Blackburn with Darwen CCG

Annual Report Quarter 1 2022-23

1 April – 30 June 2022

Contents

PERFORMANCE REPORT

ANNUAL REPORT QUARTER 1 2022-23

WELCOME

Welcome to the Quarter 1 2022-2023 Annual Report for NHS Blackburn with Darwen CCG

The national extension of the Integrated Care Board establishment meant that the CCG continued with its statutory arrangements until 30 June 2022 and established shadow arrangements from April 2022 to support the transfer of formal responsibilities for commissioning services.

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

Performance Report

This section gives an overview of who we are and what we do, some of our highlight achievements during Quarter 1 2022-23, and the key risks we faced in meeting our objectives. If you want to find out more detail about our performance in the year, you will find this information in the performance analysis section.

Statement from Chief Executive on performance

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

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

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

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

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

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

Information previously contained on CCG websites is now available via LSC Integrated Care Board :: Legacy clinical commissioning groups (CCGs) (icb.nhs.uk)

Kevin Lavery

Chief Executive

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

28 June 2023

About Blackburn with Darwen Clinical Commissioning Group (CCG)

The CCG was established without conditions by NHS England in 2013. We are responsible for planning, buying and monitoring the quality of hospital and community health services to meet the needs of patients in the borough of Blackburn with Darwen. The process of planning and buying health services is known as 'commissioning'. CCGs are led by GPs, who are clinicians, which is why it is called 'clinical commissioning'.

We serve a population of around 170,000 people, making it the largest borough in the wider Lancashire area. The majority of the borough's residents (around 142,000) live in the towns of Blackburn and Darwen with the remaining residents living in the rural villages and hamlets (Hoddlesden, Edgworth, Belmont, Chapel Town and Tockholes) that surround the two major urban centres. We have 22 GP practices.

For the first three months of 2022-23 we received £72.5 million from the government in order to commission healthcare for local people. We are responsible for ensuring that the money is spent carefully and wisely, providing efficient and effective local services.

Blackburn with Darwen has quite a diverse demographic picture. The borough as a whole has a relatively young age profile. It has a higher than average proportion of young people (0-19) compared to the national figure and conversely, a smaller proportion of older people (65 and over). This means we need to ensure their needs are taken into account when commissioning services.

As a multicultural borough, the area is home to many people with diverse ethnicities and identities. Our population is predominantly white British but there are a significant number of people of South Asian origin as well, making up approximately 28 per cent of the registered population. The borough is also home to people who identify as Chinese, African, Caribbean, Arab and people of multiple ethnicities.

Life expectancy and measures of the quality of people's lives and health are significantly lower than elsewhere in country, and lower than the national average. Blackburn with Darwen is in the top 10% most deprived boroughs in England. However, this deprivation can vary significantly in some communities, especially those within rural areas, as these are amongst the least deprived.

Smoking, alcohol and drug misuse, poor diet and lack of exercise contribute to the ill health of residents and this in turn creates extra pressure on NHS services.

We believe that because of this complex demography, it is important to understand the circumstances of people's lives, recognise the importance of community and community assets, and engage and involve patients and residents. In doing this, we can ensure that we truly improve services, and the health and wellbeing of individuals.

In response to the priorities set by NHS England nationally during period of 2022-23, local systems continued to priorities Covid-19 vaccinations, access for patients to key services, the timely discharge of patients from services, and developing enhanced 'surge planning' to prepare for predicted pressures.

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

Across Lancashire and South Cumbria there has been a continued focus on integrated working which has seen the leadership system across all partners come together to stabilise services and respond as a single system to the significant challenges faced. You can read more in this report on how the development of the ICB and the continuation of Integrated Care System relationships have supported mitigating the pressures felt across the system.

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

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

In Lancashire and South Cumbria, accelerator funding from NHS England has proved invaluable in helping the care system mitigate against some of these issues. Additional bed capacity in

hospitals across the region has been provided, enabling improvements in pre- and post-operative patient assessments.

Primary Care continues to develop their ways of working, with a range of services offered via face-to-face, telephone and digital channels with members of GP practices multi-disciplinary teams. As with other areas of the NHS, challenges remain and work has been undertaken during this period to ensure that planning and development of services across Lancashire and South Cumbria primary care is robust and effective for our primary care colleagues, patients and local populations.

Working with our partners

Lancashire and South Cumbria Health and Care Partnership

The **Covid-19 vaccination programme** – the largest in history – was well established by April 2022, both nationally and across Lancashire and South Cumbria. The Covid-19 Vaccination Programme Board, established in November 2020, continued to provide oversight during quarter one of 2022/23 as well as strategic direction to make sure the local offer met public need and was fit for purpose.

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

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

Partners including local councils, the military, fire and rescue service, police, local businesses, volunteers, returning clinical staff and many more have supported the delivery of the vaccine. More than 1,600 local people offered their support following an appeal for volunteers, and since the vaccination programme began, volunteers have logged almost 144,000 hours through Lancashire Volunteer Partnership.

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

I look forward to developing local relationships with partners, patients and local communities as the role of the ICB develops and I would like to take this opportunity to formally recognise and

thank our local teams across each CCG area for their dedication to supporting the local populations in Lancashire and South Cumbria as they continue to address the challenges that we have outlined in this work through the new and emerging structures.

Performance Analysis

Mental health: children and young people

Child and Adolescent Mental Health Services (CAMHS) have continued to see an increase in referrals, and an increased complexity of needs which has caused children and young people (CYP) to remain in services for longer. Services continue to be transformed in line with the evidence-based THRIVE model, which was developed with NHS organisations, local authorities, education, the Police, representatives from the voluntary, community, faith and social enterprise (VCFSE) sector, parents, carers and young people.

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

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

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

Mental health: adults

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

Specialist Community Perinatal Mental Health (PMH) services continue to expand in line with the NHS Long Term Plan ambitions, providing specialist care to new and expectant mothers with

moderate to severe needs up to 24 months following birth. For 2022/23, the growth is focused on developing support in terms of psychological therapies. This includes parent-infant therapy and systemic family therapy. As of May 2022, the service has supported 272 women – slightly above the national trajectory. Peer support and partner assessments are also now provided as part of the service.

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

A total of 139 referrals were accepted in quarter one, and 61 women have started treatment. Most referrals are made by the Specialist Perinatal Community Mental Health team and the specialist perinatal midwives. The service offers support and therapies to those who have experienced birth trauma, fear of childbirth (tokophobia) or perinatal loss (including early miscarriage, stillbirth, neonatal death, termination of pregnancy, and separation at birth). Fathers, birthing partners or co-parents of mothers accessing the service will be offered an assessment and signposted as appropriate.

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

Lancashire and South Cumbria NHS Foundation Trust (LSCFT) is continuing to mobilise the **Initial Response Service (IRS)** which will provide a single point of contact for all mental health urgent and routine referrals via one 24/7 phone number and a dedicated email address in each locality. The new service includes an extended crisis mental health helpline and rapid response function where urgent, face-to-face assessments are needed. In the first four weeks since launching in Pennine Lancashire, the IRS has taken around 7,000 calls – an average of 250 per day.

The process will be gradual, initially launching with the Police and North West Ambulance Service before being extended to GP practices. The Central Lancashire and West Lancashire model is based at the Avondale Unit on the Royal Preston Hospital site, and commenced in May 2022.

The Bay and Fylde Coast IRS plan to soft launch in winter 2022. Work is underway to enable appropriate NHS 111 calls to be transferred to the IRS.

Crisis alternatives such as The Central Lancashire Haven and Blackpool Light Lounge have been developed with our VCFSE partners as an alternative to A&E. They aim to provide a welcoming and non-judgmental environment for individuals struggling socially and emotionally with life challenges or who are in crisis. A re-procurement process for a crisis housing provision across Lancashire and South Cumbria is underway, with an additional crisis house for the Morecambe Bay area. Crisis houses offer short-term accommodation for people experiencing a mental health crisis and provide holistic therapeutic support and interventions to prevent hospital admissions.

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

The **Community Mental Health Transformation** is a three-year programme of large-scale change that will be completed by March 2024. Plans are being developed to reconfigure community mental health services around primary care networks (PCNs) into community mental health hubs. Lancashire and South Cumbria NHS Foundation Trust have set up a procurement framework for the VCFSE, which currently has 58 organisations listed. The framework has been used to procure peer support services for East Lancashire, Central and West Lancashire, and Lancaster – a peer support service is currently being procured for South Cumbria.

The programme includes recruiting one primary care mental health worker per PCN each year from 2021/22 to 2023/24 – funded by the Additional Roles Reimbursement Scheme (ARRS). Building on the 26 appointments made during 2021/22, roles for the 2022/23 cohort are currently being confirmed with the PCNs before recruitment can commence. Several additional roles have been recruited for 2022/23 in conjunction with the Trainee Associate Psychological Practitioners scheme (TAPPs).

Personality disorder, eating disorder and rehabilitation specialists will also form part of the staffing model for the community hubs. An adult version of the **First episode and Rapid Early intervention for Eating Disorders (FREED) service** was implemented, between April and June

2022 an additional 22 whole time equivalents were recruited into these pathways. Additional VCFSE services for low complexity eating disorders will also be offered as part of the hubs' VCSFE signposting – and will be procured in quarter two of 2022/23. Rehabilitation staff will be recruited from quarter two of 2022/23. Staff are reviewing their caseloads alongside the weighted population and considering how the teams can be reconfigured into the new hub teams. They are also looking at patient flow to improve throughput in services and reduce waiting times.

The ICS has developed an information dashboard to support primary care in delivering **physical health checks for patients on the serious mental illness (SMI) registers**. A steering group has been established to help support and drive the delivery of the health checks. A new digital remote monitoring project works across the system with a range of stakeholders assisting in delivering the checks. An improved offer for physical health monitoring and medication monitoring for SMI patients has been developed, including additional staff, improved electronic patient record keeping, and increased access to devices like echocardiograms. ECG rollout and recruitment will commence in quarter two of 2022/23.

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

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

Improving Access to Psychological Therapy services across Lancashire and South Cumbria continue to work towards expanding access while improving in-treatment waits and maintaining the existing positive performance with regards to referral-to-treatment times and recovery standards, in line with national targets.

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

- The national IAPT Lead is to undertake a review, in collaboration with LSCFT and the ICB, and provide ongoing support with several high-impact actions
- Creative World has been commissioned to deliver a package of promotional activity and market research
- A digital triage pilot is being scoped
- Investment into IAPT trainees for 2022/23 has been prioritised
- Trajectories have been developed by each provider to support the delivery of the NHS Long Term Plan ambition over the next two years.

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

Suicide prevention

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

Through real-time surveillance of suspected and attempted suicides, drug-related deaths, and self-harm episodes, themes are being identified and intelligence-led interventions are being made. A multi-agency group reviews all data and risk factors to make sure the appropriate responses are made as and when they are needed. Our combined and collaborative responses to intelligence reporting have contributed to a 16% reduction in suicides across our area over the past 12 months.

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

The 'Let's keep talking' campaign encourages local organisations, businesses and community groups to access resources that promote people to open up about their mental health. Currently on phase 10, the campaign is focusing on the cost of living and providing support services and encouraging residents to reach out for help at the earliest opportunity.

More than 6,000 people have been trained in suicide prevention and self-harm. More than 1,800 people have signed up to be orange button wearers (local people who have undergone extensive suicide prevention training wear the button to signal that while they cannot counsel people, they are trained to direct them to relevant services). The scheme has now also been rolled out across Cornwall, Devon, Somerset and Worcestershire.

Digital - Our vision for digital and data transformation

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

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

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

Digital Transformation

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

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

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

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

Stroke

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

In response, Lancashire and South Cumbria Integrated Stroke and Neurorehabilitation Delivery Network (ISNDN) has set up an Operational Implementation Group to oversee the implementation and delivery of improvements to acute stroke centres. Progress is being made in several areas of development. Ambulatory care is now operational in most trusts, although some

challenges in recruitment remain and a seven-day service has not yet been achieved across the region.

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

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

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

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

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

Diabetes

More than 100,000 people aged 17 and above in Lancashire and South Cumbria have Type 2 diabetes and it's estimated that more than 75,000 people are at a high risk of developing the condition. It is crucial to diagnose the condition as early as possible and identify those at risk so they can be supported in making healthier lifestyle choices.

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

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

Local people with Type 2 diabetes have been able to access support to manage their condition through My Way Diabetes via Your Diabetes, Your Way. Again, all face-to-face learning sessions were suspended during the pandemic, although a number of digital support resources were available online. As people with diabetes are amongst those more vulnerable to Covid-19, local health and care organisations worked together to provide practical and emotional support, especially during the winter months We are reviewing the provision of structured education for all diabetes patients for 2022/23 and additional sources of information will be available from the national team.

Cancer Alliance

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

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

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

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

Maternity

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

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

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

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

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

Our **Workforce and Education Transformation Workstream** has completed the implementation of the Maternity Support Worker (MSW) Competency Career and Education Framework – agreeing on standardised job descriptions and delivering a bridging training programme to upskill the workforce. Apprenticeship pathways will now be explored to 'grow our own midwives' during these times of significant national staff shortages.

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

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

Trusts have also received national funding to support staff retention for both midwives and MSWs and the regional maternity team is leading an international recruitment drive, which will see 10 additional midwives entering the workforce in Lancashire and South Cumbria. In addition, the development of a staff and student resource hub has been commissioned in partnership with the University of Central Lancashire (UCLan) and the University of Cumbria. The hub will host information, provide resources and training links for all students and staff working within maternity services across Lancashire and South Cumbria. This formally launched early in 2022/23 and continues to be developed.

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

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

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

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

The LMS Maternity Assurance Panel was formed in response to the Ockenden Report as part of a revised perinatal quality surveillance model (December 2020). The Panel is Chaired by a Non-Executive Director who is responsible for discharging the quality responsibilities, and has

continued to meet regularly. The essential actions arising from Ockenden identified that serious incident reports must still be shared with the LMS. A standard operating procedure for StEIS Reportable Incidents is now in place between providers, commissioners and the LMS so that timely notification of reports and investigations are shared. A member of the LMS assurance panel now attends the individual CCG Serious Incident Panels to review and discuss each incident. Bi-monthly incident reports are collated across the region, with six monthly thematic reviews undertaken, to allow any key learning and improvements to be promptly shared and enacted.

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

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

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

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

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

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

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

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

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

The National **Equity and Equality Guidance** for local maternity systems was published in September 2021 and is currently being embedded into the existing work programme. Colleagues at NHS Midlands and Lancashire Commissioning Support Unit have supported a population health needs analysis and a community assets mapping exercise has been commissioned – both of which were submitted to the regional team in November 2021. There has been a delay in the next phase of the work due to the nationally-recognised pressures across all LMSs, but planned developments remain for 2022/23.

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

Paediatrics

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

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

The **Diabetes Network** has been developed focussing on national priorities. We have refreshed our commissioning guidance for children who request a continuous glucose monitor and are now looking at any areas of inequality in the National Paediatric Diabetes Audit. A bid has been submitted for national funding to support the transition to adult services, working with the VCFSE sector and local authority to design projects to provide support for children with Type 2 diabetes and help to prevent this in school-age children.

The **Epilepsy Network** has been established to deliver on the national priorities, which include the transition to adult services, providing access to mental health assessment and psychological support, addressing the differences identified in the Epilepsy 12 Audit and standardising referral pathways.

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

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

The **Palliative Care Network** is working to improve the care for children with life-limiting illnesses and funding has been agreed to appoint a new palliative care consultant for the area. Joint working with Together for Short Lives and The Kentown Wizard Foundation will introduce five

specialist palliative care nurses across Lancashire and South Cumbria (as a national pilot), to further improve the care for children with life-limiting illnesses.

Other achievements include:

- In partnership with local hospitals, we are implementing the Paediatric Early Warning Score – a national programme to quickly identify poorly and deteriorating children
- Covid-19 pressures have continued to impact on children and young people's services, with the team supporting the wider system to plan for increased admissions throughout the year. We are working on new models of care including virtual wards
- The Integrated Care Board has ensured that children's and maternity services will have prominence in the new structures which will ensure that the voice of children and young people remain at the heart of new developments
- The new ICB also creates opportunities to strengthen our links with the four local authorities. The team has been working closely with Lancashire County Council on a programme funded through the Department for Education to enable better and appropriate sharing of information across the system.

Personalised care

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

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

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

We have seen services innovating and adapting, identifying problems and finding solutions. Services have embraced the key principles of personalised care, which is listening, and respecting the contribution that a patient can make and ensuring that the care provided helps

that person live the best life they can. We have created partnerships across Lancashire and South Cumbria, piloting the Sir Muir Gray 'Living Longer Better' approach in supporting people and communities to be more active and involved.

A model of working and workforce training has been developed and put in place to help our practitioners and partners deliver this at-scale involving primary care, community and acute service colleagues. We provide a range of personalised care workforce training, including Make Every Contact Count (MECC), Patient Activation Measure (PAM) and Health Coaching. We have developed resources to help colleagues to support people's health and wellbeing, maximise self-management and reduce further unnecessary demand on services. We are also connecting colleagues with an online support platform to help practitioners use PAM. This system helps us measure a patient's knowledge, skills and confidence to manage their health conditions and helps them build these skills and live more independently.

Health coaching delivery has been adapted so both online and face-to-face training can now be offered. We are now supporting colleagues in all our services to provide more choice and a personalised service to better meet patients' needs.

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

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

Population health management

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

Nearly one-third of people in Lancashire and South Cumbria live in some of the most deprived areas across England. More people are living in fuel poverty and unable to afford to heat their

homes than the national average (13% compared to 10.6%[1]). 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.

Workforce

The ICS developed a comprehensive plan to support and shape our workforce planning and development, to implement the requirements of the NHS People Plan, and to look more widely at the future ICB workforce functions and delivery of these. The workforce function plan is structured around delivery of the 10 people functions, which were set out in the national guidance for ICBs/ICSs (August 2021). This approach has been taken in order to ensure we implement the local and national people priorities and expectations to develop and support the 'one workforce' and make the health and care system a better place to work and live.

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

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

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

ceremony recognised the hard work, commitment and skill of the many apprentices working in health and care across the region.

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

Building on the success of our current employability programmes, we have now developed a range of programmes targeting Healthcare Support Worker (HCSW) vacancies. The employment programmes will be run across the system in partnership with trusts, Lancashire Enterprise Partnership (LEP), the Department for Work and Pensions, and Lancashire Adult Learning. An important aspect of our approach will be to work with partners focusing on how we access different groups within our local communities who may not traditionally consider roles in health and care. Programmes will be accelerated and will have guaranteed interviews at the end. The programmes will work alongside current funding given to the trusts to develop a recruitment pipeline for HCSW which includes supportive onboarding processes and pastoral support for those who are new to care.

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

- A health and wellbeing support guide for social care staff across the region
- Promoting business and staff resilience through multi-partner Social Care Workforce Forums
- A registered managers retention work plan with Skills for Care and NWADASS.

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

Most recently, the Social Care Workforce Forum received fantastic feedback as attendees heard from key speakers from the panels discussing workforce challenges and strategies targeting recruitment, retention and grow your career opportunities. Louise Taylor's opening remarks set

the context for the journey ahead and the changes needed across health and care to move towards a partnership approach.

Diagnostic Imaging

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

The Network was established to enable local hospitals to work collaboratively to share best practice, secure additional funding and support each other. Capital investment secured during 2020/21 enabled the procurement of new CT scanners at some of the hospital sites and enabled an increase in scanning capacity within community diagnostic centres. Further additional investment has funded new mobile CT and MRI scanners which will be delivered in September 2022.

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

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

Learning disabilities and autism

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

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

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

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

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

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

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

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

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

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

Cardiac

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

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

The Cardiac Pathways Improvement Programme in Lancashire and South Cumbria has helped identify significant opportunities for earlier diagnosis and better proactive management of CVD with particular focus on people in the most deprived areas of England who are almost four times more likely to die prematurely from CVD compared with the least deprived areas. The network is working with the Population Health team and Integrated Stroke and Neurorehabilitation Delivery Network (ISNDN) to prevent, detect and manage atrial fibrillation, high blood pressure (hypertension) and high cholesterol (hypercholesterolemia) to maximise resources and reduce duplication. Together these teams will work on the CORE20PLUS5 requirements for CVD.

The ICS continues to support campaigns including 'Know Your Numbers' (which encourages people to get their blood pressure checked) via the Healthy Hearts website and our Twitter account @CardiacNwc (#improvinghearthealth #HealthyHearts).

Across England, the pandemic caused a rise in waiting times for echocardiograms. In February 2022, our cardiac network, in collaboration with Lancashire and South Cumbria Community Diagnostic Centres team, successfully ran an 'echothon' – delivering echocardiograms at the weekend to reduce the wait times for local patients. This was a system-level approach through the collaborative working of skilled staff from all providers, using digital staff passporting to ensure that the needs of the population are met. The initiative reduced the waiting list by 12% in just two months and reassured those who have been waiting longer than necessary for a scan.

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

Funded care

During Q1 of 2022/23, the funded care work programme continued to work in partnership across the NHS and local authorities, meeting regularly to discuss the redesign of the whole NHS funded care service. Each element of the service is still being redeveloped including system-wide data,

reporting, finance, governance, quality assurance, communications and engagement and workforce modelling to create a service model that works across Lancashire and South Cumbria, and is designed to best meet the needs of the patients, families and carers it serves.

As part of this, patient and clinical feedback is gathered and fed into the Funded Care Group. Patients, carers and family members with lived-experience of the current processes joined the Funded Care Implementation Board (which oversees the programme of work) in 2021/22 as representatives who can help the team shape the redesign work and continue to sit on the FCIB and be part of the workstreams that they have a particular interest in.

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

Elective care

Recovering long waiting times that were impacted by the Covid-19 pandemic is a priority for the NHS. The extraordinary achievements of staff over the last two years are a testament to their determination and resilience. The pandemic has shown how the NHS can deliver transformational change for patients when needed. Whilst colleagues in every part of the country are working hard to recover elective services, significant additional government funding for elective recovery presents opportunities to build on this success.

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

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

During 2021/22, the Accelerator funding from NHS England proved fundamental in helping us in Lancashire and South Cumbria to mitigate against these issues, with elective activity scaled up to ensure we collectively see and treat as many people as we can as quickly as possible. It helped by providing additional bed capacity in hospitals across the region, enabling improvements in pre-and post-operative patient assessments, and reducing the number of unnecessary admissions for treatments such as angiograms by monitoring patients remotely. Targeted Investment Funds (TIF) were also secured to further support elective recovery – schemes included increasing elective capacity, critical care capacity and digital solutions.

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

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

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

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

Staff have gone above and beyond the call of duty, time and again, putting their own lives on the line, to make sure patients who have needed us the most have been cared for during these unprecedented times. We will be working hard to maintain the programmes of work we have put

in place in an effort to reduce the waiting lists and continue to provide the best possible care to our communities.

Primary care

Primary and Integrated Neighbourhood Care covers a range of services for patients including GP practices, pharmacies, optometry and dentistry. This annual report update will focus primarily on GP practices as part of the delegated commissioning responsibility to CCGs.

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

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

GP practices continue to provide a more flexible approach to appointments. We now offer a range of options for patients to seek advice and support from a clinician; via traditional face-to-face appointments, telephone consultations and video consultations. The latest GP Patient Survey data shows that, in line with the national average, 59% of patients were offered a choice of time, place and type of appointment as well as being offered a choice of healthcare professional. 73% of patients were satisfied with the appointment they were offered and 84% of patients agreed that reception staff were helpful2.

In the three months covered by this report (April – June 2022) data from NHS Digital demonstrates that GP services continued to increase the number of appointments available. In our last annual report, we presented data that showed there were more patient appointments each month between September 2021 and February 2022 than in the comparable period in 2019/20 prior to the pandemic. We are delighted to note that the most recent data available shows that in April and May 2022 the number of available appointments continues to rise with more than 1.5 million appointments across Lancashire and South Cumbria in just those two months[1].

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

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

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

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

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

We recognise that not everyone wishes to engage with primary care through digital solutions, but for many this offers quick, convenient and accessible ways in which to experience a range of services. Our work continues to improve video consultations and triage software solutions, telephony and the use of the NHS App[2].

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

Finally, we remain committed to tackling health inequalities. The disparities in life expectancy for people born in the most deprived areas of Lancashire and South Cumbria represent one of our biggest priorities and also one of our most significant challenges. As we move from Clinical commissioning groups to an Integrated Care Board, there is an opportunity for primary care, often the front door of the NHS, to be at the heart of integrated working to improve not just life expectancy but the quality of everyday life for our residents.

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

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

VCFSE leadership programme

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

In September 2021, Lancashire and South Cumbria VCFSE Alliance was successful in its bid for funding and support from the NHS England Voluntary Partnerships team, gaining a mix of financial investment and facilitation to the VCFSE sector to develop alliances or leadership groups across the area. The programme ran throughout 2022 and the first quarter of 2022/23, and facilitated better partnership working, as well as enhanced the VCFSE sector's role in strategy development and the design and delivery of integrated care. Lancashire and South

Cumbria VCFSE Alliance have held several workshops with wider sector partners to focus on strategy and partnership development.

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

Respiratory

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

Initially the network was asked to facilitate the setup of the Post-Covid Service with stakeholders from across the region. However, in May 2021, the need to address the backlog in respiratory disease (waiting lists for pulmonary rehabilitation and spirometry) was highlighted by the national team which prompted the formation of the Integrated Respiratory Network Delivery Board (IRNDB).

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

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

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

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

New Hospitals Programme

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

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

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

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

Clinical policies

The clinical commissioning policy development, review and harmonisation process has progressed; however, it continues to have a backlog of policies (both existing and proposed) created by the Covid-19 pandemic. In recent months, the departure of a few key members of the Policy Review team has also had an impact on the capacity to get the review process back on track.

Many of the second wave of 31 evidence-based interventions (EBI2) developed by NHS England have been implemented, but some lower priority procedures still remain. These tests, treatments or procedures have been assessed on behalf of Lancashire and South Cumbria. Some relate to clinical policies (either existing or requiring a new policy if one does not exist), and others have been identified as needing clinical audit and implementation directly within provider trusts.

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

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

Urgent and emergency care

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

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

- Transforming access to urgent and emergency care services (NHS 111 First)
- 999 Ambulance Services and Patient Transport Services (optimising performance and reducing wider service pressures)
- Developing capacity in community settings (two-hour urgent community response, virtual wards and urgent treatment centres)
- Improving flow through hospitals (Emergency Departments and Same Day Emergency Care)
- Managing hospital occupancy

- Measuring and improving performance against the proposed new Urgent and Emergency Care Standards
- Resilience and surge planning.

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

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

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

Advertising and media campaigns around winter messages such as mental health, respiratory, frailty, appropriate services, loneliness/isolation, self-care and hospital discharges have focused on How People Can Keep Well This Winter and can help their communities. These have been run (paid-for and organic) on radio, Facebook, Twitter, Instagram and Spotify. Translated images and audio clips have formed part of a larger toolkit for voluntary sector partners.

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

Ageing well

All Place Based Partnerships (PBPs) within Lancashire and South Cumbria delivered the minimum standard and had two-hour Urgent Community Response services operational by the

deadline of 31 March 2022. This includes full geographic coverage and working 8am to 8pm, seven days a week.

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

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

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

The following table describes key high-level performance indicators for the period to the 30 June 2022.

Category	Specific KPI	Period	Actual	Target
Ambulance [Based on totality of NWAS Service Performance]	Category 1 (Mean average)	Apr22 - Jun22	00:08:15	7 minutes
	Category 1 (90th Centile)	Jun22	00:13:59	15 minutes
	Category 2 (Mean average)	Apr22 - Jun22	00:40.09	18 minutes
	Category 2 (90th Centile)	Jun22	01:27:30	40 minutes
	Category 3 (90th Centile)	Jun22	07:20:40	120 minutes
	Category 4 (90th Centile)	Jun22	12:38:49	180 minutes
A&E [East Lancashire Hospital Trust]	Percentage of Patients who spent less than 4 hours in an A&E department	Apr22 - Jun22	71.90%	95%
Cancer Waits	% of Patients seen within 2 weeks for an urgent GP referral for suspected cancer	YTD Apr22 - Jun22	84.01%	93%

	% of Patients seen within 2 weeks for an urgent referral for breast symptoms	YTD Apr22 - Jun22	88.75%	93%
	Maximum 31 day wait from diagnosis to first definitive treatment for all cancers	YTD Apr22 - Jun22	89.95%	96%
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	YTD Apr22 - Jun22	87.80%	94%
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	YTD Apr22 - Jun22	100%	98%
	Maximum 31 day wait for subsequent treatment where that treatment is a course of radiotherapy	YTD Apr22 - Jun22	97.56%	94%
	Maximum 62 day wait from urgent GP referral to first definitive treatment for cancer	YTD Apr22 - Jun22	63.25%	90%
	Maximum 62 day wait from referral from an NHS Screening Service to first definitive treatment for all cancers.	YTD Apr22 - Jun22	33.33%	85%
	Maximum 62 day wait for first definitive treatment following a consultant's decision to upgrade the priority	YTD Apr22 - Jun22	68.33%	*
	Cancer: Percentage of patients meeting faster diagnosis standard.	YTD Apr22 - Jun22	72.97%	>75%
Referral to Treatment (RTT)	Patients on an incomplete pathway waiting no more than 18 weeks from referral	Jun 22	69.6%	92%
	Number of patients on an incomplete pathway waiting more than 52 weeks	Jun 22	466	0
	Number of patients on an incomplete pathway waiting more than 104 weeks	Jun 22	6	0
Diagnostics	Percentage of Patients waiting 6 weeks or more for a diagnostic test	Jun 22	16.49%	<1%
Healthcare Associated	Methicillin-resistant *Staphylococcus aureus* (MRSA)	Apr22 - Jun22	1	0

Infections (HCAI)	*Clostridium difficile* (C. dif)	Apr22 - Jun22	13	0
	Escherichia coli (E. coli)	Apr22 - Jun22	30	0

There are performance concerns in respect of the following areas:

A&E Waiting Times

A&E performance for patients to be seen within 4 hours has not achieved the target of 95% between April and June 2022 with performance at 71.9%.

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

18-week Referral to Treatment Target

Blackburn with Darwen CCG did not achieve the 92% RTT open pathway standard between April and June 2022 with performance at 69.6% at the end of June 2022. Work continues to be focused at specialty level to reduce the number of long waiting patients. A continuous programme of audit and validation is supporting the Trust Patient Tracking List (PTL) management. This focuses across outpatient, diagnostic and waiting list elements of the pathway. Full Trust validation of the waiting lists continues to take place on a weekly basis together with ongoing clinical triage at Consultant level to ensure that all patients are treated in order of clinical priority.

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

Cancer Waiting Times

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

Diagnostics

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

Sustainable Development

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

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

The unprecedented challenges seen across the NHS as it responded to the needs of the Covid-19 pandemic response has meant that we have had to divert attentions away from our sustainability agenda to focus on countering the Covid-19 Pandemic. This response and its impact on service delivery models, alongside the changed model of working for our workforce has meant that it is not possible to measure the progress of our sustainability and carbon reduction targets during the first three months of 2022/23 in comparison to previous years. That said, we have not lost our focus to reduce our carbon footprint and to become a more sustainable and environmentally friendly organisation.

Improving quality

CQUIN Update

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

LSCFT

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

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

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

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

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

Closedown for the Clinical Commissioning Groups

The CCGs have successfully concluded the CCG closedown programme on 30 June 2022 following completion of the national due diligence checklist and final assurance processes.

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

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

Engaging people and communities

How CCGs have engaged and worked with their communities

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

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

How the CCGs have engaged and worked with their communities

As a CCG, we have engaged and worked with communities through the development of campaigns and initiatives. 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 CCG has worked in partnership with other CCGs and health service providers on shared campaigns across Lancashire and South Cumbria. These 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).

During the reporting period the CCG has worked with partners across East Lancashire area to engage with people and communities to understand their experiences and perceptions of health and health services. This has in the main focused on the experiences of those with COVID-19, perceptions of the COVID-19 vaccination and vaccine hesitancy. In addition, we commissioned work with our VCFSE colleagues to understand the experience of those from more vulnerable communities and from wards where we have identified high use of services. We have undertaken surveys and engagement on access to and understanding of GP services and this has influenced the development of the new extended GP access service which was led by East Lancashire Alliance of Primary Care Networks and launched in March this year.

Our patient and public involvement networks in East Lancashire focused their volunteer work and input into supporting the response to COVID-19, working to support the vaccination hubs run by the Primary Care Networks but also helping to promote COVID aware practices and supporting GP practices in their efforts to promote access to primary care. Our Patient Partners Board, which was chaired historically by the Lay Member for Patient and Public Engagement, was suspended during the pandemic. This role has been undertaken in the interim by the Lay Member for Patient Engagement, and BwD CCG Chair.

Reducing Health Inequalities

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

Clinical Commissioning Groups (CCGs) have a key role to play in addressing equality and health inequalities, as commissioners, as employers and as local system leaders. Each of the Lancashire and South Cumbria CCGs ensure that equality is embedded in their organisations by

having named equality and diversity leaders on their Governing Bodies and strong Equality, Diversity and Inclusion (EDI) processes built into day-to-day operations.

Each of the CCGs have patient and patient involvement mechanisms, that are representative of our local communities, which help us to appropriately commission, buy, design, deliver and monitor services for the people in our communities to make sure they meet the needs of individual patients; their safety is prioritised and they are free from discrimination, harassment and victimisation under equality legislation.

When we are developing or redesigning services, we make sure all proposals are subject to robust Equality and Health Inequalities Impact and Risk Assessment (EHIIRA) processes to consider the needs of the people within our local communities. This enables the CCGs to show 'due regard' to the Public Sector Equality Duty and ensures that consideration is given prior to any policy or commissioning decision made by the Governing Body (or other decision-making committees) that may affect equality and human rights. Furthermore, this enables to us to design our services and policies in the most inclusive ways possible.

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

- Equality Delivery System 2 (EDS2)
- Workforce Race Equality Standard (WRES)

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

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

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

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

- Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T).
- Exercise their functions with a view to securing that health services are provided in an integrated way and are integrated with health-related and social care services, where they consider that this would improve quality, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved (s.14Z1).
- Include in an annual commissioning plan an explanation of how they propose to discharge their duty to have regard to the need to reduce inequalities (s. 14Z11).
- Include in an annual report an assessment of how effectively they discharged their duty to have regard to the need to reduce inequalities (s. 14Z15).

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

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

- Better health outcomes.
- Improved patient access and experience.
- A representative and supported workforce.
- Inclusive leadership.

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

3.1: Fair NHS recruitment and selection processes lead to a more representative workforce at all levels

3.2: The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations

3.3: Training and development opportunities are taken up and positively evaluated by all staff

3.4: When at work, staff are free from abuse, harassment, bullying and violence from any source

3.5: Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives

3.6: Staff report positive experiences of their membership of the workforce

Equality, Diversity and Inclusion Activity in Q1 2022-23

Equality and Inclusion Annual Report 2021-22

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

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

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

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

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

Interim Equality, Diversity and Inclusion Strategy for 2022-23

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

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

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

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

Equality and Health Inequalities Impact and Risk Assessments (EHIIRA)

The CCGs utilise the Equality and Health Inequalities Impact and Risk Assessment (EHIIRA) toolkit from the Equality and Inclusion Team at NHS MLCSU. The EHIIRA toolkit provides a framework for undertaking Equality Impact and Risk Assessments. This tool combines two assessments consisting of Equality and Human Rights. This enable the CCGs to show 'due regard' to the Public Sector Equality Duty and ensures that consideration is given prior to any policy or commissioning decision made by the Governing Body (or other committees) that may affect equality and human rights. The CCGs have continued to embed EHIIRAs into policy development and the commissioning cycle.

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

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

- Fylde Coast CCGs – Clinical Assessment Services
- Fylde Coast CCGs – FCMS Contract (ongoing)
- Fylde Coast CCGs – Data Sharing Agreement: Blackpool CCG and Blackpool Council
- CSRGP CCGs – Central Lancashire Community Diagnostics Centre (ongoing)

- Morecambe Bay CCG – Community Lymphoedema Service (ongoing)
- LSC ICB – Communications and Engagement Strategy (ongoing)
- LSC ICB – LSC Autism Intensive Support Service
- Pennine CCGs – Local Quality Contract: Cervical Screening (ongoing)
- Pennine CCGs – Safeguarding Specification within the East Lancs GP Quality Contract
- Pennine CCGs – Local Quality Contract: Osteoporosis Service
- Pennine CCGs – COVID Virtual Ward – Enhanced Local Service (ongoing)
- West Lancashire CCG – Medicines Optimisation Service – Service Specification

Equality, Diversity and Inclusion in Staff Communications

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

During Q1 2022-23, we have also provided information for the LSC CCGs' monthly Health and Wellbeing newsletter to raise the profile of national and local health and wellbeing events taking place that link in to protected characteristics, for example, Stress Awareness Month, Men's Health Week, Stroke Awareness Month, and World Diabetes Day.

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

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

Improve quality

How we improved quality, including safeguarding vulnerable adults and children

As outlined above, during 2021/22 the CCG has had to adapt normal practices, procedures and approaches to commissioning to accommodate the temporary measures brought about by the COVID-19 pandemic and the NHS being in a level 4 national incident in response to this. The Pennine Lancashire Quality Committee has met throughout the reporting period and the work of the committee, and the transitional arrangements for quality, are described in the governance statement.

Whilst normal contracting and performance mechanisms have been paused during 2020/21, performance against key quality indicators has been monitored and reported to the CCG's Governing Body on a regular basis. Further details are provided in the section "Improving the

performance of the services we commission". In addition, the CCG's quality team has continued to work with our main providers throughout the reporting period to receive assurance and monitor progress against quality standards including patient complaints and serious incident reporting.

How the CCGs improved quality and safety in healthcare

NHS Blackburn with Darwen and East Lancashire CCGs are committed to working collaboratively with system partners to maintain high quality, safe, effective, compassionate care for the local population, while driving key quality improvements and championing patient experience across the system.

Improving quality

Following the challenges in 2020/21 of adapting quality assurance processes throughout the pandemic, the CCGs have supported local providers throughout 2021/22 in restoring existing reporting mechanisms against national and locally agreed quality contracts, whilst ensuring robust oversight.

The CCGs continue to provide scrutiny and challenge of all contractual processes collectively with triangulation of other quality and experience reporting mechanisms such as complaints, compliments, soft intelligence, patient advice and liaison services (PALS), workforce, patient, family and carer surveys, and incidents. Due to our positive working relationships with system colleagues, we regularly attend provider clinical effectiveness meetings, and review effectiveness measures and outcomes, to support service improvements and development.

The CCGs continue to support the system through the pandemic with dedicated Infection Prevention and Control support, delivering widespread PPE support and simplifying access to tests and testing processes. We have worked collaboratively and supported Primary Care to ensure the COVID-19 vaccination programme continues to be effective for our most vulnerable population. Primary Care Quality Forums have been restarted and we are committed to working collaboratively with system partners in reducing variation and improving outcomes.

Hybrid ways of working have also been found to support some areas of assurance which remain impacted by pandemic guidelines with the CCGs accompanying system colleagues on 'virtual' quality visits where face-to-face restrictions remain in place.

Patient Safety

Patient Safety remains a key priority for the CCGs and system partners, who work collaboratively in an open and transparent way, to ensure there is a commitment to continuous quality and safety improvement.

The CCGs have a robust process for all serious incidents which meet the NHS England Serious Incident Framework criteria for reporting onto the Strategic Executive Information System (STEIS). Investigation reports from provider organisations are scrutinised by the CCG Serious Incident Review Group panels to collate themes and trends, whilst ensuring action plans and identified improvements are robust and effective in improving patient safety, care and experience.

We are proud to report that in preparation for the national implementation of the new Patient Safety Incident Response Framework (PSIRF), East Lancashire CCG and East Lancashire Hospitals Trust have worked collaboratively as Early Adopters of the PSIRF, representing the North-West region. The achievements to date are testament to the effective and positive working relationships between the CCG and Trust which will have a positive impact on patient safety and influence quality improvement with demonstrable outcomes. New assurance mechanisms have been implemented which will be continuously reviewed to ensure they remain effective.

The CCGs are dedicated to challenging standards of care and experience that do not meet expectation; we are committed to working with our colleagues in response to the findings from national high-profile cases, such as the most recent Ockenden review to prevent re-occurrence.

To ensure that quality and patient safety remains at the center of the CCGs governance processes, quality and performance reports are presented for scrutiny at Quality Committee meetings, and then for robust challenge and escalation to the CCG Governing Body meetings.

The Pennine Lancashire Quality Committee (PLQC) has helped to shape the ICB Quality and Performance sub-committee through the production of reports and member attendance. The Chair of the PLQC has routinely attended the sub-committee meetings playing an active role whilst assisting the development of the committee.

Health and wellbeing strategy

The health and wellbeing of our population

Health outcomes for people living in Blackburn with Darwen 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. 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.

Across Lancashire and South Cumbria, 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.

Health and wellbeing – Improving outcomes

Dr Julie Higgins, our Accountable Officer recognised that the CCG, and our partners across Lancashire and South Cumbria needed an overarching strategy for population health as residents in Blackburn with Darwen experience exceptionally poor health, and considerable health inequalities. Dr Higgins recognised that such a strategy was not only needed but that we needed to have an independent review. Across Lancashire and South Cumbria health and social

care leaders supported this view and as a result, Dr Higgins led the formation of a Health Equity Commission (HEC).

The HEC was launched by Professor Sir Michael Marmot in September 2021 and has also been chaired by him. In the Autumn of 2021, each local area submitted evidence to the Health Equity Commission. East Lancashire CCG and our partners in Pennine Lancashire gave a comprehensive presentation and showed a powerful video to the Commission which highlighted the challenges and action required in Pennine Lancashire. Alongside the evidence from local places, the Commission saw evidence from each Health and Wellbeing Board, as well as undertaking focus groups across the region, focusing on issues such as economic development, leadership, older people, mental health and the needs of children and young people. Following this, the Institute for Health Equity, led by Professor Sir Michael Marmot for the Health Equity Commission, has been analysing the data and will be presenting draft recommendations for the region, including Pennine Lancashire, from April. We anticipate that there will be a summit later in the year where these are shared with the wider community.

Health and wellbeing strategy

The CCG contributes towards the delivery of the Health and Wellbeing Strategy through its involvement in the work of the Blackburn with Darwen Health and Wellbeing Board (H&WB). The H&WB is run by Blackburn with Darwen Borough Council and has a strong focus on health and care needs of the local population. For more details of the Health and Wellbeing Strategy can be accessed here:

Health and wellbeing board | Blackburn with Darwen Borough Council

The health and wellbeing of our staff, and our people

The CGG has ensured that all staff and the associated workforce have received a robust wellbeing offer since September 2020. As a starting point we have ensured that we ensured regular two-way opportunities for communication continued throughout the year via staff briefs, staff bulletins, directorate meetings and team meetings. In addition, we created a monthly staff wellbeing bulletin which was well received. Extensive support for agile working complemented this, including guidance, grants for home office equipment, equipment and furniture from the office. We rolled out Office 365 to further enhance remote and digital capabilities. We created online “wobble” rooms and established a process for wellbeing conversations. We also trained and supported staff to become mental wellbeing champions using the evidence based and well regarded, REACT model of supporting mental health conversations.

We established a group of health and wellbeing champions and staff representatives to support, signpost and guide staff, and we created a staff welfare group with wide ranging representation including our Wellbeing Guardian; an executive level role to ensure that staff wellbeing is considered throughout the organisation. In addition to this we have supported staff to access developmental activities and ran a staff appreciation and recognition day which was very well received. Finally, we were instrumental in the development of an ICS/ICB Health and Wellbeing Group and significant contribution to this group.

All our staff have access to the Lancashire and South Cumbria Foundation Trust (LSCFT) Resilience Hub, along with an external occupational health provider, as well as signposting and support from Health and Wellbeing champions. We have a named IPC nurse who has supported throughout the pandemic and continues to support CCG to ensure staff safety during the COVID-19 pandemic. Our workspace is COVID-19 secure, and staff only have access to offices if necessary. All staff have been supported to have flu and COVID-19 vaccinations. Flu vaccinations are reimbursed for staff who would need to pay.

Staff have been supported with equipment, furniture and guidance for agile/remote working. While we have been working remotely throughout the pandemic breaks and rest periods have been strongly encouraged to avoid burn out, as the boundaries between work and home were not so clear for those focused on delivery. We monitored annual leave bookings throughout the year to ensure staff were not working long periods without a break. Senior leaders and managers have modelled this behaviour as to encourage their teams to do the same.

Our Wellbeing Guardian, HWB lead, staff representatives and HWB champions have signposted and supported staff in a supportive environment contributing to a culture of civility and respect.

All staff car parking is free. We continue to provide virtual wobble rooms to staff and have set up a wellbeing room in our reconfigured office space. Staff continue to be supported when they go on sick leave and when they return by accessing our HWB support, and support from occupational health or our employee assistance programme. We promoted and continue to promote physical health and wellbeing through our HWB offer. As well as our specific physical health related bulletins, colleagues have provided morning yoga sessions, and tips on fitness and physical exercise. Wellbeing is continually promoted, and initiatives are updated regularly.

Following a Tackling Racism exercise led by the North West Strategic Advisory Group for Black, Asian and minority ethnic colleagues (formerly BAME Assembly North West), the CCG setup a working group which has supported awareness and compiled an action plan to address inequalities. There has been significant progress in this area, including the formation of a

Pennine Lancashire Equality Diversity and Inclusion (EDI) Partnership which has already identified several priorities to implement.

We responded to the need, and mobilised staff to each local and area of the health and care system to support testing, vaccination, Gold Command and latterly CCG closedown and ICB establishment work. Our system level HR Reference Group has compiled a recruitment protocol to support swift vacancy filling from within the system. Primary care related developments are led and provided by the Lancashire and South Cumbria Training Hub. Pennine Lancashire CCGs have contributed heavily to health and care system development with many staff redeployed to assist with ICB establishment for all or part of their roles. CCG staff clinical and non-clinical are representatives at place base partnerships and supporting the development of the partnership.

Financial review

The emergency powers under which all CCGs had operated for 2021/2022 ceased, however the sheer nature of the disestablishment of CCGs from 01 July 2022, in favour of the incoming Integrated Care Boards, meant that a further temporary finance regime that allowed CCGs to operate for the first three months of the fiscal year 2022/23 was put in place. A financial plan for the CCG footprint was produced, with an anticipated expenditure level for the first three months highlighted. However, the nature of the temporary funding regime meant that CCG expenditure as at 30 June 2022 would be matched by resource and therefore all CCGs would report break even at the end of the period.

The breakdown of the total allocation for the three month period to 30 June 2022 is shown in the table below: -

Allocation Source	**Three months to 30 June 2022 £'000**
Commissioning Functions	64,905
Primary Care co-commissioning	6,835
Running Costs	756
Other in-year allocations (SDF,SR and Hosted)	0
TOTAL	**72,496**

Net expenditure is recorded against the CCG allocation and for the three months to 30 June 2022, NHS England set all CCGs a target to deliver an in-period break even position. This has been achieved.

The following table highlights the three month financial performance, with comparative data for the previous financial year:

	Three months to 30 June 2022 £'000	2021/2022 £'000
Total notified allocation *of which*	72,496	312,615
In year Revenue Resource Limit	72,496	305,213
Total Comprehensive Net Expenditure against in year Revenue Resource Limit	72,496	306,209
In year Surplus / (deficit)	0	(996)
Retained surplus brought forward	7,402	8,402
Retained surplus utilised during the year *(funded as part of in year revenue resource limit)*	0	1,000
Retained surplus carried forward	7,402	7,402
Percentage Cumulative surplus	10.21%	2.4%

From a balance sheet perspective, CCGs are limited to current assets and liabilities. CCGs do not own any premises, nor do they receive any capital resource limit that would enable them to bring long term assets onto their balance sheets.

The current and previous four years balance sheet summary is shown in the table below:

	As at 30 June 2022 £'000	2021/2022 £'000	2020/2021 £'000	2019/2020 £'000	2018/2019 £'000
Current Assets	2,155	3,305	3,644	4,325	5,952
Current Liabilities	(13,163)	(21,307)	(18,028)	(14,477)	(13,197)
Total Assets less liabilities	(11,007)	(18,002)	(14,384)	(10,152)	(7,245)

Although the level of liabilities may appear to be geared towards debt, in the ratio of 1:9.08 (1:6.45 in 2021/22), all liabilities are classed as current, i.e. that they will be cleared within a short period of time after the year end. CCGs are also a subset of a government department, and the risk of bankruptcy is considered to be negligible.

Current assets in the main relate to money owed to the CCG and stock held, as described in the notes to the accounts.

The level of current liabilities has been fairly consistent of the previous five years and amounts relate to three general areas: -

- Accrual for primary care prescribing costs for which there is a timing lag of 2 months
- Accrual for the costs of individual packages of care
- Money owed to NHS organisations based on invoices received
- Money owed to other providers based on invoices received

Kevin Lavery
Chief Executive
Lancashire and South Cumbria Integrated Care Board (on behalf of the former Blackburn with Darwen CCG)

28 June 2023

ACCOUNTABILITY REPORT

Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April to 30 June 2022, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

Members Report

Member profiles

Blackburn with Darwen CCG has 22 member practices; each practice has a nominated lead representing the interests of the CCG as a whole. The members play a role in holding elected executive members to account and holding the CCG officers to account for the delivery of the strategic priorities.

As a clinically led organisation, we use the clinical expertise and insight of local GPs to drive the commissioning of health services locally. It is this clinical expertise and insight, combined with an in-depth knowledge of patient needs and experiences, which enables us to commission high quality healthcare for our residents and to make improvements where we know that healthcare is not as effective as it could be.

We ensure that performance and any issues that are important to our patients and members are addressed by the Governing Body, and improvements made where

required. We also ensure the CCG is commissioning services that deliver best value for money.

Throughout Quarter 1 2022/23 we have continued to work within the government's COVID-19 guidelines on working safely, which has meant that we have not held meetings in public in the same way. Instead, we have used digital technology to hold "virtual meetings" to which members of the public have been invited to join.

The conduit between the Governing Body and our GP member practices are our Clinical Senate, Chair, Deputy Interim Medical Director and our Governing Body GP Executives.

They act to ensure that there is a two-way flow of information and insight between practices and the Governing Body. The CCG's performance is therefore monitored both formally and informally.

Throughout the year our member practices have been kept regularly informed of the work of the governing body and overall are satisfied with both progress and performance. They recognise the challenges within the local health economy and the work the CCG is doing to meet these challenges.

Member practices

Practice Name	**Address**
Darwen Health Link, Darwen Health Centre	Darwen Health Centre, James Street West, Darwen, BB3 1PY
Darwen Healthcare, Darwen Health Centre	Darwen Health Centre, James Street West, Darwen, BB3 1PY
Hollins Grove Surgery	153 Blackburn Road, Darwen, BB3 1PY
Spring-Fenisco Healthlink	102 Bolton Road, Darwen, BB3 1PZ
Stepping Stone Practice	Longton Close, Blackburn, BB1 1XA
Blakewater Healthcare	367 Whalley New Road, Blackburn, BB1 9SR
Bentham Road Health Centre	Bentham Road, Blackburn, BB2 4QD
Cornerstone Practice, Shadsworth Surgery	Shadsworth Road, Blackburn, BB1 2HR

Pringle Street Surgery	216-218 Pringle Street, Blackburn, BB1 1SB
Roman Road Health Centre	Fishmoor Drive, Blackburn, BB2 3UY
St Georges Surgery	62 Haslingden Road, Blackburn, BB2 3HW
William Hopwood Street Surgery	William Hopwood Street, Blackburn, BB1 1LX
Brownhill Surgery	788-792 Whalley New Road, Blackburn, BB1 9BA
Little Harwood Health Centre	Plane Tree Road, Little Harwood, Blackburn, BB1 6PH
Primrose Bank Medical Centre & Ewood Medical Centre	Primrose Bank, Blackburn, BB1 5ER 431-433 Bolton Road, Blackburn, BB2 4HY
Shifa Surgery, Bangor Street	Bangor Street, Blackburn, BB1 6DY
Olive Medical Practice	3 Lime Street, Blackburn, BB1 7EP
Limefield Surgery	293-295 Preston New Road, Blackburn, BB2 6PL
Oakenhurst Surgery Barbara Castle Way Health Centre	Barbara Castle Way Health Centre, Simmons Street, Blackburn, BB2 1AX
Redlam Surgery	62 Redlam, Blackburn, BB2 1UW
The Family Practice Barbara Castle Way Health Centre	Barbara Castle Way Health Centre, Simmons Street, Blackburn, BB2 1AX
Witton Medical Centre	29-31 Preston Old Road, Blackburn, BB2 2SU

Composition of Governing Body

Mr Graham Burgess – Chair

Dr Julie Higgins – Accountable Officer

Vacant – Medical Director

Dr Ridwaan Ahmed – Clinical Director for Quality and Primary Care

Dr Zaki Patel – Executive GP and Clinical Lead

Dr Adam Black – Executive GP and Clinical Lead

Dr Qashuf Hussain – Executive GP and Clinical Lead

Dr Mohammed Moosa - Executive GP and Clinical Lead

Mr Roger Parr – Chief Finance Officer

Vacant – Director of Population, Strategy and Transformation

Mrs Kathryn Lord – Director of Quality and Chief Nurse

Dr Geraint Jones – Secondary Care Doctor

Dr Nigel Horsfield – Lay Member

Mr Paul Hinnigan – Lay Member Governance

Committee(s), including Audit Committee

More detailed information about the Governing Body and related committees' membership is available in our Annual Governance Statement and Members Report.

Register of Interests

Managing potential conflicts of interest is essential for protecting the integrity of the overall NHS commissioning system and the Clinical Commissioning Group from any perceptions of wrongdoing. The CCG Governing Body has approved and adopted the Managing Conflicts of Interest Policy (including Gifts and Hospitality) which adheres to the NHS England revised statutory guidance, published in June 2017.

All staff are required to declare any interests when joining the organisation, or if their circumstances (e.g. role or responsibilities) change and thereafter on at least an annual basis. All Governing Body members review and declare their declarations of interest on a regular basis and the Chair of all committees receive and review member declarations prior to each meeting. In addition, all members and non-members of the CCG Governing Body and its sub-committees declare any interests pertinent to the agenda at the start of

each meeting and any interests declared are considered by the Chair and appropriate steps taken, where appropriate.

During 2022/23 NHS England's Corporate Data Collections for conflicts of interests continued to be waived, including the requirement to submit Conflict of Interest quarterly and annual self-certifications. The CCG has continued to monitor and report progress against compliance on a quarterly basis to the Audit Committee. We have also encouraged all relevant staff to undertake the mandatory Level 1 Conflict of Interest training.

The CCG's policy and declarations of interest registers are available via our website at:

https://webarchive.nationalarchives.gov.uk/ukgwa/20220803160244/https://www.blackburnwithdarwenccg.nhs.uk/

Personal data related incidents

There have been no reportable personal data related incidents during the reporting period.

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

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

Kevin Lavery

Chief Executive

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

28 June 2023

Statement of Accountable Officer's Responsibilities

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

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money,

- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the Accountable Officer, I confirm that there was adequate and sufficient handover from the previous Accounting Officer to provide me with the assurances required to make these statements. I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the NHS Blackburn with Darwen auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board (on behalf of the former Blackburn with Darwen CCG)

28 June2023

Governance Statement

Introduction and context

NHS Blackburn with Darwen CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

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

Between 1 April 2022 and 30 June 2022, the clinical commissioning group was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Blackburn with Darwen clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the Blackburn with Darwen Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the Blackburn with Darwen clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

Governance arrangements and effectiveness

The Health and Care Bill received Royal Assent on the 28th April 2022, confirming the date of the Integrated Care Board to be legally and operationally established from 1st July 2022. The following governance arrangements were those in effect from 1st April 2022 – 30th June 2022 after which the CCG was dissolved and the statutory responsibilities transferred to the ICB.

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.

CCG Constitution

Our constitution sets out the arrangements that we have put in place to help us to deliver our vision and goals, to discharge all our statutory obligations and to engage with our members, our patients and our community and other key stakeholders and partners to achieve this. It describes the CCG's 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 patient and public interest always remain central to our goals.

The Constitution is published on the CCG's website at:

[ARCHIVED CONTENT] Our Constitution | (nationalarchives.gov.uk)

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:

- A code of conduct for the Governing Body and sub-committee members showing mutual trust, respect and honesty (members of the Governing Body adhere to the seven principles of public life – Nolan Principles).
- All committees authorised by the Governing Body are responsible for keeping under review their terms of reference and membership; the Governing Body approves these and seeks regular assurance that their duties are discharged accordingly.

Governance Arrangements to support System Transition

To support the disestablishment of the eight CCGs in Lancashire and South Cumbria and the establishment of the Integrated Care Board (ICB), a sub-committee structure (with working groups) was established to oversee the closedown programme of work 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, supported by a number of working groups (finance, contracts, HR and Governance).

COVID-19 Governance Arrangements

The CCG has operated throughout the reporting period with robust governance arrangements in place to support the CCG's response to national incident levels and the associated national incident infrastructure. The regularity of the CCG's Incident Co-ordination Centre (ICC) and sub-cell meetings has also been reviewed and aligned accordingly. This has resulted in an agile approach, with meetings stepped up and down as required to enable the CCG to support the COVID-19 vaccination programme, whilst ensuring delivery against its strategic objectives and priorities.

CCG Committees and Sub-Committees

The CCG's Constitution has established the following committees/sub-committees:

- CCG Governing Body
- Audit Committee
- Primary Care Committee (meeting as a Committees in Common with East Lancashire CCG)
- Remuneration Committee (meeting as a Committees in Common with East Lancashire CCG)
- Pennine Lancashire Quality Committee
- Commissioning Business Group
- Engagement Oversight Group
- Strategic Commissioning Committee – formally the Lancashire and South Cumbria Joint Committee of Clinical Commissioning Groups

Clinical Senate

The Clinical Senate is the overarching membership body of the CCG, and each of its 22 practices has a nominated representative. Representing the interests of the CCG, the Senate plays a role in holding elected executive members to account and holding CCG officers to account for the delivery of strategic priorities. The Senate also approves the CCG's Constitution and proposed changes therein.

During Quarter 1 2022/23, the members did not formally meet, but remained informed on system reform aligned to the national proposals set out by the government, the transitional governance arrangements for 202/23 and the planning and the implementation of provider collaboration at ICS level (including partnership working at local government level).

Throughout the reporting period the members received updates on national, regional, and local issues, including updates on the decisions made by the CCGs Senior Directors (via the ICC) around the deployment of resources to support resilience within primary care. Further regular communications from the Chair, Chief Officer and interim Medical Director were issued alongside practical support for operational issues throughout the reporting period.

Governing Body

The Governing Body is responsible for discharging the statutory duties and functions of the CCG. The Governing Body draws its membership from a broad range of clinicians, staff and lay members providing the appropriate balance of skills, experience, independence, and knowledge of the organisation to enable them to discharge their respective duties and accountabilities effectively.

Between 1st April 2022 – 30th June 2022 the Governing Body has met in public (virtually) as Committees in Common with East Lancashire CCG on 2 occasions with provision made for members of the public to join the meeting using digital technology.

At its meeting in April 2022, the Governing Body set out its key areas focus for the remaining 3 months prior to the establishment of the ICB.

Key areas of focus for the Governing Body during Q1 2022/23

- Monitoring the CCG's financial performance as well as receiving local quality and performance report (updates from the Strategic Commissioning Committee)
- CCG Closedown/ transitioning the functions of the CCG into the ICS in a controlled manner closing-down the necessary duties and support the evolving ICS
- Supporting our staff in the transition to the ICS and shaping the structure of local and ICS teams
- Key contracting and commissioning decisions around 2 hour UCR
- Governing Body Assurance Framework

- BAME action plan
- Approval of the final CCG Annual Report and Annual Accounts for 2021/22

In addition to this the CCG continued to support the ongoing response to the pandemic including:

- Supporting the vaccination programme
- Supporting the testing programme
- Ensuring readiness for outbreak management that might require standing up command structures again.

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

Strategic Commissioning Committee (formally known as the Lancashire and South Cumbria Joint Committee of Clinical Commissioning Groups)

The Strategic Commissioning Committee has 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. Under normal circumstances the meetings would be held in public, and members of the public invited to attend the formal meetings, however due to COVID restrictions these meetings have been held virtually.

The committee has met (virtually) on two occasions during the reporting period with its final meeting being held on 9th June 2022; the agenda and formal papers are published on the Lancashire and South Cumbria ICS website here:

Lancashire and South Cumbria Health and Care Partnership: Strategic Commissioning Committee (healthierlsc.co.uk)

Throughout the COVID-19 pandemic, the CCGs in Lancashire and South Cumbria have worked effectively with local partners across the ICS to manage the local response, enabling joint decision making towards the operational management of services and ensuring consistency in partner, staff, patient and public communications.

Audit Committee

The Audit Committee has met (virtually), on two occasions during the reporting period. The committee has been accountable to the Governing Body for providing an

independent and objective view of our financial systems, financial information and compliance with laws, regulations and directions. The Committee is chaired by the Lay Member for Governance and includes membership from the Lay Member, the Secondary Care Consultant, and a GP Executive member of the Governing Body (this role has been vacant throughout the reporting period).

The Governing Body receives the minutes of each Audit Committee which, in accordance with its Terms of Reference assures the organisation in the following areas:

- Governance, risk management and internal control – ensuring the establishment and maintenance of an effective system of governance and risk management across the CCG, including monitoring and reviewing the organisation's assurance framework and risk register.
- Internal audit – ensuring the audit function established was effective and met the mandatory NHS Internal Audit Standards to provide appropriate assurance to the Governing Body. Ensuring internal audit reports finalised to date were providing a positive assurance overview.
- External audit – ensuring the work and findings of the appointed External Auditors and considering the implications of the management's responses to their work.
- Financial reporting – monitoring and delivery of the 2021/22 accounts timetable
- Other assurance functions including Counter Fraud arrangements and review of counter fraud work
- Reviewing the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such complaints were investigated proportionately and effectively

The Audit Committee presents an annual report to the Governing Body which summarises its work during the year.

Committee members:

Mr Paul Hinnigan - Lay Member – Governance and Chair of Audit Committee

Dr Geraint Jones - Secondary Care Consultant

Dr Nigel Horsfield - Lay Member

GP Executive - Vacant

In Attendance:

Mr Roger Parr - Chief Finance Officer

Mrs Claire Moir - Senior Corporate Business Delivery Manager

The minutes and attendance at Audit Committee meetings are published on the CCG's website along with the Term of Reference at: [ARCHIVED CONTENT] Meetings | (nationalarchives.gov.uk)

Remuneration Committee

The Remuneration Committee's primary role is to make recommendations of the appropriate remuneration and terms of service for the Accountable Officer, Directors and other very Senior Managers and Clinical Leads. The members of the Remuneration Committee are provided below.

The Committee has operated effectively within its delegated levels of authority to make recommendations to the Governing Body on the remuneration of Governing Body members, Executive Managers and clinical leaders in the CCG.

The committee has not met during the reporting period.

Committee Membership:

Mr Graham Burgess - Chair

Mr Paul Hinnigan - Lay Member (Governance)

Dr Nigel Horsfield - Lay Member

Dr Geraint Jones - Secondary Care Doctor

Primary Care Committee

NHS England has delegated the exercise of certain specific primary care functions to Blackburn with Darwen CCG and this committee is established as a sub-committee of the CCG's Governing Body. The functions of the committee are undertaken to promote increased co-commissioning to increase quality, efficiency, productivity and value for money. Its role is to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act. This includes:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract).
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services").
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF).
- Decision making on whether to establish new GP practices in an area.
- Approving practice mergers.
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

In May 2021, the committee Terms of Reference were reviewed to ensure that both Blackburn with Darwen and East Lancashire CCGs were able to continue to exercise the primary care functions delegated to them from NHS England. It was agreed that the Primary Care Commissioning Committees of both CCGs would meet, under the provisions set out in legislation, as Committees in Common. To support these working arrangements and ensure both committees were able to maintain quoracy and decision making, the Chair of the Blackburn with Darwen CCG PCC was co-opted into the role of Chair of the EL CCG PCC.

These arrangements continued during Quarter 1 2022/23; the committee has met on two occasions during the reporting period, with a third extraordinary meeting held on 28th June 2022. The membership, attendance, agendas, and minutes are published on the CCG's website at: [ARCHIVED CONTENT] Meetings | (nationalarchives.gov.uk)

Pennine Lancashire Quality Committee (PLQC)

This joint committee is accountable to both Blackburn with Darwen and East Lancashire CCGs governing bodies. This committee has responsibility for all quality and safety issues for the two organisations and provides assurance to the governing bodies on all matters relating to the delivery of high-quality services by provider organisations to the residents of Blackburn with Darwen. This includes all aspects of performance management, service effectiveness, patient safety and experience and assurance of compliance with relevant regulatory standards.

The PLQC held its final meeting in March 2022, with one further extraordinary meeting held on 15th June 2022, to review the closedown due diligence requirements and provide

an assurance overview of the handover arrangements for the quality agenda, in advance of the transition formally to the ICB.

Incident Coordination Centre (ICC)

Chaired by the CCGs Accountable Officer, with representation from the CCGs Senior Directors and Governing Body clinicians, the ICC has focused on the following areas during the reporting period:

- Supporting the deployment of the vaccinations programme
- Ensuring continued oversight and management of the CCG's role in the COVID19 response

The frequency of the ICC meetings was regularly reviewed during the reporting period and a summary of all ICC decisions taken have been presented on a quarterly basis to the CCGs Governing Bodies.

Commissioning Business Group

Following the establishment of a Strategic Commissioning Committee on 1 April 2021 the delivery and decision making (as delegated by the Governing Body) for the Lancashire and South Cumbria population was done across the Lancashire and South Cumbria footprint. The Commissioning Business Group therefore did not meet during Quarter 1 2022/23; any decisions for local determination were made under the delegations of the CCG executive officers or via the governing body.

Engagement Oversight Group

Whilst the CCG's Engagement Oversight Group has not met during the reporting period, the CCG has been part of overall system partnership approach to communication and engagement. This has seen the development of an overarching Communication and Engagement strategy for stakeholder engagement, public messaging campaigns and innovative ways of gaining insight from patients and service users. Community engagement and online focus groups have also been held to support the system planning services for 2022/23.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice

Discharge of Statutory Functions

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

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

Risk management arrangements and effectiveness

The CCG's joint Risk Management Strategy and Policy sets out the responsibilities of individuals, the governing body and its sub-committees for managing risks associated with meeting the strategic objectives of the CCG. It aims to create a framework to achieve a culture that encourages staff to:

- Identify and control risks which may adversely affect the operational ability of the CCG.
- Compare risks using a grading system.
- Where possible, eliminate or transfer risks, or reduce them to an acceptable and cost-effective level (otherwise ensure the organisation openly accepts the remaining risks).
- Identify risks which are common risks across both Pennine Lancashire CCGs and manage this collectively.

Risks are identified from a number of sources, including the Governing Body, Senior Directors, staff, the Governing Body Assurance Framework, internal and external audit reports and risk assessments. Risk management is embedded within the organisation through delivery of the Risk Management Policy and Strategy and also through assessment of specific risks, including information governance, privacy impact assessments, equality impact assessments and business continuity.

Monitoring, evaluation and control have been further developed throughout the year and all identified risks are included on the operational risk register or Governing Body Assurance Framework.

Throughout Quarter 1 2022/23 we have ensured that the governance and oversight for operational risk management has remained a priority. A monthly cycle of risk management has remained in place throughout the reporting period to enable the timely escalation (and de-escalation) of risks to the Senior Directors and Governing Body.

Capacity to Handle Risk

The responsibility for risk management is clearly defined at all levels within the organisation. The CCGs Risk Management Strategy clearly outlines the roles and responsibilities of the governing body, the Audit Committee, the Pennine Lancashire Quality Committee, the Risk Management Group, the Accountable Officer, the Chief Finance Officer, and other staff within the CCG.

The Audit Committee is responsible for reviewing the adequacy and effectiveness the CCG's Risk Management Arrangements and receives update reports on a quarterly basis.

Overall responsibility for the CCG's systems of internal control and preparation of the Annual Governance Statement is delegated to the Accountable Officer. The Chief Finance Officer has delegated responsibility for ensuring the CCG has a system in place for checking and reporting breaches of financial policies, together with a proper procedure for checking the adequacy and effectiveness of the control environment.

The CCG uses an electronic system to record and monitor risks. This is a web-based application that is available to risk owners and managers and allows risk updates to be provided in a timely manner. The information is used to provide monthly reports for the Risk Management Group and Pennine Lancashire Quality Committee on all risks held on the CCG risk register, and quarterly updates to the Governing Body for those risks held on the Governing Body Assurance Framework.

Risk Management training has been provided via virtual training sessions delivered via the Midlands and Lancashire Commissioning Support Unit. Additional support has also been provided for risk owners via 1:1 risk update sessions.

Risk Assessment

Operational risks are identified in a number of ways e.g., when a new service development is planned the risks associated with the project are scoped out and included in the business case process.

During the reporting period risks have been identified through a variety of sources:

- Complaints and incidents
- Internal investigations
- Internal/external audit reports
- ICC and Cell Leads Meetings
- Data Security and Protection Toolkit
- Risk Assessments

All risks held on the CCGs risk registers are assigned to a named risk owner (the risk lead). Risk owners are the manager responsible for ensuring the implementation of the Risk Management Policy and Framework within their own areas of control and have key functions in relation to risk management which include:

- Ensuring risks are identified and managed and mitigating actions are implemented
- Ensuring action plans for risks are prepared and reviewed on a regular basis
- Reviewing risks on a monthly basis in readiness for updating the ICC and Governing Bodies

In addition, each risk also has a Senior Director (Senior Responsible Officer) lead to further strengthen the accountability, ownership and control of CCG risks.

We use two risk scores to provide an overall risk rating:

- Current risk score – this is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move toward the target risk score as action plans to mitigate the risks are developed and implemented.
- Target (appetite) risk score – this is the score that is expected after the action plan has been fully implemented.

Governing Body Assurance Framework (GBAF)

The GBAF identifies the principal risks to delivery of the CCG's strategic objectives and any gaps in assurance and control. Our shared Corporate Objectives with East Lancashire CCG are:

- To commission the best quality and effective services to deliver optimal healthcare outcomes for our local population
- Ensure the balance of our health investment reflects our population's needs and keeps the population well
- Deliver the 10-year strategy by engagement with the population we serve and ensure we commission services that meet local needs with a clear focus on population health management strategies
- We will focus on population health outcomes through helping to deliver successful Integrated Care Partnerships and ensure decisions, provision and access to local services is based on the needs of our population
- As local health leaders, we will focus on increasing life expectancy across Pennine Lancashire to be at, or above the national average in the next 10 years

The GBAF provides a structure and robust process to enable the organisation to focus on high level strategic and reputational risks with the potential to compromise the achievement of its strategic objectives. The framework is a dynamic tool that maps out key controls, highlights any gaps in control and assurance to mitigate the risks, and provides a mechanism to assure the Governing Body of the effectiveness of these controls. It is part of the wider governance and assurance framework to ensure the

CCG's performance across the full range of its commissioning activities is monitored and managed, resulting in targets being met, objectives achieved, and good outcomes realised for patients. Crucially, the GBAF provides the Governing Body with confidence that systems and processes in place are operating in a way that is safe and effective.

Overview of Strategic Risks

During Quarter 1 2022/23 the risks held on the GBAF have been reviewed and have fallen broadly into the following areas:

- Achievement of the NHS Constitution performance indicators

- The widening of health inequalities across communities and/or between different groups due to the decline in economic circumstances across those groups, the unforeseen impact of health policy implementation and insufficient investment in anticipatory and preventative services
- Gaps in support for children and young people with an eating disorder whilst waiting for a T4 bed
- That children would not be effectively safeguarded due to lack of routine contribution to safeguarding processes
- The resilience and sustainability of general practice in Pennine Lancashire
- Delivery of CHC/FNC/joint packages of care in line with national framework
- ASD contract performance

Action plans and mitigations were put in place for any gaps identified in control and assurance, and all risks actively monitored.

There is a process in place for reporting, managing, investigating and learning from incidents. We have a Senior Information Risk Owner to support our arrangements for managing and controlling risks relating to information/data security.

Other sources of assurance

Internal Control Framework

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

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

Control mechanisms are embedded within the system of risk management within the organisation; and there were no instances during the reporting period where the control environment was breached. The control mechanisms include:

- Compliance with legislative and regulatory requirements
- Scheme of Reservation and Delegation

- Prime Financial Policies
- Sub committees of the Governing Body
- The GBAF
- The Corporate Risk Register
- Internal performance management processes as outlined in the CCG Risk Management Strategy and Policy
- Organisational policies and procedures

Such controls reduce the likelihood of a risk occurring. We also have a statutory and mandatory training regime in place which is a significant aspect of control.

The GBAF also plays a key role in ensuring the effectiveness of internal control mechanisms. At the beginning of the financial year the CCG reviews the main risks to the delivery of the strategic and operational plans and these risks are reviewed by the Governing Body on a quarterly basis.

The GBAF and Corporate Register Risks have been reviewed bi-monthly throughout the reporting period via the Pennine Lancashire Quality committee and the GBAF risks have been reviewed quarterly by the Governing Body. The full risk registers have been presented to the Audit Committee at each meeting.

Annual audit of conflicts of interest management

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

Due to the disestablishment of CCGs on 30th June 2022 there was no mandated requirement to undertake an audit of conflicts of interest during Quarter 1 2022/23. All audit recommendations made following the 2021/22 annual conflicts of interest audit were transferred to the Integrated Care Board as part of the due diligence process.

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

Data Quality

As described in the performance overview section, due to emergency measures which were introduced (nationally) in March 2020, normal contracting and performance

management mechanisms continued to be paused in response to COVID-19. However, the CCG has continued to provide high level quality and performance data to the Governing Body.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

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

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

The CCG published a “Standards Met” Data Security and Protection Toolkit assessment on 22nd June 2022.

Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, confirm that an appropriate framework and environment is in place to provide quality assurance of business critical models.

Third party assurances

NHS Blackburn with Darwen CCG received third party assurances on the support services that it commissioned and held the contracts for directly and on nationally provided services the contracts for which were held for all CCGs by NHS England.

The external auditors of each of these services undertakes and produces an annual service auditor report in which they provide an audit opinion and recommendations on the internal controls in place for that service. The support services have not been required to undertake any additional work in relation to the timeline for CCG closedown and therefore for the three month period to 30 June 2022, the CCG must rely on the service auditor reports produced as part of year end 2021/2022. To support this, each of the organisations has provided either directly to the CCG or The details of which are shown below.

Directly commissioned support services

NHS Midlands and Lancashire Commissioning Support Unit

During 2021/22, NHS Midlands and Lancashire Commissioning Support Unit (the CSU) have maintained their annual service audit reporting (SAR) process. This process provides assurance to CSU customers and their auditors, that the CSU has internal controls and control procedures in place and that these are embedded into the working practices and continue to be of an excellent standard.

Deloitte UK are the independent assessors of the CSU control processes and test compliance against the agreed control standards with exceptions and subsequent mitigating actions reported to the CCG by way of the SAR.

The outcome of the SAR for the period 01 April 2021 – 31 March 2022 showed that out of the 74 controls that had been tested, there was just 1 exception which allowed the auditor to conclude that:-

- All controls were described in a way that fairly presented the test activities
- Controls were designed in such a way as to reasonable assurance that controls objectives would be achieved during the period and
- All controls tested were operating with sufficient effectiveness to provide reasonable assurance.

East Lancashire Financial Services (ELFS)

East Lancashire Financial Services (ELFS) provide payroll services to the CCG. During 2021/22, ELFS took the decision to move to an ISAE3402 Type II report – services

system for processing user entities transactions as part of their philosophy of continuous business improvement regarding the quality of service provided to clients. Grant Thornton LLP have provided a rigorous assessment of services provided.

Grant Thornton did not identify and adverse finding or fundamental process failures across the control standards tested. They did however identify a small number of exceptions which has resulted in a qualified opinion. The CCG are assured that the exceptions identified have been fully investigated and further controls put in place to remedy those weaknesses.

Mersey Internal Audit Agency (MIAA)

Mersey Internal Audit Agency (MIAA) provide the internal audit service to the CCG. MIAA has been assessed against the requirements of the Public Sector Internal Audit Standards, an external quality assessment process which is required to be undertaken every five years. The latest assessment was published on 14 November 2020 by an assessor from the Chartered Institute of Public Finance and Accountancy (CIPFA). It included a review of key documents and processes, alongside interviews with a range of staff and a sample of key stakeholders. MIAA were assessed as being fully compliant with all standards, with the overall conclusion from CIPFA that "**MIAA fully conforms to the requirements of the Public Sector Internal Audit Standards**"

Nationally Commissioned third-party services

The service auditor reports for the following, nationally procured, contracted and managed services for 2021/22 have been shared with NHS England who will fully comment on the assurances received as part of their annual report. A summary of the findings in relation to services where the CCG is an end user is shown here. Further details, if required, can be found in the NHS England annual report 2021/22.

Service Provider & Service	**Service Auditor / Type of report**	**Opinion**
NHS Shared Business Services (SBS) - Finance & Accounting Services	Price Waterhouse Coopers LLP ISAE 3402	Qualified – 1 exception identified
NHS Digital – General Practitioners Payment Services	Price Waterhouse Coopers LLP ISAE 3000	Qualified – 2 exceptions identified

NHS Business Services Authority – Prescription Payments Process	Price Waterhouse Coopers LLP ISAE 3402	Qualified – Control objective number 2 not met
Capital Business Services Ltd – Primary Care Support	Mazars ISAE 3402	Qualified – 4/17 control objectives not met
Electronic Staff Record Programme (ESR)	Price Waterhouse Coopers LLP ISAE 3000	Qualified – 1 exception identified

NHS Pension Scheme 2022/23

NHS Blackburn with Darwen CCG confirms that as an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes and ensures that, deductions from salary in respect of employee contributions; employer contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in line with the timescales detailed within the Regulations.

Control Issues

There have been no significant control issues during the reporting period

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

The Draft Accounts for the three month period to 30 June 2022 are subject to external audit and demonstrate that: -

- The CCG has delivered break even position against allocated revenue resource limit for that period.
- Has managed within the maximum cash draw down allocated to the CCG for the period
- Managed to deliver our business within the running cost allowance
- The CCG did not have a capital resource limit during the financial year

In 2022/23 the CCG was eligible to draw down up to £7,402k of the retained historical surplus. The CCG did not draw any of that surplus down in the three month period.

Within the three months, the CCG has had an in-period QIPP target of £1,024k. Due to the nature of the financial regime adopted for that period, it has been difficult for CCGs to identify recurrent QIPP savings and therefore the in-period target has only been partly delivered and on a non-recurrent basis. This is mainly through slippage on planned investments, underspends against prescribing and independent sector activity, and one-off benefits of commitments which have not materialised.

Despite the finance regime and the continued pandemic response including level 4 emergency response status, CCGs have been required to maintain and deliver the planning expectations set out in the long-term plan, in relation to mental health services to ensure parity of esteem. During the three months, NHS Blackburn with Darwen CCG has increased its investment on mental health services, however the achievement of the mental health investment standard will be assessed on a full year basis as part of the Lancashire and South Cumbria Integrated Care Board first year accounts. As in previous years, this investment will be subject to independent corroboration through a separate external audit review.

The Governing Body receive monthly reports on the CCG's financial position and forecast for the actual out-turn. Detailed scrutiny was undertaken through the CCG's Audit Committee, chaired by a lay member. Detailed monthly monitoring is also submitted to NHS England and challenge is received where in-month performance is not aligned to the annual plan.

The CCG underspent against its in-period running cost allowance.

Delegation of functions

I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of these functions.

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

Services provided by the Midlands and Lancashire Commissioning Support Unit are reviewed through monthly meetings with a dedicated service director and issues and risks are raised through the MLCSU Customer Forum

Counter fraud arrangements

The NHS Counter Fraud Authority (CFA) require that providers and commissioners ensure that NHS resources are protected from fraud, bribery and corruption. The CCG is required to comply with all the standards sets out in the NHS CFA Standards for Commissioners to combat economic crime within the NHS.

We commission the services of assurance provider Mersey Internal Audit Agency to provide our Anti-Fraud Specialists.

We do not tolerate economic crime and we have an Anti-Fraud Bribery and Corruption Response Policy in place which is designed to make all staff aware of their responsibilities should they suspect offences being committed. When economic crime is suspected, it is fully investigated in line with legislation. Appropriate action is taken, which can result in criminal, disciplinary and civil sanctions being applied. This work is monitored by the Audit Committee as a standing agenda item at each meeting.

During Quarter 1 2022/23, due to the disestablishment of the CCG on 30th June 2022, the key areas of activity as outlined by NHS CFA and agreed within the workplan by the Audit Committee was to deliver against key risks, and ensure compliance with any mandated activity. A focus also remained around raising fraud awareness and prevention activities along with addressing any fraud referrals that may have been received. A summary of the work is outlined below:

- Fraud Awareness Activities
- Issuing alerts, fraud prevention notices, iBurns etc
- Focus on cyber fraud risks
- Focus on mandate fraud risks
- Focus on Covid-related fraud risks
- Focus on CCG wind-down fraud risks
- Completion of risk assessment/submission of NHS CFF SR
- Referral management
- Update reports to Audit Committee

A member of the executive team is proactively and demonstrably responsible for tackling fraud, bribery and corruption.

The CCG's Chief Finance Officer oversees the anti-fraud arrangements for the CCG.

Appropriate action is taken regarding any NHS Protect quality assurance recommendations.

The CCG has a “Freedom to Speak Up” policy to enable staff or members of the public to report any genuine non malicious concerns they have in confidence. This could be in relation to a possible fraud, crime, danger or other serious risk affecting patient safety, the welfare of staff or the reputation, or financial stability of the CCG or wider NHS

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group’s system of risk management, governance and internal control. The Head of Internal Audit concluded that:

The overall opinion for the period 1st April 2022 to 30th June 2022 provides substantial assurance, 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 Quarter 1 2022/23 Internal Audit Plan has been delivered with the focus on transition support and the provision of the Head of Internal Audit Opinion. This position has been reported within the progress reports across the quarter.

Review coverage has been focused on:

- CCG Closedown/ICB Transition reviews and support
- CCG Compliance with statutory functions
- Follow up of outstanding internal audit recommendations

Any recommendations provided Mersey Internal Audit Agency will be included in the CCG’s handover document to the ICB.

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

Responsibility for risk management is brought together through the Senior Directors who work collectively to oversee the key risks to the organisation. Senior Managers take a

pivotal role in the CCG reporting structure with a responsibility for co-ordinating, communicating and accelerating strategic and operational assurance issues, regularly reporting on core business activity.

Our Risk Register and Assurance Framework continues to be monitored and updated in line with the Risk Management Strategy and Policy supporting our systems of internal control throughout Quarter 1 2022/23.

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- Individual internal audit reports relating to the CCG
- External audit via their annual audit letter which provides a high-level summary of audit work carried out
- Regular Senior Directors, ICC and Senior Managers meetings
- Reports to Audit Committee by the Local Anti-Fraud Specialists
- Information Governance Data Security and Protection Toolkit work plan.
- Review of the Corporate Risk Register by the Quality Committee, Governing Body and Audit Committee
- Scrutiny of the Governing Body Assurance Framework by the Audit Committee and Governing Body
- Regular meetings with NHS England

Conclusion

As Accountable Officer, my review concludes that NHS Blackburn with Darwen 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.

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board (on behalf of the former Blackburn with Darwen CCG)

28 June 2023

Remuneration and Staff Report

Remuneration Committee

The membership of the Remuneration Committee is as follows**:**

Mr Graham Burgess - (Chair)
Mr Paul Hinnigan – Lay Member – Governance
Mr Nigel Horsfield - Lay Member
Dr Geraint Jones - Secondary Care Doctor

The Terms of Reference and Membership of the Remuneration Committee are available on our website in the CCG's Constitution.

Profiles of the members of this committee can be found within this report and a register of their interests is also available on our website.

[ARCHIVED CONTENT] Our Constitution | (nationalarchives.gov.uk)

Our Statement of Disclosure to Auditors is referenced in the members' report.

Policy on the remuneration of senior managers

Remuneration of senior managers, up to and including Band 9, is undertaken in accordance with Agenda for Change, and guided and advised by NHS Midlands and Lancashire CSU's HR service.

Remuneration of Very Senior Managers

We are obliged to review the remuneration of all our Senior Executives on an annual basis and in particular in accordance with Secretary of State Directions – those salaries which are in excess of the Prime Minister's i.e. £150,000 per annum. No individual received a salary which was in excess of the Prime Minister's salary of £150,000 per annum.

Policy on senior managers' contracts

Contracts are written in line with national terms and conditions with input and advice from the CSU HR commissioned service. The duration of the Chair and Lay Members to the

CCG are written into the CCG constitution and run for a three-year period. Governing Body clinical leads are re-elected as per the CCG constitution, every three years.

Senior managers' service contracts

There were no senior manager service contracts.

Senior manager remuneration as at 30 June 2022 (1 April to 30 June 2022 – CCG reports) (including salary and pension entitlements) (Subject to Audit)

Name & Title	Salary & Fees (bands of £5,000)	Expense payments (taxable) to nearest £100	Annual Performance Related Bonuses (bands of £5,000)	Long-term Performance Related Bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
	£000	£	£000	£000	£000	£000
Mr Graham Burgess - Chair (ii, iv)	5-10	1,000	0	0	0	10-15
Mr Paul Hinnigan – Lay Member – Governance (i)	0-5	0	0	0	0	0-5
Mr Geraint Jones – Secondary Care Doctor (i)	0-5	0	0	0	0	0-5
Mr Nigel Horsfield – Lay Member (i)	0-5	0	0	0	0	0-5
Dr Ridwaan Ahmed – Clinical Director for Quality and Primary Care (ii)	15-20	0	0	0	0	15-20
Dr Julie Higgins - Accountable Officer (ii, iii)	10-15	0	0	0	0	10-15
Mr Roger Parr – Chief Finance Officer	25-30	0	0	0	2.5-5	30-35
Mrs Kathryn Lord– Director of Quality &Chief Nurse (iii)	5-10	0	0	0	5-7.5	15-20
Dr Zaki Patel - Executive GP and Clinical Lead	5-10	0	0	0	15-17.5	20-25
Dr Adam Black - Executive GP and Clinical Lead	5-10	0	0	0	0	5-10
Dr Qashuf Hussain -Executive GP and Clinical Lead (ii)	15-20	0	0	0	0	15-20
Dr Mohammad Moosa – Executive GP and Clinical Lead (ii)	5-10	0	0	0	0	5-10

Note: Taxable expenses and benefits in kind are expressed to the nearest £100

(i) Lay Members are not eligible for membership of the NHS Pension scheme.

(ii) Dr R Ahmed, Dr Q Hussain, Dr M Moosa, Dr J Higgins and Mr M Burgess do not make contributions to the NHS Pension Scheme.

(iii) The Accountable Officer and the Director of Quality & Chief Nurse are joint posts with NHS East Lancashire CCG. 35% of costs are recharged to BwD CCG.

The figures above include 35% of salary and pension. The total salary banding for Dr J Higgins is £35,000-£40,000 and for K Lord is £25,000-£30,000.

(iv) Taxable benefit relates to a car allowance.

(v) The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

(vi) The salary figures do not include the 22/23 pay award and therefore backpay relating to this period will be paid by the ICB.

Senior manager remuneration 2021/2022 (CCG reports only – ICBs do not have a prior year) (including salary and pension entitlements) comparator information (Subject to Audit)

Name & Title	Salary & Fees (bands of £5,000)	Expense payments (taxable) to nearest £100	Annual Performance Related Bonuses (bands of £5,000)	Long-term Performance Related Bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
	£000	£	£000	£000	£000	£000
Mr Graham Burgess - Chair (iv)	35-40	4,000	0	0	0	40-45
Mr Paul Hinnigan – Lay Member – Governance (i)	15-20	0	0	0	0	15-20
Mr Geraint Jones – Secondary Care Doctor (i)	15-20	0	0	0	0	15-20
Mr Nigel Horsfield – Lay Member (i)	15-20	0	0	0	0	15-20
Dr Ridwaan Ahmed – Clinical Director for Quality and Primary Care (ii)	70-75	0	0	0	0	70-75
Dr Julie Higgins - Accountable Officer (ii, iii)	45-50	0	0	0	0	45-50
Mr Roger Parr – Chief Finance Officer	110-115	0	0	0	32.5-35	145-150
Mrs Kathryn Lord– Director of Quality &Chief Nurse (iii)	35-40	0	0	0	10-12.5	45-50
Dr Zaki Patel - Executive GP and Clinical Lead	35-40	0	0	0	10-12.5	45-50
Dr Adam Black - Executive GP and Clinical Lead	35-40	0	0	0	7.5-10	40-45
Dr Qashuf Hussain -Executive GP and Clinical Lead (ii)	35-40	0	0	0	0	35-40
Dr Mohammad Moosa – Executive GP and Clinical Lead	35-40	0	0	0	0	35-40

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

Explanation of annotation in Senior manager remuneration – 2021/2022 (Subject to Audit)

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

(i) Lay Members are not eligible for membership of the NHS Pension scheme.

(ii) Dr R Ahmed, Dr Q Hussain and Dr J Higgins have opted out of the NHS Pension Scheme.

(iii) The Accountable Officer and the Director of Quality & Chief Nurse are joint posts with NHS East Lancashire CCG. 35% of costs are recharged to Blackburn with Darwen CCG.

The figures above include 35% of salary and pension. The total salary banding for Dr J Higgins is £140,000-£145,000 and for K Lord is £100,000-£105,000.

(iv) Taxable benefit relates to a car allowance.

Pension benefits as at 30 June 2022 (Subject to Audit)

		To 30 June 2022							
		Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 30 June 2022	Lump sum at pension age related to accrued pension at 30 June 2022	Cash Equivalent Transfer Value at 01 April 2022	Real increase in Cash Equivalent Transfer Value (i)	Cash Equivalent Transfer Value at 30 June 2022	Employer's Contribution to partnership pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
Name		**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Mrs. K. Lord (ii)	Director of Quality & Chief Nurse	0 - 2.5	0 - 2.5	15 - 20	30 - 35	245	6	283	0
Dr. Z Patel	Executive GP and Clinical Lead	0 - 2.5	0 - 2.5	15 - 20	35 - 40	251	10	306	0
Dr. A Black	Executive GP and Clinical Lead	0 - 2.5	0 - 2.5	5 - 10	0 - 5	59	0	64	0
Mr. R Parr	Chief Finance Officer	0 - 2.5	0 - 2.5	50 - 55	100 - 105	871	5	933	0

(i) The factors used by the NHS Business Authority to calculate Cash Equivalent Transfer Values; C.E.T.V.s ; increased on the 29th of October

2018, affecting the calculation of the real increase of C.E.T.V.s. This together with adjustment for inflation and deduction of employee superannuation contributions gives the real increase shown.

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

(ii) Mrs K. Lord's post is a joint post with NHS East Lancashire CCG. Mrs Lord's costs are shared 65% East Lancashire CCG and 35% Blackburn with Darwen CCG. The figures above reflect the Blackburn with Darwen percentage.

(iii) Dr J. Higgins the Accountable Officer across East Lancashire and Blackburn with Darwen CCGs exited the NHS pension scheme in the 2020-21 financial year hence there are no pension disclosures for the April to June 2022 period.

Values above are adjusted to reflect the number of days an individual was in post.

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).

Pension benefits as at 31 March 2022 – prior year comparator data (Subject to Audit)

		To 31 March 2022							
		Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2022	Lump sum at pension age related to accrued pension at 31 March 2022	Cash Equivalent Transfer Value at 01 April 2021	Real increase in Cash Equivalent Transfer Value (i)	Cash Equivalent Transfer Value at 31 March 2022	Employer's Contribution to partnership pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
Name		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mrs. K. Lord (ii)	Director of Quality & Chief Nurse	0 - 2.5	0 - 2.5	10 - 15	25 - 30	229	10	245	0
Dr. Z Patel	Executive GP and Clinical Lead	0 - 2.5	0 - 2.5	10 - 15	30 - 35	234	10	251	0
Dr. A Black	Executive GP and Clinical Lead	0 - 2.5	0 - 2.5	5 - 10	0 - 5	49	4	59	0
Mr. R Parr	Chief Finance Officer	0 - 2.5	0 - 2.5	45 - 50	95 - 100	816	36	871	0

(i) The factors used by the NHS Business Authority to calculate Cash Equivalent Transfer Values; C.E.T.V.s ; increased on the 29th of October 2018, affecting the calculation of the real increase of C.E.T.V.s. This together with adjustment for inflation and deduction of employee superannuation contributions gives the real increase shown.

(ii) Mrs K. Lord's post is a joint post with NHS East Lancashire CCG. Mrs Lord's costs are shared 65% East Lancashire CCG and 35% Blackburn with Darwen CCG. The figures above reflect the Blackburn with Darwen percentage.

Values above are adjusted to reflect the number of days an individual was in post.

Losses and special payments (Subject to Audit)

In the period to 30 June 2022, no special payments were made, or losses incurred.

Compensation on early retirement for loss of office (Subject to Audit)

There has been no incidence of compensation on early retirement for loss of office during the three months to 30 June 2022 (nil return for 2021/2022).

Payments to past directors (Subject to Audit)

There has been no incidence of payments to past directors during the three months to 30 June 2022 (nil return for 2021/2022).

Fair Pay Disclosure (Subject to Audit)

Percentage change in remuneration of highest paid director

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	5.19%	0%

With the exception of those governing body members who hold very senior manager (VSM) contracts, employees of the CCG hold contracts and are paid in accordance with agenda for change. For 2021/22, the national agenda for change pay award was 3%. For VSM, there was national guidance published to state that those officers on such a contract, should not receive an in year pay award. This was accepted by the CCG's remuneration committee and no inflationary increase was awarded to those employees. This included the highest paid director. The pay award for 2022/2023 had not been settled as at 30 June 2022 and the increase is due to the changing skill mix of the organisation as members of staff chose to leave the CCGs employment ahead of its demise on 30 June 2022.

Pay ratio information

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

The banded remuneration of the highest paid director / member in NHS Blackburn with Darwen CCG in the reporting period 1 April 2022 and 30 June 2022 was £110-115k (2021-22, £110-115k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

1 April to 30 June 2022	25th percentile	Median	75th percentile
Total remuneration (£)	35,429	43,372	53,742
Salary component of total remuneration (£)	35,429	43,372	53,605
Pay ratio information	3.18:1	2.59:1	2.09:1
2021/22			
Total remuneration (£)	35,429	39,027	50,795

Salary component of total remuneration (£)	35,429	39,027	50,826
Pay ratio information	3.18:1	2.88:1	2.21:1

During the reporting period 1 April to 30 June 2022, 0 [zero] (2021-22, 0 [zero]) employees received remuneration in excess of the highest-paid director / member. Remuneration ranged from £24.8k to £112.5k (2021-22 £24.8k to £112.5k).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Staff Report

As a CCG, we need to assure ourselves and our public that we have the capacity and capabilities needed to deliver our vision and strategy.

We want to ensure that our organisation is functioning at its best and that our employees are supported to develop themselves and others.

We want to be an organisation that people want to work for, and others want to work with.

Number of senior managers

The total number of senior managers is shown in the table below. A senior manager is anybody who is remunerated on Agenda for Change band 8A or above, very senior manager (VSM) pay scale or an equivalent clinical grade.

Payscale	Headcount
VSM	7
Other Non-AFC	0
Clinical Non-AFC	12
Band 9	0

Band 8 - Range D	1
Band 8 - Range C	3
Band 8 - Range B	3
Band 8 - Range A	6

Staff numbers (Subject to Audit)

The average staff numbers for the period are shown in the table below:

	Total Number	Permanently Employed	Other
Total	35.58	35.46	0.12

The numbers above are based on the average whole-time equivalent number of employees.

They exclude those who hold a contract for services with the CCG, are lay members, are on an outward secondment or who do not hold a contract of employment and are therefore not classed as “staff”.

Staff composition

Staff composition is shown in the table below and complies with the reporting requirements of the Department of Health and Social Care Group Accounting Manual for 2021/22.

	Headcount by Gender		
Staff Grouping	**Female**	**Male**	**Totals**
All Other Employees	22	8	**30**
Governing Body	2	10	**12**
Other Senior Management (Band 8C+)	2	2	**4**
Grand Total	**26**	**20**	**46**

The above analysis is based on “head count”.

Our management and staffing structure operates within fixed running costs, and our staff have a wide range of local knowledge and professional expertise.

Staff costs (Subject to Audit)

4.1.1 Employee benefits	**Total**		**2022-23**
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	476	3	479
Social security costs	57	0	57
Employer Contributions to NHS Pension scheme	65	0	65
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	598	3	601
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	-
Total - Net admin employee benefits including capitalised costs	598	3	601
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	598	3	601

4.1.1 Employee benefits	**Total**		**2021-22**
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	1,954	12	1,966
Social security costs	219	0	219
Employer Contributions to NHS Pension scheme	388	0	388
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0

Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	2,561	12	2,573
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	2,561	12	2,573
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	2,561	12	2,573

4.1.2 Recoveries in respect of employee benefits

There were no recoveries in respect of employee benefits in 2021-22 or 2022-23.

Sickness absence data

The following table details staff sickness and absence for the financial year 2021/22 and is consistent with that reported by NHS Digital and provided to the CCG.

Staff sickness absence 2022	2023	2022
Total FTE* Days Lost	159.85	91
Total FTE Days available	30.00	12,267
Average Annual Sick Days per FTE	5.33	1.7

(* FTE = Full Time Equivalent)

Staff absences were managed through the CCG's sickness absence policy

Staff turnover percentages

The following table details staff turnover during the year 2021/2022

CCG Staff Turnover 2021-22	2022 - 2023
Average FTE Employed 2021-22	29.57
Total FTE Leavers 2021-22	3.44
Turnover Rate	11.63%

The CCG Staff Turnover Rate for 2021-22 has been calculated by dividing the total FTE Leavers in-year by the average FTE Staff in Post during the year. The CCG's Total FTE Leavers in year was 7.29. The CCG's Average FTE Staff in Post during the year was 32.69. The CCG Staff Turnover Rate for the year was 22.31%

Staff policies

All staff policies and procedures in force during the financial year are published on the CCG's website here: [ARCHIVED CONTENT] Policies and procedures | (nationalarchives.gov.uk)

Details regarding diversity and inclusion policies, initiatives and longer term ambitions will be published with the Equality and Inclusion Annual Report for 2021/22 which will be published on the CCG website once approved. This will include:

• How policies and activities undertaken in the year have or will improve the diversity and inclusiveness of the workforce.

• Whether the entity has identified any barriers to improving the diversity of its workforce and if so, what actions the entity has or will put in place.

• Changes in staff composition impacting on the diversity and inclusiveness of the workforce, including appropriate trend data.

• Performance against internal targets set in relation to diversity and inclusiveness of the workforce if applicable.'

Trade Union Facility Time Reporting Requirements

Blackburn with Darwen 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 TU representatives and area/regional representatives from those recognised unions whose time will be recorded with their employing authority.

Other employee matters

Expenditure on consultancy

During the three month period the CCG spent £0 on Consultancy to provide strategic advice. (2020/21 - £0).

Off-payroll engagements

An off-payroll engagement is defined as an arrangement whereby individuals are paid through their own companies and so are responsible for their own tax and national insurance arrangements. They are therefore not classed as CCG employees.

For the period to 30 June 2022 we had no arrangements which met this criteria.

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 30 June 2022 for more than £245* per day and that last longer than six months:

	Number
Number of existing engagements as of 30 June 2022	0
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	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

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

Should the CCG enter into an off-payroll engagement, before the contract commenced it would be subject to a risk based assessment as to whether assurance is required that the individual would be paying the right amount of tax and, where necessary, that assurance would be sought.

The CCG can confirm that there were no such engagements.

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

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

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	0
Of which:	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35	0
No. subject to off-payroll legislation and determined as out of scope of IR35	0

the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

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

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

The CCG can confirm that there were no such engagements.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2022 and 30 June 2022:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year.	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	12

Exit packages, including special (non-contractual) payments (Subject to Audit)

Table 1: Exit Packages

There have been no exit packages or special non-contractual payments made to staff during the period 01 April 2022 – 30 June 2022 (nil return 2021/2022)

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 – £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0	0	0

Table 2: Analysis of Other Departures

There have been no other departures agreed or paid during the period 01 April 2022 – 30 June 2022 (nil return 2021/2022)

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	**0**	**0**
Mutually agreed resignations (MARS) contractual costs	**0**	**0**
Early retirements in the efficiency of the service contractual costs	**0**	**0**
Contractual payments in lieu of notice*	**0**	**0**
Exit payments following Employment Tribunals or court orders	**0**	**0**
Non-contractual payments requiring HMT approval**	**0**	**0**
TOTAL	**0**	**0**

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in the exit package table which will be the number of individuals.

*any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.

**includes any non-contractual severance payment made following judicial mediation, and any amounts relating to non-contractual payments in lieu of notice.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Kevin Lavery
Chief Executive

Lancashire and South Cumbria Integrated Care Board (on behalf of the former Blackburn with Darwen CCG)
28 June 2023

Parliamentary Accountability and Audit Report

NHS Blackburn with Darwen 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 in the notes in the financial statements.

External auditor's remuneration

Grant Thornton UK LLP are the CCG's appointed external auditors and are due to be paid £56k in respect of the audit work in relation to the 3 month accounts to 30 June 2022.

The breakdown of this expenditure is as follows:-

	To 30 June 2022 £'000	2021/2022 £'000
External Audit Services	56.0	51.5
Further Assurance Work / Prior Year	0	0
Mental Health Investment Standard Assurance Work	0	15.0
Total Expenditure on external audit work	56.0	**66.5**

The work undertaken as part of the external audit service encompasses all the work carried out under the Code of Audit Practice, namely audit of the annual financial statements and the issue of a value for money conclusion on the CCG's use of resources.

Members of the appointed audit team have met with officers on a regular basis throughout the year to discuss and advise on matters ranging from technical accounting topics to discussing the audit process. They also attend Audit Committee meetings where they provide on-going audit updates, advice and discussion on any issues which are brought to their attention. This also ensure that they are formally sighted on CCG business throughout the year.

During the year, both Grant Thornton and those charged with governance of the CCG, have assess potential conflicts of interest. Both were able to conclude that none were found.

Cost Allocation and 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.

Better Payment Practice Code / Prompt Payment Code

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. Details of our payment compliance can be found in the notes to the annual accounts.

ANNUAL ACCOUNTS

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board (on behalf of the former NHS Blackburn with Darwen CCG)

28 June 2023

Independent auditor's report to the members of the Governing Body of NHS Lancashire and South Cumbria Integrated Care Board in respect of NHS Blackburn with Darwen Clinical Commissioning Group

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Blackburn with Darwen Clinical Commissioning Group (the 'CCG') for the period ended 30 June 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 1 to the financial statements, which indicates that the Health and Care Bill allowed for the establishment of Integrated Care Boards (ICBs) and abolished Clinical Commissioning Groups (CCGs). The functions, assets, and liabilities of NHS Blackburn with Darwen CCG transferred to NHS Lancashire and South Cumbria ICB on 1 July 2022. When NHS Blackburn with Darwen CCG ceased to exist on 30 June 2022, its services continued to be provided by NHS Lancashire and South Cumbria ICB from 1 July 2022.

Conclusions relating to going concern

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

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks

associated with the continuation of services provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

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

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

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

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

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

Matters on which we are required to report by exception

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

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 66 to 68, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).
- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to closing journal entries around expenditure in order to possibly manipulate the year-end financial performance.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on unusual closing journal entries around expenditure that could manipulate the year-end financial performance;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the prescribing accrual;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to the prescribing accrual.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation;
  - knowledge of the health sector and economy in which the CCG operates;
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The CCG's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework**.**

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 30 June 2022.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibilities for the review of the CCG's arrangements for securing economy, efficiency, and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources were operating effectively during the three month period ended 30 June 2022.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there were significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of NHS Blackburn with Darwen CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

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

Sarah L Ironmonger

Sarah Ironmonger, Key Audit Partner

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

Manchester

28 June 2023

Entity name:	NHS Blackburn with Darwen CCG
This period	2022-23
Last year	2021-22
This period ended	30 June 2022
Last year ended	31-March-2022
This year commencing:	01-April-2022
Last year commencing:	01-April-2021

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The Primary Statements:

Notes to the Accounts

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

	Note	3 month period end to 30 June 2022 £'000	Full year accounts 2021/22 £'000
Income from sale of goods and services	2	(4)	(6)
Other operating income	2	(361)	(621)
Total operating income		**(365)**	**(626)**
Staff costs	4	602	2,573
Purchase of goods and services	5	72,179	303,404
Depreciation and impairment charges	5	54	-
Provision expense	5	1	750
Other Operating Expenditure	5	24	109
Total operating expenditure		**72,860**	**306,836**
Net Operating Expenditure		**72,495**	**306,209**
Finance expense		1	-
Net expenditure for the Year		**72,496**	**306,209**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**72,496**	**306,209**
Other Expenditure		-	-
Sub Total		**-**	**-**
Comprehensive Expenditure for the year		**72,496**	**306,209**

Statement of Financial Position as at 30 June 2022

	Note	3 month period end to 30 June 2022 £'000	Full year accounts 2021/22 £'000
Non-current assets:			
Right-of-use assets	8.1	326	-
Total non-current assets		**326**	-
Current assets:			
Inventories	9	1,459	1,403
Trade and other receivables	10	350	1,893
Cash and cash equivalents	11	20	9
Total current assets		**1,829**	3,305
Total current assets		**1,829**	3,305
Total assets		**2,155**	3,305
Current liabilities			
Trade and other payables	12	(12,091)	(20,535)
Lease liabilities	8.2	(326)	-
Provisions	13	(746)	(772)
Total current liabilities		**(13,163)**	(21,306)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(11,007)**	(18,002)
Non-current liabilities			
Non-current Liabilities		-	-
Assets less Liabilities		**(11,007)**	(18,002)
Financed by Taxpayers' Equity			
General fund		(11,007)	(18,002)
Charitable Reserves		-	-
Total taxpayers' equity:		**(11,007)**	(18,002)

The notes on pages 5 to 32 form part of this statement

The financial statements on pages 1 to 30 have been approved in line with delegated authority granted by the Board on 21 June 2023

Chief Executive
28 June 2023

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2022-23				
Balance at 01 April 2022	(18,002)	0	0	**(18,002)**
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 2022	**(18,002)**	**0**	**0**	**(18,002)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23				
Total transition adjustment for initial application of IFRS 16	0			**0**
Net operating expenditure for the financial year	(72,496)			**(72,496)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(72,496)**	**0**	**0**	**(72,496)**
Net funding	79,490	0	0	**79,490**
Balance at 30 June 2022	**(11,007)**	**0**	**0**	**(11,007)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22				
Balance at 01 April 2021	(14,384)	0	0	**(14,384)**
Transfer of assets and liabilities from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(14,384)**	**0**	**0**	**(14,384)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22				
Net operating costs for the financial year	(306,209)			(306,209)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(306,209)**	**0**	**0**	**(306,209)**
Net funding	302,592	0	0	302,592
Balance at 31 March 2022	**(18,002)**	**0**	**0**	**(18,002)**

The notes on pages 5 to 32 form part of this statement

Statement of Cash Flows for the period ended 30 June 2022

	Note	3 month period end to 30 June 2022 £'000	Full year accounts 2021/22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(72,496)	(306,209)
Depreciation and amortisation	8.1	54	0
(Increase)/decrease in inventories	9	(56)	(206)
(Increase)/decrease in trade & other receivables	10	1,542	525
Increase/(decrease) in trade & other payables	12	(8,444)	2,612
Provisions utilised	13	(27)	(84)
Increase/(decrease) in provisions	13	1	750
Net Cash Inflow (Outflow) from Operating Activities		**(79,426)**	(302,612)
Net Cash Inflow (Outflow) before Financing		**(79,426)**	(302,612)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		79,490	302,592
Repayment of lease liabilities	8.2	(54)	0
Net Cash Inflow (Outflow) from Financing Activities		**79,436**	302,592
Net Increase (Decrease) in Cash & Cash Equivalents	11	**10**	(20)
Cash & Cash Equivalents at the Beginning of the Financial Year		**9**	29
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		**19**	9

The notes on pages 5 to 32 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

The Health and Care Act received Royal Assent on the 28th of April 2022. The Act abolished clinical commissioning groups on the 30th of June 2022. Integrated Care Boards (ICBs) have taken on the commissioning functions of CCGs from the 1st of July 2022. On this date the CCG's functions, assets and liabilities have transferred to Lancashire & South Cumbria ICB.

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

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 30 June 2022 on a going concern basis.

1.2 **Accounting Convention**

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

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

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

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

1.4 **Pooled Budgets**

The clinical commissioning group has entered into a pooled budget arrangement with Lancashire County Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for a range of activities and Note 18 provides details of the income and expenditure.

The pool is hosted by Lancashire County Council. The 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.

The Better Care Fund is accounted for net;Lancashire County Council invoices the CCG for the total amount of the Better Care Fund; the CCG in turn invoices Lancashire County Council for their share of the fund, the resulting net balance is accounted for in the CCG accounts.

1.5 **Operating Segments**

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

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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.

1.7.2 **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.

Notes to the financial statements

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

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

1.9 **Grants Payable**
Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the 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.

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

1.10.1 **The Clinical Commissioning Group as Lessee**
A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.
Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.
Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

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

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

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

1.13 **Provisions**
Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 3.27% (2021-22: - 0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 3.20% (2021-22: 0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 3.51% (2021-22 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 3.00% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

Notes to the financial statements

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

1.14 **Clinical Negligence Costs**

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

1.15 **Non-clinical Risk Pooling**

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

1.16 **Carbon Reduction Commitment Scheme**

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

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.
The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.
Allowances acquired under the scheme are recognised as intangible assets.

1.17 **Contingent liabilities and contingent assets**

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

1.18 **Financial Assets**

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

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

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

1.18.1 **Financial Assets at Amortised cost**

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

1.18.2 **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.

1.18.3 **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.

1.18.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.
The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).
HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

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

1.19 **Financial Liabilities**

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

1.19.1 **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,

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· The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

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

1.19.3 **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.

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

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

1.23 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.23.1 **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.
Any material estimates included within the accounts for the period have been made using best available actual data. There are two areas where this is applicable, prescribing and individual packages of care. The risk of these estimates resulting in a material adjustment to the carrying amounts into the next financial period has been assessed as low. The value of the prescribing accrual is £3,073k, and the value of the IPA accrual is £5,139k, less an adjustment for unutilised accruals from prior period release of £3,448k leaving a net accrual of £1,691k.

1.24 **Adoption of new standards**
On 1 April 2022, the clinical commissioning group adopted IFRS 16 'Leases'. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.
Under IFRS 16 the group will recognise a right-of-use asset representing the group's right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.
In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Impact assessment
The clinical commissioning group has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.
IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The group has utilised three further practical expedients under the transition approach adopted:
a) The election to not make an adjustment for leases for which the underlying asset is of low value.
b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.
As of 1 April 2022, the group recognised £380,000 of right-of-use assets and lease liabilities of £379,000. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was a £1,000 impact to tax payers' equity.
The group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.

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

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

2. Other Operating Revenue

	3 month period end to 30 June 2022 Admin	3 month period end to 30 June 2022 Programme	3 month period end to 30 June 2022 Total	Full year accounts 2021/2022 Total
	£'000	£'000	£'000	£'000
Income from sale of goods and services (contracts)				
Non-patient care services to other bodies	-	-	-	5
Other Contract income	-	4	4	1
Total Income from sale of goods and services	**-**	**4**	**4**	**6**
Other operating income				
Other non contract revenue	-	361	361	621
Total Other operating income	**-**	**361**	**361**	**621**
Total Operating Income	**-**	**365**	**365**	**626**

3. 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	-	-	-	-	-	-	-	-
Non NHS	-	-	-	-	-	-	4	-
Total	**-**	**-**	**-**	**-**	**-**	**-**	**4**	**-**

	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	-	-	-	-	-	-	4	-
Over time	-	-	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**	**4**	**-**

4. Employee benefits and staff numbers

4.1.1 Employee benefits	**Total**		**3 month period end to 30 June 2022**
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	476	3	479
Social security costs	57	0	57
Employer Contributions to NHS Pension scheme	65	0	65
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**599**	**3**	**602**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**599**	**3**	**602**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**599**	**3**	**602**

4.1.1 Employee benefits	Total		Full year accounts 2021/22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	1,954	12	1,966
Social security costs	219	0	219
Employer Contributions to NHS Pension scheme	388	0	388
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**2,561**	**12**	**2,573**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**2,561**	**12**	**2,573**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**2,561**	**12**	**2,573**

4.1.2 Recoveries in respect of employee benefits

There were no recoveries in respect of employee benefits in 2022-23 or 2021-22.

4.2 Average number of people employed

	3 month period end to 30 June 2022			Full year accounts 2021/22		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**35.46**	**0.12**	**35.58**	**37.56**	**0.12**	**37.68**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

There were no exit packages or other agreed departures within 2022-23 or 2021-22.

4.4 Pension costs

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

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

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

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

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

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

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

5. Operating expenses

	3 month period end to 30 June 2022 Total £'000	Full year accounts 2021/22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	754	2,850
Services from foundation trusts	14,197	62,485
Services from other NHS trusts	33,424	130,755
Purchase of healthcare from non-NHS bodies	6,706	37,095
Purchase of social care	1,915	6,861
Prescribing costs	7,005	28,661
GPMS/APMS and PCTMS	7,035	29,794
Supplies and services – clinical	32	188
Supplies and services – general	(39)	(1,081)
Establishment	152	1,558
Transport	8	31
Premises	934	4,056
Audit fees	56	96
Other non statutory audit expenditure	(2)	1
Other professional fees	4	7
Legal fees	5	18
Education, training and conferences	(4)	27
Total Purchase of goods and services	**72,179**	**303,404**
Depreciation and impairment charges		
Depreciation	54	-
Total Depreciation and impairment charges	**54**	**-**
Provision expense		
Provisions	1	750
Total Provision expense	**1**	**750**
Other Operating Expenditure		
Chair and Non Executive Members	24	97
Research and development (excluding staff costs)	-	12
Total Other Operating Expenditure	**24**	**109**
Total operating expenditure	**72,259**	**304,263**

Included in the entry for professional fees are payments for Internal Audit and Counter Fraud.

External Audit fees are shown gross of VAT.

The Auditor's liability for external audit work carried out in the financial year is limited to £2m.

6.1 Better Payment Practice Code

Measure of compliance	3 month period end to 30 June 2022 Number	3 month period end to 30 June 2022 £'000	Full year accounts 2021/22 Number	Full year accounts 2021/22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	3,158	24,117	10,646	83,900
Total Non-NHS Trade Invoices paid within target	3,103	23,819	10,618	82,016
Percentage of Non-NHS Trade invoices paid within target	**98.26%**	**98.76%**	**10618**	**82,016**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	155	50,841	443	196,130
Total NHS Trade Invoices Paid within target	155	50,841	441	196,103
Percentage of NHS Trade Invoices paid within target	**100.00%**	**100.00%**	**99.55%**	**99.99%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	3 month period end to 30 June 2022 £'000	Full year accounts 2021/22 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

7. Finance costs

	3 month period end to 30 June 2022 £'000	Full year accounts 2021/22 £'000
Interest		
Interest on lease liabilities	1	-
Total interest	**1**	**-**
Total finance costs	**1**	**-**

8. Leases

8.1 Right-of-use assets

2022-23	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 2022	-	-	-	-	-	-	-	-	-
IFRS 16 Transition Adjustment	-	380	-	-	-	-	-	-	380
Cost/Valuation at 30 June 2022	**-**	**380**	**-**	**-**	**-**	**-**	**-**	**-**	**380**
Depreciation 01 April 2022	-	-	-	-	-	-	-	-	-
Charged during the year	-	54	-	-	-	-	-	-	54
Depreciation at 30 June 2022	**-**	**54**	**-**	**-**	**-**	**-**	**-**	**-**	**54**
Net Book Value at 30 June 2022	**-**	**326**	**-**	**-**	**-**	**-**	**-**	**-**	**326**

8. Leases cont'd

8.2 Lease liabilities

2022-23	**3 month period end to 30 June 2022 £'000**	Full year accounts 2021/22 £'000
Lease liabilities at 01 April 2022	-	-
IFRS 16 Transition Adjustment	379	-
Addition of Assets under Construction & Payments on Account	-	-
Repayment of lease liabilities (including interest)	1	-
Lease remeasurement	(54)	-
Lease liabilities at 30 June 2022	**326**	-

8.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	3 month period end to 30 June 2022 £'000	Full year accounts 2021/22 £'000
Within one year	(220)	-
Between one and five years	(111)	-
Balance at 30 June 2022	**(331)**	-
Effect of discounting	5	-
Included in:		
Current lease liabilities	(326)	-
Balance at 30 June 2022	**(326)**	-

8. Leases cont'd

8.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2022-23	**3 month period end to 30 June 2022 £'000**	Full year accounts 2021/22 £'000
Depreciation expense on right-of-use assets	54	-
Interest expense on lease liabilities	1	-

8.5 Amounts recognised in Statement of Cash Flows

	3 month period end to 30 June 2022 £'000	Full year accounts 2021/22 £'000
Total cash outflow on leases under IFRS 16	(54)	-

The lease expenditure declared under IFRS 16 relates to the Headquarters of NHS Blackburn with Darwen Clinical Commissioning Group. The continuation of the lease is currently under consideration by the CCG's successor body Lancashire and South Cumbria ICB.

9. Inventories

	Loan Equipment £'000	Other £'000	Total £'000
Balance at 01 April 2022	1,403	-	**1,403**
Additions	56	-	**56**
Balance at 30 June 2022	**1,459**	**-**	**1,459**

10.1 Trade and other receivables

	Current 3 month period end to 30 June 2022 £'000	**Non-current 3 month period end to 30 June 2022 £'000**	Current Full year accounts 2021/22 £'000	Non-current Full year accounts 2021/22 £'000
NHS receivables: Revenue	-	-	800	-
Non-NHS and Other WGA receivables: Revenue	56	-	1,047	-
Non-NHS and Other WGA accrued income	182	-	-	-
VAT	113	-	46	-
Total Trade & other receivables	**351**	**-**	**1,893**	**-**
Total current and non current	**351**		**1,893**	
Included above:				
Prepaid pensions contributions	-		-	

10.2 Receivables past their due date but not impaired

	3 month period end to 30 June 2022 DHSC Group Bodies £'000	**3 month period end to 30 June 2022 Non DHSC Group Bodies £'000**	Full year accounts 2021/22 DHSC Group Bodies £'000	Full year accounts 2021/22 Non DHSC Group Bodies £'000
By up to three months	-	17	582	186
By more than six months	-	-	-	76
Total	**-**	**17**	**582**	**262**

11. Cash and cash equivalents

	3 month period end to 30 June 2022 £'000	Full year accounts 2021/22 £'000
Balance at 01 April 2022	9	29
Net change in year	11	(20)
Balance at 30 June 2022	**20**	**9**
Made up of:		
Cash with the Government Banking Service	20	9
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**20**	**9**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 30 June 2022	**20**	**9**

12. Trade and other payables	**Current 3 month period end to 30 June 2022 £'000**	**Non-current 3 month period end to 30 June 2022 £'000**	Current Full year accounts 2021/22 £'000	Non-current Full year accounts 2021/22 £'000
NHS payables: Revenue	398	-	1,112	-
NHS accruals	1,504	-	2,944	-
Non-NHS and Other WGA payables: Revenue	1,914	-	2,972	-
Non-NHS and Other WGA accruals	7,851	-	13,209	-
Social security costs	30	-	30	-
Tax	32	-	32	-
Other payables and accruals	362	-	235	-
Total Trade & Other Payables	**12,091**	**-**	**20,535**	**-**
Total current and non-current	**12,091**		**20,535**	

Other payables include £179,000 outstanding pension contributions at 30 June 2022 (£154,000 was outstanding as at 31 March 2022).

13. Provisions

	Current 3 month period end to 30 June 2022 £'000	**Non-current 3 month period end to 30 June 2022 £'000**	Current Full year accounts 2021/22 £'000	Non-current Full year accounts 2021/22 £'000
Continuing care	746	-	772	-
Total	**746**	**-**	**772**	**-**
Total current and non-current	**746**		**772**	

	Continuing Care £'000	**Other £'000**	**Total £'000**
Balance at 01 April 2022	772	-	**772**
Arising during the year	1	-	**1**
Utilised during the year	(27)	-	**(27)**
Balance at 30 June 2022	**746**	**-**	**746**
Expected timing of cash flows:			
Within one year	746	-	**746**
Between one and five years	-	-	**-**
After five years	-	-	**-**
Balance at 30 June 2022	**746**	**-**	**746**

14. Contingencies

NHS Blackburn with Darwen CCG has no contingent assets or liabilities as at the 30th of June 2022, nor did it have any contingent assets or liabilities as at the 31st of March 2022.

15. Commitments

NHS Blackburn with Darwen CCG has no capital commitments relating to Q1 2022-23, nor did it have any capital commitments for 2021-22.

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

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

16.1.1 Currency risk

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

16.1.2 Interest rate risk

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

16.1.3 Credit risk

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

16.1.4 Liquidity risk

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

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 3 month period end to 30 June 2022 £'000	Equity Instruments designated at FVOCI 3 month period end to 30 June 2022 £'000	Total 3 month period end to 30 June 2022 £'000
Trade and other receivables with external bodies	238		238
Cash and cash equivalents	20		20
Total at 30 June 2022	**257**	**-**	**257**

	Financial Assets measured at amortised cost Full year accounts 2021/22 £'000	Equity Instruments designated at FVOCI Full year accounts 2021/22 £'000	Total Full year accounts 2021/22 £'000
Trade and other receivables with NHSE bodies	786	-	786
Trade and other receivables with other DHSC group bodies	604	-	604
Trade and other receivables with external bodies	457	-	457
Cash and cash equivalents	9	-	9
Total as at 31 March 2022	**1,856**	**-**	**1,856**

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost 3 month period end to 30 June 2022 £'000	Other 3 month period end to 30 June 2022 £'000	Total 3 month period end to 30 June 2022 £'000
Trade and other payables with NHSE bodies	109		**109**
Trade and other payables with other DHSC group bodies	2,442		**2,442**
Trade and other payables with external bodies	9,804		**9,804**
Other financial liabilities	-		**-**
Total at 30 June 2022	**12,355**	**-**	**12,355**

	Financial Liabilities measured at amortised cost Full year accounts 2021/22 £'000	Other Full year accounts 2021/22 £'000	Total Full year accounts 2021/22 £'000
Trade and other payables with NHSE bodies	163	-	**163**
Trade and other payables with other DHSC group bodies	3,893	-	**3,893**
Trade and other payables with external bodies	16,416	-	**16,416**
Total as at 31 March 2022	**20,472**	**-**	**20,472**

17. Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
NHS Blackburn with Darwen CCG	72,861	(365)	**72,496**	2,155	(13,163)	**(11,008)**
Total	**72,861**	**(365)**	**72,496**	**2,155**	**(13,163)**	**(11,008)**

17.1 Reconciliation between Operating Segments and SoCNE

	3 month period end to 30 June 2022 £'000
Total net expenditure reported for operating segments	72,496
Total net expenditure per the Statement of Comprehensive Net Expenditure	72,496

17.2 Reconciliation between Operating Segments and SoFP

	3 month period end to 30 June 2022 £'000
Total assets reported for operating segments	2,155
Total assets per Statement of Financial Position	**2,155**

	3 month period end to 30 June 2022 £'000
Total liabilities reported for operating segments	(13,163)
Total liabilities per Statement of Financial Position	**(13,163)**

18. Joint arrangements - interests in joint operations

CCGs 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

			Amounts recognised in Entities books ONLY 3 month period end to 30 June 2022				Amounts recognised in Entities books ONLY Full year accounts 2021/22			
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Assets**	**Liabilities**	**Income**	**Expenditure**	**Assets**	**Liabilities**	**Income**	**Expenditure**
			£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Pooled Budget	NHS Blackburn with Darwen CCG and Blackburn with Darwen Borough Council	Better Care Fund	768	188	-1604	3519	0	0	-5859	12720

The pooled budget records the income and expenditure for the Better Care Fund as managed under a section 75 agreement. This is between NHS Blackburn with Darwen CCG and Blackburn with Darwen Council.
NHS Blackburn with Darwen CCG was required to contribute £3.5 million into a pooled budget with Blackburn with Darwen Council for the Better Care Fund for Q1 2022-23.
In 2021-22 the pooled budget underspent by £600,000, which by agreement with both parties; and allowed by the section 75 agreement; was returned to NHS Blackburn with Darwen CCG.

19 Related party transactions

Details of related party transactions with individuals are as follows:

	3 month period end to 30 June 2022			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Hollins Grove Surgery (Dr Z Patel)	88	-	-	-
East Lancashire Hospice	312	-	-	-

	Full year accounts 2021/22			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Hollins Grove Surgery (Dr Z Patel)	326	-	-	-
East Lancashire Hospice	1,179	-	-	-

Related Party Transactions are declared for Hollins Grove Surgery as Dr Z Patel is the Sole Practitioner in control of the practice. Transactions with East Lancashire Hospice are also disclosed as Related Party Transactions as certain members of the Governing Body (or parties related to them) have connections with those organisations.

The Department of Health is regarded as a related party. During the year NHS Blackburn with Darwen Clinical Commissioning Group has had a significant number of transactions with entities for which the Department of Health is regarded as the parent Department, for example:

East Lancashire Hospitals NHS Trust
Lancashire and South Cumbria NHS Foundation Trust
North West Ambulance NHS Trust
Lancashire Teaching Foundation Trust
NHS England
NHS East Lancashire CCG
NHS Midlands and Lancashire Commissioning Support Unit
NHS Property Services

In addition, NHS Blackburn with Darwen CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Blackburn with Darwen Borough Council and Community Health Partnerships Ltd.

20. Events after the end of the reporting period

The Health and Care Act received Royal Assent on the 28th of April 2022. NHS Blackburn with Darwen CCG was dissolved on the 30th of June 2022. On the 1st of July the CCG's assets, liabilities and operations transferred to Lancashire & South Cumbria ICB.

There are no adjusting events after the end of the reporting period.

21. Third party assets

No third party assets are held by Blackburn with Darwen Clinical Commissioning Group.

22. Financial performance targets

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

	3 month period end to 30 June 2022 Target	**3 month period end to 30 June 2022 Performance**	Full year accounts 2021/22 Target	Full year accounts 2021/22 Performance
Expenditure not to exceed income	72,861	72,861	305,840	306,836
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	72,496	72,496	305,213	306,209
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	756	756	3,192	3,005

Accountability Employee benefits and staff numbers

Employee benefits	**Admin**			**Programme**			**Total**			**3 month period end to 30 June 2022**
	Permanent Employees £'000	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	
Employee Benefits										
Salaries and wages	274	3	**276**	203	-	**203**	476	3	**479**	
Social security costs	27	-	**27**	30	-	**30**	57	-	**57**	
Employer contributions to the NHS Pension Scheme	43	-	**43**	22	-	**22**	65	-	**65**	
Other pension costs	-	-	**-**	-	-	**-**	-	-	**-**	
Apprenticeship Levy	-	-	**-**	-	-	**-**	-	-	**-**	
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**	
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**	
Termination benefits	-	-	**-**	-	-	**-**	-	-	**-**	
Gross employee benefits expenditure	**344**	**3**	**347**	**255**	**-**	**255**	**599**	**3**	**602**	
Less recoveries in respect of employee benefits (note 4.1)	-	-	**-**	-	-	**-**	-	-	**-**	
Total - Net admin employee benefits including capitalised costs	**344**	**3**	**347**	**255**	**-**	**255**	**599**	**3**	**602**	
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**	
Net employee benefits excluding capitalised costs	**344**	**3**	**347**	**255**	**-**	**255**	**599**	**3**	**602**	

Employee benefits	Admin			Programme			Total			Full year accounts 2021/22
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	
Employee Benefits										
Salaries and wages	1,003	12	**1,015**	951	-	**951**	1,954	12	**1,966**	
Social security costs	107	-	**107**	112	-	**112**	219	-	**219**	
Employer contributions to the NHS Pension Scheme	280	-	**280**	108	-	**108**	388	-	**388**	
Other pension costs	-	-	**-**	-	-	**-**	-	-	**-**	
Apprenticeship Levy	-	-		-	-					
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**	
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**	
Termination benefits	-	-	**-**	-	-	**-**	-	-	**-**	
Gross employee benefits expenditure	**1,390**	**12**	**1,402**	**1,171**	**-**	**1,171**	**2,561**	**12**	**2,573**	
Less recoveries in respect of employee benefits (note 4.1)	-	-	**-**	-	-	**-**	-	-	**-**	
Total - Net admin employee benefits including capitalised costs	**1,390**	**12**	**1,402**	**1,171**	**-**	**1,171**	**2,561**	**12**	**2,573**	
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**	
Net employee benefits excluding capitalised costs	**1,390**	**12**	**1,402**	**1,171**	**-**	**1,171**	**2,561**	**12**	**2,573**	

Accountability Losses and Special Payments

NHS Blackburn with Darwen CCG had no losses or special payments in either 2022-23 or 2021-22.