NHS
West Lancashire
Clinical Commissioning Group

NHS West Lancashire CCG

Annual Report

1 April – 30 June 2022

Contents

PERFORMANCE REPORT

WELCOME

Welcome to the Quarter 1 2022-2023 Annual Report for NHS West Lancashire Clinical Commissioning Group (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.

Kevin Lavery
Chief Executive
Lancashire and South Cumbria Integrated Care Board
(on behalf of the former NHS West Lancashire CCG)
28th June 2023

Performance Overview

This section gives an overview of who we were, what we did, 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. The last meeting of the NHS West Lancashire CCG Governing Body took place on 14th June at which closedown papers were presented, and formally approved.
Several documents were prepared during Quarter 1 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.
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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:
https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/legacy-clinical-commissioning-groups

On Friday 1 July 2022 clinical commissioning groups (CCGs) across the country closed and were replaced by new NHS organisations known as integrated care boards.

Therefore, NHS West Lancashire CCG no longer exists and has been replaced (along with the other seven CCGs in Lancashire and South Cumbria) by the new NHS Lancashire and South Cumbria Integrated Care Board (ICB).

NHS West Lancashire CCG, was a clinically led organisation that was made up of 15 GP practices who cared for around 113,000 patients, making it the smallest CCG in Lancashire.
The majority of patients live within West Lancashire, with the remaining patients mainly living in Wigan and Chorley but being registered with West Lancashire GP practices. West Lancashire incorporates the towns of Ormskirk, Skelmersdale, Burscough and surrounding communities; the CCG's footprint was aligned with that of West Lancashire Borough Council.

There is a diverse population in West Lancashire with a mix of rural, urban, affluent, and deprived areas, that required us to carefully target commissioned services to meet the needs of our population. Individual health outcomes can be adversely affected by lifestyle choices including smoking, alcohol and drug misuse, and factors such as diet and exercise.

“Our vision was to enable our population to be in control of their own health, commissioning the best possible care when needed.” We continued to develop the work we progressed last year in line with the NHS Long Term Plan to further develop our three Primary Care Networks (PCNs). The PCNs have continued to be key in how we have rolled out the COVID-19 mass vaccination programme and co-ordinating the GP Practices in responding to the COVID-19 pandemic in a unified way across West Lancashire. The structure of the PCNs are:

- Ormskirk & Aughton has roughly 33,000 residents and has been undertaking a structured medication review to ensure that their patients are getting the best medicines for their conditions.
- Skelmersdale has approximately 47,000 residents and has been focussing on improving outcomes for patients with a respiratory disease and a social prescribing service which aims to support people with needs such as loneliness or financial worries.
- Burscough and the Northern Parishes has a population of approximately 33,000. There is a higher percentage of older residents within this community with large rural areas; therefore, this PCN has developed the SHERIF scheme: Supporting Housebound or Elderly patients affected by Rurality, Isolation or Frailty.

The purpose of NHS CCGs was to work with local health and care partners to design services to meet the needs of the local population most appropriately and to use their allocated funding to buy the best services it can for the population. CCGs were structured to put local family doctors (GPs) in the driving seat, as they are best placed to understand the needs of their patients.
NHS West Lancashire CCG was set performance targets by the Department of Health and categorises these into those relating to improving health, transforming care, controlling costs, and enabling change, and managing operations. Within these it has identified five priority programmes, which were:

- Developing primary care.
- Transforming community care.
- Redesigning mental health services.
- Finance and strategic transformation plans, and
- Compliance, assurance, and planning.
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Although COVID-19 infections, and the corresponding restrictions associated with pandemic have reduced significantly, quarter 1 saw a continuation of the pressures put on the NHS due to COVID-19; but the brilliant health and social care staff serving West Lancashire continued their immense efforts to care for local people and vaccinate our population.

In addition, West Lancashire continued to face its own unique challenges due to the geographic position on the edges of Lancashire, Merseyside and Greater Manchester as well as the same significant challenges that confront any other NHS organisation – limits on NHS funding and a growing and ageing population, for example. We therefore fully recognised and acknowledged the need to change. The transfer of CCGs to the Lancashire and South Cumbria Integrated Care Board on 1st July, 2022 will lead to strengthened, more resilient health and care services, evolving to fully support our community's needs now and in the future.

In addition to continuing to conduct the day-to-day business of a CCG during quarter 1, the NHS West Lancashire CCG's particular focus was directed towards taking actions to effectively closedown the organisation, handover arrangements to the shadow ICB Executives, and managing the risks associated with so doing, in unison with other CCGs in the Lancashire and South Cumbria area.

The NHS West Lancashire CCG Governing Body continued to oversee and monitor the Governing Body Assurance Framework, focussing in particular on risks associated with organisational closedown, and continued compliance with the Due Dilligence Checklist that guided these tasks for all Lancashire and South Cumbria CCGs, as they then were.

The final meeting of the NHS West Lancashire CCG Governing Body took place on 14th June, with the principal purpose of the meeting to ensure that all closedown actions that could be concluded by 30th June 2022, were reviewed, and approved by that body. Throughout quarter 1, the NHS West Lancashire CCG Closedown Group continued to meet on a regular basis to ensure that progress could be tracked for each of the closedown domains within the Due Diligence Framework, and that additional actions could be highlighted and taken to ensure that the programme remained on track. The West Lancashire Closedown Group and its individual members also continued to co-ordinate actions with other CCGs in the system to deliver closedown and effective handover to the incoming ICB Executives.

The NHS West Lancashire CCG Executives at the time met with the incoming ICB Executives on 29th June, 2022 to highlight key ongoing issues, opportunities and risks that would become the responsibility of the Lancashire and South Cumbria ICB from 1st July, 2022, and these are outlined later in this report.

West Lancashire Partnership

The partnership way of working has developed further still over the course of 2021/22 and into this reporting quarter. As we to continue to build on the good work that has taken place across West Lancashire, we set out below some examples of our collaborative efforts:

- Delivery of the Science Summer School in Skelmersdale with over 400 young people in attendance. The event was the catalyst for a longer-term programme on raising aspiration as part of tackling inequalities, linked to the Place-based partnership aspiration as a teaching and learning Partnership. The work on this continues at pace, as we strive as a collective to further build pipelines into industry and healthcare – an example being the work alongside West Lancashire college which has resulted in an increase in the number of apprentices into work.
- Through our population health work, we will be aligning health and wellbeing colleagues, such as Care Coordinators and Health and Wellbeing Coaches with our community delivered interventions, for example in the Health and Wellbeing Hub in the Skelmersdale Concourse.
- The Winter Ready programme is to help encourage people to make changes to their lives to protect themselves from many common winter illnesses, such as colds, flu and Covid-19. West Lancashire Partnership worked collaboratively over the winter months to help mobilise and support the local communities to be prepared for winter.
- The Partnership has established a Health Inequalities Oversight Group whose remit is to consider the ways in which we strive as a collective group of partners on tackling the health inequalities which exist across West Lancashire.
- Linked to the above, in early 2021, health and care leaders from across Lancashire & Cumbria committed to form a Health Inequalities Commission to improve health inequalities and make a step change in people's health. This has now been renamed as the Health Equity Commission (HEC). The Health Equity Commission consists of a balanced panel comprising leaders/influencers and independent experts from across Lancashire and Cumbria. It aims to provide local organisations, partners and place-based partnerships the support to make health inequalities and the 'prevention agenda' a shared priority and provide them with a clear voice in the region and across the Integrated Care System**.** Place-based partnerships across Lancashire and South Cumbria were invited to present to the panel in late 2021. West Lancashire chose to do this via a video produced by a local organisation, which conveyed the voice of lived experience of several local residents who shared their individual stories. This piece of work, which was

commended, is a true testament to the absolute, fundamental importance of tackling inequalities. Something which was at the heart of the West Lancashire partnership.

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, and local CCGs led clear coordinated 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.

Mental health: children and young people

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

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

The funding has contributed to an increase in staff who are trained and experienced in working within the community to promote positive mental health and wellbeing – providing advice and support when required. Response and Intensive Support teams also have been recruited, supporting CYP requiring an urgent or crisis response (up to four hours) through assessment and brief response within A&E and community settings. New Risk Support Liaison Workers (RSLWs) have been created to support CYP who are unable to access an evidenced-based intervention. They provide consultation, advice, support and training to the local workforce, parents and carers to enable delivery of an AMBIT (Adaptive Mentalisation-Based Integrative Treatment) approach. Mental Health Support Teams (MHSTs) provide specific extra capacity for early intervention and ongoing help within a school and college setting. Following the establishment of six new teams in 2021/22, two more will begin working within allocated schools and colleges in Morecambe Bay and East Lancashire during 2022/23. This brings the region's total to 18 and delivers against the NHS Long Term Plan ambition of 25% coverage by 2023/24.

Mental health: adults

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

Specialist Community Perinatal Mental Health (PMH) services continue to expand in line with the NHS Long Term Plan ambitions, providing specialist care to new and expectant mothers with moderate to severe needs up to 24 months following birth. For 2022/23, the growth is focused

on developing support in terms of psychological therapies. This includes parent-infant therapy and systemic family therapy. As of May 2022, the service has supported 272 women – slightly above the national trajectory. Peer support and partner assessments are also now provided as part of the service.

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

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

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

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

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

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

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

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

The programme includes recruiting one primary care mental health worker per PCN each year from 2021/22 to 2023/24 – funded by the Additional Roles Reimbursement Scheme (ARRS). Building on the 26 appointments made during 2021/2022, roles for the 2022/23 cohort are

currently being confirmed with the PCNs before recruitment can commence. Several additional roles have been recruited for 2022/23 in conjunction with the Trainee Associate Psychological Practitioners scheme (TAPPs).

Personality disorder, eating disorder and rehabilitation specialists will also form part of the staffing model for the community hubs. An adult version of the **First episode and Rapid Early intervention for Eating Disorders (FREED) service** was implemented, between April and June 2022 an additional 22 whole time equivalents were recruited into these pathways. Additional VCFSE services for low complexity eating disorders will also be offered as part of the hubs' VCSFE signposting – and will be procured in quarter two of 2022/23. Rehabilitation staff will be recruited from quarter two of 2022/23. Staff are reviewing their caseloads alongside the weighted population and considering how the teams can be reconfigured into the new hub teams. They are also looking at patient flow to improve throughput in services and reduce waiting times.

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

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

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

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

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

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

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

Suicide prevention

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

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

Specialised suicide bereavement support services have been commissioned through the organisation AMPARO across the whole of Lancashire, enabling families bereaved by suicide to

access timely bereavement support. Suicide prevention and real-time surveillance data are now key for safeguarding across the system.

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

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

Digital - Our vision for digital and data transformation

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

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

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

Digital Transformation

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

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

Lancashire and South Cumbria is home to a growing population. More of us are getting older and experiencing long-term health problems. Some of this disease could be avoided or the ill-

effects slowed down if we took positive action. Using digital is one approach to help address the challenges we all face.

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

Stroke

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

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

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

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

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

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

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

Diabetes

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

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

In April 2022, commissioners awarded a new contract to continue the NDPP service across the region. Reed Wellbeing took over from 1 August 2022. Patients who had 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

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

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.

The West Lancashire priorities supported by the then West Lancashire Partnership during quarter 1, are outlined earlier in this report.

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.

In the West Lancashire Place, workforce pressures, particularly in Primary and Community care, continued to cause concern. Work led by the then CCG and the Health and Care Group (HCG) formerly Virgin Care, continued to develop the 'Grow your Own programme', linked to the LSC People Strategy, and the national People Plan and People Promise to address workforce gaps in the short, medium and longer term.

Specific factors targeted within the then West Lancashire Place were:

- Adoption of, a particular focus on Out of Hospital Care, specifically Community Care and development of placements across the community care providers and GP Practices.
- There is an aging population within West Lancashire with a number of young people acting as carers to elderly relatives. A key focus is on supporting career entry opportunities to retain our young people in place and aid the reduction of inequality.
- Recruitment is a key challenge in line with national pressures, and we specifically have multiple providers within an hour's commuting distance, challenging public transport availability and a rural environment that does not always attract working age adults.
- Our GP practices have historically not had investment in HR and OD support and a significant focus has therefore been to develop greater partnership with the practices and look at joint opportunities to attract, develop and retain talent.
- At a leadership level the West Lancashire Partnership has grown in maturity and meets regularly with agreed ways of working and governance structures in place. It will be important not to lose the momentum associated with this work in the future.

Summary of recent key activities extending into quarter one 2022/23

- Subgroups are in place for key areas of focus (e.g., Workforce planning, training, and development etc)
- Relationships with local Higher Education Institutions are increasingly enabled Partners to track students through their educational journey and become employers of choice. West Lancashire college has reintroduced work experience, and with our Higher Education Partners including Edge Hill and UCLAN to branch out our student offering, bringing in more students including Physician Associates.
- An Allied Health Professional Degree apprenticeship has been set up with placements proposed via rotation within the Partnership. This is providing a novel offer to students in a variety of settings whilst enhancing the learner's knowledge of our local area and its need.
- We have been partnering with our Regional Lead from Southport & Ormskirk to support preceptorships to input to the National Preceptorship Framework.
- The Urgent Care team is welcoming Paramedics as part of ARRS pilot alongside Aughton Medical Practice. We will support the development of these paramedics into Practice and work with the ICS to ensure a thorough evaluation of the program and develop any additional governance we feel may be required.

- We have placed 32 Non-Medical Prescribers. 18 in Community Services and 14 in Urgent Care. This will be complemented by an additional 7 that are underway and a further 6 that are due to commence later in the year.
- The MH PAG subgroup have been developing ways to promote our wellbeing hub
- Work has started to look at a joint bank for nursing and admin across the ICP
- Work has started to explore joint recruitment campaigns supporting opportunities to work in Health and Social Care within West Lancashire exploring a rotational apprenticeship model.

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[2].

As part of the valued contribution to commissioning decisions and service improvement our clinical colleagues contribute at both place and across Lancashire and South Cumbria, 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.

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

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[3].

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.

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.

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

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.

Performance analysis

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

These pressures have been evident across all services. Data gathered across the year clearly demonstrates the fluctuations in demand and subsequent performance as a consequence of the pandemic, and a range of additional challenges including the ongoing infection prevention control measures, 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 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 in Q1 2022.

Referral to Treatment (RTT) and Diagnostics													
		Q1			Q2			Q3			Q4		
Metric		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% Of all Incomplete RTT Pathways within 18 weeks.	Actual	68.33%	68.43%	66.65%									
Percentage of Incomplete RTT Pathways within 18 weeks of referral at the end of the period.	YTD	68.33%	68.38%	67.80%									
	Target	92.00%	92.00%	92.00%									
RTT - Number of incomplete pathways waiting > 52 weeks	Actual	385	430	463									
The number of patients on incomplete RTT pathways at period end who have been waiting more than 52 weeks since referral.	YTD	385	815	1278									
	Target	0	0	0									
% of patients waiting 6 weeks or more for a diagnostic test.	Actual	44.97%	37.55%	38.32%									
Percentage of patients on the diagnostic test waiting list at period end who have been waiting 6 weeks or more.	YTD	44.97%	41.28%	40.28%									
	Target	1.00%	1.00%	1.00%									

In West Lancashire, the quarter one experience was broadly consistent with the system position:

% of incomplete RTT Pathways within 18 Weeks.

Percentage of activity at 67.8% (Year to Date) is marginally better than that for the Lancashire and South Cumbria ICS (65.73%) but significantly below the national target of 92.00%. The incomplete pathways target suffered significantly during the COVID-19 pandemic as Acute Trusts were obliged to prioritise Emergency Care at the expense of Elective Care.

Approximately 40% of the West Lancashire Incomplete RTT Pathways were at Southport and Ormskirk Hospitals, a provider performing significantly above the local average (75.53%) for West Lancashire patients.

The 92.00% National Target was being failed for all Specialties for West Lancashire CCG with Gynaecology, Plastic Surgery, ENT, Dermatology and Gastroenterology being particular concerns.

RTT – Number of Incomplete pathways waiting > 52 weeks.

Activity against this target at 463 patients was significantly over the target of zero cases. Prior to the Covid-19 pandemic breaches of this target were extremely rare (2 isolated cases in 2019-20), but delays to treatment caused by the prioritising of Emergency Care at Acute Trusts (and the halting of Elective Care at many Independent Sector Providers) has resulted in significant numbers of patients failing this target. Since Acute providers have moved back to a more normal footing providers have endeavoured to deliver care on a clinical need basis and this has resulted in significant reductions in patients waiting over 78 weeks.

% of patients waiting 6 weeks or more for a diagnostic test.

This target has always represented a failing for West Lancashire CCG; however, before the COVID-19 pandemic achievement was in the 1-5% band (against a target of 1%). During the early part of the pandemic achievement fell to 62%, and although this has improved current performance is still disappointing at 38.2%

The principal issue is endoscopy at Southport and Ormskirk Hospital. In June 2022 performance was 65.51% for endoscopy at all providers but 71.55% at Southport and Ormskirk Hospitals. Performance for non-endoscopy tests is 28.83%.

The primary issue with endoscopy at Southport and Ormskirk Hospitals was capacity for colonoscopies, as estate issues meant it was necessary to operate only single sex lists on any one day. These issues have been addressed and it is anticipated that performance will improve.

Cancer Waiting Times													
		Q1			Q2			Q3			Q4		
Metric		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% Of patients seen within 2 weeks of an urgent referal for Breast Symptoms	Actual	57.89%	68.75%	70.83%									
Two week wait standard for patients referred with 'breast symptoms' not currently covered by	YTD	57.89%	64.71%	66.67%									
two week waits for breast cancer.	Target	93.00%	93.00%	93.00%									
% Of patients receiving 1st definitive treatment within 1 month of a cancer diagnosis.	Actual	93.75%	98.65%	95.83%									
The percentage of patients receiving their first definitive treatment for cancer within one	YTD	93.75%	96.72%	96.47%									
month (31 days) of a decision to treat.	Target	96.00%	96.00%	96.00%									
% Of patients receiving 1st definitive treatment within 2 months of a cancer referral.	Actual	50.00%	57.50%	55.00%									
The percentage of patients receiving their first definitive treatment for cancer within two	YTD	50.00%	54.55%	54.65%									
months month (62 days) of an urgent GP or Dentist referral for suspected cancer.	Target	85.00%	85.00%	85.00%									

% of patients seen within 2 weeks of an urgent referral for breast symptoms.

In Q1 2022-23 there have been 25 breaches of this target from 75 patients seen, achievement being 66.67%. The principal source of breaches is Liverpool University Hospitals NHSFT with 15 breaches from 23 pathways (34.78%). 6 breaches occurred at Lancashire Teaching Hospitals NHSFT from 11 pathways (45.45%), three breaches from 31 pathways at Wrightington, Wigan and Leigh Hospitals NHSFT (90.32%) and a single breach (from 1 pathway 0.00%) at Manchester University Hospitals NHSFT.

Southport and Ormskirk Hospitals do not offer breast cancer services.

% of patients receiving 1st definitive treatment within 1 month of a cancer diagnosis.

In Q1 2022-23 for West Lancashire CCG there have been 6 breaches of this target from 170 patient pathways (96.47%), the target being met. The largest number of breaches was 3 (from 67 pathways 95.52%) at Southport and Ormskirk Hospitals NHST with 2 breaches at Lancashire Teaching Hospitals NHSFT (from 5 pathways 60%) and a single breach at Liverpool University Hospitals NHSFT (from 17 pathways 94.12%).

In quarter 1, West Lancashire outperformed the Lancashire and South Cumbria ICS where the overall performance was 303 breaches from 2755 patient pathways (89.00%).

% of patients receiving first definitive treatment within 2 months of a cancer referral.

In Q1 2022-23 for West Lancashire, there were 39 breaches of this target from 86 patient pathways (54.65%). The largest number of breaches was 17 (from 39 pathways 56.41%) at Southport and Ormskirk Hospitals NHST, with 10 breaches at Liverpool University Hospitals

NHSFT (from 12 pathways 16.67%), 5 breaches at Clatterbridge Cancer Centre NHSFT (from 8 pathways 37.5%), 3 breaches at Wrightington, Wigan and Leigh Hospitals NHSFT (from 5 pathways 40%), 2 breaches at The Christie NHSFT (from 5 pathways 60%) and single breaches at Liverpool Womens Hospital NHSFT (from 4 pathways 75%) and Liverpool Heart and Chest Hospital (from 1 pathway 0%).

By tumour type the most breaches occurred for Urological with 18 breaches (from 25 pathways 28%), breast with 6 breaches (from 12 pathways 50%), Lung with 4 breaches (from 5 pathways 20%), Haematological three breaches (from 4 pathways 25%), Lower Gastrointestinal with 3 breaches (from 7 pathways 57.14%), Gynaecological with 2 breaches (from 7 pathways 71.43%), Head and Neck with 2 breaches (from 2 pathways 0%) and Other with 1 breach (from 1 pathway 0%).

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.

Risks were assessed in accordance with the organisational risk management strategy. Risks were identified through analysis of performance data and soft intelligence, as well as through the reporting and assurance process. The way in which risks were managed is described in the Annual Governance Statement (Risk Management Arrangements and Effectiveness) within this report.

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.

Improve quality

West Lancashire CCG regularly reported information on its performance and quality indicators via its Integrated Business Report to its Clinical Executive Committee, Quality & Safety Committee, Primary Care Commissioning Committee, Transition & Transformation Board and its Governing Body. Areas of concern were then escalated to Lancashire & South Cumbria ICS Quality and Performance Sub-Committee.

Quality remained at the heart of everything we did as a CCG. As described later in this report in relation to the CCG's constitution, our Quality and Safety Committee was fundamental to how we discharge our duty under Section 14R of the NHS Act 2006 (as amended). Reports summarising the highlights, challenges, risks and progress for each area of health that we commissioned were considered by the committee, taking into account any actions required. We linked into NHS England regionally via the Lancashire and South Cumbria Quality Surveillance Group where quality issues affecting the local area are discussed.

To continue our commitment to being transparent, we provided a quality update to our Governing Body so both our board and wider communities were aware of ongoing quality issues we were working to address. This information was in the public domain and formulated part of the detailed handover pack to the ICB.

COVID-19 continued to have a huge impact on services. In line with planning guidance from NHS England issued in March 2021 the CCG worked closely with primary care to support delivery of the NHS COVID vaccination programme and to improve access, local health outcomes and address health inequalities. The provider of community health services and urgent care services, from December 2021, HCRG (Health Care Resourcing Group) previously known as Virgin Care, worked collaboratively with the CCG and local health care providers to transform services with the aim of preventing inappropriate attendance at emergency departments and improve transfer into and out of hospital.

For those providers where we were not the lead commissioner, including Southport & Ormskirk Hospitals NHS Trust, any quality concerns were raised directly with the lead commissioner such as Southport and Formby CCG in the case of the Trust. Quality of services provided by the Third Sector and any small providers were monitored in line with the requirements laid out in the contract.

During quarter one of 2022/23 we continued to work with partners across the Lancashire and South Cumbria system to monitor the impact of COVID-19, support the restoration of elective and cancer care and manage the demand on mental health services to ensure our population continue to receive the quality care and support they needed.

The CCG's Quality Team worked alongside other providers such as Lancashire County Council's Infection Control team and supported Care Homes in the area.

The CCG had a Patient Experience framework in place that centred around the patients journey and drew upon information provided by users of commissioned services to identify learning and service improvement. Data was captured via the Patient Experience pathway from Complaints, MP Enquiries and other channels of general enquiries. Evidence of emerging trends, and early warning of weakness/ failure in commissioned services is triangulated and used to integrate learning/ service improvement with other mechanisms to monitor quality and contracting to support the Outcomes Framework.

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.

Engaging people and communities

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

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

Reducing health inequality

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

Clinical Commissioning Groups (CCGs) have a key role to play in addressing equality and health inequalities, as commissioners, as employers and as local system leaders. Each of the Lancashire and South Cumbria CCGs ensure that equality is embedded in their organisations by having named equality and diversity leaders on their Governing Bodies and strong Equality, Diversity and Inclusion (EDI) processes built into day-to-day operations.

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

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

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

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

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

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

Equality, Diversity and Inclusion Activity in Q1 2022-23

Equality and Inclusion Annual Report 2021-22

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

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

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

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

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

Interim Equality, Diversity and Inclusion Strategy for 2022-23

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

This strategy covers the core EDI responsibilities required of any NHS organisation as well as setting the scene for the ICB to develop some more ambitious objectives that recognise the need

to address and reduce the health inequalities affecting residents in Lancashire and South Cumbria.

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

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

Equality and Health Inequalities Impact and Risk Assessments (EHIIRA)

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

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

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

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

- Pennine CCGs – COVID Virtual Ward – Enhanced Local Service (ongoing)
- West Lancashire CCG – Medicines Optimisation Service – Service Specification

Equality, Diversity and Inclusion in Staff Communications

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

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

Health and wellbeing strategy

The Lancashire Health and Wellbeing Board is a statutory committee of Lancashire County Council for key leaders from the health and care system in Lancashire to build strong and effective partnerships, which improve the commissioning and delivery of services across NHS and local government, leading in turn to improving the health and wellbeing of local people.

Board members work together to understand their local community's needs, agree priorities and encourage commissioners to work in amore joined up way. As a result, patients and the public should experience more joined-up services from the NHS and their local council in the future. During 2021/22 the Board's membership was streamlined to make it more efficient and focused. During quarter 1 the CCG was represented on the Board by Dennis Gizzi (Accountable Officer for Chorley & South Ribble CCG), going forward James Fleet, Chief People Officer, will be the member of this Committee.

More detail on the Lancashire Health and Wellbeing Board including the Strategy, Joint Strategic Needs Assessment and minutes can be found using the link below:
https://www.lancashire.gov.uk/practitioners/health-and-social-care/health-and-wellbeing-board/

Locally we were committed to the actions that would lead to achieving improvement in health and wellbeing. As part of the ICB programme, the CCG contributed to driving forward the Population Health agenda, employing a new Senior System Population Health Lead and a joint appointment with West Lancashire Borough Council for a Population Health Intelligence

Advisor. There are also two new projects underway relating to priority wards and the trauma informed agenda which were transferred over to the ICB in July 2022.

The Lancashire Health and Wellbeing Board received an update in May 2022 from West Lancashire CCG and noted the commitment to continue to work with partners to address health inequalities and deliver the health and wellbeing strategy.

Financial review

Following the demise of the CCG on 30 June 2022, the CCG has produced a final set of statutory accounts covering the three month period ending on that date.

NHS England adjusted individual CCG allocations for the period to ensure that allocated resources equalled reported expenditure, thereby delivering a breakeven position for each organisation. Accordingly for the three month period the CCG is reporting both income and expenditure of £48.429m.

Further contextual information on recent expenditure trends is provided below:

	£m Q1 2022-23	£m 2021-22	£m 2020-21	£m 2019-20	£m 2018-19	£m 2017-18	£m Total
Acute	25.6	96.4	90.6	95.6	87.4	82.2	**477.6**
Ambulance	1.0	3.8	3.7	3.6	3.3	3.2	**18.5**
Community	4.1	21.6	21.2	17.3	16.0	15.7	**95.9**
Individual Care Packages	1.4	12.9	14.0	8.8	9.0	8.6	**54.8**
Mental Health	4.6	21.3	19.8	17.1	16.7	15.1	**94.7**
Other	1.8	7.5	10.1	7.7	6.4	6.0	**39.5**
Prescribing	4.9	19.9	18.8	16.9	17.0	18.0	**95.4**
Primary Care	4.4	17.3	15.4	14.0	13.7	13.1	**77.9**
Running Costs	0.5	2.2	2.2	2.5	2.4	2.2	**12.0**
Total	**48.4**	**202.8**	**195.7**	**183.5**	**171.7**	**164.1**	**966.3**

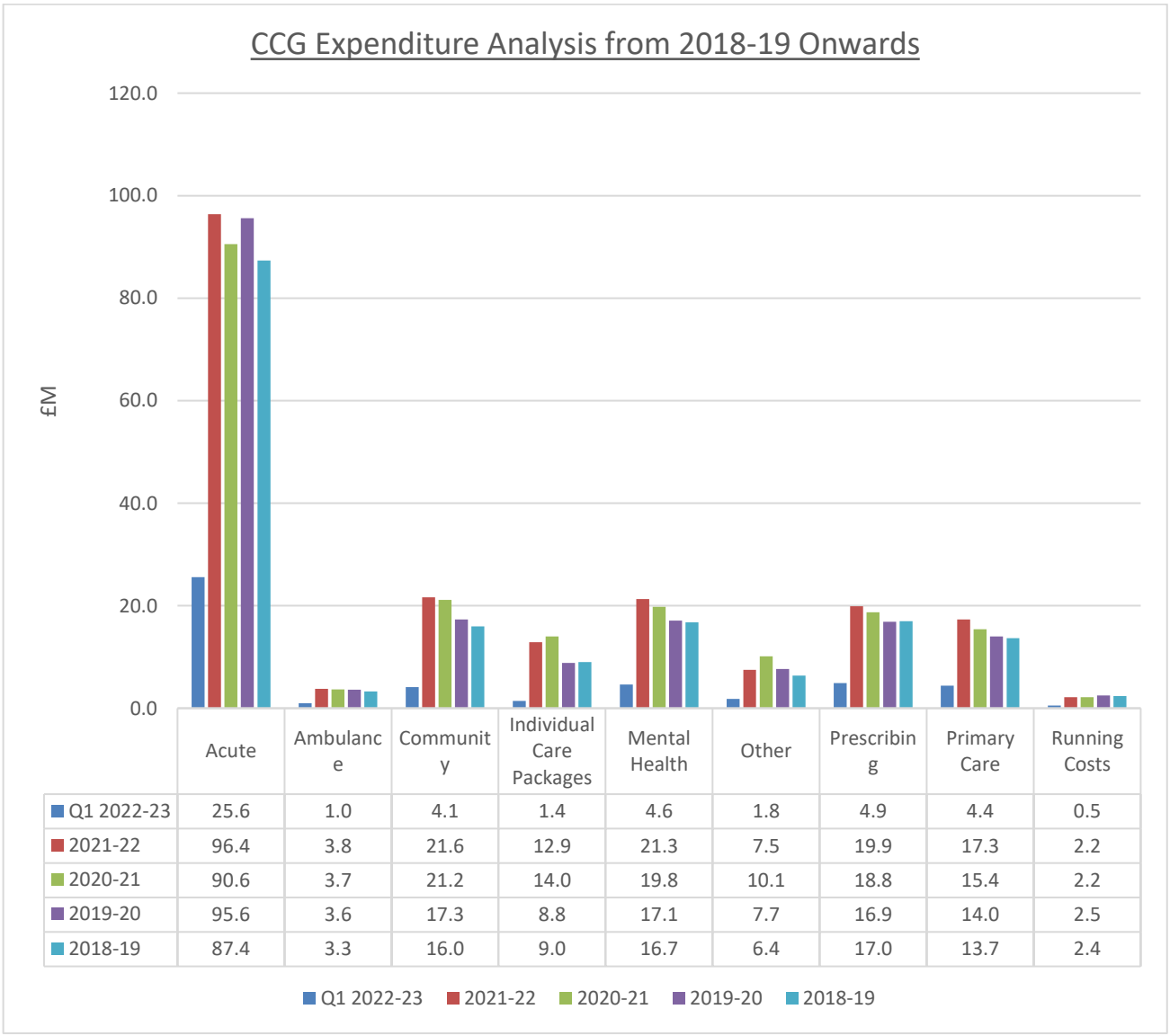
The CCG's net expenditure has increased year on year over a 5 year timeline. This increase is to be expected due to inflation.

The CCGs acute expenditure shows a decline in 2020-21 due to a change in the way providers were paid as a result of the pandemic. NHSE&I directly commissioned Independent Sector contracts, and the payments of small/medium contracts were paid by other NHS commissioners on WLCCG’s behalf.

Individual Care Packages increased in 2020-21, and remains higher than historic norms, due to the CCG funding care 4 weeks post discharge in line with national guidance.

Mental Health expenditure has increased in line with the Mental Health Investment Standard (MHIS). The CCG has invested in a number of services such as:

- IAPT Single Point of Access helping to improve access, enhance care and reduce waiting times.
- CAMHS Thrive Model which places an emphasis on prevention and early intervention to provide an integrated, person-centred and needs-led approach to delivering Mental Health services for children and young people.
- Initial response service providing 24-hour access to mental health care, advice, support and treatment.
- Expansion of specialist Perinatal Community Service supporting women with severe and/or complex mental health issues in the perinatal period



	Acute	Ambulance	Community	Individual Care Packages	Mental Health	Other	Prescribing	Primary Care	Running Costs
Q1 2022-23	25.6	1.0	4.1	1.4	4.6	1.8	4.9	4.4	0.5
2021-22	96.4	3.8	21.6	12.9	21.3	7.5	19.9	17.3	2.2
2020-21	90.6	3.7	21.2	14.0	19.8	10.1	18.8	15.4	2.2
2019-20	95.6	3.6	17.3	8.8	17.1	7.7	16.9	14.0	2.5
2018-19	87.4	3.3	16.0	9.0	16.7	6.4	17.0	13.7	2.4

Closedown of the West Lancashire Clinical Commissioning Group

During Quarter 1 we have been working closely with the incoming ICB to ensure that there was a smooth transition, The work was monitored and positively received by the West Lancashire CCG Closedown and Transition Group, the local SMT, Audit Committee and Governing Body, and through the LSC Closedown (Governance) Group. The work at local and LSC level was aligned to the national due diligence framework. MIAA provided system checkpoints, guidance, assurance and oversight that the closedown process was delivered on time and according to plan. MIAA issued a Head of Internal Audit Opinion (HoIAO) for NHS West Lancashire CCG for the quarter that provided significant assurance in the way in which the CCG had discharged its functions during quarter 1 of 2022/23.

The NHS West Lancashire CCG handed over operations to the NHS LSC ICB at the end of quarter 1 of 2022/23 financial year, on 30th June 2022. The Handover Pack highlighted a range of key areas for further intervention by the ICB, and these were discussed in detail during an Executive meeting between the outgoing NHS West Lancashire CCG team, and the incoming NHS LSC ICB senior team including the Chief Medical Director (CMO), the Chief Nursing Officer (CNO), and the Chief People Officer (CPO). In summary, these included:

Primary Care

Low levels of investment in Primary Care in West Lancashire when compared to comparable services in the rest of the LSC footprint, largely due to West Lancashire moving to delegated commissioning in 2017, much later than peers in other areas of the system.

Estates is major issue across West Lancashire again due to the lack of investment and the high number of properties that are GP/Practice owned will be an issue moving forward. The majority of the practices where the premises are GP owned will see a large proportion of this cohort retire within the next 4/5 years which will cause a huge problem as these practices hold patient lists for over half of the West Lancashire population.

With the focus on collaborative working, the estates are also proving a problem, as we have no NHS owned estates to innovate and expand into. The NHSPS properties we do have, the practices have outgrown due to the increase of patient numbers from large housing developments and no investment in General Practice Estates.

Detailed discussions took place with ICB Executives during quarter 1 2022/23 to highlight these issues and to inform the development of a longer term plan to address the matters raised.

Commissioning

Dermatology: WLCCG patients had experienced ‘closed doors’ to dermatology services in the Cheshire and Mersey system. The issue was escalated to the C&M ICS and they have now engaged to ‘re-open doors’ to these services. Moreover, they have asked for evidence of any other areas in their system where West Lancashire patients are having a similar experience. The Director of Transformation and Integration is leading this discussion from West Lancashire, and good progress has been made to resolve matters in the first quarter of 2022/23.

Telehealth and Telecare: the CCG had to commission Advice and Guidance (A&G) from Consultant Connect rather than its local acute hospital as they had insufficient capacity to deliver this. As a result our GPs have access to Tele-dermatology and other consultant input outside of our local health system to support their patient management in primary care. For telemonitoring the CCG used Merseycare as their care coordination hub in Liverpool had a significant amount of infrastructure already established and therefore, paid at marginal cost to add in our small amount of activity to their service.

Virtual Ward: our virtual ward has been slow to establish but is developing now based on frail and respiratory patients. We now have some consultant engagement from S&OHT who are keen to manage more patients in the community.

ACCOUNTABILITY REPORT

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board

(on behalf of the former NHS West Lancashire CCG)

28th June 2023

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

The Membership Council Chair was also the Chair of the CCG. The Membership Council held overall responsibility for all decisions made by the Group's established committees, and those taken by defined senior officers of the Group including the then Accountable Officer and Chief Finance Officer. The CCG's Constitution highlighted the role of the Membership Council within the governance structure, and included, as an appendix, the Group's Scheme of Reservation and Delegation (SORD). The SORD clearly set out decisions reserved for the Membership Council, and those that were delegated to Governing Body, specific committees, or senior officers. The Constitution also outlined how emergency and urgent decisions could be executed safely, in the absence of formal meetings of the Group. The CCG also developed and implemented an Interim Decision Making Framework (IDMF) that was used particularly during the height of the COVID-19 pandemic, and through closedown when it was not possible to convene quorate meetings in person, or virtually.

Below are the elected clinical members (denoted by an asterix*) and the appointed senior executives of the CCG for the period of 1st April – 30th June 2022, membership and attendance at meetings can be found on page 65-66.

Dr Peter Gregory, CCG Chair*

Dr D Bisarya*

Dr Jack Kinsey*

Andrew Bennett, Accountable Officer

Claire Heneghan, Chief Nurse

Paul Kingan, Chief Finance Officer and Deputy Accountable Officer

Jackie Moran, Director of Integration and Transformation

Member profiles

A list of the GP membership council members for the period 1st April - 30th June 2022 is set out below. The Membership Council did not meet in quarter 1 of 2022/23.

Member practices

All GP practices within the boundaries of West Lancashire are members of the CCG and are listed below:

1. Dr AK & A Bisarya: Sandy Lane Health Centre, Sandy Lane, Skelmersdale, WN8 8LA
2. Ormskirk Medical Practice: 18 Derby Street, Ormskirk, L39 2BY
3. Beacon Primary Care:
    i. Sandy Lane Health Centre, Sandy Lane, Skelmersdale, WN8 8LA11
    ii. Railway Road Surgery, 11 Railway Road, Ormskirk, L39 2DN
    iii. North Meols: Medical Centre, Church Road, Banks, PR9 8ET
    iv. Hillside Health Centre, Tanhouse, Skelmersdale, WN8 6DS
4. Parbold Surgery: 4 The Green, Parbold, WN8 7DN
5. Hall Green Surgery: 164 Ormskirk Road, Upholland, Skelmersdale, WN8 0AB
6. Parkgate Surgery:
    i. Parkgate Surgery,28 St Helens Road, Ormskirk, L39 4QR
    ii. County Road Surgery, 109 County Road, Ormskirk, L39 1NL
7. Tarleton Group Practice: Tarleton Health Centre, Gorse Lane, Tarleton, PR4 6UJ
8. Stanley Court Surgery: Burscough Health Centre, Stanley Court, Burscough, L40 4LA
9. Lathom House Surgery: Burscough Health Centre, Stanley Court, Burscough, L40 4LA
10. Excel Primary Care:
    i. Sandy Lane Health Centre, Skelmersdale, WN8 8LA

ii. Birleywood Health Centre, Digmoor, Skelmersdale, WN8 9BW
iii. Matthew Ryder Clinic, 20 Dingle Lane, Upholland, WN8 OEN

11. Ashurst Primary Care: Ashurst Health Centre, Ashurst, Skelmersdale, WN8 6QS
12. Manor Primary Care: Hilldale Health Centre, Tanhouse Road, Skelmersdale, WN8 6BA
13. Aughton Surgery: 19 Town Green Lane, Aughton, L39 6SE
14. Burscough Family Practice: Burscough Health Centre, Stanley Court, Burscough, L40 4LA
15. The Elms: 16 Derby Street, Ormskirk, L39 2BY

Composition of Governing Body

The Membership Council delegated responsibility to the governing body to oversee CCG responsibilities that were not reserved to the Membership Council itself, during 1st April – 30th June 2022. The CCG Executives (outlined above) continued to manage CCG affairs on a day-to-day basis.

The Governing Body ensured that the CCG had appropriate arrangements in place so it could exercise its functions effectively, efficiently, and economically, with good governance and in accordance with the terms of the CCG constitution as agreed by its members. The Governing Body led on setting vision and strategy, approved commissioning plans, monitored performance, and provided assurance on strategic risks, informed by the views of the Audit Committee.

The Governing Body had 10 members. These included three local GPs (one was the CCG Chair), a hospital consultant, a Chief Nurse, three lay members, a Chief Finance Officer, and a Chief Officer who was also our Accountable Officer. A full list of Governing Body members is in this report on page 65.

Committee(s), including Audit Committee

Committees supported the role of the governing body as follows:

• the **Audit Committee** was responsible for providing assurance to the Governing Body that there is a sound system of integrated governance, risk management and internal control across the CCG's activities including financial compliance and regulation,

• the **Remuneration Committee** determined arrangements for pay and conditions for the most senior (non-AFC) CCG employees and for Lay Members and Elected Clinical Leads covered by fixed term contracts based upon defined sessions.

• the **Quality and Safety Committee** strived to ensure that services commissioned by the CCG met quality standards in terms of being safe, clinically effective, and providing a good patient experience,

• the **Clinical Executive Committee** ensured that items going to the governing body have had thorough clinical input,

• the **Primary Care Commissioning Committee** commissioned appropriate quality GP services,

• the **Finance and QIPP Committee** oversaw the financial position of the CCG and the achievement of schemes designed to improve efficiency.

MEMBERSHIP AND ATTENDANCE OF MEETINGS

Membership Council

The Membership Council did not meet in quarter 1 of 2022/23 financial year.

Governing Body

Governing Body Membership and Attendance – April– June 2022	
Dr Peter Gregory, Chair	2/2
Dr Dheraj Bisarya, GP Executive Lead	2/2
Dr John (Jack) Kinsey, GP Executive Lead	2/2
Doug Soper, Lay Member	2/2
Greg Mitten, Lay Member	2/2
Steve Gross, Lay Member	2/2
Dr Adam Robinson, Secondary Care Doctor	1/2
Andrew Bennett, Interim Chief Officer	2/2
Paul Kingan, Chief Finance Officer	2/2
Claire Heneghan, Chief Nurse	1/2

Governing Body Part II Attendance – April – June 2022	
Dr Peter Gregory, Chair	2/2
Dr Dheraj Bisarya, GP Executive Lead	1/2
Dr John (Jack) Kinsey, GP Executive Lead	2/2
Doug Soper, Lay Member	2/2
Greg Mitten, Lay Member	2/2
Steve Gross, Lay Member	2/2
Dr Adam Robinson, Secondary Care Doctor	1/2
Andrew Bennett, Interim Chief Officer	2/2
Paul Kingan, Chief Finance Officer	2/2
Claire Heneghan, Chief Nurse	2/2

Audit Committee

Audit Committee Membership and Attendance – April – June 2022	
Doug Soper, Lay Member (Chair)	2/2
Greg Mitten, Lay Member	1/2
Dr John (Jack) Kinsey, GP Executive Lead	1/2
Dr Adam Robinson, Secondary Care Doctor	2/2
Claire Heneghan, Chief Nurse	1/2

Clinical Executive Committee

Clinical Executive Committee Membership and Attendance – April – June 2022	
Dr Peter Gregory, Chair	3/3
Dr Dheraj Bisarya, GP Executive Lead	1/3
Dr John (Jack) Kinsey, GP Executive Lead	3/3
Paul Kingan, Chief Finance Officer	2/3

Quality and Safety Committee

Quality and Safety Committee Membership and Attendance – April – June 2022	
Greg Mitten, Lay Member (Chair)	2/2
Dr Jack Kinsey, Clinical lead for clinical engagement	2/2
Claire Heneghan, Chief Nurse	1/2

Primary Care Commissioning Committee

Primary Care Commissioning Committee Membership and Attendance – April - June 2022	
Steve Gross, Lay Member (Chair)	1/2
Doug Soper, Lay Member	2/2
Claire Heneghan, Chief Nurse	0/2
Paul Kingan, Chief Finance Officer	2/2
Dr Adam Robinson, Secondary Care Doctor	2/2

Register of Interests

Statutory guidance on managing conflicts of Interest that CCGs adhered to is available at:

https://www.england.nhs.uk/publication/managing-conflicts-of-interest-revised-statutory-guidance-for-ccgs-2017/

To ensure that our business was conducted in an open and fair way, all governing body members declared any conflicts of interest they may have had. Our conflict-of-interest policy was updated and approved in April 2021 by the Audit Committee with ratification by the Governing Body in July 2021. The policy was published to the CCG website:

https://webarchive.nationalarchives.gov.uk/ukgwa/20220808102719/https://www.westlancashireccg.nhs.uk/resources/policies-and-procedures/

The CCG's Register of Interests as at 31st January 2022 was available on the CCG website and can be viewed using the following link: https://webarchive.nationalarchives.gov.uk/ukgwa/20220808102657/https://www.westlancashireccg.nhs.uk/about-us/whos-who/

Personal data related incidents

No Information Commissioner reportable data security breaches occurred during quarter 1 of the 2022/23 financial year.

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

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

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Andrew Bennett to be the Accountable Officer of NHS West Lancashire CCG. The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14Rof the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

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

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

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

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board

(on behalf of the former NHS West Lancashire CCG)

28th June 2023

Governance Statement

Introduction and context

NHS West Lancashire CCG was a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The clinical commissioning group's statutory functions were set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG was, in particular, required to arrange for the provision of certain health services to such extent as it 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 had responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I was personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledged my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

Governance arrangements and effectiveness

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

This was achieved by operating within the CCG constitution as signed by all GP practices in West Lancashire. The constitution outlined the principles of good governance which must always have been adhered when the CCG conducted its business. These included observing the highest standards of propriety, impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business. In September 2020, the constitution was due for review; however, the Governing Body decided to postpone this as it would have been a significant process whilst the organisation was in the midst of a continued emergency response, and as the commissioning reforms were imminent, it was deemed pragmatic to delay this work.

The CCG remained accountable for all of its functions, including those that it has delegated, and all business was conducted in the name of the group. The constitution which was available on the CCG website: https://webarchive.nationalarchives.gov.uk/ukgwa/20220808102721/https://www.westlancashireccg.nhs.uk/resources/corporate-documents/ set out a scheme of reservation and delegation which detailed the powers designated to its Membership Council, Governing Body and those decisions that were the responsibility of individual members and employees.

Details of the Group's Governing Body and Committees membership, attendance and responsibilities can be found under the Members Report, page 61-67.

As mentioned earlier in this report, part of the CCG's response to the COVID-19 pandemic involved, the Governing Body implementing an Interim Decision-Making Framework (IDMF). The purpose of the framework was to ensure that critical decisions and actions to tackle the pandemic could be taken in an effective and transparent manner, whilst at the same time reducing the burden on clinicians to attend a multitude of meetings at a time of national crisis. The IDMF provided a clear structure and process for how the CCG could continue to conduct urgent Covid-19 business outside a formal meeting structure. The IDMF was based upon the emergency and urgent decision-making arrangements outlined in the CCG's Constitution and approved by the Governing Body. The IDMF can be accessed using the link below: https://webarchive.nationalarchives.gov.uk/ukgwa/20220808102721/https://www.westlancashireccg.nhs.uk/resources/corporate-documents/

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. Our corporate governance arrangements have been reported on by drawing upon best practice available, including those aspects of the UK Corporate Governance Code considered 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 was clear about the legislative requirements associated with each of the statutory functions for which it was responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power was clearly allocated to a lead Director. Directorates 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 acknowledged that good awareness and understanding of risks associated with managing healthcare commissioning was critical to the successful delivery of improved outcomes and experience of the population of West Lancashire. During quarter one of the 2022/23 financial year, the CCG was particularly focussed on the management of risks as a result of closing the CCG down and a successful transition to the new organisation, the Lancashire and South Cumbria Integrated Care Board.

In addition to the risk management process described below, as part of the CCG's robust close down monitoring, and to ensure consistency across all the CCGs, there was additional reporting into the Lancashire and South Cumbria Close Down Governance Group, Merseyside Internal Audit Agency and the Strategic Commissioning Committee. The CCG also established an internal close down group to ensure the process was effectively managed, during the reporting quarter the group increased how regularly it met from every 3 weeks in April to weekly in June. This enabled close monitoring of the programme of work and ensured risks could be identified and mitigated early.

The Governing Body had ultimate responsibility for NHS West Lancashire CCG risks and the management of them, this was a delegated responsibility from Membership Council, as identified in the risk management strategy, which was ratified in February 2021, this document can be found at:
https://webarchive.nationalarchives.gov.uk/ukgwa/20220808102719/https://www.westlancashireccg.nhs.uk/resources/policies-and-procedures/

When the risk management strategy was approved, an updated process was also agreed with a view to improving the risk management culture within the CCG and the assurance cycle. The primary change was clarifying the role of the CCG's committees in the risk management and assurance process.

The aims and objectives of the risk management strategy were:

- An integrated approach was taken to manage all risks (clinical, financial, and organisational), ensuring that all were identified, assessed and managed appropriately.
- Commitment to ensuring the principles of risk management were embedded throughout our organisation and formulated a key element of our systems and processes.
- To maintain a risk management framework, which included providing assurance to the Governing Body that strategic and operational risks were being managed effectively, as well as ensuring we were meeting all our statutory obligations.
- Our system ensured that risk was 'everyone's business'. Our approach to risk needed to be easily understood by our staff, those contracted to us and our members, to enable our population to understand that commissioning decisions were based upon a detailed and sensible understanding of the risks involved. We supported an open culture, in which everyone was encouraged to identify risks and report incidents.
- We also used risk management as a tool to support achievement of – and continuous improvement against – all externally and internally set performance measures.

The risk management strategy set out the CCG's appetite for risk, attitude towards risk and the culture that underpinned its successful management and delivery. The CCG had an approved integrated board assurance framework, which was utilised alongside the risk strategy; together ensuring that a systematic and consistent approach to managing risk was adopted throughout the organisation. The strategy further detailed a model for implementing risk management, which was to identify, quantify, manage and mitigate

each presented risk, thus making it a routine process for all staff. To facilitate this all risks were recorded on a corporate risk register which was saved on the network and was available to all staff to access.

The corporate risk register was a management tool that enabled the CCG to understand its comprehensive risk profile. It was a repository of information detailing the totality of risks evident through the organisation's activities at both a strategic and operational level, including quality, clinical, financial, and business risks. This repository was the hub of the internal control system.

The CCG had an automated risk module, which included an electronic form to identify and assess new risks. Once the form was completed and approved by an Executive Officer, the risk was added to the register and monitored on a monthly basis. The quantification of all risks was undertaken utilising a five by five matrix (see section of this report on Risk Assessment) along with appropriate descriptors to assist in determining the consequence and likelihood of the impact of the risk (appendix c in the risk management strategy link supplied on page 74).

All risks were monitored by an appropriate Committee regardless of risk score. In the case of a risk graded as 'high' (score of 12 or above) there is an obvious potential impact to the organisation, and they are reported to the Clinical Executive Committee and to Audit Committees and Governing Body Meetings via the board assurance framework and live dashboards. During the COVID-19 pandemic, new governance structures and arrangements were agreed which supported the management of risks during this time. More detail is provided on this under the next section of the report 'Capacity to Handle Risk'.

The assurance framework provided the CCG with a comprehensive method for the effective and focused management of the significant risks that may impact on the delivery of the CCG's strategic objectives. Executive officers had oversight of all risks, this was to ensure there was robust management and awareness of principal risks to business objectives or achievement of priorities at a strategic level within the organisation. Some operational risks were at a corporate level and were reported to the Governing Body through the assurance framework, while others were not, as they were managed at project level and mitigated accordingly.

The Governing Body was responsible for assuring itself that the CCG identified and effectively managed any risks which could affect the achievement of the strategic objectives or priorities. The Governing Body provided leadership, scrutiny, challenge, and support for risk management. The Accountable Officer had overall responsibility for corporate governance within the organisation, which included risk management activities. Risk owners were responsible for ensuring that their risks were under review at appropriate intervals, and the risk register was updated under the co-ordination of the Corporate Business Manager at the agreed frequency in line with the risk matrix. Executive Officers were responsible for ensuring that:

- the risk strategy and associated policies, procedures and guidelines were adhered to within their areas of expertise,
- the risk register was reviewed relating to their Service areas such as clinical, planning and delivery, quality and performance, corporate services, finance and contracting,
- all risks were identified, assessed, and included on the risk register,
- assurance was provided to the committees overseeing each risk,

All the Committees received risk reports via ‘live’ dashboards, specific to their areas of business, which provided on-going assurance to the Governing Body over the management of risks and this was reflected in the assurance framework. Specific detail on individual committee responsibility can be found in the risk management strategy (link provided above). When linked, the risk register, risk reporting mechanisms into committees and the assurance framework, all formalised the process of securing assurance and scrutinising risk, which is inherent in any effective risk management and accountability process.

The Governing Body and Audit Committee reviewed the assurance framework and gained assurance that risks were being appropriately managed throughout the organisation and linking in with the System on close down specific risks. Assurance is further gained by minutes from Committees, Executive Officers in attendance at board meetings (which are held in public) and who also attended System Executive Meetings. The assurance framework and ‘live’ risk reporting is also considered by the Clinical Executive Committee on a regular basis.

Risk management was embedded in the activity of the organisation through the above measures and also through assessments of specific risks – for example, the Project Management Office (PMO) had a set of consistent project initiation documentation which was completed for any internal project, and included data protection impact assessments, equality impact assessments and quality impact assessments.

There were other policies supporting the management of risk such as the information governance policies, safeguarding frameworks, the serious untoward incident (SUI) policy and procedure, the health and safety policies and the equality strategy. All of these were available on the CCG website – archive link provided at the start of this report.
Incident reporting was encouraged in the CCG and the constitution positively encouraged whistleblowing as a means of gaining awareness of potential fraud, bribery and corruption. The CCG had linked policies for whistleblowing, bribery and corruption with alignment to safeguarding policies.

Capacity to Handle Risk

The CCG's risk management process evolved during the management of the close down process, as the CCGs improved in working together to manage and report on risks. The Governance Close Down Group met as a minimum bi-weekly during quarter 1 of this financial year; it monitored closely the programme for ensuring the CCGs closed down correctly and that all the necessary evidence was available for handover to the ICB on the 1st July 2022. The group had an Executive Senior Responsible Officer, that reported into the ICS Executives, the Transitional Oversight Board and the Strategic Commissioning Committee. The risks highlighted and monitored by this group, were also recorded on the CCG corporate risk register and, where appropriate, the board assurance framework.

As previously mentioned in this report the CCG implemented an IDMF which clearly identified when under an incident response who had emergency powers (via delegated authority) and the process for these to be exercised, to enable urgent decisions to be made and urgent business to continue. Moreover, it mitigated against the risk of business-as-usual processes and governance causing inappropriate delays when responding to an emergency situation. The IDMF was extended to 30th June 2022 to provide stability during the transition period of closing down the CCG, but also to ensure the CCG was still able to respond promptly the ongoing pandemic response.

To support efficiency and speed of decision making during the transition period and throughout the pandemic, approval of risks could be granted through the Internal Incident Command Team (IICT), set up at the start of the pandemic, as well as through Executive Officers.

The CCG was operating in incident response during quarter 1 as well as preparing to close the CCG down; therefore, the process and governance structures described above were utilised; however, during times when the national response was stepped down and recovery & restoration became more of a priority the following structures were be adhered to:

Governing Body approved the assurance framework at the start of the financial year and received bi-monthly reports on progress.

Clinical Executive Committee ensured that there was continuous engagement with the CCG membership, and that membership views were reflected in the work of the CCG; it reviewed all planning documents and recommended them to the Governing Body after checking that they are patient focused, effective, economic and efficient. It also oversaw the delivery of these plans and ensured compliance with governance requirements and legal duties.

Audit Committee was responsible for providing assurance to the governing body that there was a sound system of integrated governance, risk management and internal control across the CCG's activities.

Quality and Safety Committee provided assurance that commissioned services were clinically safe, effective and provide good patient experience.

Remuneration Committee monitored, reviewed and reduced risks relating to conflicts of interest and financial remuneration.

Primary Care Commissioning Committee managed risks relating to the commissioning of primary care services.

Finance and QIPP managed risks relating to achievement of financial targets on behalf of the Governing Body.

The Accountable Officer was responsible for ensuring robust systems were in place regarding corporate governance within the CCG, including risk management activities. The Chief Finance Officer had delegated responsibility from the Accountable Officer for progressing organisational risk management and governance activity.

All CCG employees and representatives were responsible for identifying, assessing and managing risks of all types in their work area, following any codes of conduct issued by their professional bodies. Appraisal processes ensured that all staff had the training and other resources required to equip them for their roles with regards to risk management.

Risk Assessment

Risks were assessed according to a matrix which scored the impact should they have happened (score of between 1 and 5) and the likelihood that they would happen (score of between 1 and 5). The likelihood and impact scores were then multiplied to give an overall risk score of between 1 (1 multiplied by 1) and 25 (5 multiplied by 5).

Scores of 12 or more were reported to Governing Body which was held in public. This was to enable the Governing Body to focus on the higher risks, and for the lower risks to be managed by Committees and responsible officers under delegated authority.

At the 30th June 2022, the CCG was recording 24 risks, of which 5 were assessed as extreme (risk score 15 and above). There was no change in this during the reporting quarter (1st April – 30th June 2022). The risk profile of the organisation has been maintained from the end of the previous financial year (2021/22) and throughout the reporting quarter with staff fatigue, burn out and resilience being an ongoing significant risk which has transferred to the ICB. The impact of COVID in terms of increased waiting lists has also been transferred to the ICB. These risks were not unique to West Lancashire and were seen across Lancashire and South Cumbria; they were and continue to be reflective of the sustained unparalleled system pressures being experienced nationally within the NHS.

The extreme risks were:

- Long term impact of COVID-19 on Health Inequalities. This was an area which the CCG had been working significantly with partners to address, utilising population health management techniques. For further detail on this work please see the section title “Reducing Health Inequalities” within the performance overview section of this report.

- Failure to deliver financial balance remained a risk for the CCG in this quarter. WL CCG worked closely with the other Lancashire and South Cumbria CCGs to mitigate this risk in a united way, in readiness for the transition to the ICB.

- There was a risk that due to the uncertainty of the staffing structure in the new ICB organisation that CCG staff would leave to secure alternative employment, leaving insufficient staff to manage CCG closedown and transition, and to undertake the responsibilities of the new system. This would have resulted in a loss of system knowledge and expertise. In attempt to understand how staff were feeling the LSC CCGs utilised health and wellbeing questionnaires, set aside time for informal conversations and made available opportunities for colleagues to process the challenges being faced through virtual team chats.
- There was a risk the CCG would not be sufficiently resourced to deliver its priorities. This was very closely aligned to the risk above but related specifically to CCG continuing to have statutory duties and having the appropriate level of resource to deliver those duties. The pandemic had been a significant factor in this, but as the organisation's resilience reduced increased pressure from close down and transition was increasing the risk of impacting on delivery.
- Unmanageable levels of customer enquiries and information requests. The CCG continued to receive a high number of customer enquiries through all channels and statutory timescales for responses were not relaxed during the height of the pandemic or during this reporting quarter in readiness for transition to the ICB. All enquiries were triangulated for consistency of response and in attempt to reduce duplication. The FOI process changed as of 1st March 2021 with the Corporate Team coordinating requests to relevant departments within the CCG to improve efficiency.

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.

The sections of this report entitled ‘governance arrangements and effectiveness’ and ‘delegation of functions’ describe how the internal control arrangements operated. There was a clear process for reporting, management, investigation and learning from incidents. There was a Senior Information Risk Owner (SIRO) to support the arrangements for managing and controlling risks relating to information/ data security, with information asset owners being nominated and trained across functions. The CCG Chair, who was a practising GP, was the Caldicott Guardian to ensure that patient confidentiality was protected.

There was a scheme of reservation and delegation, standing financial instructions and standing orders. The CCG received assurance in relation to the internal control framework of Midlands and Lancashire Commissioning Support Unit (MLCSU) via update reports presented to the Audit Committee. The Chief Finance Officer met regularly with MLCSU representatives to discuss controls and during full financial years the CCG would gain assurance through service auditor reports, shared with MLCSU customers and their Audit Committees. This reporting quarter there have been no changes in the control environment and bridging letters have been received by the CSU, Capita, NHS Business Services Authority and Shared Business Services to provide the ICB with appropriate assurance.

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.

An annual audit of conflicts of interest would typically take place in January 2023 for this financial year. As this report only covers the first quarter of the 2022/23 financial year, 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. More detail on all audits undertaken for this quarter are provided within the Head of Internal Audit Opinion section of this Annual Report on page 86.

Data Quality

The Governing Body received data relating to the performance of the CCG. This included activity and financial data. The quality of data received from providers the CCG commissioned services from was routinely validated to ensure accuracy. If any anomalies or unexpected trends occurred, they were investigated. The integrated business report was a regular item on the Governing Body agenda and could be found on the website.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, 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.

The CCG submitted the 2021 – 2022 DSPT and achieved ‘standards met’ in June 2022, as part of the submission and preparation for transition to the ICB a full in-depth review of the information asset register was undertaken, and this reflected the CCG’s electronic filing system being migrated to Office 365. This assurance has transferred over to the ICB as part of the closed down process of the CCG.

The CCG placed high importance on ensuring there were robust information governance systems and processes in place to help protect patient and corporate information. We established an information governance management framework and developed information governance processes and procedures in line with the DSPT. All staff undertook annual information governance training and there was a staff information

governance handbook to ensure employees were aware of their information governance roles and responsibilities.

Business Critical Models

These were largely provided by MLCSU. They were subject to regular external review, the outputs of which are submitted to their client CCGs through service auditor reports (bridging letters for this reporting quarter).

Within the CCG, business critical models were mostly spreadsheet-based. These were all identified and formed part of the CCG's information asset register, each with a suitably qualified information asset owner.

Third party assurances

Where the CCG relied on third party providers, such as the Midlands and Lancashire Commissioning Support Unit (MLCSU) and Mersey Internal Audit Agency (MIAA), contracts were agreed with the relevant organisations together with monitoring arrangements to ensure contract compliance. Furthermore, the CCG received independent reports produced by external auditors providing assurance in relation to the functions provided by third party organisations.

Control Issues

There were no significant control issues facing the CCG.

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

The Audit Committee oversaw these elements on behalf of the governing body, raised any key issues and reported its minutes to the Governing Body in meetings held in public. The Accountable Officer was responsible for ensuring that the CCG operated economically, efficiently, and effectively on a day-to-day basis. He was supported in this role by a senior team and a management structure. Key functions were performed by the Chief Nurse (providing assurance from a clinical perspective) and the Chief Finance Officer (ensuring overall economy, efficiency and effectiveness).

Internal audit services provided an independent review of CCG functions, according to an annual plan which reflected relative risk. Internal audit linked with the Chief Finance

Officer on a day-to-day basis and reported to the Audit Committee as a standing item on each agenda. Internal audit had access to whatever officers and documents (electronic or hard copy) they needed to do their job.

The CCG reported to NHS England, which monitored its performance, again providing assurance as to its economy, efficiency and effectiveness. A financial budget was prepared for this quarter and was approved by the Governing Body. This highlighted how the CCG allocated the money allocated to it by the Department of Health, and also demonstrated how it would comply with Department of Health business rules. Monthly integrated business reports were produced, comparing performance to date with expected performance at that point in the year, for both financial and other performance targets (being a combination of national requirements and locally determined targets). In the case of financial performance, a forecast to the financial year end was also included.

As public bodies, CCGs were expected to keep their running (management) costs as low as possible, consistent with delivering their functions to a high standard. This was to ensure that as much resource as possible was available to support services to patients, carers and the wider public.

The NHS Oversight Framework was intended as a focal point for joint work, support and dialogue between NHS England, NHS Improvement, CCGs, providers and sustainability and transformation partnerships and integrated care systems.

Consistent with the national policy direction to move to system oversight, discussions throughout 2021/22 were at a system level, rather than solely with individual CCGs. Similar to 2020/21, a simplified approach was taken to the annual performance review, taking account of the different circumstances and challenges CCGs have faced in managing the different phases of the NHS response to Covid-19 and preparing for the transition to new organisations, Integrated Care Boards. It was concluded in June 2022 that the CCG has maintained focus and energy throughout a challenging year. The leadership team and the entire CCG workforce were acknowledged for having worked extremely hard, at pace, and under difficult conditions.

NHSE/I commended the CCG in the continued development of Primary Care Networks and their contribution to the COVID-19 response, supporting the Lancashire and South

Cumbria system to respond to emergency demands and manage winter pressures with the development of a 2 hour crisis response service being particularly notable.

It was recorded that the CCG did not meet its statutory financial duty to break-even in 2021/22 as a result of writing off a prescribing prepayment in year. The CCG did meet its statutory financial duty by not exceeding its Running Cost Allowance and delivered the Mental Health Investment Standard. It was highlighted that the CCG received a substantial assurance rating from its External Auditors in respect of having effective systems and processes in place.

This was the last time that the CCG was assessed, as the Health and Social Care Act 2022 has superseded this requirement, due to the establishment of Integrated Care Boards and the decommission of CCGs as of 1st July 2022.

Delegation of functions

For business-as-usual processes, the governing body had an approved scheme of delegation, identifying which functions it retained, and which were delegated to its committees and senior officers. Committees which reported to the governing body operated under terms of reference approved by the governing body, which reflected their delegated roles. Committees submitted their minutes to governing body meetings. A management structure, various communication mechanisms, and a system of regular line manager supervision meetings ensured that delegated functions were followed up.

Internal audit provided independent assurance to inform management and the audit committee if there were failures in this regard. External auditors provided an opinion on value for money secured from the CCG's commissioning activities and also gave an opinion on the true and fair view presented to readers of the CCG's annual accounts. This gave assurance and assisted the Audit Committee in recommending to Governing Body that the CCG's annual accounts were adopted.

Auditors had regular progress meetings with the Chief Finance Officer and had access to other officers as required. Where functions were delegated to external organisations, such as MLCSU (for various management functions provided on a large scale to provide greater economy and resilience to client CCGs) and the Mersey Internal Audit Agency (providing internal audit services to a wide range of organisations again to achieve

greater economy, concentration of specialist expertise, and improved organisational resilience) contracts were agreed with the relevant organisations together with monitoring arrangements to ensure contract compliance.

For externally delegated functions, the CCG also received service auditor reports from the external auditors of those organisations (bridging letters have been utilised for this reporting quarter). These were independent reports to inform clients of the organisations concerned.

As mentioned earlier in this report, as part of the CCG's response to the COVID-19 pandemic, the Governing Body implemented an IDMF. The purpose of the framework was to ensure that critical decisions and actions to tackle the pandemic could be taken in an effective and transparent manner whilst at the same time reducing the burden on clinicians to attend a multitude of meetings at a time of national crisis. The IDMF provided a clear structure and process for how the CCG could continue to conduct urgent Covid-19 business and respond to urgent transitional issues outside the formal meeting structure. Moreover, all Chairman's decisions made using the IDMF were reported to the next scheduled Governing Body for completeness and transparency.

The CCG had also been required to provide significant operational guidance and support to our providers in all settings (care homes, community and acute). Operational oversight throughout the pandemic had been through specialist leads with escalation through to Senior and Executive Managers when required, with situational reports received by senior management on a daily basis during peaks in the pandemic.

The response to the pandemic saw effective and streamlined ways of working through the ICS; escalation from a local, place level, was through the ICS and NHS England command and control structures utilising our Internal Incident Command Team, External Incident Command Team, and implementation of the CCG Business Continuity Plans with specialist management oversight through the Emergency Preparedness Resilience and Response Lead. These structures and plans ensured services and providers supported each other through mutual aid processes ensuring our patients received a continuity of service that met the quality standards the CCG requires.

Counter fraud arrangements

The Local Counter Fraud Specialist (LCFS) reported to the Audit Committee. Their reports updated the committee on proactive (preventing, deterring, creating and maintaining a culture of honesty) and reactive work (responding to whistleblowing, conducting investigations, pursuing available sanction and recovering amounts due) that was being undertaken. The Audit Committee approved the plan for anti-fraud, bribery and corruption activities to ensure that a significant proportion of time is devoted to proactive work.

The LCFS was employed by Mersey Internal Audit Agency, with which the CCG held a contract for the provision of anti-fraud services, which included the completion of the Counter Fraud Functional Standard Return on behalf of the CCG and the submission of the CCG's response to the Fraud Prevention Guidance Impact Assessment.

The LCFS was visible within the organisation and liaised regularly with the Chief Finance Officer, who was accountable for tackling fraud, bribery and corruption, for support and direction.

The Audit Committee ensured that appropriate action was taken with regard to LCFS recommendations and NHS Counter Fraud Authority quality assurance recommendations. The NHS Counter Fraud Authority (NHSCFA) is a national organisation charged with making sure that a high level of professionalism exists in anti-fraud work and with undertaking investigations when they are needed across a larger area.

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:

Key Area	Summary
Head of Internal Audit Opinion	The overall opinion for the period 1st April 2022 to 30th June 2022 provides **Substantial Assurance**, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
Planned Audit Coverage and Outputs	The Quarter 1 2022/23 Internal Audit Plan has been delivered with the focus on transition support and the provision of your Head of Internal Audit Opinion. This position has been reported within the progress reports across the quarter. Review coverage has been focused on: • CCG Closedown/ICB Transition reviews and support; • CCG compliance with statutory functions; and • Follow up of outstanding internal audit recommendations.
MIAA Quality of Service Indicators	MIAA operate systems to ISO Quality Standards. The External Quality Assessment, undertaken by CIPFA (2020), provides assurance of MIAA's full compliance with the Public Sector Internal Audit Standards.

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

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

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

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

- The board
- The audit committee
- If relevant, the risk / clinical governance / quality committee
- Internal audit
- Other explicit review/assurance mechanisms.

Conclusion

No significant internal control issues have been identified.

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board

(on behalf of the former NHS West Lancashire CCG)

28th June 2023

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The Committee was established by NHS West Lancashire CCG to approve the remuneration and terms of service for the Chief Officer, other staff on very senior manager (VSM) pay terms and conditions, and GP Governing Body members.

In the first year of operation the Committee set baseline salaries in accordance with national and local guidance, and the performance elements required of Bands 8c and above under Agenda for Change.

Pay for board members and other senior staff is mainly in accordance with nationally determined pay rates. Where pay is determined locally this is agreed by the Committee.

The Committee did not meet in 2022-23.

It is the responsibility of the Committee in its discussions to:

• include all aspects of salary (including any performance related element, bonuses and any other allowances), provisions for other benefits including pensions and car allowance, and arrangements for termination of employment and other contractual issues in decision making

• approve any non-contractual payments at any level that may be regarded as novel and/or contentious and which required Treasury approval.

Policy on the remuneration of senior managers

No bonus payments were awarded by the Remuneration Committee during 2022-23.

Remuneration of Very Senior Managers

No senior managers received remuneration in excess of £150,000 per annum (pro rata). For the purposes of this note GP Governing Body members have not been classed as very senior managers.

Senior manager remuneration (including salary and pension entitlements)

Salaries and allowances – SUBJECT TO AUDIT

Single total figure table

		1st April 22 to 30th June 22					
Name	**Title**	**Salary (Bands of £5,000)**	**Expense Payments (Taxable) (Rounded to nearest £100)**	**Perfor-mance Pay and Bonuses (Bands of £5,000)**	**Long-term Perfor-mance Pay and Bonuses (Bands of £5,000)**	**All Pension Related Benefits (Bands of £2,500)**	**Total (Bands of £5,000)**
		£000	£	£000	£000	£000	£000
Andrew Bennett	Accountable Officer	0-5				0	0-5
Paul Kingan	Chief Finance Officer	25-30	700			2.5-5	30-35
Jackie Moran	Director of Integration and Transformation	20-25				17.5-20	40-45
Claire Heneghan	Chief Nurse	15-20	2,300			0	20-25
Dr Peter Gregory	GP Executive Lead	25-30				0	25-30
Dr John (Jack) Kinsey	GP Executive Lead	5-10				22.5-25	30-35
Greg Mitten	Lay Member	0-5				0	0-5
Douglas Soper	Lay Member	0-5				0	0-5
Dr Adam Robinson	Secondary Care Consultant	0				0	0-5
Steve Gross	Lay Member	0-5				0	0-5
Dr Dheraj Bisarya	GP Executive Lead	5-10				0	5-10

		2021-22					
Name	**Title**	**Salary**	**Expense Payments (Taxable)**	**Performance Pay and Bonuses**	**Long-term Performance Pay and Bonuses**	**All Pension Related Benefits**	**Total**
		(Bands of £5,000)	**(Rounded to nearest £100)**	**(Bands of £5,000)**	**(Bands of £5,000)**	**(Bands of £2,500)**	**(Bands of £5,000)**
		£000	£	£000	£000	£000	£000
Amanda Doyle	Chief Clinical Officer	10-15	-			0	10-15
Andrew Bennett	Accountable Officer	10-15	-			0	10-15
Paul Kingan	Chief Finance Officer	105-110	5,100			42.5-45	155-160
Jackie Moran	Director of Integration and Transformation	90-95	-			37.5-40	130-135
Claire Heneghan	Chief Nurse	75-80	9,600			0	85-90
Dr Peter Gregory	GP Executive Lead	85-90	-			25-27.5	115-120
Dr John (Jack) Kinsey	GP Executive Lead	35-40	-			0	35-40
Greg Mitten	Lay Member	5-10	-			0	5-10
Douglas Soper	Lay Member	10-15	-			0	10-15
Dr Adam Robinson	Secondary Care Consultant	0	-			0	0
Steve Gross	Lay Member	5-10	-			0	5-10
Dr Dheraj Bisarya	GP Executive Lead	35-40	-			10-12.5	45-50

Notes

1. 2021-22 figures are disclosed for information (they cover a 12 month period)

2. The figures shown above for Mr Andrew Bennett represent the proportion of Mr Bennett's remuneration relating to West Lancashire CCG only.

Mr Bennett's total salary (excluding taxable benefits) for the three months April to June 2022 is £0-5K which is split as follows:

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

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

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

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

The charges to the CCGs are based on the population split between the three CCGs. The pension and taxable benefits disclosure has not been apportioned and is showing in full in Blackpool CCG's Annual Report only.

3. Adam Robinson is an employee of Salford Royal NHS Foundation Trust. Due to a change in NHS payment processes as a result of Covid-19, no charges were directly incurred by the CCG in 2022-23 for Adam Robinson.

4. The taxable benefits listed above relate to lease cars.

Pension benefits as at 30th June 2022

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 30 June 2022 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 30 June 2022 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2022	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 30 June 2022	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Paul Kingan, Chief Finance Officer	0-2.5	0	40-45	80-85	710	7	724	0
Jackie Moran, Director of Integration and Trans-formation	0-2.5	0-2.5	35-40	75-80	723	21	751	0
Dr John (Jack) Kinsey, GP Executive Lead	0-2.5	0-2.5	20-25	35-40	294	20	317	0

Notes

1. Figures in brackets represent negative values.

2. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive directors.

3. The Pension Benefits and Benefits in Kind for Andrew Bennett whose salary costs are currently being recharged from Morecambe Bay CCG have not been apportioned and are showing in full in Blackpool CCG's Annual Report.

4. The CCG was only able to obtain confirmation of the movement in the cash equivalent transfer values for the directors' pension entitlements for the period from 1 April 2022 to 31 March 2023. As a result the CCG has apportioned the movement on a straight line basis to estimate the cash equivalent transfer value at 30 June 2022. This is considered to be a reasonable approximation of the movement in the value of the entitlements during the year.
5. The CCG were unable to obtain pension information for D Bisarya and P Gregory due to a change in classification from officer to GP Solo.
6. 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.

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. No CETV will be shown for members over 60 (1995 Section).

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pensions due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

The method used to calculate CETVs changed, to remove the adjustment for the Guaranteed Minimum Pension (GMP) on 8 August 2019.

Payments to past members

The CCG has not made any payments to past members up to 30 June 22.

Compensation on early retirement of for loss of office

The CCG has not made any payments for retirement or loss of office up to 30 June 22.

Pay multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce.

The banded remuneration of the highest paid director / member in West Lancashire CCG up to 30 June 22 was £182,500 (2021-22, £182,500) and the median remuneration of the workforce was £47,126 (2021-22 £47,126).

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
2022-23	5.28:1	3.87:1	2.96:1
2021-22	5.15:1	3.87:1	2.41:1

Pay ratio information (subject to audit)

As at 30 June 22, remuneration ranged from £7,882 to £182,500 (0% against 2021-22: £7,882 - £182,500) based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff).

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

A number of factors contribute to the increase in the median salary. These include annual pay awards, staff receiving incremental increases in line with Agenda for Change Terms & Conditions and reflect additional responsibilities undertaken by certain members of staff. As a consequence, the pay multiple has decreased.

The average percentage change from 2021/22 to 30 June 2022 in respect of employees of the entity is 5.01% increase on salary and allowances, there was no movement on performance pay and bonuses.

Remuneration of West Lancashire CCG's staff is shown in the table below:

1st April 2022 – 30th June 2022	**25th percentile**	**Median**	**75th percentile**
All Staff' remuneration based on annualisation, full-time equivalent remuneration of all staff (including temporary and agency staff)	£34,593	£47,126	£61,588
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£32,194	£47,126	£61,588

2021/ 22	**25th percentile**	**Median**	**75th percentile**
All Staff' remuneration based on annualisation, full-time equivalent remuneration of all staff (including temporary and agency staff)	£35,435	£47,126	£75,874
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£35,435	£47,126	£75,874

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

The banded remuneration of the highest paid director / member in West Lancashire CCG in the financial year 2022-23 was £182,500 (2021-22, £182,500), a 0% increase on 2021/22 salary and allowances. The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th Percentile total remuneration ratio	25th percentile Salary ratio	Median total Remuneration ratio	Median Salary Ratio	75th percentile total remuneration ratio	75th percentile salary ratio
2022-23	5.28:1	5.67:1	3.87:1	3.87:1	2.96:1	2.96:1
2021-22	5.15:1	5.15:1	3.87:1	3.87:1	2.41:1	2.41:1

During the reporting period 1 April to 30 June 2022,0 (2021-22, 0) employees received remuneration in excess of the highest-paid director / member. Actual remuneration ranged from £7,882 to £ 117,455 (2021-22 £7,882 to £113,133)

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

The CCG's performance regarding this is regulated by NHS England. We are a small CCG, so we buy in support services from NHS Midlands and Lancashire Commissioning Support Unit (MLCSU). We also receive support from public health colleagues from Lancashire County Council.

The member makeup of the governing body is 1 female and 9 males. 1 of the 10 members is on the very senior manager pay scale.

Number of senior managers

We have 4 Senior Managers (excluding Governing body and Directors) at band 8c and above, of whom 1 is male and 3 are female. The bandings are listed below:

Table of Senior Managers by band	
Band	**Number**
8c	3
8d	1
Total	4

Staff numbers and costs (Subject to Audit)

An analysis of staff numbers (full time equivalent) and costs can be found in the financial statements note 3.1 and 3.2.

Staff composition

The staff composition excludes the lay members.

	Female	**Male**
Directors	2	5
Senior managers	3	1
Other employees of the CCG	26	6

The average number of staff employed during Q1 2022/23 is 40.37.

The 7 directors in the table above include:

The CCG Chair, Peter Gregory, and 2 other local family doctors as referred to in the Corporate Governance section of this report.

The Chief Nurse, Claire Heneghan

The Chief Officer, Andrew Bennett

The Chief Financial Officer, Paul Kingan

The Director of Integration and Transformation, Jackie Moran

Sickness absence data

Staff sickness absence 2022	2022 Number
Total Days Lost	166.63
Total Staff Years	39.82
Average Working Days Lost	4.18

The CCG managed staff sickness in line with the agreed Staff Sickness Policy.
The clinical commissioning group did not agree any early retirements due to ill health grounds as at 30 June 2022 or the prior year ending 31 March 2022.

Staff Turnover Percentages

CCG Staff Turnover 2022-23	2022-23 Number
Average FTE Employed 2022-23	40.37
Total FTE Leavers 2022-23	6.00
Turnover Rate	14.86%

Staff policies

The CCG recognised one of its greatest assets was its employees. It was never more crucial to understand the team, in terms of what inspired them but more importantly to understand how they were feeling physically and mentally. To ensure the CCG received this feedback from colleagues, the organisation-maintained appraisals and one-to-one protected time throughout quarter 1. The CCG also had representation on the Lancashire and South Cumbria CCGs Health and Wellbeing Group, which oversaw a system wide Health and Wellbeing Festival which was open to all West Lancashire CCG colleagues. The CCG continued to utilise:

• Virtual team chats for all colleagues to come together and keep abreast of any ongoing developments nationally or locally
• Briefing and development sessions
• Staff health and wellbeing survey – linking in with the Lancashire and South Cumbria ICS approach
• Health and wellbeing conversations in one-to-one protected time
• Our Board Level Health and Wellbeing Champion oversaw the implementation of the People Plan
• Where required, risk assessments of those particularly vulnerable to COVID-19 infection

• Continued to engage with the NW BAME Assembly to protect, support, develop and understand the needs of staff within these groups

No staff policies were updated during quarter 1 of 2022/23 financial year. For details relating to equality, diversity and inclusion please see page 52-56 in the report.

Trade Union Facility Time Reporting Requirements

The CCG did not employ anyone who undertook relevant union official duties as outlined in the Trade Union (Facility Time Publication Requirements) Regulations 2017 and therefore no time was released from this employer in relation to official duties. The CCG liaised and worked with CSU TU representatives and area/ regional representatives from those recognised unions whose time will be recorded with their employing authority.

Expenditure on consultancy

Total expenditure on consultancy for 2022/23 as at 30th June 2022 was £34k (2021/22 was £163k).

Off-payroll engagements

The CCG is required to report on certain off-payroll arrangements.

All off-payroll engagements as of 30th June 2022, for more than £245 per day and that last longer than 6 months:

	Number
Number of existing engagements as of 30 June 2022	2
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	2

All existing off-payroll engagements as at 30th June 2022 have been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

For all new off-payroll engagements between 1st April 2022 and 30th June 2022, for more than £245 per day and that lasted longer than six months:

No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	Number
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
No. 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

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1st April 2022 and 30th June 2022:

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	11

Exit packages, including special (non-contractual) payments

Table 1: Exit Packages

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	NIL	NIL	NIL	NIL Agrees to A below	NIL	NIL	NIL	NIL

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme. Exit costs in this note are the full costs of departures agreed in the year. Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

Table 2: Analysis of Other Departures

	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	**NIL**	**NIL A – agrees to total in table 1**

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 this Note 3 which will be the number of individuals.

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

**includes any non-contractual severance payment made following judicial mediation, and 0 relating to non-contractual payments in lieu of notice.

0 non-contractual payments (£0,000) were made to individuals where the payment value was more than 12 months’ of their annual salary.

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

Parliamentary Accountability and Audit Report

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

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

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS West Lancashire 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 West Lancashire CCG transferred to NHS Lancashire and South Cumbria ICB on 1 July 2022. When NHS West Lancashire 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 68 to 69, 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 West Lancashire 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 West Lancashire 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

29 June 2023

ANNUAL ACCOUNTS

Kevin Lavery

Chief Executive

Lancashire and South Cumbria Integrated Care Board

(on behalf of the former NHS West Lancashire CCG)

28th June 2023

Data entered below will be used throughout the workbook:

Entity name:	NHS West Lancashire CCG
This year	3 month period end to 30 June 2022
Last year	Full year accounts 2021-22
This year ended	30 June 2022
Last year ended	31-March-2022
This year commencing:	01-April-2022
Last year commencing:	01-April-2021

NHS West Lancashire CCG - 3 month period end to 30 June 2022

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the 3 month period end to 30 June 2022

	Note	**3 month period end to 30 June 2022 £'000**	Full year accounts 2021-22 £'000
Other operating income	2	(595)	(1,279)
Total operating income		**(595)**	**(1,279)**
Staff costs	3	708	2,930
Purchase of goods and services	4	48,309	201,093
Provision expense	4	0	74
Other Operating Expenditure	4	7	29
Total operating expenditure		**49,024**	**204,126**
Net Operating Expenditure		**48,429**	**202,847**
Comprehensive Expenditure for the Financial Period		**48,429**	**202,847**

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
Current assets:			
Inventories	6	489	489
Trade and other receivables	7	1,505	701
Cash and cash equivalents	8	38	47
Total current assets		**2,032**	**1,237**
Total assets		**2,032**	**1,237**
Current liabilities			
Trade and other payables	9	(9,789)	(11,320)
Provisions	10	(146)	(145)
Total current liabilities		**(9,935)**	(11,465)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(7,903)**	**(10,228)**
Financed by Taxpayers' Equity			
General fund		(7,903)	(10,228)
Total taxpayers' equity:		**(7,903)**	**(10,228)**

The notes on pages 5 to 22 form part of this statement

The financial statements on pages 1 to 4 have been approved in line with delegated authority granted by the Board of Lancashire and South Cumbria Integrated Care Board (as successor organisation to NHS West Lancashire CCG) on 21st June 2023 and are signed on its behalf by:

Kevin Lavery
Chief Executive

Samantha Proffitt
Chief Finance Officer

Statement of Changes In Taxpayers Equity for the 3 month period end to 30 June 2022

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 3 month period end to 30 June 2022		
Balance at 01 April 2022	(10,229)	(10,229)
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(10,229)**	**(10,229)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 3 month period end to 30 June 2022		
Net operating expenditure for the financial year	(48,429)	**(48,429)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(48,429)**	**(48,429)**
Net funding	50,755	50,755
Balance at 30 June 2022	**(7,903)**	**(7,903)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for Full year accounts 2021-22		
Balance at 01 April 2021	(12,129)	(12,129)
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(12,129)**	**(12,129)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for Full year accounts 2021-22		
Net operating costs for the financial year	(202,847)	(202,847)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(202,847)**	**(202,847)**
Net funding	204,748	204,748
Balance at 31 March 2022	**(10,228)**	**(10,228)**

The notes on pages 5 to 22 form part of this statement

Statement of Cash Flows for the 3 month period end to 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		(48,429)	(202,847)
(Increase)/decrease in inventories	6	0	(51)
(Increase)/decrease in trade & other receivables	7	(804)	922
Increase/(decrease) in trade & other payables	9	(1,531)	(2,846)
Increase/(decrease) in provisions	10	0	74
Net Cash Inflow (Outflow) from Operating Activities		**(50,764)**	**(204,748)**
Net Cash Inflow (Outflow) before Financing		**(50,764)**	**(204,748)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		50,755	204,748
Net Cash Inflow (Outflow) from Financing Activities		**50,755**	**204,748**
Net Increase (Decrease) in Cash & Cash Equivalents	8	(9)	0
Cash & Cash Equivalents at the Beginning of the Financial Year		47	47
Cash & Cash Equivalents (including bank overdrafts) at the End of 3 month accounts to 30 June 2022		**38**	**47**

The notes on pages 5 to 22 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

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

1.1 **Going Concern**

These accounts have been prepared on a going concern basis**.**

The Health and Care Act received Royal Assent on 28 April 2022. The Act allows for the establishment of Integrated Care Boards (ICB) across England and the abolition of clinical commissioning groups (CCG). ICBs took on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities transferred to NHS Lancashire and South Cumbria ICB.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated.

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

1.2 **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

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.

Notes to the financial statements

1.4 **Joint arrangements**

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

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

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

1.5 **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 Learning Difficulties and Social Care. Note 14 provides details of the income and expenditure.

The pools are 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

1.6 **Operating Segments**

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

1.7 **Revenue**

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

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

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

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

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

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

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

Payment terms are standard reflecting cross government principles.

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees.

Notes to the financial statements

1.8.2 **Retirement Benefit Costs**

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

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

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

1.9 **Other Expenses**

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

1.10 **Grants Payable**

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

Notes to the financial statements

1.11 **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.

1.11.1 **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

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.

1.12 **Inventories**

Inventories are valued at the lower of cost and net realisable value. The CCG classes community equipment within individuals' homes as an inventory and has employed a methodology that considers the age of the equipment to determine its net realisable value.

1.13 **Cash**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.
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.

1.14 **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.

1.15 **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.

1.16 **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.

1.17 **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.

Notes to the financial statements

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

1.19.2 **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.

Notes to the financial statements

1.20 **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.

1.21 **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.

1.22 **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.

1.22.1 **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:

Timing differences. There are a number of accruals and prepayments within the Statement of Financial Position where estimation techniques have been applied. This is because the outturn information is not available at the time of preparation of the financial statements
Prescribing. The CCG has included an accrual of £3.284m which relate to the estimated charges to the CCG for medicines in May and June 2022. The estimates are based on recent expenditure trends and seasonal profiles.

1.35 **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.
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.

1.36 **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 Total £'000	Full year accounts 2021-22 Total £'000
Other operating income		
Other non contract revenue	595	1,279
Total Other operating income	**595**	**1,279**

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the clinical commissioning group and credited to the General Fund.

Revenue is totally from the supply of services. The clinical commissioning group received no revenue from the sale of goods for the 3 month period end 30th June 2022 or for the prior year ending 31 March 2022.

3. Employee benefits and staff numbers

3.1 Employee benefits	Total Permanent Employees £'000	Other £'000	3 month period end to 30 June 2022 Total £'000
Employee Benefits			
Salaries and wages	547	1	548
Social security costs	64	0	64
Employer Contributions to NHS Pension scheme	96	0	96
Gross employee benefits expenditure	**707**	**1**	**708**
Less recoveries in respect of employee benefits	0	0	0
Total - Net admin employee benefits including capitalised costs	**707**	**1**	**708**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**707**	**1**	**708**

	Total Permanent Employees £'000	Other £'000	Full year accounts 2021-22 Total £'000
Employee Benefits			
Salaries and wages	2,282	39	2,321
Social security costs	232	0	232
Employer Contributions to NHS Pension scheme	377	0	377
Gross employee benefits expenditure	**2,891**	**39**	**2,930**
Less recoveries in respect of employee benefits	0	0	0
Total - Net admin employee benefits including capitalised costs	**2,891**	**39**	**2,930**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**2,891**	**39**	**2,930**

3.2 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	**45.81**	**0.00**	**45.81**	**45.16**	**1.00**	**46.16**

3.3 Exit packages agreed in the financial year

	3 month period end to 30 June 2022 Compulsory redundancies		3 month period end to 30 June 2022 Other agreed departures		3 month period end to 30 June 2022 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	Full year accounts 2021-22 Compulsory redundancies		Full year accounts 2021-22 Other agreed departures		Full year accounts 2021-22 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	3 month period end to 30 June 2022 Departures where special payments have been made		Full year accounts 2021-22 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

Analysis of Other Agreed Departures

	3 month period end to 30 June 2022 Other agreed departures		Full year accounts 2021-22 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	**0**	**0**	**0**	**0**

* As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.
These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.
Redundancy and other departure costs have been paid in accordance with contractual terms.
Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.
The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

3.5 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:

3.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 30 June 2022, is based on valuation data as 31 March 2022, updated to 30 June 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary (for 30 June 2022), 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.

3.5.2 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.

4. 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	651	2,908
Services from foundation trusts	12,305	46,499
Services from other NHS trusts	15,642	60,171
Purchase of healthcare from non-NHS bodies	9,073	47,794
Prescribing costs	5,052	20,668
GPMS/APMS and PCTMS	4,702	18,133
Supplies and services – clinical	250	1,001
Supplies and services – general	40	1,716
Consultancy services	34	163
Establishment	41	299
Transport	3	794
Premises	409	768
Audit fees	58	73
Other professional fees	31	8
Legal fees	17	80
Education, training and conferences	1	18
Total Purchase of goods and services	**48,309**	**201,093**
Provision expense		
Provisions	0	74
Total Provision expense	**0**	**74**
Other Operating Expenditure		
Chair and Non Executive Members	7	29
Total Other Operating Expenditure	**7**	**29**
Total operating expenditure	**48,316**	**201,196**

5.1 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	2,246	18,158	9,405	76,944
Total Non-NHS Trade Invoices paid within target	2,236	18,129	9,373	76,758
Percentage of Non-NHS Trade invoices paid within target	**99.55%**	**99.84%**	**99.66%**	**99.76%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	179	28,917	475	112,288
Total NHS Trade Invoices Paid within target	178	28,791	466	112,222
Percentage of NHS Trade Invoices paid within target	**99.44%**	**99.56%**	**98.11%**	**99.94%**

The Better Payment Practice Code required 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.

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

6 Inventories

	Loan Equipment £'000	Total £'000
Balance at 01 April 2022	489	**489**
Balance at 30 June 2022	**489**	**489**

7.1 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	134	0	89	0
NHS prepayments	211	0	0	0
NHS accrued income	8	0	148	0
Non-NHS and Other WGA receivables: Revenue	4	0	269	0
Non-NHS and Other WGA prepayments	151	0	68	0
Non-NHS and Other WGA accrued income	982	0	131	0
VAT	15	0	(4)	0
Total Trade & other receivables	**1,505**	**0**	**701**	**0**
Total current and non current	**1,505**		**701**	

The clinical commissioning group did not hold any collateral against receivables outstanding at the 3 month period end to 30 June 2022 or for the prior year ending 31 March 2022.

7.2 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	95	0	88	78
By three to six months	39	2	0	1
By more than six months	0	2	0	174
Total	**134**	**4**	**88**	**253**

7.3 Provision for impairment of receivables

The clinical commissioning group had no provision for impairment of receivables at the 3 month period end to 30 June 2022 or for the prior year ending 31 March 2022.

The clinical commissioning group's aged debt report is reviewed in order to determine the recovery status of the debtor balances. Each item is considered on a case by case basis.

8 Cash and cash equivalents

	3 month period end to 30 June 2022 £'000	Full year accounts 2021-22 £'000
Balance at 01 April 2022	47	47
Net change in year	(9)	0
Balance at 30 June 2022	**38**	**47**
Made up of:		
Cash with the Government Banking Service	38	47
Cash and cash equivalents as in statement of financial position	**38**	**47**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 30 June 2022	**38**	**47**
Patients' money held by the clinical commissioning group, not included above	0	0

9 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	1,181	0	1,148	0
NHS accruals	843	0	582	0
Non-NHS and Other WGA payables: Revenue	1,498	0	922	0
Non-NHS and Other WGA accruals	1,692	0	3,565	0
Non-NHS and Other WGA deferred income	41	0	135	0
Social security costs	36	0	32	0
Tax	31	0	30	0
Other payables and accruals	4,467	0	4,906	0
Total Trade & Other Payables	**9,789**	**0**	**11,320**	**0**
Total current and non-current	**9,789**		**11,320**	

10 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	145	0	145	0
Total	**145**	**0**	**145**	**0**
Total current and non-current	**145**		**145**	

	Continuing Care £'000	**Other £'000**	**Total £'000**
Balance at 01 April 2022	**145**	**0**	**145**
Balance at 30 June 2022	**145**	**0**	**145**
Expected timing of cash flows:			
Within one year	145	0	**145**
Balance at 30 June 2022	**145**	**0**	**145**

11 Financial instruments

11.1 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.

11.1.1 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.

11.1.2 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.

11.1.3 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.

11.1.4 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.

11.1.5 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.

11 Financial instruments cont'd

11.2 Financial assets

	Financial Assets measured at amortised cost	Total
	3 month period end to 30 June 2022 £'000	3 month period end to 30 June 2022 £'000
Trade and other receivables with NHSE bodies	60	60
Trade and other receivables with other DHSC group bodies	858	858
Trade and other receivables with external bodies	211	211
Cash and cash equivalents	38	38
Total at 30 June 2022	**1,167**	**1,167**
Items not classed as financial instruments	376	376
Total trade and other receivables + cash and cash equivalents	**1,543**	**1,543**

11.3 Financial liabilities

	Financial Liabilities measured at amortised cost	Total
	3 month period end to 30 June 2022 £'000	3 month period end to 30 June 2022 £'000
Trade and other payables with NHSE bodies	327	**327**
Trade and other payables with other DHSC group bodies	2,069	**2,069**
Trade and other payables with external bodies	7,285	**7,285**
Total at 30 June 2022	**9,681**	**9,681**
Items not classed as financial instruments	108	108

12 Operating segments

The clinical commissioning group consider they have only one segment: commissioning of healthcare services.

13 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.

13.1 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**
LD Pool	LCC, Chorley & South Ribble CCG, Greater Preston CCG	Services for Adults with Learning Disabilities - Central Pooled Fund	0	0	(101)	336	0	0	(405)	1,473
Better Care Fund	Lancashire County Council	Better Care Fund Social Care	0	0	(1,472)	2,238	0	0	(5,886)	8,787

13.2 Services for Adult Learning Difficulties

The clinical commissioning group has a pooled budget arrangement with Lancashire County Council. The pool is hosted by Lancashire County Council.
Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for Services for Adults with Learning Disabilities.

13.3 Better Care Fund

The clinical commissioning group has a pooled budget arrangement with Lancashire County Council, NHS Morecambe Bay CCG, NHS Fylde and Wyre CCG, NHS Greater Preston CCG, NHS Chorley and South Ribble CCG and NHS East Lancashire CCG. The pool is hosted by Lancashire County Council.

14 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
NHS Morecambe Bay CCG	0	0	7	0
Parkgate Surgery (Chair - Dr Peter Gregory)	272	0	0	0
Parbold Surgery (GP Exec Lead - Dr John Kinsey)	205	0	0	0
Dr A Bisarya (GP Exec Lead - Dr Dheraj Bisarya)	100	0	0	0
Excel Primary Care (GP Exec Lead - Dr Dheraj Bisarya)	530	0	0	0
Liverpool University Hospitals NHST FT	2514	0	19	0
Lancashire Teaching Hospitals NHS FT	630	0	6	0
OWLS	1107	0	0	0
NHSE/I	0	0	0	(42)
CVS West Lancashire Ltd	0	0	0	0
Twinkle House	33	0	4	0

The transactions above to Practices are in relation to Enhanced Services and Tier 2 services (such as Anti-Coagulation, Minor Surgery and Phlebotomy) provided by the above mentioned GP Practices and also for Primary Care Co-Commissioning.

OWLS CIC Ltd provide urgent care services to the West Lancashire population including out of hours provision and an acute visiting service.

The Department of Health and Social Care is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department of Health and Social Care is regarded as the parent Department. For example:

- NHS England
- NHS Foundation Trusts
- NHS Trusts
- NHS Litigation Authority
- NHS Business Services Authority
- NHS Property Services
- Community Health Partnerships

In addition, the clinical commissioning group 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 Lancashire County Council in respect of joint enterprises.

	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
Parkgate Surgery (Chair - Dr Peter Gregory)	1,032	0	0	0
Parbold Surgery (GP Exec Lead - Dr John Kinsey)	852	0	0	0
Dr A Bisarya (GP Exec Lead - Dr Dheraj Bisarya)	372	0	0	0
Excel Primary Care (GP Exec Lead - Dr Dheraj Bisarya)	2,163	0	0	0
Lancashire Teaching Hospitals NHS FT	2,462	0	0	0
Liverpool University Hospitals NHST FT	9,587	0	0	0
OWLS	3,137	0	0	0
CVS West Lancashire Ltd	95	0	0	0
Twinkle House Ltd	78	0	8	0

15 Events after the end of the reporting period

The Health and Care Act received Royal Assent on 28 April 2022. The CCG was dissolved on 30 June 2022. On 1 July the assets, liabilities and operations transferred to NHS Lancashire and South Cumbria ICB.

16 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	49,024	49,024	203,485	204,126
Capital resource use does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	48,429	48,429	202,206	202,847
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	540	540	2,204	2,157

The CCG reported a breakeven position against its allocated resources for the three month period ending 30th June 2022, therefore delivering all the financial performance targets reported above.