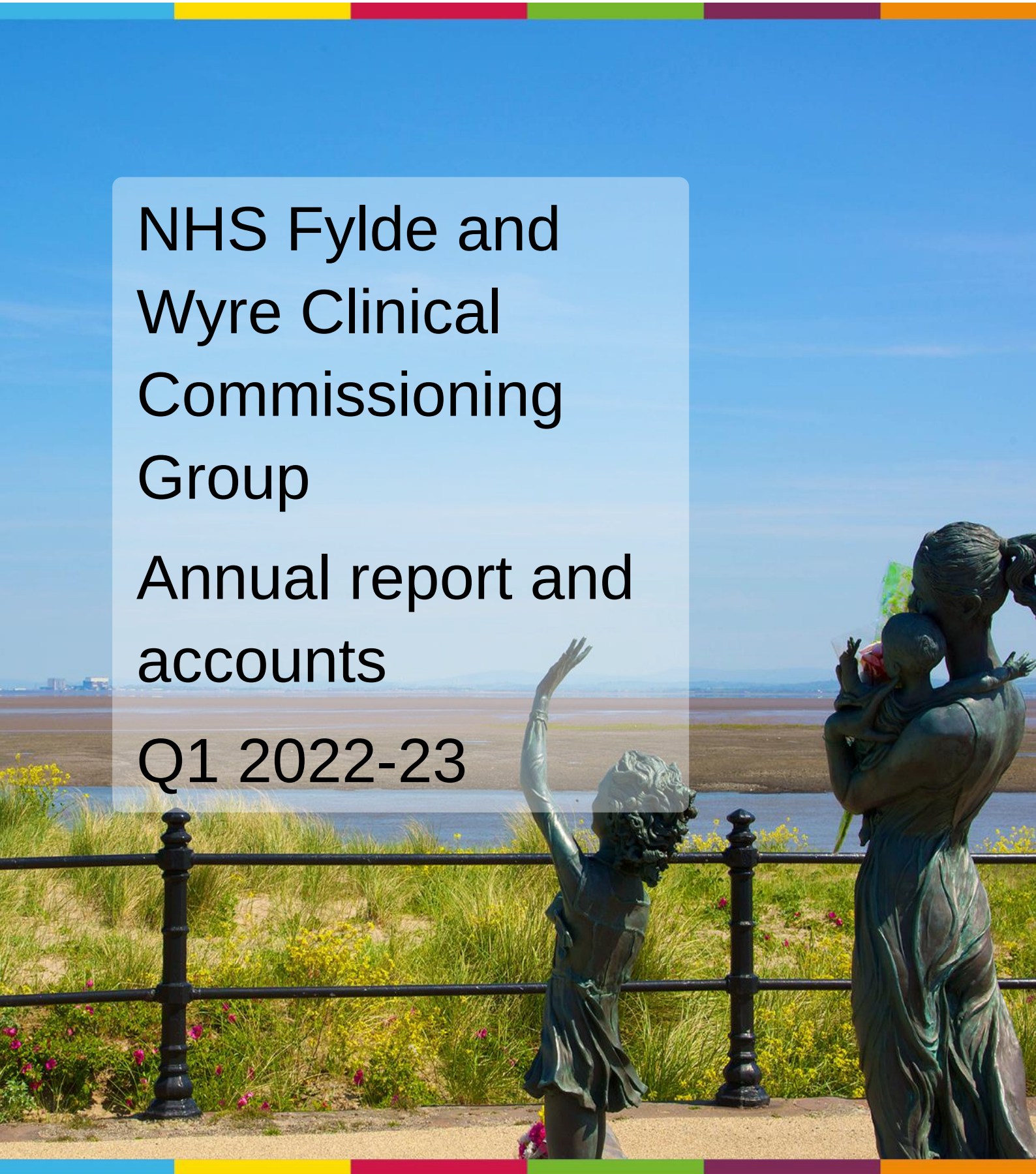
NHS
Fylde and Wyre
Clinical Commissioning Group

NHS Fylde and Wyre Clinical Commissioning Group

Annual report and accounts

Q1 2022-23



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Welcome

Welcome to the Quarter 1 2022-2023 Annual Report for NHS Fylde and Wyre Clinical Commissioning Group.

The national extension of the Integrated Care Board establishment meant that the CCG continued with its statutory arrangements until 30 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.

This is the last report from the CCG and at the time of writing we are already working as our newly formed Integrated Care Board. Although our teams and the place based partnerships will continue the incredible work done in Fylde and Wyre over the last eleven years we must take this opportunity to thank you for your support, valued input and continued interest in the NHS. We continue to strive for the best NHS services we can offer to serve our very diverse population.

Thank you.

About this Annual Report

This annual report has been written within the requirements of the Department of Health's annual report and accounts guidance. We have attempted to make sure this document is:

- People-focused,
- Informative
- Easy to read and understand, and
- Visually appealing.

As you will read much of the activities of the CCG during April-July 2022 were carried out in a manner that was in line with the transition to the new integrated care board which came in to being from 1 July 2022. As such, much of the activity was carried out across Lancashire and South Cumbria and the content of this annual report is therefore prepared as a joint narrative for all CCGs in the Lancashire and South Cumbria system. Some figures referenced in the performance report may represent this system wide approach. Likewise, some analysis may only be available as part of a Fylde Coast approach to joint working which we started three years ago. We have ensured all figures are properly explained and attributed to the correct area.

Where possible we have taken the views of the public into account when preparing the report. For last year's report we heard some of you telling us there was too much information. Due to the shorter timeframe represented by this report there is less information to share however we wanted to be as thorough as possible. We have tried to reduce the amount of jargon and use other ways of representing information where possible.

Part 1: 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.

NHS Fylde and Wyre Clinical Commissioning Group is a clinically led organisation, which brings together 19 local GP practices and other health professionals to plan and design services to meet local patients' needs. Our GP practices serve a registered population of 178,000 across 449sq/km of a largely coastal area. We have an allocated budget of £405.2m that we spend on health and care services for our population.

The CCG is responsible for commissioning (or buying) a range of services for people living in Fylde and Wyre, including urgent care (such as A&E and the out-of-hours GP service), routine hospital treatment, mental health and learning disability services, community healthcare (such as district nursing) and continuing healthcare packages.

The primary provider organisations with whom we have contractual arrangements for services include:

- Blackpool Teaching Hospitals NHS Foundation Trust
- Lancashire and South Cumbria NHS Foundation Trust
- North West Ambulance Service NHS Trust
- Fylde Coast Medical Services Ltd
- Spire Fylde Coast Hospital

We also work with Healthwatch, the independent champion for local people who use health and social care services.

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

In response to the priorities set by NHS England nationally during period of 2021-22, local systems continued to prioritise 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.

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.

Working with our partners

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.

We 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

Accountable Officer

Lancashire and South Cumbria Integrated Care Board

(on behalf of the former Fylde and Wyre Clinical Commissioning Group)

21 June 2023

Performance Overview

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 [1]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 helpful.

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.[2]

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,

[1] https://www.gp-patient.co.uk/
[2] Appointments in General Practice, May 2022 - NHS Digital

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.

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 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

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 critical 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 supports 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 Northwest 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 Northwest 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.

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.

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. A funding awards event is scheduled for July 2022, supported by leaders from Populations Health, Active Lancashire, Health Transformation and more.

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 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.

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. A surge in June 2020 has been sustained 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 last year, roles for 2022/23 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** will be implemented, with staff recruited in early 2022/23. 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 in April and May 2022.

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.

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.

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.

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.

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 (#improvingheartheath #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.

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.

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.

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).

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.

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 and University Hospitals Morecambe Bay NHS Foundation Trust actively using the new system. Blackpool Teaching Hospitals NHS Foundation Trust is due to go live in early summer 2022.

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 March 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.

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.

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.

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%[3]). We know that adverse living conditions (including child poverty) leads to significant variation in childhood development and school readiness. The percentage of children living in poverty ranges from 12% to 38% (the national average is 30%).

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

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

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

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

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

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

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

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

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.

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 will facilitate better partnership working, as well as enhance 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.

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.

Performance Analysis

Quality and performance indicators		Actual (YTD)	Target
A&E waiting times	% patients admitted, transferred or discharged within four hours of arrival at A&E	**78.92%**	95.00%
Referral to treatment (RTT) times for non-urgent consultant-led treatment	% patients on incomplete pathway waiting less than 18 weeks	**63.79%**	92.00%
Diagnostic waiting times	% patients waiting no more than six weeks for diagnostic test	**23.11%**	1.00%
Cancer two-week wait	% patients with maximum two-week wait for first outpatient appointment when referred urgently with suspected cancer by a GP	**86.43%**	93.00%
	% patients with maximum two-week wait for first outpatient appointment when referred urgently with breast symptoms (cancer not initially suspected) by a GP	**88.00%**	93.00%
Cancer 31-day wait	% patients with maximum 31-day wait from diagnosis to first definitive treatment for all cancers	**87.33%**	96.00%
	% patients with maximum 31-day wait for subsequent treatment (surgery)	**67.11%**	94.00%
	% patients with maximum 31-day wait for subsequent treatment (anti-cancer drug regime)	**100.00%**	98.00%
	% patients with maximum 31-day wait for subsequent treatment (radiotherapy)	**98.25%**	94.00%
Cancer 62-day waits	% patients with a maximum 62-day wait from urgent GP referral to first definitive treatment for cancer.	**63.89%**	85.00%
	% patients with a maximum 62-day wait from referral from an NHS screening service to first definitive treatment for cancer.	**75.00%**	90.00%
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of a patient (all cancers)	**83.50%**	No target

Quality and performance indicators		Actual (YTD)	Target
Mental health: Care Programme Approach (CPA)	The proportion of people under adult mental health specialties on CPA who were followed up within seven days of discharge from psychiatric in-patient care during the period	**100.00%**	95.00%
Referral to treatment waiting times	Number of more than 52-week waiters (incomplete pathways)	**1066**	0
Incidence of healthcare associated infection	CDI (C Difficile Infections): Number of infections	**29**	89
	MRSA: Number of infections	**0**	0
Never events[4]	Number of events	**0**	0
Serious incidents[5]	New incidents	**13**	0
Dementia	Estimated diagnosis rate for people with dementia	**58.81%**	66.70%
Improving Access to Psychological Therapies (IAPT)	The recovery rate of people using IAPT services	**58.82%**	50.00%
	The proportion of people that wait 18 weeks or fewer from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	**98.77%**	95.00%
	The proportion of people that wait six weeks or fewer from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	**91.63%**	75.00%

There are performance concerns in respect of the following areas:

A&E Waiting Times

A&E performance for patients to be seen within 4 hours has not achieved the target of 95% between April and June 2022 with performance at 78.92%.

The infection prevention and control (IPC) guidelines, which were adapted to ensure safety during the COVID-19 pandemic are closely followed by the Trust for patients entering A&E. This clearly does impact upon the time taken between patients and consequently upon waiting times for patients.

The CCG is working collaboratively with the Trust and all Fylde Coast providers and partners to ease these pressures by ensuring patients are signposted to the most appropriate clinical setting for their conditions to be treated appropriately and efficiently.

[4] Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. An example could be an operation on wrong limb.
[5] Serious incidents are events where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive investigation.

18-week Referral to Treatment Target

Fylde and Wyre CCG did not achieve the 92% RTT open pathway standard between April and June 2022 with performance at 63.79%. Work continues to be focused at specialty level to reduce the number of long waiting patients. A continuous programme of audit and validation is supporting the Trust Patient Tracking List (PTL) management. This focuses across outpatient, diagnostic and waiting list elements of the pathway. Full Trust validation of the waiting lists continues to take place on a weekly basis together with ongoing clinical triage at Consultant level to ensure that all patients are treated in order of clinical priority.

The Fylde Coast CCGs have also continued to engage with independent sector providers across Lancashire throughout 2022/23 to increase capacity and reduce waiting times for patients. This has focussed on equity of access with clinical priorities taking first place, followed by long waiting patients being treated in turn. There has also been a concerted focus on the timely discharge of patients to maximise all available bed stock and improve patient flow within Blackpool Teaching Hospitals.

Cancer Waiting Times

The CCG is not meeting some of its cancer waiting times targets and action plans; led by the Lancashire and South Cumbria Cancer Alliance are in place to support improvement and recovery trajectories.

Diagnostics

The diagnostics standard of less than one per cent of patients waiting no longer than six weeks has not been achieved by Fylde and Wyre CCG, this is predominantly due to constraints within the endoscopy service which have been exacerbated by the COVID-19 pandemic. Blackpool Teaching Hospitals has an action plan in place which has improved performance; however, it is important to note that there are performance issues within the endoscopy services across Lancashire.

Estimated Diagnosis rate for people with dementia

The dementia diagnosis rate of 66.7 per cent has not been achieved by Fylde and Wyre CCG between April and June 2022. The service has an action plan in place to improve performance.

Serious Incidents

The Serious Incident Framework (SIF) identifies the process for providers to use to notify the CCG that an incident meeting the serious incident criteria has occurred. The provider submits a rapid review to the CCG within 72 hours of notification, followed by a comprehensive investigation within 60 working days. On receipt of the investigation the CCG reviews and approves the learning, recommendations and actions before the incident can be closed.

Sustainable Development

We are required to report our progress in delivering against sustainable development indicators.

We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

We will ensure we comply with our obligations under the Climate Change Act 2008, including the Adaptation Reporting Power, and the Public Services (Social Value) Act 2012.

We have a sustainable development management plan which sets out our commitments as a socially responsible employer. This features:

- compliance with environmental legislation.
- governance.
- organisational and workforce development.
- partnerships and networks.
- finance.
- energy and carbon management.
- commissioning and procurement.
- low carbon travel transport and access.
- water and waste.
- designing building environment.

Key to delivery is working with other stakeholders such as NHS Property Services in areas where joint understanding and working is necessary.

The COVID pandemic has meant that we have endorsed an ‘agile working’ approach across our organisation. This means that our employees have adopted a mix of work arrangements, spending the majority of their working hours away from a formal office and flexibility about where people can work if they do need to attend a CCG office for a specific reason or work activity. Our workforce has embraced the opportunities that agile working brings to support our sustainable development work, for example; reduction in travel time by using virtual meeting options such as Microsoft Teams, reduction in paper usage, more effective use of technology, reduced travel impact (for example cost and fuel usage) and lower energy consumption in offices.

We recognise our responsibility towards sustainability and the many benefits it brings. Working closely with our partners and providers, we continue to support new ways of working and development that embrace the concept of sustainability.

Any new projects, either new build or refurbishment, will include a sustainable package of measures that for example will include low energy lighting (LEDs) sustainable drainage solutions, heating controls and procurement of locally sourced materials and labour as standard and much more.

Working closely with health partners, encouragement will be given to the feasibility of ‘one-stop health provision’ and the reduction in the need to make multiple trips to several locations in the same town. Travel plans will be explored to reduce car journeys and shared with stakeholders.

Such an approach will be undertaken with new developments to co-locate health services under one roof. The CCG will be investigating further opportunities for other services at all of its sites. Continuing dialogue will be held with staff and providers.

The CCG's estates strategy sets out the vision for the next few years ahead where sustainability will play a key role in all developments.

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.

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 52 week wait 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 district nurse service and a risk matrix framework to assess children's needs to identify those children that can effectively be seen 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 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 Marie Gascoigne model is being developed in Pennine Lancashire 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 CCGs successfully concluded the CCG closedown programme on 30 June 2022 following completion of the national due diligence checklist and final assurance processes.

Mersey Internal Audit Agency (MIAA) were integral to this process throughout and the CCGs received full assurance of the systems and processes in place to deliver the programme, with no recommendations for improvement.

The CCGs transitioned to the Lancashire and South Cumbria Integrated Care Board (ICB) on 1 July 2022 in line with legislation. A robust handover process took place between the CCGs and the ICB to facilitate smooth transition to the new organisation.

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.

PPGs in Blackpool, Fylde and Wyre

Primary care on the Fylde Coast continues to benefit from incredible dedication from a number of local volunteers who are members of their GP practice's patient participation group (PPG).

Unfortunately, during the COVID-19 pandemic, many PPGs were unable to continue with the valuable work they had done to support their GP practices and fellow patients due to the necessary restrictions that were imposed.

However, with the lifting of those restrictions, groups have steadily begun to return to business as usual with a number of PPGs now holding regular meetings, many of these now in a face-to-face setting. Wider activities hosted by PPGs across the Fylde Coast include listening tables in surgeries, while some are taking part in public events and awareness-raising activities for specific health conditions.

The PPG Network, which brings together representatives of PPGs across the Fylde Coast, continues to meet on a bimonthly basis and allows members to hear updates from their local NHS and also to share best practice and learn from the activities of fellow groups in other areas.

Keeping people informed

We make use of three main social media channels as well as our website to keep people informed. The below diagram shows the impact our social media has had during April-July.

Channel	Posts	Reach/impressions	Link clicks	Followers
Facebook	278	453,754	1,710	9117
Twitter	264	35,795	917	6,096
LinkedIn	2	86	7	249
Totals	544	489,635	2,634	15,462

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 ensured 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 had 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 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 July 2022, the newly established Lancashire and South Cumbria Integrated Care Board (ICB) 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

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.

Financial performance

As a result of the dissolution of Fylde and Wyre CCG on 30 June 2022, this report covers the financial performance for the first quarter of the 2022-23 financial year i.e., 1 April to 30 June 2022.

During this period financial performance was undertaken in accordance with the 2022-23 financial framework, requiring CCGs to report a breakeven position at 30 June 2022.

As in 2021-22, the CCG continued to operate within a system planning environment approach with key finance decisions being evaluated and discussed by the Lancashire & South Cumbria system healthcare organisations.

International Reporting Standard IFRS16: Leases has been introduced in the healthcare sector with effect from 1 April 2022. A review of the CCG's arrangements identified no material impact on Fylde and Wyre CCG's accounts for the period 1 April to 30 June 2022 in respect of IFRS16.

As part of the CCG financial monitoring, the progress of service providers (for example local hospitals, community services, primary care practices) were tracked against several national outcomes indicators and ensure that patient rights within the NHS Constitution were maintained. Financial performance reports were presented to and scrutinised by every meeting of the Governing Body (papers for these are available from the CCG website).

NHS providers continued to receive a nationally determined 'block' contract payment from the CCG for the period 1 April to 30 June 2022. This was to maintain a measure of financial stability for all parties.

The CCG managed to achieve cost saving efficiencies of £1,508k during this financial period.

Financial key performance indicators

The CCG's performance is measured against several 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 £81.9m	Total expenditure £81.9m	Achieved
Delivery of a control total of breakeven	Deliver a control total of breakeven	Breakeven	Achieved
Revenue administration resource use does not exceed the amount specified in Directions	Maintain administration (running costs) expenditure within the allocated resource of £0.836m	Total administration (running costs) expenditure £0.836m	Achieved

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 99.0% by number, 99.2% by value NHS payables 96.8% by number, 99.6% by value	Achieved

Allocation

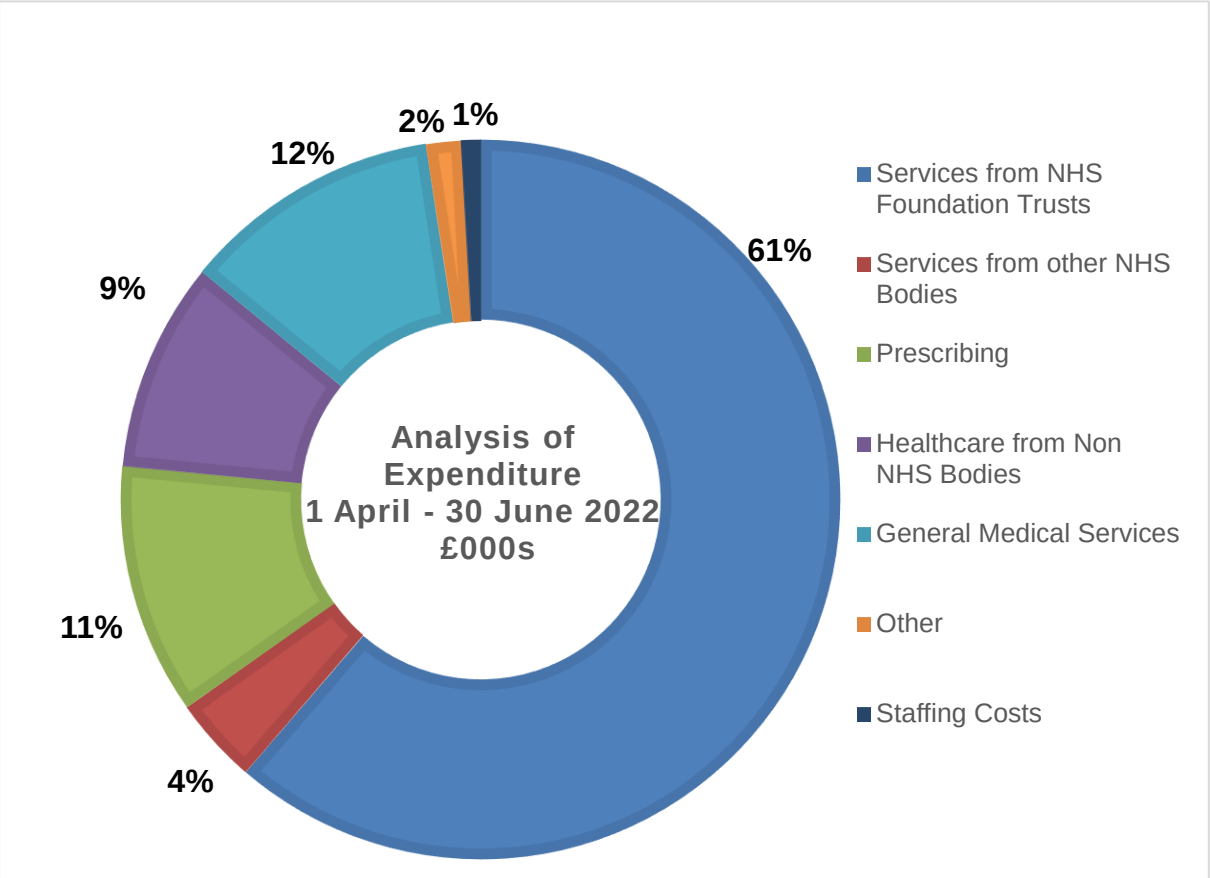
The total allocation to Fylde and Wyre CCG for 1 April to 30 June 2022 of £81.9m was divided into the following categories:

- We received allocations totalling £72.9m for commissioning NHS services for both the local community
- We received a further allocation of £8.188m for delegated commissioning of primary care medical services
- We received a further allocation of £0.836m from which we were expected to cover all our running costs.

Accounting policies

The CCG's accounting policies are shown in full in Note 1 to the Annual Accounts. The Annual Accounts have been prepared on the 'going concern' basis (Note 1.1 to the Accounts provides further detail on the adoption of the going concern assumption). This policy allows for the transfer of services to the Lancashire & South Cumbria Integrated Care Board from 1 July 2022. 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.

Analysis of operating expenses 1 April to 30 June 2022



Kevin Lavery

Accountable Officer

Lancashire and South Cumbria Integrated Care Board

(on behalf of the former Fylde and Wyre Clinical Commissioning Group)

21 June 2023

Part 2: ACCOUNTABILITY REPORT

Corporate Governance Report

Members' Report

The Member Practices of the CCG

NHS Fylde and Wyre CCG is a clinically led organisation that brings together local GP practices and other health professionals to plan and design services to meet local patients' needs. The Council of Members represents all of our member practices and usually meets monthly. Voting members include the clinical chief officer of the CCG and a nominated clinical representative from each of the 19 GP practices that made up the CCG during April to June 2022. The practice clinical representatives as at 30 June 2022 are presented below.

Surname	First name	Practice	Address
Adam	Safaraz	Parcliffe Medical Practice*	St Annes Health Centre, Durham Avenue, St Annes, FY8 2EP
Bolton	Claire	Over Wyre Medical Centre	Wilkinson Way, Off Pilling Lane, Preesall, FY6 0FA
Chandrasekar (Vice Chair)	Vellore	Beechwood Surgery	Old Bank Medical Centre, 155 Victoria Road East, Thornton-Cleveleys, FY5 5HH
Chavali	Madhu	Ash Tree House	Church Street, Kirkham, PR4 2SE
Cutting	Tom	Great Eccleston Health Centre	Raikes Road, Preston PR3 0ZA
Daruzzaman	Adam	Fernbank Surgery	Lytham Primary Care Centre, Victoria Street, Lytham, FY8 5DZ
Dingle	George	Garstang Medical Practice	Kepple Lane, Garstang, Preston, PR3 1PB
Greenwood (Chair)	Kath	Queensway Medical Centre	Queensway, Poulton-Le-Fylde, FY6 7ST

Surname	First name	Practice	Address
Guest	Felicity	Thornton Practice	Church Road, Thornton-Cleveleys, FY5 2TZ
Hardwick	Stephen	Kirkham Health Centre	Moor Street, Kirkham, PR4 2DL
Janjua	Adam	Fleetwood Surgery	West View Health Village, Fleetwood, FY7 8GU
Hakeem-Habeeb	Ajibola	Mount View Practice	Fleetwood Health and Wellbeing Centre, Dock Street, Fleetwood, FY7 6HP
Kirkham	Ian	Lockwood Surgery	Civic Centre, Breck Road, Poulton-Le-Fylde, FY6 7PU
Norcross	James	Ansdell Medical Centre	Albany Road, Lytham St Annes, FY8 4GW
Pandya	Preeti	Village Practice	Church Road, Thornton-Cleveleys, FY5 2TZ
Sloan	Morag	Holland House Surgery	Lytham Primary Care Centre, Victoria Street, Lytham, FY8 5DZ
Samad	Shahid	Poplar House Surgery	St Annes Health Centre, Durham Avenue, St Annes, FY8 2EP
Smyth	Rob	Broadway Medical Centre	West View Health Village, Broadway, Fleetwood, FY7 GU
Thorpe	Russell	Old Links Surgery	104 Highbury Road East, St Annes, FY8 2LY
Varia	Meenakshi	Parcliffe Medical Centre*	St Annes Health Centre, Durham Avenue, St Annes, FY8 2EP

*Parcliffe Medical Centre had two named representatives following the merger of Park Medical Practice and Clifton Medical Practice, albeit one GP attended meetings as the Practice Representative.

The Register of Interests for the Council of Members can be accessed at the following link: https://www.fyldecoastccgs.nhs.uk/about-us/lists-and-registers/
www.lancashireandsouthcumbria.ICB.NHs.uk/legacyccgs

The CCG Governing Body

- Dr Adam Janjua, Chair/Elected Clinical Member
- Andrew Bennett, Interim Accountable Officer
- Michael Nuttall, Lay Member (Governance) / Chair, Audit Committee
- Kevin Toole, Lay Member (Patient and Public Involvement) / Vice Chair / Member, Audit Committee
- Dr Kath Greenwood, Elected Clinical Member / Council of Members' Chair
- Dr Peter Benett, Elected Clinical Member
- Dr Vellore Chandrasekar, Elected Clinical Member
- Dr Ian Stewart, Secondary Care Doctor / Member, Audit Committee
- Andrew Harrison, Chief Finance Officer
- *John Gaskins, Acting Chief Finance Officer assumed Executive responsibility on behalf of Andrew Harrison as and when required*
- Jane Scattergood, Director of Nursing and Quality (During the period 1 April 2022 to 30 June 2022, a Director of Nursing and Quality within Lancashire and South Cumbria Integrated Care System and Chief Nurse/SRO COVID-19 Vaccination Programme)
- *Nick Medway, Interim Deputy Director of Nursing and Quality assumed Executive responsibility on behalf of Jane Scattergood (During the period 1 April 2022 to 30 June 2022)*

The following were in attendance at Governing Body meetings (non-voting):

- Dr Neil Hartley-Smith, Clinical Director

- Jane Higgs, NHS Interim Management and Support (Locality Director)

The Register of Interests for the Governing Body Members can be accessed at the following link:https://www.fyldecoastccgs.nhs.uk/about-us/lists-and-registers/
www.lancashireandsouthcumbria.ICB.NHs.uk/legacyccgs

The Register of Gifts and Hospitality can be accessed at the following link:https://www.fyldecoastccgs.nhs.uk/about-us/lists-and-registers/
www.lancashireandsouthcumbria.ICB.NHs.uk/legacyccgs

Committees of the Governing Body

Six committees assisted in the delivery of the statutory functions and key strategic objectives of the CCG:

- Audit Committee
- Clinical Commissioning Committee
- Finance and Performance Committee
- Primary Care Commissioning Committee
- Remuneration Committee
- Quality Improvement and Engagement Committee

For full details of committee functions, membership and attendance during April to June 2022, please see the Governance Statement section.

The membership of the Audit Committee is as follows:

- Michael Nuttall, Lay Member (Governance) (Chair)
- Kevin Toole, Lay Member (Patient and Public Involvement)
- Dr Ian Stewart, Secondary Care Doctor

External Audit

- Fee - During April to June 2022, KPMG LLP was the external auditor for NHS Fylde and Wyre CCG. KPMG's fee for external audit services for this period was £51,500 (exclusive of VAT).
- The financial statements also include an estimate for one quarter of the fee associated with the audit of the 2022/23 mental health investment standard return. It is expected that this audit will take place in 2023/24. The fee for 2022/23 is estimated at £10,000 (exclusive of VAT) and therefore one quarter of this is £2,500 (exclusive of VAT).

Statement of Disclosure to Auditors

Each individual who was a member of the CCG during the time the Members' Report relates to confirmed:

- So far as the member was aware, there was no relevant audit information of which the CCG's auditor was unaware that would be relevant for the purposes of their audit report;
- The member took 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 was aware of it.

Personal Data Related Incidents

The CCG recognised the importance of maintaining data in a safe and secure environment. It used the Serious Incidents Requiring Investigation (SIRI) tool to assess any matters involving potential data loss to the organisation. The tool required the reporting of any data incidents rated at level two or above via the information governance toolkit.

Modern Slavery Act

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

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). An Interim Accountable Officer was appointed in post from 1 April 2022 up to 30 June 2022.

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.
- 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);
- 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 Section 14R of the National Health Service Act 2006 (as amended));
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS/E/I 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 net expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer was 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;
- Prepare the financial statements on a going concern basis;
- 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 Fylde and Wyre

Clinical Commissioning Group's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board

(on behalf of the former Fylde and Wyre Clinical Commissioning Group)

21 June 2023

Governance Statement

Introduction and Context

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

The CCG'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 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 CCG 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 supported the achievement of the 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 my Clinical Commissioning Group Interim Accountable Officer Appointment Letter.

I was responsible for ensuring that the CCG was administered prudently and economically and that resources were applied efficiently and effectively, safeguarding financial propriety and regularity. I also had 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 was to ensure that the CCG made appropriate arrangements for ensuring that it exercised its functions effectively, efficiently and economically and complied with such generally accepted principles of good governance as were relevant to it.

The members of the CCG were responsible for determining its governing arrangements, which were set out in the CCG's Constitution and published on the CCG's website:

https://www.fyldecoastccgs.nhs.uk/document/fylde-and-wyre-ccg-constitution-31-july-2019-v5-7-pdf/ www.lancashireandsouthcumbria.ICB.NHs.uk/legacyccgs

The CCG was accountable for exercising its statutory functions. It could grant authority to act on its behalf to any of its members, its Governing Body, employees or a committee or sub-committee of the CCG. Section 6 of the CCG's Constitution detailed the governing structure of the CCG. The extent of the authority to act of the respective bodies and individuals depended on the powers delegated to them by the CCG as expressed through the Constitution; the CCG's Scheme of Reservation and Delegation; and for committees, their terms of reference.

The CCG's Scheme of Reservation and Delegation (Appendix D of the Constitution) set out those decisions that were reserved for the membership as a whole, and those decisions that were the responsibilities of the Governing Body, committees and sub-committees, individual members and employees.

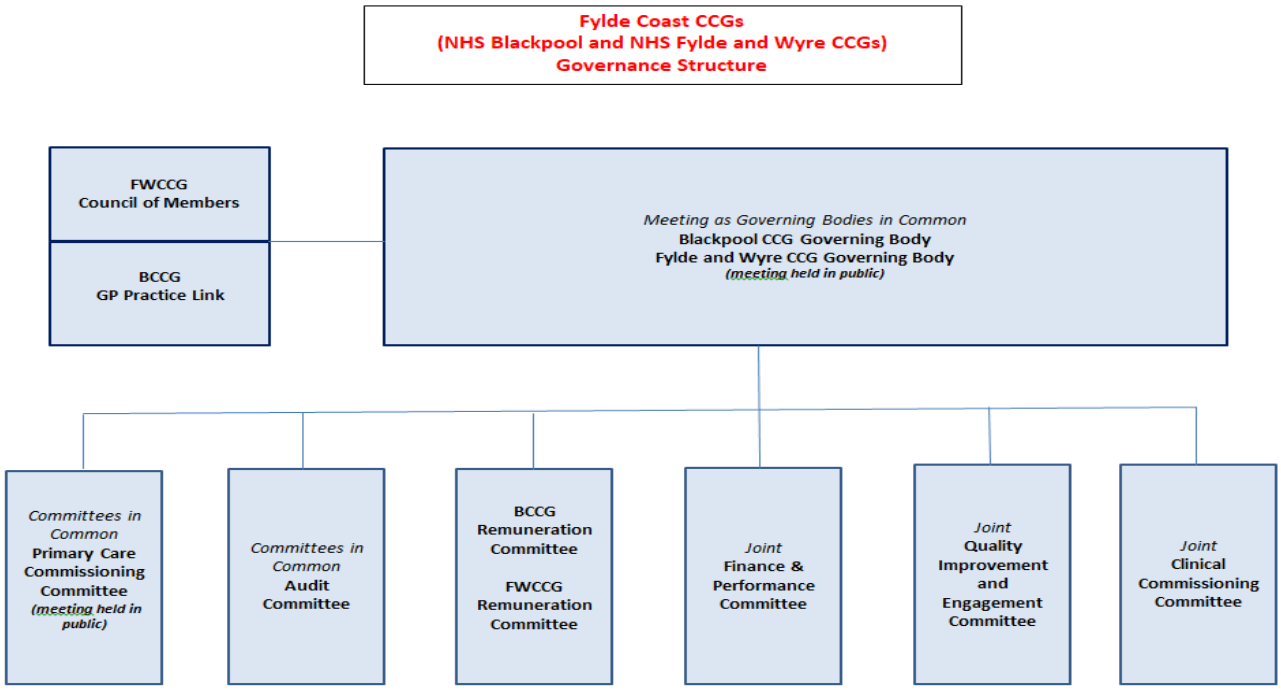
During the reporting period, arrangements were maintained to ensure that the CCG was able to properly discharge its statutory functions, duties and responsibilities. In addition, robust performance management processes remained in place with clear lines of accountability through established formal arrangements.

The CCG's Constitution outlined the principles of good governance which must be adhered to at all times in the way by which the CCG conducted its business. They included the need for the highest standards of propriety, impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business.

The CCG's Constitution established those matters and arrangements that were reserved to the Council of Members and those which were delegated to the Governing Body and the relevant CCG committees.

Taken together, the documents enabled maintenance of a robust system of internal control. The CCG remained accountable for all of its functions, including any it had delegated.

Assurance was provided to the Council of Members through the following structural and organisational control:



Fylde Coast CCGs Committee Arrangements

Committees of the Governing Body were established as either 'Joint Committees' or 'Committees in Common' as appropriate, except the Remuneration Committee. 'Joint committees' operated as a single committee containing members from both CCGs. They used a single agenda and usually reached one conclusion or recommendation on matters put before them. A 'committees in common' meeting was effectively a forum in which separate organisations held their equivalent committees within the same arrangements.

Membership of 'committees in common' was therefore exclusive to those proposed by the host organisation and whilst there may have been different agendas, there was common debate around single topic items for these agendas. However, decisions and voting took place consecutively with each organisation making its decision specific to its' own agenda.

Terms of reference and membership of the Governing Body committees – In light of the proposed structural changes to establish greater integrated commissioning across Lancashire and South Cumbria and the need to prioritise how existing CCG staffing resources were used, it was recommended and subsequently agreed by the Governing Body that the review of all committee terms of reference would not be undertaken but recognising that should there be any changes in terms of CCGs or committee business, reviews would be considered. Terms of reference and membership of the Governing Body committees can be found at https://www.fyldecoastccgs.nhs.uk/about-us/governing-bodies/fylde-and-wyre-ccg-committees/ www.lancashireandsouthcumbria.ICB.NHs.uk/legacyccgs

Fylde Coast CCGs Leadership Arrangements

During April to June 2022, Andrew Bennett was the Interim Accountable Officer of NHS Blackpool CCG, NHS Fylde and Wyre CGG and NHS West Lancashire CCG.

During April to June 2022, in addition to her role of CCG Director of Nursing and Quality, Jane Scattergood was also a Director of Nursing and Quality within Lancashire and South Cumbria Integrated Care System and Chief Nurse/SRO COVID-19 Vaccination Programme).

Andrew Harrison continued in his role as Chief Finance Officer of NHS Morecambe Bay CCG in addition to his existing roles as Chief Finance Officer of NHS Fylde and Wyre CCG and NHS Blackpool CCG. In order to support this arrangement, John Gaskins continued in his role as Acting Chief Finance Officer for Blackpool CCG and Fylde and Wyre CCG.

During April to June 2022, interim leadership and management arrangements continued to be in place to ensure the Fylde Coast CCGs continued to operate effectively and safely. Dr Neil Hartley-Smith, Clinical Director, continued to take on the formal Chief Operating Officer responsibilities, supported by Jane Higgs providing interim management and support.

COVID-19 Pandemic

During April to June 2022, all NHS organisations continued to work extremely hard in their response to the COVID-19 pandemic. As reported in previous reports, the CCG modified its arrangements and CCG staff continued to work from home. The CCG operated in accordance with guidance issued by NHSE/I and whilst there was some relaxation of 'business as usual' requirements, organisations continued to have a statutory responsibility to ensure effective and robust governance arrangements were in place. This enabled organisations to realign their capacity and resources in order to operate effectively in the

current climate and make safe decisions. Governing Body and committee meetings continued to be held via video conference during April to June 2022.

Council of Members

The Council of Members had final authority for all CCG business and established the vision, values and overall strategic direction for the organisation. It had reserved powers with respect to authorisation of the CCG Constitution, commissioning strategy and election/ratification of key appointments to the CCG Governing Body.

The Council of Members met in June 2022 (virtually) which was a joint meeting with Blackpool CCG's GP Practice Link. Where decisions required the membership's approval, arrangements were put in place to enable these to be carried out virtually.

Governing Body

The Governing Body had its functions conferred on it by sections 14L(2) and (3) of the 2006 Health and Social Care Act, inserted by section 25 of the 2012 Health and Social Care Act. In particular, it had responsibility for:

- ensuring the CCG had appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance (its main function).
- determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act.
- approving any functions of the CCG that are specified in regulations (section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act)
- planning, setting the vision, strategy and operational plans
- approving commissioning plans
- monitoring performance against plans
- providing assurance of strategic risk
- commissioning community health services; maternity services, elective hospital services, urgent and emergency services. Ambulance, 111, patient transport services and out of hours, older people's services, children's services including those with complex healthcare needs, rehabilitation services, wheelchair services, mental health services, learning disability services, continuing healthcare and certain specific primary care functions delegated to the CCG by NHSE/I
- those matters delegated to it within the CCG's Constitution.

During April to June 2022, in response to the COVID-19 pandemic, there continued to be an emphasis on system working across Lancashire and South Cumbria and the NHS continued to enact a Command-and-Control system wherein national direction was implemented through a distinct chain of command directly linking strategic intent with operational delivery. NHS England/Improvement (NHSE/I) guidance was issued to support providers and commissioners to free up capacity and resource to focus on the challenges of the pandemic.

The Governing Body met in May and June 2022. As in the previous year, due to the COVID-19 pandemic and Government social isolation requirements constituting special reasons to avoid face to face gatherings, meetings of the Governing Body continued to be held via videoconference. Members of the public were invited to submit questions to the Governing Body in advance of the meetings and were able to join the meetings virtually to observe. Agendas incorporated a range of reports to support delivery of its key functions including

quality performance and finance. Regular updates were provided on the development and implementation of key aspects of service delivery across the Lancashire and South Cumbria Integrated Care System (ICS), the Fylde Coast Place Based Partnership (PCB) and Primary Care Networks (PCNs).

Agendas, papers including minutes which showed attendance at meetings are published on the CCG's website at: www.fyldecoastccgs.nhs.uk/about-us/governing-bodies/ www.lancashireandsouthcumbria.ICB.NHs.uk/legacyccgs

The Governing Body was quorate if five members were present, including at least one Lay Member, either the Chief Clinical Officer or the Chief Finance Officer and at least three clinicians. During April to June 2022, the Governing Body met 'in common' with the NHS Blackpool CCG Governing Body, on two occasions.

The Governing Body had delegated responsibility for a range of functions to its committees, which were set out in the approved terms of reference of each committee/group and the CCG's standing orders and scheme of reservation and delegation. The CCG's operational scheme of delegation was regularly overseen by the Audit Committee to ensure it facilitated informed and prompt decision-making, was 'fit for purpose' and that the robust and appropriate organisational and financial controls across the CCG were maintained.

It is my view that the Governing Body operated effectively in meeting its responsibilities throughout the period 1 April 2022 to 30 June 2022.

Audit Committee (Committees in Common held with Blackpool CCG)

The Audit Committee provided the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the CCG. The key duties of the Audit Committee were governance, risk management and internal control. The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's activities that supported the achievement of the CCG's objectives. In particular, the committee will reviewed the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Governance Statement), together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to submission to the Governing Body.
- The underlying assurance processes that indicated the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The underlying assurance process that indicated the degree of Financial Systems robustness and responsiveness to delivering financial control.
- The underlying assurance process for complying with the Value for Money responsibilities of the CCG.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
- The policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA.

The members of the Audit Committee were the Lay Members on the CCG's Governing Body (with the exception of the CCG Chair) and the CCG's Secondary Care Doctor. The Lay Member for Governance chaired the committee and they also held the office of the Conflicts

of Interest Guardian. The committee met twice during April to June 2022. Minutes and attendance at Audit Committee meetings were published on the CCG's website via the Governing Body meeting papers.

Remuneration Committee

The Remuneration Committee made recommendations to the Governing Body on the remuneration, fees and other allowances for employees and other persons providing services on behalf of the CCG.

Members of the Remuneration Committee were the Lay Members on the CCG's Governing Body, the Chair of the Council of Members and the Secondary Care Doctor.

Finance and Performance Committee (Joint meetings held with Blackpool CCG)

The Finance and Performance Committee had responsibility to:

- Oversee the performance of the CCG in delivering the national targets and objectives included in the local commissioning plan, ensuring the effective and efficient use of resources whilst delivering financial balance
- Assure that the commissioning portfolio delivers against contracted performance metrics and outcomes, (recognising the leadership of the Primary Care Commissioning Committee for primary care contracts)
- Give assurance to the CCG Governing Body on finance, performance, service reviews, procurement and planning of all commissioned services and contracts, including those dependent upon Partnership Agreements and joint working arrangements, (recognising the leadership of the Quality Improvement and Engagement Committee for quality matters).
- Receive routine monitoring reports that evaluate CCG performance against mandated national and regional metrics as well as locally agreed indicators that ensure the CCG is meeting its defined objectives.
- Undertake monitoring of commissioned services via Provider performance reporting and provide assurance to the CCG Governing Body that services delivered for patients are done so effectively, consistently and in line with specified requirements and regulation.
- Scrutinise the performance of commissioned contracts, assure the CCG Governing Body of compliance and oversee action plans where performance is deemed to need corrective actions.
- Consider and review high level financial issues and risks, and ensure corrective plans are in place where variation from plan requires action.
- Ensure the CCG met its financial duties and objectives
- Ensure the CCG complied with all information governance requirements.
- During April to June 2022 the environment the CCG operated within mirrored that over the previous two years in response to the COVID-19 pandemic. In response to the pandemic during 2020/21 an internal review of governance arrangements when operating under the command and control structures was undertaken following which the CCGs stood down the Finance and Performance Committee meetings ensuring that the oversight that the committee would previously have provided was undertaken by the Governing Body from a finance perspective with the Quality Improvement and

Engagement Committee having oversight on performance matters. This arrangement was reviewed and continued during the period April to June 2022.

- Membership comprised representatives from across the Fylde Coast CCGs and included two Lay Members (of which one was the committee Chair and one the Vice Chair), the Chief Clinical Officer or a Clinical Director, four GP Elected Clinical Members, the Chief Finance Officer and one other Executive. Other officers were invited to attend on an ad hoc basis.

Quality Improvement and Engagement Committee (Joint meetings held with Blackpool CCG)

The Quality Improvement and Engagement Committee provided strategic oversight and assurance to the Governing Body relating to the quality, public and service user engagement and the continual improvement of all CCG directly and jointly commissioned services. It ensured that effective, relevant and appropriate decisions were made in protecting the health and wellbeing of the population we serve. The key responsibilities of the committee were that:

- Service quality, patient engagement and involvement were integral to the work of the CCG.
- All the services that the CCG commissioned, including its joint and partnership arrangements (ICP/ICS etc), were safe and effective and had been influenced by tangible public and patient involvement and engagement.
- There was continuous scrutiny in the quality of commissioned services, including primary care and patient outcomes.
- The principles of quality assurance and clinical governance were integral to performance monitoring arrangements for all CCG commissioned services and were embedded within consultation, service development and redesign, evaluation of services and the decommissioning of services
- Assurance was provided to the Governing Body about public involvement and the difference it made, and that the CCG was meeting its statutory duties.
- There was oversight of the development, implementation and monitoring of:
    - The CCG's strategic approach to Quality Improvement Strategy and Quality Assurance
    - Communications and Engagement Strategy
    - Equality and Inclusion Strategy
    - Risk Management Strategy
    - Safeguarding
    - Other relevant strategies
- Patients had effective and safe care, with a positive experience of services.
- The quality and outcomes of treatment and care commissioned by the CCG, or provided by its member practices, was improving against national or locally agreed measures.
- Early warning systems were in place to identify concerns relating to the quality and safety of services and that appropriate action was taken in response to those concerns.
- The views of all our communities underpinned the work of the CCG and met its Constitutional duties and requirements.

- The CCG is fulfilling its statutory duties for Equality and Diversity, particularly the Equality Act 2010, through the implementation of the Equality Delivery System.
- CCG corporate governance arrangements were robust (e.g. regarding service quality risk identification and risk management; FOIs; statutory Health and Safety responsibilities).

The Quality Improvement and Engagement Committee provided assurance in the delivery of the above responsibilities and duties to the Governing Body by regularly reviewing and approving performance reports. The committee held to account the relevant Governing Body leads and the senior management team of the CCG for their relevant responsibility and accountable areas.

The Membership comprised representatives from across the Fylde Coast CCGs and includes the Secondary Care Doctor, two Lay Members, up to seven GP Elected Clinical Members, a CCG Clinical Director, the Chief Operating Officer, Director of Nursing and Quality (nominated deputy) and Head of Quality. Other officers attended on an ad hoc basis.

During April to June 2022, the committee met once (June) however, during April and May, committee members were provided with regular reports/updates in order that they maintained an oversight of quality issues. Minutes and attendance at Quality Improvement and Engagement Committee meetings were published on the CCG's website via the Governing Body meeting papers.

Patient and Public Engagement and Involvement Forum (PPEI)

The Fylde Coast Patient and Public Engagement and Involvement Forum (PPEI) was accountable to the Quality Improvement and Engagement Committee. The Forum met monthly and had responsibility for ensuring that the voice of patients and carers, and public and stakeholders views informed the commissioning decisions of the CCG. The key aims of the forum were to:

- Ensure the CCG fulfilled its statutory responsibilities to make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for change and involve and engage people in line with the Equality Act 2010
- Work in partnership with relevant bodies such as the Health and Wellbeing Board and Healthwatch, and engage with different groups and communities, and
- Ensure effective mechanisms are in place to capture the voice of practice populations.

The Forum was chaired by the CCG's Lay Member for patient and public involvement. Membership included representation from Healthwatch, patient representatives and people from the community, voluntary and faith sector, including those representing older people, carers, children and young people and the LGBT community. During April to June 2022, the Forum met virtually three times.

Primary Care Commissioning Committee (Committees in Common held with Blackpool CCG)

NHS England and NHS Improvement (NHSE/I) /I had delegated to the CCG the authority to exercise certain specified primary care commissioning functions. The Primary Care Commissioning Committee had responsibility for the management of these delegated functions and the exercise of the delegated powers in accordance with the agreement entered into between NHSE/I and the CCG. The committee made decisions on the review,

planning and procurement of primary care services, under delegated authority to the CCG from NHSE/I. Meetings were usually held bi-monthly and held in public. Papers for the meetings were accessed via the CCG's website.

The membership comprised all of the CCG's Lay Members, one of whom chaired the committee and one acting as Vice Chair of the committee (excluding the Audit Committee Chair), the Secondary Care Doctor (and proxy Lay Member), the Chief Operating Officer, the Chief Finance Officer, the Director of Nursing and Quality (nominated deputy) and a CCG Clinical Director. Representatives from the local authority, Healthwatch, Lancashire Coastal Local Medical Committee and NHSE/I were also invited to attend committee meetings. Other officers were required to attend on an ad hoc basis. Minutes and attendance at the Primary Care Commissioning Committee meetings were published on the CCG's website.

During April to June 2022, the committee met on two occasions and meetings were held via videoconference. The committee welcomed representation from two Patient Participation Group chairs who were able to bring their valuable experience of working with local GP Practices to the discussions.

Clinical Commissioning Committee (Joint meetings held with Blackpool CCG)

The Clinical Commissioning Committee provided clinical advice and insight and assurance to the Governing Body that the CCG was commissioning and actioning the operational implementation of service priorities in line with the needs of the local population and the strategic objectives of the CCG. It operated throughout the reporting period.

The membership comprised all the GP Elected Clinical Members, from whom the Chair and Vice Chair are nominated, the Chief Operating Officer, the Director of Nursing and Quality, the Secondary Care Doctor and the Directors of Public Health (Blackpool Council and Lancashire County Council). Other CCG officers were invited to participate in support of the committee's work. During April to June, the committee met twice and the minutes and attendance were published on the CCG's website via the Governing Body meeting papers.

UK Corporate Governance Code

NHS Bodies were not required to comply with the UK Code of Corporate Governance. However, whilst the detailed provisions of the UK Corporate Governance Code were not mandatory for public sector bodies, compliance with relevant principles of the code was considered to be appropriate and good practice. This Governance Statement is intended to demonstrate how the CCG had due regard to the principles set out in the Code and which were considered appropriate for CCGs.

Discharge of Statutory Functions

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

Responsibility for each duty and power were clearly allocated to a lead Director. Directors confirmed that their structures provided the necessary capability and capacity to undertake all of the CCG's statutory duties.

Risk Management Arrangements and Effectiveness

The CCG accepted that all activities had elements of inherent risk, identifying and mitigating the risks are fundamental CCG activities. This facilitated flexible and dynamic planning/provision and oversight and promoted clear standards of internal control. The Corporate Risk Register and Governing Body Assurance Framework were the tools that continuously promoted, embedded and supported risk management principles throughout the organisation.

The Governing Body was responsible for risk management within the CCG, ensuring that a framework of systems and processes for effective risk management were in place and for monitoring compliance in line with risk appetite. The Governing Body Assurance Framework (GBAF) was the vehicle for strategic review and reporting significant CCG risks.

Both Fylde Coast CCGs continued to consolidate their work, staffing structures, and risk management processes, so whilst remaining two separate statutory bodies, the two Governing Bodies remained clearly sighted on both existing and new risks across the whole Fylde Coast footprint.

The Accountable Officer was responsible for assuring the Governing Body that an effective system of governance and internal control exists within the CCG.

Risk leadership was driven from executive level, built into the strategic planning process, and then managed operationally through a robust process of governance around decision-making as set out in the CCG's Scheme of Delegation within the CCG's Constitution.

The Accountable Officer had responsibility for the overall management of arrangements for corporate governance and takes an executive level responsibility for physical risks, in particular health and safety, fire, safeguarding and compliance with claims and complaints, with the Director of Nursing and Quality (nominated Deputy) taking a day-to-day responsibility for those risks. The Head of Quality was the Caldicott Guardian.

The Chief Finance Officer, as well as being the Senior Information Risk Owner (SIRO) was responsible for ensuring that all financial risk, security, information governance, business support and procurement risks were managed.

Senior managers were responsible for ensuring the implementation of risk management systems and processes within their area of control.

Staff members at all levels completed mandatory training including those aspects of risk management that were relevant to their role. This ensured that staff had the capabilities and knowledge of basic risk management principles, including foreseeing potential risks. Information and learning from good practice were shared through staff briefings. All staff were aware that they must comply with the CCG's risk management policies.

The CCG's Risk Register was a prioritised list of risks identified to the CCG through the risk assessment process. All CCG managers were responsible for ensuring that risk assessments were undertaken and reviewed within their area of control which forms the Risk Register.

The Executives, the Senior Management Team, the Quality Improvement and Engagement Committee, the Finance and Performance Committee and the Primary Care Commissioning Committee regularly reviewed and agreed the scoring of all risks. Risks scoring 12 and

above on the Risk Register were submitted to the Governing Body and Audit Committee via the Governance Body Assurance Framework.

The challenge of COVID-19 across the period presented new risk considerations for the CCG incorporating risks to staff from the isolation of home working to an emerging focus on restoration of services. Although necessitated by COVID-19 as a legacy and in transition to an ICB, CCGs adopted a stance of agile working as a permanent operating model.

It was the policy of the Fylde Coast CCGs to:

- provide clear leadership and direction on risk management, promoting openness and transparency
- embed a culture where risk management principles are implemented, and risk management is an essential function of the organisation's activity
- ensure structures, processes and sufficient resources are in place to support the identification, assessment, management and monitoring of risks
- assure the public, patients, staff, partner organisations and other stakeholders that Fylde Coast CCGs implement their commitment to manage risk effectively.

Key Risks Summary

The COVID-19 pandemic continued to challenge routine CCG activity during April to June 2022 including rolling over of existing commissioning arrangements and centralisation of commissioning and finance arrangements. This together with disparate homebased and arm's length working arrangements and the imperatives of CCG staff supporting incident management and specific pandemic responses (e.g. testing; vaccination; novel service development) has presented significant challenge to normal working practices, including risk management.

Looking to forthcoming organisational change, risk owners and functional leads were being challenged to critically review their existing risks in line with identified risk appetite and distil a focussed suite of risks that would safely communicate Governing Body concerns into the new Integrated Care Board from 1 July 2022. All risks were reviewed by the Quality Improvement and Engagement Committee on 14 June 2022 and the Governing Body Assurance Framework was submitted to the Governing Body meeting on 28 June 2022 with no new risks being identified.

Within this context key current risks related to staffing capacity, financial resources available versus the demand on this and service delivery of several commissioned services against quality and performance targets.

Internal Control Framework

The system of internal control was the set of processes and procedures in place in the CCG to ensure it delivered its policies, aims and objectives. It was 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 risk 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 CCG's Governing Body Assurance Framework was the internal control process that enabled the CCG to focus on risks in delivering its principle annual objectives, be assured

that adequate controls were operating to reduce those risks to acceptable levels and highlight any gaps in control and assurance that may hinder the achievement of those objectives.

The Governing Body had an agreed risk appetite, articulated in an overall statement and all risks were considered and reviewed against this.

The Governing Body's own assessment of the effectiveness of the organisation's system of internal control was aided through delivery of the risk-based internal audit plan, as approved by the Audit Committee, including reviews of the assurance framework, and a range of control systems. In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit provided an opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This was achieved through a risk-based plan of work.

Annual Audit of Conflicts of Interest Management

The Managing Conflicts of Interest Policy (including Gifts and Hospitality), aligned across both Blackpool CCG and Fylde and Wyre CCG, was reviewed at an Audit Committees in Common meeting in December 2021. The policy was subsequently approved at a Governing Bodies in Common meeting (Blackpool CCG and Fylde and Wyre CCG) in February 2022. The policy followed NHSE/I statutory guidance (latest published June 2017) and can be accessed at:

https://www.fyldecoastccgs.nhs.uk/document/fylde-coast-ccgs-managing-conflicts-of-interest-policy-v1-2-final-february-2022-pdf-2/
www.lancashireandsouthcumbria.ICB.NHs.uk/legacyccgs

CCGs were required to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHSE/I published a template audit framework.

It is expected that the 2022/23 annual audit will be undertaken by the internal auditors appointed by the Lancashire and South Cumbria Integrated Care Board.

Data Quality

Service Auditor Reports were not provided to cover the 1 April to 30 June 2022 reporting period. Service organisations were asked to issue a bridging letter to confirm there have been no changes in the CCG's control environment since the last Service Auditor Report was issued covering 1 April 2021 to 31 March 2022. The bridging letter received from NHS Midlands and Lancashire CSU in July 2022 confirmed that this was the case.

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

Information Governance

The NHS Information Governance (IG) Framework sets the processes and procedures by which the NHS handles information about patients and employees, personal identifiable information. The NHS Information Governance Framework is supported by the Data Security and Protection (DSP) Toolkit and the annual submission process provides assurance to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.

The CCG's information governance fed into the Governing Body as part of the CCG's integrated governance structure. The CCG's Chief Finance Officer had Executive level responsibility for information governance and was the CCGs the Senior Information Risk Officer (SIRO), with responsibility for ensuring that information risk was assessed and managed within the organisation.

For the period from April 2021 – June 2022, the Head of Quality was the Caldicott Guardian for the CCG. The Caldicott Guardian acted as the 'conscience' for the organisation and was responsible for protecting the confidentiality of patient/service-user information and enabling appropriate information sharing.

Throughout this period the CCG was continually reviewing its information governance provision. Control measures were in place to ensure risks to data security were managed and controlled. The CCG had robust information risk management processes in place led by the SIRO. Information asset owners and administrators were in place to ensure that all information asset registers and data flow maps where CCG's main systems and records stores, along with information held at team level.

There was high importance on ensuring that there were robust systems and processes in place to help protect patient and staff personal information. An information governance management framework and structure chart was created to highlight lines of responsibility for information governance within the organisation. All staff were required to undertake annual information governance training electronically, via ESR. The CCG had in place three policies in relation to Information Governance to ensure that staff where aware of their responsibilities for protecting personal information These policies were the Data Security and Protection Policy, a Staff IG Handbook, and an IG Code of Conduct. The signatory for the code of conduct document was created on Microsoft teams and circulated to staff to complete.

There are processes and systems in place for incident reporting and investigation of serious incidents.

The CCG's Information Governance Handbook provides information and best practice for staff to follow whilst working from home during the COVID-19 pandemic. Bi-monthly newsletters are circulated to staff which highlight different themes for information governance. An example being hints and tips for staff to ensure there are physical controls and information are protected whilst working from home.

Information Risk and U Assure

The CCGs Information risk work programme was agreed by the SIRO to identify what information the CCG holds, stores, shares and receives from other organisations. Due to the CCGs migration of corporate information from Network drives to o365 tenant, all assist registers and data flows maps where required to be updated with their new file location. All teams complete this work for the DSPT submission and as part of CCG close down and transition work.

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

The U Assure system risk scores the asset dependent on the information recorded by both the IAA and IAO. Assets scoring higher than 12 are classed as high-risk asset and an action plan is put in place to mitigate the risk. Additionally, if an asset is unable to be accessed after 3 days and this has a noticeable impact on the organisation, patients, or legal obligation the asset would be classed as business critical.

Data flow maps are created for information that is distributed between internal teams and is sent from or to external organisations. The method of transfer is also risk assessed.

Data Security

The CCG provides formal assurance of its compliance with information governance requirements annually through the Data Security and Protection (DSP) Toolkit. The DSP Toolkit is a national annual self-assessment and reporting tool that the CCG must use to assess local performance in line with the requirements set out by NHS Digital.

NHS Fylde and Wyre Clinical Commissioning Group submitted a compliant DSPT on the 29 June 2022 with *'Standards Met'.*

During the period 1 April 2021 to 30 June 2022, there were no incidents categorised as reportable to the ICO within the CCG.

Business Critical Models

Service Auditor Reports were not provided to cover the 1 April to 30 June 2022 reporting period. Service organisations were asked to issue a bridging letter to confirm there have been no changes in the CCG's control environment since the last Service Auditor Report was issued covering 1 April 2021 to 31 March 2022. The bridging letter received from NHS Midlands and Lancashire CSU in July 2022 confirmed that this was the case.

Business critical systems were mainly provided by Midlands and Lancashire Commissioning Support Unit. They were subject to regular external review, the outputs of which were reported to the CCG's Audit Committee through service auditor reports. The CCG's business critical systems were identified and formed part of the CCG's Information Asset Register each with a suitably qualified Information Asset Owner.

Control Issues

In continued response to COVID-19 pressures (including movements between level 3 and 4 incidents) and the operating environment that was system first in respect of planning and delivery, previous 'business as usual' committees and reporting was, as in 2021/22, stood down or operated virtually. In order to mitigate any potential resulting control issue, the virtual approach to governance was reviewed by each committee in the CCG to ensure respective workplan items/statutory duties were covered and that committee decision making could continue to operate. The Governing Body and Audit Committee received papers and agreed recommendations in respect of how governance oversight and control was

maintained when operating through virtual committees and in the COVID-19 operating environment.

Under system operating principles some clearly documented decision making was delegated to system committees with appropriate governance in place. In responding to the national incident, the cell structure remained in operation and held responsibility on some previous CCG decision making.

The single joint cell arrangements - hospital and out-of-hospital cell – continued to operate which enabled colleagues in the NHS and local authorities to continue working closely together at system, place, and neighbourhood levels to maintain operational service delivery, take actions to mitigate risks to the system, specific sectors or communities using mutual aid when necessary.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

NHSE/I was legally required to review CCGs' performance on an annual basis. This was carried out under the NHS Oversight Framework with the overall assessment ratings based on a CQC-style four label categorisation.

As a result of the continued impact of COVID-19 and the need for the NHS to update their priorities across the different phases of the response, it was not possible to apply the established methodology to determine CCG ratings.

Previously, NHSE/I noted that both NHS Blackpool CCG and NHS Fylde and Wyre CCG were fully engaged with supporting both the Integrated Care System and Integrated Care Partnership developments during 2021/22.

The CCG continued to be impacted by COVID-19 but its focus remained on improved performance across all indicators. Some challenges remained on specific indicators, but focus continued against robust improvement plans.

The CCG continued to have experienced and capable Executives, Clinicians, Lay Members and senior management team delivering plans across all functions. The CCG's leadership had a strong track record of delivery across the various functions, as well as providing leadership within the Integrated Care Partnership/Integrated Care System (ICP/ICS).

The Fylde Coast CCG's shared leadership team worked closely with colleagues at Blackpool Teaching Hospitals NHS Foundation Trust to ensure delivery of health and care services across the Fylde Coast. They also worked closely with colleagues at Blackpool Council and Lancashire County Council as they developed integrated health and social care. This work continued during the pandemic and greater partnership working can be evidenced despite some of the operational challenges brought about by the pandemic.

During April to June 2022, the CCG continued to operate under command-and-control structures and processes due to the COVID-19 pandemic, which focused on system delivery and financial position underpinned and delivered by organisational planning and performance. Strong financial planning and budgetary controls were in place to ensure the CCG understood its financial position and delivered its agreed plan within the context of the overall ICS plan. Risks to delivery being discussed at the Governing Body within the context of the wider ICS approach and system resource.

I received advice from the internal and external auditors on the efficacy of the organisation's arrangements to ensure the effective use of resources and accept their independent view that the CCG had sound processes in place.

Anti-fraud Arrangements

All commissioners and providers of NHS services are required to put in place arrangements to tackle fraud, bribery and corruption, for Fylde and Wyre CCG this was undertaken by the CCG's nominated Anti-fraud Specialist, together with the wider Anti-fraud Team at MIAA. The CCG's Chief Finance Officer has overseen the anti-fraud arrangements for the CCG.

The Anti-fraud Specialist provided an Anti-fraud Annual Report which offered the CCG's Audit Committee the opportunity to review in totality the anti-fraud work completed during the year. The ultimate aim of all anti-fraud work at the CCG has been to support improved NHS services and ensure that fraud within the NHS is clearly seen as being unacceptable.

Between 1 April 2022 to 30 June 2022, the Anti-fraud Specialist completed a range of work across the main key areas of counter fraud activity, as per the Q1 22/23 workplan that was approved by the Audit Committee. The following was achieved during this period:

- Attendance at Audit Committee (Committee in Common with Blackpool CCG)
- Meetings with key personnel including the Chief Finance Officer, the Head of Finance and Business Development/Counter Fraud Champion and with Internal Audit
- Completion and submission of the NHS Counter Fraud Authority's Standards for Commissioner's Self Review Tool by the June 2022 deadline; this included a CCG closedown fraud risk assessment as required by Component 3 of the Standard.
- Newsletters/briefings/circulars covering various anti- fraud and bribery related topics issued
- Finalisation of the required National Fraud Initiative Exercise
- Completion of an Overtime review
- Relevant alerts and FPCs issued and actioned
- Responded and provided advice to management as necessary

In respect of the CCG's requirement to comply with all the Standards for Commissioners issued by the NHS Counter Fraud Authority for the period April to June 2022, the Integrated Care Board will be required to undertake a self-assessment and submit a return in their own right covering the period July 2022 to April 2023.

Review of the Effectiveness of Governance, Risk Management and Internal Control

My review of the effectiveness of the system of internal control was informed by the work of the internal auditors, executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review was 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 CCG achieving its principle objectives had been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee, the Finance and Performance Committee, the Quality Improvement and Engagement Committee, Internal Audit, and a commitment to ensure continuous improvement of the internal control system in place using the Governing Body Assurance Framework, the CCG's Risk Register, and the NHS Oversight Framework process.

Conclusion

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control that supported the achievement of the CCG's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible. My review has been informed in the ways outlined above. The Interim Director of Internal Audit has also provided substantial assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

I therefore conclude that NHS Fylde and Wyre Clinical Commissioning Group had a generally sound system of internal control that supported the achievement of its policies, aims and objectives.

Kevin Lavery

Accountable Officer

Lancashire and South Cumbria Integrated Care Board

(on behalf of the former Fylde and Wyre Clinical Commissioning Group)

21 June 2023

Internal Audit and Internal Control

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 Fylde & Wyre 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.
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. Please include the summary text in the table above when referring to the Head of Internal Audit Opinion in your Annual Governance Statement.
MIAA Quality of Service Indicators	MIAA operate systems to ISO Quality Standards. The External Quality Assessment, undertaken by CIPFA (2020), provides assurance of MIAA's full compliance with the Public Sector Internal Audit Standards.

4. Head of Internal Audit Opinion

4.1 Roles and responsibilities

The whole Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievements of policies, aims and objectives;

the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and

the conduct and results of the review of the effectiveness of the system of internal control, including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the AGS requirements.

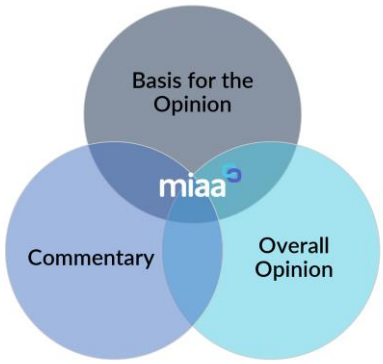
In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit

Committee, which can provide assurance, subject to the inherent limitations described below. The outcomes and delivery of the internal audit plan are provided in Section 4.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Governing Body takes into account in making its AGS.

4.2 Opinion

Our opinion is set out as follows:



4.2.1 Basis for the opinion

The basis for forming our opinion is as follows:

An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account the relative materiality of systems reviewed and management's progress in respect of addressing control weaknesses identified.
An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

4.2.2 Overall Opinion

Our overall opinion for the period 1st April 2022 to 30th June 2022 is:

High Assurance, can be given that there is a strong system of internal control which has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed.	
Substantial Assurance, can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.	✓
Moderate Assurance, can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk.	
Limited Assurance, can be given that there is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls impacts on the overall system of internal control and puts the achievement of the organisation's objectives at risk.	

No Assurance, can be given that there is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the organisation's objectives.	

4.3.3 Commentary

The commentary overleaf provides the context for our opinion and together with the opinion should be read in its entirety.

Our opinion covers the period 1st April 2022 to 30th June 2022 inclusive, and is underpinned by the work conducted through the risk based internal audit plan.

4.3.3.1 Compliance with Statutory Functions

Assurance has been provided that the CCG has continued to comply with its statutory functions pre ICB transfer.

Scope limitations – this review focussed on overarching arrangements and detailed testing was not undertaken in line with the approved Internal Audit Plan.

4.3.3.2 CCG Transition - System Support

The following system support, covering a number of transition elements and workstreams, has been undertaken in year. This work complements and supports local transition work.

Lancashire and South Cumbria

Financial Closedown Assurance: MIAA have continued to provide specific assurance to support in the delivery of the workstream that meet NHSEI financial closedown requirements.

Assurance 'Spot Checks': MIAA have provided assurance against reported progress in relation to the Transition Programme Plan on actions completed.

SBS Project Board: MIAA have continued to undertake a project assurance role supporting the SBS Project Board in the implementation of the ICS ledger.

System Group Representation and Reporting: Continued attendance and contribution at:

- Finance Transition Group
- Governance Leads Group
- Executive Closedown Group

4.3.3.3 CCG Transition - Local Support

To enable us to comment on the processes in place regarding the adequacy of transition plans, we have continued to undertake a number of activities including:

Transition working group attendance; and

Assessing the governance processes for the completion, monitoring and sign off of the CCG's Due Diligence Checklist.

We can provide assurance that processes were established and maintained for the completion and monitoring of the Programme Plan over the period reviewed. Note: the assurance provided above does not provide confirmation of the accuracy and completeness of the Due Diligence Checklist/Transition Plan

4.3.3.4 Follow Up

During the course of the year we have undertaken follow up reviews and can conclude that the organisation has made good progress with regards to the implementation of recommendations.
4 recommendations have been assessed as not fully implemented. 0 of the recommendations have been superseded due to CCG closedown and 4 are for transfer to the ICB. The recommendations requiring transfer are in relation to the reviews of Cyber Security, Safeguarding, Primary Care Framework and Assurance Framework and will be included in MIAA's handover document to the ICB.

4.3.3.5 Wider organisation context

This opinion is provided in the context that the Governing Body like other organisations across the NHS is facing a number of challenging issues and wider organisational factors particularly with regards to ICB transition processes. The challenges for organisations have included continuing to ensure an effective pandemic response, delivering business as usual requirements and implementing and managing a transition process for the establishment of ICBs.

During the Covid response, there has been an increased collaboration between organisations as they have come together to develop new ways of delivering services safely and to coordinate their responses to the pandemic. This focus on collaboration will continue as the NHS progresses on its journey towards integrated care systems.

In providing this opinion I can confirm continued compliance with the definition of internal audit (as set out in your Internal Audit Charter), code of ethics and professional standards. I also confirm organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

Chris Harrop

Managing Director, MIAA

June 2022

Louise Cobain

Assurance Director, MIAA

June 2022

Remuneration and Staff Report

Remuneration Committee

The remuneration committee made recommendations to the Governing Body on the remuneration, fees and other allowances for employees and other persons providing services on behalf of the CCG. The members of the Remuneration Committee were:

- Michael Nuttall, Lay Member (Governance) – Acting Chair of the Committee
- Kevin Toole, Lay Member (Patient and Public Involvement)
- Dr Ian Stewart, Secondary Care Doctor
- Dr Kath Greenwood, Council of Members' Chair

Policy on Remuneration of Senior Managers

The principles of remuneration below that guide the CCG's Remuneration Committee were based on NHS England guidance issued to CCGs in 2013.

1. CCGs may appoint persons to be employees as it considers appropriate and is able to pay its employees remuneration and travelling or other allowances in accordance with determinations made by its Governing Body, and employ them on such terms and conditions as it may determine.

2. NHS England has issued guidance to CCGs on remuneration based on the following key principles, which are informed by and consistent with the principles set out in the *Will Hutton 'Fair Pay Review':*

    - Remuneration should fairly reward each individual's contribution to their organisation's success and should be sufficient to recruit, retain and motivate employees of sufficient calibre. However, organisations should be mindful of the need to avoid paying more than is necessary in order to ensure value for money in the use of public resources.
    - Remuneration must be set through a process that is based on a consistent framework and independent decision-making based on accurate assessments of the weight of roles and individuals' performance in them.
    - Remuneration should be determined through a fair and transparent process via bodies that are independent of the people whose pay is being set, and who are qualified or experienced in the field of remuneration. No individual should be involved in deciding his or her own pay.
    - There should be appropriate delegated authority to CCG remuneration committees.
    - Remuneration must be based on the principle of equal pay for work of equal value.

3. CCGs must have a Remuneration Committee drawn from the CCG's Governing Body. In common with all public sector organisations and NHS bodies, the Remuneration Committee should bear in mind the need for properly defensible remuneration packages, which are linked to clear statements of responsibilities, and with rewards linked to the measurable discharge of those responsibilities.

4. CCG Remuneration Committees must at all times:

- Observe the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds and the management of the bodies concerned.
- Maximise value for money through ensuring that services are delivered in the most efficient and economical way, within available resources, and with independent validation of performance achieved wherever practicable.
- Be accountable to Parliament, to users of services, to individual citizens, and to staff for the activities of the bodies concerned, for their stewardship of public funds and the extent to which key performance targets and objectives have been met.
- Comply fully with the principles of the Citizen's Charter and the Code of Practice on Access to Government Information, in accordance with the Government policy on openness.
- Bear in mind the necessity of keeping comprehensive written records of their dealings, in line with general good practice in corporate governance.

5. The CCG's Remuneration Committee comprises two CCG Lay Members, the Secondary Care Doctor and the Chair of the Council of Members, who have agreed that the Lay Member with a lead role in overseeing key elements of financial management and audit will be the Chair of the Remuneration Committee. In all of their decisions, Remuneration Committees should also remain aware that each individual NHS organisation is corporately responsible for ensuring that its pay arrangements are appropriate in terms of Equal Pay requirements and other relevant legislation. No Senior Managers should be present for discussions about their own remuneration, although it is reasonable for the Chief Clinical Officer and other Senior Managers where appropriate, to attend meetings of the Remuneration Committee during which the remuneration of other staff is discussed.

6. The 2022/23 pay award for NHS staff was approved by the Government on 19 July 2022. The Remuneration committee did not meet to discuss this as it was after the cessation of the CCG. This represents a £1,400 consolidated uplift to the full-time equivalent salary for all NHS employees covered by NHS terms and conditions of service (Agenda for Change). This will be enhanced for pay points at the top of Band 6 and all pay points in Band 7 so it is equal to a 4% uplift.

7. All salary figures and narrative disclosures identified within the CCG's Remuneration and Staff report exclude the effect of the 2022/23 pay award. The pay award is backdated to 1 April 2022 and the associated backpay for the period 1 April – 30 June 2022 will be processed and paid by the ICB.

Remuneration Report

Salaries and Allowances [(1)] of the Governing Body 1 April to 30 June 2022 (subject to audit)

Name	Title	Salary and Fees	Taxable Benefits	All Pension Related Benefits	Total
		(bands of £5000)	(Rounded to the nearest £00)	(bands of £2,500)	(bands of £5,000)
		£000	£00	£000	£000
Dr A Janjua	Chair	10-15	0	0	10-15
Mr M Nuttall	Lay Member	0-5	0	0	0-5
Mr K Toole	Lay Member	0-5	0	0	0-5
Dr I Stewart	Secondary Care Doctor	0-5	0	0	0-5
Dr K Greenwood	GP Member	0-5	0	0	0-5
Dr V Chandrasekar	GP Member	10-15	0	0	10-15
Dr P Benett	GP Member	10-15	0	0	10-15
Mr A Harrison (Note 3)	Chief Finance Officer	5-10	0	5-7.5	10-15
Dr N Hartley-Smith (Note 2 & 4)	Clinical Director	5-10	0	0	5-10
Mr J Gaskins (Note 2 & 3)	Acting Chief Finance Officer	10-15	0	7.5-10	15-20
Mr N Medway (Note 2)	Deputy Director of Nursing & Quality	10-15	0	0	10-15
Mr A Bennett (Note 5)	Interim Accountable Officer	5-10	0	0	5-10
Mrs J Higgs (Note 2 & 4)	Locality Director	15-20	0	0	15-20

Notes (All figures shown in bands of £5k):

Note 1: The above figures do not include any payments associated with the 2022/23 NHS pay award which was published in July 2022. Any backpay due to these individuals for the period of 1st April 2022 to 30th June 2022 will be paid by the CCG's successor organisation, Lancashire and South Cumbria ICB.

Note 2: For the three months April to June 2022, the two Fylde Coast CCGs continued to operate under a joint executive management structure. The above salary disclosures therefore represent the proportion of remuneration relating to Fylde and Wyre CCG only. In each case this is 50% of total salary for the period in post which in full would be:

Mr J Gaskins	£20-25K
Dr N Hartley-Smith	£10-15K
Mr N Medway	£20-25K
Mrs J Higgs	£30-35K

The pension benefits disclosure for these individuals has not been apportioned between the two Fylde Coast CCGs. Dr N Hartley-Smith's figures can therefore be observed in the Blackpool CCG annual report. Figures for Mr J Gaskins and Mr N Medway are identified in Fylde and Wyre CCG's annual report. This reflects the original employing organisation of each individual.

Note 3: The figures shown in the above table for Mr A Harrison represent the proportion of Mr Harrison's remuneration relating to Fylde and Wyre CCG only.

From 1st August 2020 Mr A Harrison became temporary Chief Finance Officer for Morecambe Bay CCG alongside his existing joint Chief Finance Officer role for Fylde and Wyre CCG and Blackpool CCG.

Mr Harrison's total salary (excluding taxable benefits) for the three months April to June 2022 is £30-35K which is split as follows:

£5-10K in relation to Fylde and Wyre CCG in respect of Chief Finance Officer duties;

£5-10K charged to Blackpool CCG in respect of Chief Finance Officer duties; and

£15-20K charged to Morecambe Bay CCG in respect of Chief Finance Officer duties.

The recharges from Fylde and Wyre CCG to Blackpool CCG and Morecambe Bay CCG are based on the population split between the three CCGs.

The pension and taxable benefits disclosure has not been apportioned and is showing in full in Fylde and Wyre CCG's Annual Report only.

Note 4: Dr N Hartley-Smith and Mrs J Higgs did not have Governing Body voting rights.

Note 5: The figures shown above for Mr Andrew Bennett represent the proportion of Mr Bennett's remuneration relating to Fylde and Wyre CCG only, for the three months April to June 2022.

Mr Bennett's total salary (excluding taxable benefits) for the three months April to June 2022 is £35-40K which is split as follows:

£5-10K to Blackpool CCG in respect of Accountable Officer duties;

£10-15K to the Integrated Care System for work as the ICS Lead;

£5-10K to Fylde and Wyre CCG in respect of Interim Accountable Officer duties; and

£0-5K charged to West Lancashire CCG in respect of Accountable Officer duties.

The charges to the CCGs are based on the population split between the three CCGs.

The pension and taxable benefits disclosure has not been apportioned and is showing in full in Blackpool CCG's Annual Report only.

The figures in the column headed 'All Pension Related Benefits' represent the annual increase in pension entitlements for the individual over the lifetime of the pension. The figures have been calculated in line with the HMRC method. This does not represent an actual payment made to an individual.

The CCG does not have a performance-related pay scheme. There is, therefore, no reference to performance-related bonuses in the Salaries and Allowances table.

Please note that the Department of Health and Social Care has directed that calculations that result in negative figures are shown as zeros in the Salaries and Allowances and Pension Entitlements disclosure notes.

2021/22 Salaries and Allowances of the Governing Body (subject to audit)

Name	Title	Salary and Fees	Taxable Benefits	All Pension Related Benefits	Total
		(bands of £5000)	(Rounded to the nearest £00)	(bands of £2,500)	(bands of £5,000)
		£000	£00	£000	£000
Dr A Janjua	Chair	50-55	0	0	50-55
Dr A Doyle (Note 1)	Chief Clinical Officer (to 31.7.21)	15-20	0	0	15-20
Mr M Nuttall	Lay Member	10-15	0	0	10-15
Mr K Toole	Lay Member	10-15	0	0	10-15
Dr I Stewart	Secondary Care Doctor	15-20	0	0	15-20
Dr K Greenwood	GP Member	15-20	0	0	15-20
Dr V Chandrasekar	GP Member	40-45	0	0	40-45
Dr J Panesar	GP Member	40-45	0	0	40-45
Dr P Benett	GP Member	40-45	0	0	40-45
Mr A Harrison (Note 3)	Chief Finance Officer	30-35	0	110-112.5	140-145
Mrs J Scattergood (Note 2)	Director of Nursing and Quality (to 30.6.21)	10-15	0	0	10-15
Dr B Butler-Reid (Note 2 & 4)	Clinical Director (to 31.8.21)	15-20	0	0	15-20
Dr N Hartley-Smith (Note 2 & 4)	Clinical Director	25-30	0	0	25-30
Mr J Gaskins (Note 2 & 3)	Acting Chief Finance Officer	45-50	0	65-67.5	110-115

Mr N Medway (Note 2)	Deputy Director of Nursing & Quality (from 1.7.21)	35-40	0	160-162.5	195-200
Mr A Bennett (Note 5)	Interim Accountable Officer (from 1.8.21)	15-20	0	0	15-20
Mrs J Higgs (Note 2 & 4)	Locality Director	65-70	0	0	65-70

Notes (All figures shown in bands of £5k):

Note 1: The figures shown above for Dr Amanda Doyle represent the proportion of Dr Doyle's remuneration relating to Fylde and Wyre CCG only, for the time in post 01/04/2021 to 31/07/2021.

Dr Doyle's total salary for the period of office (excluding taxable benefits) is £75-80K which is split as follows:

£15-20K Blackpool CCG in respect of Accountable Officer duties;

£30-35K to the Integrated Care System for work as the ICS Lead;

£15-20K to Fylde and Wyre CCG in respect of Accountable Officer duties; and

£10-15K charged to West Lancashire CCG in respect of Accountable Officer duties.

The recharges from Blackpool CCG to Fylde and Wyre CCG and West Lancashire CCG are based on the population split between the three CCGs.

The pension and taxable benefits disclosure, however, has not been apportioned and is showing in full in Blackpool CCG's Annual Report only.

Note 2: During 2021/22 the two Fylde Coast CCGs continue to operate under a joint executive management structure. The above salary disclosures therefore represent the proportion of remuneration relating to Fylde and Wyre CCG only. In each case this is 50% of total salary for the period in post which in full would be:

Mrs J Scattergood (to 30/06/2021)	£20-25K
Mr J Gaskins	£90-95K
Dr B Butler-Reid (to 31/8/2021)	£30-35K
Dr N Hartley-Smith	£50-55K
Mr N Medway (from 01/07/2021)	£70-75K
Mrs J Higgs (from 01/04/2021)	£135-140K

The pension benefits disclosure for these individuals has not been apportioned between the two Fylde Coast CCGs. Mrs J Scattergood's, Dr B Butler-Reid's and Dr N Hartley-Smith's figures can therefore be observed in the Blackpool CCG annual report. Figures for Mr J Gaskins and Mr N Medway are identified in Fylde and Wyre CCG's annual report. This reflects the original employing organisation of each individual.

Note 3: The figures shown in the above table for Mr A Harrison represent the proportion of Mr Harrison's remuneration relating to Fylde and Wyre CCG only.

From 1st August 2020 Mr A Harrison became temporary Chief Finance Officer for Morecambe Bay CCG alongside Mr Harrison's existing joint Chief Finance Officer role for Fylde and Wyre CCG and Blackpool CCG.

Mr Harrison's total salary (excluding taxable benefits) is £130-135K which is split as follows for 2021/22:

£30-35K in relation to Fylde and Wyre CCG in respect of Chief Finance Officer duties;

£30-35K charged to Blackpool CCG in respect of Chief Finance Officer duties; and

£65-70K charged to Morecambe Bay CCG in respect of Chief Finance Officer duties.

The recharges from Fylde and Wyre CCG to Blackpool CCG and West Lancashire CCG are based on the population split between the three CCGs.

The pension and taxable benefits disclosure has not been apportioned and is showing in full in Fylde and Wyre CCG's Annual Report only

Note 4: Dr Ben Butler-Reid (for the period in post), Dr Neil Hartley-Smith and Mrs Jane Higgs do not have Governing Body voting rights.

Note 5: The figures shown above for Mr Andrew Bennett represent the proportion of Mr Bennett's remuneration relating to Fylde and Wyre CCG only, for the time in post (from 01/08/2021).

Mr Bennett's total salary for the period of office (excluding taxable benefits) is £90-95K which is split as follows:

£15-20K to Blackpool CCG in respect of Accountable Officer duties;

£45-50K to the Integrated Care System for work as the ICS Lead;

£15-20K to Fylde and Wyre CCG in respect of Interim Accountable Officer duties; and

£10-15K charged to West Lancashire CCG in respect of Accountable Officer duties.

The charges to the CCGs are based on the population split between the three CCGs.

The pension and taxable benefits disclosure has not been apportioned and is showing in full in Blackpool CCG's Annual Report only.

The figures in the column headed 'All Pension Related Benefits' represents the annual increase in pension entitlements for the individual over the lifetime of the pension. The figures have been calculated in line with the HMRC method. This does not represent an actual payment made to an individual.

The CCG does not have a performance-related pay scheme. There is, therefore, no reference to performance-related bonuses in the Salaries and Allowances table.

Please note that the Department of Health and Social Care has directed that calculations that result in negative figures are shown as zeros in the Salaries and Allowances and Pension Entitlements disclosure notes.

Pension Entitlements of Senior Managers as at 30 June 2022 (subject to audit)

Name	Title	Real increase in pension at pension age (bands of £2,500) at 30 June 2022	Real increase in pension lump sum at pension age (bands of £2,500) at 30 June 2022	Total accrued pension at pension age at 31 March 2023 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2022	Real increase in Cash Equivalent Transfer Value at 30 June 2022	Cash Equivalent Transfer Value at 31 March 2023
		£000	£000	£000	£000	£000	£000	£000
Mr A Harrison	Chief Finance Officer	0-2.5	0	50-55	100-105	997	0	1,045
Mr J Gaskins	Acting Chief Finance Officer	0-2.5	0	20-25	35-40	401	0	423

Notes:

The CCG was only able to obtain confirmation of the movement in the cash equivalent transfer values for the directors' pension entitlements for the period from 1 April 2022 to 31 March 2023. As a result, the CCG has apportioned the movement on a straight line basis to estimate the real increase in cash equivalent transfer value *at 30 June 2022. This is considered to be a reasonable approximation of the movement in the value of the entitlements during the year.*

The same apportionment has been undertaken for the real increase in pension at pension age and real increase in pension lump sum.

Not all members of the Governing Body receive pensionable remuneration or are members of the NHS Pension Scheme (for officer status). As such there are no entries in respect of pensions for these individuals

Cash Equivalent Transfer Values

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

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

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension

scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Compensation on Early Retirement or for Loss of Office

There have been no payments for compensation on early retirement or for loss of office made during the three months April to June 2022 (nil 2021/22).

Payments to Past Members

There have been no payments that require disclosure made to any individual who had previously been a Governing Body member of the CCG during the three months April to June 2022 (nil 2021/22).

Fair Pay Disclosure (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director 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.

As at 30 June 2022, remuneration ranged from £22,549 to £230,400 (2021/22: £22,549 to £230,400) based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Remuneration of Fylde and Wyre CCG staff is shown in the table below:

	25th percentile		Median		75th percentile	
	1 April to 30 June 2022	**2021/22**	**1 April to 30 June 2022**	**2021/22**	**1 April to 30 June 2022**	**2021/22**
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£37,813	£40,057	£53,219	£54,963	£76,164	£77,613
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£37,813	£40,057	£53,219	£54,963	£76,164	£77,613

Percentage Change in remuneration of highest paid director

	Salary and allowances	**Performance pay and bonuses**	**All taxable benefits**
The percentage change from the previous financial year in respect of the highest paid director	0%	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	-3%	0%	0%

The banded remuneration of the highest paid director in Fylde and Wyre CCG in the three months April to June 2022, inclusive of taxable benefits was £140,000-£145,000 (2021/22: £140,000-£145,000). There is zero percentage change in the salary of this individual.

During 1 April to 30 June 2022 two individuals received annualised remuneration in excess of the Highest Paid Director (2021/22, two).

The 3% decrease seen in the average pay of the employees of the entity reflects a change in staff composition.

Pay Ratio Information

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

Year	25th percentile total remuneration ratio	25th percentile salary ratio	Median total remuneration ratio	Median salary ratio	75th percentile total remuneration ratio	75th percentile salary ratio
1 April to 30 June 2022	**3.8:1**	**3.8:1**	**2.7:1**	**2.7:1**	**1.9:1**	**1.9:1**
2021/22	3.6:1	3.6:1	2.6:1	2.6:1	1.8:1	1.8:1

The slight increase in the pay ratios observed between 1 April to 30 June 2022 and 2021/22 reflect the change is staff composition. The changes resulted in lower salaries seen at the 25th percentile, median and 75th percentile points as at 30 June 2022 than at 31 March 2022.Overall the headcount of staff included in the ratio calculations increased between the two periods (from 42 at 31.3.22 to 44 at 30.6.22).

As the remuneration of the highest paid director did not change, any changes in the ratio can only be attributed to the composition of the workforce.

Staff Report

The Staff Report includes a number of items that are subject to the scrutiny of External Audit and some sections where External Audit is not required to give an opinion on the content. The items that are subject to audit are identified throughout the report.

Staff Numbers - Senior Managers

The number of Senior Managers in the CCG, taken as at 30 June March 2022, is shown below, both in terms of headcount (number) and whole time equivalent (WTE):

Pay Band	Number	WTE
VSM	4	1.27
9	2	0.74
8d	5	4.35
8c	1	1.00
8b	1	0.70
TOTAL	**13**	**8.06**

For the purposes of this disclosure, the term 'Senior Managers' includes those staff on the Governing Body, and those managers who report directly to the members of the Executive Team.

Remuneration of Very Senior Managers

The Secretary of State wrote on 2 June 2015 to Chairs of NHS organisations about the pay of Very Senior Managers (VSMs). This included the introduction of controls on appointments of VSMs on salaries exceeding £142,500 per annum, reflecting the Prime Minister's salary. The Prime Minister's salary has now increased to £150,000. The Salaries and Allowances of the Governing Body table above identifies one individual whose salaries and fees figure exceeds this value if calculated as an annualised full time equivalent.

This was an interim appointment to provide additional executive support to the CCG following the departure of a number of key individuals.

Staff Numbers and Costs

A detailed note showing staff numbers and costs in the year can be viewed at Note 4 to the Annual Accounts.

Staff Categorisation

The following is an analysis of staff numbers, taken as at 30 June 2022, showing the categorisation of CCGs employees both in terms of headcount (number) and whole time equivalent (WTE):

Category	**Number**	**WTE**
Medical Staff	3	1.09
Nursing Staff	6	4.18
Administration and Estates Staff	36	31.10
TOTAL	**45**	**36.37**

Note: the category definitions are consistent with those in the Information Centre's Occupational Code Manual. This may be observed via its website: www.ic.nhs.uk

Staff Composition

The following is a breakdown of the staff numbers, taken as at 30 June 2022, identifying the gender of CCG employees both in terms of headcount (number) and whole time equivalent (WTE):

Category	Male		Female		TOTAL	
	WTE	Number	WTE	Number	WTE	Number
Senior Managers – Executive Team	5	1.82	1	0.30	6	2.12
Senior Managers – Other	2	1.85	5	4.09	7	5.94
Other CCG Employees	3	2.50	29	25.81	32	28.31
TOTAL	**10**	**6.17**	**35**	**30.20**	**45**	**36.37**

Staff Policies

The CCG had a range of HR policies covering issues such as recruitment, disciplinary, flexible working etc. The HR policies were refreshed on an ongoing basis to reflect latest employment legislation and good practice.

Workforce Diversity and Inclusion

The CCG was committed to creating an inclusive and diverse workforce. The CCG was represented on the North West BAME (Black, Asian and Ethnic Minority) Assembly and continued to work towards addressing disproportionate impacts of COVID-19 on the NHS workforce.

The Fylde Coast (Blackpool and Fylde and Wyre) CCGs' Workforce Race Equality Standard (WRES) reporting, and action plan was approved by CCG governance processes and published on the CCG website. In summary, the WRES report included:

- Workforce data of staff employed by Fylde Coast CCGs.
- An action plan aligned to publication of the NHS People Plan and NHS Model Employer Strategy

As at 30 June 2022:

- 172 staff are employed by the Fylde Coast CCGs, of which 84.1% self-reported their ethnicity on the Electronic Staff Records (ESR) system (improvement from 82.6% previously).
- The proportion of staff from BAME backgrounds is 3.7% (previously 4.8%).
- The proportion of BAME representation across the CCGs' Governing Body members was 17.6% and in senior leaders (NHS AfC Band 8B and above) was 1.9%.

The CCG received human resources support from NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) and ensured that advice and support was available to all staff, and that fair and equitable recruitment practices were in place. The TRAC Jobs website system was used to recruit new members of staff, and the CCG was supported by the Recruitment Team at MLCSU.

The CCG was committed to holding up to date information about the workforce, in line with current data protection legislation, to help ensure that strategic decisions affecting the workforce are based on accurate reporting and data.

The CCG aimed to have a workforce that was representative of its local communities. Due to low workforce numbers, it was not possible to publish specific data relating to age, religion and belief, sexual orientation, gender reassignment, pregnancy and maternity, marriage, and civil partnership as there was a risk of identifying individual members of staff through the publication of this data. As at 30 June 2022, the following information on the Fylde Coast CCGs' staff groups was:

Age: There was variation across age groups with lowest representation across younger age groups – under 24 years. The largest age groups represented were 45 to 59 years.

Sex: Within our workforce 75% were women compared to 25% which were men.

Disability: The CCG had a low number of staff who had declared they had a disability. There was a significant percentage of staff that had not disclosed their disability status. Despite the low numbers, there were a number of staff members who had required 'reasonable adjustments' to be made in the workplace due to a disability or long-term condition.

There were a number of policies and processes in place to address any disproportionate barriers faced by staff with a disability / long term condition. In summary they included:

- Staff completed a Display Screen Equipment (DSE) assessment form annually and undertook annual mandatory training. This help identify where any reasonable adjustments were needed.
- Staff could access support from Occupational Health.

Mandatory Equality and Inclusion training for the CCG was monitored by ESR. Staff had the option to complete the training module online via ESR, or to attend an annual face to face training session virtually that was provided by the Equality and Inclusion Team at MLCSU. Compliance with Equality and Inclusion Training as at 30 June 2022 was 87.04% for NHS Fylde and Wyre CCG.

Trade Union Facility Time Reporting Requirements

Blackpool CCG was an active participant in the Staff Partnership Forum facilitated by NHS Midlands and Lancashire Commissioning Support Unit. The CCG utilised this form as a vehicle and mechanism to support proactive staff engagement, consultation and, where appropriate, negotiation. The CCG did not employ anyone who undertook relevant union official duties as outlined in the Trade Union (Facility Time Publication Requirements) Regulations 2017 and therefore no time is released from this employer in relation to official duties. The CCG liaised and worked with CSU TU representatives and area/regional representatives from those recognised unions whose time was recorded with their employing authority.

Other Employee Matters

We tried hard to ensure that the CCG was a great place to work by creating a friendly, informal organisational culture in which our employees are encouraged to make decisions within their levels of authority; to ask questions; to contribute, clarify and confirm how to move issues forward; and to develop themselves to their full potential through formal training, real-life work experiences and projects.

Staff wellbeing was a priority for the CCG, particularly during the COVID-19 pandemic and recovery and to support staff through the planned period of transformation. To support staff, a staff wellbeing group was established to bring together best practice from all CCGs in Lancashire and South Cumbria and to support different ways of working in the future. Staff were supported to continue to work effectively at home with plans to move to an agile working model. Staff were kept informed through team briefings and the staff bulletin about plans under the 'Our Ways of Working' approach contributing their views via surveys and submitting questions via email. Further work to collate the wide range of staff wellbeing support took place and were available in one document for ease of access.

We took our responsibilities for workplace health, safety, and wellbeing seriously, and ensured all employees undertook an annual refresher on workplace health and safety and knew how to access independent occupational health wellbeing support if needed.

The CCG provided a monthly Team Brief session in addition to the wider Lancashire and South Cumbria briefing. This offered staff the opportunity to ask any further questions or discuss any concerns. Line managers were encouraged to have wellbeing conversations with their teams via regular 1:1s.

Staff Sickness Absence Data

Published information in respect of sickness absence rates can be found via NHS Digital's NHS workforce statistics using the following link:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates*Staff Turnover*

Published information in respect of staff turnover percentages and headcount can be found via NHS Digital's NHS workforce statistics using the following link:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Ill Health Retirement

The CCG did not have any incidences of ill health retirement to report during the three months April to June 2022 (nil 2021/22).

Expenditure on Consultancy

The CCG did not have any expenditure on consultancy during the three months April to June 2022 (nil 2021/22).

Off-Payroll Engagements (not subject to audit)

There is a Treasury requirement for public sector bodies to report arrangements whereby individuals are paid through their own companies and so are responsible for their own tax and National Insurance arrangements.

Payments to GP practices for the services of GPs and employees are included in these disclosure requirements.

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 30 June 2022, for more than £245* per day.

	Number
Number of existing engagements as of 30 June 2022	1
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	1
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	0
for between four or more years at the time of reporting	0

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

Table 2: Off-payroll workers engaged at any point during the financial period

For all new off-payroll engagements between 1 April 2022 and 30 June 2022, for more than £245 [(1)] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	0
Of which:	
No. not subject to off-payroll legislation [(2)]	0
No. subject to off-payroll legislation and determined as in-scope of IR35 [(2)]	0
No. subject to off-payroll legislation and determined as out of scope of IR35 [(2)]	0
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

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

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

Off-payroll engagements regarding the Governing Body:

Number of off-payroll engagements of Governing Body members between 1 April 2022 and 30 June 2022	1[1]
Number of individuals that have been deemed Governing Body members between 1 April 2022 and 30 June 2022 (this figure includes both off-payroll and on-payroll engagements).	13

[1] Please note that the individual identified as being on the Governing Body with an off-payroll engagement did not have voting rights.

Exit Packages

There have been no exit packages agreed between 1 April 2022 and 30 June 2022 (2021/22 nil).

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board

(on behalf of the former Fylde and Wyre Clinical Commissioning Group)

21 June 2023

Parliamentary Accountability and Audit Report

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

Independent Auditor's Report to the members of the Governing Body of NHS Fylde and Wyre Clinical Commissioning Group

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD IN RESPECT OF NHS FYLDE AND WYRECLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Fylde and Wyre Clinical Commissioning Group ("the CCG") for the three-month period ended 30 June 2022 which comprise of the Statement of Financial Position, the Statement of Comprehensive Net Expenditure, the Statement of Cash Flows, the Statement of Changes in Taxpayers Equity, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 30 June 2022 and of its income and expenditure for the three month period then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 22 June 2022 as being relevant to CCGs in England and included in 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).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG and NHS Lancashire and South Cumbria Integrated Care Board ("the ICB") in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Emphasis of matter – going concern

We draw attention to the disclosure made in note 1 to the financial statements which explains that on 1 July 2022, NHS Fylde and Wyre CCG was dissolved and its services transferred to NHS Lancashire and South Cumbria Integrated Care Board. Under the continuation of service principle the financial statements of the CCG have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in respect of this matter.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis as the CCG has been dissolved and its services transferred to another public sector entity, the ICB, and the Accountable Officer has not been informed by the relevant national body of the intention to cease the services previously provided by the CCG. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the CCG and transferred to the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and

- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the services provided by the CCG will continue to be provided by the successor body.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee of the successor ICB and internal audit and inspection of policy documentation as to the CCG's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the CCG's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the CCG by NHS England.
- Reading Governing Body and Audit Committee minutes of the CCG and the ICB.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls, in particular the risk that CCG management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the CCG, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. We did not identify any additional fraud risks.

In determining the audit procedures, we took into account the results of our evaluation of the design and implementation of the operating effectiveness of some of the CCG-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries to test based on high-risk criteria and comparing the identified entries to supporting documentation. These included journal entries made by individuals who typically do not post journals, journals posted to seldom used ledger accounts, cash journals posted to an unexpected ledger account, and material post-closing journal entries.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Reviewing the completeness of information provided by the CCG as part of the 'NHS Agreement of Balances' exercise to ensure consistency with the information in the accounts.
- Assessing the completeness and accuracy of recorded expenditure through specific testing over purchases from non-NHS bodies and non-NHS accruals.

- Inspecting a sample of invoices received and payments made before and after year end to corroborate whether those items were recorded in the correct accounting period.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board of the CCG and ICB and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the CCG is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The CCG is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the CCG is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

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

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements; and

- in our opinion the other information has been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022/23.

Annual Governance Statement

We are required by 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") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022/23. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 45, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; 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 either cease the services provided by the CCG or dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

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 conform to the authorities which govern them.

Report on 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 if we identify any significant weaknesses in the arrangements that have been made by the CCG to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 45, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. 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 the use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the CCG had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if we refer a matter to the Secretary of State and NHS England 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.

We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Board of NHS Lancashire and South Cumbria Integrated Care Board in respect of NHS Fylde and Wyre CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Fylde and Wyre CCG for the three-month period ended 30 June 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Debra Chamberlain
for and on behalf of KPMG LLP
Chartered Accountants
KPMG LLP
1 St Peter's Square
Manchester
M2 3AE

29 June 2023

Data entered below will be used throughout the workbook:

Entity name:	NHS Fylde and Wyre Clinical Commissioning Group
This year	2022-23
Last year	2021-22
This year ended	30 June 2022
Last year ended	31-March-2022
This year commencing:	01-April-2022
Last year commencing:	01-April-2021

NHS Fylde and Wyre Clinical Commissioning Group - 3 month accounts to 30 June 2022

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The Primary Statements:

Notes to the Accounts

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

	Note	3 Month Accounts to period end 30 June 2022 £'000	Full Year Accounts 2021-22 £'000
Income from sale of goods and services	2	(229)	(130)
Other operating income	2	(1)	(81)
Total operating income		**(230)**	**(211)**
Staff costs	4	699	2,657
Purchase of goods and services	5	81,372	331,348
Provision expense	5	0	604
Other Operating Expenditure	5	73	301
Total operating expenditure		**82,144**	**334,910**
Net Operating Expenditure		**81,914**	**334,699**
Comprehensive Expenditure for the Financial Period		**81,914**	**334,699**

Statement of Financial Position as at 30 June 2022

	Note	3 Month Accounts to period end 30 June 2022	Full Year Accounts 2021-22
		£'000	£'000
Current assets:			
Inventories	16	644	647
Trade and other receivables	17	1,957	2,068
Cash and cash equivalents	20	12	224
Total current assets		**2,613**	2,939
Total assets		**2,613**	2,939
Current liabilities			
Trade and other payables	23	(11,938)	(15,767)
Provisions	28	(604)	(604)
Total current liabilities		**(12,542)**	(16,371)
Assets less Liabilities		**(9,929)**	(13,432)
Financed by Taxpayers' Equity			
General fund		(9,929)	(13,432)
Total taxpayers' equity:		**(9,929)**	(13,432)

The notes on pages 5 to 30 form part of this statement

The financial statements on pages 1 to 4 were approved by Board of the Lancashire and South Cumbria Integrated Care Board (as successor organisation to NHS Fylde and Wyre Clinical Commissioning Group) on 21 June 2023 and are signed on its behalf by:

Kevin Lavery
Chief Accountable Officer, Lancashire and South Cumbria Integrated Care Board

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

Changes in taxpayers' equity for 2022-23	**(3 months to period end 30 June 2022)**	**General fund £'000**	**Total reserves £'000**
Balance at 01 April 2022		**(13,432)**	**(13,432)**
Net operating expenditure for the financial period		(81,914)	**(81,914)**
Net funding		85,417	**85,417**
Balance at 30 June 2022		**(9,929)**	**(9,929)**

Changes in taxpayers' equity for 2021-22	(full year accounts)	**General fund £'000**	**Total reserves £'000**
Balance at 01 April 2021		(18,004)	(18,004)
Net operating costs for the financial year		(334,699)	(334,699)
Net funding		339,271	339,271
Balance at 31 March 2022		(13,432)	(13,432)

The notes on pages 5 to 30 form part of this statement

Statement of Cash Flows for the period ended

30 June 2022	Note	**3 Month Accounts to period end 30 June 2022** **£'000**	Full Year Accounts 2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial period		(81,914)	(334,699)
(Increase)/decrease in inventories		3	(122)
(Increase)/decrease in trade & other receivables	17	111	(136)
Increase/(decrease) in trade & other payables	23	(3,829)	(4,704)
Increase/(decrease) in provisions	28	0	604
Net Cash Inflow (Outflow) from Operating Activities		**(85,629)**	(339,057)
Net Cash Inflow (Outflow) before Financing		**(85,629)**	(339,057)
Cash Flows from Financing Activities			
Drawdown Funding Received		85,417	339,271
Net Cash Inflow (Outflow) from Financing Activities		**85,417**	339,271
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(212)**	214
Cash & Cash Equivalents at the Beginning of the Financial Period		224	10
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Period		**12**	224

The notes on pages 5 to 30 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

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

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.
The Health and Social Care Bill received Royal Assent on 28 April 2022. The Act allows for the establishment of Integrated Care Boards (ICB) across England and the abolishment of clinical commissioning groups (CCG) from 1 July 2022. ICBs will take on the commissioning functions of CCGs and all assets and liabilities will therefore transfer to NHS Lancashire and South Cumbria ICB 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 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.

1.2 **Accounting Convention**

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

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

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Joint arrangements**

Arrangements over which the clinical commissioning group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.
A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the clinical commissioning group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.
The CCG's pooled budget arrangement described below is considered to fall under the provisions of a joint operation.
A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.
The CCG does not consider itself to be involved in any joint ventures.

1.5 **Pooled Budgets**

From 1st April 2015 the CCG has entered into pooled budget arrangements hosted by Lancashire County Council in respect of the Better Care Fund (BCF) Initiative. The BCF is designed to create a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.
The BCF section 75 agreement in Lancashire is considered to fall under the provisions of a 'joint operation' due to the following factors:
- Relevant decisions must be unanimous
'- All members hold providers to account for delivery
'- Risks are borne equally

All partners account for their own share of the pool's income, expenditure, assets and liabilities in line with the agreement. These balances are shown at Note 33 to the Annual Accounts.

1.6 **Operating Segments**

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

1.7 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.
The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.
The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Notes to the financial statements

1.80 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

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

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

1.8.2 **Retirement Benefit Costs**

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

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

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

1.9 **Other Expenses**

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

1.10 **Grants Payable**

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

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.12 **Intangible Assets**

1.12.1 **Recognition**

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

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

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

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

1.12.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.
Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.12.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself.
Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.
At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.
A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.13 **Donated Assets**

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 **Government grant funded assets**

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 **Non-current Assets Held For Sale**

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.
The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.
Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The clinical commissioning group assesses whether a contract is or contains a lease, at inception of the contract.

1.16.1 **The Clinical Commissioning Group as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.
Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.
Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

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The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.
Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.
Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.
For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.
Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.17 **Inventories**

Inventories are valued at the lower of cost and net realisable value.

1.18 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.19 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 3.27% (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 3.20% (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 3.51% (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 3.00% (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.

1.20 **Clinical Negligence Costs**

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

1.21 **Non-clinical Risk Pooling**

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

1.22 **Carbon Reduction Commitment Scheme**

The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The clinical commissioning group is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.
The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.
The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.
Allowances acquired under the scheme are recognised as intangible assets.

1.23 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

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1.24 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

1.24.1 **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.

1.24.2 **Financial assets at fair value through other comprehensive income**

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

1.24.3 **Financial assets at fair value through profit and loss**

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

1.24.4 **Impairment**

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

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

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

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

1.25 **Financial Liabilities**

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

1.25.1 **Financial Guarantee Contract Liabilities**

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

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

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

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

1.25.3 **Other Financial Liabilities**

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

1.26 **Value Added Tax**

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

1.27 **Foreign Currencies**

The clinical commissioning group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 30 June. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.28 **Third Party Assets**

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

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1.29 **Losses & Special Payments**

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

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

1.30 **Critical accounting judgements and key sources of estimation uncertainty**

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

1.30.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the clinical commissioning group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The clinical commissioning group's management has reviewed the organisation's lease arrangements and judged that there are no right-of-use assets to be disclosed under IFRS 16: Leases (also see 1.32 below).

1.30.2 **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.

There are a number of accruals within the Statement of Financial Position where estimation techniques are applied. This is because the outturn information is not available at the time of preparation of the financial statements. Examples of significant accruals involving estimates are prescribing costs and continuing healthcare costs.

1.31 **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.

1.32 **Adoption of new standards**

On 1 April 2022, the clinical commissioning group adopted IFRS 16 ‘Leases’. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.

Under IFRS 16 the group will recognise a right-of-use asset representing the group’s right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Impact assessment

The clinical commissioning group has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The group has utilised three further practical expedients under the transition approach adopted:

a) The election to not make an adjustment for leases for which the underlying asset is of low value.

b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.

c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.

As of 1 April 2022, the group did not recognise any right-of-use assets for buildings previously treated as operating leases. On adoption of IFRS 16 there was no impact to tax payers’ equity.

The following table reconciles the group’s operating lease obligations at 31 March 2022, disclosed in the group’s 21/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

1.33 **New and revised IFRS Standards in issue but not yet effective**

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

2 Other Operating Revenue	3 Month Accounts to period end 30 June 2022 Total £'000	Full Year Accounts 2021-22 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**229**	130
Other Contract income	**0**	0
Total Income from sale of goods and services	**229**	**130**
Other operating income		
Other non contract revenue	**1**	81
Total Other operating income	**1**	**81**
Total Operating Income	**230**	**211**

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

3 month period to 30 June 2022 Source of Revenue	Non-patient care services to other bodies £'000	Other Contract income £'000
NHS	229	0
Non NHS	0	0
Total	**229**	**0**

3 month period to 30 June 2022 Timing of Revenue	Non-patient care services to other bodies £'000	Other Contract income £'000
Point in time	229	0
Over time	0	0
Total	**229**	**0**

2021-22 (Full Year Accounts) Source of Revenue	Non-patient care services to other bodies £'000	Other Contract income £'000
NHS	130	0
Non NHS	0	0
Total	130	0

2021-22 (Full Year Accounts) Timing of Revenue	Non-patient care services to other bodies £'000	Other Contract income £'000
Point in time	130	0
Over time	0	0
Total	130	0

3.2 Transaction price to remaining contract performance obligations

There is no contract revenue expected to be recognised in future periods relating to current contract perf obligations (nil 2021/22).

4. Employee benefits and staff numbers

4.1.1 Employee benefits: 3 month period to 30 June 2022

	Total Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**520**	**17**	**537**
Social security costs	**65**	**0**	**65**
Employer Contributions to NHS Pension scheme	**97**	**0**	**97**
Gross employee benefits expenditure	**682**	**17**	**699**
Net employee benefits excluding capitalised costs	**682**	**17**	**699**

4.1.1 Employee benefits: Full year accounts 2021-2022

	Total Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	1,957	84	2,041
Social security costs	220	0	220
Employer Contributions to NHS Pension scheme	396	0	396
Gross employee benefits expenditure	2,573	84	2,657
Net employee benefits excluding capitalised costs	2,573	84	2,657

4.2 Average number of people employed

	Permanently employed Number	Other Number	Total Number
3 month period to 30 June 2022	**35.33**	**0.30**	**35.63**
Full year accounts 2021-22	34.65	0.69	35.34

4.3 Exit packages agreed in the financial year

The clinical commissioning group did not agree any exit packages in 2022/23 i.e. from 1st April 2022 to 30th June 2022 (nil 2021/22).
There were no other departures during the period from 1st April 2022 to 30th June 2022 where special payments were made (nil 2021/22).

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

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

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

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

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to 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.

5. Operating expenses	**3 Month Accounts to period end 30 June 2022 Total £'000**	Full Year Accounts 2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	472	2,487
Services from foundation trusts	50,228	193,974
Services from other NHS trusts	2,699	10,192
Services from Other WGA bodies	1	4
Purchase of healthcare from non-NHS bodies	7,709	47,230
Purchase of social care	1,375	5,140
Prescribing costs	9,278	36,945
General Ophthalmic services	6	22
GPMS/APMS and PCTMS	9,527	36,994
Supplies and services – general	(230)	(2,884)
Establishment	44	80
Premises	202	1,002
Audit fees	52	77
Other non statutory audit expenditure		
· Other services	3	12
Legal fees	5	68
Education, training and conferences	1	5
Total Purchase of goods and services	**81,372**	**331,348**
Provision expense		
Provisions	0	604
Total Provision expense	**0**	**604**
Other Operating Expenditure		
Chair and Non Executive Members	17	88
Inventories consumed	56	213
Total Other Operating Expenditure	**73**	**301**
Total operating expenditure	**81,445**	**332,254**

The clinical commissioning group's contract with its external auditors (KPMG LLP) provides for a limitation of the auditor's liability. The principal terms of this limitation are as follows:
Liability for all defaults resulting in direct loss or damage to the property of the other party shall be subject to a limit of £1M. In respect of all other defaults, claims, losses or damages the liability shall not exceed £1M.

6.1 Better Payment Practice Code

Measure of compliance	3 Month Accounts to period end 30 June 2022 Number	3 Month Accounts to period end 30 June 2022 £'000	Full Year Accounts 2021-22 Number	Full Year Accounts 2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	3,190	26,686	13,500	103,676
Total Non-NHS Trade Invoices paid within target	3,158	26,482	13,370	101,004
Percentage of Non-NHS Trade invoices paid within target	**99.00%**	**99.24%**	99.04%	97.42%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	158	53,279	315	209,367
Total NHS Trade Invoices Paid within target	153	53,083	303	209,250
Percentage of NHS Trade Invoices paid within target	**96.84%**	**99.63%**	96.19%	99.94%

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

The clinical commissioning group has not made any interest payments in respect of late payment of commercial debts in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

7 Income Generation Activities

The clinical commissioning group has not undertaken any income generation activities in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

8. Investment revenue

The clinical commissioning group had no investment revenue in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

9. Other gains and losses

The clinical commissioning group had no other gains or losses in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

10. Finance costs

The clinical commissioning group incurred no finance costs in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

11. Net gain/(loss) on transfer by absorption

The clinical commissioning group has not received any gain or incurred any loss relating to the transfer of services or functions by absorption costing in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

12 Property, plant and equipment

The clinical commissioning group held no property, plant or equipment at 30 June 2022 (nil at 31 March 2022).

There is no revaluation reserve balance in respect of Property, Plant and Equipment at 30 June 2022 (nil 31 March 2022).

12.1 Additions to assets under construction

The clinical commissioning group made no additions to assets under construction in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

12.2 Donated assets

The clinical commissioning group held no donated assets in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

12.3 Government granted assets

The clinical commissioning group held no government granted assets in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

12.4 Property revaluation

The clinical commissioning group held no property in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

12.5 Compensation from third parties

The clinical commissioning group received no compensation from third parties for assets impaired, lost or given up, that is included in the Statement of Comprehensive Net Expenditure in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

12.6 Write downs to recoverable amount

No assets were written down to recoverable amounts and there were no reversals of previous write-downs in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

12.7 Temporarily idle assets

The clinical commissioning group had no temporarily idle assets as at 30 June 2022 (nil at 31 March 2022).

12.8 Cost or valuation of fully depreciated assets

The clinical commissioning group had no fully depreciated assets still in use as at 30 June 2022 (nil at 31 March 2022).

12.9 Economic lives

No assets were held by the clinical commissioning group at 30 June 2022 (nil at 31 March 2022).

13 Leases: right-of-use assets

The clinical commissioning group held no right-of-use assets at 30 June 2022 (nil at 31 March 2022).

There is no revaluation reserve balance in respect of right-of-use assets at 30 June 2022 (nil 31 March 2022).

14 Intangible non-current assets

The clinical commissioning group held no intangible non-current assets as at 30 June 2022 (nil at 31 March 2022).
There is no revaluation reserve balance in respect of intangible assets at 30 June 2022 (nil in 31 March 2022).

14.1 Donated assets
The clinical commissioning group held no donated intangible assets in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

14.2 Government granted assets

The clinical commissioning group held no government granted intangible assets in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

14.3 Revaluation

The clinical commissioning group revalued no intangible assets in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

14.4 Compensation from third parties
The clinical commissioning group received no compensation from third parties for intangible assets impaired, lost or given up, that is included in the Statement of Comprehensive Net Expenditure in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

14.5 Write downs to recoverable amount
No intangible assets were written down to recoverable amounts and there were no reversals of previous write-downs in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

14.6 Non-capitalised assets
No intangible assets were written down to recoverable amounts and there were no reversals of previous write-downs in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

14.7 Temporarily idle assets
The clinical commissioning group had no temporary idle assets as at 30 June 2022 (nil at 31 March 2022).

14.8 Cost or valuation of fully amortised assets
The clinical commissioning group had no fully depreciated assets still in use as at 30 June 2022 (nil at 31 March 2022).

15 Investment property

The clinical commissioning group held no investment property as at 30 June 2022 (nil at 31 March 2022).

16 Inventories

	Loan Equipment £'000	Total £'000
Balance at 01 April 2022	647	**647**
Additions	53	**53**
Inventories recognised as an expense in the period	(56)	**(56)**
Balance at 30 June 2022	**644**	**644**

The above balance includes community loan store equipment.

17.1 Trade and other receivables	**Current 3 Month Accounts to period end 30 June 2022 £'000**	Current Full Year Accounts 2021-22 £'000
NHS receivables: Revenue	109	928
NHS prepayments	3	5
NHS accrued income	0	91
Non-NHS and Other WGA receivables: Revenue	75	168
Non-NHS and Other WGA prepayments	1,543	533
Non-NHS and Other WGA accrued income	215	327
VAT	12	16
Total Trade & other receivables	**1,957**	**2,068**
Total current and non current	**1,957**	**2,068**

17.2 Receivables past their due date but not impaired	**3 Month Accounts to period end 30 June 2022 DHSC Group Bodies £'000**	**3 Month Accounts to period end 30 June 2022 Non DHSC Group Bodies £'000**	Full Year Accounts 2021-22 DHSC Group Bodies £'000	Full Year Accounts 2021-22 Non DHSC Group Bodies £'000
By up to three months	62	0	418	136
By three to six months	0	0	0	0
By more than six months	0	0	0	0
Total	**62**	**0**	**418**	**136**

The CCG reviewed its financial assets at 30 June 2022 and did not consider it to be necessary to provide for losses based on its portfolio.

18 Other financial assets

18.1 Current

The clinical commissioning group held no other current financial assets as at 30 June 2022 (nil at 31 March 2022).

18.2 Non-current

The clinical commissioning group held no other non-current financial assets as at 30 June 2022 (nil at 31 March 2022).

19 Other current assets

The clinical commissioning group held no other current assets as at 30 June 2022 (nil at 31 March 2022).

20 Cash and cash equivalents

	3 Month Accounts to period end 30 June 2022 £'000	Full Year Accounts 2021-22 £'000
Balance at 01 April 2022	224	10
Net change in year	(212)	214
Balance at 30 June 2022	**12**	**224**
Made up of:		
Cash with the Government Banking Service	12	224
Cash and cash equivalents as in statement of financial position	**12**	**224**
Balance at 30 June 2022	**12**	**224**

21 Non-current assets held for sale

The clinical commissioning group held no non-current assets held for sale as at 30 June 2022 (nil at 31 March 2022).

22 Analysis of impairments and reversals

The clinical commissioning group had no impairments or reversals of impairments of any description in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

23 Trade and other payables	**Current 3 Month Accounts to period end 30 June 2022 £'000**	Current Full Year Accounts 2021-22 £'000
NHS payables: Revenue	649	883
NHS accruals	960	364
Non-NHS and Other WGA payables: Revenue	1,821	1,296
Non-NHS and Other WGA accruals	8,043	12,675
Social security costs	42	41
Tax	34	36
Other payables and accruals	389	472
Total Trade & Other Payables	**11,938**	**15,767**

Other payables include £251K outstanding pension contributions at 30 June 2022 (£254K as at 31 March 2022).

24 Other financial liabilities

The clinical commissioning group held no other financial liabilities as at 30 June 2022 (nil at 31 March 2022).

25 Other liabilities

The clinical commissioning group held no other liabilities as at 30 June 2022 (nil at 31 March 2022).

26 Borrowings

The clinical commissioning group had no borrowings as at 30 June 2022 (nil at 31 March 2022).

27 Finance lease receivables

The clinical commissioning group had no finance lease receivables as at 30 June 2022 (nil at 31 March 2022).

28 Provisions

	Current 2022-23 £'000	**Non-current 2022-23 £'000**	Current 2021-22 £'000	Non-current 2021-22 £'000
Continuing care	604	0	604	0
Total	**604**	**0**	**604**	**0**
Total current and non-current	**604**		**604**	

	Continuing Care £'000	**Total £'000**
Balance at 01 April 2022	**604**	**604**
Balance at 30 June 2022	**604**	**604**
Expected timing of cash flows:		
Within one year	604	**604**
Balance at 30 June 2022	**604**	**604**

The provision balance recognised is in respect of packages of continuing healthcare that have been funded by the local authority (Lancashire County Council). The funding for these cases however should have been provided by the clinical commissioning group, according to national CHC framework guidance. Discussions with the local authority on the interpretation of the guidance is ongoing and at the time of accounts preparation there is uncertainty as to the exact amount and date of any financial settlement.

29 Contingencies

The clinical commissioning group had no contingent assets or liabilities as at 30 June 2022 (nil 31 March 2022).

30 Commitments

30.1 Capital commitments

There are no contracted capital commitments as at 30 June 2022 not otherwise included within these financial statements (nil 31 March 2022).

30.2 Other financial commitments

The clinical commissioning group has not entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

31 Financial instruments

31.1 Financial risk management

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

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

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

31.1.1 Currency risk

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

31.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

31.1.3 Credit risk

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

31.1.4 Liquidity risk

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

31.1.5 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.

31 Financial instruments cont'd

31.2 Financial assets

	Financial Assets measured at amortised cost	**Total**	Total Full Year Accounts
	3 Month Accounts to period end 30 June 2022	**3 Month Accounts to period end 30 June 2022**	2021-22
	£'000	**£'000**	£'000
Trade and other receivables with NHSE bodies	91	91	975
Trade and other receivables with other DHSC group bodies	141	141	336
Trade and other receivables with external bodies	167	167	204
Cash and cash equivalents	12	12	224
Total at 30 June 2022	**411**	**411**	1,739

31.3 Financial liabilities

	Financial Liabilities measured at amortised cost	**Total**	Total Full Year Accounts
	3 Month Accounts to period end 30 June 2022	**3 Month Accounts to period end 30 June 2022**	2021-22
	£'000	**£'000**	£'000
Trade and other payables with NHSE bodies	659	**659**	749
Trade and other payables with other DHSC group bodies	1,255	**1,255**	808
Trade and other payables with external bodies	9,947	**9,947**	14,132
Total at 30 June 2022	**11,861**	**11,861**	15,689

32 Operating segments

3 Month Period to 30 June 2022

The CCG considers itself to only have one operating segment (i.e. Healthcare) in the 3 month period to 30 June 2022.

33 Joint arrangements - interests in joint operations

33.1 Interests in joint operations

From 1st April 2015 the CCG has entered into pooled budget arrangements in respect of the Better Care Fund (BCF) initiative. This is hosted by Lancashire County Council under Section 75 of the NHS Act 2006. The BCF is designed to create a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

The clinical commissioning group shares of the income and expenditure handled by the pooled budget in the financial year were:

	3 Month Accounts to period end 30 June 2022	Full Year Accounts 2021-22
	£'000	£'000
Income	2,669	10,081
Expenditure	(4,030)	(15,221)

33.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

The clinical commissioning group does not have any interests in entities not accounted for under IFRS 10 or IFRS 11 to disclose in the three month accounting period to June 2022 (nil for full year 2021/22).

34 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Peter Benett - Single inaugural £1 shareholder of Fylde Coast Medical Services (FCMS).	1190	0	20	0
Andrew Bennett - Interim Accountable Officer - Interim ICS Lead, Lancashire and South Cumbria	0	0	0	0
Andrew Bennett - Interim Accountable Officer -Spouse is a Specialist Nurse employed by Lancashire Teaching Hospital NHS Foundation Trust	5535	0	0	0
Andrew Bennett - Interim Accountable Officer - Brother is a Partner in the Orthmeor Group which is currently providing advice to the ICS elective Care Recovery Group	0	0	0	0
Dr Vellore Chandrasekar is a GP principal of Beechwood Surgery.	275	0	0	0
Dr Vellore Chandrasekar is a Clinical Assistant in orthopaedics at Blackpool Teaching Hospitals NHS Foundation Trust for 1 session per week.	33501	0	232	(1)
Dr Vellore Chandrasekar is a GP appraiser for North West Revalidation team (Health Education England)	0	0	0	0
Dr Vellore Chandrasekar is Chair of Wyre Integrated Network - Primary Care Network	0	0	0	0
Dr Vellore Chandrasekar teaches under-graduate medical students from Manchester University Medical School at Primary care in GP practice placement	0	0	0	0
Dr Kath Greenwood - GP retainer at Queensway Medical Centre.	367	0	0	0
Andrew Harrison - Chief Finance Officer for Morecambe Bay CCG (joint with Blackpool and Fylde and Wyre CCGs)	0	(1)	9	0
Andrew Harrison - Relative receiving personal health budget via continuing healthcare funding from Fylde and Wyre CCG	0	0	0	0
Dr Adam Janjua - GP Partner at Fleetwood Surgery (West View Health Village/Broadway Surgery)	468	0	0	0
Dr Adam Janjua - Director of Fleetwood Community Care Limited (GP Federation).	0	0	0	0
Dr Adam Janjua - Sole director of Adam Janjua Limited.	0	0	0	0
Dr Adam Janjua - Spouse is a GP Partner at Parcliffe Medical Practice (Clifton Medical Practice)	652	0	0	0
Nick Medway - wife works as a nurse at Lancashire Teaching Hospital NHS Foundation Trust	5535	0	0	0
Nick Medway - Daughter is an occupational therapist at Blackpool Teaching Hospitals NHS Foundation Trust	33501	0	232	(1)
Michael Nuttall - Trustee of My Life Charity	0	0	0	0
Jane Scattergood - Registrant member for Fitness to Practise Hearings at the Nursing & Midwifery Council	0	0	0	0
Jane Scattergood - Provides expert advice on BBC and PHE copy and products aimed at the pregnant and very early years population	0	0	0	0
Jane Scattergood - standing member of the NICE Quality Standards Advisory Committee as the public health member	0	0	0	0
Jane Scattergood - National Chair of the ICON project.	0	0	0	0
Jane Scattergood - Engaged in writing a research paper on scaling up breastfeeding countrywide in England and in another paper in the UK. This is in collaboration with the University of Central Lancashire.	0	0	0	0
Jane Scattergood - volunteer as an Independent Custody Visitor for the Independent Police Commissioner for Cumbria Constabulary	0	0	0	0
Jane Scattergood - Queen's Nurse	0	0	0	0
Jane Scattergood - Honorary Member of the faculty of Public Health	0	0	0	0
Kevin Toole - Patient and Public Voice (PPV) expert advisor to NHS England and specialised commissioning IFR panel member.	0	0	0	(13)
Dr Neil Hartley-Smith - (non-voting attendee) - GP Partner and Director of Bloomfield Medical Centre, Blackpool	0	0	0	0
Dr Neil Hartley-Smith - (non-voting attendee) - Director of Bloomfield Medical Centre, Blackpool including the provision of the Walk-in Centre (Fylde Coast Integrated Urgent Care) and DVT Service in Blackpool	0	0	0	0
Dr Neil Hartley-Smith - (non-voting attendee) - GP with Special Interest - Commissioning - NMO Medical Limited	0	0	0	0
Jane Higgs - Director and Shareholder of Jane Higgs Consulting Ltd.	17	0	0	0
Andrew Harrison, Jane Scattergood, Dr Neil Hartley-Smith, John Gaskins, Jane Higgs, Andrew Bennett and Nick Medway have worked as a joint Executive Management Team across both Blackpool and Fylde and Wyre CCGs (either for full or part year) Q1 of 22/23 . Transactions in year between Blackpool CCG and Fylde and Wyre CCG are:	13	0	372	(78)

Please note that the above figures represent the total value of transactions between the clinical commissioning group and the organisations identified as an interest. The values do not represent transactions with the individuals named.
The above table concentrates on the interests and related transactions of the members of the CCG Governing Body only.
The Department of Health and Social Care is regarded as a related party.
During the year the CCG had a significant number of material transactions with entities for which the Department is regarded as the parent Department.
Those bodies not already included in the table above with transactions greater than £1 million are:

North West Ambulance Services NHS Trust
Lancashire and South Cumbria NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Foundation Trust

In addition, the CCG has had a number of transactions with other government departments and other central and local government bodies.
The government body with transactions greater than £1 million that is not already included in the above table is:

Lancashire County Council

35 Events after the end of the reporting period

The clinical commissioning group did not have any events after the end of the reporting period to disclose that would have a material effect on the statements as at 30 June 2022.

On 28 April 2022 the Health and Care Act received Royal Assent. This confirmed the establishment of Integrated Care Boards in England. As a result of this the CCG was wound up on 30 June 2022 and NHS Lancashire and South Cumbria Integrated Care Board was formed on 1 July 2022. As explained in Note 1 the CCG's accounts were still prepared on a going concern basis due to the continued provision of the CCG's commissioning functions by the ICB.

36 Third party assets

The clinical commissioning group held no third party assets as at 30 June 2022 (nil at 31 March 2022).

37 Analysis of charitable reserves

The clinical commissioning group had no charitable reserves in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

38 Losses and Special Payments

38.1 Losses

The clinical commissioning group made no losses in the 3 month period ending 30 June 2022 (one fruitless payment in full year 2021/22. £0K).

38.2 Special Payments

The clinical commissioning group made no special payments in the 3 month period ending 30 June 2022 (nil in full year accounts 2021/22).

39 Financial performance targets

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

	3 Month Accounts to period end 30 June 2022 Target	**3 Month Accounts to period end 30 June 2022 Performance**	**Target Achieved**
Expenditure not to exceed income	82,145	82,144	Yes
Revenue resource use does not exceed the amount specified in Directions	81,914	81,914	Yes
Revenue administration resource use does not exceed the amount specified in Directions	836	836	Yes

	Full Year Accounts 2021-22 Target	Full Year Accounts 2021-22 Performance	**Target Achieved**
Expenditure not to exceed income	334,927	334,910	Yes
Revenue resource use does not exceed the amount specified in Directions	334,716	334,699	Yes
Revenue administration resource use does not exceed the amount specified in Directions	3,320	3,315	Yes