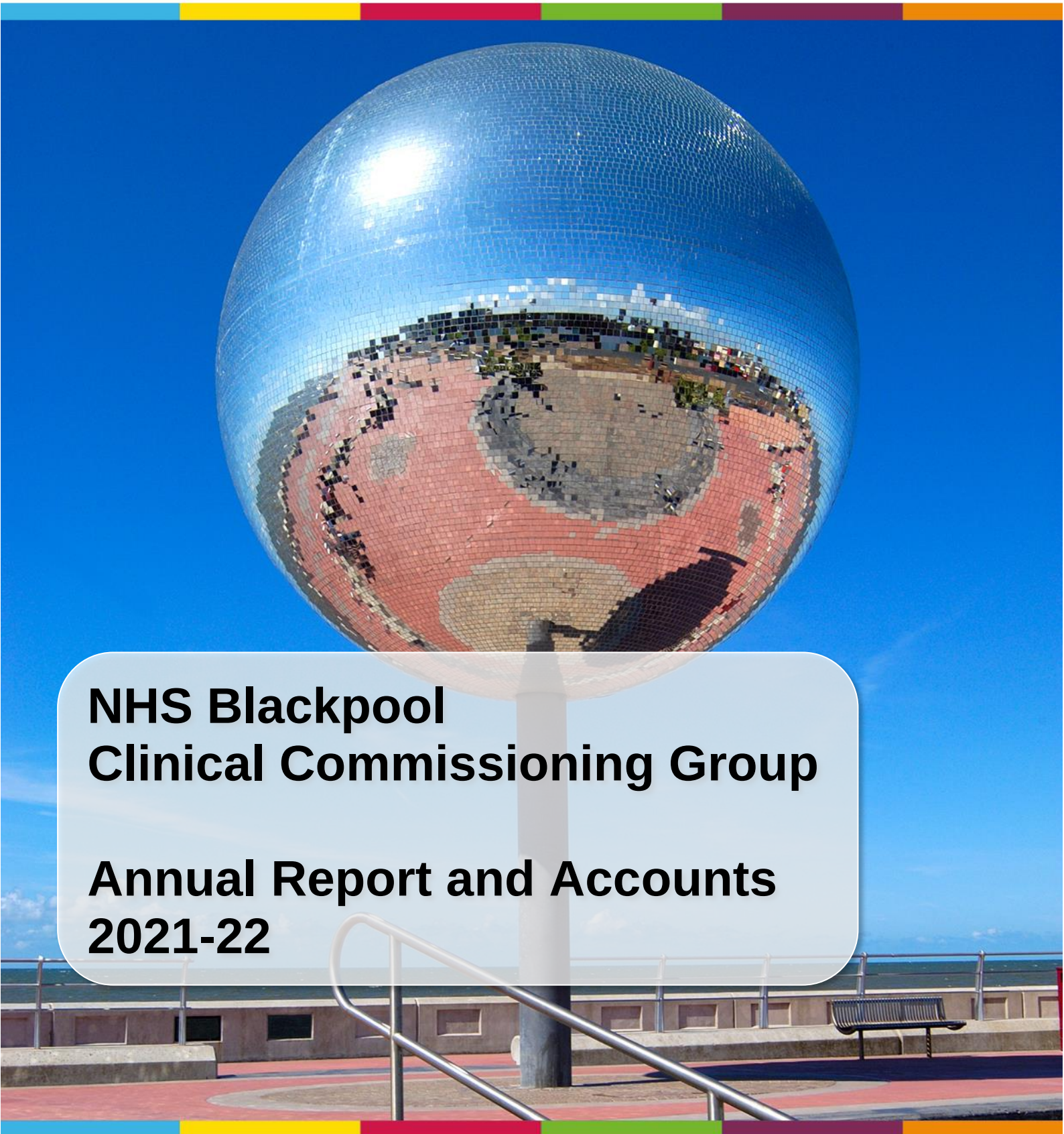
NHS
Blackpool
Clinical Commissioning Group



NHS Blackpool Clinical Commissioning Group

Annual Report and Accounts 2021-22

Welcome to the CCG's Annual Report 2021/22

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

At the time of writing, we remain in a pandemic and because we are not able to fully predict the future of COVID-19, there remains a level of uncertainty about the continued effects of the disease on the NHS and wider public services. For this reason, we would encourage people to stay safe and help to protect the most vulnerable in our society. We also recognise there is much to do to continue the work to restore, recover and develop excellent local services.

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

Our staff have continued to work in new and innovative ways, working remotely or taking up other roles and changing priorities when required. The professionalism and commitment they have shown is highly commendable. Looking forwards and subject to Parliament agreeing the current Health and Care Bill, our teams will complete their preparations for the next steps in commissioning transformation with the creation of an NHS Integrated Care Board for Lancashire and South Cumbria. For this reason, many colleagues are already working collaboratively across Lancashire and South Cumbria for at least part of their roles.

NHS England and Improvement's white paper Integrating care: Next steps to building strong and effective integrated care systems across England[1] (February 2021) details how Integrated Care Systems, and the organisations within them, will work more effectively and more collaboratively in future. Working at system level has

[1] https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/

already demonstrated benefits locally, such as the response to COVID-19, the new hospitals programme and actions to improve the system's financial position.

The Health and Care Bill includes a move towards a 'system wide' organisation with the eight CCGs across Lancashire and South Cumbria undertaking a process of closedown to support the creation of a statutory Integrated Care Board (ICB) for Lancashire and South Cumbria.

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

On the Fylde Coast it has long been recognised that there is a disparity in life expectancy between the most affluent areas and those areas which experience high levels of deprivation. Indeed, some areas of Blackpool are amongst the most deprived communities in England resulting in people experiencing a range of preventable diseases which affect quality of life and lead to increased morbidity. On the Fylde Coast we are strongly committed to reducing health inequalities through our population health management approach, identifying those most vulnerable and targeting help and support to them when they need it.

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

We wish everyone an optimistic and successful year ahead.

Roy Fisher, Chair

Andrew Bennett, Interim Accountable Officer

About this Annual Report

This annual report has been written with patients and the public in mind. Working 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.

Thanks to the feedback received during preparation for last year's annual report we will be repeating the new practices we put in place to make this report more accessible to all.

As well as the printed version of the annual report and the usual downloadable annual report we will once again be making each section available as its own web page. This proved popular last year especially those who use 'browsealoud' [2]technology for the visually impaired. We are happy that this valued audience can access our reports more easily.

Once again, we engaged with our various resident and patient groups, which are made up of members of the public who help to guide our work. This year, a draft of the content was shared with members of the CCG's Influence Panel and representatives from each of the Patient Participation Groups that work within GP practices as well as the Patient and Public Engagement and Involvement forum (PPEI).

Some of the content of the report has been prepared for use by all CCGs within Lancashire and South Cumbria and 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 two years ago. We have ensured all figures are properly explained and attributed to the correct area.

[2] A built in web application that reads the content of a webpage out loud for those who find reading the text on screen difficult.

Contents

Part 1: Performance report

NHS Blackpool Clinical Commissioning Group (CCG) is a clinically led organisation, which brings together 16 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 174,000 across 32sq/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 Blackpool, 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.

The co-ordinated response to the COVID-19 pandemic continues, led at both a national and regional level with service provision handled as part of a system-wide approach across Lancashire and South Cumbria.

The CCGs of the Fylde Coast have been working together for some time and over the last year more joint working has been taking place across all the CCGs in Lancashire and South Cumbria.

We continue to work in an agile way which we began at the start of the COVID-19 pandemic with many staff working from home or in different roles on a temporary basis. Whilst some changes that were made during the pandemic have begun to revert to their previous delivery model, often referred to as service restoration, others have been retained and a blended approach of old and new service delivery models offers more options for patients. For example, GP practices now offer a range of face to face, video and telephone appointments with many patients finding the convenience of the latter improves their ability to access support from a GP, practice nurse or other allied health professional when they need it. The safety of our patients and staff remains our number one priority and we will continue to review and improve patient experience and quality as part of our core offer to our residents.

It is widely publicised across the country that the COVID-19 pandemic response has had a negative effect on waiting lists with some people waiting much longer for appointments for both secondary and primary care. This is also the case on the Fylde Coast and compounded by the fact that almost a third of our population

experience a long-term condition such as respiratory conditions, cancer, diabetes, kidney disease, frailty, or mental health: many patients also have more than one long-term condition.

Blackpool experiences one of the highest levels of deprivation and health inequalities in England with a low level of life expectancy for both men and women compared to other parts of the country.

It is important to acknowledge that these challenges require a long-term commitment to resolving health inequalities, and it is more important than ever that we do not lose sight of our role in protecting people's long-term health and wellbeing.

Over the last year we have continued to progress our work across Healthier Fylde Coast as a place-based partnership (PBP) and many of our achievements are the result of joint working with our partners across all sectors.

Performance Overview

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

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

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

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

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

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

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

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

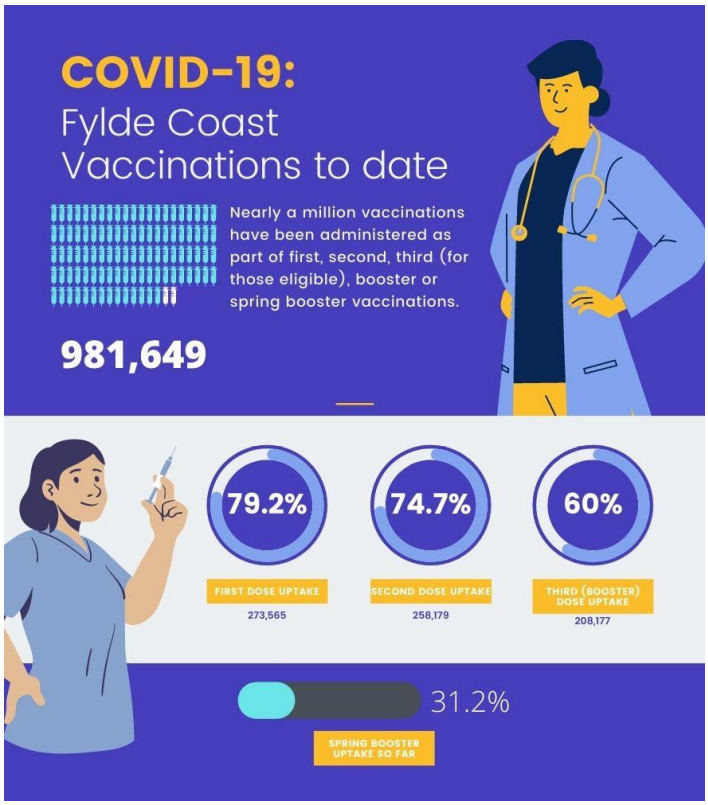
System-wide staff notices and information have been circulated to inform the wearing of face coverings across all healthcare settings (hospital trusts, GP practices, dentists), including information for the wearing of face coverings by patients and visitors. These have been re-circulated as necessary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

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

New variants and infection rates have required constant amendments and updates to testing guidance and testing regimes across all these sectors, along with self-isolation periods, which have changed regularly. The Lancashire and South Cumbria NHS Testing Group, established in 2020, reviews the Testing Strategy for the NHS across the region regularly and issues the strategy and other testing notices and information to the Hospital and Out of Hospital cells, the LRF and other groups. Lancashire and South Cumbria is one of the few areas across the country to successfully embed the LAMP saliva testing regime across its hospital trusts and these tests have become the primary asymptomatic staff testing programme. This was achieved by a close working partnership with the University of Central Lancashire.

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

The **COVID-19 vaccination programme** – the largest in history – was well established by April 2021, both nationally and across Lancashire and South Cumbria. The COVID-19 Vaccination Programme Board, established in November



2020, continued to provide oversight during 2021/22 as well as strategic direction to make sure the local offer met public need and was fit for purpose.

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

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

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

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

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

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

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

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

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

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

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

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

> On the Fylde Coast CCG the COVID Oximetry@home service can support 90 people at any one time. Since inception the COVID Oximetry @Home service has supported 1404 people who have tested positive for COVID-19. Of those, only 115 people supported by oximetry at home were admitted to hospital.

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

CCGs are working closely together within a joint **Adult Social Care and Health Partnership** which was established under the joint cell. It has given a forum for senior NHS and the four upper tier local authority leaders to oversee integrated workstreams for Lancashire and South Cumbria. This includes key areas such as intermediate care and discharge, and strategic planning for the care sector that impact early intervention to avoid escalating needs and to facilitate system flow. There have been extremely challenging pressures in the peaks experienced from COVID-19 during 2021/22, which has resulted in reduced capacity across the system from staff absences and outbreaks in care settings. The partnership has

worked closely together to maintain capacity and support flow by commissioning additional capacity, keeping close contact with the sector to understand the daily position and flexing workforce. The excellent partnership working displayed and innovative approaches tested, such as the nationally recognised discretionary payments and support to informal carers as part of the discharge scheme, will now help to re-shape the intermediate system work as we go forward.

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

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

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

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

The NHS England and NHS Improvement White Paper Integrating care: Next steps to building strong and effective integrated care systems across England[3] (February 2021) detailed how ICSs and the organisations within them will work more effectively and more collaboratively in future.

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

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

[3] https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/

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

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

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

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

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

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

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

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

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

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

Following the ICS Design Framework, a number of national guidance documents were published, including a Readiness to Operate Checklist, HR Framework for Developing ICBs, CCG Close Down and ICB Establishment Due Diligence Checklist,

Thriving places: Guidance on the development of PBPs, and ICS Implementation Guidance on Working with People and Communities.

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

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

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

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

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

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

Health and Care Partnership work programmes

This section contains a summary of a broad range of programmes which have continued to move forwards during 2021/22. Many colleagues from across the Fylde Coast have been involved in this programme activity working closely with our wider partners in Lancashire and South Cumbria.

Child and adolescent mental health services

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

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

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

The ICS has secured an additional eight **Mental Health Support Teams** (MHSTs) as part of the next phase of roll out. MHSTs provide specific extra capacity for early intervention and ongoing help within a school and college setting.

> Six of the eight teams have been allocated in 2021/22 and will be located in Blackpool, Wyre, Greater Preston, Chorley and South Ribble and West Lancashire.

Two more will be located in Morecambe Bay and East Lancashire in 2022/23. This brings the total across Lancashire and South Cumbria to 18, and delivers against the NHS Long Term Plan ambition of MHSTs achieving 25% coverage by 2023/24. MHSTs will result in additional early intervention support to over 145,000 local children in schools. The Fylde Coast teams launched their MHST service on 7 February 2022, coinciding with the start of Children and Young People's Mental

Health Week when Blackpool Tower was illuminated green to demonstrate the importance of children and young people's mental health.

The Fylde Coast teams launched their MHST service on 7 February 2022 following a best practice co-production process where young people were recruited to work with commissioners to design the service from start to finish.

The team provides direct mental health support to 24 education settings across Blackpool and Wyre.

The launch coincided with the start of Children and Young People's Mental Health Week when Blackpool Tower and other local landmarks were illuminated green to demonstrate the importance of children and young people's mental health.

Mental health: adults

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

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

The NHS Long Term Plan set out the ambition to establish **Maternal Mental Health Services** (MMHSs) in all areas of England by 2023/24. This will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience. In 2020/21, Blackpool Teaching Hospitals NHS Foundation Trust bid successfully for Early Implementer and Fast Follower transformation funding from NHSEI to develop and test the service across the whole of Lancashire and South Cumbria. This much-needed service will provide evidence-based care for women who have post-traumatic stress disorder following birth trauma or loss, neonatal admission, termination of pregnancy, separation, or severe fear of childbirth (tokophobia). The MMHS will reinforce the wider transformation programmes so that services are better integrated and provide appropriate access to psychological support for women and

their families. The LSC model is based on national guidance and local needs – it will deliver a multi-disciplinary approach to care and treatment in a community setting. The Lancashire and South Cumbria Reproductive Trauma Service (MMHS) went live on 28 March 2022 and is now taking referrals.

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

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

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

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

The **Community Mental Health Transformation** is a three-year programme of large-scale change that will be completed by March 2024. Plans are being developed to reconfigure community mental health services around primary care

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

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

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

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

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

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

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

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

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

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

one in ten go on to achieve independent living within this period. People receiving rehabilitation support are eight times more likely to achieve or sustain community living, compared to those supported by usual community mental health services.

Suicide prevention

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

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

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

The 'Let's keep talking' campaign encourages local organisations, businesses and community groups to access resources that promote people to open up about their mental health. Currently on phase 6, the campaign is focusing on debt support services and encouraging residents to reach out for help at the earliest opportunity. An online directory of suicide prevention and bereavement services[4] across Lancashire and South Cumbria has had more than 20,000 hits since being published.

More than 4,500 people have been trained in suicide prevention and self-harm. More than 1,270 people have signed up to be orange button wearers[5] (local people who have undergone extensive suicide prevention training wear the button to signal that while they cannot counsel people, they are trained to direct them to relevant services). The scheme has now been rolled out across Cornwall, Devon, Somerset and Worcestershire.

Digital

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

The region has been the highest user of a **shared care record** (SCR) in the country. The Lancashire Patient Record Exchange Service (LPRES) has almost 7,000 registered users, and more than 8 million documents currently available to support

[4] https://www.healthierlsc.co.uk/suicide
[5] https://www.healthierlsc.co.uk/OrangeButtonScheme-1

patient care. A Centralised Viewer enables partners across the ICS to share documents, images and other media files. Plans are under development to use the SCR to support specific pathways such as end of life and palliative care records and unified medicines records.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stroke

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

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

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

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

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

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

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

Diabetes

More than 100,000 people aged 17+ in Lancashire and South Cumbria have type 2 diabetes, and it's estimated that more than 75,000 people are at a high risk of developing the condition. It's essential to diagnose type 2 diabetes as early as possible, and to identify people at risk of the condition, so they can be supported to make healthier lifestyle choices to reduce their risk. In Lancashire and South Cumbria, people identified as being at risk are offered tailored support through the local Healthier You[6] service. Normally the programme involves a series of face-to-face group sessions, but virtual meetings were established during the pandemic. These have continued with provider Ingeus receiving nearly 3,500 referrals across Lancashire and South Cumbria between April 2021 and February 2022.

Local people with type 2 diabetes have been able to access support to manage their condition through My Way Diabetes via Your Diabetes, Your Way[7]. Again, all face-to-face learning sessions were temporarily suspended during the pandemic, but a lot of digital support and online resources were available. As people with diabetes are amongst those more vulnerable to COVID-19, local health and care organisations worked together to provide practical and emotional support – especially during the winter months. During 2021, there were 206 registrations of patients compared to 16 patients in 2020. There are 57 practices across Lancashire and South Cumbria with at least one or more patient registered with the platform. Looking ahead we are reviewing the provision of structured education for people with type 1 and 2 diabetes for 2022/23 and there will be additional sources of information from the national team available.

Pathology collaboration

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

[6] https://www.stopdiabetes.co.uk/
[7] https://ydyw.co.uk/

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

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

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

Cancer alliance

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

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

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

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

Exciting new programmes including genomics and targeted lung health checks[8] are helping to detect cancers earlier. We have also been successful in becoming part of a North West Endoscopy Academy, with Lancashire and South Cumbria leading on training for endoscopists and supporting the whole training programme for these staff.

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

Maternity

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

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

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

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

[8] https://lungcheckslsc.co.uk/

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

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

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

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

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

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

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

System-wide, standardised Smoke-Free Pregnancy annual training, a CO_2 monitoring during COVID-19 pandemic Standard Operating Procedure (SOP) and a Trauma Informed Care Training and Supervision package sre now in place for

maternity services. These will be delivered by a commissioned provider from April 2022.

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

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

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

Paediatrics

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

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

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

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

We are part of a national pilot project to provide specialist clinics for children and young people with excess weight, ensuring that this care can be provided closer to home. Through a newly-developed Healthier Weight Healthier Futures network, we

are working closely with the local authorities and voluntary sector to help children and young people achieve healthier lifestyles.

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

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

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

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

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

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

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

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

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

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

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

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

Personalised care

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

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

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

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

A model of working and workforce training has been developed and put in place to help our practitioners and partners deliver this at-scale. Although face-to-face Patient Activation Measure (PAM) training was unable to take place, online workshops and resources have helped colleagues to support people's health and wellbeing, maximise self-management and reduce further unnecessary demand on services. We are also connecting colleagues with an online support platform to help

practitioners use PAM. This system helps us measure a patient's knowledge, skills and confidence to manage their health conditions and helps them build these skills and live more independently.

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

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

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

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

Population health management

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

Nearly one-third of people in Lancashire and South Cumbria live in some of the most deprived areas across England. More people are living in fuel poverty and unable to afford to heat their homes than the national average (13% compared to 10.6%[9]). 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%).

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

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

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

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

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

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

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

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

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

Workforce

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

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

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

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

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

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

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

Diagnostics and imaging

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

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

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

Learning disabilities and autism

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

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

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

- strengthened multi-disciplinary Community Learning Disability teams by increasing nursing and allied health professionals in the community

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

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

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

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

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

Cardiac

Heart disease remains the second highest cause of death in England, with an age-standardised mortality rate of 130 per 100,000 population. Furthermore, an

estimated 6.1 million people in England currently live with cardiovascular disease (CVD).

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

During COVID-19, there has been a reduction in the number of people with high blood pressure having regular checks and medication reviews, which increases the potential risk of a cardiac event or stroke. The ICS continues to support campaigns including 'Know Your Numbers' (which encourages people to get their blood pressure checked) via the Healthy Hearts website[10] and our Twitter account @CardiacNwc (#improvinghearthealth #HealthyHearts).

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

The Fylde Coast CCGs are awaiting the publication of the Cardiovascular Disease (CVD) Prevention and Diagnosis service specification as part of the PCN Des. Once published commissioners will prioritise the implementation within primary care.

Funded care

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

[10] https://www.healthierlsc.co.uk/healthyhearts

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

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

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

Elective care

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

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

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

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

In Lancashire and South Cumbria, the Accelerator funding from NHS England has proved critical in helping us mitigate against these issues, with elective activity scaled up to ensure we collectively see and treat as many people as we can as

quickly as possible. It has helped by providing additional bed capacity in hospitals across the region, enabling improvements in pre- and post-operative patient assessments, and reducing the number of unnecessary admissions for treatments such as angiograms by monitoring patients remotely.

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

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

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

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

Primary care

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

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

Throughout 2021/22, COVID-19 pressures have continued to impact the way in which primary care services were delivered. To ensure the most vulnerable patients

are protected from infection and to ensure our staffing levels and capacity are maintained, the majority of appointments have been via telephone or video consultation where safe and appropriate and face-to-face appointments being offered to those with a clinical need. Demand for primary care services has also increased during this time. Data shows there were more patient appointments each month between September 2021 and February 2022 than in the comparable period in 2019/20 prior to the pandemic. The latest appointments data for NHS England shows that in comparison GP appointments overall in Lancashire and South Cumbria during this time have increased by 10%. Of the appointments between September 2021 and February 2022 an average of 63% were face to face appointments, 36% were telephone appointments and the remainder were home visits or video and online consultations.[11]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VCFSE leadership programme

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

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

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

Respiratory

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

In line with the NHS five-point plan, the first task was to facilitate the set-up of the Post COVID-19 Assessment Service (PCAS). The team came together in January 2021, starting with the placement of the lead provider, Lancashire and South Cumbria NHS Foundation Trust, creating an ICS admin hub to receive and process

referrals, and setting up five Post COVID-19 Assessment Hubs to address the mental and physical symptoms of patients through holistic therapy.

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

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

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

New Hospitals Programme

Following the publication of our Case for Change report[12] in July 2021, the Lancashire and South Cumbria New Hospitals Programme [13]has now entered an important phase. The programme team has collected information on everything from what future clinical and technological developments might need to be accommodated in new hospital facilities, to potential land availability and building specifications. Thousands of patients, staff and stakeholders have been involved in conversations to start to build a picture of how new hospital facilities should operate.

In March 2022, a list of shortlisted proposals [14]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.

[12] https://newhospitals.info/CaseForChange
[13] https://newhospitals.info/
[14] https://newhospitals.info/shortlist

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

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

Clinical policies

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

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

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

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

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

2021/22 ended with an eclectic mix of policies completing the full policy development and review process. This includes three policies with a wider public and patient impact (Continuous and Flash Glucose Monitors for people with diabetes, the

provision of wigs, and hernia surgery), two of which are expanding patient access, and other EBI2 policies.

Urgent and emergency care

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

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

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

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

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

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

NHS partners have worked together to develop a shared and robust ICS communications and engagement plan for 2021/22 to support winter pressures and to support people to access the right services at the right time. The plan included campaign messages to alleviate pressures and demand across UEC services including a range of advice and self-care videos[15] along with sharing flu and vaccine information. There has been a joined-up approach across the NHS Communications

[15] https://www.healthierlsc.co.uk/getinvolved/self-care

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'[16] and can help their communities. These have been run (paid-for and organic) on radio, Facebook, Twitter, Instagram and Spotify. Translated images and audio clips have formed part of a larger toolkit for voluntary sector partners. LSCFT led on a Resilience Hub 60-day social media campaign during December 2021 and January 2022 to promote mental health support to nursing and NHS staff across Lancashire and South Cumbria. A 'Thank You' campaign on radio and digital channels for health and care workers, vaccination volunteers and carers began in February 2022.

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

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

Ageing well

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

[16] https://www.healthierlsc.co.uk/KeepWellThisWinter

Fylde Coast specific work programmes

Both Fylde Coast CCGS have been involved in all the programmes outlined in the previous section with the benefits of working across Lancashire and South Cumbria being seen in the development of the services on offer to our residents.

The following are additional programmes that have taken place across the Fylde Coast only either as an addition to the partnership programmes or separate from it due to being specific Fylde Coast issues.

Winter planning

Pre and during winter 2021/22, there was a significant increase in demand across our health and social care provision on the Fylde Coast i.e., vaccination requirements on primary care, increased numbers and higher acuity of patients attending ED, increase demand on packages of care and crisis hours etc.

The impacts of COVID-19 continued to create significant challenges on workforce across all services, however, Place Based Partners worked collaboratively to develop a system winter plan and throughout the winter period identified resolutions to challenges being faced on a day-to-day basis.

The key focus areas agreed were:

- Respiratory Syncytial Virus (RSV) and management of COVID+ patients
- Mental Health
- Discharge/patient flow
- Care Home Sector
- Frailty and;
- Same Day Emergency Care

Through a Winter Planning and Oversight Group, several schemes were identified to increase services and staffing capacity to meet the demand focussing on the key areas identified above. Of the schemes submitted, twenty-six were deemed high priority totalling circa £4.6m.

The schemes ranged from preventing admission, supporting patient flow and management of care following discharge i.e. increasing capacity in Urgent Treatment Centres, development of Same Day Emergency Care pathways, commissioning additional care sector beds.

Measures for each of the schemes are in place and an evaluation exercise will be undertaken April 2022 which will support and inform winter planning for 2022/2023.

Health equalities commission / Population health management

The Fylde Coast CCGs have been a key partner in the development of the Lancashire and South Cumbria Population Health Operating Model. This has predominantly been coordinated through the Fylde Coast Population Health Management Forum (PHM Forum), a multi-agency collaborative group with a focus on developing approaches to tackle health inequalities. Discussions between partners at the PHM Forum have helped shape the Lancashire and South Cumbria approach, building on the local priorities identified.

The priorities of the PHM Forum are:

To embed a population health management approach across the partnership through the use of data-driven insights in the planning, design, development and delivery of health and care services.

To create a learning environment where people working in health and care services on the Fylde Coast, in both statutory and voluntary, charity, faith and social enterprise sector organisations, have the skills and knowledge to effectively use data-driven insights in their work.

Although the scope of the PHM Forum is not to directly plan, design, develop and deliver health and care services the various members of the PHM Forum do have this responsibility. The PHM Forum has therefore been able to identify the priorities and work with partners to carry out activities aligned with them. During 2021/22 these have included:

Supported targeting specific groups of people during the COVID-19 vaccination programme by providing advice on ways to engage with those groups and providing links to share information.

Developing a partnership approach to supporting vulnerable people to address clinical and social vulnerability, including a stratified approach to identifying vulnerability, to be implemented in 2022/23

Developing the 2021/22 Fylde Coast plan for implementing the initial phases of the Lancashire and South Cumbria population health operating model, including identifying local personnel and community engagement needs to embed the model on the Fylde Coast.

Primary Care

Blackpool CCG has had a practice close during the financial year. Elizabeth Street practice was experiencing staffing difficulties and made the decision to hand back the GMS contract to the CCG. The CCG put a caretaker in place for 6 months whilst a permanent solution was sought. It was agreed that the practice should close given the proximity to other practices in the area and disperse the patients. The practice closed on the 31st of October. Patients were registered at the 3 neighbouring practices.

The Primary Care Networks (PCNs) have run incredibly successful COVID vaccination programmes with Blackpool PCNs achieving very high vaccination rates given the deprivation and the issues we face with hard-to-reach groups.

The PCNs continue to recruit to the additional ARRS roles, and we have seen significant increase during the year across all ten possible roles. The staff are being embedded into Primary care. Once challenge that has arisen is the lack of Estates provision for the staff with some PCNs now employing over 20 staff it is a considerable number to find space for in existing premises.

Workforce retention and recruitment continues to be a barrier on the Fylde Coast with many practices having staff vacancies across all disciplines. This will remain a high priority moving into 2022/23

Respiratory

Fylde Coast CCGs continue to work together with place-based partners to implement the Fylde Coast vision for respiratory care:

> *'To reduce the future prevalence of respiratory diseases, and to improve quality of care, improve quality of life, improve outcomes and reduce health inequalities for those living with respiratory diseases.'*

In collaboration with partners Fylde Coast CCGs actively support the work of the Fylde Coast respiratory transformation programme and have commenced the process for procuring an Adult Integrated Respiratory Service (AIRS) bringing community respiratory services together to help prevent, identify, and manage respiratory disease within the community closer to home.

Community pharmacy consultation service

Since 2016, NHS England has funded and tested several operational service models throughout England that can be used to enhance community pharmacy's role in urgent care provision.

Using the evidence from these pilots, the Community Pharmacist Consultation Service (CPCS) was commissioned as an advanced service from 29 October 2019. When the

service first commenced the referrals to community pharmacies were made by NHS 111. In October 2020 the service was extended to cover referrals for low acuity minor illness from general practice settings.

During the pilot of referrals from GPs nine out of 10 patients were treated by pharmacists without the need for other referrals to other specialties. General feedback from patients involved was favourable.

The Fylde Coast was named as a pilot site by NHS England and Improvement in November to test further expansion of the service to incorporate referrals from urgent and emergency settings including A&E and Urgent Treatment Centres.

The service launched in December 2021 with 25 pharmacies taking part and receiving referrals from urgent and emergency settings such as the three urgent treatment centres and Blackpool Victoria Hospital's Emergency Department.

Patients who attend the A&E or Urgent Treatment centre are triaged and assessed as being suitable for the referral to the CPCS and are assisted in choosing the most appropriate community pharmacist for their needs, based on locality and accessibility etc. The pharmacy of choice is notified of the referral and sent all relevant details. The patient then attends the pharmacy for a consultation and all being well the issue is resolved. Should the consultation reveal that a further intervention such as a GP appointment is required the pharmacist will have the ability to make an onward referral.

Performance analysis

Performance dashboard

Quality and performance indicators		Actual (YTD)	Target
A&E waiting times	% Patients admitted, transferred, or discharged within four hours of arrival at A&E	**81.03%**	95.00%
Referral to treatment (RTT) times for non-urgent consultant-led treatment	% Patients on incomplete pathway waiting less than 18 weeks	**64.88%**	92.00%
Diagnostic waiting times	% Patients waiting less than six weeks for diagnostic test[17]	**28.27%**	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	**87.51%**	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	**79.07%**	93.00%
Cancer 31-day wait	% Patients with maximum 31-day wait from diagnosis to first definitive treatment for all cancers	**93.43%**	96.00%
	% Patients with maximum 31-day wait for subsequent treatment (surgery)	**81.08%**	94.00%
	% Patients with maximum 31-day wait for subsequent treatment (anti-cancer drug regime)	**97.74%**	98.00%
	% Patients with maximum 31-day wait for subsequent treatment (radiotherapy)	**96.43%**	94.00%
Cancer 62-day waits	% Patients with a maximum 62-day wait from urgent GP referral to first definitive treatment for cancer.	**65.67%**	85.00%
	% Patients with a maximum 62-day wait from referral from an NHS screening service to first definitive treatment for cancer.	**54.55%**	90.00%

[17] Less than 1% of patients waiting no more than six weeks for a diagnostic test

Quality and performance indicators		Actual (YTD)	Target
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of a patient (all cancers)	**79.08%**	No 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	**96.15%**	95.00%
Referral to treatment waiting times	Number of more than 52-week waiters (incomplete pathways)	**866**	0
Incidence of healthcare associated infection	CDI (C Difficile Infections): Number of infections	**87**	82
	MRSA: Number of infections	**4**	0
Never events[18]	Number of events	**2**	0
Serious incidents[19]	New incidents	**34**	0
Dementia	Estimated diagnosis rate for people with dementia	**68.87%**	66.70%
Improving Access to Psychological Therapies (IAPT)	The recovery rate of people using IAPT services	**54.05%**	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	**99.09%**	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	**96.36%**	75.00%

Table 1: BCCG - Performance data as at February 2022 (Never events and Serious incidents data is for the full year including March 2022)

[18] 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.
[19] 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.

Performance narrative

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 February 2022 with performance at 81.03%.
The infection prevention and control (IPC) guidelines, which were adapted to ensure patient and staff safety during the COVID-19 pandemic, are closely followed by the Trust for patients entering A&E. This clearly impacts 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.

18-week referral to treatment target

Blackpool CCG did not achieve the 92% RTT open pathway standard between April and February 2022 with performance at 64.88%. Work continues to be focused on 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 2021/22 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.

Diagnostics

The diagnostics standard of less than 1% of patients waiting no longer than six weeks has not been achieved by Blackpool CCG predominantly due to constraints within the endoscopy service 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.

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 most 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 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.

Improve quality

The NHS Constitution sets out a clear set of rights our patients can expect, and we intend, as an organisation, for these to be met and for our patients to experience the best possible care and effective outcomes.

The CCG is committed to commissioning local services that deliver safe, effective, high-quality healthcare that meets nationally set guidance, policy, and procedures. Continual improvement in the quality of services that our patients receive is paramount and incorporates improvements in both patient experience and patient outcomes as well general quality measures. Our work is underpinned by the principles of good engagement and involvement of patients, carers, and the community to support our aspirations and the expectations of the NHS Long Term Plan.

Over the past year NHS Blackpool CCG has worked hard to make sure quality continues to be an integral strand to the services it commissions. One way in which the CCG checks the impact of services on quality is by reviewing quality impact risk assessments. A sample of the assessments that have been reviewed in the last year is below.

Table 2: Quality Impact Assessments (QIAs) / Equality Impact Risk Assessments (EIRAs)

Service	Outline of Service	Approved
Long COVID Service	The service is available for patients with signs and symptoms that develop during or after an infection consistent with COVID-19, continue for more than 12 weeks and are not explained by an alternative diagnosis.	Approved 11 May 2021
Fylde Coast COVID vaccine hotline	A COVID-19 Vaccine Hotline to support people living on the Fylde Coast who require access to information regarding the Fylde Coast COVID-19 Vaccination Programme.	Approved 11 May 2021
Review of uptake of Severe Mental Illness (SMI) annual physical health checks (PHC) in Primary Care and Secondary Care	The purpose of the SMI Physical Health Check Task & Finish Group is to review the uptake of the annual health checks both in Primary Care and Secondary Care.	Approved 11 May 2021

Diabetes Community Clinic Pilot Scope	The Community Diabetes Clinic pilot has ended, and community clinics have been paused. The pilot was intended to test out an alternative model of service providing multi-disciplinary support to unstable diabetic patients. The CCGs worked with Blackpool Teaching Hospitals to produce an evaluation.	Approved 13 July 2021
Mental Health Support Teams for Children and Young People in Education	To commit to establish a Mental Health Support Team (MHST) in Blackpool and a team in Wyre.	Submitted in August 2021 (not approved) Resubmitted in September with amends to the risk score and additional justification of the areas and schools selected. The Committee approved the QIA/EIRA on 14 September 2021
Parent Infant Relationship Service	A mapping exercise across the Fylde Coast ascertained that there was a notable gap for teams that provide specialist clinical interventions for under 2s, with a need identified across Blackpool for the provision of a Specialised Parent-Infant Relationship Team.	Submitted in August 2021 (not approved) Resubmitted with assurance that discussions were being held with the CCGs Director of Finance with work around processes and criteria being undertaken for the scheme to be considered a priority for use of funding. The Committee approved the QIA/EIRA on 14 September 2021
Blackpool Children and Young People with Learning Disabilities Service	The aim of the service is to provide a local accessible, responsive, early intervention community based, specialist service to children and young people aged 0-18 with a moderate to severe Learning Disability who present with behaviours that challenge and/or mental health issues, whose needs cannot be met by existing services.	Approved 14 September 2021

Quality Impact Assessment (QIA) update	As an aide memoire the Head of Quality provided background information on the procedure for submitting QIAs to the QI & EC and reminded the Committee of the importance of why QIAs were executed.	Received and noted 12 October 2021
Funding request to support community access (EIRA only)	Specific funding request for an additional 25 hours per week 2:1 to support community access.	Stage 1 EIRA was received and noted 14 December 2021

Planned on-site quality assurance visits have largely not been undertaken during the pandemic to reduce the risk of transmission. Nevertheless, the CCG's quality and safeguarding teams and commissioning managers have continued to be in contact with providers and have responded promptly to information, concerns, or queries in relation to patient safety and/or patient experience. As far as possible, the CCG's teams have sought to understand and address the challenges experienced by providers to delivering high quality care; to offer support wherever practicably possible and where necessary, have put additional challenge and monitoring arrangements in place.

On site visits have been made to the Blackpool Teaching Hospitals Trust during periods of high demand on services, particularly the emergency department, to ensure patients and staff are safe and supported. The Care Home sector and primary care have also received a range of additional advice, support and monitoring to ensure patient safety, working collaboratively with other local commissioners and regulators.

Services supporting people with learning disabilities or autism in an in-patient setting have continued to be subject to regular quality assurance checks and Care and Treatment Reviews. Additional safe and well checks, in line with a national approach, have also taken place with overall assurance being received and agreed by the Lancashire and South Cumbria integrated care system team.

All contracted services have continued to be subject to a level of routine quality monitoring and reporting, with contract meetings taking place on a risk-based approach and reporting of quality has continued through the CCG's Quality and Engagement Committee, meeting monthly. Where CQC inspections have required action plans, the CCG has continued to monitor and support providers as required, in the delivery against identified actions, to be compliant with the standards and to improve patient safety and patient experience.

Engaging people and communities

All Clinical Commissioning Groups (CCG) have a legal duty to involve the public (individuals and communities) in their commissioning activities. Whether this be in keeping them informed of changes, seeking feedback on plans, listening to suggestions for changes to inform our decisions or allowing the public to actively contribute to the decision-making process engagement is embedded into our constitution.

A snapshot of some of the engagement opportunities on the Fylde Coast throughout the year is below.

Health equalities commission

- Robust engagement has taken place to learn from the experiences of people living with health inequalities on the Fylde Coast. Some evidence was gathered from the resident's inquiries conducted in Blackpool in 2019 and we also filtered other pieces of engagement that provided insights that were useful. The CCG identified gaps in the evidence and the place-based partnership agreed to conduct further evidence gathering. Focus groups were used over an online platform. This provided a list of recommendations and priority initiatives that were then reported to the Health Equalities Commission. We are awaiting the results of the first commission hearing which will be reported in April 2022.

CPCS pilot

- As this is a national pilot much of the engagement prior to launch was completed on a national level however on the fylde coast we aimed to inform all groups that could be affected by the potential of having to travel to another location for a pharmacy consultation. This was done making use of voluntary sector organisations to cascade information. A range of materials were produced to inform people who were being referred to the service which have been shared with other pilot areas for use nationally.

Mental health support teams in schools

- The CCGs led on engaging with school aged children to discuss the development of the service. Focus groups were held to decide how and when young people should be able to engage with the service and how the service would meet their needs. A competition to create a service identity was also run. A survey that ran alongside the focus groups recieved 507 responses.

Elizabeth Street Surgery closure

- Elizabeth Street Surgery closed its doors on Friday 29 October 2021 after the practice's managing partners gave up their contract to provide general practice services.
- The 4,500 registered patients were contacted directly and given details of the nearest GP practices available to them.
- The CCG also hosted four drop in sessions for patients to ask questions although only a small number of patients attended these.

Commissioning policies

- As part of the Lancashire and South Cumbria policy harmonisation programme the CCGs on the Fylde Coast have promoted the opportunity for people to complete various surveys.

Parent infant relationship team

- The CCGs worked with Blackpool Better Start to set up a service to support new parents or carers who feel their bond with their baby isn't what it should be. Engagement took place through a seres of surveys availabe in local parenting hubs and groups. There were 49 responses to the survey.

Adult integrated respiratory service

- The NHS on the Fylde Coast is in the process of re-procuring pulmonary rehabilitation and home oxygen services. This means we are looking to commission a provider of these services for the next few years.

Our Lay Member for Patient and Public Engagement, Helen Williams ensures our commitment to excellent engagement is championed at all levels within the CCG. Her role is to make sure the voice of the local population is heard and that opportunities are created and protected for patient and public empowerment. Helen sits on the Governing Body and so supports the CCG's efforts at the highest level.

The CCGs rely on public feedback and checking our engagement activity is robust. To do this we call three different meetings of groups as outlines in the following sections.

As a CCG, we have contributed to several campaigns and initiatives across Lancashire and South Cumbria[20]. The objectives of these campaigns have been to inform people about local services, and genuinely involve and co-produce new ways of working with our population and partners. Campaign materials and toolkits have been produced by the Communications teams supporting each of the initiatives and shared across the system.

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

Patient and Public Engagement and Involvement Forum (PPEI):

Our engagement activity is scrutinised by our Fylde Coast Patient and Public Engagement and Involvement (PPEI) Forum. Vice-Chaired by the Lay Member for Patient and Public Involvement, the forum is part of our formal governance process, directly reporting to the CCG's quality improvement, governance and engagement committee and Governing Body.

The PPEI Forum advises on appropriate levels of engagement with the wider public and acts as a critical friend to make sure we are engaging with the right people at the right time during any form of service redesign.

It includes representation from Healthwatch, disadvantaged groups, the voluntary sector, disability representatives, carers, and older people.

The forum has met intermittently and online over the last year with some meetings being cancelled but they have gone ahead when possible.

They have discussed several topics including:

- Improving access to primary care
- The primary care surveys

[20] https://www.healthierlsc.co.uk/getinvolved

- The Health Equity Commission
- Self-care week
- Winter pressures
- The community pharmacy consultation service pilot for emergency care
- Commissioning reform

They have also been fundamental in disseminating information across their wider networks to support COVID-19 messaging.

Influence panel

The Influence Panel, made up of members of the public from all walks of life who help the CCGs shape local decision-making, was suspended for the majority of 2021/22 due to the COVID-19 pandemic. It did meet once, in June, to support the rollout of the Community Pharmacy Consultation Scheme. Panel members were largely supportive of such a service being launched on the Fylde Coast but were keen to ensure it included a mechanism to collect patient feedback and offered pharmacists the opportunity to prescribe some non-over-the-counter medicines to further streamline the process. This was fed back to the NHS programme leads and feedback mechanisms have been put in place that will be analysed at the end of the pilot.

We also make use of a newsletter system that residents of the Fylde Coast can sign up to and receive information and opportunities to provide complete surveys and provide feedback on projects. The newsletter is sent to 1,194 people and over the last year 15 issues have been sent.

Patient participation group (PPG) network meeting

Every GP practice on the Fylde Coast has a PPG of some sort. Many meets in person or have used virtual platforms during the pandemic. Others are emailed by their practices. Some PPGs are more active than others, but all are fundamental to the work of their practices. The most active PPGs have worked as volunteers to help with the vaccination programme in their practices and helped keep in touch with the more vulnerable patients.

The CCG brings together the chairs of PPGs to a meeting to share ideas with others and to act as an engagement channel for CCG projects. The PPG network meeting has met consistently each month throughout 2021-22 discussing a range of topics including:

- Commissioning reform.
- Vaccination programme.
- Third party prescription ordering.
- General Practice Data for Planning and Research Directions 2021.
- Delivering integrated care and system reform
- Medical equipment recycling
- Pharmacy services
- Abuse of primary care staff

The minutes of the PPG network meeting are fed back to the PPEI Forum and are included in the forum's reports to the Quality and improvement and engagement committee, and the patient and public engagement update submitted to the Governing Body. Two PPG representative attend the CCGs Primary Care Commissioning Committees in common meetings and provide valuable contributions to the meetings.

Keeping our population informed

Due to the pandemic restrictions digital based platforms have been invaluable on reaching a wide audience and ensuring that people are equipped with the most up to date information.

Across all social media and all workstreams there have been 3,171 posts over the year resulting in 14,866719 people seeing the information shared and 13,452 clicks to our website for more information. This is roughly the same number of posts but much fewer interactions however this may be down to the nature of the information being shared. In 2020-21 the information was around the then developing situation around the pandemic and therefore there was more interest. In the last year there have been fewer changes to restrictions and advice has stayed roughly the same and has not generated the same level of interest.

Where possible we strive to reply to questions and comments to our social media within 24 hours although the comments from over the weekend are often picked up on a Monday. In the last year we have had 697 comments to our posts however it should be noted that only around 20 per cent of these require a response.

We have relied heavily on community groups, friends, and families to spread information to those who do not have access to online information resources. For this we have used our links with the local media, local authorities, and voluntary sector.

Reducing health inequality

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.

The NHS Long Term Plan, published in January 2019, sets out the need to address the health and wellbeing gap, preventing any further widening of health inequalities. To do so requires a move towards greater investment in health and healthcare where the level of deprivation is higher. Public Health England define health inequalities as: *Health inequalities are the preventable, unfair, and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental, and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to act and access treatment when ill health occurs.*

The World Health Organisation (WHO) defines health inequalities as 'differences in health status or in the distribution of health determinants between different population groups'[1] . There is clear evidence that reducing health inequalities improves life expectancy and reduces disability across the social gradient. Tackling this is therefore core to improving access to services, health outcomes, improving the quality of services and the experiences of people. It is also core to the NHS Constitution and the values and purpose of the NHS.

The NHS Constitution[2] states that the NHS has a duty to '*…pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population*'. This is reflected in the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), which introduced for the first-time legal duties to reduce health inequalities, with specific duties on CCGs and NHS England.

The Health and Social Care Act 2012 introduced the first legal duties on health inequalities, with specific duties on NHS England and CCGs, as well as duties on the Secretary of State for Health (covering the Department of Health and executive agencies Annex A) and NHS Improvement. These duties, which took effect from 1 April 2013, were:

- Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T).
- Exercise their functions with a view to securing that health services are provided in an integrated way and are integrated with health-related and social care services, where they consider that this would improve quality,

[1] World Health Organisation (2014) Health Impact Assessment Glossary of Terms Used [Online] Available at: http://www.who.int/hia/about/glos/en/index1.html

[2] NHS Constitution for England (2012) [Online] Available at: https://www.gov.uk/government/publications/thenhs-constitution-for-england

reduce inequalities in access to those services or reduce inequalities in the outcomes achieved (s.14Z1).
- Include in an annual commissioning plan an explanation of how they propose to discharge their duty to have regard to the need to reduce inequalities (s. 14Z11).
- Include in an annual report an assessment of how effectively they discharged their duty to have regard to the need to reduce inequalities (s. 14Z15).

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

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

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

The EDS grading event for 2021-22 assessed the Fylde Coast CCGs' performance in relation to Goal 3 – a representative and supportive workforce. The CCG scored 'Achieving' in each of the following outcomes:

3.1: Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
3.2: The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
3.3: Training and development opportunities are taken up and positively evaluated by all staff
3.4: When at work, staff are free from abuse, harassment, bullying and violence from any source
3.5: Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
3.6: Staff report positive experiences of their membership of the workforce

Good equality practice has been reflected in a range of case studies that are published on the CCG's website.

The CCG also conducts equality impact risk assessments for each of its commissioning projects to ensure plans have taken in to account the needs of the population and services are accessible to all people whatever their characteristics.

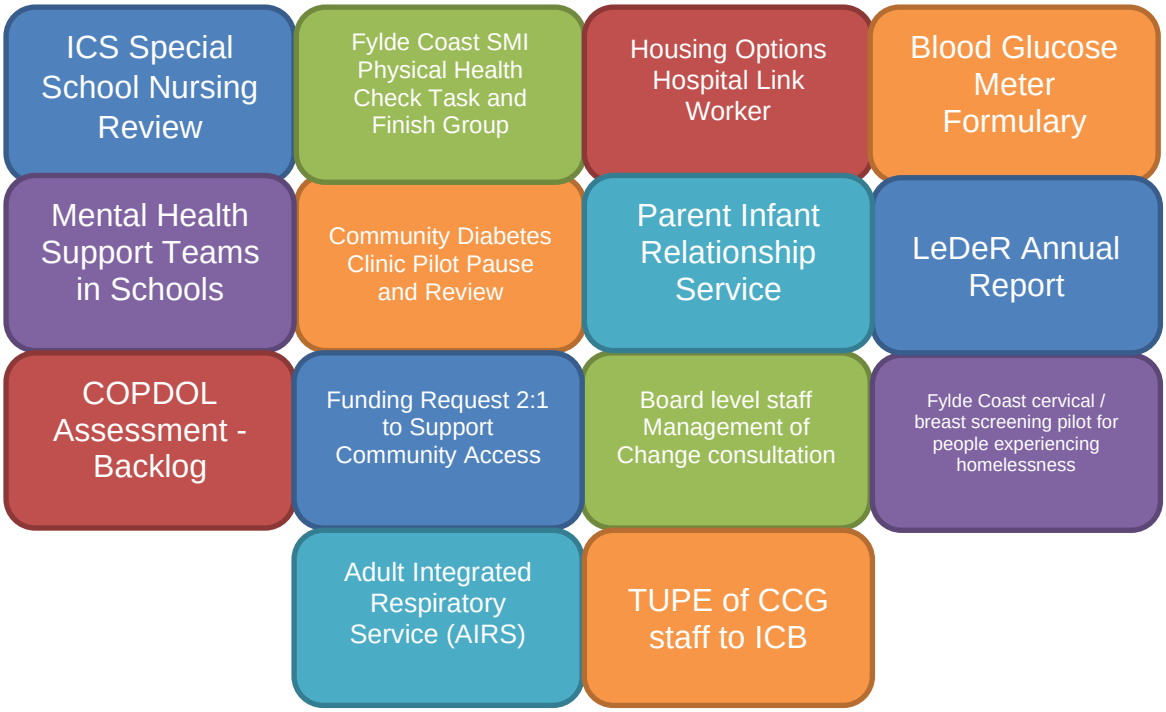


Figure 1: Some of the equality impact risk assessments carried out in 2021-22.

In January 2020 the Fylde Coast CCGs approved the Fylde Coast Prevention and Health Inequalities Strategy, developed by the local Public Health team. The strategy outlines key priorities for tackling health inequalities on the Fylde Coast including initial developments for Fylde Coast partners to implement. The key priorities are:

- Smoking
- Alcohol
- Healthy Weight
- Maternity and Early Years
- Mental Health
- Community-centred Approaches for Health and Wellbeing
- Drug Related Deaths
- Aging and Dementia

During 2021/22 the Fylde Coast CCGs undertook the following developments aligned to these priorities:

- Development of an inpatient smoking cessation service, aligned to the CURE tobacco dependency treatment model. An interim service soft-launched in January 2022 with the full service launching in April 2022. This includes integration with local authority commissioned community-based tobacco dependency treatment services to ensure support for people beyond their hospital admission.
- Development of a nurse-led homeless health service. This was initially planned for delivery in 2020 however the COVID-19 pandemic resulted the service becoming a COVID-19 response, to support people who are homeless when they had COVID-19, and targeting reducing the risks associated with contracting the virus (e.g. ensuring underlying health conditions were

identified and addressed). Learning from the COVID-19 response, including the importance of a holistic partnership approach to supporting people who are homeless with their health, shaped the service that has been implemented.

- Working with Blackpool Better Start to set up a specialised 'parent-infant relationship team' in Blackpool. Parent-infant relationship teams are multi-disciplinary teams with expertise in supporting and strengthening the important relationships between babies and their parents or carers. The team will work predominantly with children aged 0-2 and their families but will also provide therapeutic interventions to the 3-5 cohort working in partnership with CAMHS and universal health to ensure that children and their families are able to access support where there are difficulties in the nurturing relationship.

Health and wellbeing strategy

Blackpool CCG is an active member of the Blackpool Health and Wellbeing Board. The chair of the Health and Wellbeing Board and the director of public health attend CCG Governing Body meetings held in public. Minutes of the Health and Wellbeing Board meetings are included on Governing Body agendas.

The focus of the Blackpool Health and Wellbeing Board is on improving outcomes and reducing inequalities through every stage in people's lives. due to the pandemic the refresh of the health and wellbeing strategy has been delayed although more recently the CCG in conjunction with Blackpool council public health have produced a Fylde coast place-based health inequalities strategy which we are working to implement. However, the CCG continues to implement the health and wellbeing strategy building on the principles within it. The strategy has been used as a basis for recommendations to the health equality commission across Lancashire and South Cumbria.

The current Blackpool Health and Wellbeing Strategy can be found at: https://www.blackpool.gov.uk/Residents/Health-and-social-care/Documents/HWB-Strategy-2016-19-final.pdf.

Financial performance

Financial performance during 2021-22 has been undertaken with the continuation of the national regime introduced in March 2020 in response to the COVID pandemic. The CCG has operated within the cell structure environment and the finance regime altered to the revised ways of working required to free up staff time for the pandemic response. During 2021-22, the CCG has been operating within a system planning environment approach with key finance decisions being evaluated and discussed by the Lancashire & South Cumbria system healthcare organisations.

During 2021-22, in preparation for the introduction of International Reporting Standard IFRS16, the CCG has been securing information on the number, value and types of leases held. IFRS 16 is to be introduced for the healthcare sector with effect from 1 April 2022 and will be reported on in the next financial year.

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

The CCG, in line with the financial position discussed and agreed in advance with NHSEI, has delivered a deficit position of £5.39M in 2021/22 and therefore utilised more resource in year than was allocated to it by NHSEI. Prior agreement notwithstanding it is however a breach of the CCG's financial duty to spend within its revenue resource limit and results in the CCG's external auditors issuing both a qualified regularity opinion and a referral to the Secretary of State under Section 30(b) of the Local Audit and Accountability Act 2014.

The £5.39M deficit has arisen from two agreed non recurrent (one off) technical adjustments, prior to the transition to the Integrated Care Board (ICB), as follows:

i) £4.26M – in respect of hosted funds accounted for through the CCG on behalf of the Lancashire and South Cumbria Integrated Care System (ICS).
This reflects the opposite entry to the £4.26M surplus that the CCG was required to report in 2020/21 due to the deferral of equivalent ICS income by Lancashire and South Cumbria NHS Foundation Trust. The CCG did not receive an adjustment to its cumulative surplus position in 2020/21 for this transaction and did not receive an allocation in 2021/22 to facilitate the unwinding of the prepayment. As such this has resulted in this in year deficit in respect of ICS hosted funds.

i) £1.13M – relating to a change in the accounting estimate used to calculate the prescribing accrual in the CCG's accounts.
This reflects an unadjusted audit error reported by external audit in 2019/20 and 2020/21. CCGs were asked during 2021/22 to eliminate any such items in advance of the transition to the ICB. No allocations however were provided to cover the additional expenditure associated with the adjustment and therefore a deficit has arisen.

As both adjustments are technical in nature, they ***do not*** reflect a failure in financial control within the CCG. The historic cumulative surplus for the CCG will not be decreased due to the deficit position and therefore resource available for patient care services is unaffected.

NHSEI has indicated that the CCG will not be penalised in performance management terms for reporting this deficit and no regulatory action will be triggered.

Financial key performance indicators

The CCG's performance is measured against several financial key performance indicators as outlined below:

Table 3: performance is measured against several financial key performance indicators

Key performance indicator	Target	Actual	Result
Revenue resource use does not exceed the amount specified in Directions	Maintain expenditure within the allocated resource of £1,003.4m	Total expenditure £1,008.8m	Target not achieved; deficit position reported
Delivery of a control total of breakeven	Deliver a control total of breakeven	Total position £5.39m deficit	Target not achieved; deficit position reported
Achieve the Mental Health Investment Standard	Deliver growth in Mental Health Expenditure	Total Expenditure £47.64m	Achieved
Maintain expenditure within the Annual Cash Drawdown Requirement	Annual Cash Drawdown Requirement total £1,005m	Total cash outflow £980m	Achieved
Revenue administration resource use does not exceed the amount specified in Directions	Maintain administration (running costs) expenditure within the allocated resource of £3.35m	Total administration (running costs) expenditure £3.34m	Achieved
QIPP savings targets identified, and savings achieved	No QIPP savings targets were set due to the amended financial regime in place because of the COVID-19 pandemic	No QIPP savings targets were set due to the amended financial regime in place because of the COVID-19 pandemic	N/A
Maintain capital expenditure on primary care IT within the limits set by NHSEI	Maintain expenditure within the allocated primary care IT capital allocation of £0.382m	Total primary care IT expenditure £0.391m	Achieved in line with agreed tolerance

Comply with the Better Payment Practice Code (BPPC)	Ensure 95% (by number and volume) of all valid invoices are paid by the due date or within 30 days of receipt of a valid invoice, whichever is later	Non-NHS payables 98.5% by number, 97.5% by value NHS payables 97.4% by number, 99.9% by value	Achieved

Financial review

Due to the COVID-19 pandemic, a level four national incident was declared resulting in NHSEI introducing temporary measures in late March and early April 2020 that impacted on the current ways of working, and in particular the NHS finance regime.

These measures included:

- moving to a nationally determined monthly 'block' contract payment; subsidised with a top-up payment where necessary
- cash management supporting faster payment to providers
- changes to monthly revenue reporting
- revisions to the resource allocation process.

The following section provides a brief overview of the CCG's financial performance in 2021/22. The financial accounts have been prepared under a Direction issued by NHSEI under the National Health Service Act 2006 (as amended).

Allocation

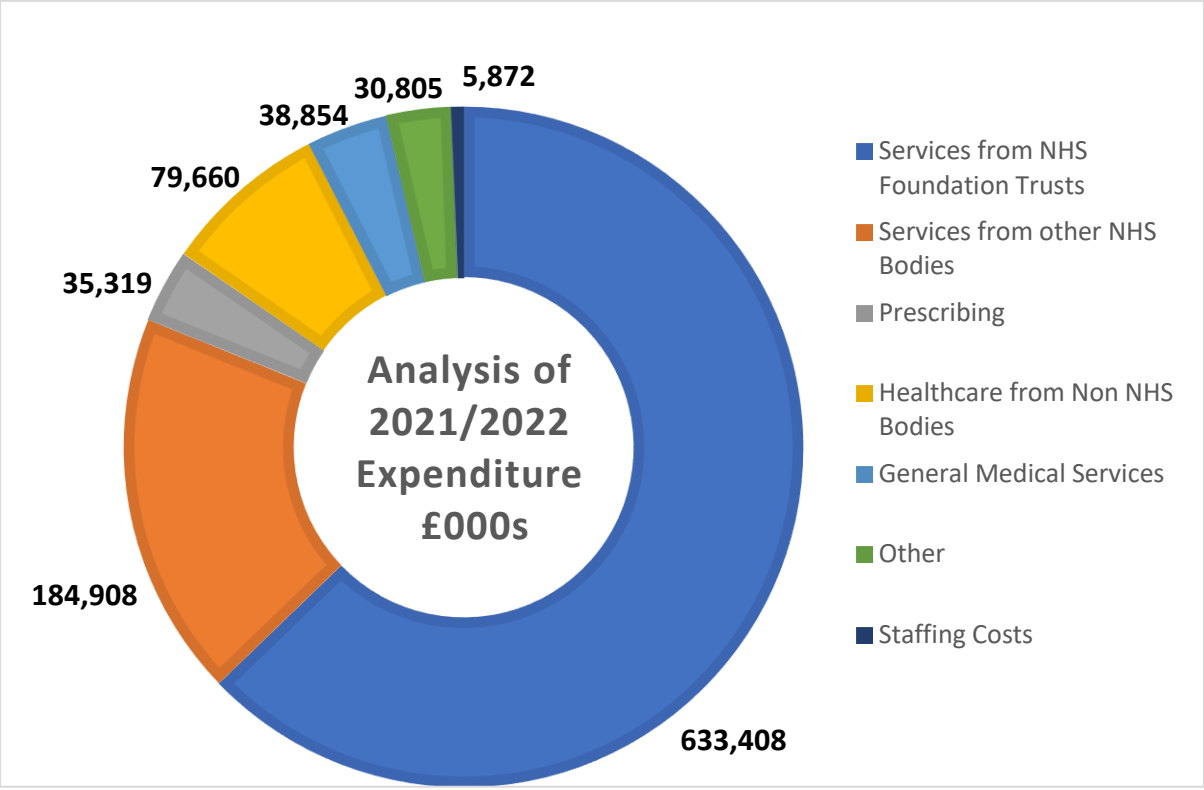
The total allocation to Blackpool CCG for 2021/22 was divided into the following categories:

- We received allocations totalling £964.25m for commissioning NHS services for both the local community and for the Lancashire commissioning system. NHS Blackpool CCG, as in recent years, acted as host for Lancashire and South Cumbria system monies in 2021/22
- We received a further allocation of £35.84m for delegated commissioning of primary care medical services
- We received a further allocation of £3.346m 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 planned organisational transfer to the Lancashire & South Cumbria Integrated Care Board during 2022/23. 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 2021/22 operating expenses



Andrew Bennett
Interim Accountable Officer, NHS Blackpool Clinical Commissioning Group
13 June 2022

Part 2: ACCOUNTABILITY REPORT

Corporate Governance Report

Members' Report

The Member Practices of the CCG

Practice Name	Address
Abbey Dale Medical Centre	50 Common Edge Road, Blackpool. FY4 5AU
Adelaide Street Family Practice	118 Adelaide Street, Blackpool. FY1 4LN
Arnold Medical Centre	204 St Anne's Road, Blackpool. FY4 2EF
Bloomfield Medical Centre (and Grange Park Health Centre)	118-120 Bloomfield Road, Blackpool. FY1 6JW (Dinmore Avenue, Grange Park, Blackpool. FY3 7RW)
Cleveleys Group Practice	Kelso Avenue, Cleveleys, Blackpool. FY5 3LF
Crescent Surgery Cleveleys	Cleveleys Health Centre, Kelso Avenue, Cleveleys, Blackpool. FY5 3LF
Elizabeth Street Surgery **(Closed 31 October 2021)**	61 Elizabeth Street, Blackpool. FY1 3JG
Glenroyd Medical Centre	Moor Park Health and Leisure Centre, Bristol Avenue, Blackpool. FY2 0JG
Highfield Surgery	South Shore Primary Care Centre, Lytham Road, Blackpool. FY4 1TJ
Layton Medical Centre	200 Kingscote Drive, Blackpool. FY3 7EN
Marton Medical Practice	Whitegate Health Centre, Whitegate Drive, Blackpool. FY3 9ES
Newton Drive Health Centre	Newton Drive, Blackpool. FY3 8NX
North Shore Surgery	Moor Park Health and Leisure Centre, Bristol Avenue, Blackpool. FY2 0JG
South King Street Medical Centre	25 South King Street, Blackpool. FY1 4NF
Stonyhill Medical Practice	South Shore Primary Care Centre, Lytham Road, Blackpool. FY4 1TJ
St Paul's Medical Centre	Dickson Road, North Shore, Blackpool. FY1 2HH
Waterloo Medical Centre	178 Waterloo Road, Blackpool. FY4 3AD

The Members' Council (known locally as the Practice Link meetings)

The membership and Register of Interests for the Members' Council can be accessed on the CCG website: https://www.fyldecoastccgs.nhs.uk/about-us/lists-and-registers/

The CCG Governing Body

- Roy Fisher, CCG Chairman
- Dr Amanda Doyle, Chief Clinical Officer / Accountable Officer (up to 31 July 2021)
- Andrew Bennett, Interim Accountable Officer (from 1 August 2021)
- David Edmundson, Lay Member (Governance) / Chairman, Audit Committee
- Chris Brown, Lay Member / Member, Audit Committee
- Helen Williams, Lay Member (Patient and Public Engagement) / Member, Audit Committee
- Dr Marie Williams, GP Member / Vice Chairman
- Dr Leanne Rudnick, GP Member
- Dr Sujata Singh, GP Member
- Dr Cruz Augustine, GP Member
- Dr Michelle Martin, GP Member
- Dr Susan Green, GP Member (up to 30 April 2021)
- 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 (Director of Nursing and Quality, Lancashire and South Cumbria Integrated Care System from 1 July 2021)
  - *Nick Medway, Interim Deputy Director of Nursing and Quality assumed Executive responsibility on behalf of Jane Scattergood from 1 July 2021*
- Dr Arif Rajpura, Director of Public Health, Blackpool Council

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

- Yvonne Rispin, Director of Ambulance and NHS111 Commissioning
- Dr Ben Butler-Reid, Clinical Director (up to 31 August 2021)
- 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 on the CCG website: https://www.fyldecoastccgs.nhs.uk/about-us/lists-and-registers/
The Register of Gifts and Hospitality can be accessed on the CCG website: https://www.fyldecoastccgs.nhs.uk/about-us/lists-and-registers/

Committees of the Governing Body

Six committees assist 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 for 2021/22, see pages 75-83 of the Governance Statement.

Members of the CCG Audit Committee

- David Edmundson, Lay Member (Governance) (Chair)
- Chris Brown, Lay Member
- Helen Williams, Lay Member (Patient and Public Engagement)
- Dr Ian Stewart, Secondary Care Doctor

External Audit

- Fee - During 2021/22, KPMG LLP was the external auditor for NHS Blackpool CCG. The CCG has paid KPMG £76,500 for external audit services which includes £62,500 base audit fee, £10,000 for the value for money aspect of the audit and £4,000 for the audit of IFRS 16 implementation (all figures exclusive of VAT).
- The financial statements also include an estimate of the fee associated with the audit of the 2021/21 mental health investment standard returns. It is expected that this additional service will be undertaken by KPMG in 2022/23. The fee is estimated at £10,000 (exclusive of VAT).

Cost Allocation and Charges for Information

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

Statement of Disclosure to Auditors

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

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

Personal Data Related Incidents

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

Modern Slavery Act

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

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHSE/I). NHSE/I has appointed the Chief Clinical Officer to be the Accountable Officer of Blackpool Clinical Commissioning Group (up to 31 July 2021). An Interim Accountable Officer was appointed in post from 1 August 2021.

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), NHSE/I has directed each Clinical Commissioning Group to prepare for each financial year financial 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 is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHSE/I, 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;
- Assess the CCG's ability to continue as a going concern, disclosing as applicable, matters related to going concern;
- Prepare the financial statements on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced, and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced, and understandable.

To the best of my knowledge and belief, and subject to the disclosures set out below, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

The CCG's deficit for 2021/22 has been reported by the external auditors under Section 30(b) of The Local Audit and Accountability Act 2014.

I also confirm that:

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

Andrew Bennett
Interim Accountable Officer, NHS Blackpool Clinical Commissioning Group
13 June 2022

Governance Statement

Introduction and Context

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

The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 31 March 2022, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of Responsibility

As Interim Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports 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 am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

Governance Arrangements and Effectiveness

The main function of the Governing Body is to ensure that the CCG has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently, and economically and complies with such generally accepted principles of good governance as are relevant to it.

The members of the CCG are responsible for determining its governing arrangements, which are set out in the CCG's Constitution which is published on the CCG's website:
https://www.fyldecoastccgs.nhs.uk/document/blackpool-ccg-constitution-pdf/

The CCG is accountable for exercising its statutory functions. It may 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 details the governing structure of the CCG. The extent of the authority to act of the

respective bodies and individuals depends 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) sets out those decisions that are reserved for the membership as a whole, and those decisions that are the responsibilities of the Governing Body, committees and sub-committees, individual members, and employees.

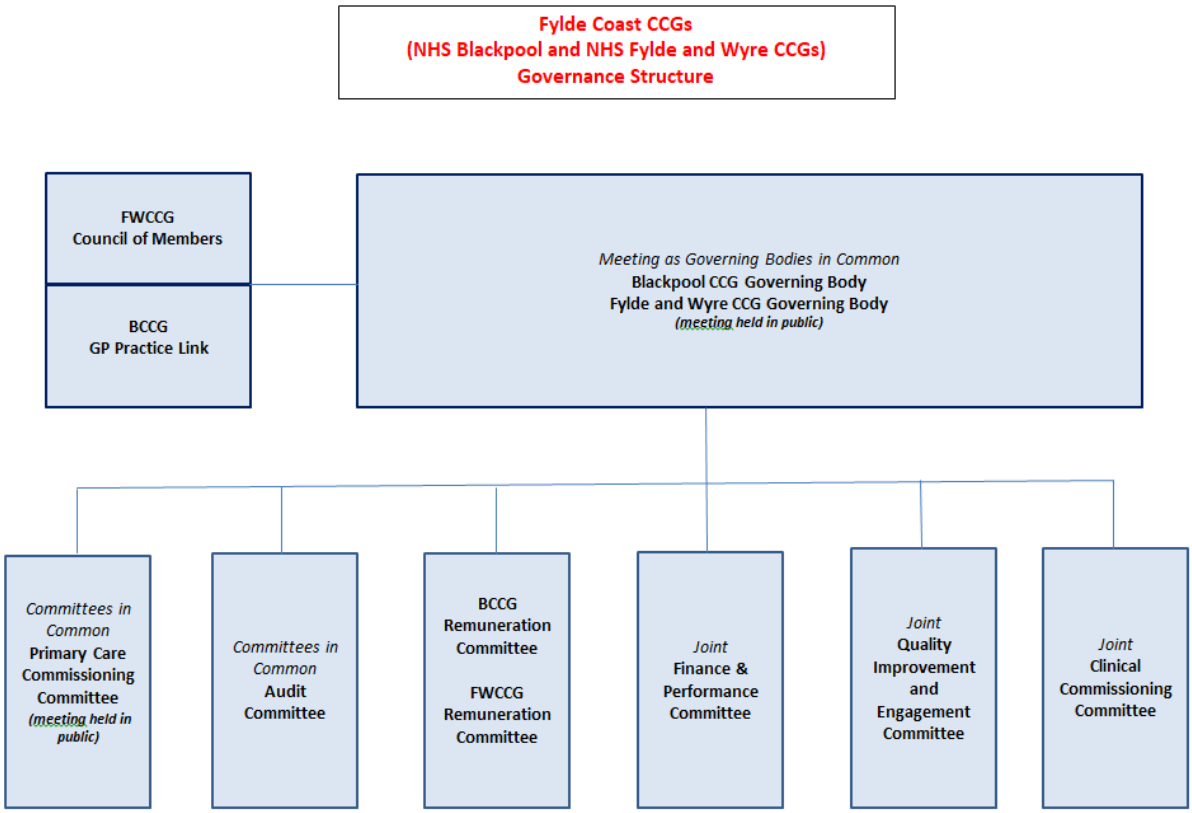
During the reporting period, arrangements have been maintained to ensure that the CCG was able to properly discharge its statutory functions, duties, and responsibilities. In addition, robust performance management processes remained in place with clear lines of accountability through established formal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

The CCG's Constitution outlines the principles of good governance which must be adhered to at all times in the way by which the CCG conducts its business. These include 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 establishes those matters and arrangements that are reserved to the Members' Council and those which are delegated to the Governing Body and the relevant CCG committees.

Taken together these documents enable maintenance of a robust system of internal control. The CCG remains accountable for all of its functions, including any it has delegated.

Assurance is provided to the Members' Council through the following structural and organisational control:



Fylde Coast CCGs Committee Arrangements

Committees of the Governing Body have been established as either 'Joint Committees' or 'Committees in Common' as appropriate, except the Remuneration Committee. 'Joint Committees' operate as a single committee containing members from both CCGs. They use a single agenda and usually reach one conclusion or recommendation on matters put before them. A 'Committees in Common' meeting is effectively a forum in which separate organisations hold their equivalent committees within the same arrangements.

Membership of 'Committees in Common' is, therefore, exclusive to those proposed by the host organisation and whilst there may be different agendas, there is common debate around single topic items for those agendas. However, decisions and voting takes 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/blackpool-ccg-committees/.

Fylde Coast CCGs Leadership Arrangements

Up to and including 31 July 2021, Dr Amanda Doyle was the Accountable Officer (AO) / Chief Clinical Officer (CCO) of NHS Blackpool CCG, NHS Fylde and Wyre CCG and NHS West Lancashire CCG. This was in addition to her role of Senior Responsible Officer (SRO) for the Lancashire and South Cumbria Integrated Care System (ICS). From 1 August 2021, Andrew Bennett was the Interim Accountable Officer of NHS Blackpool CCG, NHS Fylde and Wyre CCG and NHS West Lancashire CCG. This was in addition to his role of Senior Responsible Officer (SRO) for the Lancashire and South Cumbria Integrated Care System (ICS) (this latter role up to 13 March 2022).

During 2021/22, in addition to her role of CCG Director of Nursing and Quality, Jane Scattergood was also the Lancashire and South Cumbria ICS Director of Nursing and Quality.

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 Blackpool CCG and NHS Fylde and Wyre 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 2021/22, interim leadership and management arrangements were put in place to ensure the Fylde Coast CCGs continued to operate effectively and safely. Dr Neil Hartley-Smith and Dr Ben Butler-Reid, Clinical Directors, took on the formal Chief Operating Officer responsibilities, supported by Jane Higgs providing interim management and support.

COVID-19 Pandemic

During 2021/22, all NHS organisations continued to work extremely hard in their response to the COVID-19 pandemic. As reported in the previous year's report, 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 videoconference throughout the year.

Members' Council (known locally as the GP Practice Link meetings)

The CCG has an established Members' Council known as the GP Practice Link. The membership is the Member Practices' representatives and the terms of reference of the Members' Council are:

- To provide clinical input into clinical commissioning decisions
- To provide Member Practice input on CCG governance issues needing the approval of Member Practices
- To provide opportunities for sharing best practice for localities and workstreams.

During 2021/22, due to the revised COVID-19 governance arrangements described above, the GP Practice Link met once (virtually), and this was a joint meeting with the Fylde and Wyre CCG Council of Members to receive communications on national, regional, and local issues.

Governing Body

The Governing Body has responsibility for:

- Ensuring that the CCG has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently, and economically and complies with the CCG's principles of good governance
- Determining the remuneration, fees, and other allowances payable to employees or other persons providing services to the Group and the allowances payable under any pension scheme it may establish under paragraph 11 (4) of Schedule 1A of the 2006 Act, inserted in 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 including accident and emergency, ambulance, NHS111, 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 specified primary care functions delegated to the CCG by NHSE/I.

During 2021/22, 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 quarterly under this strategic framework and its agendas were more focussed and its papers streamlined. Agendas incorporated a range of reports to support delivery of its key functions including quality performance and finance. A regular update was also 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). The Governing Body received regular update reports on the COVID-19 pandemic.

Throughout 2021/22, 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 since January 2021 have been able to join the meetings virtually to observe.

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

The quorum for the Governing Body is no less than half of the core membership, including at least one Lay Member and a minimum of two clinicians. During 2021/22, the Governing Body met 'in common' with the NHS Fylde and Wyre CCG Governing Body, on eight occasions.

The Governing Body has delegated responsibility for a range of functions to its committees, which are 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 has been regularly overseen by the Audit Committee to ensure it facilitates informed and prompt decision-making, is 'fit for purpose' and that the robust and appropriate organisational and financial controls across the CCG are maintained.

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

The committees with delegated responsibilities of the Governing Body are as follows and the terms and reference and membership for each can be accessed on the CCG website: https://www.fyldecoastccgs.nhs.uk/blackpool-ccg-committees/.

Audit Committee (Committees in Common held with Fylde and Wyre CCG)

The Audit Committee provides 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 are 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 support the achievement of the CCG's objectives. In particular, the committee will review 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 indicate 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 indicates 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 are the Lay Members on the CCG's Governing Body (with the exception of the CCG Chairman) and the CCG's Secondary Care Doctor. The Lay Member for Governance chairs the committee and holds the office of the Conflicts of Interest Guardian. The committee met six times during the year. Minutes and attendance at Audit Committee meetings are published on the CCG's website via the Governing Body meeting papers.

Remuneration Committee

The Remuneration Committee determines the pay and remuneration, fees, and other allowances for employees. The committee also determines the remuneration and conditions of service and reviews the performance of the Accountable Officer and other very senior team members and determines annual salary awards if appropriate.

The members of the Remuneration Committee are the CCG Chairman and the three Lay Members of the CCG's Governing Body. The Remuneration Committee met once during the year.

Finance and Performance Committee (Joint meetings held with Fylde and Wyre CCG)

The Finance and Performance Committee has 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 meets its financial duties and objectives
- Ensure the CCG complies with all information governance requirements.

During 2020/21, a command-and-control structure was put in place associated with the NHS response to the COVID-19 pandemic. This along with the changed nature of NHS commissioner to provider contractual relationships and the CCG's most material Independent Sector contracts operating under a national contract as part of the pandemic response resulted in many of the previously usual finance and performance oversight arrangements becoming less complex. In response to this situation, an internal review of governance arrangements when operating under the command and control structures was undertaken following which a further review was carried out and 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 continued during 2021/22.

Membership comprises representatives from across the Fylde Coast CCGs and includes two Lay Members (of which one is 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 would attend on an ad hoc basis.

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

The Quality Improvement and Engagement Committee provides 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 ensures that effective, relevant, and appropriate decisions are made in protecting the health and wellbeing of the population we serve. The key responsibilities of the committee are that:

- Service quality, patient engagement and involvement are integral to the work of the CCG.

- All the services that the CCG commissions, including its joint and partnership arrangements (ICP/ICS etc), are safe and effective and have been influenced by tangible public and patient involvement and engagement.
- There is continuous scrutiny in the quality of commissioned services, including primary care and patient outcomes.
- The principles of quality assurance and clinical governance are integral to performance monitoring arrangements for all CCG commissioned services and are embedded within consultation, service development and redesign, evaluation of services and the decommissioning of services
- Assurance is provided to the Governing Body about public involvement and the difference it has made, and that the CCG is meeting its statutory duties.
- There is 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 have 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, is improving against national or locally agreed measures.
- Early warning systems are in place to identify concerns relating to the quality and safety of services and that appropriate action is taken in response to those concerns.
- The views of all our communities underpin the work of the CCG and meet 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 are robust (e.g. regarding service quality risk identification and risk management; FOIs; statutory Health and Safety responsibilities).

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

The committee usually meets monthly. The Membership comprises 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 2021/22, the committee met on 11 occasions and meetings were held via videoconference with reduced agendas and focussed/exception reports where appropriate. Minutes and attendance at Quality Improvement and Engagement

Committee meetings are 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) is accountable to the Quality Improvement and Engagement Committee. The Forum meets monthly and has responsibility for ensuring that the voice of patients and carers, and public and stakeholders views inform the commissioning decisions of the CCG. The key aims of the forum are to:

- Ensure the CCG fulfils 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 is chaired by a Fylde Coast CCG Lay Member for patient and public involvement. Membership includes 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 2021/22 the meeting has been held virtually but has also been paused at times due to the pandemic.

Primary Care Commissioning Committee (Committees in Common held with Fylde and Wyre CCG)

NHS England and NHS Improvement (NHSE/I) has delegated to the CCG the authority to exercise certain specified primary care commissioning functions. The Primary Care Commissioning Committee has 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 makes decisions on the review, planning and procurement of primary care services, under delegated authority to the CCG from NHSE/I and NHS Improvement. Meetings are usually held bi-monthly and are held in public. Papers for the meetings can be accessed via the CCG's website.

The membership comprises all the CCG's Lay Members, one of whom Chairs 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 are also invited to attend committee meetings. Other officers may be required to

attend on an ad hoc basis. Minutes and attendance at the Primary Care Commissioning Committee meetings are published on the CCG's website.

During 2021/22, the committee met on five 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 Fylde and Wyre CCG)

The Clinical Commissioning Committee provides clinical advice and insight and assurance to the Governing Body that the CCG is 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 has operated throughout the reporting period.

The membership comprises 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 are invited to participate in support of the committee's work. The committee usually meets six times a year and the minutes of the meetings are available on the CCG's website via the Governing Body meeting papers.

UK Corporate Governance Code

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

Discharge of Statutory Functions

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

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

Risk Management Arrangements and Effectiveness

The CCG accepts that all activities have elements of inherent risk, identifying and mitigating the risks are fundamental CCG activities. This facilitates flexible and dynamic planning/provision and oversight and promotes clear standards of internal control. The Corporate Risk Register and Governing Body Assurance Framework are the tools that continuously promote, embed and support risk management principles throughout the organisation.

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

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

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

Risk leadership is 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 has 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 these risks. The Head of Quality is the Caldicott Guardian.

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

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

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

The CCG's Risk Register is a prioritised list of risks identified to the CCG through the risk assessment process. All CCG managers are responsible for ensuring that risk assessments are 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 review and agree the scoring of all risks. Risks scoring 12 and above on the Risk Register are 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 are now adopting a stance of agile working as a permanent operating model.

It is 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 2021/22 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 are being challenged to critically review their existing risks in line with identified risk appetite and distil a focussed suite of risks that will safely communicate Governing Body concerns into the new Integrated Care Board from 1 July 2022 (subject to legislation).

Within this context key current risks relate 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 is the set of processes and procedures in place in the CCG to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically.

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

The CCG's Governing Body Assurance Framework is the internal control process that enables 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.

Within year, the Governing Body has revisited and affirmed its risk appetite and whilst there can be no tolerance for safeguarding, fraud and regulatory breaches considering each risk against its stated appetite, the Governing Body can agree tolerances or direct required actions appropriately. This has been augmented by the presentation of risks in a more user-friendly version of the Governing Body Assurance Framework.

The Governing Body's own assessment of the effectiveness of the organisation's system of internal control is 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 provides an annual 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 provides a reasonable level of assurance.

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 2021. The policy follows 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/

CCGs are 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.

MIAA carried out the annual audit of conflicts of interest with the CCG during December 2021 to February 2022. Overall, the CCG has demonstrated that arrangements are in place to satisfy NHSE/I requirements with regard to conflicts of interest. The following compliance levels, as per NHSE/I requirements, have been assigned to each area:

Scope Area	RAG Rating	Level
Governance arrangements	●	Fully Compliant
Declarations of interests and gifts and hospitality	●	Fully Compliant
Register of interests, gifts and hospitality and procurement decisions	●	Fully Compliant
Decision making processes and contract monitoring	●	Fully Compliant
Reporting concerns and identifying and managing breaches/non-compliance	●	Fully Compliant

Key:
● Fully Compliant ● Partially Compliant ● Non-Complaint

Overall, there has been a consistent level of compliance with NHSE/I guidance compared to the previous years.

Data Quality

The CCG contracts several services from the Midlands and Lancashire Commissioning Support Unit (MLCSU), from which the data provided is utilised in presentations to the Governing Body and relevant committees. The 2021/22 Service Auditor's Report on MLCSU provides assurance on financial data including accounts payable, accounts receivable, treasury and cash management, the financial ledger and financial reporting.

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 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 an Information Governance 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 feeds into Finance and Performance Committee then into the Governing Body as part of the CCG's integrated governance structure. The CCG's Chief Finance Officer has Executive responsibility for information governance and is the Senior Information Risk Officer (SIRO), with responsibility for ensuring that information risk is assessed and managed within the organisation.

The Head of Quality is the Caldicott Guardian for the CCG. The Caldicott Guardian acts as the 'information conscience' for the organisation and is responsible for protecting the confidentiality of patient/service-user information and enabling appropriate information sharing.

The CCG is continually reviewing its information governance provision. Control measures are in place to ensure risks to data security are managed and controlled. The CCG has put an information risk management process in place led by the SIRO. Information asset owners and administrators have been identified to cover the CCG's main systems and records stores, along with information held at team level.

There is high importance on ensuring that there are robust information governance systems and processes in place to help protect patient and staff personal information. An information governance management framework and structure chart has been created to highlight lines of responsibility for information governance within the organisation. All staff are required to undertake annual information governance training electronically, via ESR. The CCG has a Data Security and Protection Policy, a Staff Information Governance Handbook, and an Information Governance Code of Conduct to ensure staff are aware of their information governance roles and responsibilities.

There are processes and systems in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

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 CCG has in place an information risk work programme that has been agreed by the SIRO to identify what information the CCG holds, stores, shares and receives from other organisations.

The CCG utilises the U Assure system to log information assets, internal and external data flows and systems used within the organisation. Each team has nominated Information Asset 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. The information risk programme is an ongoing task throughout the year.

Data Security

The CCG provides formal assurance of its compliance with information governance requirements annually through the Data Security and Protection Toolkit (DSPT). The DSPT 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.

Subject to the passage of legislation, it is expected that Integrated Care Boards (ICBs) will be established on 1 July 2022 and Clinical Commissioning Groups (CCGs) will be abolished. This change in timescale from April 2022, announced at the end of December 2021, means that the CCG will be required to submit a DSPT for 2021/22, which is due by 30 June 2022. The CCG will continue to be supported by the CSU IG Team to deliver a compliant DSPT by this date and currently sees no underlying issues with achieving this.

For 2021/22, NHS Digital proposed no requirement for the CCG to submit a baseline submission or for the CCG to complete a DSPT Audit for 2021/22, although the CCGs opted to go ahead with the internal audit. The audit has been conducted by MIAA and is currently in progress.

During the period 1 April 2021 to 31 March 2022, there were no incidents categorised as reportable within the CCG.

Business Critical Models

Business critical systems are mainly provided by Midlands and Lancashire Commissioning Support Unit. They are subject to regular external review, the outputs of which are reported to the CCG's Audit Committee through service auditor reports. The CCG's business critical systems have been identified and form 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 is system first in respect of planning and delivery, previous 'business as usual' committees and reporting has, as in 2020/21, been stood down or operated virtually. In order to mitigate any potential resulting control issue, the virtual approach to governance has been reviewed by each committee in the CCG to ensure respective workplan items/statutory duties are covered and that committee decision making can continue to operate. The Governing Body and Audit Committee have received papers and agreed recommendations in respect of how governance oversight and control is maintained when operating through virtual committees and in the COVID-19 operating environment.

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

In December 2021, in light of the declaration of a Level 4 national incident in the NHS, the cell arrangements were reviewed and with effect from 20 December 2021, the hospital and out-of-hospital cell meetings were merged to provide a single joint cell. This 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.

In March 2020, the operational scheme of delegation in respect of Individual Patient Activity (IPA) services was temporarily amended in order to expedite continuing healthcare claims and facilitate discharge of patients during the COVID-19 incident management period. Further six-month extensions to the revised arrangements were approved in October 2020 and March 2021 (up to 30 September 2021) in order to sustain resilience during the recovery period. These amendments were all appropriately approved via the Audit Committee meeting or Chair's approval and subsequent ratification by the full committee in line with the CCG's scheme of delegation.

A further extension of the revised arrangements was not sought in advance of the approval lapsing on 30 September 2021. As such there was a period of time whereby IPA staff were operating outside of the CCG's approved scheme of delegation and were continuing to apply the delegation rules that had been in place

over the previous 18 months. There is no evidence to indicate that any untoward incidents occurred as a result of the lapse and, therefore, retrospective support of the extension to 31 March 2022 was agreed by the CCG. This matter was formally brought to the attention of the Governing Body in March 2022.

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

NHS England is legally required to review CCGs' performance on an annual basis. Historically, this has been carried out under the auspices of the CCG Improvement and Assessment Framework and, more recently, 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 set new and updated priorities across the different phases of the response, it was not possible to apply the established methodology to determine CCGs' ratings for 2020/21. Therefore, a simplified approach to the 2020/21 CCG annual performance review was undertaken, taking account of the different circumstances and challenges CCGs have faced in managing recovery across the phases of the NHS response to COVID-19.

NHS England commented 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 throughout the year.

Over the course of the year, like all areas of England, the CCG has continued to be impacted by COVID-19, but its focus remains on improved performance across all indicators. Some challenges remain on specific indicators, but progress is being made and robust plans are in place to improve and sustain performance.

The CCG has experienced and capable Executives, Clinicians, Lay Members, and senior management team delivering plans across all functions. The CCG's leadership has 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 Executives are supported by strong challenge from experienced Lay representatives on the Governing Body and other committees.

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

The CCG has operated during 2020/21 under command-and-control structures and processes due to the COVID-19 pandemic, these have focused on system delivery and financial position underpinned and delivered by organisational planning and performance. Strong financial planning and budgetary controls are in place to ensure

the CCG understands its financial position and delivers 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 have 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 has 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, and this is undertaken by the CCG's nominated Anti-fraud Specialist, together with the wider Anti-fraud Team at MIAA. The CCG's Chief Finance Officer oversees the anti-fraud arrangements for the CCG.

The Anti-fraud Specialist provides an Anti-fraud Annual Report which offers 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 is to support improved NHS services and ensure that fraud within the NHS is clearly seen as being unacceptable.

During 2021/22, the Anti-fraud Specialist has completed a wide range of work across the main key areas of activity as outlined by the NHS Counter Fraud Authority and agreed within the workplan approved by the Audit Committee. The following has been achieved during the year:

- Attendance at Audit Committees (Committees in Common with Fylde and Wyre CCG)
- Regular meetings with key personnel including the Chief Finance Officer, and Internal Audit
- Completion and submission of the NHS Counter Fraud Authority's Standards for Commissioner's Self Review Tool
- Newsletters/briefings/circulars covering various fraud and bribery related topics
- MIAA fraud awareness video x 3 provided to the CCG for distribution to staff
- Undertaking the latest National Fraud Initiative Exercise
- Updating the Anti-fraud, Bribery and Corruption Policy Counter Fraud Policy
- COVID-19 related alerts issued to the CCG
- Completed on behalf of the CCG, the NHSCFA Impact Assessment Return
- Completion of various requests from the NHS Counter Fraud Authority in respect of fraud activities at the CFA
- Completed a Personal Health Budgets proactive review
- Commenced an Overtime review
- Alerts, guidance papers and warnings issued and actioned
- Responded and provided advice to management on potential fraud concerns

The CCG is required to comply with all the Standards for Commissioners issued by the NHS Counter Fraud Authority. The CCG's overall self-assessment against these

standards for 2021/22 is confirmed to be GREEN, based on the collation of evidence undertaken by the Anti-Fraud Specialist.

Internal Audit and Internal Control

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 Governing Body in the completion of its Annual Governance Statement (AGS), 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 is in the process of transition to an ICB and like other organisations across the NHS has continued to faced unprecedented challenges due to COVID-19.

2021/22 Internal Audit Service Delivery

2.1 CCG Closedown

- Throughout 21/22 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, each of the Lancashire CCGs agreed to ring fence approximately 10% of their 2021/22 internal audit plan days for pan system transition support. Outcomes from this work support the Head of Internal Audit Opinion (HoIAO) and is summarised in section 4.3.3.5.
- 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 4.3.3.6.

2.2 COVID-19 Challenges

- COVID-19 has continued to impact all public services, however, MIAA's response during 2020/21 and the need to work differently has provided a strong basis for the delivery of planned work in 2021/22. We have continued to act as a critical friend throughout the pandemic providing key assurances across a range of areas including governance, risk management, finance, and quality, sharing best practice and learning from other organisations. There has remained a strong focus on engagement with organisations and the Audit Committee, with regular briefings and updates to support assurance requirements.

- The re-introduction of restrictions and increased levels of staff sickness (both internal audit and at organisations) due to the Omicron variant and the subsequent 'stand down' letter issued by NHSE/I has provided additional challenges to the delivery of planned work, during the final quarter of the year. However, there has been a clear focus by both internal auditors and organisations on requirements to deliver a HoIAO and to support year end reporting.

We would like to take this opportunity to thank the Audit Committee and all the staff at the CCG for their ongoing support during the year.

Executive Summary

This annual report provides the 2021/2022 Head of Internal Audit Opinion for NHS Blackpool CCG, together with the planned internal audit coverage and outputs during 2021/2022 and MIAA Quality of Service Indicators.

Key Area	Summary
Head of Internal Audit Opinion	The overall opinion for the period 1st April 2021 to 31st March 2022 provides **Substantial Assurance**, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
Planned Audit Coverage and Outputs	The 2021/22 Internal Audit Plan has been delivered with the focus on the provision of your Head of Internal Audit Opinion. This position has been reported within the progress reports across the financial year. Review coverage has been focused on: • The organisation's Assurance Framework • Core and mandated reviews, including follow up; • A range of individual risk-based assurance reviews; and • CCG Closedown/ICB Transition support *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.

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 annual 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 considers 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:

1	An assessment of the design and operation of the underpinning Assurance Framework and supporting processes.
2	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.
3	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 2021 to 31st March 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 2021 to 31st March 2022 inclusive, and is underpinned by the work conducted through the risk based internal audit plan.

4.3.3.1 Assurance Framework

Phase 1 Opinion

Structure	The organisation's AF is structured to meet the NHS requirements.
Engagement	The AF is visibly used by the organisation on an ongoing basis.

Opinion

Structure	The organisation's AF is structured to meet the NHS requirements.
Engagement	The AF is visibly used by the organisation.
Quality & Alignment	The AF clearly reflects the risks discussed by the Board.

4.3.3.2 Core & Risk Based Reviews Issued

We issued:

1 high assurance opinions:	Primary Care Framework – Commissioning & Procurement
2 substantial assurance opinions:	Data Security & Protection Toolkit (2020/21) (Self-assessment) Data Security & Protection Toolkit (2021/22)
1 **moderate** assurance opinions:	Data Security & Protection Toolkit (2020/21) (Assessment against the National Data Guardian Standards)
0 **limited** assurance opinions:	No reviews received a limited assurance opinion.
0 no assurance opinions:	No reviews received a no assurance opinion.
2 reviews without an assurance rating	Conflicts of Interest CCG Transition Group briefing note

4.3.3.3 Conflicts of Interest

As required by NHS England's Managing Conflicts of Interest: Revised Statutory Guidance for CCGs (June 2017), an audit of conflicts of interest was completed following the prescribed framework issued by NHS England. The following compliance levels were assigned to each scope area:

	Scope Area	Compliance Level	RAG rating
1	Governance Arrangements	**Fully Compliant**	●
2	Declarations of interests and gifts and hospitality	**Fully Compliant**	●
3	Register of interests, gifts and hospitality and procurement decisions	**Fully Compliant**	●
4	Decision making processes and contract monitoring	**Fully Compliant**	●
5	Reporting concerns and identifying and managing breaches / noncompliance	**Fully Compliant**	●

4.3.3.4 Primary Medical Care Commissioning and Contracting

The Primary Medical Care Commissioning and Contracting Internal Audit Framework for Delegated CCGs was issued in August 2018. NHSE require an internal audit of delegated CCGs primary medical care commissioning arrangements. The purpose of this is to provide information to CCG's that they are discharging NHSE's statutory primary medical care functions effectively, and in turn to provide aggregate assurance to NHSE and facilitate NHSE's engagement with CCGs to support improvement.

The 2021/22 Primary Medical Care Commissioning and Contracting review focused upon Commissioning and Procurement and provided **Full Assurance** *(assurance rating provided as per the NHSE guidance).*

4.3.3.5 CCG Transition - System Support

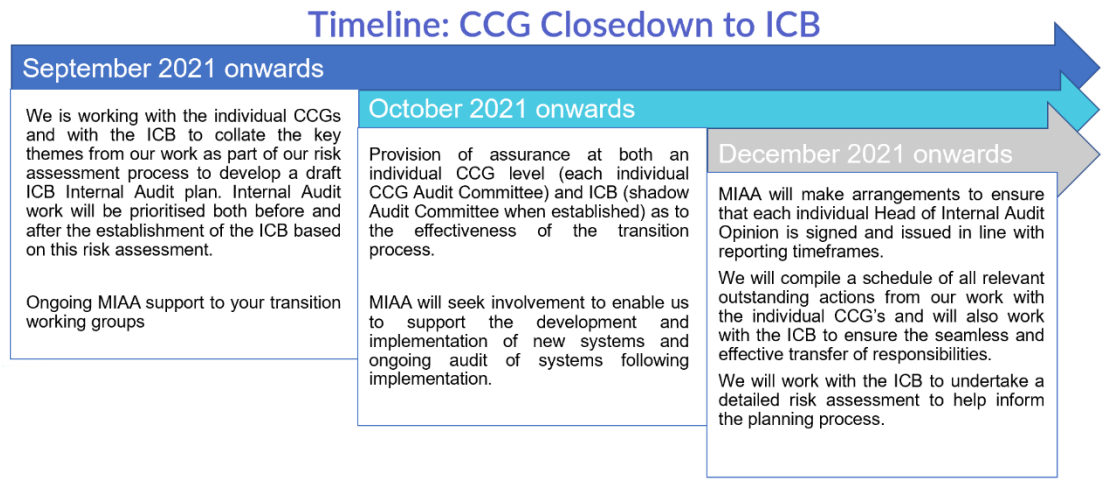
The following system support, covering a number of transition elements and workstreams, has been undertaken in year. This work complements and supports local transition work.

Lancs and South Cumbria

- **Audit Committee Engagement Events**: Briefing session facilitated for Audit Committee members on CCG Transformation and ICB Establishment.
- **Financial Closedown Assurance**: MIAA are providing specific assurance to support in the delivery of the workstream that meet NHSEI financial closedown requirements. This support incorporates:

    - regular contact with the Chief Finance Officer financial closedown lead to provide real time insight and guidance on proposals
    - providing assurance to the Finance Transition Group of the current delivery position for the financial closedown workstream. This is focusing upon the processes in place and includes sample testing of actions.
- Assurance 'Spot Checks': MIAA will provide assurance against reported progress in relation to the Transition Programme Plan on a risk-based sample basis. This work is ongoing.
- **SBS Project Board:** MIAA are undertaking a project assurance role supporting the SBS Project Board in the implementation of the ICS ledger.
- **System Group Representation and Reporting:** Attendance and contribution at:
    - Finance Transition Group
    - Governance Leads Group
    - Executive Closedown Group

4.3.3.6 CCG Transition - Local Support



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

- Transition working group attendance; and
- Assessing the governance processes for the completion, monitoring and sign off the CCG's Due Diligence Checklist/Programme plan.

We can provide assurance that effective processes have been established for the completion and monitoring of the Programme Plan.

Note: the assurance provided above does not provide confirmation of the accuracy and completeness of the Due Diligence Checklist/Transition Plan.

4.3.3.7 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. We will continue to track and follow up outstanding actions.

We have raised 1 recommendation as part of the reviews undertaken during 2021/22. All recommendations raised by MIAA have been accepted by management.

Of these recommendations: **0** were **critical and 0** were **high risk recommendations.**

4.3.3.8 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 the ongoing pandemic response and 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.

Steve Connor
Managing Director, MIAA
March 2022

Louise Cobain
Assurance Director, MIAA
March 2022

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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the 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 is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principle objectives have 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 Interim Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control that supports 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 Managing 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.

My review recognises the control issue arising in respect of the lapse in approval of the extension of the scheme of delegation arrangements for Individual Patient Activity. However, I am satisfied that appropriate steps have been undertaken to address this matter, including bringing it to the attention of the Governing Body.

I therefore conclude that NHS Blackpool Clinical Commissioning Group has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Andrew Bennett
Interim Accountable Officer
13 June 2022

Remuneration and Staff Report

Remuneration Committee

The Members of the Remuneration Committee are:

- David Edmundson, Chair/Lay Member (Governance)
- Roy Fisher, CCG Chairman
- Chris Brown, Lay Member
- Helen Williams, Lay Member (Patient and Public Engagement)

The Remuneration Committee met once during the year and the following provided advice to the Remuneration Committee:

- Mr H Naylor, Head of Programme Management and Corporate Business, Blackpool CCG (employee)
- Mrs C Owen, Strategic People and Organisational Development Lead, Midlands and Lancashire Commissioning Support Unit
- Mrs J Burrell, Senior HR Business Partner, Midlands and Lancashire Commissioning Support Unit

Policy on Remuneration of Senior Managers

The principles of remuneration below that guide the CCG's Remuneration Committee are based on NHSE/I 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. NHSE/I 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 four CCG Lay 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 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 CCG has implemented the 2021/22 nationally agreed 3% pay award uplift for all NHS employees covered by NHS terms and conditions service (Agenda for Change). For CCG employees not covered by this 2021/22 pay award uplift, the CCG's Remuneration Committee agreed to implement a pay freeze, as advised by the Cabinet Office and NHS England and Improvement for all NHS staff engaged on non-Agenda for Change contracts.

Remuneration Report

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
Mr R Fisher	Chair	35-40	0	0	35-40
Dr A Doyle (Note 1)	Chief Clinical Officer (to 31.7.21)	15-20	0	0	15-20
Mr D Edmundson	Lay Member	10-15	0	0	10-15
Mr C Brown	Lay Member	5-10	0	0	5-10
Dr M Williams	GP Member	25-30	0	0	25-30
Dr L Rudnick	GP Member	25-30	0	0	25-30
Dr S Singh	GP Member	25-30	0	7.5-10	30-35
Dr C Augustine	GP Member	25-30	0	0	25-30
Dr M Martin	GP Member	25-30	0	7.5-10	30-35
Dr S Green	GP Member (to 30.04.21)	0-5	0	10-12.5	10-15
Mr A Harrison (Note 3)	Chief Finance Officer	30-35	0	0	30-35
Mrs J Scattergood (Note 2)	Director of Nursing and Quality (to 30.6.21)	10-15	0	172.5-175	180-185
Mrs Y Rispin (Note 4)	Director of Ambulance and NHS 111 Commissioning	100-105	0	37.5-40	140-145
Mrs H Williams	Lay Member	5-10	0	0	5-10
Dr B Butler-Reid (Note 2 & 4)	Clinical Director (to 31.8.21)	15-20	0	10-12.5	25-30
Dr N Hartley-Smith (Note 2 & 4)	Clinical Director	25-30	0	0	25-30
Mr J Gaskins (Note 2)	Acting Chief Finance Officer	45-50	0	0	45-50
Mr N Medway (Note 2)	Deputy Director of Nursing & Quality (from 1.7.21)	35-40	0	0	35-40
Mr A Bennett (Note 5)	Interim Accountable Officer (from 1.8.21)	15-20	0	150-152.5	165-170

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 Blackpool CCG only, for the time in post 01/04/2021 to 31/07/2021.

Dr Doyle's total salary for the period of office (excluding taxable benefits) is £75-80K which is split as follows:
£15-20k to Blackpool CCG in respect of Accountable Officer duties;
£30-35k to the Integrated Care System for work as the ICS Lead;
£15-20k to Fylde and Wyre CCG in respect of Accountable Officer duties; and
£10-15k charged to West Lancashire CCG in respect of Accountable Officer duties.

The recharges from Blackpool CCG to 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 Blackpool 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 Blackpool CCG only.

From 1st August 2020 Mr 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: Mrs Y Rispin, Mrs J Higgs, Dr N Hartley-Smith, and Dr B Butler-Reid (for the period in post) 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 Blackpool 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 Interim Accountable Officer duties;
£45-50K to the Integrated Care System for work as the ICS Lead;
£15-20K to Fylde and Wyre CCG in respect of Accountable Officer duties; and
£10-15K charged to West Lancashire CCG in respect of Accountable Officer duties.

The 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.

2020/21 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
Mr R Fisher	Chair	35-40	0	0	35-40
Dr A Doyle (Note 1)	Chief Clinical Officer	45-50	0	0	45-50
Mr D Edmundson	Lay Member	10-15	0	0	10-15
Mr C Brown	Lay Member	5-10	0	0	5-10
Dr M Williams	GP Member	25-30	0	0	25-30
Dr L Rudnick	GP Member	25-30	0	0	25-30
Dr S Singh	GP Member	25-30	0	0	25-30
Dr C Augustine	GP Member	25-30	0	0	25-30
Dr M Martin	GP Member	25-30	0	0	25-30
Dr S Green	GP Member	25-30	0	0	25-30
Mr D Bonson (Note 2)	Chief Operating Officer (to 8.1.21)	40-45	0	0	40-45
Mr A Harrison (Note 3)	Chief Finance Officer	40-45	0	0	40-45
Mrs J Scattergood (Note 2)	Director of Nursing and Quality	45-50	0	342.5-345	385-390
Mrs Y Rispin (Note 4)	Director of Ambulance and NHS 111 Commissioning	100-105	0	0	100-105
Mrs H Williams	Lay Member	5-10	0	0	5-10
Dr B Butler-Reid (Note 2 & 4)	Clinical Director	30-35	0	10-12.5	40-45
Dr N Hartley-Smith (Note 2 & 4)	Clinical Director	25-30	0	7.5-10	30-35
Mr J Gaskins (Note 2 & 3)	Acting Chief Finance Officer (from 1.8.20)	30-35	0	0	30-35

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 Blackpool CCG only.

Dr Doyle's total salary (excluding taxable benefits) is £225-230k which is split as follows for 2020/21:
£45-50k to Blackpool CCG in respect of Accountable Officer duties;
£100-105k to the Integrated Care System for work as the ICS Lead;
£45-50k to Fylde and Wyre CCG in respect of Accountable Officer duties; and
£30-35k 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 2020/21 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 Blackpool CCG only. In each case this is 50% of total salary for the period in post which in full would be:

Mr D Bonson (to 8.1.21)	£80-85k
Mrs J Scattergood	£90-95k
Mr J Gaskins (from 1.8.20)	£60-65k
Dr B Butler-Reid	£60-65k
Dr N Hartley-Smith	£50-55k

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 and Mr J Gaskins figures are identified in Fylde and Wyre CCG's annual report. This split 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 Blackpool CCG only.

From 1st August 2020 Mr 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 £125-130k which is split as follows for 2020/21:
£40-45k in relation to Fylde and Wyre CCG in respect of Chief Finance Officer duties;
£40-45k charged to Blackpool CCG in respect of Chief Finance Officer duties; and
£40-45k charged to Morecambe Bay CCG in respect of Chief Finance Officer duties.

In the period to 31 July 2020 the costs are split equally between Blackpool and Fylde and Wyre CCGs. From 1 August 2020 the costs 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.

Mr J Gaskins became Acting Chief Finance Officer for Fylde and Wyre CCG and Blackpool CCG on 1 August 2020 and from that date the costs are split equally between the two CCGs. This role was established in order to provide sufficient level of executive cover to the Governing Bodies throughout the period of Mr Harrison's additional duties as Chief Finance Officer for Morecambe Bay CCG.

Note 4: Mrs Yvonne Rispin, Dr Butler-Reid and Dr Hartley-Smith do not have Governing Body voting rights.
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 31 March 2022 (subject to audit)

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022
		£000	£000	£000	£000	£000	£000	£000
Mrs J Scattergood	Director of Nursing and Quality (to 30.6.21)	0-2.5	2.5-5	35-40	85-90	579	38	748
Mrs Y Rispin	Director of Ambulance and NHS 111 Commissioning	0-2.5	0-2.5	40-45	110-115	942	52	1,012
Dr C Augustine	GP Member	0	0-2.5	10-15	30-35	246	0	241
Dr M Martin	GP Member	0-2.5	0-2.5	10-15	25-30	219	11	235
Dr S Green	GP Member (to 30.4.21)	0-2.5	0-2.5	10-15	20-25	166	11	178
Dr S Singh	GP Member	0-2.5	0-2.5	10-15	20-25	212*	10	227
Dr B Butler-Reid	Clinical Director (to 31.8.21)	0-2.5	0	5-10	0-5	40	9	50
Dr Neil Hartley-Smith	Clinical Director	0	0	10-15	25-30	242	0	238
Mr A Bennett	Interim Accountable Officer (from 1.8.21)	5-7.5	7.5-10	55-60	125-130	967	94	1,134

Notes:

* NHS Business Services Authority has advised that the pension figures provided for Dr S Singh that were reported in the 2020/21 Remuneration Report for Blackpool CCG have been subsequently revised. The Cash Equivalent Transfer Value at 1 April 2021 reported in the above table therefore does not correspond to the Cash Equivalent Transfer Value at 31 March 2021 reported in the previous year's Remuneration Report which was £465K.

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.

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 in 2021/22 (nil 2020/21).

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 in 2021/22 (nil 2020/21).

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 31 March 2022, remuneration ranged from £11,804 to £230,400 (2020/21: £12,612 to £132,707) 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 Blackpool CCG staff is shown in the table below:

	25th percentile		**Median**		**75th percentile**	
	2021/22	**2020/21**	**2021/22**	**2020/21**	**2021/22**	**2020/21**
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£32,306	£30,615	£42,120	£38,890	£54,764	£53,168
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£32,306	£30,615	£42,120	£38,890	£54,764	£53,168

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	-20%	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	11%	0%	0%

The banded remuneration of the highest paid director in Blackpool CCG in the financial year 2021/22, inclusive of taxable benefits, was £140,000-145,000 (representing a decrease of 20% against 2020/21: £175,000-£180,000). This reflects a change in the individual occupying the post considered to be the highest paid director and associated salary.

In 2021/22, one individual received annualised remuneration in excess of the Highest Paid Director (2020/21, zero).

The 11% increase seen in the average pay of the employees of the entity reflects a change in staff composition alongside workforce pay awards and increments.

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
2021/22	4.4:1	4.4:1	3.4:1	3.4:1	2.6:1	2.6:1
2020/21	5.8:1	5.8:1	4.6:1	4.6:1	3.3:1	3.3:1

The decrease in the pay ratios observed between 2021/22 and 2020/21 is a combination of two factors:

- The 20% decrease observed between the remuneration of the highest paid director in post as at 31 March 2022 compared with the remuneration of the highest paid director in post as at 31 March 2021.

- The headcount of staff included in the ratio calculations has decreased between the two years (from 104 at 31.3.21 to 90 at 31.3.22) and this change in staff composition, as well as workforce pay awards and increments, has resulted in higher salaries seen at the 25th percentile, median and 75th percentile points as at 31 March 2022 than at 31 March 2021.

The two factors together result in smaller ratios observed between the pay of the highest paid director and that 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 31 March 2022, is shown below, both in terms of headcount (number) and whole time equivalent (WTE):

Pay Band	Number	WTE
VSM	2	1.20
9	2	0.75
8d	5	3.65
8c	3	2.80
8b	1	1.00
TOTAL	**13**	**9.40**

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. Whilst the '2021/22 Salaries and Allowances of the Governing Body' table does not identify any individuals with salaries and fees in excess of this value, the following should be noted in relation to the salary of the Chief Clinical Officer who was in post until 31 July 2021:

The full time equivalent annual salary of the Chief Clinical Officer was £225-230k. However, the total salary relating the Chief Clinical Officer's time in post from 1 April 2021 to 31 July 2021 (excluding taxable benefits) was £75-80k recharged across a number of organisations as follows by value (all figures shown in bands of £5k) and % of total salary:

- £30-35k to the Integrated Care System (46%)
- £10-15k to West Lancashire CCG (13%)
- £15-20k to Fylde and Wyre CCG (21%)
- £15-20k to Blackpool CCG (21%)

All elements of the remuneration were agreed by NHSEI.

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 31 March 2022, showing the categorisation of CCGs employees both in terms of headcount (number) and whole time equivalent (WTE):

Category	Number	WTE
Medical Staff	7	3.50
Nursing Staff	22	16.24
Administration and Estates Staff	62	57.54
TOTAL	**91**	**77.28**

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 31 March 2022, identifying the gender of CCG employees both in terms of headcount (number) and whole time equivalent (WTE):

Category	Male		Female		TOTAL	
	Number	WTE	Number	WTE	Number	WTE
Senior Managers – Executive Team	4	1.30	2	1.30	6	2.60
Senior Managers – Other	5	3.95	3	3.00	8	6.95
Other CCG Employees	20	16.62	57	51.11	77	67.73
TOTAL	**29**	**21.87**	**62**	**55.41**	**91**	**77.28**

Staff Policies

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

Workforce Diversity and Inclusion

The CCG is committed to creating an inclusive and diverse workforce. The CCG is represented on the North West BAME (Black, Asian and Ethnic Minority) Assembly and is continuing 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 has been approved by CCG governance processes and is now published on the CCG website. In summary, the WRES report includes:

- Workforce data of staff employed by Fylde Coast CCGs on 31 March 2021
- An action plan aligned to publication of the NHS People Plan and NHS Model Employer Strategy

The report shows:

- 167 staff are employed by the Fylde Coast CCGs, of which 82.6% are self-reporting their ethnicity on the Electronic Staff Records (ESR) system (improved from 81% previous year).
- The proportion of staff from BAME backgrounds is 4.8% (previous year 3.7%).
- The proportion of BAME representation across the CCGs' Governing Body members is 16.7% and in senior leaders (NHS AfC Band 8B and above) is 2.6%.

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

The CCG is 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 aims to have a workforce that is representative of our local communities. Due to low workforce numbers, we are not able to publish specific data relating to age, religion and belief, sexual orientation, gender reassignment, pregnancy and maternity, marriage, and civil partnership as there is a risk of identifying individual members of staff through the publication of this data. The following information on Fylde Coast CCGs' staff groups has been published:

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

Sex: Across the Fylde Coast, the population has nearly the same proportion of males (49.6 per cent) as females (50.4%). Within our workforce 73% of our workforce is women compared to 27% men. The NHS workforce nationally is predominantly made up of a female workforce – 77%.

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

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

- Staff complete a Display Screen Equipment (DSE) assessment form annually and undertake annual mandatory training. This helps identify where any reasonable adjustments are needed.
- Staff can access support from Occupational Health.

Mandatory Equality and Inclusion training for the CCG is monitored by ESR. Staff have the option to complete the training module online via ESR, or to attend an annual face to face training session that is provided by the Equality and Inclusion Team at MLCSU. Compliance with Equality and Inclusion Training in 2021 was 90.48% for NHS Blackpool CCG (+3.78% from 2020).

Trade Union Facility Time Reporting Requirements

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

Other Employee Matters

We try hard to ensure that the CCG is 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 is 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 has been convened to bring together best practice from all CCGs in Lancashire and South Cumbria and to support different ways of working in the future. Staff have been supported to continue to work effectively at home with plans to move to an agile working model. Staff have been

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 has taken place with this now available in one document for ease of access. In March 2022, the staff wellbeing group also hosted a wellbeing festival, a full day programme of interactive virtual sessions on a range of topics which staff could attend as appropriate.

In December 2021, the CCG's Governing body signed up to the North West HR Directors' staff wellbeing pledge. This means supporting staff health and wellbeing, adopting a flexible and person-centred approach, and ensuring a robust policy framework and leadership to support this. By ensuring wellbeing services that support all our colleagues are in place, the CCG will adopt a person-centred wellbeing framework and encourage leadership development that supports managers to undertake this new approach.

As part of our focus on staff wellbeing we share a staff survey bi-monthly across Lancashire and South Cumbria. The results of this survey are broken down to CCG level and analysed by the wellbeing group. Appropriate action is taken where appropriate, and recommendations offered to the HR reference group for further consideration. Regular communications and engagement with staff encourage people to complete the survey and feedback is provided on how their views have shaped our approach to wellbeing.

We take our responsibilities for workplace health, safety, and wellbeing seriously, and ensure all employees undertake an annual refresher on workplace health and safety and know how to access independent occupational health wellbeing support if needed.

The CCG provides a monthly Team Brief session in addition to the wider Lancashire and South Cumbria briefing. This offers staff the opportunity to ask any further questions or discuss any concerns. Line managers are 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 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 in 2021/22 (nil 2020/21).

Expenditure on Consultancy

The CCG spent £4,000 on consultancy from 1 April 2021 to 31 March 2022 (2020/21, £131,000). This related to consultancy fees associated with the implementation of NHS 111 First in the North West.

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 31 March 2022, for more than £245* per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2022	3
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	2
for between two and three years at the time of reporting	1
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 year

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

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

Off-payroll engagements regarding the Governing Body:

For any off-payroll engagements of Governing Body members between 01 April 2021 and 31 March 2022:

Number of off-payroll engagements of Governing Body members during the year.	1(1)
Number of individuals that have been deemed Governing Body members during the financial year (this figure includes both off-payroll and on-payroll engagements).	20

(1) Please note that the individual identified as being on the Governing Body with an off-payroll engagement does not have voting rights.

Exit Packages

There have been no exit packages agreed between 1 April 2021 and 31 March 2022 (2020/21 nil).

Andrew Bennett
Interim Accountable Officer
13 June 2022

Parliamentary Accountability and Audit Report

Blackpool 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 Blackpool Clinical Commissioning Group

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS BLACKPOOL CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Blackpool Clinical Commissioning Group ("the CCG") for the year ended 31 March 2022 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, 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 31 March 2022 and of its income and expenditure for the year 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 as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2021/22.

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 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 Blackpool CCG will be dissolved and its services transferred to 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 this respect.

Going concern basis of preparation

The Accountable Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity. 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 to the CCG's operating model and analysed how those risks might affect the CCG's financial resources or ability to continue operations 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;
- 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 CCG will continue in operation.

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 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.
- Reading Governing Body and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the CCG's accounting policies.

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, and taking into account possible pressures to meet delegated statutory resource limits, 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. However, in line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we recognised a fraud risk related to expenditure recognition which focused on non-NHS accruals.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included entries made to unrelated accounts linked to the recognition of expenditure and accruals and other unusual journal characteristics.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Assessing the existence and accuracy of recorded expenditure through specific testing over 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 non-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 directors and other management (as required by auditing standards), 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 National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items and our work on the regularity of expenditure incurred by the CCG in the year of account.

We are also required to make a referral to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 if 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.

As outlined in the section of this report dealing with other legal and regulatory matters, we qualified our regularity opinion on the basis that the expenditure incurred by the CCG in 2021/22 exceeded its Revenue Resource Limit by £5.39m. We also made a Section 30 referral to the Secretary of State and NHS England on 11 May 2022.

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 presented in the Annual Report together with the financial statements. 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;
- 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 2021/22.

Annual Governance Statement

We are required 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 2021/22. 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 accordance with the Department of Health and Social Care Group Accounting Manual 2021/22.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 69, the Accountable Officer 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 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 25(1) of the Local Audit and Accountability Act 2014.

Qualified opinion

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularly paragraph below, in all material aspects the expenditure and income recorded in

the financial statements have been applied to the purposes intended by parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion

The CCG has a statutory duty under Section 223H of the National Health Service Act 2006 to ensure that its expenditure which is attributable to the performance by it of its functions in the financial year does not exceed the Revenue Resource Limit specified by the NHS Commissioning Board. In 2021/22 the expenditure of the CCG was £1,008.83 million, which was £5.39 million in excess of its Revenue Resource Limit of £1,003.44 million.

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 69, 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 also required to report to you if we refer a matter to the Secretary of State and the NHS Commissioning Board 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.

On 11 May 2022 we made a referral to the Secretary of State and the NHS Commissioning Board under Section 30(1)(b) of the Local Audit and Accountability Act 2014 as a consequence of the CCG breaching its Revenue Resource Limit by £5.39 million in the year ending 31 March 2022.

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

This report is made solely to the Members of the Governing Body of NHS Blackpool CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, 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 Governing Body, 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 Blackpool CCG for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Timothy Cutler
for and on behalf of KPMG LLP,
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE
20 June 2022

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Intangible assets	14	36	74
Total non-current assets		36	74
Current assets:			
Trade and other receivables	17	2,673	12,667
Cash and cash equivalents	20	166	0
Total current assets		**2,839**	12,667
Total assets		**2,875**	12,741
Current liabilities			
Trade and other payables	23	(50,148)	(31,314)
Total current liabilities		**(50,148)**	(31,314)
Assets less Liabilities		**(47,273)**	(18,573)
Financed by Taxpayers' Equity			
General fund		(47,273)	(18,573)
Total taxpayers' equity:		**(47,273)**	(18,573)

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

The financial statements on pages 1 to 4 were approved by the Audit Committee on 13 June 2022 and signed by:

Andrew Bennett
Interim Accountable Officer, NHS Blackpool Clinical Commissioning Group