Better Health, Better Care,
Delivered Sustainably

NHS
Morecambe Bay
Clinical Commissioning Group

ANNUAL REPORT AND ACCOUNTS 2021/22

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Foreword

Welcome to the NHS Morecambe Bay Clinical Commissioning Group 2021/22 Annual Report published at the conclusion of another extraordinary year.

We cannot begin to reflect on the local circumstance in which we found ourselves without acknowledging the wider context of tumultuous change taking place around us in April 2022.

A year ago it would have seemed inconceivable that major conflict could happen in Europe but today Ukrainian refugees are being welcomed to homes in the North West. It is heartening to see the offers of hospitality being made.

We are all dealing with a range of pressures – a rise in the price of domestic energy is the latest aspect of a general rise in the 'cost of living'. Whilst we cope with Covid we have entered a 'Living with Covid' phase of our response to the pandemic and responsibility for infection prevention will become weaved into the fabric of everyday lives.

In Morecambe Bay we have worked diligently throughout the year to maximise the uptake of Covid vaccinations and to support effective infection prevention control.

Against this backdrop we have dealt with the impact of severe weather – including major power cuts in November 2021 and their implications for vulnerable people. Storm Arwen saw thousands of people in the north of England enduring many nights without power. The local NHS joined the emergency response by checking on and supporting many households to ensure they were safe and well.

Even before the influx of people fleeing Ukraine, the North West of England was welcoming refugees to the area. Barrow-in-Furness saw the first Asylum Hotel in the Morecambe Bay area. A second opened in Lancaster in early 2022. The CCG was part of the welcome for vulnerable individuals coming to the area, assisting with the complex process of arranging health checks and ongoing access to care.

The CCG continues to listen to staff and hear the impact current circumstances are having on them. Staff have coped with pressures of being ill themselves or having to support family, friends and colleagues. Colleagues have adapted to new agile ways of working and we thank them and their families for the sacrifices they have made in allowing their homes to double as workspaces. We recognise that the change has introduced a degree of isolation as people work from home and also blurred the boundaries between home and work. Our Health and Wellbeing team is doing an exceptional job to support staff as they adapt to these new hybrid ways of working.

Not only has this been a year of exceptional circumstances, it is also one which, subject to legislation, will be the last full year for Morecambe Bay CCG.

On the assumption that the legislative process continues as anticipated there will be a final set of Accounts for Morecambe Bay CCG in 2022/2023. This will give an opportunity to acknowledge the achievements of the CCG from the days of its formation as Lancashire North CCG from 2012 through the creation of Morecambe Bay CCG in 2017, to the opening of the Alfred Barrow Health Centre and the implementation of Mental Health Support Teams in schools in 2019 and up to the early start and high uptake of the Covid vaccination programme in 2020 and 2021. We take this opportunity to say a sincere

and heartfelt thank you to staff and partners who have worked long, hard and diligently to ensure that the services provided to the population of Morecambe Bay are those that are needed and that they are provided in the best way possible. This is no simple task and we thank people for doing a good job in difficult circumstances.

Jerry Hawker
Accountable Officer
22 June 2022

Dr Geoff Jolliffe
Clinical Chair
22 June 2022

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Performance Overview

Introduction

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. Morecambe Bay CCG's 2019/20 assessment rating was good.

NHSE wrote to Morecambe Bay CCG in June 2021 with an annual assessment letter. Whilst there is no overall assessment categorisation this year, the letter was positive about the CCG's Covid response and recognises that the CCG has been fully engaged with supporting the NHS system whilst taking a lead role in a number of areas, such as the New Hospitals Programme.

The letter also recognises the challenges the CCG faces including those in quality and financial performance, in continuing to manage the Covid response locally and in continuing to support the system reform agenda.

Legislation is anticipated shortly which will change the way in which health services are commissioned in England.

The structure and content of the Annual Report reflects this focus with much of the activities and initiatives described taking place across the Lancashire and South Cumbria footprint.

Much of the focus of our work this year has been in anticipation of these changes – preparing for the closedown of CCGs and the handover of roles and responsibilities to the Integrated Care Board and Integrated Care System.

Nevertheless there are significant matters to report which are unique to Morecambe Bay and the vital importance of Morecambe Bay as a place will not be subsumed by the broader perspective brought about by the commissioning changes.

In Morecambe Bay the CCG has:

- Continued to focus on partnership working and the development of Morecambe Bay as a Place.
- Maintained an understanding of changes to local government and, in particular, those in Cumbria, where reorganisation plans create boundaries which are not coterminous with the CCG or ICS footprint.
- Played a key part in the system preparedness for the challenging winter of 2021/2022.
- Continued to monitor and mitigate the impacts of the ongoing Covid emergency response.
- Sought assurance that improvement actions are being taken by University Hospitals Morecambe Bay Trust in response to a number of inspections and reports.
- Engaged with all providers on how to stabilise domiciliary and regulated care in the light of workforce challenges around recruitment and retention.
- Engaged with the population regarding community Services in South Lakeland.

To learn about more of the CCG's achievements this year, please read further into the Annual Report.

Jerry Hawker
Accountable Officer
22 June 2022

Statement of purpose and activities of the CCG

This section of the Annual Report provides summary information on NHS Morecambe Bay CCG – its purpose, key risks to the achievement of the organisation's objectives and how the organisation has performed during the 2021/22 financial year.

About us

NHS Morecambe Bay Clinical Commissioning Group (CCG) is a statutory body established under the Health and Social Care Act 2012.

NHS Morecambe Bay CCG was created in April 2017, merging NHS Lancashire North CCG with the South Cumbria area of NHS Cumbria CCG. The CCG's boundary therefore covers both Lancashire and Cumbria County Councils. It is fully authorised as a Clinical Commissioning Group with no conditions on its operations and the principal location of our business is at Moor Lane Mills, Lancaster LA1 1QD.

The CCG has 32 member practices that provide care for a range of communities varying in size from around 1,000 residents to our largest practice of 66,000. Collectively we provide primary care for around 352,000 patients, making us the second biggest CCG operating in the Lancashire and South Cumbria Integrated Care System.

We are all committed to making a difference by putting patients at the heart of our decision making and ensuring that every clinician is involved. By striving for the best possible standards, we want patients to be confident that they can access safe and quality care locally.

Morecambe Bay CCG is responsible for designing and purchasing (commissioning) healthcare in the Morecambe Bay area:

- We plan what services are needed to support the health needs of our local population.
- We commission services such as mental health, hospital care and community services.
- We monitor these services to ensure patients in Morecambe Bay have safe and quality care.

This means we commission services from a range of providers, including:

- Acute services – University Hospitals of Morecambe Bay NHS Foundation Trust, Lancashire Teaching Hospitals NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust.
- Mental health and learning disability services – Lancashire and South Cumbria Care NHS Foundation Trust and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.
- Community services – University Hospitals of Morecambe Bay NHS Foundation Trust, Blackpool Teaching Hospitals NHS Foundation Trust and North Cumbria Integrated Care NHS Foundation Trust.
- Patient transport services – North West Ambulance Service NHSTrust.

In addition, we commission services from the voluntary, community and faith sector, care homes, independent sector and local authorities.

We also work closely with other organisations including NHS England and NHS Improvement (NHSEI), which is the organisation responsible for buying GP, pharmacy, dental and specialised services across England, to ensure that health services delivered locally are joined up.

In addition to our statutory duties, we also discharge the responsibility, on behalf of NHSEI, for co-commissioning primary care services in our area.

Equality, Diversity and Inclusion

The CCG takes equality, diversity and inclusion very seriously. Our Equality and Inclusion Annual Report demonstrates how we are meeting our commitments to equality, diversity and human rights and sets out how we comply with our statutory duties under the Equality Act (2010) and the Public Sector Equality Duty. A joint Lancashire and South Cumbria CCGs Equality and Inclusion Annual Report for 2021/22 is currently being prepared and, once approved by Governing Body, will be published on the CCG website at following link:
https://www.morecambebayccg.nhs.uk/about-us/equality-and-inclusion

Equality Impact and Risk Assessments (EIRAs) are undertaken as part of decision-making processes and are embedded in the organisation's approach to risk management. All business cases and reports presented to Governing Body and Committee meetings are required to present evidence of the CCG's robust completion of EIRAs.

Modern Slavery Act

NHS Morecambe Bay CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement is available on our website - https://www.morecambebayccg.nhs.uk/about-us/equality-and-inclusion/modern-day-slavery-act

Our vision and triple aim

Our vision is: "To see a network of communities across Morecambe Bay enjoying great physical, mental and emotional wellbeing, supported by a health and care system that is recognised as being as good as it gets."

To achieve our vision, we will deliver our 'triple aim':

- Better Health – we will improve population health and wellbeing and reduce health inequalities.
- Better Care – we will improve individual outcomes, quality and experience of care.
- Delivered Sustainably – we will create an environment for motivated, happy staff and achieve our control total.

In meeting our aims, we strive to exercise CCG functions effectively, efficiently and economically, and in accordance with generally accepted principles of good governance and as an employer of choice.

Population challenges

The majority of our approximately 352,000 patients live in the districts of Lancaster, South Lakeland and Barrow-in-Furness, with the remaining smaller groups of patients mainly coming from Copeland and Craven, aligning on the Bay boundaries. The registered population is evenly split between females (50.1 per cent) and males (49.9 per cent), with 22 per cent of the population aged 65+ and 27 per cent aged 0-24, reflecting the large

student population who reside temporarily in the Bay. The remaining 51 per cent are aged 25–64.

With the integration of South Lakeland district into the CCG we see a growth in our older resident population and with predicted demographic growth in over-65s expected over the next 10+ years, we need to be mindful of the potential impact on health and wellbeing services across the Bay.

Deprivation measures show that while Barrow-in-Furness and Lancaster are two of the more deprived districts in England, South Lakeland is among the least deprived districts in England (based on the IMD 2015 average score). However, we must be aware that often those facts can mask pockets of deprivation and affluence and by the nature of the age profile for South Lakeland we recognise substantial challenges from the age demographic. While 45 per cent (164,059) of the population live within some of the most affluent lower layer super output areas (LSOAs) in England (IMD 2015 quintiles 4 and 5), 32 per cent (116,092) are living within some of the most deprived (IMD 2015 quintiles 1 and 2).

To provide accessible health care, services in the Bay are focused around three localities: Furness, South Lakeland and Lancaster with Morecambe. Where physical buildings are required – for example to provide hospital care – three sites in the localities are provided and based in Kendal, Barrow-in-Furness and Lancaster. Community services for physical and mental health care are equally focused around the three localities and reach into the communities, wrapping care at different levels based on the specialty or the needs of the populations.

As a CCG, we are committed to working with patients and clinicians to help people manage their long-term conditions, and to ensure services can support the ageing population we have.

Working with our partners

Lancashire and South Cumbria Health and Care Partnership

Responding to the Covid-19 pandemic

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

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

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

The Hospital cell covered elective care, tertiary services, critical care, cancer, paediatrics, mutual aid and clinical prioritisation. The Out of Hospital cell co-ordinated the work of community services, mental health, learning disabilities and primary care. It also worked with social care, with a Care Sector sub-cell run jointly with the Lancashire LRF and with

connections to Cumbria. A Joint Hospital and Out of Hospital cell chaired by Kevin McGee, Chief Executive of Lancashire Teaching Hospitals and the Provider Collaboration, was strengthened to enable collective system decision making with revised membership, which included the involvement of Directors of Adult Social Care from local authorities.

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

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

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

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

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

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

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

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

of Hospital cells, and across the Health and Care Partnership.

The **Covid-19 vaccination programme** – the largest in history – was well established by April 2021, both nationally and across Lancashire and South Cumbria. The Covid-19 Vaccination Programme Board, established in November 2020, continued to provide oversight during 2021/22 as well as strategic direction to make sure the local offer met public need and was fit for purpose.

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

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

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

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

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

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

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

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

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

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

The services have also expanded to include a lighter-touch pathway for lower-risk

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

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

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

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

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

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

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

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

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

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

From April 2021, a Strategic Commissioning Committee replaced the Joint Committee of CCGs, with a primary role to focus on delivery and decision making for the Lancashire and South Cumbria population with the authority to make decisions at a Lancashire and South

Cumbria level. The Committee brings the leadership of the eight Lancashire and South Cumbria CCGs together with ICS strategic commissioning leaders who have collectively committed to improve and transform health and care services across the area, delivering the highest quality of care possible within the resources available.

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.

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

Mental health: children and young people

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

CAMHS services continue to be transformed in line with the evidence-based THRIVE model (developed with NHS organisations, local authorities, education, the police, and representatives from the voluntary, community, faith, and social enterprise sector, parents,

carers and young people). As part of a government commitment, an additional £10.7 million has been invested over a three-year period to offer quality mental health services for children and young people. This will reduce waiting times, improve experience and quality of care, and ensure consistent levels of care are provided across the region. A focus will be on developing crisis care and making sure there is support 24/7, reducing the need for hospital admissions.

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

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

Mental health: adults

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

Specialist Community Perinatal Mental Health (PMH) services have now been expanded to provide locality-based teams. This will allow new and expectant mothers with moderate to severe symptoms to access specialist care where they live. Additional investment has increased the availability to women who need ongoing support from 12 months to up to 24 months following childbirth. This service supported 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. 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 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 2021 – targeted communications activity promoting IAPT to small and medium enterprises, local authorities, NHS workforce, 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
- 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

- 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 with LSCFT. This bid has three strands, which will include a digital communications / social media campaign, due for launch in Q1 of 2022, and the provision of additional digital capacity that commenced 1 April 2022 with a focus on 16-18 year old students
- Working with NHSEI, further High Impact Actions to increase access to IAPT services have been drawn together and an implementation plan is being worked up.

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

Psychoeducation empowers patients to understand their illnesses and improve their coping strategies. A typical length of stay is 12 to 18 months, but could be much shorter. Rehabilitation services are shown to successfully support two in three people progress to successful community living within 18 months of admission, whilst two in three do not require hospital admission within five years, and around one in ten go on to achieve independent living within this period. People receiving rehabilitation support are eight times more likely to achieve or sustain community living, compared to those supported by usual community mental health services.

Suicide prevention

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

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

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

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

More than 4,500 people have been trained in suicide prevention and self-harm. More than 1,270 people have signed up to be orange button wearers (local people who have undergone extensive suicide prevention training wear the button to signal that while they

cannot counsel people, they are trained to direct them to relevant services). The scheme has now been rolled out across Cornwall, Devon, Somerset and Worcestershire.

Digital

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

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

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

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

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

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

The **Digital Diagnostics programme** has launched the HiPRES solution, and supported Covid-19 testing over the last 12 months – with 10,000 registered users as at March 2022 and with other use cases to follow. The Artificial Intelligence (AI) for Stroke programme is supporting patients around the region. University Hospitals of Morecambe Bay test picture archive and communication system (PACS) has been successfully connected to the centralised cloud-based imaging platform, and radiology images have been successfully

sent across this network. This enables the transfer of patient imaging between all trust systems through a secure and cost-effective cloud environment. All SCR users will be able to see patient imaging in real time – eliminating the need for admin support, and improving our ability to provide quality care and timely decision making for patients wherever they are receiving treatment across the region.

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

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

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

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

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

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

solutions are designed around the needs of the people using them.

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

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

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

Stroke

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

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

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

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

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

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

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

Association's 'Hope After Stroke' campaign.

Diabetes

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

Local people with type 2 diabetes have been able to access support to manage their condition through My Way Diabetes via Your Diabetes, Your Way. Again, all face-to-face learning sessions were temporarily suspended during the pandemic, but a lot of digital support and online resources were available. As people with diabetes are amongst those more vulnerable to Covid-19, local health and care organisations worked together to provide practical and emotional support – especially during the winter months. During 2021, there were 206 registrations of patients compared to 16 patients in 2020. There are 57 practices across Lancashire and South Cumbria with at least one or more patients 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.

In year, work has progressed to form a single pathology service and the outline business case proposing how the future service will run was submitted to NHS England 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 in year 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 listening 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 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 & 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 forwards.

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 in-year has been the procurement of a new Laboratory Information Management System that will be implemented across all laboratories. The contract has been awarded to the preferred supplier and the new system will provide a common platform across all pathology services, enabling the storing and communication of results, access to these results wherever a patient presents, and a more effective use of data that can inform future service developments. This is a significant service development and an example of what is possible through collaboration.

Cancer Alliance

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

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

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

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

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

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

Maternity

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

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

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

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

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

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

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

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

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

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

The following services achieved gold accreditation in the Baby-Friendly Initiative Awards: East Lancashire Hospitals NHS Trust Maternity Services, Lancashire Children and Family Wellbeing Service and Virgin Care 0 to 19 Service, Blackburn with Darwen Children's

Centres and LSCFT's 0 to 19 Service, University of Central Lancashire's Midwifery and Health Visiting Programmes.

System-wide, standardised Smoke-Free Pregnancy annual training, a CO_2 monitoring during Covid-19 pandemic Standard Operating Procedure (SOP) and a Trauma Informed Care Training and Supervision package are now in place for maternity services. These will be delivered by a commissioned provider from April 2022.

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

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

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

Paediatrics

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

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

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

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

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

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

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

The 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 not 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 upper-tier 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.

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 Disabilities Mortality Reviews) and we 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, although Morecambe Bay CCG has one of the higher rates in the ICS and has performed above the national average.

Cardiac

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

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

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

Across England, the pandemic caused a rise in waiting times for echocardiograms

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

Funded care

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

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

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

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

Elective care

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

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

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

The plan sets out ambitions, guidance, and best practice to help systems address key issues, ensuring there is consistent focus on elective recovery for years to come. Supporting staff is also a key part of the recovery of elective services, recognising that

staff need to be looked after so they can look after patients. Together, this plan will help the NHS deliver millions more tests, checks and procedures to patients in England.

In Lancashire and South Cumbria, the Accelerator funding from NHS England has proved critical in helping us mitigate against these issues, with elective activity scaled up to ensure we collectively see and treat as many people as we can as quickly as possible. It has helped by providing additional bed capacity in hospitals across the region, enabling improvements in pre- and post-operative patient assessments, and reducing the number of unnecessary admissions for treatments such as angiograms by monitoring patients remotely.

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

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

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

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

Primary care

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

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

Throughout 2021/22, Covid-19 pressures have continued to impact the way in which primary care services were delivered. To ensure the most vulnerable patients are protected from infection and to ensure our staffing levels and capacity are maintained, the majority of appointments have been via telephone or video consultation where safe and appropriate and face-to-face appointments being offered to those with a clinical need. Demand for primary care services has also increased during this time. Data shows

there were more patient appointments each month between September 2021 and February 2022 than in the comparable period in 2019/20 prior to the pandemic. The latest appointments data for NHS England shows that in comparison GP appointments overall in Lancashire and South Cumbria during this time have increased by 10%. Of the appointments between September 2021 and February 2022 an average of 63% were face to face appointments, 36% were telephone appointments and the remainder were home visits or video and online consultations.

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.

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

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

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

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

to make the best use of the range of health professionals here to support them.

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

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

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

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

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

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

VCFSE leadership programme

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

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

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

Respiratory

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

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

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

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

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

New Hospitals Programme

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

In September 2021, a longlist of ten possible solutions was published to address some or all 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). Proposals include rebuilding on the existing sites, rebuilding on new sites, building a completely new hospital on a single site, and refurbishing existing buildings and facilities.

Members of the public have had the opportunity to have their say in person at roadshows with Healthwatch Together, as well as through an online survey, which received nearly 3,500 responses. A range of focus groups and workshops were also held, targeting people likely to be most impacted by new hospital facilities. NHS staff and Foundation Trust members shared their feedback, and 1,895 people joined the Big Chat online discussion. MPs and local authorities have also been kept up-to-date with progress.

All the feedback received will be used to help narrow down the proposals to a shortlist, currently anticipated to conclude in spring 2022.

Clinical policies

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

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

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

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

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

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

Urgent and emergency care

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

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

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

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

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

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

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

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

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

In January 2022, the ICS put forward spokespeople for regional and local radio to increase the visibility of NHS voices and to provide public messages around increased system pressures. This included specific messages to support the Covid-19 booster campaign, discharges across trusts, uptake of Covid virtual wards and pulse oximetry at

home services, encouragement for people to attend elective appointments and to demonstrate support of the care sector. There has also been a high level of support for the social care recruitment campaigns across NHS partners.

Ageing well

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

Bay Health and Care Partners (BHCP)

Partnership working through the pandemic

Bay Health and Care Partners (BHCP) Place Based Partnership has continued to show great strength and commitment to work collaboratively in 2021/22. The focus has always been to support patients and local people through the continuing demands of the Covid-19 pandemic, even as restrictions were removed.

Teams have worked tirelessly over the past 12 months – in particular with the demanding rollout of the Covid-19 vaccination booster programme. The ongoing process and undertaking to keep the vaccination sites fully operational has been significant but rewarding – thanks to the contributions of all partners, alongside many volunteers. The partnership has continued to ensure communities had the best opportunity to receive their first, second and booster vaccination quickly and safely.

Where possible, BCHP continued to take forward transformation programmes and progressed its aims for integrated care in light of the national health and care system reforms for 2022/23. Work continued to develop and support the system reform programmes across health and care both within the Place Based Partnership, and the wider impact across Lancashire and South Cumbria Integrated Care System.

Sharing the benefits of local projects

The Morecambe Bay Set for Surgery project applied for and received one million pounds in order to roll out across Lancashire and South Cumbria, following fantastic successes in the pilot scheme.

The programme, now known as LCS (Lancashire and South Cumbria) Optimise, aims to provide surgery patients with bespoke support ahead of their surgery. The initiative developed between GPs and hospital services aims to help patients waiting for surgery across Lancashire and South Cumbria to improve their general health before their operation. Patients seeking a new referral will also benefit.

The new approach has been captured in a Patient Charter, which invites patients to set goals for themselves, to both improve their own health, and to support the NHS by helping the maximum number of patients become fit and well more quickly. It supports patients to make positive health changes – and underpins the correct treatment choices.

Some treatments, especially surgical operations, can affect the body for several months afterwards and pre-existing poor health reduces the body's ability to recover from treatment. Simple changes, such as exercising more, eating more healthily or reducing

how much alcohol is consumed ahead of the operation can all help to increase patient's ability to recover.

More than 80% of those who took part in the initial pilot showed an improvement in at least one core area; and a number of patients improved so much, that they no longer needed surgery at all.

Workforce Development

Bay Health and Care Partner's vision of high quality, sustainable care, built around preventative care for the whole population, can only be achieved if there is a sufficiently skilled, organised, engaged and motivated workforce, available in the right numbers and at the right locations, in order to deliver it.

Our first priority for the next 12 months is ensuring the health and wellbeing of all colleagues in the patch, rolling out the "Flourish" approach across the whole place-based partnership with all partners contributing to the services and resources Allied to this is ensuring high levels of take-up for both flu and COVID vaccinations across health and social care.

The Workforce Strategy project group has begun mapping where staff are employed, to get a sense of the numbers working in health and care and, importantly, where there are shortages or gaps in skills.

There are nearly 16,000 people working in Morecambe Bay, though that number doesn't reflect those employed in mental health or the ambulance service (as those numbers are less easy to break down to the Morecambe Bay patch). More than half, 53%, of staff in a caring role work in social care.

Planning for the future

Engagement with local communities continued throughout 2021/22, including the launching of the Let's Talk Community Conversations. Let's Talk is an online platform, accessible to the public, where they can feedback on issues important to themselves and their communities. The platform aims to bring together feedback from sources across Morecambe Bay, including public and third sector organisations and ensure that future plans take into account a population health approach.

The voices of our communities are central to our new way of working. A particular highlight is a project that is taking place with young people in Barrow to raise awareness of knife crime. The initiative looks at the effects that carrying a knife can have on potential victims, the perpetrator, families, medical staff, peer groups and the wider community. The interactive programme was set up in May 2021, after several serious crime incidents in Barrow and concerns that some young people felt the pressure to carry a knife as a means of protection.

Future development

Bay Health and Care Partners have also been working closely together to incorporate the significant system reform that will take place in early 2022/23 for health and care organisations. We have undertaken significant planning and development work as Bay partners, including through our Leadership Team sessions and two key workshops (with further workshops planned in the first quarter of 2022/23). The CCG led the development

on behalf of partners of a local PBP Development Programme which sets out key areas of work around: partnership arrangements; workforce and financial arrangements; and delivery of key Better Care Together priorities of Population Health and Intermediate Care. A key part of the partnership arrangements development work has focussed on clarity on the scope of services to be led and delivered at system and place level; this was initially developed and agreed in the Bay and then shared for discussion and agreement across the Lancashire and Cumbria ICS. Similarly, our work on developing neighbourhood and locality arrangements in the Bay has also been taken up across the ICS. As a Place Based Partnership, BHCP will work with local people to ensure that local needs are met, and that the Integrated Care System continues to support our local communities**.**

Primary care

Much of the work of the CCG's Primary Care Team this year has been to support the response to the Covid pandemic. Several different phases of the vaccination programme have been fully supported. It was reported in December 2022 that, in Morecambe Bay, the uptake for booster and second dose vaccinations has been good and that all care home residents had been offered first, second and third doses of vaccination. The uptake of flu vaccinations in Morecambe Bay was good, albeit for certain areas below average, and the CCG worked with Public Health to address discrepancies.

The CCG supported general practice to bolster their resilience throughout the year. This took several forms including regular dial-in meetings for Practice Managers, work with Primary Care Networks (PCNs) in relation to the development of the workforce, work on developing a flexible staff pool, the commencement of additional phlebotomy collections and the production of a 'Day in the life of a GP' video to help patients understand the pressures within primary care and the changes put in place to respond to the pandemic.

Remote consultations have helped maintain distancing between people and prevented the spread of infection. Video consultations and text messaging have been used successfully and development work in this area continues.

Work on the Primary Care estate is ongoing and the CCG's Primary Care Team has supported PCNs to develop Estate Plans.

At short notice support was put in place for the first Home Office Hotel in Morecambe Bay in Barrow-in-Furness in early 2022. Support was given for health checks, dental services, optometric appointments and vaccinations. Arrangements were being made for a second hotel to home asylum seekers in Lancaster later in 2022.

A revision, to improve the forms used to record decisions on whether to attempt resuscitation (Do Not Attempt Cardiopulmonary Resuscitation or DNACPR forms) has been supported by the Primary Care Team. The subject is recognised as being potentially controversial and sensitive and care was taken in the planning of communications with patients and the public.

This is not an exhaustive list of the Primary Care Team's work supporting Primary Care and the population of Morecambe Bay in 2021/2022. Much work has been collaborative across the Lancashire and South Cumbria footprint and is descried earlier in the Working with Partners section.

Key issues and risks

The principal risk for Morecambe Bay CCG and the health economy is the significant risk related to ensuring a safe and sustainable service across Morecambe Bay to serve our population within available resources, considering quality variation. Together with our

partners, we are working to mitigate this risk through the refreshed Better Care Together programme. We are also working across the Healthier Lancashire and South Cumbria ICS to find sustainable solutions to our challenges.

Our approach to risk management and identification of risks is highlighted in the Governance Statement in this report.

Performance Analysis

Performance Summary

We track the progress of our service providers (for example local hospitals, community services, primary care practices) against several national outcomes indicators and ensure that patient rights within the NHS Constitution are maintained. Additionally, we have set local priorities against which provider progress is monitored. Performance reports are presented to and scrutinised by every meeting of the Finance and Performance Committee and a summary of key issues presented to the Governing Body.

The performance reports can be found on our website

Financial Key Performance Indicators

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

Key performance indicator	Target	Actual	Result
Revenue resource use does not exceed the amount specified in Directions	Maintain expenditure within the allocated resource of £648.924m	Total expenditure £651.024 The CCG revised its accounting estimate for the prescribing prepayment, in response to a request from NHSE/I as part of the preparations for the dissolution of the CCG at 30/06/2022. NHSE/I has advised that the CCG will not be penalised in performance management terms for the deficit but will be referred to the Secretary of State for a failure to fulfil its statutory duties under Section 30(1)(b) of the Local Audit and Accountability Act 2014	Not achieved (see note on deficit)
Delivery of a control total of breakeven	Deliver a control total of breakeven	Total position £2.088m deficit (see note on deficit)	Not achieved (see note on deficit)
Maintain expenditure within the Annual Cash Drawdown Requirement	Annual Cash Drawdown Requirement total £651.922m	Total cash outflow £648.674m	Achieved
Revenue administration resource use does not exceed the amount specified in	Maintain administration (running costs) expenditure within the allocated resource of	Total administration (running costs) expenditure £6.561m	Achieved

Directions	£6.567m		
QIPP savings targets identified and savings achieved	Overall QIPP savings target £5.344m (£2.954m in H1 and £2.390m in H2)	Total QIPP savings £1.241m	Not achieved (shortfall covered by additional growth allocations and underspends in other areas)
Maintain capital expenditure on primary care IT within the limits set by NHSEI	Maintain expenditure within the allocated primary care IT capital allocation of £0.493m	Total primary care IT expenditure £0.493m	Achieved
Comply with the Better Payment Practice Code (BPPC)	Ensure 95% (by number and volume) of all valid invoices are paid by the due date or within 30 days of receipt of a valid invoice, whichever is later	Non-NHS payables 99.95% by number, 99.44% by value NHS payables 100.00% by number, 100.00% by value	Achieved

Financial review

As a result of the continued impact of the Covid-19 pandemic, many of the temporary measures introduced by NHSE/I in late March and early April 2020 in response to the level 4 national incident were continued into the 2021/2022 financial year, including some of those relating to the NHS finance regime. As a result, all CCGs have had to continue to adapt their normal practices, payment and reporting mechanisms to accommodate those temporary measures.

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

These measures included:

- moving to a nationally determined monthly ‘block’ contract payment; subsidised with a top-up payment where necessary
- changes to cash management, to support faster payment to providers
- changes to monthly revenue reporting
- suspension of non-contract activity invoicing
- 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). A full set of accounts, including associated certificates, is included later in this report.

Allocation

As in the previous financial year, the total allocation to Morecambe Bay CCG for 2021/22 was split between the first half of the year and the second, due to the implementation of the revised financial regime outlined above. In the first half of the year, the allocations were as follows:

- We received allocations totalling £277.055m for commissioning NHS services for the local community
- We received a further allocation of £26.133m for delegated commissioning of primary care medical services
- We received a further allocation of £3.193m from which we were expected to cover all our running costs
- We received further allocations totalling £2.900m to cover further additional costs in the second half of the year from ICS reserves
- We received further allocations totalling £1.082m for out of envelope reimbursements for Hospital Discharge Programme (HDP)

In the second half of the year the allocations were as follows:

- We received allocations totalling £297.622m for commissioning NHS services for the local community
- We received further allocations totalling £27.806m for delegated commissioning of primary care medical services
- We received further allocations totalling £3.374m from which we were expected to cover all our running costs
- We received further allocations totalling £5.600m to cover further additional costs in the second half of the year from ICS reserves
- We received further allocations totalling £4.159m for out of envelope reimbursements for Hospital Discharge Programme (HDP) and additional flu venues

2021/22 financial duties

The CCG's performance against each of its financial duties, as reported in Note 2 to the Accounts, for the 2021/22 financial year was as follows:

- The CCG, in line with the financial position discussed and agreed in advance with NHSE/I, has delivered a deficit position of £2.088m in 2021/22 and has therefore utilised more resource in year than was allocated to it by NHSE/I. Prior agreement notwithstanding, it is, however, a breach of the CCG's financial duty to spend within its 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(1)(b) of the Local Audit and Accountability Act 2014.

  The £2.088m deficit has arisen from an agreed, non recurrent (one-off) technical adjustment, prior to the transition to the ICB, relating to a change in the accounting estimate used to calculate the prescribing accrual in the CCG's accounts totalling

£2.112m. Without this reversal, the CCG would clearly have ended the financial year with a small surplus. This reflects an unadjusted audit error reported by external audit in 2019/20 and 2020/21. CCG's were asked during 2021/22 to eliminate any such items in advance of the transition to the ICB. No allocations were provided, however, to cover the additional expenditure associated with the adjustment, and therefore a deficit has arisen.

As this adjustment is technical in nature, it ***does not*** reflect a failure in financial control within the CCG. There will be no adjustment to the CCG's allocation and therefore resource available for patient care services is unaffected.

NHSE/I has confirmed that the CCG will not be penalised in performance management terms for reporting this deficit and no regulatory action will be triggered.

- The CCG remained within the cash limit
- The CCG maintained its administration expenditure within its Running Costs Allowance.

Financial Performance

We have faced a number of financial pressures during 2021/22. The revised financial regime, which was introduced in 2020/21 to assist organisations in dealing with the Covid-19 pandemic, as described above, was extended into 2021/22, with a number of amendments. The financial year was again split into two halves and in both the CCG was given fixed allocations for programme, delegated primary care commissioning and running costs expenditure. As per last year, NHS England and NHS Improvement (NHSEI) determined block payment values for all NHS providers, which was a departure from the usual Payment by Results system in operation for most providers. These initial allocations were supplemented by additional allocations for; Covid-19 related expenditure in respect of the Hospital Discharge Programme (HDP) and Covid-19 expansion fund for Primary Care Networks (PCNs); Primary Care costs of recruitment to posts under the Additional Roles Reimbursement Scheme (ARRS); and expenditure under the Winter Access Fund (WAF).

In addition, system growth funding was allocated at an ICS level and the ICS partner organisations worked together to distribute this funding in a way which would enable each organisation in the ICS to report a breakeven. As a result, NHS Morecambe Bay CCG was allocated an additional £24.200m in system growth funding over the course of the financial year.

As part of the planning process, CCGs were expected to make Quality, Improvement, Productivity and Prevention (QIPP) savings during the year, based on an ICS system agreed percentage of allocation. The CCG's overall target for the full year was £5.344m (£2.954m in H1 and £2.390m in H2) but, due to the constraints imposed by the introduction of the block payments to providers as part of the revised financial regime, the only schemes able to deliver significant savings were in medicines management. Overall, the CCG realised savings of £1.241m, with the shortfall having been covered by unplanned underspends in some areas and use of the system growth funding allocated to the CCG as described above.

Analysis of Covid-19 expenditure

As explained above, the CCG was in receipt of additional allocations to cover expenditure

incurred as a result of the Covid-19 pandemic, although the level and scope of what was able to be reimbursed was much reduced compared to the 2020/21 financial year. Total expenditure on Covid-19 related items was as follows:

	£'m
Hospital Discharge Programme (HDP)	5.241
General Practice Covid-19 expansion fund	0.727
Total all Covid-19 expenditure	**5.968**

The majority of expenditure was related to the Hospital Discharge Programme, which was a continuation of the scheme established by NHS England to cover the costs incurred in enabling patients to be discharged from hospital and placed in nursing homes. Expenditure on the first 6 weeks (reduced to the first 4 weeks from 1 July 2021 onwards) post discharge were reimbursed from a centrally-held fund. Robust processes were established to ensure that only eligible expenditure was included in claims for reimbursement. The only other Covid-19-related expenditure reimbursed was in relation to a specific scheme to fund PCN's from the Covid-19 expansion fund.

All CCG Covid-19 expenditure incurred was covered by allocations, with no unused allocations at year end. The vast majority of costs were reimbursed on an actual basis, with very little estimation required.

Analysis of EU exit related expenditure

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

Accounting policies

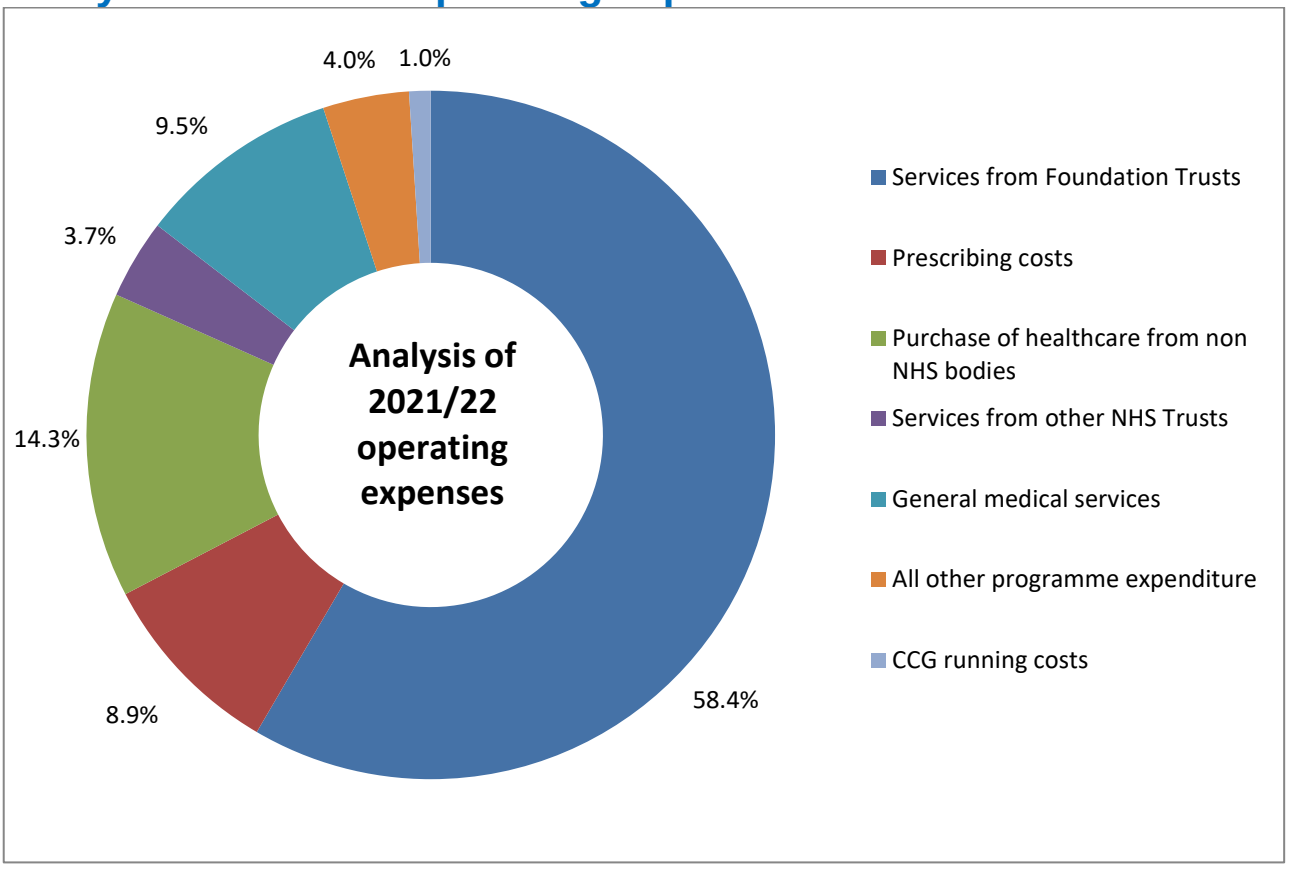
The CCG's accounting policies are shown in full in Note 1 to the Annual Accounts. As explained more fully on page 13 onwards, following the publication of the Health and Care Bill on 6 July 2021, the CCG will be dissolved on 30 June 2022. Whilst the CCG as an entity will cease to exist on that date, the activities undertaken by the CCG will continue to be undertaken by the Healthier Lancashire and South Cumbria Integrated Care Board. In accordance with the Department of Health and Social Care Group Accounting Manual, the continuation of the provision of services within the public sector means that the accounts of the CCG should be prepared on a 'going concern' basis (Note 1.1 to the Accounts provides further detail on the adoption of the going concern assumption). The accounting policies follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury.

We have made one change to accounting estimates during the 2021/22 financial year, reversing the change to accounting estimates introduced in the 2019/20 financial year. The CCG had amended its method for calculating the year end accrual for prescribing expenditure, to take account of items prescribed in March but which would only be consumed in April. As part of the preparation for the demise of the CCG on 30 June 2022, at the request of NHSEI to eliminate any unadjusted audit differences, the CCG has reversed this method and reverted to accounting for all prescribing expenditure in the financial year in which it is incurred. In addition, as described above, the Payment by Results system was suspended at a national level and replaced by a series of block payments to NHS providers above a set level of expenditure. As such, payments to NHS providers have, in general, been fixed irrespective of levels of activity undertaken. This is

a departure from the usual approach, undertaken as a temporary measure to address the financial issues faced by the NHS as a result of the Covid-19 pandemic and done under instruction from NHSEI.

Further details of accounting estimates made are reported in Note 1.33 to the Accounts, “Critical accounting judgements and key sources of estimation uncertainty”.

Analysis of 2021/22 operating expenses



Performance and Business Intelligence

In 2021/22 financial year the main priority for NHS services both local and national was seen as recovering elective services, overburdened from the COVID pandemic, as far as possible.

However, this came alongside a variety of issues including:

- recurrent COVID waves caused by emerging variants of concern,
- difficulties in admitting and discharging hospital patients caused by
    - continued staff absences in the health, care and social sectors due to illness or deferred leave
    - patients in hospital being COVID positive and therefore unable to move to preferred place
    - COVID outbreaks in care sector meaning homes being closed to new admissions
    - Increase Infection Prevention and Control measures meaning fewer beds being available

Due to the pandemic, a number of historical performance targets were seen as no longer relevant, or not currently achievable.

In 2021/22, the NHS System Oversight Framework (SOF) was introduced to replace the NHS Oversight Framework that was used in 2019/20 and prior. This new framework brought together a number of key performance metrics for Clinical Commissioning Groups (CCGs) into a single document. The metrics were in line with the vision set out in the NHS Long Term Plan, the White Paper Integration and Innovation: Working Together to Improve Health and Social Care for All and aligns with the priorities set out in the 2021/22 Operation Planning Guidance.

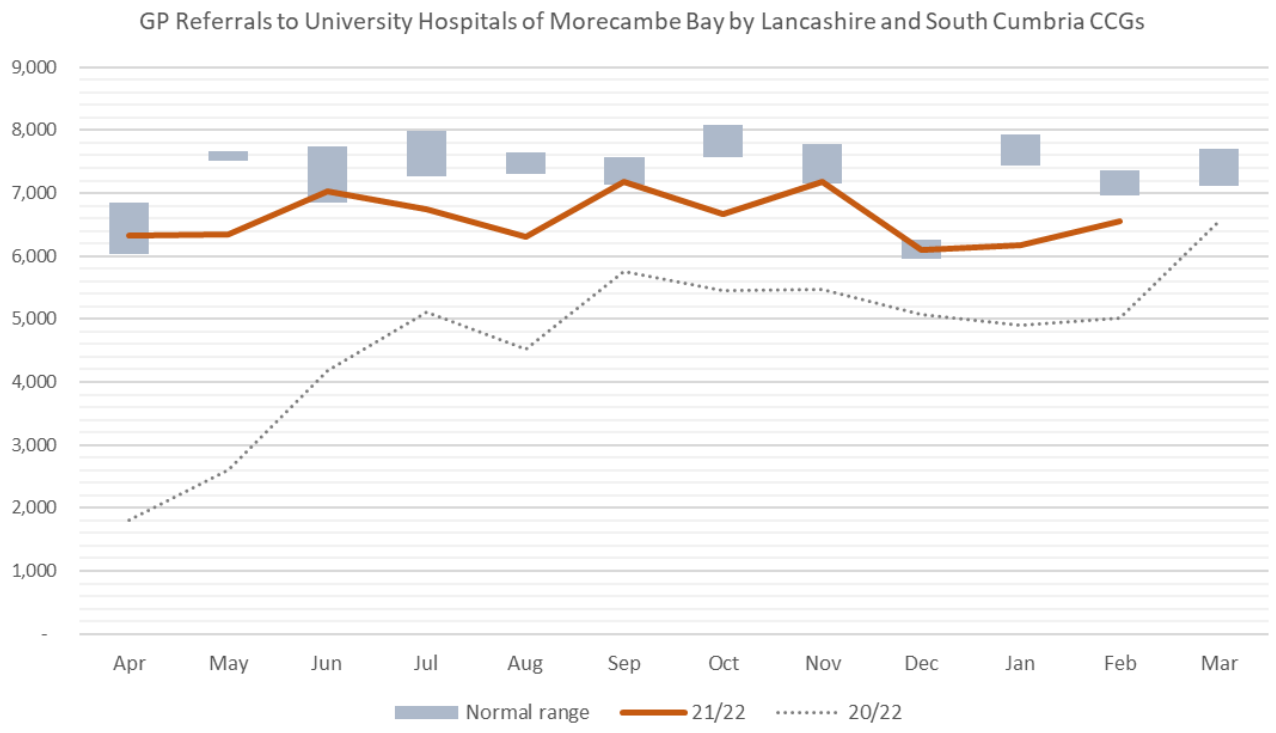
Below is the performance against the 2021/22 SOF for Morecambe Bay CCG. Performance management has been undertaken by all 8 CCGs in Lancashire and South Cumbria collectively during 2021/22 through the Strategic Commissioning Committee as part of the joint response to the Level 4 outbreak. This also has the benefit of supporting the transition to the Lancashire and South Cumbria Integrated Care Board during 2022/23.

	Indicator	Latest Period	Previous Value	Latest Value	Target/National Average*	.	National Value	Rank
S001a	Appointments in general practice	w/e 30/01/2022	37,096	37,802 ↗	60,655*	✗	6,429,388	58/106
S008a	Overall size of the waiting list	2022 01	29,126	30,043 ↗	53,492*	✓	5,670,142	40/106
S009a	Patients waiting more than 52 weeks to start consultant-led treatment	2022 01	1,934	1,804 ↘	2,705*	✓	286,703	60/106
S010a	Cancer - first treatments	2022 01	185	182 ↘	239*	✗	25,301	53/106
S010b	Cancer - urgent referrals seen	2022 01	1,409	1,378 ↘	1,905*	✗	181,952	54/106
S012a	Cancer - % meeting faster diagnosis standard	2022 01	74%	72% ↘	>75%	✗	63.8%	18/106
S013a	Diagnostic activity levels - Imaging	2022 01	8,723	8,739 ↗	13,821*	✗	1,465,001	54/106
S013b	Diagnostic activity levels - Physiological measurement	2022 01	722	661 ↘	1,152*	✗	122,154	66/106
S013c	Diagnostic activity levels - Endoscopy	2022 01	760	930 ↗	1,100*	✗	116,620	52/106
S014a	Cancer - proportion of people that survive cancer for at least 1 year after diagnosis	2018		75.9% →	73.6%*	✗		11/97
S015a	Cancer - proportion of cancers diagnosed at stages 1 or 2	2018		52.8% →	54.7%*	✗		63/79
S022a	Maternity - number of stillbirths per 1,000 total births	2019	4.29	2.77 ↘	3.46*	✓	3.33	22/88
S023a	Maternity - number of neonatal deaths per 1,000 live births	2019	1.32	1.04 ↘	1.74*	✓	1.55	7/64
S030a	Percentage of people aged 14+ on the GP learning disability register receiving an annual health check	21-22 Q3	23.8%	41% ↗	40.0%*	✓	40.5%	47/106
S031a	Number of personalised care interventions	21-22 Q3	10,409	13,097 ↗	25,377*	✗		65/106
S032a	Personal Health Budgets	21-22 Q3	848	1,089 ↗	1,042*	✓		28/97
S033a	Social Prescribing unique patient referrals	21-22 Q3	3,757	4,715 ↗	7,798*	✗		56/106
S037a	Patient experience of GP services	2021	86.7%	86% ↘	83.1%*	✓	83.0%	24/106
S040a	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections	2022 01	1	0 ↘	0.6*	✓	63	1/106
S041a	Clostridium difficile infections	2022 01	11	11 →	10*	✗	1,103	65/106
S042a	E. coli blood stream infections	2022 01	20	21 ↗	28*	✓	3,004	55/106
S044a	Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	Jan 2021 - Dec 2021	0.833	0.850 ↗	<0.87	✓	0.817	44/106
S044b	Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	Jan 2021 - Dec 2021	11.1%	11% ↘	<10%	✓	9.1%	97/106
S046a	Population vaccination coverage - MMR for two doses (5 years old) to reach the optimal standard nationally (95%)	21-22 Q2	91.4%	89.9% ↘	>95%	✗	85.5%	54/105
S047a	Percentage of people aged 65 and over who received a flu vaccination	2022 01	84.3%	85.2% ↗	82.2%*	✓	82.0%	20/106
S050a	Cancer - cervical screening coverage, females aged 25-64, attending screening within target period	21-22 Q2	72.8%	72.3% ↘	72.4%*	✗	70.7%	67/106
S052a	Diabetes patients that have achieved all the NICE recommended treatment targets (adults and children)	2020-21	33.8%	30.1% ↘	34.9%*	✗	34.6%	103/106
S055a	General Practice Referrals to NHS Digital Weight Management Programme - Crude Rate/100,000 population	21-22 Q3	61.5	117.9 ↗	61.78*	✓	66.99	17/106
S081a	IAPT access (total numbers accessing services)	21-22 Q2	1,490	1,435 ↘	2,828*	✗	299,725	69/106
S082a	IAPT recovery rate (%)	21-22 Q2	55.4%	53.2% ↘	50.0%*	✓	50.2%	22/106
S083a	Estimated diagnosis rate for people with dementia	2022 01	69.7%	69.3% ↘	62.9%*	✓	61.6%	15/106
S084a	Children and young people (ages 0-17) mental health services access (number with 1+ contact)	2021 12	4,180	4,265 ↗	5,939*	✗	627,695	52/106
S085a	People with severe mental illness receiving a full annual physical health check and follow up interventions	21-22 Q3	844	955 ↗	1,736*	✗	183,971	59/106
S087a	Rate per 100,000 population of people in adult acute mental health beds with a length of stay over 60 days	2021 12	13.9	10.3 ↘	7.73*	✗	8.32	77/106
S087b	Rate per 100,000 population of people in older adult acute mental health care with a length of stay over 90 days	2021 12	6.5	0 ↘	7.07*	✓	9.19	1/106
S088a	Number of women accessing specialist community perinatal mental health services	Jan 2021 - Dec 2021	7.92%	7.28% ↘	6.2%*	✓	6.1%	26/106
S089a	Waiting times for Urgent Referrals to Children and Young People's Eating Disorder services	Jan 2021 - Dec 2021	57.1%	57.1% →	66.7%*	✗	59.0%	70/106
S089b	Waiting times for Routine Referrals to Children and Young People Eating Disorder Services	Jan 2021 - Dec 2021	84.2%	69.6% ↘	63.3%*	✗	66.4%	56/106

Delivery on Key Performance Targets

Elective demand

2020/21 saw a substantial drop in GP Referrals to hospitals services, initially as a result of a closedown of services and subsequently impacted by patient reluctance to attend GP services, the requirement of Primary Care to deliver vaccinations en masse, staff absences and leave, as well as increased infection prevention and control measures.

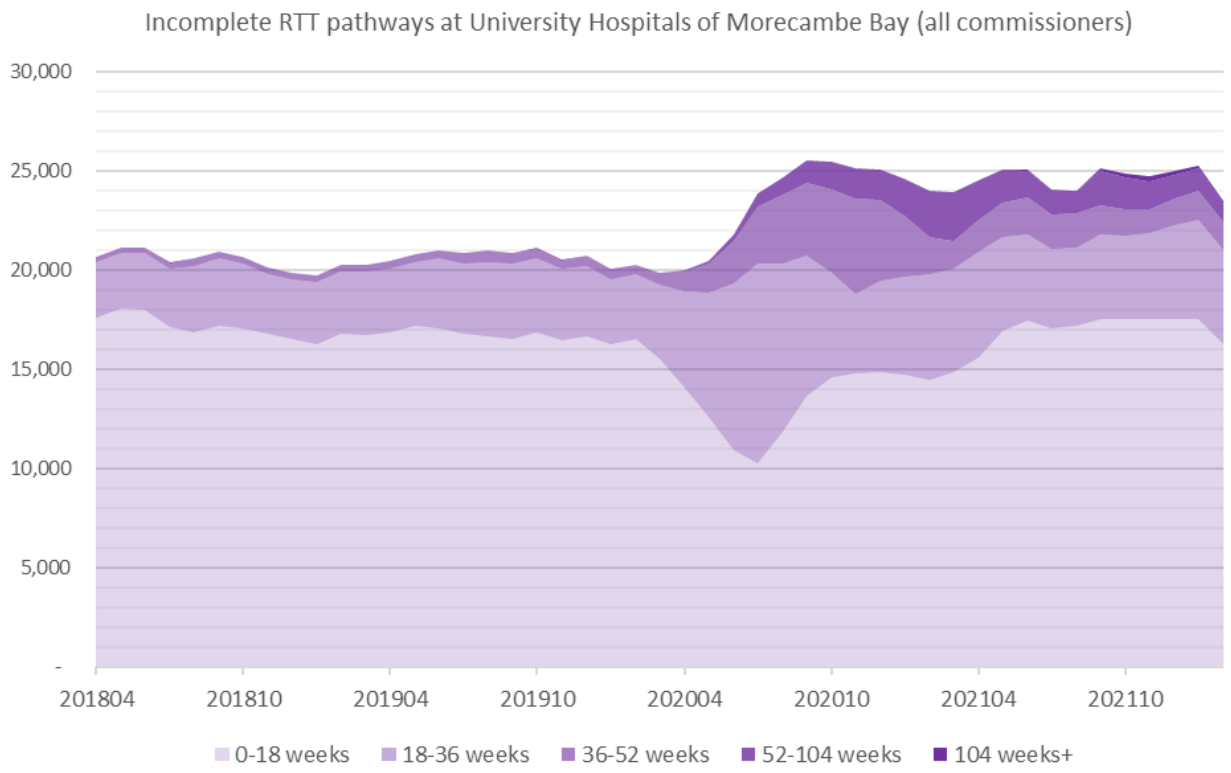


During 2021/22 GP referrals have recovered close to levels seen pre-pandemic although remain on the lower end of expected levels.

Elective waiting lists

The pandemic increased the total size of the NHS waiting list, going from around 20,000 incomplete pathways in March 2020 to a peak of over 25,500 in September 2020.

The number of incomplete pathways has largely plateaued between 24,000 and 25,000 in the period since



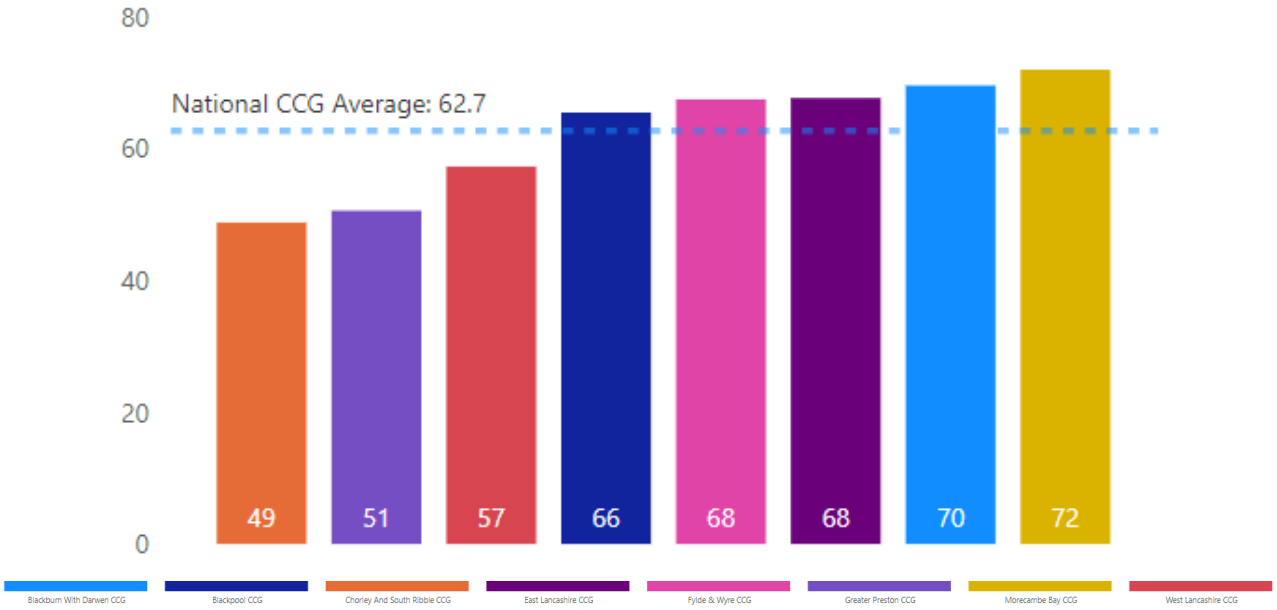
The number of long waiting patients has increased since the beginning of the pandemic, and one of the main priorities for the next financial year is to reduce the number of pathways waiting over 2 years to zero and reduce the number of incomplete pathways waiting over 1 year as much as possible.

One way in which this may be achieved is through close working between providers in Lancashire and South Cumbria to utilise mutual aid and ensure all services are maximised.

Cancer standards

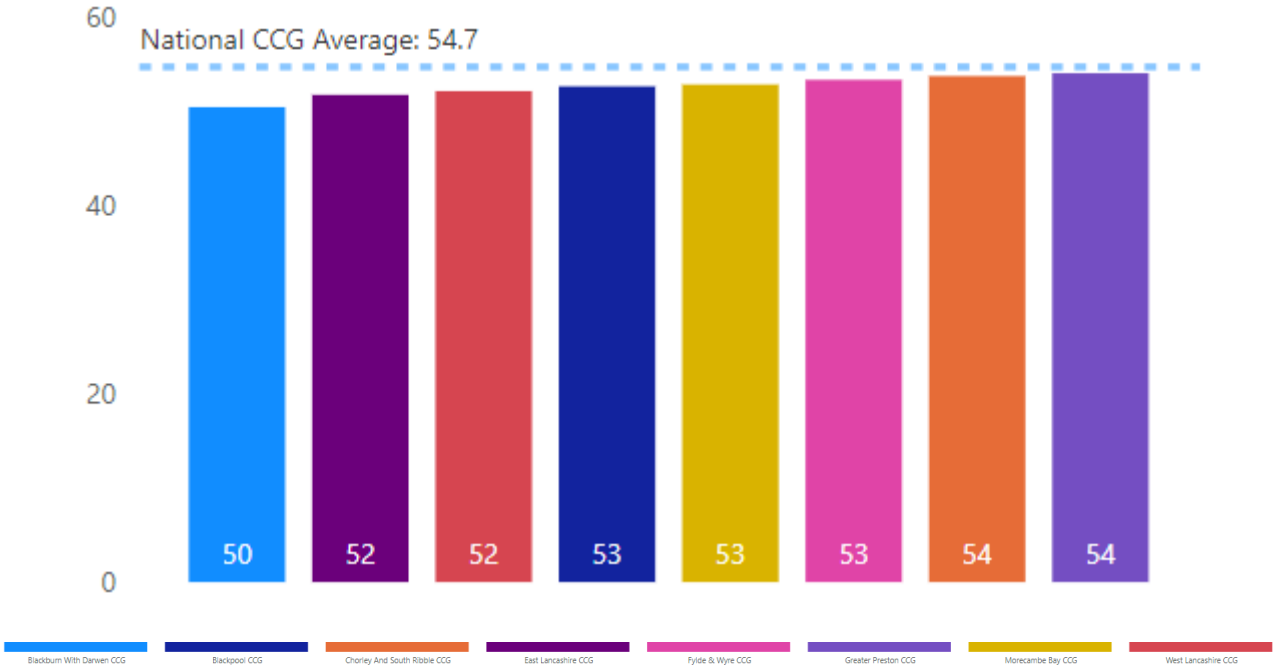
As part of the operational response to Covid-19, coordination of cancer services have been led by the Lancashire and South Cumbria Cancer Alliance. The Cancer Alliance have worked with each local hospital to transfer and move patients to ensure that every available treatment slot is maximised.

S012a: Cancer - % meeting faster diagnosis standard



Morecambe Bay CCG are currently meeting the national target of 75% of cancer pathways meeting the faster diagnosis standard (or patients having cancer diagnosed or ruled out within 28 days of urgent referral), and also have the highest proportion across all Lancashire and South Cumbria CCGs.

S015a – Cancer – proportion of cancers diagnosed at stages 1 or 2



All CCGs within Lancashire and South Cumbria ICS perform below the national average figure for proportion of cancers diagnosed at stage 1 or 2, with Morecambe Bay CCG scoring in the middle across the health system.

S014a: Cancer – proportion of people that survive cancer for at least one year after diagnosis

Organisation	Previous Value	Latest Value	.	Rank
Blackburn With Darwen CCG		72%	✗	82/97
Blackpool CCG		71%	✗	93/97
Chorley And South Ribble CCG		74.6%	✓	22/97
East Lancashire CCG		71.9%	✗	86/97
Fylde & Wyre CCG		74.1%	✓	32/97
Greater Preston CCG		74.5%	✓	26/97
Morecambe Bay CCG		75.9%	✓	11/97
West Lancashire CCG		74.5%	✓	26/97

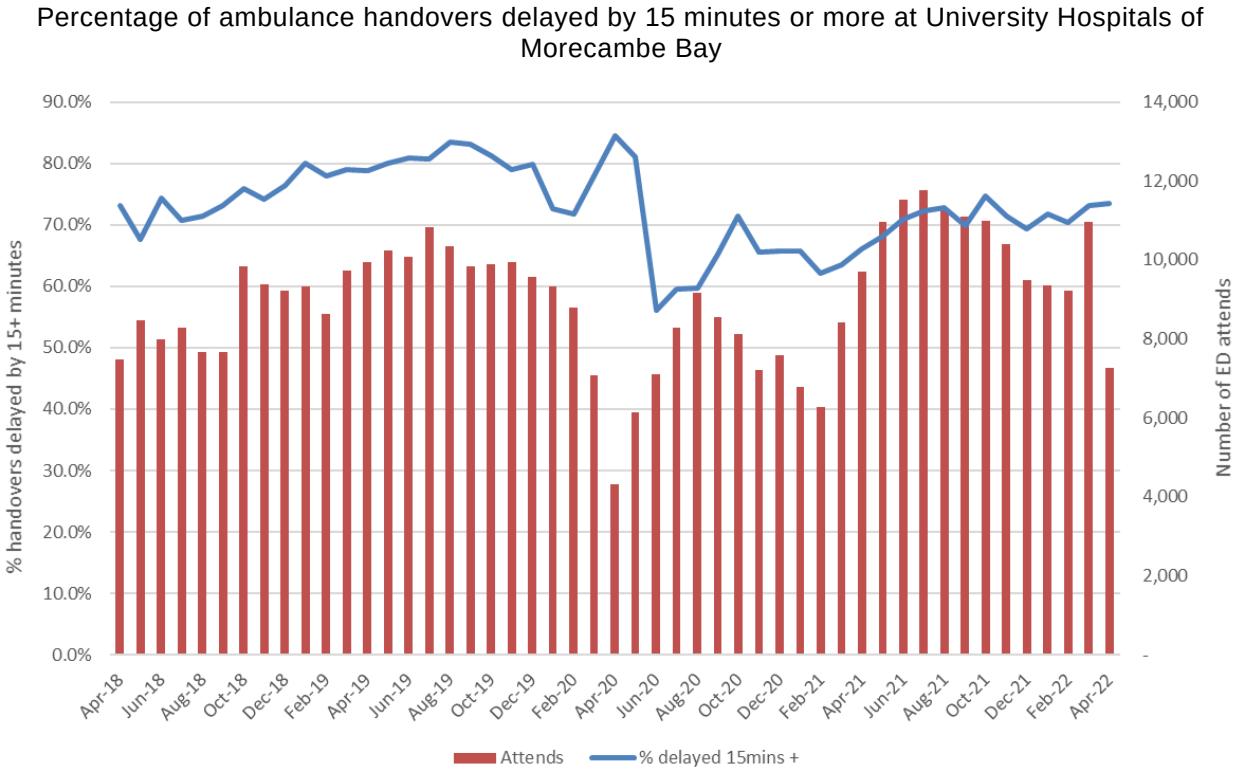
75.9% of Morecambe Bay CCG patients that are diagnosed with cancer survive at least one year from diagnosis, above the national average of 73.6%.

Urgent care

While most of the focus has been on treating COVID patients, or the recovery process of this, urgent care has continued to be an issue due to a significant increase in demand.

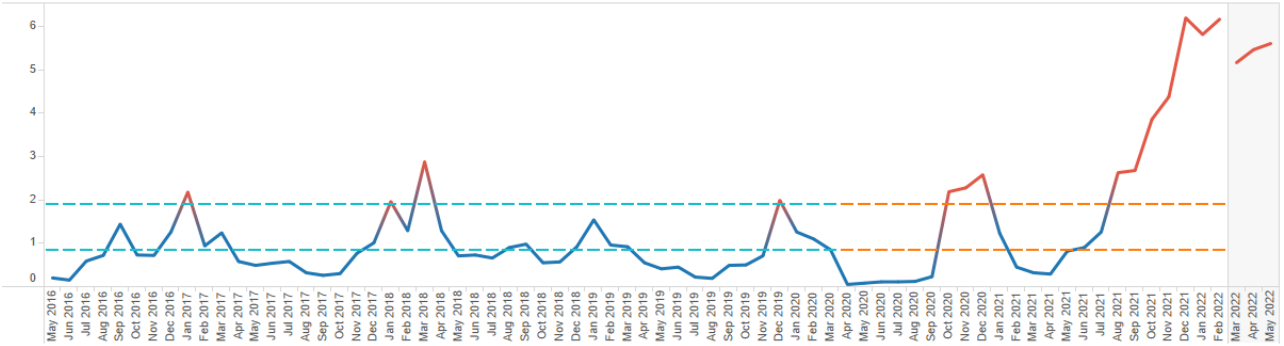
This can be seen in metrics that show the ability to get patients into either A&E departments, or admitted to a bed, and in metrics designed to show the ability to discharge patients from either of these settings.

This has been caused by a number of factors including staff absences and the availability of beds in care providers outside of hospital due to the pandemic.



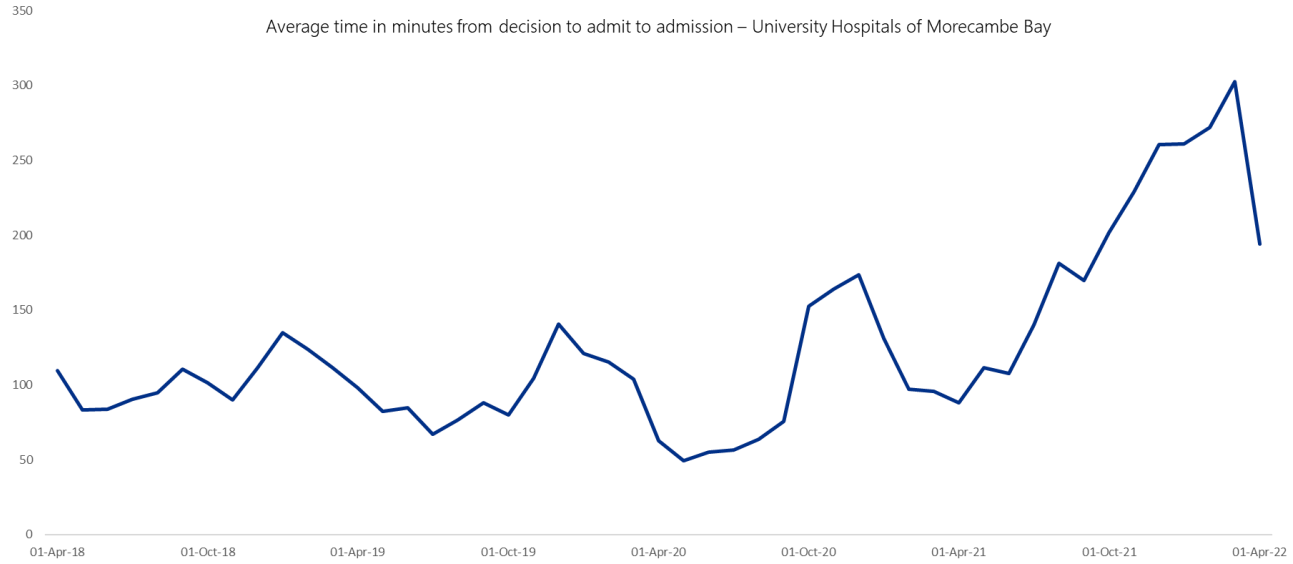
The proportion of ambulance handovers at A&E that are delayed by 15 minutes was steadily rising prior to the initial wave of COVID, with this coming alongside a steady increase in A&E attends. There was a sharp decrease in the proportion of delayed handovers in April 2020 when the number of arrivals decreased due to lockdown. Since then, the proportion of delayed handovers has increased steadily and is now similar to the proportion seen pre-COVID, although this is continuing to increase despite a recent decrease in the number of attends.

Percentage of A&E attenders waiting 12 hours or more from arrival to departure at University Hospitals of Morecambe Bay

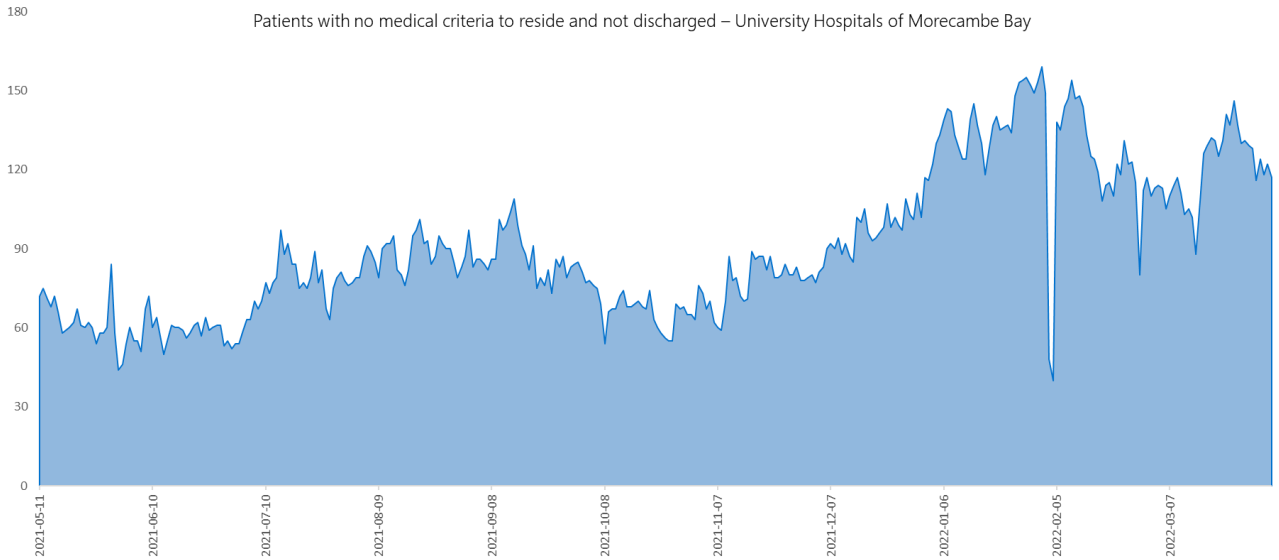


Once a patient is in an A&E department, the time it takes to leave the department is also increasing. The proportion of all A&E attendances that take 12 hours or more from arrival to departure (either discharge or admission) has increased substantially over the last year.

Once a decision has been taken by an A&E department to admit a patient into a hospital bed, the length of time it takes for the patient to be admitted has increased. This is due to staffing pressures and bed availability caused by isolation rules, infection prevention and control measures and the inability to discharge patients. In April 2022 the average time from decision to admit to admission was 194 minutes.



There are also issues with discharging patients, even those patients that are medically fit for discharge. The number of patients that reside in a hospital bed that have no medical right to reside has increased in recent months. This is due to staffing pressures in the hospital, care and social sectors, as well as care home closures caused by COVID outbreaks.



Engaging People and Communities

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

The system-wide programmes 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).

Morecambe Bay CCG engaged diligently with the population of south Cumbria in late 2021 in a consultation entitled Where would you like to be Cared for in South Lakeland. The conclusions from this consultation were taken to the CCG Governing Body meeting in February 2022 where one of four options to redesign services was supported. This option, to decommission all community beds on the Langdale Unit at Westmorland General Hospital and re-distribute resource into community staffing and a range of complementary services is now being developed.

Reducing health inequality - Population health management

Health outcomes for people living in Lancashire and South Cumbria, particularly in areas such as Barrow and Morecambe, 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%). We know that

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

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

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

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

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

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

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

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

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

Health and wellbeing strategy

The Cumbria Health and Wellbeing Board held 4 meetings during the financial year.

Morecambe Bay CCG is represented on the Board by the Director of Planning and Performance, Anthony Gardner. The Board Vice-Chair is CCG Clinical Chair, Dr Geoff Jolliffe.

Throughout the year the Board received reports from the NHS and partners working in health and care including those on the response to Covid-19, pressures across the health and care system, health and local government reform, the New Hospitals Programme and Special Educational Needs (SEND) improvement.

The Lancashire Health and Wellbeing Board held two meetings in the financial year receiving reports including those on Lancashire Health and Wellbeing Priorities, the strategic approach to care, health and wellbeing, the Healthy Hearts strategy, and Health Equity.

Clinical Commissioning Groups in Lancashire and South Cumbria are represented on the Lancashire Health and Wellbeing Board by Denis Gizzi, CEO Chorley and South Ribble and Greater Preston CCGs, who is the Deputy Chair of the Board.

Financial review

The Financial review can be found on page 44.

Accountability Report

Corporate Governance Report

Members Report

The Members Report details the information related to the Membership Council and the Governing Body. We are committed to being open and transparent and a register of interests is featured in the Annual Governance Statement.

Member practices of the CCG:

- Abbey Road Surgery
- Ash Trees Surgery
- Atkinson Health Centre
- Bay Medical Group
- Bentham Medical Practice
- Bridgegate Medical Centre
- Burnett Edgar Medical Centre
- Captain French Surgery
- Cartmel Surgery
- Central Lakes Medical Group
- Coniston Medical Practice
- Hoad Medical Practice
- Dr Murray and Partners
- Duddon Valley Medical Practice
- Duke Street Surgery
- The Family Practice
- Haverthwaite Surgery
- The James Cochrane Practice
- Lancaster Medical Practice
- Liverpool House Surgery
- Lunesdale Surgery
- Market Street Medical Practice
- Norwood Medical Centre
- Nutwood Medical Practice
- Park View Surgery
- Queen Square Medical Practice
- Risedale Surgery
- Sedbergh Medical Practice
- St Mary's Surgery
- Station House Surgery
- Waterloo House Surgery
- Windermere and Bowness Medical Practice

Member practice information is available on our website.

Membership Council

This is the overarching strategic body of the CCG, and each of the member practices based in the three localities of Morecambe Bay has nominated representatives. It brings together the voices of practices and their patients in setting the agenda.

The Membership Council also plays a role in holding elected executive members to account and holding CCG officers to account for the delivery of our priorities. Nominated representation from across general practice ensures that the depth and breadth of the patient voice is heard.

Governing Body

The role of the Governing Body is to provide assurance that we are compliant with our statutory obligations and that we meet public organisations' key national requirements for

governance. The Governing Body has oversight of committees such as the Audit Committee and the Quality Improvement Committee and will ensure that the key duties of the CCG are delivered.

The Governing Body is chaired by the CCG's clinical leader. It also contains seven local GPs (including the chair), a registered nurse member, a hospital consultant, four senior managers, and three lay members.

The primary role of the Governing Body is to ensure that we have appropriate arrangements in place to exercise our functions effectively, efficiently and economically and in accordance with CCG principles of good governance and the CCG Constitution.

Full details of the voting members of the Membership Council, and the Governing Body and its constituent committees, are contained in the Governance Statement.

Strategic Commissioning Committee

On page 13 of this Report we describe the formation of the Strategic Commissioning Committee, bringing together leaders to improve and transform health and care services. More information about the Committee can be found on the Boards and Committees section of the Lancashire and South Cumbria Integrated Care Partnership website.

Other relevant disclosures

The CCG has made no political or charitable donations during the year.

There are no important events since the end of the financial year which affect the CCG. The CCG does not have any branches outside the UK.

Pension liabilities

The CCG's treatment of pension liabilities in the accounts is detailed in Note 5.4 to the Annual Accounts.

External Audit

The CCG's external auditor is: KPMG LLP, One St Peter's Square Manchester, M2 3AE

The audit fee for 2021/22 is £79,800 (including VAT) and relates to the statutory audit and services carried out in relation to the statutory audit, including the Value for Money audit fee of £12,000 (including VAT). In addition, the CCG paid KPMG £4,800 (including VAT) for work carried out in respect of the implementation of IFRS.

Cost allocation and setting of charges for information

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

Disclosure of 'Personal Data Breaches or Incidents'

The Information Governance Framework ensures that all information, in particular person identifiable data related to patients, staff and corporate information, is handled in a confidential, secure, ethical and legal manner. We recognise the importance of appropriately managing information and keeping it secure and reporting any incident or breach.

The CCG has an IG Handbook and Information Governance Breach Reporting Standard Operating Procedure which set out staff responsibilities should they become aware of a

data security and protection breach. These also articulate the process for reporting IG incidents.

Information Governance incidents 2021/22

The CCG reported one breach of confidentiality however this was considered low level and therefore not reportable to the ICO.

Statement as to disclosure to auditors

Each individual who is a member of the Governing Body 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 external auditor is unaware that would be relevant for the purposes of their audit report.
- That the member has taken all the steps that they ought to have taken as a member in order to make themselves aware of any relevant audit information and to establish that the CCG's auditor is aware of that information.

Jerry Hawker
Accountable Officer
22 June 2022

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHEI). NHSEI has appointed the Chief Officer to be the Accountable Officer of NHS Morecambe Bay CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the CCG 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 Section14R of the National Health Service Act 2006 (as amended)).
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHSEI has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and Social Care and in particular to:

- Observe the Accounts Direction issued by NHSEI , 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 Group Accounting Manual issued by the Department of Health and Social Care have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and,
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and

Accounts and the judgements for determining that it is fair, balanced and understandable.

To the best of my knowledge and belief, and subject to the disclosure 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

Jerry Hawker
Accountable Officer
22 June 2022

Governance Statement

Introduction and context

NHS Morecambe Bay CCG is a body corporate established by NHS England on 1 April 2013 as NHS Lancashire North (the CCG's name at that time) changed to NHS Morecambe Bay CCG 1 April 2017 under the National Health Service Act 2006 (as amended).

Our statutory functions are set out under the National Health Service Act 2006 (as amended). Our general function is arranging the provision of services for persons for the purposes of the health service in England. We are, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population. As at 1 April 2019, we were not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

We were licensed from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006. As at 1 April 2019, we continued to be licensed without conditions.

Scope of responsibility

As 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 CCG 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.

Compliance with the UK Corporate Governance Code

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 good practice. This Governance Statement is intended to demonstrate how the CCG had regard to the principles set out in the Code considered appropriate for CCGs.

The CCG Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L (2) (b) states:

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

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

organisation, to ensure that decisions are taken in an open and transparent way and that our patients' and public's interests always remain central to our goals.

It applies to all of our members, to our employees, and to anyone who is a member of our Membership Council, CCG Governing Body, its committees, joint committees, sub-committees or anyone else acting on behalf of the CCG. Together we work within our resources to commission care in the most appropriate setting with the aim of our patients having the best experience and the best clinical outcomes from that care. The Constitution document is available on our website.

Governance and committee arrangements include:

- Membership Council
- Governing Body
- Audit Committee
- Executive Committee
- Remuneration and Terms of Service Committee
- Quality and Improvement Committee
- Primary Care Commissioning Committee.

Management assurance to the Membership Council is through the Governing Body and its sub committees, whilst independent assurance is through the Audit Committee.

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

- Having codes of conduct for the Governing Body and sub-committee members showing mutual trust, respect and honesty. Members of the CCG Governing Body adhere to the seven principles of Public Life (Nolan Principles)
- All CCG staff follow a code of professional conduct which sets out the behaviours expected. These are based on values of respect, empowerment, empathy, trustworthiness, integrity and justice
- All committees authorised by the Governing Body are accountable to the Governing Body. Each committee is responsible for approving and for keeping under review the terms of reference and membership of each of their committees.

Membership Council

This is the overarching strategic body of the CCG, bringing together the voices of practices and their patients in setting the agenda.

Functions of the Membership Council include:

- approving the CCG's Constitution and proposed changes to the Constitution
- making arrangements for members joining and leaving the CCG
- approving the appointment of:
    i. the chair of the Governing Body
    ii. clinicians to represent member practices on the Governing Body
    iii. all other Governing Body members

- determining the remuneration and travelling or other allowances of members of its Governing Body, who are not employees of the CCG
- jointly publishing with the Governing Body, the CCG's Annual Report and Annual Accounts
- holding the Governing Body members, both individually and collectively, to account for the performance of the Governing Body
- influencing the recommendations and decisions of the Governing Body's Executive Committee in respect of the CCG's commissioning and related plans
- agreeing initiatives for implementation by member practices to improve the quality and outcomes of patient care and better use of resources
- contributing towards the goals of the CCG as set out in its commissioning and financial plans
- approving an application by the CCG to enter into a merger, separation or dissolution.

There were no meetings held during 2021/22.

Voting members of the Membership Council

Member Practice	Name
Abbey Road Surgery	Dr Arun Thimmiah
Ash Trees Surgery	Dr Chris Coldwell Dr David Wrigley
Bay Medical Group	Dr Muhammad Akhtar Dr Andy Maddox
Bentham Medical	Dr Louise Morgan
Bridgegate Medical Centre	Dr Lauren Dixon
Captain French Surgery	Dr Shawn Gibson
Cartmel Surgery	Dr Julie Colclough
Lancaster Medical Practice	Dr Duncan Hallam Dr Rahul Keith
Norwood Medical Centre	Dr Sarah Arun
Nutwood Surgery	Dr Hugh Reeve
Park View Surgery	Dr Jim Hacking
Sedbergh Medical Centre	Dr William Lumb
Station House Surgery	Dr Susan Frost
St Mary's Surgery	Dr Daniel Hughes
Stoneleigh Surgery	Dr Andy Knox

Declarations of interest are noted on an annual basis and published on our website.

Governing Body

The Governing Body has oversight of committees such as the Audit Committee and the Quality Improvement Committee and will ensure that the key duties of the CCG are delivered.

Its primary role is to ensure that appropriate arrangements are in place to exercise our functions effectively, efficiently and economically and in accordance with CCG principles of good governance and the CCG Constitution.

The Governing Body also leads and approves the setting of the CCG vision and strategy and its annual commissioning and financial plans, arrangements for financial and risk management and jointly publishing, with the CCG Membership Council, the CCG Annual Report and Annual Accounts.

The main focus of the Governing Body includes:

- ensuring the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with CCG principles of good governance (its main function)
- determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG, including nominated practice representatives, and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act
- approving any functions of the CCG that are specified in regulations
- discharging all of the CCG's remaining statutory functions (with the exception of those functions reserved to the CCG Membership Council).

There were five meetings held during 2021/22.

Voting members of the Governing Body who attended and voted

Position	Name	Number of meetings attended	% attendance over the year
GP Executive Lead – Commissioning	Dr Sarah Arun	3 out of 5	60%
Lay Member	Mike Bone	5 out of 5	100%
GP Executive Lead – Primary and Community Care	Dr Lauren Dixon	0 out of 5	0%
Chief Operating Officer	Hilary Fordham	4 out of 5	80%
Director of Planning and Performance	Anthony Gardner	4 out of 5	80%
GP Executive Lead – Urgent Care and Mental Health	Dr Jim Hacking	4 out of 5	80%
Chief Finance Officer	Andrew Harrison	5 out of 5	100%
Chief Officer	Jerry Hawker	5 out of 5	100%

Lead Nurse Quality and Head of Safeguarding	Jane Jones	5 out of 5	100%
Clinical Chair	Dr Geoff Jolliffe	4 out of 5	80%
GP Executive Lead – Quality and Performance	Dr Rahul Keith	4 out of 5	80%
GP Executive Lead – Population Health	Dr Andy Knox	4 out of 5	80%
Lay Member	Hazel Parsons	4 out of 5	80%
Secondary Care Doctor for the Governing Body	Dr Andrew Severn	5 out of 5	100%
Lay Member	Clive Unitt	5 out of 5	100%
Lay Nurse	Margaret Williams	5 out of 5	100%

Declarations of interest are recorded annually and published on our website.

Committees of the Governing Body

The following have been established as committees of the Governing Body. The minutes of these committees are submitted to the Governing Body once ratified by the committee.

Audit Committee

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 in relation to finance.

The Audit Committee also reviews the effectiveness of the system of governance, risk management and internal control, incorporating the arrangements for the Membership Council and the arrangements made by the CCG for managing conflicts of interest, whistle blowing and fraud (both clinical and non-clinical).

There were four meetings held during 2021/22.

Voting members of the Audit Committee who attended and voted

Position	Name	Number of meetings attended	% attendance over the year
Lay Member and Chair	Clive Unitt	4 out of 4	100%
Lay Member	Hazel Parsons	4 out of 4	100%
Secondary Care Doctor for the Governing Body	Dr Andrew Severn	3 out of 4	75%

Executive Committee

The Executive Committee is charged with delivering the routine work of the CCG. The committee is made up of four elected clinical members of the Governing Body, the Chief Officer, Chief Finance/Director of Governance, Chief Commissioning Officer, Chief Nurse and Clinical Chair.

The functions of the Executive Committee include:

- Ensuring there is continuous engagement with the CCG's membership and that

members' views influence and inform the development of commissioning priorities plans, and arrangements for their implementation

- Recommending the CCG's two year, five year and annual commissioning and financial plans to the Governing Body and demonstrating that:
    - plans are informed by patients and the public and that they are patient-centred
    - they are effective, efficient and economic
    - the Committee has oversight of the delivery of those plans and ensures that risks associated with delivery are being mitigated.
- Reviewing the CCG's governance requirements and legal duties and ensuring compliance; maintaining operational oversight of the CCG's responsibilities, including organisational development, and ensuring that regular reports are provided to the Governing Body on the CCG's operational and risk management
- Providing assurance to the Governing Body that the CCG's collaborative arrangements are being discharged in accordance with the arrangements approved by the Governing Body.

There were 21 meetings held during 2021/2022.

Voting members of the Executive Committee who attended and voted

Position	Name	Number of meetings attended	% attendance over the year
Clinical Chair	Dr Geoff Jolliffe	18 out of 21	86%
GP Clinical Executive	Dr Sarah Arun	15 out of 21	71%
GP Clinical Executive	*Dr Lauren Dixon	15 out of 21	71%
Chief Operating Officer	Miss Hilary Fordham	18 out of 21	86%
Director of Planning and Performance	Mr Anthony Gardner	19 out of 21	90%
GP Clinical Executive	Dr Jim Hacking	20 out of 21	95%
Chief Finance Officer/Director of Governance (from 1/8/20)	Mr Andrew Harrison	20 out of 21	95%
Lead Nurse Quality and Head of Safeguarding	Jane Jones	18 out of 21	86%
GP Clinical Executive	Dr Rahul Keith	20 out of 21	95%
GP Clinical Executive	*Dr Andy Knox	14 out of 21	67%

***** In order for Dr Lauren Dixon and Dr Andy Knox to concentrate on their other roles as Clinical Chief Integrated Services and Director of Population Health and Engagement respectively, the Executive Committee have agreed it was acceptable for them to attend whenever their diaries allowed.

Remuneration Committee

The Remuneration Committee makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees, and for people who provide services to the CCG, and on determinations about allowances under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme.

Where the Audit and Remuneration Committees review or advise on matters which concern the functions of the Membership Council, they will report directly to the Membership Council.

There were two meetings held during 2021/22.

Voting members of the Remuneration Committee who attended and voted

Position	Name	Number of meetings attended	% attendance over the year
Lay Member and Chair	Clive Unitt	2 out of 2	100%
Lay Member	Mike Bone	2 out of 2	100%
Lay Member	Hazel Parsons	1 out of 2	50%
Secondary Care Doctor for the Governing Body	Dr Andrew Severn	2 out of 2	100%

Quality Improvement Committee

The Quality Improvement Committee provides assurance to the Governing Body that the services the CCG commissions are safe and effective, that quality and patient experience are central to our work and that there is continuous improvement in the quality of commissioned services and patient outcomes. This includes robust arrangements to ensure partnership working to support the wellbeing of children and vulnerable adults and that the CCG meets its statutory functions in relation to safeguarding.

Through the CCG's established assurance processes, the Quality Improvement Committee has received unique insights into how local providers deliver effective care. This has included review and consideration of local clinical service user intelligence, early warning systems and performance and quality information. Information has then been triangulated with patient stories, service delivery, deep dive of risks recorded on the Assurance Framework and Corporate Risk Register, Clinical Audit and Clinical Effectiveness. This approach has enhanced the Committee's ability to ensure that what we learn from people's experiences of care is at the centre of our work.

When poor care delivery is reported, we have systems, processes and responses in place that seek to promptly correct the problems and minimise the impact on patient care, and to ensure that the commissioned services respond in a timely and effective manner to address concerns. During the Covid-19 pandemic, we have adapted our approach to be responsive to quality concerns and when required to undertake quality visits remotely and in collaboration with partners across the ICP. Site visits resumed during Q3 2021'22. The CCG continue to monitor and respond to quality concerns and seek assurance of improvement actions through a variety of measures including, triangulation of intelligence and incident reports, patient experience feedback, performance and quality data and assurance visits including specific deep dives across speciality areas. Assurance and agreed improvement measures are reported through current governance structures and

for speciality level deep dives which include a heat map report setting out CCG assurance position. This has continued to provide assurance that our commissioned services have implemented actions and learning to ensure a cycle of continuous improvement.

Committee members continue to gain momentum both individually and collectively as system leaders, maturing our relationships with Bay Health and Care Partners to identify areas for improvement in line with agreed ICB and BHCP priorities. Over the past year, the committee has continued to oversee a number of quality assurance initiatives as well as supporting the continued Covid-19 priorities. Examples have included the support for our regulated care providers in relation to outbreak management and market fragility, UHMBT assurance work following a number of published external reviews, primary care quality reviews, access to testing and roll out of the Covid-19 mass vaccination programme. The CHC framework was reinstated nationally and the CCG has been working with partners to support recovery and restoration of the IPA provision to meet national requirements in ensuring a high level and timely response for individual patient activity has remained a priority.

The CCG has undertaken targeted assurance work specific to UHMBT following a number of internal and external reviews and CQC inspection outcomes during 2021.The CCG has, as part of its statutory function but also in a supportive capacity, been engaged with the Recovery Support Programme and NHSE established System Improvement Board.

Bay Health Care and Partners Quality and Performance Committee are reviewing quality priorities for Morecambe Bay, in line with the National Quality Board priority areas. There continues to be focus on collaborative assurance of quality across Bay Health and Care Partners. We aim to drive quality improvement through co-design and redesigning of work processes, systems and pathways that future-proof the delivery of better ‘value’ outcomes.

Our strategic quality approach is underpinned by the CCG Assurance and Accountability Framework which sets out agreed accountability arrangements associated with all our services, our population and our workforce. We will continue to measure our compliance and progress against the NHSEI Oversight Framework. The framework was reviewed and updated in Q4 2021’22 to reflect governance arrangements for Provider assurance which will change as NHS reform progresses and an ICB Quality Assurance Framework will be developed as the CCG transitions to new structures.

We aim to continue to build the quality and patient safety expertise of our Committee members, ensuring that systems and processes enable commissioning decisions to take into full account the quality of care received. We will continue to build local intelligence to drive improvement, and demonstrate continued improved outcomes for the care commissioned by the CCG on behalf of our population.

A key area of focus going forward will be implementation of the Patient Safety Incident Response Framework (PSIRF) which is part of the Patient Safety Strategy. MBCCG has been working closely with one of the early adopter sites for the PSIRF to receive peer support and guidance through the process. MBCCG will continue to engage with and support providers, as appropriate, as we plan our road map to the rollout and is engaging with Providers with early planning and engagement.

Over the last few years the Morecambe Bay Health Economy has collaboratively been working to enrich quality improvements, address quality variation and the impact of failing standards. We need to collectively be in a position to evidence that learning is embedded and how cultural change, openness, clinical engagement, transparency and partnership working will improve the experiences and outcomes for our population. In the coming year, we will maintain our statutory functions of the CCG while recognising reform. CCG Quality

responsibilities will transition into the receiving organisation as of July 2022. Pre and post transition, quality oversight and governance will be maintained both at CCG place and at ICB level. A register of 'live' Morecambe Bay quality issues will be handed over to the receiving organisation and at the point of transition. Work is now underway to agree relevant metrics and quality outcomes to support management of our priorities and ensure integrated delivery planning takes place to determine the key actions required to deliver against the priorities in 2022/23.

As system reforms evolve, our focus will be to engage with and incorporate emerging ICB quality and safeguarding priorities into the local place-based assurance. Our ambition is sustained improvement that will benefit the population, by operating within a high-trust environment, offering inclusiveness and appropriate challenge. We aim to work within a culture of openness that uses incidents and issues as system learning opportunities, collectively recommending delivery actions to maintain safe care and ensuring that they are considered and acted upon in a timely way. We will achieve this through development of a Bay Health and Care Partners Quality Strategy, with clear objectives for sustained improvement and ensuring commitment and capacity to apply our framework for improvement.

An ICB statutory framework for Quality is expected during 2022 and a quality model for Lancashire and South Cumbria is being developed.

There were five meetings held during 2021/22. An additional meeting was held in March to present initial closure reports and positional status against due diligence requirements in relation to quality governance and CCG Close Down.

Voting members of the Quality Improvement Committee who attended and voted

Position	Name	Number of meetings attended	% attendance over the year
Lay Member and Chair	Mike Bone	5 out of 5	100%
Senior Manager Corporate Services	John Barbour	4 out of 5	80%
Head of Quality	Sue Bishop	4 out of 5	80%
Director of Planning and Performance representing the Chief Finance Officer	Anthony Gardner	5 out of 5	100%
Chief Finance Officer/Director of Governance	Andrew Harrison	Director of Planning and Performance representing the Chief Finance Officer	
Lead Nurse Quality and Head of Safeguarding	Jane Jones	5 out of 5	100%
GP Executive Lead – Quality and Performance	Dr Rahul Keith	4 out of 5	80%
Lay Member	Hazel Parsons	5 out of 5	100%
Secondary Care Doctor	Dr Andrew Severn	5 out of 5	100%

for the Governing Body			
Lay Nurse	Margaret Williams	3 out of 5	60%

Primary Care Commissioning Committee

The Joint Committee of Lancashire North CCG and NHS England is responsible for commissioning primary medical services under section 83 of the NHS Act, except those relating to individual GP performance management, which have been reserved to NHS England.

There were five meetings held during 2021/22.

Voting members of the Primary Care Commissioning Committee who attended and voted

Position	Name	Number of meetings attended	% attendance over the year
Lay Member and Chair	Hazel Parsons	5 out of 5	100%
Lay Member	Mike Bone	5 out of 5	100%
Senior Finance Manager representing the Chief Finance Officer	Michael Cleary	5 out of 5	100%
Chief Operating Officer	Hilary Fordham	5 out of 5	100%
Director of Planning and Performance representing the Chief Finance Officer	Anthony Gardner	5 out of 5	100%
Lead Nurse Quality and Head of Safeguarding representing Chief Executive Nurse	Jane Jones	1 out of 5	20%
Secondary Care Doctor for the Governing Body	Dr Andrew Severn	5 out of 5	100%

Declarations of interest are noted on an annual basis and published on our website

Risk Management

Risk management arrangements and effectiveness

During 2021/22 and ongoing Covid-19 pandemic respond, the National Command and Control Structure remained in place. As part of core business requirements, risk reporting continued throughout the financial year to ensure Governing Body continued to receive assurance regarding identification and management of organisational risk alongside the effectiveness of mitigating actions and controls. As a consequence, planned development work to further enhance risk mitigation and communication across Morecambe Bay was further delayed.

The CCG High Level Risks are recorded within the Assurance Framework that records risk against the CCG delivery of its triple aim objectives. The Corporate Risk Register records risk associated with the delivery of the CCG's statutory functions and clinical workstreams.

The reporting format enables:

- Clearer risk descriptors
- A concise matrix that visually demonstrates initial, current and target risk level trends
- The risk ratings set against each risk will form part of performance monitoring. The difference between the initial, current and target risk will act as a proxy measure of improvement and will support to direct and or review improvement action as appropriate
- Identification of risk appetite
- The identification of the relevant Assuring Committee
- A structured layout that enables easy identification of assurance, control and actions
- An assurance heat map that details where each risk falls on the scoring matrices utilising a visual grid methodology.
- Ahead of CCG Closedown and transition into the Integrated Care Board (ICB), an additional transition gateway date has been identified against each risk which provides the anticipated risk level at the point of CCG close down and transition.

Formal review of the Assurance Framework has been postponed during 2020/21 and 2021/22 due to ongoing pressures resulting from the Covid Pandemic response. This has resulted in elevation of the NHS National Emergency level and resulting impact on the operating environment. The Morecambe Bay CCG Assurance Framework risks are currently aligned against the Triple Aim objectives for Bay Health Care and Partners.

During 2021/22, Executive Committee, Audit Committee and Governing Body members have continued to be sighted on the identified organisational risks and scrutiny of these has been maintained through formal reporting structures, with agreement that the Assurance Framework continues to represent the current organisational risk profile.

Capacity to Handle Risk

Each risk has a named Senior Responsible Offer and a Senior Manager or Executive Lead responsible for the maintenance of the risk plan, providing updates and escalation of risk actions required. Risk escalation processes sit across a number of areas and are in place to facilitate a prompt response, they include raising opportunities across:

- Director Management Group
- Verbally into Chairs of committees / groups
- Via Risk review process
- Part of the ‘deep dive’ discussions
- Operational Groups
- One-to-ones with staff teams.

Additionally, each risk is allocated to a committee / group to oversee the management of the risk. It is the responsibility of the Senior Risk Owner to ensure that the risks are placed on the appropriate meeting agenda for discussion as part of the review process. It should be noted that a number of Assuring Committees were temporarily stood down during 2020/21 and 2021/22 due to the Covid-19 pandemic response work, but identified Executive Leads and Senior Managers have continued to review and update the risks to ensure they are reflective of the current position in terms of assurance, mitigating actions and risk movement.

For 2021/22 and where feasible, committee administrators have continued to receive a schedule of when risks needed to be discussed in which forum and given dates to align to monthly updates. It is proven that this increases the ownership of risk, removing duplication of effort and improved efficiency.

Risk Appetite is the level, amount or degree of risk that the CCG or a particular delegated authority is willing to accept. Risk Appetite is measured through the CCG Risk Maturity Matrix and it will also support each specific CCG committee and groups to address the committee’s risk information needs more accurately.

The Chief Finance Officer and Director of Governance is responsible for advising the Audit Committee on all matters relating to risk management. This includes ensuring the Audit Committee receives assurance of the group’s processes relating to the Assurance Framework and Corporate Risk Register, and that risk registers are in place and maintained to support the group’s discharge of its statutory functions.

Risk Management Methodology

The CCG is aware that risk needs to be managed within a number of interdependencies and constraints on the CCG:

- To deliver against the NHS Long Term Plan
- Delivery of the NHS constitutional targets
- Statutory duties as per the Health and Social Care Act 2012
- CCG NHS Oversight Framework
- CCG delivery plan and priorities
- Achievement of the CCG’s triple aim objectives
- To commission services that can recruit workforce and change the care environment in which our workforce work.

It is important that the Governing Body understands what and how the level of risk is being managed. The Governing Body needs to understand the short-term actions, medium- and long-term trajectories that are being worked towards. Assurance is provided to the Governing Body that all risks in relation to the achievement of the CCG Strategic Objectives have been identified and are being monitored and managed appropriately. Quarterly reporting to Governing Body has continued throughout 2021/22.

The Audit Committee is responsible for providing assurance to the Governing Body in relation to the existence, suitability and robustness of risk management systems across the CCG. The Chief Finance Officer also ensures risk management systems are in place throughout the CCG, oversees the management of all risks and ensures that the CCG Assurance Framework and Risk Register is regularly reviewed and updated.

The Assurance Framework and Risk Register documents are reviewed by the Audit Committee on a quarterly basis. In this process critical changes are ratified, including discussion relating to risks that may require transfer from the Risk Register to the Assurance Framework.

Executive Committee continues to have oversight of the Risk Management process, including quarterly update reports, to ensure the organisation is demonstrating commitment to the continuous improvement of risk management practice by those CCG groups and committees who have key responsibilities for risk mitigation.

The approach provides a simple but comprehensive method for the effective and focused management of risks that arise in meeting strategic objectives and delivering core operational functions. This also provides a structure for evidencing successful in-year delivery and therefore support the Annual Governance Statement.

Safeguarding

The CCG has statutory responsibility for safeguarding roles and functions in accordance with the NHS Accountability and Assurance Framework (2019), Children and Social Work Act (2017), Working Together to Safeguard Children (2018), Promoting the Health and Well-being of Children Looked After (2015) and the Care Act (2014). It remains the responsibility of every NHS-funded organisation and each individual healthcare professional working in the NHS to ensure that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied, with the wellbeing of those adults and children at the heart of what we do. For adult safeguarding, this also needs to respect the autonomy of adults and the need for empowerment of individual decision making, in keeping with the Mental Capacity Act (2005) and its Code of Practice.

As commissioners of local health services, CCG's need to assure themselves that the organisations from which they commission services have effective safeguarding arrangements in place. Standard arrangements for safeguarding assurance for Morecambe Bay CCG include assurance visits, Safeguarding Standards Audit, Section 11 Audit and attendance at provider safeguarding performance and operational committees. This also includes the Regulated Care Sector and Primary Care.

Due to the footprint of Morecambe Bay, the CCG is a safeguarding partner in both the Cumbria and Lancashire arrangements, as well as contributing to North Yorkshire partnership arrangements for those adults, children and families living on the border. The Safeguarding team has maintained full representation at Cumbria and Lancashire Safeguarding Adults Board's, Safeguarding Children's Partnership and associated sub group meetings, as required to fulfil its commissioning and statutory safeguarding responsibilities. The CCG Safeguarding Team also contribute to the North Yorkshire arrangements.

The CCG submits an annual Safeguarding Self-Assessment to provide assurance of its arrangements to NHSE/I, as well as to the Adult Boards and Children's Safeguarding Partnership's. This year has seen the move to an online live Safeguarding Commissioning Assurance Toolkit (S-CAT). Morecambe Bay CCG declared full compliance this year and

are due to publish a comprehensive Annual Safeguarding Report to reflect such activity.

The CCG's Safeguarding Team is part of the Lancashire and South Cumbria ICS Safeguarding system, which has further evolved with the formation of a single Safeguarding Health Executive to streamline decision making, agree key actions and strengthen partnership working. Over the last 12 months these new ways of working have been the focus for the Safeguarding Health Executive Lead and the Designate leads of all CCG's; we have made great strides in strengthening our safeguarding governance and reporting structure, inclusive of wider partnership arrangements. These arrangements places us in a strong position to move forward in to the ICB.

On the 24th March, the ICS Safeguarding System were proud to be able to showcase our achievements to the National Safeguarding Team when they conducted a visit to Lancashire and South Cumbria. With an underlying theme and focus on trauma informed practice, presentations were given on our Violence Reduction Partnership work, Self-Neglect, Contextual Abuse, Domestic and Sexual Abuse. The National team took away some significant headlines, not only the brilliance of colleagues, teams and partnership working but a deep understanding of what is needed to improve lives across our communities.

We have engaged in several initiatives across Lancashire and Cumbria to influence safeguarding practice, particularly for children and adults who are most vulnerable, including Looked After Children. These include:

- responding to new statutory requirements, specifically the new Domestic Abuse Act and the Mental Capacity Amendment Act, which includes the Liberty Protection Safeguards
- continuing with our commitment to the Learning Disabilities Mortality Review (LeDeR) programme. We have strengthened local governance through placed base LeDeR steering group, which seeks assurance surrounding implementation of learning form reviews
- being a key member of a strategic partnership group to deliver Safer Sleeping and ICON (abusive head trauma) messages to Primary Care, including an e-learning package, resource library and template for the EMIS clinical system
- jointly leading on the development of a single ICS Service specification and Health Strategy for Looked After Children and Care Leavers
- being key members of strategic partnership groups to deliver Neglect workstreams, which includes the development of strategies, thematic audits and a review of training offers to our workforce.

Covid-19 has continued to place extreme pressures across all systems, with an evidential increase in complexities of cases as a result of not only hidden harm but the longevity of the pandemic. Our key NHS providers and Primary Care have maintained a clear focus on safeguarding throughout the pandemic, and it is positive that they have continued to work closely with the CCG's in putting in mitigation and support where needed. Where there have been complex or challenging situations, virtual working has allowed additional flexibility and timeliness in our ability to respond locally and as a system.

Risk assessment

Our approach to risk management encompasses the breadth of the organisation by considering financial, organisational, and reputational and project risks; both clinical and non-clinical; and for all parts of the organisation involved. Risks are assessed in

accordance with our Risk Management Strategy and Procedures. Risks are identified from several sources, including the senior commissioning managers, who hold their own risk issues log.

When operational issues cannot be managed, or new risks are identified, the Risk Register is completed, and a risk rating assigned according to the severity and likelihood and any existing controls in place. A decision is then made, initially via the Senior Management Team and nominated responsible Executive Lead, as to the most appropriate course of action for managing the risk. The Audit Committee considers risks requiring transfer to the Assurance Framework. During the reporting period risks were identified from a variety of sources, including:

- Complaints and incidents
- Internal and external audit reports
- Commissioner meetings
- Risk issues identified and managed by or through CCG committees and groups
- Membership Council
- Governing Body.

The CCG operates two systems to facilitate the management of risk throughout the organisation:

- Proactive risk management via the risk assessment process (Health and Safety Policy: Guidance on Carrying out Risk Assessments and Populating Risk Registers)
- Reactive risk management via incident reporting, investigation, the learning of lessons and the consequent changing of practice (Health and Safety Policy: Untoward Incident Reporting and Investigation, Serious and Untoward Incident Policy).

We manage risks via the operation of a number of interconnected risk issues logs and a corporate risk register which holds risks which are noted to have a multi-faceted impact.

In accordance with the Risk Management Strategy and Policy, new risks identified for inclusion on the risk register are assessed for their likelihood and consequence using the 5x5 risk matrix. As part of the identification of the risks from various sources, the following significant risks (i.e. those risks that score 12-plus on the risk matrix). One new 12-plus risk was raised on the Board Assurance Framework during 2021/22.

Delivery and adherence to risk management arrangements is the responsibility of everyone within the organisation and every individual staff member has the right to identify any potential or actual risk for service users, staff and the organisation. This is supported by dedicated resources to support managers and staff to ensure compliance with the organisation's risk management requirements.

Examples of where the target risk has been managed and met over the course of the year

Reference	Risk Description	Status
AF206	The end of the EU Exit Transition period 31/12/20 (whether deal or no deal) may present adverse or unexpected challenges for the provision & maintenance of healthcare across	Target risk level achieved during Quarter 1 2021/22

	Morecambe Bay	
RR205	Gaps in service due to capacity in NCIC Strengthening Families service leads to Looked After Children and CYP with safeguarding risks not receiving appropriate care, especially those placed in Cumbria from out of area.	Target risk level achieved during Quarter 2 2021/22

Risk Management Strategy and Policy

The CCG Risk Management Strategy and Policy reflects processes and ensures that the principles, processes and procedures for best practice risk management are consistent across the organisations and fit for purpose. It outlines our appetite for risk, attitude towards risk, and the culture that will underpin its successful management and delivery. This ensures that both a systematic and consistent approach to managing risk is adopted throughout the organisation.

During 2021/22, the CCG Risk Management Strategy and Policy was reviewed and updated, resulting in v0.14 which has been published on the CCG website. Changes to the policy were minimal but reflected inclusion of a Fraud and Bribery statement.

The current version of the Risk Management Strategy and Policy can be accessed via our website.

The Risk Management Strategy and Policy articulates the foundations that integrate governance and quality processes across the organisation

Internal Control Framework

A system of internal control is the set of processes and procedures in place to ensure we deliver our 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.

We utilise the key elements of our Risk and Internal Control Framework to secure assurance for the prevention, deterrent and management of risks, as outlined within our Risk Management Strategy and Policy. The Strategy and Policy include details of the criteria used to assess risk and the governance process used to ensure that risks are controlled and escalated where necessary. This enables the CCG to recognise, manage and brief the Governing Body on significant risks and controls as required. We involve key partners and stakeholders in the identification and management of risks.

They state how the CCG:

1. Defines and documents the roles and responsibilities of the Governing Body, Executive and Lay Members, including the scrutiny and Accountable Officer functions, with clear delegated arrangements and protocols for effective management, provision and communication of risk

This is done by:

- Clearly setting out the rules for the Governing Body, Executive and Audit Committees

- Providing strategic management through the Senior Managers and quarterly reporting of high-level risks as required into the Executive Team
- The Executive Committee receive regular reports on quality concerns, budgets, progress of improvement programmes, risks, controls and mitigation
- After each update, all staff are reminded of its presence and the process of the update. New risks are identified outside the reviews, mainly through established risk management processes, commissioning managers and team discussions.

2. Captures risk, using the agreed reporting template, to aid the discussion with Committee Members, ensuring the quality and experience of Morecambe Bay CCG's resident population is of a consistently safe and high standard, and that services are accessed and delivered in accordance with CCG objectives and outcomes

This is done by:

- Using a range of soft intelligence feedback mechanisms, including a weekly assurance group, incident reporting, Commissioner Group and one-to-one meetings with key stakeholders
- Ensuring rigorous provider contract quality governance and reporting processes, including early warning triggers and escalation process
- Delivery of CCG quality improvement measuring success through performance indicators based on recognised improvement methodology
- Engaging with the public
- Being an active member in stakeholder meetings, including Lancashire and South Cumbria wide Quality Surveillance and Assurance Groups, Lancashire Safeguarding Children and Adults Board – ensuring the CCG contributes as a pivotal decision-maker, steering the Lancashire and South Cumbria strategy
- Ensuring that any new business case is aligned to, and advances, CCG priorities and objectives
- Maintaining and annually updating CCG fraud and bribery risk assessments
- Holding regular cross-departmental team briefs led by senior executives
- Continually advancing internal governance and assurance systems through regular and timely reporting of risks, opportunities and concerns
- Regularly monitoring provider service delivery through reports to the Governing Body, Audit Committee, Executive Management Team and the Membership Council. When below target performance is significant, escalation, explanations and corrective actions are planned and implemented.

3. Provides effective arrangements for whistleblowing and for receiving and investigating complaints from the public

This is done by:

- Having a Whistleblowing Policy – a confidential reporting process which clearly documents the procedure for staff to report matters of concern, which is regularly updated and communicated to staff
- Having an annually updated Anti-Fraud, Bribery and Corruption Policy

- Maintaining an effective internal audit function
- Having a clear complaints procedure
- Using complaints and compliments as a positive improvement.

During 2021/22, Mersey Internal Audit (MIAA) undertook a review of the Morecambe Bay CCG Assurance Framework. The overall objective was to assess the approach to which the organisation maintains and uses the Assurance Framework to support the overall assessment of governance, risk management and internal control.

The review included assessment of the following sub-objectives:

- The structure of the Assurance Framework meets NHS requirements
- There is Governing Body engagement in the review and use of the Assurance Framework
- The quality of the content of the Assurance Framework demonstrates clear connectivity with the Governing Body agenda and external environment.

The outcome of the MIAA review 2021/22 was that the Morecambe Bay CCG Assurance Framework fully meets the assessment criteria.

CCG Closedown and Transition

The Integrated Care Board (ICB) will take a lead role in co-ordinating assumptions around risks for the whole system, so each CCG and NHS Provider contributes to the discussion, ensuring shared knowledge and increased awareness of potential risks at place which may either have an impact or be replicated locally. At the time of writing, CCG Board Assurance Framework scoping is underway from an ICB perspective to determine the type and level of strategic risk each Lancashire and South Cumbria CCG is holding.

Conversations are ongoing regarding the risk management handover and ICB approach, with a number of options being considered.

During 2021/22, preparatory work has been commenced ahead of CCG closedown and transition to ensure organisational risk registers are up to date.

CCG Closedown - Risk Identification and Management

National guidance recognises that planning for CCG closedown should involve the identification and management of risks associated with transition, it particularly emphasises the importance of quality and patient safety being considered throughout the transition period.

The Governance Leads Close Down Group has finalised a risk register which reflects the key risks to the programme. Progress against this risk register is overseen by the Governance Leads Close Down Group and any concerns or risks scoring 15 or above, or whereby specific actions require Executive attention, are escalated to the Executive Group for Close Down. Transition Board receives monthly risk update reports.

Annual audit of conflicts of interest management

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

The CCG has carried out their annual internal audit of conflicts of interests which included:

- Governance arrangement
- Declarations of interests and gifts and hospitality
- Register of interest, gift and hospitality and procurement decisions
- Decisions making processes and contract monitoring
- Reporting concerns and identifying and managing breaches or non-compliance.

Overall, the CCG was judged to have demonstrated that arrangements are in place to satisfy NHSEI requirements with regard to conflicts of Interest.

Third Party Assurances

The CCG relies on third party providers for commissioning support, transactional functions and provision of information. The CCG has strong working relationships with NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) and continues to be actively involved in the Customer Forum, along with the other CCGs in Lancashire and South Cumbria.

This process is supported with a service level agreement across all Lancashire and South Cumbria CCGs that was developed during 2018/19.

Transactional finance functions continue to be provided by Shared Business Services (SBS) under the terms of the national NHSEI contract in place for all CCGs.

Delegation of Functions

The CCG has not delegated any functions other than the review of patients in receipt of Continuing Healthcare (CHC) and the approval of some CHC expenditure by the MLCSU team. Feedback on the performance of this team and use of resources comes via the IPA Programme Board, which is chaired by a representative from one of the other Lancashire CCGs and is attended for Morecambe Bay CCG by the Chief Nurse. Comprehensive performance information is provided on a regular basis.

In addition, the CCG has delegated shared decision-making in relation to commissioning policies to the Lancashire and South Cumbria Joint Committee of CCGs.

Counter Fraud Arrangements

The CCG has strong counter fraud arrangements in place, including;

- An accredited counter fraud specialist contracted from Mersey Internal Audit Agency (MIAA) who undertakes counter fraud work proportionate to the risks identified
- Counter Fraud updates are reported to each audit committee meeting as a standing agenda item. The counter fraud specialist provides an annual report against each of the fraud standards for commissioners
- The CCG Chief Finance Officer is responsible for all issues relating to fraud, bribery and corruption and ensures that all relevant updates re communicate to staff and Governing Body members
- Action on any NHS Protect quality recommendations is taken as appropriate.

Control issues

No significant internal control issues have been identified.

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

As covered in the Financial Review on page 44, temporary measures introduced as a result of the Covid-19 pandemic impacted on the current ways of working, and in particular the NHS finance regime.

We have continued to operate within the context of significant financial issues across Morecambe Bay and the wider Healthier Lancashire and South Cumbria system, on which we have been working in partnership with partners across the ICS footprint. Locally, this work continues to concentrate on the development and implementation of the Better Care Together strategy and delivery plan, which aim to transform services in Morecambe Bay to provide both financial and clinical resilience and sustainability. As a subset of this, the Better Care Fund helps to facilitate the delivery of parts of the overall Better Care Together programme.

As a result of the measures introduced to mitigate the effects of the Covid-19 pandemic, as described above, there was a recognition at Healthier Lancashire and South Cumbria system level that the scope for delivery of efficiency savings has been severely limited for CCGs. The Quality, Innovation, Productivity and Prevention (QIPP) process was therefore reserved for influenceable spend only, with QIPP savings targets being set for H1 and H2 totalling £5.344m. Achievement against this target proved difficult and additional system growth allocations received from NHSEI were used to cover any shortfalls.

As at 31 March 2022, we have delivered a financial position of £2.088m deficit. Of this total, £2.112m relates to the revision to the accounting estimate in respect of the prescribing accrual. This has been deemed by NHSEI to be an “allowable deficit” and the CCG has, therefore, delivered both our financial duties and our NHSEI control total. This has been achieved with receipt of £5.241m of Commissioner Sustainability Funding (CSF) from NHSEI, in the form of additional allocations for Covid-19 funding and out of envelope reimbursements, in line with national arrangements for all CCGs, along with additional growth funding allocations from ICS resource totalling £24.200m. During the year we have continued to see significant financial pressures against prescribing and high cost packages budgets.

Our Finance and Performance Committee receives reports on the financial position for discussion and challenge each month, with remedial action identified where necessary. Reports are also provided to Governing Body at each meeting. Both the Finance and Performance Committee and Governing Body have been kept appraised of the funding position throughout the year.

We have robust procedures for our key financial systems, which continue to be reviewed as appropriate in line with the annual audit plan and reported to the Audit Committee.

For 2022/23, the CCG has again submitted a financial plan for break-even which covers the whole of the financial year, as part of a wider financial plan for the proposed Lancashire and South Cumbria Integrated Care Board (ICB), as per NHSEI requirements. As a result of the imminent demise of the CCG on 30 June 2022, the plan has been split into two parts; quarter 1 relates to the CCG as a stand-alone organisation; and quarters 2 to 4 are combined with the other Healthier Lancashire and South Cumbria CCGs which will form the ICB. NHSEI has indicated that CCGs will be given sufficient allocation to cover all costs in quarter 1 of the 2022/23 financial year, within an overall annual allocation for the ICB as a whole. This plan meets the investment requirements of the NHS Long Term Plan. We will, however, need to deliver efficiencies of in excess of

£16.9m to achieve this. As stated above, in developing this financial plan for 2022/23 the CCG is working within the constraints of the wider ICB system. The CCG will only be in existence for the first quarter of the financial year, but decisions made and expenditure incurred will have an effect on the ICB's finances for the remainder of the financial year.

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

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the CCG.

Capacity to handle risk

Responsibility for risk management and health and safety is brought together through the Executive Management team who work collectively to integrate both functions and oversee the work relating to operational safety. The Senior Managers take on pivotal roles in the CCG committee structure, with a responsibility for coordinating, communicating and accelerating strategic and operational assurance issues, regularly reporting on core business activity.

We identify the development needs of members, senior officers and staff in relation to their roles, through:

- Induction training for all new CCG staff, Governing Body and committee members
- Annual risk management awareness and training with the Quality Improvement Committee and CCG commissioning managers
- Being proactive partners in the NHS Leadership Academy
- Maintaining a performance and appraisal system so that all members of staff know what is expected of them
- Ensuring that emergencies can be appropriately addressed through regular testing of the Major Incident and Business Continuity plans and membership of the Lancashire Health Resilience Partnership.

Review of effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the 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.

The Governing Body Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles 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 and the Quality Improvement Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is informed by a number of reports and audits received throughout the year, including:

- External Audit via their Annual Audit Letter, which provides a high-level summary

of audit work carried out

- Regular team meetings
- Reports to Audit Committee by the Local Counter Fraud Specialists
- Information Governance Toolkit submission
- Review of the corporate risk register by the CCG Governing Body and Audit Committee
- Scrutiny of the Assurance Framework by the Audit Committee
- Regular meetings with NHS England Area Team (Quality Surveillance Groups / quarterly checkpoints)
- Attendance at Quality Committee meetings for the main providers of acute, community and mental health services.

Following completion of the planned audit work for the financial year, the Director of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of our system of risk management, governance and internal control. The details of the Head of Internal Audit Opinion are contained later in this report.

Data quality

During 2021/22, in conjunction with NHS Midlands and Lancashire Commissioning Support Unit, we continued to establish robust processes for managing patient identifiable information which included the processing of all identifiable information via an Accredited Safe Haven (ASH). This allows the CCG to receive anonymised data which supports:

- Contract monitoring
- Invoice payment
- Service redesign
- Business planning.

Business Critical Models

Business Critical Models are mainly provided by NHS Midlands and Lancashire Commissioning Support Unit. They are subject to regular external review, the outputs of which are reported to Clinical Commissioning Groups through Service Auditor Reports. We have not relied on the outputs of the Service Auditor Reports as we consider that the internal controls systems and processes in place within the CCG provide sufficient assurance.

Information Governance

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

Due to the current Covid-19 situation, NHS Digital had postponed the DSP Toolkit submission deadline for 2019/20 to 30 September 2020. This gave NHS organisations the flexibility to be able to deal with the pandemic. Due to the previous extension, NHS Digital

extended the 2020/21 submission deadline to 30 June 2021.

We chose to postpone the submission of the toolkit since focus is required for the operational and strategic planning of the current crisis. Authorisation for submission of the 2020/21 toolkit will be obtained later to ensure that all mandatory evidence items are available, accurate and have been fully met.

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

For any incidents reported to Morecambe Bay CCG from their providers, we seek assurance through our Serious Incident Group (SIG) and use that forum to learn from, and share lessons learnt across our partnerships.

Data security

Following the issue of national criteria in 2008, CCGs have to categorise all incidents involving personal confidential data. These are considered serious untoward incidents when involving data loss or confidentiality breaches.

Serious data loss or data security incidents are managed via a Root Cause Analysis investigation process. As an organisation registered with the DSP Toolkit, we are required to report incidents that are categorised as ‘reportable’ through the IG Incident Reporting Tool. Incidents, where appropriate, may be escalated to organisations such as Care Quality Commission or NHSEI.

Read more about disclosure of ‘Personal Data Breaches or Incidents’ on page 61.

Discharge of statutory functions

Arrangements put in place by the CCG, and explained within the *Corporate Governance Framework*, were developed to ensure compliance with all the relevant legislation. That advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

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

Responsibility for each duty and power has been clearly allocated to a lead Executive who has confirmed that their structures provide the necessary capability and capacity to undertake all of the Clinical Commissioning Group’s statutory duties.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the Clinical Commissioning Group, the Head of Internal Audit (HoIA) issued an independent and objective opinion on the adequacy and effectiveness of the Clinical Commissioning Group's system of risk management, governance and internal control. The Head of internal Audit concluded that:

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 of the "FINAL Internal Audit Annual Report and Head of Internal Audit Opinion 2021/2022". The full document is available on request.

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

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.	✓

The overall opinion for the period 1 April 2021 to 31 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.

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

Review	Assurance opinion
Assurance Framework	Meets requirements
Primary Care Commissioning and Contracting: Commissioning and Procurement of Primary Medical Services	High
Conflicts of Interest	Full compliance
Local Transition Closedown Group Attendance and Reporting Briefing Note	N/A
2021/22 Data Protection Security Toolkit: CCG to Integrated Care Systems Handover Review Summary Report	Moderate

Conclusion

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways outlined above. The Head of Internal Audit has also confirmed that 'there is a generally sound system of internal control, designed to meet the organisations objectives, and that controls are generally being applied consistently'.

My review concludes that NHS Morecambe Bay Clinical Commissioning Group has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and that no significant internal control issues have been identified.

Jerry Hawker
Accountable Officer
22 June 2022

Remuneration and Staff Report

Remuneration Report

Remuneration Committee Report (not subject to audit)

Members of the Remuneration Committee

Position	Name	Number of meetings attended	% attendance over the year
Lay Member and Chair	Clive Unitt	2 out of 2	100%
Lay Member	Mike Bone	2 out of 2	100%
Lay Member	Hazel Parsons	1 out of 2	50%
Secondary Care Doctor for the Governing Body	Dr Andrew Severn	2 out of 2	100%

Note: *there were two Remuneration Committee meetings held in the financial year (and).*

Policy on Remuneration of Directors and Very Senior Managers (not subject to audit)

Senior Managers' and Directors' remuneration and terms of condition have been determined according to national guidelines issued under Agenda for Change and Very Senior Managers' guidance. In the case of the CCG Chair, remuneration was determined following an exercise carried out on behalf of the Lancashire Clinical Commissioning Group Network by PricewaterhouseCoopers LLP (PwC), which proposed a salary range for GP Chairs based on size of organisation and time commitment. The Membership Council, following recommendation from the Remuneration Committee, approved this arrangement.

Remuneration for other GP members of the Governing Body and Membership Council was agreed by the Membership Council, in line with the CCG Constitution.

Remuneration of Very Senior Managers and GP members of the Governing Body and Membership Council for future years will be assessed and recommended by the Remuneration Committee based on national guidelines in place at the time.

Senior Managers' Performance Related Pay (not subject to audit)

Performance related pay arrangements are not in place in the CCG.

Policy on Senior Managers' Contracts (not subject to audit)

The CCG Chair and Clinical Members of the Governing Body are elected by the Member practices of the Membership Council. The terms of office for the CCG Chair and GP members of the Governing Body and Membership Council are as determined by the Membership Council.

These were staggered in order to maintain a level of continuity and to ensure experience and expertise are retained. These appointments are not subject to termination payments. In order to maintain organisational stability during the 2021/22 and 2022/23 financial years

in the lead up to the move to an ICB from 1 July 2022, all Governing Body members have had contracts extended to 30 June 2022.

Other employed Senior Managers are appointed as per Agenda for Change regulations, including any provision for notice periods and termination payments. These Senior Managers are employed on permanent substantive contracts.

Senior Managers' Service Contracts (not subject to audit)

Governing Body members' contract terms

Name	Contract start date	Contract end date	Term of office	Notice period
Dr G Jolliffe	1 April 2017	30 June 2022	30 June 2022	2 months
Dr A Knox	1 April 2015	30 June 2022	30 June 2022	2 months
Dr J Hacking	1 April 2017	30 June 2022	30 June 2022	2 months
Dr L Dixon	1 April 2017	30 June 2022	30 June 2022	2 months
Dr R Keith	23 May 2019	30 June 2022	30 June 2022	2 months
Dr S Arun	1 September 2019	30 June 2022	30 June 2022	2 months

Salaries and allowances (subject to audit)

Salaries and allowances

Name	Title	Effective dates	Salary (bands of £5,000) £'000	Expense payments (taxable) to the nearest £100 £'00	All pension-related benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
Dr Geoff Jolliffe *see note 3 below	Chair		75 – 80			75 – 80
Mr Jerry Hawker *see note 2 and 6 below	Chief Officer (seconded from NHS Eastern Cheshire CCG)		120 – 125			120 – 125
Mr Andrew Harrison *see note 1 below	Chief Finance Officer (seconded from NHS Fylde and Wyre CCG)		65 – 70			65 – 70
Ms Hilary Fordham	Chief Commissioning Officer		95 – 100		32.5 – 35	130 – 135
Mrs Margaret Williams	Chief Nurse		35 – 40			35 – 40
Mr Anthony Gardner	Director of Planning and Performance		110 – 115	62	35 – 37.5	150 – 155
Dr Andy Knox *see note 3 below	Executive GP		75 – 80			75 – 80
Dr Jim Hacking	Executive GP		60 – 65		15 – 17.5	75 – 80
Dr Lauren Dixon *see note 3 below	Executive GP		75 – 80			75 – 80
Dr Rahul Keith *see note 3 below	Executive GP		75 – 80			75 – 80
Dr Dimple Sarah Arun	Executive GP		30 – 35			30 – 35

***see note 3 below**						
Mr Clive Unitt	Lay Member		5 – 10			5 – 10
Ms Hazel Parsons	Lay Member		5 – 10			5 – 10
Mr Mike Bone	Lay Member		5 – 10			5 – 10
Dr Andrew Severn	Secondary Care Doctor		10 – 15			10 - 15

Notes:

1. Mr Andrew Harrison is on secondment from NHS Fylde and Wyre CCG from 1 August 2020.
2. Mr Jerry Hawker remains on secondment from NHS Eastern Cheshire CCG, having replaced Mr Andrew Bennett, who was seconded to NHS England and NHS Improvement from 10 September 2018.
3. Executive GP salaries are paid through Payroll to the relevant GP practices, not direct to individuals (other than for Dr Jim Hacking, who is a CCG employee).
4. The CCG does not have a performance-related pay scheme; the performance of staff is measured through the CCG's annual appraisal process. There is therefore no reference to performance-related bonuses.
5. Expense payments (taxable) to the nearest £100 relate to the net taxable benefit of the use of a lease car.
6. Mr Jerry Hawker took up a role with the New Hospitals Programme on 1 March 2021. Mr Hawker will remain as the Chief Officer of the CCG for statutory purposes but he has relinquished day to day responsibilities.
7. Pension-related benefits are calculated as follows:

   ((20 x PE) + LSE) – ((20 x PB) + LSB) – Employee contribution

   Where:

   PE = the annual rate of unreduced pension that would be payable to the senior manager if they became entitled to it at the end of the financial year.

   LSE = the amount of unreduced lump sum that would be payable to the senior manager if they became entitled to it at the end of the financial year.

   PB = the annual rate of unreduced pension, adjusted for inflation, that would be payable to the senior manager if they became entitled to it at the beginning of the financial year.

LSB = the amount of unreduced lump sum, adjusted for inflation, that would be payable to the senior manager if they became entitled to it at the beginning of the financial year.

Ees cont = employee pension contributions for the financial year.

To adjust PB and LSB for inflation the Consumer Prices Index (CPI) of 0.5% has been used.

The following page includes 2020/21 comparative figures:

Name	Title	Effective dates	Salary (bands of £5,000) £'000	Expense payments (taxable) to the nearest £100 £'00	All pension-related benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
Dr Geoff Jolliffe *see note 3 below	Chair		75 – 80			75 – 80
Mr Jerry Hawker *see note 2 below	Chief Officer (seconded from NHS Eastern Cheshire CCG)		135 – 140			135 – 140
Mr Gareth James *see note 1 below	Chief Finance Officer (seconded from NHS Western Cheshire CCG)	1 April – 31 July 2020	35 – 40			35 – 40
Mr Andrew Harrison *see note 1 below	Chief Finance Officer	1 August 2020 – 31 March 2021	50 – 55			50 – 55
Ms Hilary Fordham	Chief Commissioning Officer		95 – 100		25 – 27.5	120 – 125
Mrs Margaret Williams	Chief Nurse		95 – 100		452.5 – 455	545 – 550
Mr Anthony Gardner	Director of Planning and Performance		100 - 105	62	25 – 27.5	135 - 140
Dr Andy Knox *see note 3 below	Executive GP		75 - 80			75 - 80
Dr Jim Hacking	Executive GP		60 - 65		12.5 – 15	70 – 75
Dr Lauren Dixon *see note 3 below	Executive GP		75 – 80			75 – 80
Dr Rahul Keith *see note 3 below	Executive GP		75 – 80			75 – 80
Dr Dimple Sarah Arun *see note 3 below	Executive GP		55 – 60			55 – 60

Mr Clive Unitt	Lay Member		5 - 10			5 - 10
Ms Hazel Parsons	Lay Member		5 - 10			5 - 10
Mr Mike Bone	Lay Member		5 - 10			5 - 10
Dr Andrew Severn	Consultant Member		10 – 15			10 - 15

Notes:

1. Mr Gareth James was on secondment from NHS Western Cheshire CCG but resigned from his post on 31 July 2020 and was replaced by Mr Andrew Harrison on secondment from NHS Fylde and Wyre CCG from 1 August 2020.
2. Mr Jerry Hawker remains on secondment from NHS Eastern Cheshire CCG, having replaced Mr Andrew Bennett, who was seconded to NHS England and NHS Improvement from 10 September 2018.
3. Executive GP salaries are paid through Payroll to the relevant GP practices, not direct to individuals.
4. The CCG does not have a performance-related pay scheme; the performance of staff is measured through the CCG's annual appraisal process. There is therefore no reference to performance-related bonuses.
5. Expense payments (taxable) to the nearest £100 relate to the net taxable benefit of the use of a lease car.
6. Mr Jerry Hawker took up a role with the New Hospitals Programme on 1 March 2021. Mr Hawker will remain as the Chief Officer of the CCG for statutory purposes but he has relinquished day to day responsibilities.
7. Pension-related benefits are calculated as follows:

   ((20 x PE) + LSE) – ((20 x PB) + LSB) – Employee contribution

   Where:

   PE = the annual rate of unreduced pension that would be payable to the senior manager if they became entitled to it at the end of the financial year.

   LSE = the amount of unreduced lump sum that would be payable to the senior manager if they became entitled to it at the end of the financial year.

   PB = the annual rate of unreduced pension, adjusted for inflation, that would be payable to the senior manager if they became entitled to it at the beginning of the financial year.

   LSB = the amount of unreduced lump sum, adjusted for inflation, that would be payable to the senior manager if they became

entitled to it at the beginning of the financial year.

Ees cont = employee pension contributions for the financial year.

To adjust PB and LSB for inflation the Consumer Prices Index (CPI) of 1.7% has been used.

Compensation on early retirement or for loss of office (subject to audit)

The CCG made no payments for early retirement or for loss of office during the financial year.

Payments to past Directors (subject to audit)

The CCG made no payments to past Directors during the financial year.

Pension benefits (subject to audit)

Pension benefits

Name	Title	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2021 £'000	Cash Equivalent Transfer Value at 31 March 2022 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's contribution to partnership pension £'000
Ms Hilary Fordham	Chief Commissioning Officer	0 – 2.5	0 – 2.5	25 – 30	45 – 50	469	515	33	
Mrs Margaret Williams	Chief Nurse	0 – 2.5	0 – 2.5	0 – 5	0 – 5	1,225	0	0	
Mr Anthony Gardner	Director of Planning and Performance	0 – 2.5	0 – 2.5	25 – 30	0 – 5	367	411	30	
Dr Jim Hacking	Executive GP	0 – 2.5	0 – 2.5	20 – 25	45 – 50	381	408	16	

Notes:

1. Executive GP salaries (other than for Dr Jim Hacking) are paid through Payroll to the relevant GP practices, not direct to individuals. These persons have therefore been excluded from the above table.
2. The payments made to the Lay Members and Consultant Member do not include pension contributions. These persons have therefore been excluded from the above table.
3. Mr Andrew Bennett was seconded to NHS England and NHS Improvement from 10 September 2018 and was replaced by Mr Jerry Hawker on secondment from NHS Eastern Cheshire CCG from 1 September 2018. Mr Jerry Hawker remains on the payroll of NHS Eastern Cheshire CCG.

4. Mr Andrew Harrison is on secondment from NHS Fylde and Wyre CCG from 1 August 2020. Mr Andrew Harrison remains on the payroll of NHS Fylde and Wyre CCG.

5. For comparative purposes the CETV figures at 31 March 2021 have been inflated by 0.5%. The real increase in CETV is calculated as follows:

   CETV at 31/03/2022 – [(CETV at 31/03/2021 + 0.5%) + 2021/2022 Employee superannuation contributions]

Cash Equivalent Transfer Values

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

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

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

Real increase in CETV

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

Fair pay disclosure (subject to audit)

Percentage change in remuneration of highest paid member:

Reporting bodies are required to disclose the percentage change from the previous financial year in respect of the highest paid member and the average percentage change from the previous financial year in respect of employees of the reporting body, taken as a whole:

2021/2022	Highest paid Director	Average for all employees
Salary and allowances	**0.00%**	**2.41%**
Performance pay and bonuses	**0.00%**	**0.00%**
All taxable benefits	**0.00%**	**0.00%**

Pay ratio information:

As at 31 March 2022, remuneration ranged from £20,343 (this is the whole-time equivalent figure, the post holder works 20 hours per week, actual annual salary is £10,843) (2020/21: £19,737) to £183,042 (this is the whole-time equivalent figure, the post holder works 6 hours per week, actual annual salary is £29,287) (2020/21: £183,042 / £58,573).

Total remuneration includes salary, non-consolidated performance-related pay, and benefits-in-kind, but not severance payments. It does not include employer pension contributions and the Cash Equivalent Transfer Value of pensions.

Remuneration of NHS Morecambe Bay CCG's staff is shown in the table below (figures in brackets are for 2020/21):

	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	**£42,121 (£38,890)**	**£53,219 (£51,668)**	**£91,218 (£96,286)**
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	**£42,121 (£38,890)**	**£53,219 (£51,668)**	**£91,218 (£96,286)**

The ratios of staff remuneration against the mid-point of the banded remuneration of the highest paid member is illustrated in the table below:

Year	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
2021/22	**4.33:1**	**3.43:1**	**2.00:1**
2020/21	**4.69:1**	**3.53:1**	**1.90:1**

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid member's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid member of the Membership Council / Governing Body in Morecambe Bay CCG in the financial year 2021/22 was £180,000 - £185,000 (this is the whole time equivalent figure, the post holder works 6 hours per week, actual annual salary is £29,287) (2020/21: £180,000 - £185,000/ £58,573) (**note:** nine of the CCG's GP Executives and Leads are remunerated at this level). The relationship to the remuneration of the organisation's workforce is disclosed in the below table:

Year	25th percentile total remuneration ratio	25th percentile salary ratio	Median total remuneration ratio	Median salary ratio	75th percentile total remuneration ratio	75th percentile salary ratio
2021/22	**4.33:1**	**4.33:1**	**3.43:1**	**3.43:1**	**2.00:1**	**2.00:1**
2020/21	**4.69:1**	**4.69:1**	**3.53:1**	**3.53:1**	**1.90:1**	**1.90:1**

In 2021/22, no employees received remuneration in excess of the highest paid member of the Membership Council / Governing Body (2020/21: nil).

The salary range for GP Executive members was agreed at the outset of the CCG and was in line with national guidance. Although the extrapolated figure for the highest paid employees is £183,042, these individuals only work part time and therefore actual individual payments are significantly lower.

Summary

The highest paid member of the Membership Council is one of 16 GP Executives and Leads whose remuneration has remained static during the year, in line with the CCG's

practice over the last few years. The remuneration of all other staff has increased either via the application of the national pay award or through incremental progression or both, by an average of 2.41% across all staff.

As a result of this pay freeze for the 16 most highly paid staff and an increase for the other staff, the CCG's 25th percentile and median pay ratios have reduced between 2020-21 and 2021-22. Conversely the 75th percentile pay ratio has increased due to the resignation of two members of staff who were paid above the 75th percentile and who were not replaced. As a result, the 75th percentile member of staff is on a lower salary than the corresponding member of staff in the prior year, the effect of which is that the comparable ratio has increased.

Overall staff numbers have remained consistent, with 16 GP Executives and Leads and 64 other members of staff employed at 31 March 2022 (17/64 at 31 March 2021).

The reduction in the median pay ratio is consistent with the CCG's pay, reward and progression policies. The CCG has maintained an effective freeze on the salaries of the most senior and highly paid members, whilst applying the national pay uplifts and incremental progression for all staff employed under Agenda for Change terms and conditions. The median pay ratio has therefore continued the downward trend experienced over the last few years, as anticipated.

Off-payroll engagements (not subject to audit)

Following the *Review of Tax Arrangements of Public Sector Appointees* published by the Chief Secretary to the Treasury on 23 May 2012, CCGs must publish information on their highly paid and/or senior off-payroll engagements.

Off-payroll engagements

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

For all off-payroll engagements as of 31 March 2022, for more than £245(1) per day:

	Number
Number of existing engagements as of 31 March 2022	**6**
Of which, the number that have existed:	
• **for less than one year at the time of reporting**	**0**
• **for between one and two years at the time of reporting**	**1**
• **for between two and three years at the time of reporting**	**2**
• **for between three and four years at the time of reporting**	**0**
• **for four or more years at the time of reporting**	**3**

Note:

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

(2) All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual pays the right amount of Income Tax and National Insurance and, where necessary, that assurance has been sought.

(3) Of the six individuals outlined above, five are Executive GPs on the CCG's

Governing Body, for whom payments are made to the respective GP practices via the CCG's Payroll. The Tax and National Insurance liabilities for these individuals have therefore been treated correctly. The sixth individual is employed by and on the payroll of an agency and therefore the off-payroll legislation does not apply.

Off-payroll engagements

Table 2: off-payroll workers engaged at any point during the financial year

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

	Number
Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	**6**
Of which:	
• **Number not subject to off-payroll legislation**	**5**
• **Number subject to off-payroll legislation and determined as in-scope of IR35**	**0**
• **Number subject to off-payroll legislation and determined as out of scope of IR35**	**1**
• **Number of engagements reassessed for compliance or assurance purposes during the year**	**1**
• **Of which: number of engagements that saw a change to IR35 status following review**	**0**

Note:

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

Off-payroll engagements

Table 3: off-payroll board member /senior official engagements

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

	Number
Number of off-payroll engagements of board members, and / or senior officers with significant financial responsibility, during the financial year ***see note 1 below**	**5**
Total number of individuals on payroll and off-payroll that have been deemed "board members and / or senior officials with significant financial responsibility" during the financial year ***see note 2 below**	**13**

Note:

1. The five individuals outlined above are all Executive GPs on the CCG's Governing Body, for whom payments are made to the respective GP practices via the CCG's Payroll. The Tax and National Insurance liabilities for these individuals have therefore been treated correctly.

2. The total figure of 13 above excludes both Mr Jerry Hawker who is on secondment from NHS Eastern Cheshire CCG in the post of Chief Officer and Mr Andrew Harrison who is on secondment from NHS Fylde and Wyre CCG in the post of Chief Finance Officer.

Related party transactions

Information in respect of related party transactions is detailed in Note 19 to the Annual Accounts.

Better Payment Practice Code (BPPC)

Information in respect of the Better Payment Practice Code (BPPC) is detailed in Note 7 to the Annual Accounts.

Parliamentary Accountability and Audit Report

NHS Morecambe Bay 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 with this report. An audit certificate and report are also included in this Annual Report.

Staff Report

Number of senior managers (whole numbers) by band (at 31 March 2022):

Band	Total number
GP Executive	**6**
GP Lead	**10**
Very Senior Manager	**3**
Band 9	**1**
Band 8d	**4**
Band 8c	**8**
Band 8b	**5**
Band 8a	**12**
Total	**49**

Number of people (average whole time equivalent) employed by NHS Morecambe Bay CCG (subject to audit):

	Total number	Permanently employed number	Other number	2020/21 total number
Total	72	65	7	66
Costs:	**£'000**	**£'000**	**£'000**	**£'000**
Salaries and wages	£4,306	£3,689	£617	£4,077
Social security cost	£408	£408	£0	£374
NHS pension cost	£731	£731	£0	£533
Other pension cost	£0	£0	£0	£0
Apprenticeship levy	£4	£4	£0	£2
Recoveries in respect of employee benefits	(£472)	(£472)	£0	(£339)
Total costs	£4,977	£4,360	£617	£4,646
Of the above, number of whole time equivalent people engaged on capital projects	0	0	0	0

The average number of people permanently employed has remained relatively stable over the last two financial years, the slight increase relates to additional posts in respect of investments in Population Health Management.

Staff composition (end of year figures - whole numbers):

	Male	Female
Membership Council	15	5
Governing Body	8	5
Very Senior Managers	0	0
CCG (excluding those employed but on Governing Body)	15	54

There are no figures reported for Very Senior Managers in the table above as they are all members of the Governing Body and are thus included in the Governing Body totals.

Information about employees

We have well established recruitment, retention, performance and appraisal processes to ensure that we recruit the high-quality staff required to discharge our duties. We monitor our staff performance and development, and ensure that all staff undertake regular appraisals and performance reviews. Our progress in this area is monitored by the CCG Executive Team, with regular reports to the Governing Body.

Employee consultation

We have a strong ethos of employee engagement, communication and consultation. We have a number of mechanisms through which we communicate and consult with the 84 staff who are directly employed by the CCG (Governing Body, including Lay Members, and other CCG staff). These include regular one-to-ones with individual staff, face-to-face briefings and a twice monthly team briefing session. We operate a wider leadership team where senior managers regularly contribute to and review the CCG's performance and other matters of significance.

In addition, we routinely disseminate policies, minutes of meetings and new information electronically to all staff through a weekly newsletter.

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

Staff turnover

Published information (publication date 31 March 2022) in respect of staff turnover percentages and headcount can be found via NHS Digital's NHS workforce statistics using the following link:

Turnover to the NHS by staff group and NHSE region, December 2019 to December 20 - NHS Digital

This data series is an official statistics publication complying with the UK Statistics Authority's Code of Practice.

Trade Union (Facility Time Publication Requirements) Regulations 2017

The CCG is required to publish details of numbers, costs and time spent of employees engaged in trade union facility time in its Annual Report and on its website. The relevant details are included in the tables below.

Table 1: Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent number
0	**0**

Table 2: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	N/A
1% - 50%	N/A
51% - 99%	N/A
100%	N/A

Table 3: Percentage of pay bill spent on facility time

First column	Figures
Provide the total cost of facility time	£0
Provide the total pay bill	£4,976,852
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0%

Table 4: Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: **(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100**	**N/A**

Employees with a disability

Employing people with a disability is important for any organisation providing services for the public as they need to reflect the many and varied experiences of people they serve. In the provision of health services it is perhaps even more important, as people with disabilities make up a significant proportion of the population, and those with long-term medical conditions use the services of the NHS. Our commitment to people with

disabilities includes:

- Guaranteeing an interview to people with disabilities who meet the minimum criteria for a job vacancy
- Proactively considering the adjustments that people with disabilities might require in order to take up a job or continue working in a job
- Mandatory equality and diversity training, which raises awareness of a range of issues impacting on people with disabilities
- Ensuring any employee who needs training, either because they work with people with disabilities, or because they have acquired an impairment or medical condition, receives it.

Sickness absence data

We take staff sickness absence very seriously. We have an agreed sickness absence policy that seeks to:

- Encourage good attendance
- Minimise sickness absence levels and their effect on services
- Ensure that all employees are treated fairly and consistently
- Define the responsibilities of management and employees
- Provide a framework to enable managers to explore a range of actions, considering individual circumstances
- Set clear targets for improvement in cases of problem absence, and clearly define the consequences of failure to improve
- Promote good communications between managers and employees
- Comply with the requirements of the Disability Discrimination Act 2005

Sickness absence figures are reported on a calendar year basis i.e. for the 12 months January to December 2021. During this period, there were a total of 117 days lost to sickness absence, which equates to an average of 1.1 days per whole time equivalent staff member (2020/2021 – information not reported). Our sickness absence rate for this period is 0.49%.

For further information, see the NHS Digital publication series on NHS Sickness Absence Rates. Sickness absence data is the sole and exclusive property of the Health and Social Information Centre and is owned by NHS Digital.

Consultancy expenditure

During this financial year we have spent approximately £11k on external consultancy services (2020/21 - £7k).

Jerry Hawker
Accountable Officer
22 June 2022

Data entered below will be used throughout the workbook:

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

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Income from sale of goods and services	3	(638)	(376)
Other operating income	3	(244)	(228)
Total operating income		**(882)**	**(605)**
Staff costs	5	5,449	4,985
Purchase of goods and services	6	643,093	622,703
Depreciation and impairment charges	6	-	-
Provision expense	6	3,165	-
Other Operating Expenditure	6	200	59
Total operating expenditure		**651,906**	**627,747**
Net Operating Expenditure		**651,024**	**627,142**
Finance income		-	-
Finance expense		-	-
Net expenditure for the Year		**651,024**	**627,142**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**651,024**	**627,142**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Net (gain)/loss on assets held for sale		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net (gain)/loss on revaluation of other Financial Assets		-	-
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Sub total		**-**	**-**
Comprehensive Expenditure for the year		**651,024**	**627,142**

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Property, plant and equipment	9	-	-
Trade and other receivables	11	-	-
Total non-current assets		-	-
Current assets:			
Inventories	10	405	347
Trade and other receivables	11	6,133	1,363
Cash and cash equivalents	12	61	13
Total current assets		**6,599**	1,723
Total current assets		**6,599**	1,723
Total assets		**6,599**	1,723
Current liabilities			
Trade and other payables	13	(37,385)	(33,324)
Provisions	14	(3,165)	-
Total current liabilities		**(40,550)**	(33,324)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(33,951)**	(31,601)
Non-current liabilities			
Trade and other payables	13	-	-
Provisions	14	-	-
Total non-current liabilities		**-**	-
Assets less Liabilities		**(33,951)**	(31,601)
Financed by Taxpayers' Equity			
General fund		(33,951)	(31,601)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(33,951)**	(31,601)

The notes on pages 122 to 149 form part of this statement

The financial statements on pages 118 to 149 were approved by the Audit Committee on 9 June 2022 and signed on behalf of the Governing Body by:

Accountable Officer
Jerry Hawker

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22				
Balance at 01 April 2021	(31,601)	0	0	**(31,601)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	**(31,601)**	**0**	**0**	**(31,601)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22				
Net operating expenditure for the financial year	(651,024)			**(651,024)**
Net gain/(loss) on revaluation of property, plant and equipment		0		**0**
Net gain/(loss) on revaluation of intangible assets		0		**0**
Net gain/(loss) on revaluation of financial assets		0		**0**
Total revaluations against revaluation reserve		**0**		**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(651,024)**	**0**	**0**	**(651,024)**
Net funding	648,674	0	0	**648,674**
Balance at 31 March 2022	**(33,951)**	**0**	**0**	**(33,951)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21				
Balance at 01 April 2020	(16,371)	0	0	**(16,371)**
Transfer of assets and liabilities from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	**(16,371)**	**0**	**0**	**(16,371)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21				
Net operating costs for the financial year	(627,142)			(627,142)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve		0		**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(627,142)**	**0**	**0**	**(627,142)**
Net funding	611,913	0	0	611,913
Balance at 31 March 2021	**(31,601)**	**0**	**0**	**(31,601)**

The notes on pages 122 to 149 form part of this statement

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(651,024)	(627,142)
Depreciation and amortisation	6	0	0
Impairments and reversals	6	0	0
Non-cash movements arising on application of new accounting standards		0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		(58)	(54)
(Increase)/decrease in trade & other receivables	11	(4,770)	5,858
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	13	4,061	9,418
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	14	0	0
Increase/(decrease) in provisions	14	3,165	0
Net Cash Inflow (Outflow) from Operating Activities		**(648,626)**	(611,921)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Non-cash movements arising on application of new accounting standards		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(648,626)**	(611,921)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		648,674	611,913
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**648,674**	611,913
Net Increase (Decrease) in Cash & Cash Equivalents	12	**47**	(8)
Cash & Cash Equivalents at the Beginning of the Financial Year		**13**	21
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**61**	13

The notes on pages 122 to 149 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of NHS Clinical Commissioning Groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to NHS Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the NHS Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the NHS Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis, despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014.

The Health and Care Act received Royal Assent on 28 April 2022. The Act allows for the establishment of Integrated Care Boards (ICB) across England and will abolish NHS Clinical Commissioning Groups. ICBs will take on the commissioning functions of NHS Clinical Commissioning Groups. As a result the functions, assets and liabilities of the NHS Clinical Commissioning Group will therefore transfer to the NHS Lancashire and South Cumbria Integrated Care Board.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a NHS Clinical Commissioning Group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern. If services will continue to be provided the financial statements are prepared on the going concern basis. As the NHS Clinical Commissioning Group's functions will continue to be delivered by the ICB, the CCG has therefore assessed that it remains a going concern as at 31 March 2022.

1.2 **Accounting Convention**

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

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

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

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Subsidiaries**

Entities over which the NHS Clinical Commissioning Group has the power to exercise control are classified as subsidiaries and are consolidated. The NHS Clinical Commissioning Group has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities. The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS Clinical Commissioning Group or where the subsidiary's accounting date is not coterminous.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.5 **Associates**

Material entities over which the NHS Clinical Commissioning Group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the NHS Clinical Commissioning Group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the NHS Clinical Commissioning Group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the NHS Clinical Commissioning Group from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.6 **Joint arrangements**

Arrangements over which the NHS Clinical Commissioning Group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the NHS Clinical Commissioning Group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.7 **Pooled Budgets**

The NHS Clinical Commissioning Group has entered into pooled budget arrangements with Lancashire County Council in respect of Learning Disabilities Services and the Better Care Fund initiative and with Cumbria County Council in respect of Learning Disabilities Services and the Better Care Fund initiative in accordance with section 75 of the NHS Act 2006. Under these arrangements, funds are pooled for Learning Disabilities and Better Care Fund initiative services and Note 18 to the accounts provides details of the income and expenditure.

The pools are hosted by Lancashire County Council and Cumbria County Council respectively. The NHS Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

1.8 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the NHS Clinical Commissioning Group.

1.9 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard the NHS Clinical Commissioning Group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The NHS Clinical Commissioning Group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the NHS Clinical Commissioning Group to reflect the aggregate effect of all contracts modified before the date of initial application.
The main source of funding for the NHS Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.
The value of the benefit received when the NHS Clinical Commissioning Group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.10 **Employee Benefits**

1.10.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.10.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Clinical Commissioning Group commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.11 **Other Expenses**

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

1.12 **Grants Payable**

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

1.13 **Property, Plant & Equipment**

1.13.1 **Recognition**

Property, plant and equipment is capitalised if:
· It is held for use in delivering services or for administrative purposes;
· It is probable that future economic benefits will flow to, or service potential will be supplied to the NHS Clinical Commissioning Group;

· It is expected to be used for more than one financial year;
· The cost of the item can be measured reliably; and,
· The item has a cost of at least £5,000; or,
· Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
· Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.13.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
· Land and non-specialised buildings – market value for existing use; and,
· Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.13.3 **Subsequent Expenditure**

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

1.14 **Intangible Assets**

1.14.1 **Recognition**

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

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

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

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

1.14.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.14.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Clinical Commissioning Group expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Clinical Commissioning Group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the NHS Clinical Commissioning Group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.15 **Donated Assets**

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

1.16 **Government grant funded assets**

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

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

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

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

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.18 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.18.1 **The NHS Clinical Commissioning Group as Lessee**

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

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

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

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

1.18.2 **The NHS Clinical Commissioning Group as Lessor**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS Clinical Commissioning Group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the NHS Clinical Commissioning Group's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.19 **Private Finance Initiative Transactions**

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the NHS Clinical Commissioning Group. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- payment for the fair value of services received
- repayment of the finance lease liability, including finance costs, and
- payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.19.1 **Services Received**

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.19.2 **PFI Asset**

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at current value in existing use.

1.19.3 **PFI Liability**

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

1.19.4 **Lifecycle Replacement**

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Clinical Commissioning Group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.19.5 **Assets Contributed by the NHS Clinical Commissioning Group to the Operator For Use in the Scheme**

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Clinical Commissioning Group's Statement of Financial Position.

1.19.6 **Other Assets Contributed by the NHS Clinical Commissioning Group to the Operator**

Assets contributed (e.g. cash payments, surplus property) by the NHS Clinical Commissioning Group to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS Clinical Commissioning Group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.20 **Inventories**

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

1.21 **Cash & Cash Equivalents**

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS Clinical Commissioning Group's cash management.

1.22 **Provisions**

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

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

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

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

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

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

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

A restructuring provision is recognised when the NHS Clinical Commissioning Group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.23 **Clinical Negligence Costs**

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

1.24 **Non-clinical Risk Pooling**

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

1.25 **Carbon Reduction Commitment Scheme**

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

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

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

Allowances acquired under the scheme are recognised as intangible assets.

1.26 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Clinical Commissioning Group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Clinical Commissioning Group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.27 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

1.27.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

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

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

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

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

1.27.4 **Impairment**

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

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

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

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

1.28 **Financial Liabilities**

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

1.28.1 **Financial Guarantee Contract Liabilities**

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

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

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

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

1.28.3 **Other Financial Liabilities**

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

1.29 **Value Added Tax**

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

1.30 **Foreign Currencies**

The NHS Clinical Commissioning Group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the NHS Clinical Commissioning Group's surplus/deficit in the period in which they arise.

1.31 **Third Party Assets**

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

1.32 **Losses & Special Payments**

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

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

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

In the application of the NHS Clinical Commissioning Group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.33.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the NHS Clinical Commissioning Group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- The NHS Clinical Commissioning Group's portfolio of leases has been reviewed and a management judgement has been made that the leases should be classified as operating leases.

1.33.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- There are a number of accruals within the Statement of Financial Position where estimation techniques are applied. This is because the outturn information is not available at the time of preparation of the financial statements. Examples of significant accruals involving estimates are; prescribing costs.
- The NHS Clinical Commissioning Group has discontinued its adjusted method for calculating the year end accrual for prescribing expenditure, first introduced in 2019/2020, to take account of items prescribed in March 2022 but which will be consumed in April 2022.
- Community Equipment Store inventory continued to be recognised in the accounts for 2021-22.

1.34 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.35 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022-23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – IFRS 16 Leases has been deferred until 1 April 2022, but NHS Clinical Commissioning Groups will still need to provide adequate disclosure on the impact of the new standard. HM Treasury have issued application guidance which will assist entities in assessing the impact and this can be found at IFRS_16_Application_Guidance_December_2020.pdf (publishing.service.gov.uk).

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The NHS Clinical Commissioning Group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the NHS Clinical Commissioning Group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the NHS Clinical Commissioning Group's incremental borrowing rate. The NHS Clinical Commissioning Group's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022-23, the NHS Clinical Commissioning Group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The NHS Clinical Commissioning Group has undertaken an assessment of the impact of IFRS 16 Leases and has determined that it is not material.

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

2. Financial performance targets

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

	2021-22 Target	**2021-22 Performance**	2020-21 Target	2020-21 Performance
Expenditure not to exceed income	649,806	651,906	627,884	627,747
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	648,924	651,024	627,279	627,135
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	6,567	6,561	6,060	6,059

As at 31 March 2022, NHS Morecambe Bay Clinical Commissioning Group delivered a deficit of £2.088m against its allocation received from NHS England and Improvement, caused by the reversal of a £2.112m prescribing prepayment in year. This reverses a change in accounting estimate first introduced in the 2018-19 financial year. NHS England and Improvement has advised that the NHS Clinical Commissioning Group will not be penalised in performance management terms for the deficit, but will be referred to the Secretary of State for a failure to fulfil its statutory duties, under Section 30(1)(b) of the Local Audit and Accountability Act 2014.

Throughout the year, a significant level of financial risk was reported to the Governing Body, along with notification of significant amounts of additional allocation received from NHS England and Improvement as part of the revised financial regime introduced to assist NHS organisations in managing their financial positions against the backdrop of the Covid-19 pandemic. This financial position was, therefore, achieved following a series of non-recurrent mitigations, including the receipt of additional allocations.

3. Other Operating Revenue

	2021-22 Total	2020-21 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	**20**	11
Non-patient care services to other bodies	**-**	4
Patient transport services	**-**	-
Prescription fees and charges	**-**	-
Dental fees and charges	**-**	-
Income generation	**-**	-
Other Contract income	**146**	22
Recoveries in respect of employee benefits	**472**	339
Total Income from sale of goods and services	**638**	**376**
Other operating income		
Rental revenue from finance leases	**-**	-
Rental revenue from operating leases	**-**	-
Charitable and other contributions to revenue expenditure: NHS	**-**	-
Charitable and other contributions to revenue expenditure: non-NHS	**-**	18
Receipt of donations (capital/cash)	**-**	-
Receipt of Government grants for capital acquisitions	**-**	-
Continuing Health Care risk pool contributions	**-**	-
Non cash apprenticeship training grants revenue	**-**	-
Other non contract revenue	**244**	210
Total Other operating income	**244**	**228**
Total Operating Income	**882**	**605**

Education, training and research revenue relates to a research grant from Health Education England.
Other contract income relates to income from; NHS Frimley CCG in respect of a Violence Prevention Programme (£100k); Police funding for a role within Community Services (£28k); and a reclaim of funding for Home Care (£15k).
Recoveries in respect of employee benefits relates to reimbursement of salary costs for staff seconded to; Lancashire and South Cumbria ICS; Morecambe Bay Primary Care Collaborative; Lancashire Teaching Hospitals NHS Foundation Trust; and recharges to all other Lancashire and South Cumbria Clinical Commissioning Groups for a hosted post.
Other non contract revenue relates to income from; NHS North East Commissioning Support Unit in respect of recharges for the use of offices (£181k); income from NHS Morecambe Bay NHS Foundation Trust for the provision of a phlebotomy service (£60k); and reimbursement of excess treatment costs from Liverpool University Hospitals NHS Foundation Trust (£3k).

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

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue								
NHS	-	-	-	-	-	-	100	442
Non NHS	20	-	-	-	-	-	46	30
Total	**20**	**-**	**-**	**-**	**-**	**-**	**146**	**472**

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue								
Point in time	20	-	-	-	-	-	146	1
Over time	-	-	-	-	-	-	-	471
Total	**20**	**-**	**-**	**-**	**-**	**-**	**146**	**472**

4.1 Disaggregation of Income - Income from sale of good and services (contracts) - 2020-21 comparators

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue								
NHS	-	4	-	-	-	-	-	336
Non NHS	11	-	-	-	-	-	22	3
Total	**11**	**4**	**-**	**-**	**-**	**-**	**22**	**339**

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue								
Point in time	11	4	-	-	-	-	22	3
Over time	-	-	-	-	-	-	-	336
Total	**11**	**4**	**-**	**-**	**-**	**-**	**22**	**339**

4.2 Transaction price to remaining contract performance obligations

Contract revenue expected to be recognised in the future periods related to contract performance obligations not

	2021-22 Total	Revenue expected from NHSE Bodies	Revenue expected from Other DHSC Group Bodies	Revenue expected from Non-DHSC Group Bodies	2020-21 Total	Revenue expected from NHSE Bodies	Revenue expected from Other DHSC Group Bodies	Revenue expected from Non-DHSC Group Bodies
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Not later than 1 year	-	-	-	-	-	-	-	-
Later than 1 year, not later than 5 years	-	-	-	-	-	-	-	-
Later than 5 Years	-	-	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

5. Employee benefits and staff numbers

5.1.1 Employee benefits	Total 2021-22		
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**3,689**	**617**	**4,306**
Social security costs	**408**	**-**	**408**
Employer Contributions to NHS Pension scheme	**731**	**-**	**731**
Other pension costs	**-**	**-**	**-**
Apprenticeship Levy	**4**	**-**	**4**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	4,832	617	5,449
Less recoveries in respect of employee benefits (note 5.1.2)	**(472)**	**-**	**(472)**
Total - Net admin employee benefits including capitalised costs	4,360	617	4,977
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	4,360	617	4,977

5.1.1 Employee benefits	Total 2020-21		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**3,481**	**595**	4,077
Social security costs	**370**	**4**	374
Employer Contributions to NHS Pension scheme	**520**	**13**	533
Other pension costs	**-**	**-**	-
Apprenticeship Levy	**2**	**-**	**2**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	4,373	613	4,985
Less recoveries in respect of employee benefits (note 4.1.2)	**(339)**	**-**	**(339)**
Total - Net admin employee benefits including capitalised costs	4,033	613	4,646
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	4,033	613	4,646

5.1.2 Recoveries in respect of employee benefits			2021-22	2020-21
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Total £'000
Employee Benefits - Revenue				
Salaries and wages	**(472)**	**-**	**(472)**	**(339)**
Social security costs	**-**	**-**	**-**	**-**
Employer contributions to the NHS Pension Scheme	**-**	**-**	**-**	**-**
Other pension costs	**-**	**-**	**-**	**-**
Other post-employment benefits	**-**	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**	**-**
Total recoveries in respect of employee benefits	(472)	-	(472)	(339)

5.2 Average number of people employed

	2021-22			2020-21		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**64.68**	**7.07**	**71.75**	**58.79**	**6.79**	**65.58**

The NHS Clinical Commissioning Group had no staff engaged on capital projects during the financial year.

5.3 Exit packages agreed in the financial year

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

	2020-21 Compulsory redundancies		2020-21 Other agreed departures		2020-21 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	1	12,642	1	12,642
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**1**	**12,642**	**1**	**12,642**

	2021-22 Departures where special payments have been made		2020-21 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

Analysis of Other Agreed Departures

	2021-22 Other agreed departures		2020-21 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	1	12,642
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**-**	**-**	**1**	**12,642**

5.4 Pension costs

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

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

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

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

5.4.1 Accounting valuation

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

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

5.4.2 Full actuarial (funding) valuation

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

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

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

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

6. Operating expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	4,417	4,197
Services from foundation trusts	380,400	362,704
Services from other NHS trusts	24,298	23,807
Provider Sustainability Fund	-	-
Services from Other WGA bodies	5	4
Purchase of healthcare from non-NHS bodies	93,297	95,761
Purchase of social care	16,606	19,130
General Dental services and personal dental services	-	-
Prescribing costs	58,063	56,117
Pharmaceutical services	-	-
General Ophthalmic services	88	49
GPMS/APMS and PCTMS	62,058	55,689
Supplies and services – clinical	308	344
Supplies and services – general	179	334
Consultancy services	11	7
Establishment	1,308	2,097
Transport	25	25
Premises	1,739	2,156
Audit fees	80	72
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	12	12
Other professional fees	93	20
Legal fees	101	108
Education, training and conferences	7	70
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Non cash apprenticeship training grants	-	-
Total Purchase of goods and services	**643,093**	**622,703**
Depreciation and impairment charges		
Depreciation	-	-
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets	-	-
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**-**	**-**
Provision expense		
Change in discount rate	-	-
Provisions	3,165	-
Total Provision expense	**3,165**	**-**
Other Operating Expenditure		
Chair and Non Executive Members	39	38
Grants to Other bodies	-	-
Clinical negligence	-	-
Research and development (excluding staff costs)	20	8
Expected credit loss on receivables	-	-
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Other expenditure	141	13
Total Other Operating Expenditure	**200**	**59**
Total operating expenditure	**646,457**	**622,762**

Notes:

The Clinical Commissioning Group's contract with its external auditors (KPMG LLP) provides for a limitation of the auditor's liability, this is limited at £1m.

7.1 Better Payment Practice Code

Measure of compliance	2021-22 Number	2021-22 £'000	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	34,169	189,828	36,101	174,785
Total Non-NHS Trade Invoices paid within target	34,153	188,770	36,087	174,588
Percentage of Non-NHS Trade invoices paid within target	**99.95%**	**99.44%**	**99.96%**	**99.89%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	478	410,701	1,724	394,945
Total NHS Trade Invoices Paid within target	478	410,701	1,722	394,944
Percentage of NHS Trade Invoices paid within target	**100.00%**	**100.00%**	**99.88%**	**100.00%**

Under revised Procurement Policy Note (PPN) guidelines, NHS Clinical Commissioning Groups were expected to pay suppliers within 7 days during the financial year, in response to cash flow issues caused by Covid-19 (effective 19 March 2020).

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

The NHS Clinical Commissioning Group made no payments under the Late Payment of Commercial Debts (Interest) Act 1998 during the financial year.

8. Operating Leases

Despite no leases formally being in place in respect of the NHS Clinical Commissioning Group's occupation of premises and its relationship with NHS Property Services Ltd., the substance of these arrangements suggests that they are leases. Payments made in 2020-21 are disclosed as minimum lease payments under the buildings column of Note 8.1.1.

8.1.1 Payments recognised as an Expense

	2021-22				2020-21			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payments recognised as an expense								
Minimum lease payments	-	1,175	19	**1,194**	-	1,561	20	**1,581**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**1,175**	**19**	**1,194**	**-**	**1,561**	**20**	**1,581**

The NHS Clinical Commissioning Group occupies property leased and managed by NHS Property Services Ltd. For 2021-22 rental payments based on market rents were agreed. This is reflected in Note 8.1.1. Whilst the NHS Clinical Commissioning Group's arrangements with NHS Property Services Ltd. fall within the definition of operating leases, the rental charge for future years has not yet been agreed. Consequently this note does not include future minimum lease payments for these arrangements only.

8.1.2 Future minimum lease payments

	2021-22				2020-21			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payable:								
No later than one year	-	-	10	**10**	-	-	13	**13**
Between one and five years	-	-	7	**7**	-	-	1	**1**
After five years	-	-	-	**-**	-	-	-	**-**
Total	**-**	**-**	**17**	**17**	**-**	**-**	**13**	**13**

9. Property, plant and equipment

2021-22	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2021	-	-	-	-	-	-	69	62	131
Disposals other than by sale	-	-	-	-	-	-	(69)	(62)	(131)
Cost/Valuation at 31 March 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Depreciation 01 April 2021	-	-	-	-	-	-	69	62	131
Disposals other than by sale	-	-	-	-	-	-	(69)	(62)	(131)
Charged during the year	-	-	-	-	-	-	(0)	0	-
Depreciation at 31 March 2022	**-**	**-**	**-**	**-**	**-**	**-**	**0**	**(0)**	**-**
Net Book Value at 31 March 2022	**-**	**-**	**-**	**-**	**-**	**-**	**(0)**	**0**	**-**
Purchased	-	-	-	-	-	-	-	-	-
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Asset financing:									
Owned	-	-	-	-	-	-	-	-	-
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 31 March 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2021	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
Balance at 31 March 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

9.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	2	5
Furniture & fittings	5	10

10. Inventories

	Drugs	Consumables	Energy	Work in Progress	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 01 April 2021	-	-	-	-	347	-	**347**
Additions	-	-	-	-	58	-	**58**
Inventories recognised as an expense in the period	-	-	-	-	-	-	**-**
Write-down of inventories (including losses)	-	-	-	-	-	-	**-**
Reversal of write-down previously taken to the statement of comprehensive net expenditure	-	-	-	-	-	-	**-**
Transfer (to) from -Goods for resale	-	-	-	-	-	-	**-**
Balance at 31 March 2022	**-**	**-**	**-**	**-**	**405**	**-**	**405**

11.1 Trade and other receivables

	Current 2021-22 £'000	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS receivables: Revenue	1,924	-	342	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	-	-	-	-
NHS accrued income	3,272	-	11	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	582	-	767	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	134	-	176	-
Non-NHS and Other WGA accrued income	219	-	34	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	-	-	-	-
VAT	2	-	33	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	-	-	-	-
Total Trade & other receivables	**6,133**	**-**	**1,363**	**-**
Total current and non current	**6,133**		**1,363**	
Included above:				
Prepaid pensions contributions	-		-	

The great majority of trade is with NHS England and Improvement. As NHS England and Improvement is funded by Government to provide funding to NHS Clinical Commissioning Groups to commission services, no credit scoring of them is considered necessary.

11.2 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	**2021-22 Non DHSC Group Bodies £'000**	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000
By up to three months	1,924	444	316	541
By three to six months	-	37	13	0
By more than six months	-	77	24	152
Total	**1,924**	**558**	**353**	**693**

The NHS Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2022.

12. Cash and cash equivalents

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	13	21
Net change in year	47	(8)
Balance at 31 March 2022	**61**	**13**
Made up of:		
Cash with the Government Banking Service	61	13
Cash with Commercial banks	-	-
Cash in hand	-	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**61**	**13**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2022	**61**	**13**

13. Trade and other payables	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	4,869	-	3,070	-
NHS payables: Capital	-	-	-	-
NHS accruals	909	-	266	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	9,514	-	9,417	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	19,984	-	11,708	-
Non-NHS and Other WGA deferred income	-	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	59	-	57	-
VAT	-	-	-	-
Tax	56	-	55	-
Payments received on account	-	-	-	-
Other payables and accruals	1,995	-	8,751	-
Total Trade & Other Payables	**37,385**	**-**	**33,324**	**-**
Total current and non-current	**37,385**		**33,324**	

Other payables include £682k outstanding pension contributions at 31 March 2022 (31 March 2021: £503k).
The NHS Clinical Commissioning Group has conducted a review of the "Other payables and accruals" line and as a result, £8.93m has been reclassified to "Non-NHS and Other WGA payables: Revenue", in order to better reflect the nature of these balances.

14. Provisions

	Current 2021-22 £'000	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	-	-
Continuing care	3,165	-	-	-
Other	-	-	-	-
Total	**3,165**	**-**	**-**	**-**
Total current and non-current	**3,165**		**-**	

	Pensions Relating to Former Directors £'000	**Pensions Relating to Other Staff £'000**	**Restructuring £'000**	**Redundancy £'000**	**Agenda for Change £'000**	**Equal Pay £'000**	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2021	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Arising during the year	-	-	-	-	-	-	-	3,165	-	**3,165**
Utilised during the year	-	-	-	-	-	-	-	-	-	**-**
Reversed unused	-	-	-	-	-	-	-	-	-	**-**
Unwinding of discount	-	-	-	-	-	-	-	-	-	**-**
Change in discount rate	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**3,165**	**-**	**3,165**
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	-	3,165	-	**3,165**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**3,165**	**-**	**3,165**

The Continuing care provision has arisen from claims by Lancashire County Council and Cumbria County Council in respect of CHC packages of care which the Local Authorities have paid for but for which the individual patients did not have an assessment within the 28 day timescale specified in the national CHC Framework. Whilst in principle the NHS Clinical Commissioning Group accepts liability for the issue and acknowledges a failure to follow the guidance on timescales for assessments, the interpretation of some aspects of the guidance is being discussed with the Local Authorities and therefore it has not been possible to transact a financial remedy prior to the end of the 2021-22 financial year. The NHS Clinical Commissioning Group has therefore adopted a prudent approach and based the provision on case lists and estimated costs provided by the Local Authorities. It is anticipated that this issue will be resolved some time in the 2022-23 financial year.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the NHS Clinical Commissioning Group. However the legal liability remains with the NHS Clinical Commissioning Group. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of the NHS Clinical Commissioning Group as at 31 March 2022 is £0.

15. Contingencies

The NHS Clinical Commissioning Group had no contingent liabilities as at 31 March 2022. Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the NHS Clinical Commissioning Group. However the legal liability remains with the NHS Clinical Commissioning Group. The total value of legacy NHS Continuing Healthcare contingent liabilities accounted for by NHS England on behalf of the NHS Clinical Commissioning Group as at 31 March 2022 is £0.

16. Financial instruments

16.1 Financial risk management

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

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

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

16.1.1 Currency risk

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

16.1.2 Interest rate risk

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

16.1.3 Credit risk

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

16.1.4 Liquidity risk

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

16.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

16. Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost 2021-22 £'000	Equity Instruments designated at FVOCI 2021-22 £'000	Total 2021-22 £'000
Equity investment in group bodies		-	-
Equity investment in external bodies		-	-
Loans receivable with group bodies	-		-
Loans receivable with external bodies	-		-
Trade and other receivables with NHSE bodies	5,142		5,142
Trade and other receivables with other DHSC group bodies	57		57
Trade and other receivables with external bodies	797		797
Other financial assets	-		-
Cash and cash equivalents	61		61
Total at 31 March 2022	**6,058**	**-**	**6,058**

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	1,275		**1,275**
Trade and other payables with other DHSC group bodies	4,640		**4,640**
Trade and other payables with external bodies	31,356		**31,356**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2022	**37,271**	**-**	**37,271**

17. Operating segments

The NHS Clinical Commissioning Group considers that it has only one segment; commissioning of healthcare services.

18. Joint arrangements - interests in joint operations

NHS Clinical Commissioning Groups should disclose information in relation to joint arangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

18.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY 2021-22				Amounts recognised in Entities books ONLY 2020-21			
			Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Lancashire County Council Better Care Fund/iBCF	Lancashire County Council, Morecambe Bay CCG, Fylde & Wyre CCG, Chorley and South Ribble CCG, Greater Preston CCG, East Lancashire CCG, West Lancashire CCG	Better Care Fund services	0	0	7,610	(11,412)	0	0	7,393	(11,094)
Cumbria County Council Better Care Fund/iBCF	Cumbria County Council, Morecambe Bay CCG	Better Care Fund services	0	0	0	(9,415)	0	0	0	(8,919)

19. Related party transactions

The NHS Clinical Commissioning Group's Governing Body Members were asked to disclose any material transactions that they or their family (or any business that the own or control) have had with any local health-related body during 2020-21.

Details of related party transactions with individuals are as follows:

***NOTE: payments shown are those made by the NHS Clinical Commissioning Group to the related party organisation, not the individual listed:**

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr G Jolliffe (CCG Clinical Chair) ***see note above:**				
- GP employee, Cumbria Health On Call (CHOC)	3,950		52	
- Spouse is employed as HCA at Risedale Surgery	1,104			(2)
- Daughter is employed in Pharmacy at University Hospitals of Morecambe Bay NHS Foundation Trust	290,834		146	
Dr A Knox (Governing Body GP Member) ***see note above:**				
- GP Partner, Ash Trees Surgery	4,966		4	
Dr J Hacking (Governing Body GP Member) ***see note above:**				
- GP Partner, Park View Surgery, Milnthorpe	922		7	
- Member of South Cumbria Primary Care Collaborative (now Morecambe Bay Primary Care Collaborative)	1,106			
- Spouse is a Biomedical Scientist employed by University Hospitals of Morecambe Bay NHS Foundation Trust	290,834		146	
Dr L Dixon (Governing Body GP Member) ***see note above:**				
- GP Partner, Bridgegate Medical Centre	1,656		2	
Dr R Keith (Governing Body GP Member) ***see note above:**				
- GP Partner, Lancaster Medical Practice	9,379			(8)
- Shareholder of North Lancashire Medical Services Ltd. (now Morecambe Bay Primary Care Collaborative	1,106			
Dr S Arun (Governing Body GP Member) ***see note above:**				
- GP Principle, Norwood Medical Centre	1,574		2	
- Spouse is a GP at Abbey Road Surgery	1,023		1	
- Spouse is Chief Executive Officer for Morecambe Bay Primary Care Collaborative	1,106			
Mr J Hawker (Chief Officer 01/09/2018 - 31/03/2019) ***see note above:**				
- Spouse is the Director of Commissioning for NHS Wirral CCG				
Mr A Harrison (Chief Finance Officer 01/08/2020 - 31/03/2021) ***see note above:**				
- Chief Finance Officer, NHS Blackpool Clinical Commissioning Group	1,559		53	(1,481)
- Chief Finance Officer, NHS Fylde and Wyre Clinical Commissioning Group	(61)		75	(11)

The Department of Health and Social Care is regarded as a related party. During the year the NHS Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department, including:

University Hospitals of Morecambe Bay NHS Foundation Trust	290,834		146	
Lancashire & South Cumbria NHS Foundation Trust	50,380		3,073	(22)
Blackpool Teaching Hospitals NHS Foundation Trust	4,183		17	
North West Ambulance Services NHS Trust	23,087			
Wrightington, Wigan and Leigh NHS Foundation Trust	3,122			
Manchester University NHS Foundation Trust	3,184			
Lancashire Teaching Hospitals NHS Foundation Trust	13,429		6	(25)
East Lancashire Hospitals NHS Trust	1,212			
North Cumbria Integrated Care NHS Foundation Trust	5,563		1,207	

In addition, the NHS Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies, including:

Lancashire County Council	8,329		1,278	(82)
Cumbria County Council	6,052		6,033	(432)

20. Events after the end of the reporting period

On 28 April the Health and Care Act received Royal Assent. This confirms the establishment of Integrated Care Boards (ICBs) in England. As a result of this the NHS Clinical Commissioning Group expects to be wound up on 30 June 2022 and NHS Lancashire and South Cumbria Integrated Care Board to be formed on 1 July 2022. As explained in Note 1.1, the NHS Clinical Commissioning Group's accounts are still prepared on a going concern basis due to the continued provision of the NHS Clinical Commissioning Group's commissioning functions by the ICB.

21. Losses and special payments

21.1 Losses

The NHS Clinical Commissioning Group had no losses cases during the financial year (2020-21: £nil).

21.2 Special payments

The NHS Clinical Commissioning Group made no special payments during the financial year (2020-21: 1 / £13k).