Better Health, Better Care,
Delivered Sustainably

Morecambe Bay
Clinical Commissioning Group

ANNUAL REPORT AND ACCOUNTS Q1 2022/23

NHS Morecambe Bay Clinical Commissioning Group Annual Report and Accounts for the period 1 April 2022 to 30 June 2022

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Welcome

Welcome to the Quarter 1 2022-2023 Annual Report for Morecambe Bay 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.

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

Thank you.

PERFORMANCE REPORT

Performance Overview

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

Statement from Chief Executive on performance

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

In line with the Health and Care Act (2022), which completed the Parliamentary process in April, the eight Lancashire and South Cumbria CCGs were closed on 30 June 2022. The CCGs' statutory responsibilities were transferred to the new organisation, NHS 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 NHS Lancashire and South Cumbria ICB constitution was signed off and the Readiness to Operate 'ROS' checklist was given approval from the regional team. The hard work and dedication of all colleagues who worked on the closedown of CCGs and establishment of the ICB must be recognised here.

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

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

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

Information previously contained on CCG websites is now available via:http://lancashireandsouthcumbria.icb.nhs.uk/legacyccgs

Kevin Lavery

Chief Executive Officer

NHS Lancashire and South Cumbria Integrated Care Board

(on behalf of the former NHS Morecambe Bay CCG)

21 June 2023

Statement of purpose and activities of the CCG

This section of the Annual Report provides summary information on NHS Morecambe Bay CCG – its purpose, key risks to the achievement of the organisation's objectives and how the organisation has performed during the first quarter of the 2022/23 financial year.

About us

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

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

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

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

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

- We planned what services were needed to support the health needs of the local population.
- We commissioned services such as mental health, hospital care and community services.
- We monitored these services to ensure patients in Morecambe Bay had safe and quality care.

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

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

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

We also worked closely with other organisations including NHS England and NHS

Improvement (NHSEI), the organisation responsible for buying GP, pharmacy, dental and specialised services across England, to ensure that health services delivered locally were joined up.

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

Equality, diversity and inclusion

The CCG took equality, diversity and inclusion very seriously. Our Equality and Inclusion Annual Report demonstrated how we met our commitments to equality, diversity and human rights and set out how we complied with statutory duties under the Equality Act (2010) and the Public Sector Equality Duty.

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

Modern Slavery Act

NHS Morecambe Bay CCG fully supported the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement was available on our website.

Our vision and triple aim

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

To achieve our vision, we delivered our 'triple aim':

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

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

Population challenges

The majority of our approximately 352,000 patients lived in the districts of Lancaster, South Lakeland and Barrow-in-Furness. The remaining smaller groups of patients mainly came from Copeland and Craven, aligning on the Bay boundaries. The registered population was evenly split between females (50.1 per cent) and males (49.9 per cent), with 22 per cent of the population aged 65+ and 27 per cent aged 0-24, reflecting the large student population who resided temporarily in the Bay. The remaining 51 per cent were aged 25–64.

With the integration of South Lakeland district into the CCG we saw a growth in our older resident population and with predicted demographic growth in over-65s expected over the

next 10+ years, we needed to be mindful of the potential impact on health and wellbeing services across the Bay.

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

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

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

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

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

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

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

Work has continued across the year to recover elective services, however as we saw in 2021-22, the pandemic has created significant backlogs across different activities, creating challenges that remain across the country to restore elective care systems to pre-pandemic levels. Locally we are facing significant challenges to achieve restoration in elective services and quickly reduce the backlog in waiting time activity, which has

continued to have an effect on meeting Referral to Treatment (RTT) targets moving into Q1 2022. Local trends are described later in this Report.

In Lancashire and South Cumbria, accelerator funding from NHS England has proved invaluable in helping the care system mitigate against some of these issues. Additional bed capacity in hospitals across the region has been provided, enabling improvements in pre- and post-operative patient assessments.

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

Working with our partners

Lancashire and South Cumbria Health and Care Partnership

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

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

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

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

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

Mental health: children and young people

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

An additional £10.7 million of government funding has been awarded over a three-year period to help reduce waiting times, improve experience and quality of care, and ensure

consistent levels of care are provided across the region. Priorities include increasing access to services and enhancing support for CYP who need more help and risk support through further development of crisis care, and making sure there is support 24/7 – reducing hospital admissions.

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

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

Mental health: adults

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

Specialist Community Perinatal Mental Health (PMH) services continue to expand in line with the NHS Long Term Plan ambitions, providing specialist care to new and expectant mothers with moderate to severe needs up to 24 months following birth. For 2022/23, the growth is focused on developing support in terms of psychological therapies. This includes parent-infant therapy and systemic family therapy. As of May 2022, the service has supported 272 women – slightly above the national trajectory. Peer support and partner assessments are also now provided as part of the service.

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

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

The specialist team includes maternal mental health midwives, psychological therapists, mental health practitioners, peer support coordinators and volunteers with lived experience. The service is being co-produced with people with experience of reproductive trauma and/or loss to gain a better understanding of their needs. To help explain the

services on offer, a film was produced in collaboration with four mothers. Please note that contents may trigger unsettling feelings for individuals affected by birth trauma and/or loss. The film is also available with subtitles.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Suicide prevention

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

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

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

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

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

Digital - Our vision for digital and data transformation

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

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

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

Digital Transformation

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

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

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

In 2018, Lancashire and South Cumbria published its 'Our Digital Future' and set out partnership working as a system. This strategy outlines a set of principles aligned to inter-connected themes. Read more here:

https://www.lancashireandsouthcumbria.icb.nhs.uk/our-work/digital-transformation

Stroke

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

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

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

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

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

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

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

Diabetes

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

In Lancashire and South Cumbria people identified as being at risk are offered tailored support through the local Healthier You service. Healthier You is a nationally-commissioned diabetes prevention programme aimed at reducing the risk of developing or delaying the onset of Type 2 diabetes. The latest evidence shows the programme can

have a major impact on people's lives, and almost one million people have been referred to the programme since it was first launched in 2016 with participants who complete the programme achieving an average weight loss of 3.3kg. During April and May 2022, there were 856 referrals to the programme.

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

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

Cancer Alliance

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

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

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

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

Maternity

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

The Covid-19 pandemic has enforced unprecedented staffing pressures across the system, but all providers have continued to maintain safe services whilst also responding to national demands, such as those laid out in the Ockenden Report's Immediate and Essential Actions (IEAs). Services which were forced to close during 2020/21 have all

been reinstated and wherever possible (by monitoring staffing levels daily), women have been able to give birth in their chosen setting.

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

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

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

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

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

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

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

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

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

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

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

The LMS Maternity Assurance Panel was formed in response to the Ockenden Report as part of a revised perinatal quality surveillance model (December 2020). The Panel is Chaired by a Non-Executive Director who is responsible for discharging the quality responsibilities, and has continued to meet regularly. The essential actions arising from Ockenden identified that serious incident reports must still be shared with the LMS. A standard operating procedure for StEIS Reportable Incidents is now in place between providers, commissioners and the LMS so that timely notification of reports and investigations are shared. A member of the LMS assurance panel now attends the individual CCG Serious Incident Panels to review and discuss each incident. Bi-monthly incident reports are collated across the region, with six monthly thematic reviews undertaken, to allow any key learning and improvements to be promptly shared and enacted.

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

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

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

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

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

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

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

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

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

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

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

Paediatrics

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

The **Asthma Network** has worked on several projects relating to improving asthma care. We are taking part in a national pilot which aims to identify those children who are most at risk of an asthma attack to ensure they are on the most appropriate treatment. The

asthma digital passport will be introduced in September as part of another national pilot. The Communications and Engagement team has supported the development of essential resources to enable the Asthma-friendly Schools programme to commence.

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

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

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

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

The **Palliative Care Network** is working to improve the care for children with life-limiting illnesses and funding has been agreed to appoint a new palliative care consultant for the area. Joint working with Together for Short Lives and The Kentown Wizard Foundation will introduce five specialist palliative care nurses across Lancashire and South Cumbria (as a national pilot), to further improve the care for children with life-limiting illnesses.

Other achievements include:

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

Personalised care

Personalised care is a key element in delivering Lancashire and South Cumbria's vision for future healthcare. We need to change the way we deliver health and wellbeing support, address health inequalities and work together with mutual respect and shared

responsibility. We need to promote the prevention of illness, early identification of conditions, timely intervention, and enablement. We need people to be as active and independent as possible, living their best life.

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

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

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

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

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

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

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

Population health management

Health outcomes for people living in Lancashire and South Cumbria are significantly worse compared to the national average. There are also significant health inequalities between different areas, and the pace of improvement has slowed down – in many areas,

life expectancy has fallen. Therefore, urgent action is required to reduce health inequalities and to tackle the major causes of ill-health and premature mortality.

Nearly one-third of people in Lancashire and South Cumbria live in some of the most deprived areas across England. More people are living in fuel poverty and unable to afford to heat their homes than the national average (13% compared to 10.6%[1]). We know that adverse living conditions (including child poverty) leads to significant variation in childhood development and school readiness. The percentage of children living in poverty ranges from 12% to 38% (the national average is 30%).

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

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

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

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

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

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

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

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

As a system, an overarching strategy for population health is needed and will be shaped by the recommendations of the Health Equity Commission (HEC). The HEC was launched by Professor Sir Michael Marmot in September 2021, and is also chaired by him.

Workforce

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

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

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

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

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

Building on the success of our current employability programmes, we have now developed a range of programmes targeting Healthcare Support Worker (HCSW) vacancies. The employment programmes will be run across the system in partnership with trusts, Lancashire Enterprise Partnership (LEP), the Department for Work and Pensions, and Lancashire Adult Learning. An important aspect of our approach will be to work with partners focusing on how we access different groups within our local communities who may not traditionally consider roles in health and care. Programmes will be accelerated

and will have guaranteed interviews at the end. The programmes will work alongside current funding given to the trusts to develop a recruitment pipeline for HCSW which includes supportive onboarding processes and pastoral support for those who are new to care.

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

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

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

Most recently, the Social Care Workforce Forum received fantastic feedback as attendees heard from key speakers from the panels discussing workforce challenges and strategies targeting recruitment, retention and grow your career opportunities. Louise Taylor's opening remarks set the context for the journey ahead and the changes needed across health and care to move towards a partnership approach.

Diagnostic Imaging

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

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

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

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

Learning disabilities and autism

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

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

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

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

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

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

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

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

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

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

Cardiac

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

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

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

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

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

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

Funded care

During Q1 of 2022/23, the funded care work programme continued to work in partnership across the NHS and local authorities, meeting regularly to discuss the redesign of the whole NHS funded care service. Each element of the service is still being redeveloped including system-wide data, reporting, finance, governance, quality assurance, communications and engagement and workforce modelling to create a service model that works across Lancashire and South Cumbria, and is designed to best meet the needs of the patients, families and carers it serves.

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

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

Elective care

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

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

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

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

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

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

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

We are grateful to the efforts of every single one of our staff in achieving the gains we have to date, especially against the backdrop of the North West being one of the areas of the country hardest-hit by the pandemic and suffering the greatest losses. Covid-19

patients in the region occupied an average of 10% more hospital beds than the rest of England. Added to this, the North West spent almost two months longer in lockdown compared with the length of lockdowns in the rest of the country.

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

Primary care

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

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

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

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

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

appointments continues to rise with more than 1.5 million appointments across Lancashire and South Cumbria in just those two months[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.

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

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

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

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.

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 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.

Bay Health and Care Partners (BHCP)

The Bay Health and Care Partners ongoing development of the Place Based Partnership programme was a top priority and the leadership team formally endorsed the BHCP priorities for 2022/23. These were:

- Taking more action on prevention and health inequalities through a 'population health' approach
- Further strengthening the sustainability of general practice and providing improved care through Integrated Care Communities and new Primary Care Networks to support thriving communities
- Delivering care that prioritises real improvements in mental health, cancer, emergency care and planned care and met national standards
- Improving financial and clinical sustainability alongside the quality of service delivery

- Developing and delivering more integrated care locally using the new NHS infrastructure at three levels: Lancashire and South Cumbria Integrated Care System; Morecambe Bay Integrated Care Partnership; and Integrated Care Community and Primary Care Network

Sharing the benefits of local projects

The Morecambe Bay Set for Surgery began a roll out across Lancashire and South Cumbria, following fantastic successes in the pilot scheme.

The programme, known as LSC (Lancashire and South Cumbria) Optimise, aimed to provide surgery patients with bespoke support ahead of their surgery. The initiative, developed between GPs and hospital services, aimed to help patients waiting for surgery across Lancashire and South Cumbria to improve their general health before their operation.

Some treatments, especially surgical operations, affect the body for several months afterwards and pre-existing poor health reduced the body's ability to recover from treatment. Simple changes, such as exercising more, eating more healthily, or reducing how much alcohol is consumed ahead of an operation could all help to increase patient's ability to recover and support the NHS by helping the maximum number of patients to become fit and well quickly.

Workforce Development

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

The BHCP Leadership team requested the People Board to risk stratify the workforce challenges that had been identified by all partners.

In December 2021, the BHCP People Board held a workshop session where previously identified challenges were reviewed and placed in order of highest to lowest risk. The top four were then classified as work streams priority for BHCP People Board.

Eight workforce challenges had been identified by the People Board. These were noted as: Vacancies, Retention, Training, Health and Wellbeing, Age Profile, Mobility between Employers, Growth Expectations and Pay Differential.

Another priority for 2022/23 was ensuring the health and wellbeing of all colleagues in the patch, rolling out the "Flourish" approach across the whole place-based partnership. The Workforce Strategy project group began mapping where staff were employed and workshops identified key areas of cooperation, for example mutual corporate benefits.

Community Engagement

Engagement with local communities continued throughout 2022/23, including the launch of a series of engagements with community assets across Morecambe Bay. The Bay Health and Care Partners Community and Engagement arranged face to face meetings with key community organisations around Morecambe Bay, ensuring that our priorities aligned with the needs of our communities.

The team also began filming a new series of informative health videos, featuring local GPs and covering a range of common ailments. The videos were designed to ensure that

people experiencing symptoms knew when to access health services and helped spread awareness. Topics included menopause, prostate problems and cancers.

Future development

On 28th April, 2022, the Health and Care Bill received Royal Assent by enacting new health legislation into law.

- The act introduced measures to tackle the COVID-19 backlogs and rebuild health and social care services from the pandemic
- The Health and Care Act built on the proposals for legislative change set out by NHS England in the Long-Term Plan, while also incorporating valuable lessons learnt from the pandemic to benefit both staff and patients.
- It marked an important step in the health and care agenda, setting up systems and structures to reform how health and adult social care work together and addressed some of the long-term challenges including a growing and ageing population, chronic conditions and inequalities in health outcomes.

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.

Key issues and risks

The principal risk for Morecambe Bay CCG and the health economy was the significant risk related to ensuring a safe and sustainable service across Morecambe Bay to serve our population within available resources, considering quality variation. Together with our partners, we worked to mitigate this risk through the refreshed Better Care Together programme. We also worked across the Healthier Lancashire and South Cumbria ICS to find sustainable solutions to our challenges.

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

Performance Analysis

Performance and Business Intelligence

In 2022/23 financial year the main priority for NHS services both local and national was seen as recovering elective services, overburdened from the COVID pandemic, as far as possible.

However, this came alongside a variety of issues including:

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

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

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

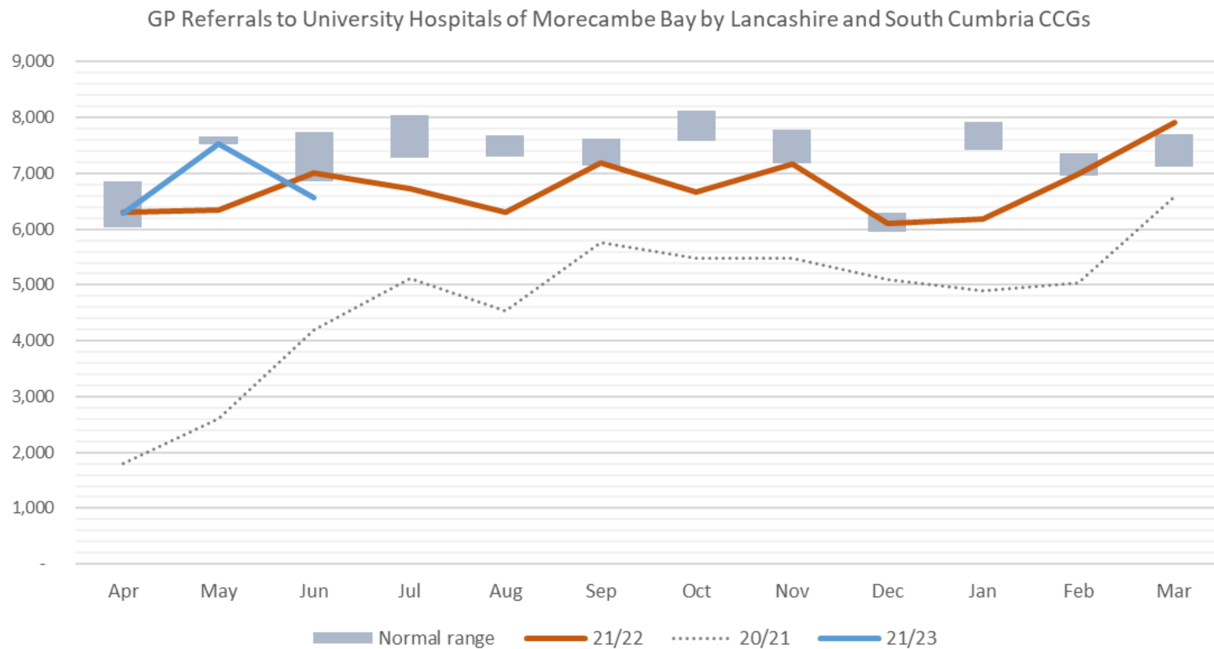
Below is the performance against the 2022/23 SOF for Morecambe Bay CCG, using data as up to date as possible, at the time of writing.

	Indicator	Latest Period	Previous Value	Latest Value	Target/National Average*	.	National Value	Rank
S001a	Appointments in general practice	w/e 03/04/2022	37,893	37,018 ↘	60,144*	✗	6,375,313	58/106
S008a	Overall size of the waiting list	2022 04	31,293	32,039 ↗	56,840*	✓	6,024,998	41/106
S009a	Patients waiting more than 52 weeks to start consultant-led treatment	2022 04	1,554	1,558 ↗	2,795*	✓	296,285	51/106
S010a	Cancer - first treatments	2022 04	173	146 ↘	220*	✗	23,338	56/106
S010b	Cancer - urgent referrals seen	2022 04	1,875	1,358 ↘	1,924*	✗	203,917	53/106
S012a	Cancer - % meeting faster diagnosis standard	2022 04	80.8%	81.8% ↗	>75%	✓	70.8%	6/106
S013a	Diagnostic activity levels - Imaging	2022 04	9,443	8,761 ↘	13,530*	✗	1,434,148	53/106
S013b	Diagnostic activity levels - Physiological measurement	2022 04	860	848 ↘	1,137*	✗	120,549	49/106
S013c	Diagnostic activity levels - Endoscopy	2022 04	1,056	902 ↘	1,062*	✗	112,532	50/106
S014a	Cancer - proportion of people that survive cancer for at least 1 year after diagnosis	2018		75.9% →		✗		11/97
S015a	Cancer - proportion of cancers diagnosed at stages 1 or 2	2018		52.8% →		✗		63/79
S022a	Maternity - number of stillbirths per 1,000 total births	2019	4.29	2.77 ↘	3.46*	✓	3.33	22/88
S023a	Maternity - number of neonatal deaths per 1,000 live births	2019	1.32	1.04 ↘	1.74*	✓	1.55	7/64
S030a	Percentage of people aged 14+ on the GP learning disability register receiving an annual health check	21-22 Q4	41%	64.6% ↗	71.3%*	✗	71.3%	88/106
S031a	Number of personalised care interventions	21-22 Q3	10,409	13,097 ↗	25,377*	✗	2,689,956	65/106
S032a	Personal Health Budgets	21-22 Q4	1,089	1,356 ↗	1,202*	✓	124,964	28/104
S033a	Social Prescribing unique patient referrals	21-22 Q4	4,715	5,625 ↗	9,369*	✗	993,139	56/106
S037a	Patient experience of GP services	2021	86.7%	86% ↘	83.0%*	✓	83.0%	24/106
S040a	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections	2022 04	1	0 ↘	0.7*	✓	69	1/106
S041a	Clostridium difficile infections	2022 04	14	11 ↘	11*	✓	1,179	62/106
S042a	E. coli blood stream infections	2022 04	17	20 ↗	29*	✓	3,070	53/106
S044a	Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	Apr 2021 - Mar 2022	0.867	0.881 ↗	<0.87	✗	0.853	41/106
S044b	Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	Apr 2021 - Mar 2022	0.11%	0.11% ↘	<10%	✓	8.7%	98/106
S046a	Population vaccination coverage - MMR for two doses (5 years old) to reach the optimal standard nationally (95%)	21-22 Q2	91.4%	89.9% ↘	>95%	✗	85.5%	54/105
S047a	Percentage of people aged 65 and over who received a flu vaccination	2022 02	85.2%	84.9% ↘	82.3%*	✓	82.3%	31/106
S050a	Cancer - cervical screening coverage, females aged 25-64, attending screening within target period	21-22 Q3	72.3%	71.6% ↘	70.3%*	✗	70.3%	69/106
S052a	Diabetes patients that have achieved all the NICE recommended treatment targets (adults and children)	2020-21	33.8%	30.1% ↘	34.6%*	✗	34.6%	103/106
S055a	General Practice Referrals to NHS Digital Weight Management Programme - Crude Rate/100,000 population	21-22 Q4	117.5	103.6 ↘	105.42*	✗	111.59	37/106
S068a	Sickness absence (working days lost to sickness)	2022 01	1.57%	1.52% ↘	0.03*	✓	6.8%	14/86
S081a	IAPT access (total numbers accessing services)	21-22 Q4	1,295	1,145 ↘	3,031*	✗	321,305	84/106
S082a	IAPT recovery rate (%)	21-22 Q4	58.7%	57.8% ↘	50.5%*	✓	50.5%	10/106
S083a	Estimated diagnosis rate for people with dementia	2022 05	70.5%	70.8% ↗	61.9%*	✓	61.9%	13/106
S084a	Children and young people (ages 0-17) mental health services access (number with 1+ contact)	2022 03	4,585	4,710 ↗	6,236*	✗	659,195	48/106
S085a	People with severe mental illness receiving a full annual physical health check and follow up interventions	21-22 Q4	955	1,186 ↗	2,138*	✗	226,583	63/106
S087a	Rate per 100,000 population of people in adult acute mental health beds with a length of stay over 60 days	2022 03	7.2	8.2 ↗	7.37*	✗	8.47	62/106
S087b	Rate per 100,000 population of people in older adult acute mental health care with a length of stay over 90 days	2022 03	7.7	10.3 ↗	8.26*	✗	9.75	69/106
S088a	Number of women accessing specialist community perinatal mental health services	Apr 2021 - Mar 2022	9.82%	10.8% ↗	6.58	✓	6.6%	8/106
S089a	Waiting times for Urgent Referrals to Children and Young People's Eating Disorder services	Apr 2021 - Mar 2022	57.1%	70.4% ↗	61.9%	✗	61.9%	55/106
S089b	Waiting times for Routine Referrals to Children and Young People Eating Disorder Services	Apr 2021 - Mar 2022	69.6%	76% ↗	64.1%	✗	64.1%	43/106

Delivery on Key Performance Targets

Elective demand

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

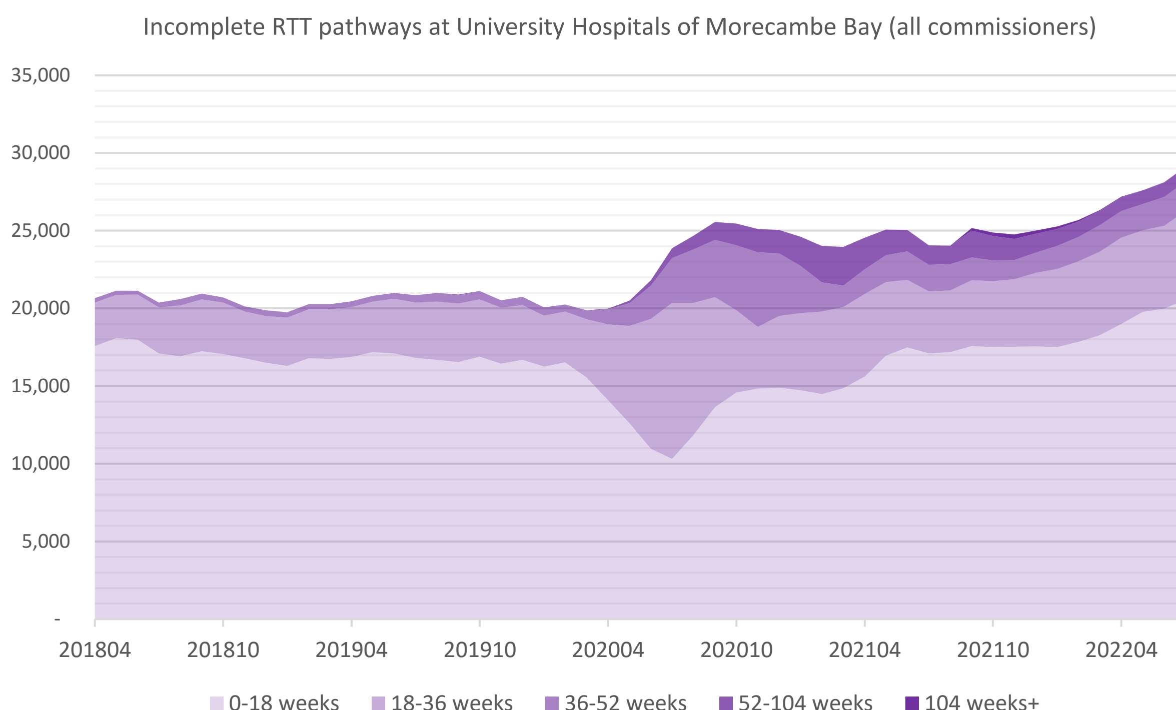


During 2021/22 and into 2022/23 GP referrals recovered close to levels seen pre-pandemic although remain on the lower end of expected levels.

Elective waiting lists

The pandemic increased the total size of the NHS waiting list, going from around 20,000 incomplete pathways in March 2020 to a peak of over 29,000 in July 2022.

The number of incomplete pathways over 104 weeks has fallen in the last six months, with only 1 in July 2022 (down from a peak of 273 in Nov 2021).

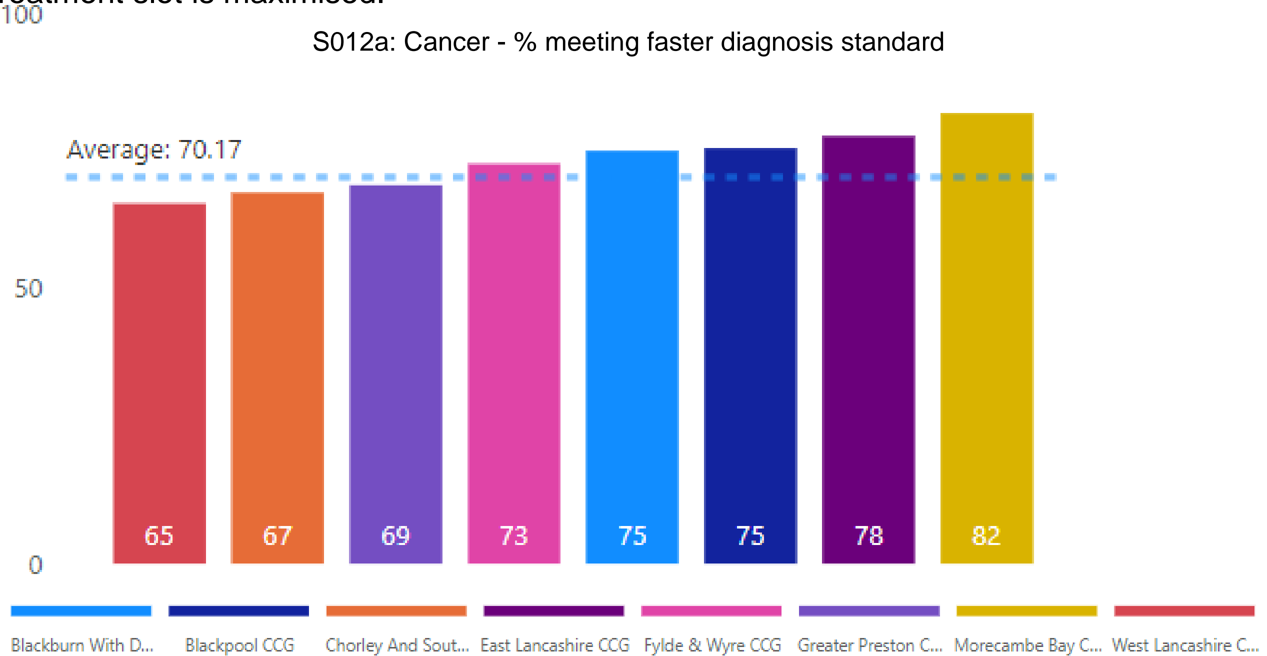


The number of long waiting patients has increased since the beginning of the pandemic, and one of the main priorities for the next financial year is to reduce the number of pathways waiting over 72 weeks to zero and reduce the number of incomplete pathways waiting over 1 year as much as possible.

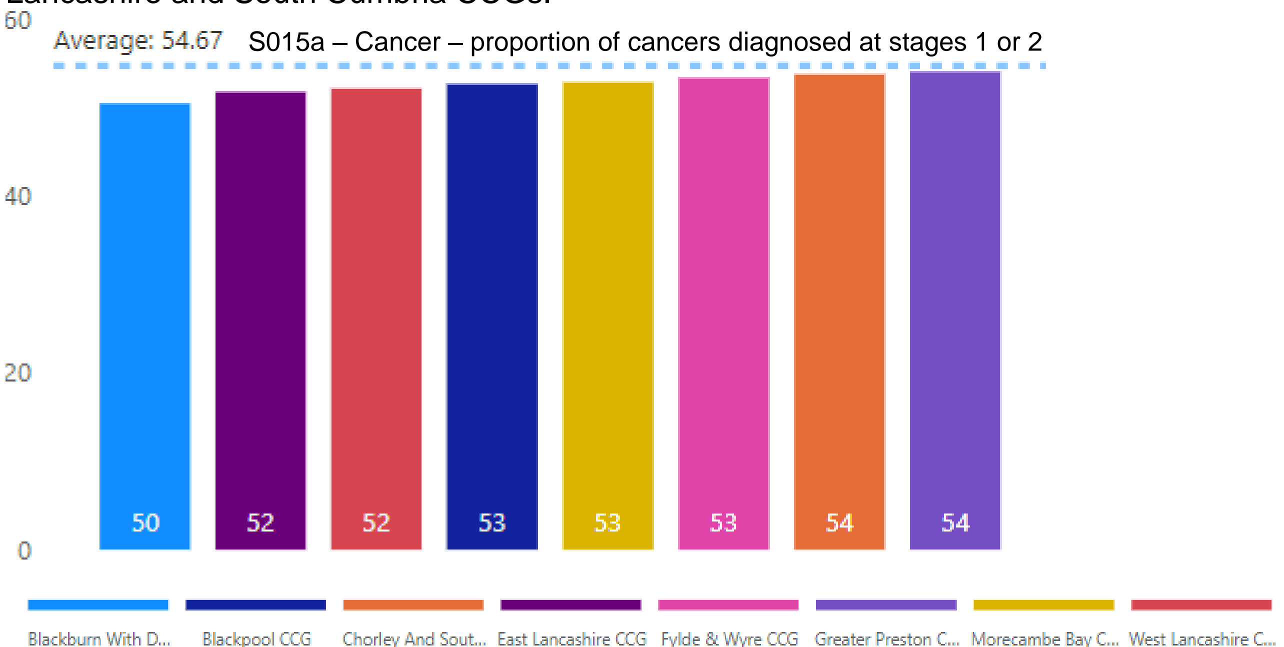
One way in which this may be achieved is through close working between providers in Lancashire and South Cumbria to utilise mutual aid and ensure all services are maximised.

Cancer standards

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



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

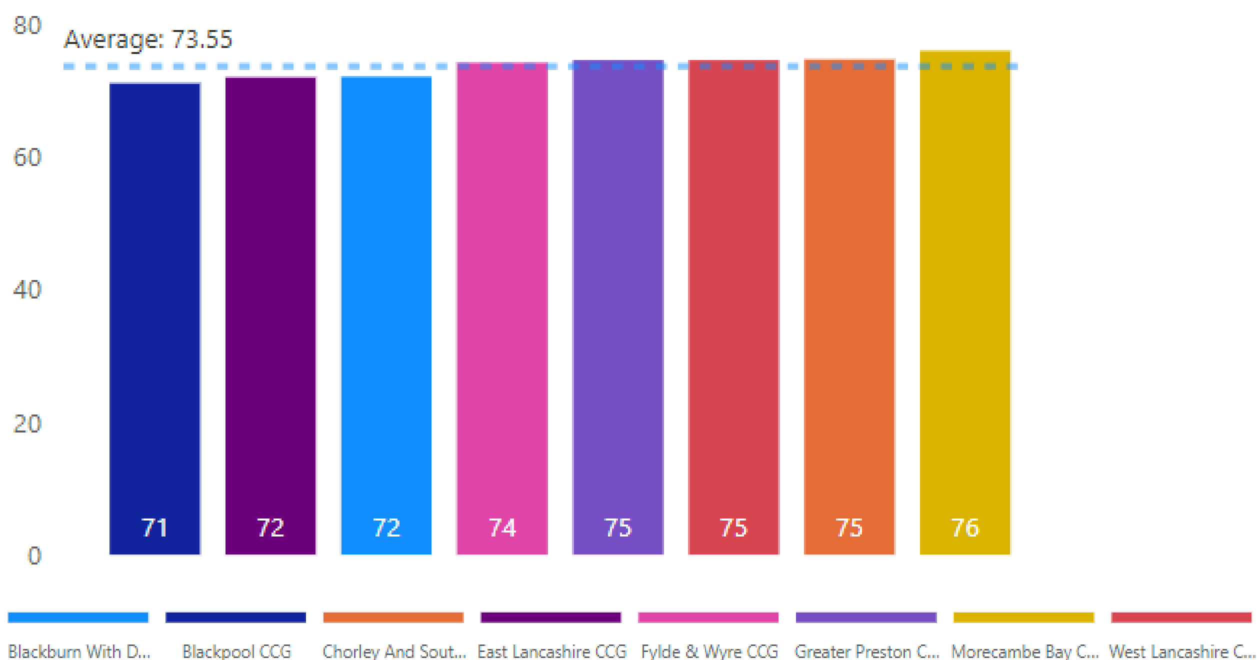


All CCGs within Lancashire and South Cumbria ICS perform below the national average figure for proportion of cancers diagnosed at stage 1 or 2, with Morecambe Bay CCG scoring in the middle across the health system.

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

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

75.9% of Morecambe Bay CCG patients that are diagnosed with cancer survive at least one year from diagnosis, above the national average of 73.55%.



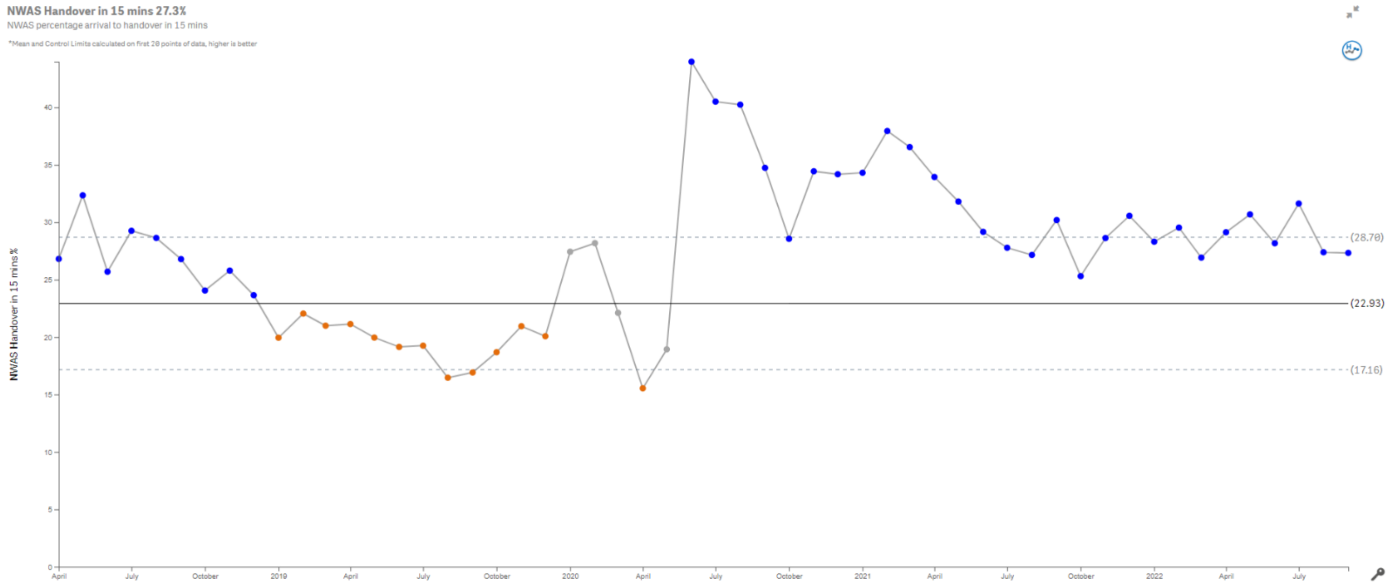
Urgent Care

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

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

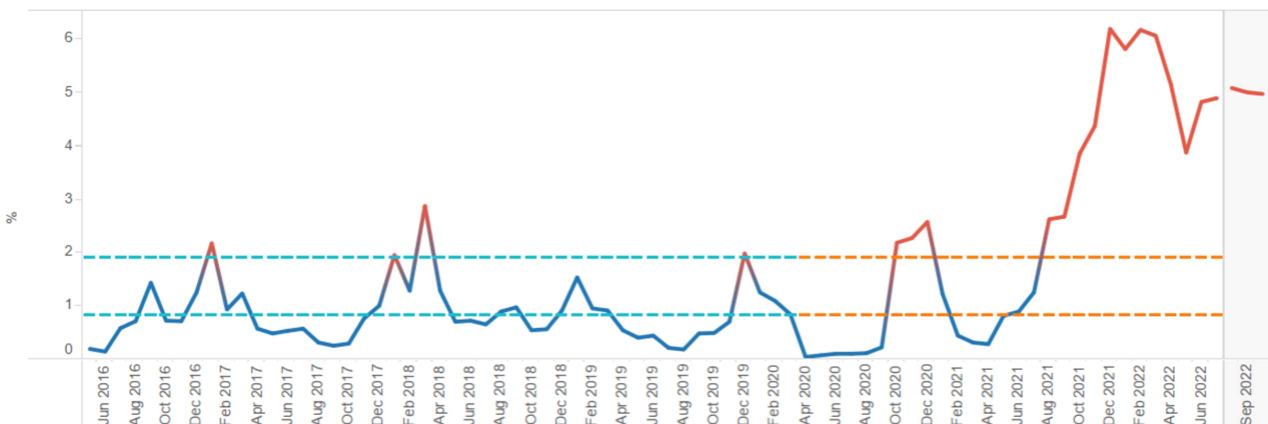
This has been caused by a number of factors including staff absences and the availability of beds in care providers outside of hospital.

Percentage of ambulance handovers within 15 minutes at University Hospitals of Morecambe Bay



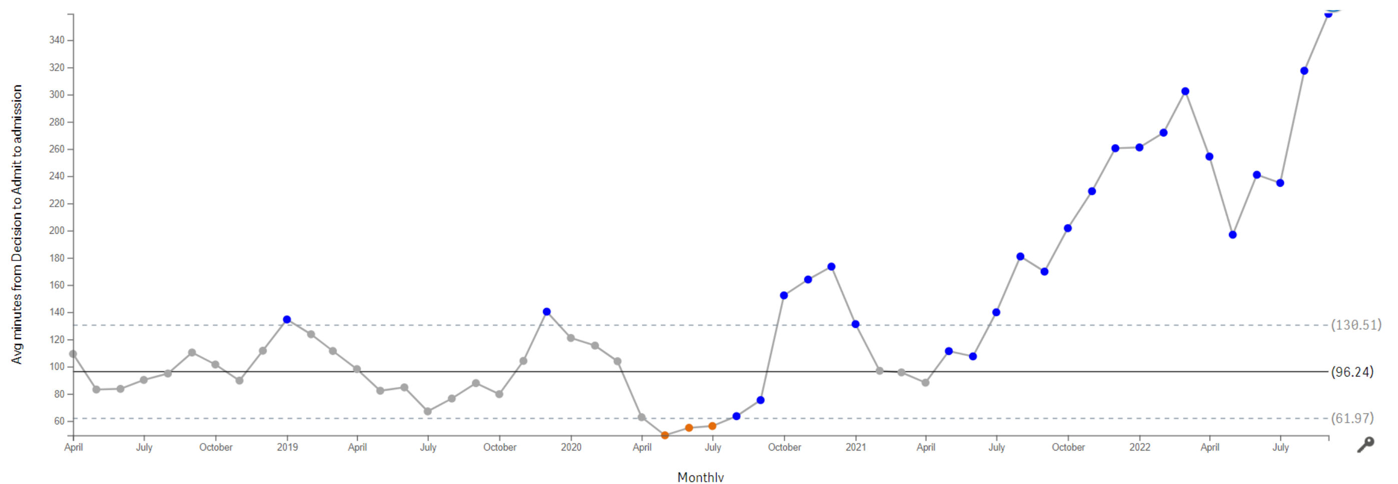
The number of ambulance handovers at A&E that are completed within 15 minutes or less remains below 30%. In August 2022 over 72% of all ambulance handovers saw a minimum 15-minute delay.

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

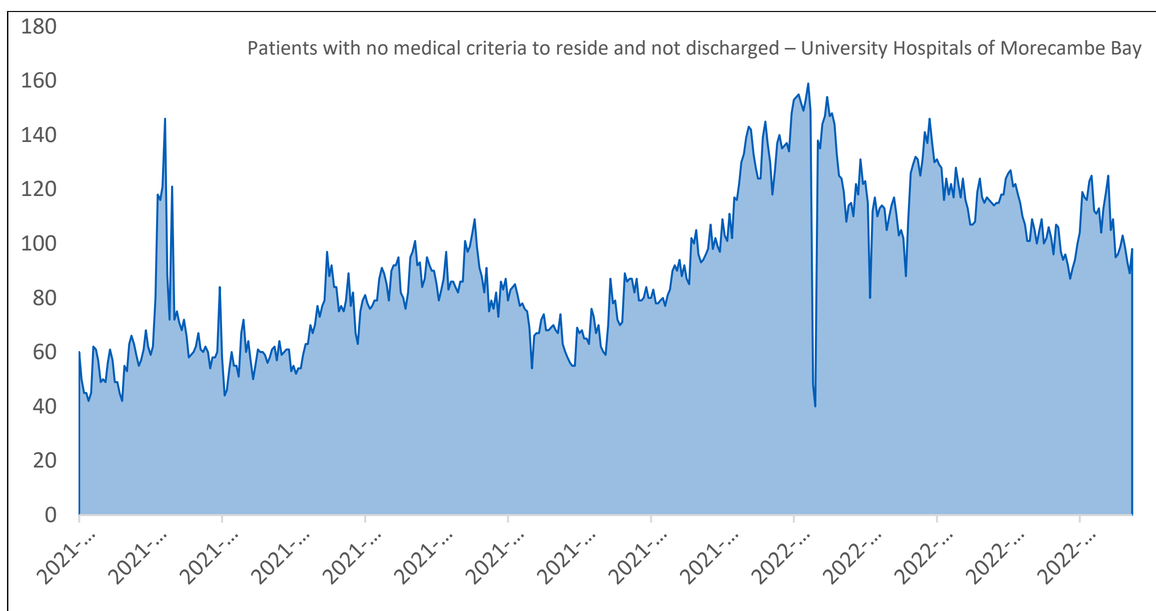


Once a patient is in an A&E department, the time it takes to leave the department is also increasing. The proportion of all A&E attendances that take 12 hours or more from arrival to departure (either discharge or admission) has increased substantially over the last year, and despite the expected seasonal reduction in April, remain much higher than previous years.

Once a decision has been taken by an A&E department to admit a patient into a hospital bed, the length of time it takes for the patient to be admitted has increased. This is due to staffing pressures and bed availability caused by isolation rules, infection prevention and control measures and the inability to discharge patients. In April 2022 the average time from decision to admit to admission was 194 minutes, in September 2022 this had increased to an average of 359 minutes.



There are also issues with discharging patients, even those patients that are medically fit for discharge. The number of patients that reside in a hospital bed that have no medical right to reside has increased in the last twelve months. This is due to staffing pressures in the hospital, care and social sectors, as well as care home closures caused by COVID outbreaks. (last data update 18th June 2022).



Performance Summary

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

Financial Key Performance Indicators

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

Key performance indicator	Target	Actual	Result
Revenue resource use does not exceed the amount specified in Directions	Maintain expenditure within the allocated resource of £162.387m	Total expenditure £162.386m	Achieved
Delivery of a control total of breakeven	Deliver a control total of breakeven	Total position breakeven	Achieved
Maintain expenditure within the Annual Cash Drawdown Requirement	Annual (quarter 1) Cash Drawdown Requirement total £162.493m	Total cash outflow £170.488m	Not achieved (shortfall to be recovered by the Lancashire and South Cumbria Integrated Care Board during the remainder of the financial year)
Revenue administration resource use does not exceed the amount specified in Directions	Maintain administration (running costs) expenditure within the allocated resource of £1.661m	Total administration (running costs) expenditure £1.661m	Achieved
QIPP savings targets identified and	Overall QIPP savings target	Total QIPP savings £0.379m	Not achieved (shortfall covered by

savings achieved	£2.473m		additional growth allocations and underspends in other areas)
Maintain capital expenditure on primary care IT within the limits set by NHSEI	Maintain expenditure within the allocated primary care IT capital allocation of £0.00m	Total primary care IT expenditure £0.00m	Achieved
Comply with the Better Payment Practice Code (BPPC)	Ensure 95% (by number and volume) of all valid invoices are paid by the due date or within 30 days of receipt of a valid invoice, whichever is later	Non-NHS payables 99.93% by number, 99.86% by value NHS payables 100.00% by number, 100.00% by value	Achieved

Financial review

As a result of the dissolution of the CCG on 30 June 2022, this report only covers the first quarter of the 2022/2023 financial year. In order to ensure all CCGs could report a breakeven position at 30 June 2022, NHS England made adjustments to individual CCG allocations in month 3 to cover any deficits incurred in quarter 1. As such, the CCG was allocated an additional £3.636m to ensure that overall allocation and expenditure were matched.

In order to ensure financial balance across the whole financial year under this arrangement, NHS England will adjust the allocation for quarters 2 to 4 for the Lancashire and South Cumbria Integrated Care Board by the aggregate amount of allocation adjusted for all eight constituent CCGs.

During the first quarter, the previous arrangement under which NHS providers were paid a nationally determined monthly ‘block’ contract payment was continued, to enable a measure of financial stability for all parties.

The following section provides a brief overview of the CCG’s financial performance in the first quarter of 2022/23. The financial accounts have been prepared under a Direction issued by NHSEI under the National Health Service Act 2006 (as amended). A full set of accounts, including associated certificates, is included later in this report.

Allocation

As described above, the total allocations to NHS Morecambe Bay CCG for 2022/23 relate to the first quarter of the year only and were as follows:

- We received allocations totalling £143.107m for commissioning NHS services for

the local community

- We received a further allocation of £13.992m for delegated commissioning of primary care medical services
- We received a further allocation of £1.652m from which we were expected to cover all our running costs

In order to enable the CCG to report a breakeven position at the end of quarter 1, we also received the following allocations:

- An additional allocation of £3.500m for commissioning NHS services for the local community
- An additional allocation of £0.127m for delegated commissioning of primary care medical services
- An additional allocation of £0.009m to cover all our running costs

2022/23 financial duties

The CCG's performance against each of its financial duties, as reported in Note 2 to the Accounts, for the first quarter of the 2022/23 financial year was as follows:

- The CCG achieved its in year control total of a breakeven, but this was only achieved with the assistance of an additional £3.636m of allocations as described above
- The CCG did not remain within the cash limit, but the shortfall will be recovered by the Lancashire and South Cumbria Integrated Care Board during the remainder of the financial year
- The CCG maintained its administration expenditure within its Running Costs Allowance.

Financial Performance

We have faced a number of financial pressures during the first quarter of 2022/23. The revised financial regime first introduced in 2020/21 to assist organisations in dealing with the Covid-19 pandemic, was largely replaced by a return to business as usual arrangements, with no additional funding for the Hospital Discharge Programme and the majority of other Covid-19 related expenditure being funded from within CCG allocations. The block contract arrangements in place with NHS providers for the previous two financial years have been maintained and adapted to cover payments to providers outside of the Integrated Care Board boundary, such that any contract values above £0.500m with individual providers are subject to a formal contract, with any below that value covered by Low Value Activity (LVA) arrangements, both of which are determined at an aggregated Integrated Care Board level.

As part of the planning process, CCGs were expected to make Quality, Improvement, Productivity and Prevention (QIPP) savings during the year, based on an ICS system agreed percentage of allocation. The CCG's overall target for the first quarter was £2.473m but, due to the constraints imposed by the introduction of the block payments to providers as part of the revised financial regime, the only schemes able to deliver significant savings were in medicines management. Overall, the CCG realised savings of £0.379m, with the shortfall having been covered by unplanned underspends in some areas and the additional allocations received to ensure a breakeven position could be reported, as described above.

Analysis of Covid-19 expenditure

The CCG received no additional allocations to cover expenditure incurred as a result of the Covid-19 pandemic during the first quarter of the financial year.

Analysis of EU exit related expenditure

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

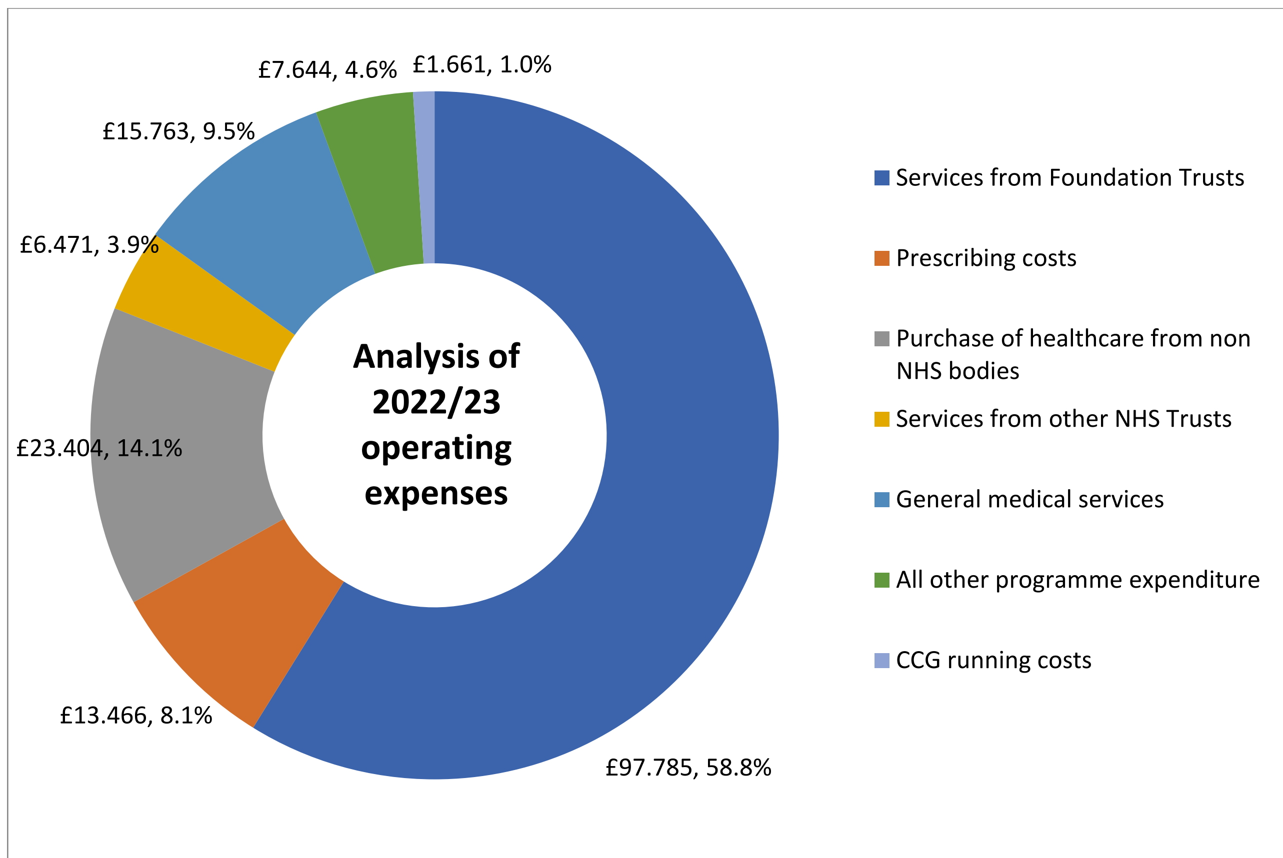
Accounting policies

The CCG's accounting policies are shown in full in Note 1 to the Annual Accounts. Following the Health and Care Act receiving Royal Assent on 28 April 2022, which allowed for the establishment of Integrated Care Boards across England and the abolition of CCGs, Integrated Care Boards took on the commissioning functions of CCGs. As a result, the functions, assets and liabilities of the CCG transferred to the Lancashire and South Cumbria Integrated Care Board on 1 July 2022. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. Where a CCG 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. As NHS Morecambe Bay CCG's functions will continue to be delivered by the Lancashire and South Cumbria Integrated Care Board, the CCG has therefore assessed that it remains a going concern as at 30 June 2022 (Note 1.1 to the Accounts provides further detail on the adoption of the going concern assumption). The accounting policies follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury.

We have made no changes to accounting estimates during quarter 1 of the 2022/23 financial year, however, as described above, the CCG has continued to contract with NHS providers on a block basis and payments have therefore, in general, been fixed irrespective of levels of activity undertaken.

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

Analysis of 2022/23 operating expenses



Sustainable Development

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

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

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

Improving quality

CQUIN Update

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

Lancashire and South Cumbria NHS Foundation Trust (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 is 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 Lancashire to define the service offer.

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

Closedown for the Clinical Commissioning Groups

During Quarter 1 we have been working closely with the incoming ICB to ensure that there was a smooth transition, the work was monitored by Mersey Internal Audit Agency and was positively received.

Engaging people and communities

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

The system-wide programmes 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 Inequalities

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

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

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

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

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

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

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

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

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 Cumbria Health and Wellbeing Board held one meeting during the first quarter of 2022/23.

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

The Board received reports from the NHS and partners working in health and care including those on the response to Covid-19, pressures across the health and care system, health and local government reform and Mental Health developments.

The Lancashire Health and Wellbeing Board held one meeting during the first quarter of 2022/23.

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

ACCOUNTABILITY REPORT

Corporate Governance Report

Members Report

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

Member practices of the CCG:

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

Member practice information was available on our website.

Membership Council

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

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

Governing Body

The role of the Governing Body was to provide assurance that we are compliant with our statutory obligations and that we met public organisations' key national requirements for governance. The Governing Body had oversight of committees such as the Audit Committee and the Quality Improvement Committee and ensured that the key duties of the CCG were delivered.

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

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

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

Strategic Commissioning Committee

The Strategic Commissioning Committee, brought together leaders to improve and transform health and care services. More information about the Committee can be found on the Boards and Committees section of the Lancashire and South Cumbria Integrated Care Board website.

Other relevant disclosures

The CCG made no political or charitable donations during the first quarter of the year.

There were no important events since the end of the first quarter of financial year which affect the CCG. The CCG did not have any branches outside the UK.

Pension liabilities

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

External Audit

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

The audit fee for the three months to 30 June 2022 is £72,000 (including VAT) and relates to the statutory audit and services carried out in relation to the statutory audit, including the Value for Money audit fee of £12,000 (including VAT).

Cost allocation and setting of charges for information

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

Disclosure of 'Personal Data Breaches or Incidents'

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

The CCG had an IG Handbook and Information Governance Breach Reporting Standard Operating Procedure which set out staff responsibilities should they have become aware of a data security and protection breach. This also articulate the process for reporting IG incidents.

Information Governance incidents Q1 2022/23

The CCG reported four IG breach in processes during the period and four IG breaches in confidentiality. All of these were low level and therefore not reportable to the ICO.

Statement as to disclosure to auditors

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

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

Kevin Lavery

Chief Executive Officer

NHS Lancashire and South Cumbria Integrated Care Board

(on behalf of the former NHS Morecambe Bay CCG)

21 June 2023

Statement of Accountable Officer's Responsibilities

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

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

- The propriety and regularity of the public finances for which the Accountable Officer is answerable.
- Keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction).
- Safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money.
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)).
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

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

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

understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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

Kevin Lavery

Chief Executive Officer

NHS Lancashire and South Cumbria Integrated Care Board

(on behalf of the former NHS Morecambe Bay CCG)

21 June 2023

Governance Statement

Introduction and context

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

NHS Morecambe Bay CCG's statutory functions are set out under the National Health Service Act 2006 (as amended).

The Clinical Commissioning Group's general function is arranging the provision of services for persons for the purposes of the health service in England. The Clinical Commissioning Group is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

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

Scope of responsibility

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

I am responsible for ensuring that the NHS Morecambe Bay CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the Clinical Commissioning Group as set out in this Governance Statement.

Compliance with the UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance with relevant principles of the Code is considered to be good practice. This Governance Statement is intended to demonstrate how the CCG had regard to the principles set out in the Code considered appropriate for CCGs.

The CCG Governance Framework

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

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

Our Constitution sets out the arrangements that we had put in place to help us to deliver our vision and goals, to discharge all of our legal obligations and to engage with our members, our patients and our community and other key stakeholders and partners to

achieve this. It described our governing principles: the rules and procedures that we had established to ensure probity and accountability in the day-to-day running of our organisation, to ensure that decisions were taken in an open and transparent way and that our patients' and public's interests always remained central to our goals.

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

Governance and committee arrangements included:

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

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

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

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

Membership Council

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

Functions of the Membership Council include:

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

iii. all other Governing Body members

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

There were no meetings held during the first quarter of 2022/23.

Voting members of the Membership Council

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

Declarations of interest were noted on an annual basis and published on the CCG's website.

Governing Body

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

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

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

The main focus of the Governing Body includes:

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

There were two meetings held during 2022/23.

Voting members of the Governing Body who attended and voted

Position	Name	Number of meetings attended	% attendance over the year
GP Executive Lead – Commissioning	Dr Sarah Arun	2 out of 2	100%
Lay Member	Mike Bone	2 out of 2	100%
GP Executive Lead – Primary and Community Care	Dr Lauren Dixon	2 out of 2	100%
Chief Operating Officer	Hilary Fordham	2 out of 2	100%
Director of Planning and Performance	Anthony Gardner	2 out of 2	100%
GP Executive Lead – Urgent Care and Mental Health	Dr Jim Hacking	2 out of 2	100%
Chief Finance Officer	Andrew Harrison	2 out of 2	100%
Chief Officer	Jerry Hawker	2 out of 2	100%

Lead Nurse Quality and Head of Safeguarding	Jane Jones	2 out of 2	100%
Clinical Chair	Dr Geoff Jolliffe	1 out of 2	50%
GP Executive Lead – Quality and Performance	Dr Rahul Keith	1 out of 2	50%
GP Executive Lead – Population Health	Dr Andy Knox	1 out of 2	50%
Lay Member	Hazel Parsons	2 out of 2	100%
Secondary Care Doctor for the Governing Body	Dr Andrew Severn	2 out of 2	100%
Lay Member	Clive Unitt	2 out of 2	100%
Lay Nurse	Margaret Williams	2 out of 2	100%

Declarations of interest were noted on an annual basis and published on the CCG's website.

Committees of the Governing Body

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

Audit Committee

The Audit Committee provides the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the CCG in relation to finance.

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

There was one meeting held during 2022/23.

Voting members of the Audit Committee who attended and voted

Position	Name	Number of meetings attended	% attendance over the period
Lay Member and Chair	Clive Unitt	1 out of 1	100%
Lay Member	Hazel Parsons	0 out of 1	0%
Secondary Care Doctor for the Governing Body	Dr Andrew Severn	1 out of 1	100%

Executive Committee

The Executive Committee is charged with delivering the routine work of the CCG. The committee is made up of five elected clinical members of the Governing Body, the Clinical Chair, Chief Officer, Chief Finance/Director of Governance, Chief Operating Officer, Director of Planning and Partnerships and Lead Nurse Quality and Head of Safeguarding.

The functions of the Executive Committee include:

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

There were 6 meetings held up to June 2022.

Voting members of the Executive Committee who attended and voted

Position	Name	Number of meetings attended	% attendance over the period
Clinical Chair	Dr Geoff Jolliffe	6 out of 6	100%
GP Clinical Executive	Dr Sarah Arun	2 out of 6	33%
GP Clinical Executive	*Dr Lauren Dixon	4 out of 6	67%
Chief Operating Officer	Miss Hilary Fordham	5 out of 6	83%
Director of Planning and Performance	Mr Anthony Gardner	5 out of 6	83%
GP Clinical Executive	Dr Jim Hacking	4 out of 6	67%
Chief Finance Officer/Director of Governance **(from 1/8/20)**	Mr Andrew Harrison	4 out of 6	67%
Lead Nurse Quality and Head of Safeguarding	Jane Jones	5 out of 6	83%
GP Clinical Executive	Dr Rahul Keith	6 out of 6	100%
GP Clinical Executive	*Dr Andy Knox	3 out of 6	50%

Notes:

* In order for Dr Lauren Dixon and Dr Andy Knox to concentrate on their other roles as

Clinical Chief Integrated Services and Director of Population Health and Engagement respectively, the Executive Committee have agreed it was acceptable for them to attend whenever their diaries allowed.

Jerry Hawker remained the CCG Chief Officer however it had been agreed that his operation role was carried out by the Chief Operating Officer and the Director of Planning and Partnerships while he was the SRO for the New Hospitals Programme.

Remuneration Committee

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

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

There were no meetings held Up to June 2022.

Voting members of the Remuneration Committee who attended and voted

Position	Name	Number of meetings attended	% attendance over the period
Lay Member and Chair	Clive Unitt	0 out of 0	*There were no meetings held up to June 2022.*
Lay Member	Mike Bone	0 out of 0	
Lay Member	Hazel Parsons	0 out of 0	
Secondary Care Doctor for the Governing Body	Dr Andrew Severn	0 out of 0	

Quality Improvement Committee

The purpose of the Quality Improvement Committee was to provide assurance to the Governing Body that the services the CCG commissioned were safe and effective, that quality and patient experience were central to our work and that there was continuous improvement demonstrated in the quality of commissioned services and patient outcomes. This included robust arrangements to ensure partnership working to support the wellbeing of children and vulnerable adults and that the CCG met its statutory functions in relation to safeguarding.

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

When poor care delivery was reported, we had systems, processes and responses in place that sought to promptly correct the problems and minimise the impact on patient

care, and to ensure that the commissioned services responded in a timely and effective manner to address concerns. During the COVID-19 pandemic, we adapted our approach to be responsive to quality concerns and when required to undertake quality visits remotely and in collaboration with partners across the ICP.

The CCG continued to monitor and respond to quality concerns and seek assurance of improvement actions through a variety of measures including, triangulation of intelligence and incident reports, patient experience feedback, performance and quality data and assurance visits including specific deep dives across speciality areas. Assurance and agreed improvement measures were reported through governance structures and for speciality level deep dives which included a heat map report setting out the CCG assurance position. This continued to provide assurance that our commissioned services had implemented actions and learning to ensure a cycle of continuous improvement.

During Q1 2022/23, the committee continued to oversee a number of quality assurance initiatives as well as supporting the continued COVID-19 priorities. Examples included the support for our regulated care providers in relation to outbreak management and market fragility and UHMBT assurance work following a number of published external reviews. The CHC framework was reinstated nationally and the CCG worked with partners to support recovery and restoration of the IPA provision to meet national requirements in ensuring a high level and timely response for individual patient activity remained a priority.

The CCG undertook targeted work specific to providers from whom we commissioned services.

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

The strategic quality approach was underpinned by the CCG Assurance and Accountability Framework which set out agreed accountability arrangements associated with all our services, our population and workforce. The framework was reviewed and updated in Q4 2021/22 to reflect governance arrangements for Provider assurance which will change as NHS reform progresses and an ICB Quality Assurance Framework will be developed as the CCG transitioned to new structures.

A key area of focus going forward is the implementation of the Patient Safety Incident Response Framework (PSIRF) which is part of the Patient Safety Strategy. MBCCG worked closely with one of the early adopter sites for the PSIRF to receive peer support and guidance through the process. MBCCG continued to engage with and support providers, as appropriate, as we planned our road map to the rollout. This work has been carried forward to the ICB.

Over the last few years the Morecambe Bay Health Economy had collaboratively been working to enrich quality improvements, address quality variation and the impact of failing standards. We needed to collectively be in a position to evidence that learning was embedded and how cultural change, openness, clinical engagement, transparency and partnership working improved the experiences and outcomes for our population. We maintained our statutory functions of the CCG whilst recognising reform and ahead of CCG Quality responsibilities transitioning into the receiving organisation as of July 2022. Pre transition, quality oversight and governance was maintained both at CCG place and at ICB level. A register of ‘live’ Morecambe Bay quality issues was handed over to the

receiving organisation and at the point of transition. Work was undertaken to agree relevant metrics and quality outcomes to support management of our priorities and ensure integrated delivery planning took place to determine the key actions required to deliver against the priorities in 2022/23.

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

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

There were two meetings held during Q1 2022/23. These meeting had a specific focus on CCG close down, transition and Provider quality accounts.

Voting members of the Quality Improvement Committee who attended and voted

Position	Name	Number of meetings attended	% attendance over the period
Lay Member and Chair	Mike Bone	2 out of 2	100%
Senior Manager Corporate Services	John Barbour	1 out of 2	50%
Head of Quality	Sue Bishop	2 out of 2	100%
Director of Planning and Performance representing the Chief Finance Officer	Anthony Gardner	2 out of 2	100%
Chief Finance Officer/Director of Governance	Andrew Harrison	Director of Planning and Performance representing the Chief Finance Officer	
Lead Nurse Quality and Head of Safeguarding	Jane Jones	2 out of 2	100%
GP Executive Lead – Quality and Performance	Dr Rahul Keith	2 out of 2	100%
Lay Member	Hazel Parsons	2 out of 2	100%
Secondary Care Doctor for the Governing Body	Dr Andrew Severn	2 out of 2	100%
Lay Nurse	Margaret Williams	1 out of 2	50%

Safeguarding

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

The CCG undertook targeted work specific to providers from whom we commissioned services.

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

The CCG submitted an annual Safeguarding Self-Assessment to provide assurance of its arrangements to NHSE/I, as well as to the Adult Boards and Children's Safeguarding Partnership's. during 2021/22, there was a move to an online live Safeguarding Commissioning Assurance Toolkit (S-CAT). NHS Morecambe Bay CCG declared full compliance and published a comprehensive Annual Safeguarding Report to reflect such activity.

The CCG's Safeguarding Team was part of the Lancashire and South Cumbria ICS Safeguarding system, which further evolved with the formation of a single Safeguarding Health Executive to streamline decision making, agree key actions and strengthen partnership working. During Q1 2022/23, we continued to make great strides in strengthening our safeguarding governance and reporting structure, inclusive of wider partnership arrangements. These arrangements placed us in a strong position to move forward in to the ICB.

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

- Responding to new statutory requirements, specifically the new Domestic Abuse Act and the Mental Capacity Amendment Act, which included the Liberty Protection Safeguards.
- Continuing with our commitment to the Learning Disabilities Mortality Review (LeDeR) programme. We strengthened local governance through placed base LeDeR steering group, which sought assurance surrounding implementation of learning form reviews.
- Being a key member of a strategic partnership group to deliver Safer Sleeping and ICON (abusive head trauma) messages to Primary Care, including an e-learning

package, resource library and template for the EMIS clinical system.

- Jointly leading on the development of a single ICS Service specification and Health Strategy for Looked After Children and Care Leavers.
- Being key members of strategic partnership groups to deliver Neglect workstreams, which included the development of strategies, thematic audits and a review of training offers to our workforce.

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

Primary Care Commissioning Committee

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

There were two meetings held during 2022/23.

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

Position	Name	Number of meetings attended	% attendance over the period
Lay Member and Chair	Hazel Parsons	2 out of 2	100%
Lay Member	Mike Bone	2 out of 2	100%
Senior Finance Manager representing the Chief Finance Officer	Michael Cleary	1 out of 2	50%
Chief Operating Officer	Hilary Fordham	2 out of 2	100%
Director of Planning and Performance representing the Chief Finance Officer	Anthony Gardner	2 out of 2	100%
Lead Nurse Quality and Head of Safeguarding representing Chief Executive Nurse	Jane Jones	0 out of 2	0%
Secondary Care Doctor for the Governing Body	Dr Andrew Severn	2 out of 2	100%

Declarations of interest were noted on an annual basis and published on the CCG's website.

Risk Management

Risk Management Arrangements and Effectiveness

During Quarter 1 (Q1) 2022/23, the National Command and Control Structure remained in place. As part of core business requirements, risk reporting continued throughout the quarter to ensure Governing Body continued to receive assurance regarding identification and management of organisational risk alongside the effectiveness of mitigating actions and controls.

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

The reporting format enabled:

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

Formal review of the Assurance Framework was postponed during 2021/22 and Q1 2022/23 due to ongoing pressures resulting from the Covid Pandemic response. This resulted in elevation of the NHS National Emergency level and subsequent impact on the operating environment.

During Q1 2022/23, Executive Committee, Audit Committee and Governing Body members maintained oversight of identified organisational risks and scrutiny of these was reported through formal governance structures, with agreement that the Assurance Framework continued to represent the organisational risk profile. The NHS Morecambe Bay CCG Assurance Framework risks were aligned against the Triple Aim objectives for Bay Health Care and Partners. They also reviewed and signed off the full suite of handover documents to the new ICB to assist with the readiness to operate risk management processes for that organisation.

Capacity to Handle Risk

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

- Director Management Group

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

Additionally, each risk was allocated to a committee / group to oversee the management of the risk. It was the responsibility of the Senior Risk Owner to ensure that the risks were placed on the appropriate meeting agenda for discussion as part of the review process. Executive Leads and Senior Managers continued to review and update the risks to ensure they were reflective of the current position in terms of assurance, mitigating actions and risk movement.

Risk Appetite was measured through the CCG Risk Maturity Matrix and supported each specific CCG committee and groups to address the committee's risk information needs more accurately.

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

Risk Management Methodology

The CCG managed risk within a number of interdependencies and constraints:

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

It was important that the Governing Body understood what the level of risk was being managed and understand the short-term actions, medium- and long-term trajectories that were being worked towards. Assurance was provided to the Governing Body that all risks in relation to the achievement of the CCG Strategic Objectives were identified, monitored and managed appropriately. Quarterly reporting continued during Q1 2022/23.

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

Executive Committee continued to have oversight of the Risk Management process, to ensure the organisation was demonstrating commitment to the continuous improvement of risk management practice by those CCG groups and committees who had key responsibilities for risk mitigation.

The approach provided a simple but comprehensive method for the effective and focused

management of risks that arose in meeting strategic objectives and delivering core operational functions. This also provided a structure for evidencing successful in-year delivery and therefore support the Annual Governance Statement.

Risk assessment

Our approach to risk management encompassed the breadth of the organisation by considering financial, organisational reputational and project risks; both clinical and non-clinical; and for all parts of the organisation involved. Risks were assessed in accordance with our Risk Management Strategy and Procedures. Risks were identified from several sources, including the senior commissioning managers, who held their own risk issues log.

When operational issues could not be managed, or new risks were identified, the Risk Register template was completed, and a risk rating assigned according to the severity and likelihood and any existing controls in place. A decision was then made, initially via the Senior Management Team and nominated responsible Executive Lead, as to the most appropriate course of action for managing the risk. Risks were identified from a variety of sources, including:

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

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

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

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

In accordance with the Risk Management Strategy and Policy, new risks identified for inclusion on the risk register were assessed for their likelihood and consequence using the 5x5 risk matrix. As part of the identification of the risks from various sources. There were no significant risks (i.e. those risks that score 12-plus on the risk matrix) raised on the Assurance Framework or Corporate Risk Register during Q1 2022/23.

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

Examples of where either the target risk has been managed and met over the course of the year or there was another reason for closure.

Reference	Risk Description	Status
RR186	Mitigation of quality variation in the developing Place Based Partnership and Integrated Care Board	Risk duplicative of AF199 - Failure to achieve level of improvement activity required to ensure quality and patient safety is upheld for the population of Morecambe Bay
RR203	Risk of instability in safeguarding arrangements due to significant system wide transition and timelines for implementation.	Closed due to establishment of ICS safeguarding system and robust governance structures.

Risk Management Strategy and Policy

The CCG Risk Management Strategy and Policy reflected processes and ensured that the principles, processes and procedures for best practice risk management were consistent across the organisations and fit for purpose. It outlined our appetite for risk, attitude towards risk, and the culture that underpinned its successful management and delivery. This ensured that both a systematic and consistent approach to managing risk was adopted throughout the organisation.

The current version of the Risk Management Strategy and Policy was available on our website.

The Risk Management Strategy and Policy articulated the foundations that integrated governance and quality processes across the organisation.

Internal Control Framework

A system of internal control was the set of processes and procedures in place to ensure we delivered our policies, aims and objectives. It was designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they have been realised, and to manage them efficiently, effectively and economically.

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

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

They stated how the CCG:

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

This was done by:

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

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

This was achieved by:

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

When below target performance was significant, escalation, explanations and corrective actions were planned and implemented.

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

This was done by:

- Having a Whistleblowing Policy – a confidential reporting process which clearly documented the procedure for staff to report matters of concern, which was regularly updated and communicated to staff.
- Having an annually updated Anti-Fraud, Bribery and Corruption Policy.
- Maintaining an effective internal audit function.
- Having a clear complaints procedure,
- Using complaints and compliments as a positive improvement.

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

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

CCG Closedown and Transition

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

During 2021/22, work was undertaken to ensure organisational risk registers were up to date. At the end of June 2022, the CCG handed over up to date strategic and corporate risk registers to the receiving organisation.

CCG Closedown - Risk Identification and Management

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

The Governance Leads Close Down Group finalised a risk register which reflected the key risks to the programme. Progress against this risk register was overseen by the Governance Leads Close Down Group and any concerns or risks scoring 15 or above, or whereby specific actions required Executive attention, were escalated to the Executive Group for Close Down. Transition Board received monthly risk update reports.

Annual audit of conflicts of interest management

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

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

Third Party Assurances

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

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

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

Delegation of Functions

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

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

Counter Fraud Arrangements

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

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

Control issues

No significant internal control issues had been identified.

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

As covered in the Financial Review, temporary measures introduced as a result of the Covid-19 pandemic relating to the NHS finance regime have been largely lifted, with a return to business as usual arrangements in the main. The exception to this is the continuation of block payment arrangements for the vast majority of NHS providers, which

has helped to stabilise financial risk for all parties.

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

As the block payment arrangements for NHS providers introduced to mitigate the effects of the Covid-19 pandemic continued to operate, there was a recognition at Healthier Lancashire and South Cumbria system level that the scope for delivery of efficiency savings has been severely limited for CCGs. The Quality, Innovation, Productivity and Prevention (QIPP) process was therefore reserved for influenceable spend only, with QIPP savings targets being set for the first quarter of the financial year totalling £2.473m. Achievement against this target proved difficult and additional system growth allocations received from NHSEI were used to cover any shortfalls.

As at 31 March 2022, we have delivered a financial position of breakeven. This has been achieved in part due to the receipt of an additional £3.636m of allocations in month 3. At the start of the financial year, NHS England had indicated that all CCGs would have allocation adjustments to enable a breakeven position at the end of quarter 1, with the consequent surplus or deficit being added to the successor Integrated Care Board position for the remainder of the financial year (so that, in total, the CCGs and Integrated Care Board allocation across the year taken as a whole would total the correct amount). For the 8 CCGs making up the Lancashire and South Cumbria Integrated Care Board, additional allocations totalling £20.618m were required to ensure all CCGs achieved a breakeven position. During the first quarter we have continued to see significant financial pressures against prescribing and high cost packages budgets.

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

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

For the remainder of 2022/23, the Lancashire and South Cumbria Integrated Care Board has again submitted a financial plan for break-even which covers the whole of the financial year. As a result of the demise of the CCGs on 30 June 2022, the plan was split into two parts; quarter 1 related to the CCGs as stand-alone organisations; and quarters 2 to 4 are combined with the other Healthier Lancashire and South Cumbria CCGs which have formed the ICB. This plan meets the investment requirements of the NHS Long Term Plan. There is, however, a significant efficiency programme required to achieve this.

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

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

Capacity to handle risk

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

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

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

Review of effectiveness

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

The Governing Body Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and the Quality Improvement Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- External Audit via their Annual Audit Letter, which provides a high-level summary of audit work carried out
- Regular team meetings
- Reports to Audit Committee by the Local Counter Fraud Specialists
- Information Governance Toolkit submission
- Review of the corporate risk register by the CCG Governing Body and Audit Committee
- Scrutiny of the Assurance Framework by the Audit Committee

- Regular meetings with NHS England Area Team (Quality Surveillance Groups / quarterly checkpoints)
- Attendance at Quality Committee meetings for the main providers of acute, community and mental health services.

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

Data quality

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

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

Business Critical Models

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

Information Governance

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

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

Data security

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

Serious data loss or data security incidents were managed via a Root Cause Analysis investigation process. As an organisation registered with the DSP Toolkit, we were required to report incidents that were categorised as ‘reportable’ through the IG Incident Reporting Tool. Incidents, where appropriate, would have been escalated to organisations

such as Care Quality Commission or NHSEI.

Discharge of statutory functions

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

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

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

Head of Internal Audit Opinion

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

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which can provide assurance, subject to the inherent limitations described below. The outcomes and delivery of the internal audit plan are provided in section 4 of the "Head of Internal Audit Annual Opinion Quarter 1 of 2022/2023". The full document is available on request.

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

Substantial Assurance can be given that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.	

The overall opinion for the period 1 April 2022 to 30 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.

Conclusion

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways outlined above. The Head of Internal Audit has also confirmed that 'there is a generally sound system of internal

control, designed to meet the organisations objectives, and that controls are generally being applied consistently’.

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

Kevin Lavery

Chief Executive Officer

NHS Lancashire and South Cumbria Integrated Care Board

(on behalf of the former NHS Morecambe Bay CCG)

21 June 2023

Remuneration and Staff Report

Remuneration Report

Remuneration Committee Report (not subject to audit)

Members of the Remuneration Committee

Position	Name	Meetings attended
Lay Member and Chair	Mr Clive Unitt	*There were no meetings held up to 30 June 2022.*
Lay Member	Mr Mike Bone	
Lay Member	Ms Hazel Parsons	
Secondary Care Doctor for the Governing Body	Dr Andrew Severn	

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

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

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

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

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

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

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

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

These were staggered in order to maintain a level of continuity and to ensure experience and expertise are retained. These appointments are not subject to termination payments. In order to maintain organisational stability during the 2021/22 and 2022/23 financial years in the lead up to the move to an ICB from 1 July 2022, all Governing Body members had contracts extended to 30 June 2022.

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

Senior Managers' Service Contracts (not subject to audit)

Governing Body members' contract terms

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

Salaries and allowances (subject to audit)

Senior Manager remuneration (including salary and pension entitlements)

Salaries and allowances

Name	Title	Effective dates	Salary (bands of £5,000) £'000	Expense payments (taxable) to the nearest £100 £'00	All pension-related benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
Dr Geoff Jolliffe *see note 3 below	Chair	01/04/2022 – 30/06/2022	15 – 20			15 – 20
Mr Jerry Hawker *see note 2 and 6 below	Chief Officer (seconded from NHS Eastern Cheshire CCG)	01/04/2022 – 30/06/2022	30 – 35			30 – 35
Mr Andrew Harrison *see note 1 below	Chief Finance Officer (seconded from NHS Fylde and Wyre CCG)	01/04/2022 – 30/06/2022	15 – 20			15 - 20
Ms Hilary Fordham	Chief Commissioning Officer	01/04/2022 – 30/06/2022	20 – 25		7.5 – 10	30 – 35
Mrs Margaret Williams	Chief Nurse	01/04/2022 – 30/06/2022	10 – 15			10 – 15
Mr Anthony Gardner	Director of Planning and Performance	01/04/2022 – 30/06/2022	25 – 30	62	5 – 7.5	35 – 40
Dr Andy Knox *see note 3 below	Executive GP	01/04/2022 – 30/06/2022	15 – 20			15 – 20
Dr Jim Hacking	Executive GP	01/04/2022 – 30/06/2022	15 – 20		0 – 2.5	15 – 20
Dr Lauren Dixon *see note 3 below	Executive GP	01/04/2022 – 30/06/2022	15 – 20			15 – 20

Dr Rahul Keith *see note 3 below	Executive GP	01/04/2022 – 30/06/2022	15 – 20			15 – 20
Dr Dimple Sarah Arun *see note 3 below	Executive GP	01/04/2022 – 30/06/2022	5 – 10			5 – 10
Mr Clive Unitt	Lay Member	01/04/2022 – 30/06/2022	0 – 5			0 – 5
Ms Hazel Parsons	Lay Member	01/04/2022 – 30/06/2022	0 – 5			0 – 5
Mr Mike Bone	Lay Member	01/04/2022 – 30/06/2022	0 – 5			0 – 5
Dr Andrew Severn	Secondary Care Doctor	01/04/2022 – 30/06/2022	0 – 5			0 – 5

Notes:

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

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

   Where:

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

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

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

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

Ees cont = employee pension contributions for the financial year.

To adjust PB and LSB for inflation the Consumer Prices Index (CPI) of 3.1% has been used.

8. Full year equivalent salaries are as follows (bands of £5,000):

Dr Geoff Jolliffe	75 - 80
Mr Jerry Hawker	120 - 125
Mr Andrew Harrison	65 - 70
Ms Hilary Fordham	95 - 100
Mrs Margaret Williams	55 - 60
Mr Anthony Gardner	105 - 110
Dr Andy Knox	75 - 80
Dr Jim Hacking	60 - 65
Dr Lauren Dixon	75 - 80
Dr Rahul Keith	75 - 80
Dr Dimple Sarah Arun	25 - 30
Mr Clive Unitt	5 - 10
Ms Hazel Parsons	5 - 10
Mr Mike Bone	5 - 10
Dr Andrew Severn	10 - 15

The following page includes 2021/22 comparative figures:

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

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

Notes:

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

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

   Where:

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

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

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

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

Ees cont = employee pension contributions for the financial year.

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

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

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

Payments to past Directors (subject to audit)

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

Pension benefits (subject to audit)

Pension benefits

Name	Title	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 30 June 2022 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 30 June 2022 (bands of	Cash Equivalent Transfer Value at 1 April 2022 £'000	Cash Equivalent Transfer Value at 30 June 2022 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's contribution to partnership pension £'000
Ms Hilary Fordham	Chief Commissioning Officer	0 – 2.5	0 – 2.5	30 – 35	45 – 50	531	583	10	N/A
Mrs Margaret Williams	Chief Nurse	0 – 2.5	0 – 2.5	0 – 5	0 – 5	0	0	0	N/A
Mr Anthony Gardner	Director of Planning and Performance	0 – 2.5	0 – 2.5	25 – 30	0 – 5	424	463	6	N/A
Dr Jim Hacking	Executive GP	0 – 2.5	0 – 2.5	25 – 30	45 – 50	421	436	2	N/A

Notes:

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

4. Mr Andrew Harrison is on secondment from NHS Fylde and Wyre CCG from 1 August 2020. Mr Andrew Harrison remains on the payroll of NHS Fylde and Wyre CCG.
5. For comparative purposes the CETV figures at 31 March 2022 have been inflated by 3.1%. The real increase in CETV is calculated as follows:

   {CETV at 31/03/2023 – (CETV at 31/03/2022 + 3.1%)} / 365 x 91 - 2022/2023 Employee superannuation contributions

   Where 91 represents the number of days between 1 April 2022 to 30 June 2022.
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 2024 CETV figures.
7. The Clinical Commissioning Group 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 Clinical Commissioning Group has apportioned the movement on a straight line basis to estimate the cash equivalent transfer value at 30 June 2022 (as described in 5. above). This is considered to be a reasonable approximation of the movement in the value of the entitlements during the year.

Cash Equivalent Transfer Values

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

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

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

Real increase in CETV

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

Fair pay disclosure (subject to audit)

Percentage change in remuneration of highest paid member:

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

2022/2023	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid Director	**0.00%**	**0.00%**
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	**0.02%**	**0.00%**

Pay ratio information:

As at 30 June 2022, remuneration ranged from £20,000 - £25,000 (2021/22: £20,000 - £25,000) to £180,000 £185,000 (this is the whole-time equivalent figure, the post holder works 16 hours per week, actual annual salary is £75,000 - £80,000) (2021/22: £180,000 - £185,000 / £25,000 - £30,000).

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

Remuneration of NHS Morecambe Bay CCG's staff is shown in the table below (figures in brackets are for 2021/22):

	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	**£40,057 (£42,121)**	**£53,219 (£53,219)**	**£91,218 (£91,218)**
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	**£40,057 (£42,121)**	**£53,219 (£53,219)**	**£91,218 (£91,218)**

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

The banded remuneration of the highest paid member of the Membership Council / Governing Body in NHS Morecambe Bay CCG in the financial year 2022/23 was £180,000 - £185,000 (this is the whole time equivalent figure, the post holder works 16 hours per week, actual annual salary is £75,000 - £80,000) (2019/20: £180,000 - £185,000/ £55,000 - £60,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table:

2022/23	25th percentile total remuneration ratio	Median total remuneration ratio	75th percentile total remuneration ratio
Total remuneration (£)	**£40,057**	**£53,219**	**£91,218**
Salary component of total remuneration (£)	**£40,057**	**£53,219**	**£91,218**
Pay ratio information	**4.56:1**	**3.43:1**	**2.00:1**

2021/22	25th percentile total remuneration ratio	Median total remuneration ratio	75th percentile total remuneration ratio
Total remuneration (£)	**£42,121**	**£53,219**	**£91,218**
Salary component of total remuneration (£)	**£42,121**	**£53,219**	**£91,218**
Pay ratio information	**4.33:1**	**3.43:1**	**2.00:1**

In 2022/23, no employees received remuneration in excess of the highest paid member of the Membership Council / Governing Body (2021/22: nil).

The salary range for GP Executive members was agreed at the outset of the CCG and was in line with national guidance. Although the extrapolated figure for the highest paid employee is £183,045, these individuals only work part time and therefore actual individual payments are significantly lower.

Off-payroll engagements (not subject to audit)

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

Off-payroll engagements

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

For all off-payroll engagements as of 30 June 2022, for more than £245[(1)] per day:

	Number
Number of existing engagements as of 30 June 2022	**6**
Of which, the number that have existed:	
• **for less than one year at the time of reporting**	**0**
• **for between one and two years at the time of reporting**	**1**
• **for between two and three years at the time of reporting**	**2**
• **for between three and four years at the time of reporting**	**0**
• **for four or more years at the time of reporting**	**3**

Note:

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

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

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

Off-payroll engagements

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

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

	Number
Number of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	**6**
Of which:	
• **Number not subject to off-payroll legislation**	**5**
• **Number subject to off-payroll legislation and determined as in-scope of IR35**	**0**
• **Number subject to off-payroll legislation and determined as out of scope of IR35**	**1**
• **Number of engagements reassessed for compliance or assurance purposes during the year**	**1**
• **Of which: number of engagements that saw a change to IR35 status following review**	**0**

Note:

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

Off-payroll engagements

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

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

	Number
Number of off-payroll engagements of board members, and / or senior officers with significant financial responsibility, during the financial year ***see note 1 below**	**5**
Total number of individuals on payroll and off-payroll that have been deemed "board members and / or senior officials with significant financial responsibility" during the financial year ***see note 2 below**	**10**

Note:

1. The five individuals outlined above are all Executive GPs on the CCG's Governing Body, for whom payments are made to the respective GP practices via the CCG's Payroll. The Tax and National Insurance liabilities for these individuals have therefore been treated correctly.
2. The total figure of 10 above excludes both Mr Jerry Hawker who was on

secondment from NHS Eastern Cheshire CCG in the post of Chief Officer and Mr Andrew Harrison who was on secondment from NHS Fylde and Wyre CCG in the post of Chief Finance Officer.

Related party transactions

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

Better Payment Practice Code (BPPC)

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

Staff Report

Number of senior managers (whole numbers) by band (at 30 June 2022):

Band	Total number
GP Executive	6
GP Lead	10
Very Senior Manager	3
Band 9	1
Band 8d	3
Band 8c	9
Band 8b	5
Band 8a	10
Total	47

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

	Total number	Permanently employed number	Other number	2021/22 total number
Total	67	62	5	72
Costs:	**£'000**	**£'000**	**£'000**	**£'000**
Salaries and	£968	£894	£74	£4,306
Social security	£111	£111	£0	£408
NHS pension cost	£122	£122	£0	£731
Other pension	£0	£0	£0	£0
Apprenticeship	£1	£1	£0	£4
Recoveries in respect of employee benefits	(£4)	(£4)	£0	(£472)
Total costs	£1,198	£1,124	£74	£4,977
Of the above, number of whole time equivalent people engaged on capital projects	0	0	0	0

The reduction in the number of people permanently employed is due to posts not being replaced when becoming vacant as the CCG was moving towards closedown.

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

	Male	Female
Membership Council	15	5
Governing Body	8	4
Very Senior Managers	0	0
CCG (excluding those employed but on Governing Body)	16	52

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

Information about employees

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

Employee consultation

We have a strong ethos of employee engagement, communication and consultation. We have a number of mechanisms through which we communicate and consult with the 83 staff who are directly employed by the CCG (Governing Body, including Lay Members, and other CCG staff). These include regular one-to-ones with individual staff, face-to-face briefings and a twice monthly team briefing session. We operate a wider leadership team where senior managers regularly contribute to and review the CCG's performance and other matters of significance.

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

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

Staff turnover

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

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

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

Trade Union (Facility Time Publication Requirements) Regulations 2017

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

Table 1: Relevant union officials

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

Table 2: Percentage of time spent on facility time

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

Table 3: Percentage of pay bill spent on facility time

First column	Figures
Provide the total cost of facility time	£0
Provide the total pay bill	£1,197,503
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0%

Table 4: Paid trade union activities

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

Employees with a disability

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

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

Sickness absence data

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

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

Sickness absence figures are reported on a calendar year basis i.e. for the 12 months January to December 2022. During this period there were a total of 105 days lost to sickness absence, which equates to an average of 3.0 days per whole time equivalent staff member, with a sickness absence rate of 1.35% (2021/22: 117 days / 1.1 days per whole time equivalent / sickness absence rate 0.49%). Further information on sickness absence is detailed in Note 4.3 to the Annual Accounts.

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

Consultancy expenditure

During this financial year we have spent approximately £2k on external consultancy services (2021/22 - £11k).

Parliamentary Accountability and Audit Report

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

Kevin Lavery

Chief Executive Officer

NHS Lancashire and South Cumbria Integrated Care Board

(on behalf of the former NHS Morecambe Bay CCG)

21 June 2023

INDEPENDENT AUDITOR’S REPORT TO THE MEMBERS OF THE BOARD OF NHS LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD IN RESPECT OF NHS MORECAMBE BAY CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

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

In our opinion the financial statements:

- give a true and fair view of the state of the CCG’s affairs as at 30 June 2022 and of its income and expenditure for the three month period then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 22 June 2022 as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

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

Emphasis of matter – going concern

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

Going concern

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

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

Our conclusions based on this work:

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

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

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

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

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

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

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

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

We also performed procedures including:

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

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

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

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

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

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

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

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

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

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

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

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

Other information in the Annual Report

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

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

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

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

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022/23. We have nothing to report in this respect.

Remuneration and Staff Reports

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

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 57, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the CCG or dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

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

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

Report on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the CCG to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

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

As explained more fully in the statement set out on page 57, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

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

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

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

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

29 June 2023

Data entered below will be used throughout the workbook:

Entity name:	NHS Morecambe Bay Clinical Commissioning Group
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 Morecambe Bay Clinical Commissioning Group - 3 month accounts to 30 June 2022

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NHS Morecambe Bay Clinical Commissioning Group - 3 month accounts to 30 June 2022

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
Income from sale of goods and services	3	(271)	(638)
Other operating income	3	3	(244)
Total operating income		**(268)**	**(882)**
Staff costs	5	1,201	5,449
Purchase of goods and services	6	161,442	643,093
Depreciation and impairment charges	6	-	-
Provision expense	6	-	3,165
Other Operating Expenditure	6	12	200
Total operating expenditure		**162,655**	**651,906**
Net Operating Expenditure		**162,387**	**651,024**
Finance income		-	-
Finance expense		-	-
Net expenditure for the Year		**162,387**	**651,024**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Period		**162,387**	**651,024**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of right-of-use assets		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Net (gain)/loss on assets held for sale		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net (gain)/loss on revaluation of other Financial Assets		-	-
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Total other comprehensive net expenditure		**-**	**-**
Comprehensive Expenditure for the Financial Period		**162,387**	**651,024**

NHS Morecambe Bay Clinical Commissioning Group - 3 month accounts to 30 June 2022

Statement of Financial Position as at 30 June 2022

	Note	**3 month period end to 30 June 2022**	Full year accounts 2021-22
		£'000	£'000
Non-current assets:			
Property, plant and equipment	9	-	-
Trade and other receivables	11	-	-
Total non-current assets		-	-
Current assets:			
Inventories	10	389	405
Trade and other receivables	11	539	6,133
Cash and cash equivalents	12	602	61
Total current assets		**1,530**	6,599
Total current assets		**1,530**	6,599
Total assets		**1,530**	6,599
Current liabilities			
Trade and other payables	13	(24,226)	(37,385)
Provisions	14	(3,165)	(3,165)
Total current liabilities		**(27,391)**	(40,550)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(25,860)**	(33,951)
Non-current liabilities			
Trade and other payables	13	-	-
Provisions	14	-	-
Total non-current liabilities		-	-
Assets less Liabilities		**(25,860)**	(33,951)
Financed by Taxpayers' Equity			
General fund		(25,860)	(33,951)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(25,860)**	(33,951)

The notes on pages 115 to 145 form part of this statement

The financial statements on pages 111 to 145 were approved by the Board of NHS Lancashire and South Cumbria Integrated Care Board (as successor to NHS Morecambe Bay Clinical Commissioning Group) on 21 June 2023 and signed on its behalf by:

Chief Executive Officer
Kevin Lavery

NHS Morecambe Bay Clinical Commissioning Group - 3 month accounts to 30 June 2022

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

Changes in taxpayers' equity for 3 month period end to 30 June 2022	**General fund £'000**	**Revaluation reserve £'000**	**Other reserves £'000**	**Total reserves £'000**
Balance at 01 April 2022	(33,951)	0	0	**(33,951)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 30 June 2022	**(33,951)**	**0**	**0**	**(33,951)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 3 month period end to 30 June 2022				
Total transition adjustment for initial application of IFRS 16	0	0	0	**0**
Net operating expenditure for the financial period	(162,386)	0	0	**(162,386)**
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	**0**
Net gain/(loss) on revaluation of right-of-use assets	0	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	0	**0**
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(162,386)**	**0**	**0**	**(162,386)**
Net funding	170,477	0	0	**170,477**
Balance at 30 June 2022	**(25,860)**	**0**	**0**	**(25,860)**

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

The notes on pages 115 to 145 form part of this statement.

NHS Morecambe Bay Clinical Commissioning Group - 3 month accounts to 30 June 2022

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 period		(162,386)	(651,024)
Depreciation and amortisation	6	0	0
Impairments and reversals	6	0	0
Non-cash movements arising on application of new accounting standards		0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		16	(58)
(Increase)/decrease in trade & other receivables	11	5,593	(4,770)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	13	(13,159)	4,061
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	14	0	0
Increase/(decrease) in provisions	14	0	3,165
Net Cash Inflow (Outflow) from Operating Activities		**(169,936)**	(648,626)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Non-cash movements arising on application of new accounting standards		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(169,936)**	(648,626)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		170,477	648,674
Other loans received		0	0
Other loans repaid		0	0
Repayment of lease liabilities		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**170,477**	648,674
Net Increase (Decrease) in Cash & Cash Equivalents	12	**541**	47
Cash & Cash Equivalents at the Beginning of the Financial Year		**61**	13
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**602**	61

The notes on pages 115 to 145 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

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

1.1 **Going Concern**

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

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

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

Where a NHS Clinical Commissioning Group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern. If services will continue to be provided the financial statements are prepared on the going concern basis. As the NHS Clinical Commissioning Group's functions will continue to be delivered by the ICB, the CCG has therefore assessed that it remains a going concern as at 30 June 2022.

1.2 **Accounting Convention**

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

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

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

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

1.4 **Subsidiaries**

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

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

1.5 **Associates**

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

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

1.6 **Joint arrangements**

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

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

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

1.7 **Pooled Budgets**

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

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

1.8 **Operating Segments**

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

Notes to the financial statements

1.9 **Revenue**

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

1.10 **Employee Benefits**

1.10.1 **Short-term Employee Benefits**

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

1.10.2 **Retirement Benefit Costs**

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

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

1.11 **Other Expenses**

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

1.12 **Grants Payable**

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

1.13 **Property, Plant & Equipment**

1.13.1 **Recognition**

Property, plant and equipment is capitalised if:
· It is held for use in delivering services or for administrative purposes;
· It is probable that future economic benefits will flow to, or service potential will be supplied to the NHS Clinical Commissioning Group;
· It is expected to be used for more than one financial year;
· The cost of the item can be measured reliably; and,
· The item has a cost of at least £5,000; or,
· Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
· Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.
Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.13.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
· Land and non-specialised buildings – market value for existing use; and,
· Specialised buildings – depreciated replacement cost.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.13.3 **Subsequent Expenditure**

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

Notes to the financial statements

1.14 **Intangible Assets**

1.14.1 **Recognition**

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

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

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

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

1.14.2 **Measurement**

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

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

1.14.3 **Depreciation, Amortisation & Impairments**

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

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

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

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

1.15 **Donated Assets**

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

1.16 **Government grant funded assets**

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

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

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

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

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

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

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

Notes to the financial statements

1.18 **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 NHS Clinical Commissioning Group assesses whether a contract is or contains a lease, at inception of the contract.

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

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

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

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

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

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

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases
When the group is an intermediate lessor, it accounts for the head lease and the sub-lease as two separate contracts. The sub-lease classification is assessed with reference to the right-of-use asset arising from the head lease.
Amounts due from lessees under finance leases are recognised as receivables at the amount of the group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the net investment in the lease.
Rental income from operating leases is recognised on a straight-line basis over the term of the relevant lease.

1.19 **Private Finance Initiative Transactions**

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the NHS Clinical Commissioning Group. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.
The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
• payment for the fair value of services received
• repayment of the finance lease liability, including finance costs, and
• payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.19.1 **Services Received**

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

1.19.2 **PFI Asset**

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

1.19.3 **PFI Liability**

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.
An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.
The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.
An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

1.19.4 **Lifecycle Replacement**

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Clinical Commissioning Group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.
The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.
Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.19.5 **Assets Contributed by the NHS Clinical Commissioning Group to the Operator For Use in the Scheme**
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Clinical Commissioning Group's Statement of Financial Position.

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

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

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

1.22 **Provisions**
Provisions are recognised when the NHS Clinical Commissioning Group has a present legal or constructive obligation as a result of a past event, it is probable that the NHS Clinical Commissioning Group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.47% (2021-22: 0.47% for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.70% (2021-22: 0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 0.95% (2021-22 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 0.66% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.
When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the NHS Clinical Commissioning Group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

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

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

1.25 **Carbon Reduction Commitment Scheme**
The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO_2 emissions. The NHS Clinical Commissioning Group is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO_2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO_2 emissions are made.
The carrying amount of the liability at the financial year end will therefore reflect the CO_2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.
The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.
Allowances acquired under the scheme are recognised as intangible assets.

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

1.27 **Financial Assets**
Financial assets are recognised when the NHS Clinical Commissioning Group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:
· Financial assets at amortised cost;
· Financial assets at fair value through other comprehensive income and ;
· Financial assets at fair value through profit and loss.
The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

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

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

Notes to the financial statements

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

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

1.27.4 **Impairment**

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

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

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

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

1.28 **Financial Liabilities**

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

1.28.1 **Financial Guarantee Contract Liabilities**

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

· The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,

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

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

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

1.28.3 **Other Financial Liabilities**

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

1.29 **Value Added Tax**

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

1.30 **Foreign Currencies**

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

1.31 **Third Party Assets**

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

1.32 **Losses & Special Payments**

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

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

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

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

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

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

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

1.33.2 **Sources of estimation uncertainty**

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

- There are a number of accruals within the Statement of Financial Position where estimation techniques are applied. This is because the outturn information is not available at the time of preparation of the financial statements. Examples of significant accruals involving estimates are; prescribing costs.
- The NHS Clinical Commissioning Group has discontinued its adjusted method for calculating the year end accrual for prescribing expenditure, first introduced in 2019/2020, to take account of items prescribed in June 2022 but which will be consumed in July 2022.
- Community Equipment Store inventory continued to be recognised in the accounts for the three months to 30 June 2023.

1.34 **Gifts**

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

Notes to the financial statements

1.35 **Adoption of new standards**

On 1 April 2022, the NHS 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 NHS 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.

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

Operating lease commitments at 31 March 2022	1,194
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	(11)
Operating lease commitments discounted used weighted average IBR	1,183
Add: Finance lease liabilities at 31 March 2022	0
Add: Residual value guarantees	0
Add: Rentals associated with extension options reasonably certain to be exercised	0
Less: Short term leases (including those with <12 months at application date)	(1,183)
Less: Low value leases	0
Less: Variable payments not included in the valuation of the lease liabilities	0
Lease liability at 1 April 2022	**(0)**

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. 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	162,655	162,655	649,806	651,906
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	162,387	162,387	648,924	651,024
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	1,661	1,661	6,567	6,561

Throughout the quarter, a significant level of financial risk was reported to the Governing Body, along with notification of significant amounts of additional allocation received from NHS England and Improvement. This financial position was, therefore, achieved following a series of non-recurrent mitigations, including the receipt of additional allocations.

3. Other Operating Revenue

	3 month period end to 30 June 2022 Total	Full year accounts 2021-22 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	-	20
Non-patient care services to other bodies	-	-
Patient transport services	-	-
Prescription fees and charges	-	-
Dental fees and charges	-	-
Income generation	-	-
Other Contract income	267	146
Recoveries in respect of employee benefits	4	472
Total Income from sale of goods and services	**271**	**638**
Other operating income		
Rental revenue from finance leases	-	-
Rental revenue from operating leases	-	-
Charitable and other contributions to revenue expenditure: NHS	-	-
Charitable and other contributions to revenue expenditure: non-NHS	-	-
Receipt of donations (capital/cash)	-	-
Receipt of Government grants for capital acquisitions	-	-
Continuing Health Care risk pool contributions	-	-
Non cash apprenticeship training grants revenue	-	-
Other non contract revenue	(3)	244
Total Other operating income	**(3)**	**244**
Total Operating Income	**268**	**882**

Other contract income relates to income from; NHS East Lancashire CCG in respect of the Clinical Commissioning Group's share of FTA monies (£253k); and recharges of specialist childrens equipment to Lancashire County Council (£14k).
Recoveries in respect of employee benefits relates to reimbursement of salary costs for staff seconded to; NHS Fylde and Wyre, NHS Blackpool and NHS West Lancashire Clinical Commissioning Groups.
Other non contract revenue relates to a reversed accrual from 2021-22.

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

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue								
NHS	-	-	-	-	-	-	254	4
Non NHS	-	-	-	-	-	-	13	-
Total	**-**	**-**	**-**	**-**	**-**	**-**	**267**	**4**

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue								
Point in time	-	-	-	-	-	-	267	4
Over time	-	-	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**	**267**	**4**

4.1 Disaggregation of Income - Income from sale of good and services (contracts) - 2021-22 comparators

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

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

5. Employee benefits and staff numbers

5.1.1 Employee benefits	**Total**		**3 month period end to 30 June 2022**
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**894**	**74**	**968**
Social security costs	**111**	**0**	**111**
Employer Contributions to NHS Pension scheme	**122**	**0**	**122**
Other pension costs	**0**	**0**	**0**
Apprenticeship Levy	**1**	**0**	**1**
Other post-employment benefits	**0**	**0**	**0**
Other employment benefits	**0**	**0**	**0**
Termination benefits	**0**	**0**	**0**
Gross employee benefits expenditure	1,128	74	1,202
Less recoveries in respect of employee benefits (note 4.1.2)	**(4)**	**0**	**(4)**
Total - Net admin employee benefits including capitalised costs	1,124	74	1,198
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	1,124	74	1,198

5.1.1 Employee benefits	Total		Full year accounts 2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**3,689**	**617**	4,306
Social security costs	**408**	**0**	408
Employer Contributions to NHS Pension scheme	**731**	**0**	731
Other pension costs	**0**	**0**	0
Apprenticeship Levy	**4**	**0**	**4**
Other post-employment benefits	**0**	**0**	**0**
Other employment benefits	**0**	**0**	**0**
Termination benefits	**0**	**0**	**0**
Gross employee benefits expenditure	4,832	617	5,449
Less recoveries in respect of employee benefits (note 4.1.2)	**(472)**	**0**	**(472)**
Total - Net admin employee benefits including capitalised costs	4,360	617	4,977
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	4,360	617	4,977

5.1.2 Recoveries in respect of employee benefits			**3 month period end to 30 June 2022**	Full year accounts 2021-22
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Total £'000
Employee Benefits - Revenue				
Salaries and wages	**(4)**	**0**	**(4)**	**(472)**
Social security costs	**0**	**0**	**0**	**0**
Employer contributions to the NHS Pension Scheme	**0**	**0**	**0**	**0**
Other pension costs	**0**	**0**	**0**	**0**
Other post-employment benefits	**0**	**0**	**0**	**0**
Other employment benefits	**0**	**0**	**0**	**0**
Termination benefits	**0**	**0**	**0**	**0**
Total recoveries in respect of employee benefits	(4)	0	(4)	(472)

5.2 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	**62.25**	**5.27**	**67.52**	**64.68**	**7.07**	**71.75**

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

5.3 Exit packages agreed in the financial year

The NHS Clinical Commissioning Group agreed no exit packages during the threeee month period end to 30 June 2022.

5.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.
In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

5.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 30 June 2022, is based on valuation data as 31 March 2021, 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, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

5.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.
The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.
The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.
HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

6. Operating expenses

	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	1,069	4,417
Services from foundation trusts	97,785	380,400
Services from other NHS trusts	6,471	24,298
Provider Sustainability Fund	-	-
Services from Other WGA bodies	1	5
Purchase of healthcare from non-NHS bodies	23,404	93,297
Purchase of social care	3,566	16,606
General Dental services and personal dental services	-	-
Prescribing costs	13,466	58,063
Pharmaceutical services	-	-
General Ophthalmic services	20	88
GPMS/APMS and PCTMS	15,763	62,058
Supplies and services – clinical	24	308
Supplies and services – general	79	179
Consultancy services	2	11
Establishment	551	1,308
Transport	15	25
Premises	(837)	1,739
Audit fees	66	80
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	(12)	12
Other professional fees	(18)	93
Legal fees	26	101
Education, training and conferences	1	7
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Non cash apprenticeship training grants	-	-
Total Purchase of goods and services	**161,442**	**643,095**
Depreciation and impairment charges		
Depreciation	-	-
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of right-of-use assets	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets	-	-
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**-**	**-**
Provision expense		
Change in discount rate	-	-
Provisions	-	3,165
Total Provision expense	**-**	**3,165**
Other Operating Expenditure		
Chair and Non Executive Members	10	39
Grants to Other bodies	-	-
Clinical negligence	-	-
Research and development (excluding staff costs)	-	20
Expected credit loss on receivables	-	-
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Other expenditure	2	141
Total Other Operating Expenditure	**12**	**200**
Total operating expenditure	**161,454**	**646,460**

Notes:

The Clinical Commissioning Group's contract with its external auditors (KPMG LLP) provides for a limitation of the auditor's liability, this is limited at £1m.

The negative balance of -£837k against Premises relates to the reversal of an accrual input at the end of the 2021-22 financial year for which no expenditure was actually incurred. This was reported as an unadjusted audit item in the NHS Clinical Commissioning Group's accounts for 2021-22.

NHS Morecambe Bay Clinical Commissioning Group - 3 month accounts to 30 June 2022

7.1 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	9,554	57,241	34,169	189,828
Total Non-NHS Trade Invoices paid within target	9,547	57,161	34,153	188,770
Percentage of Non-NHS Trade invoices paid within target	**99.93%**	**99.86%**	**99.95%**	**99.44%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	254	107,097	478	410,701
Total NHS Trade Invoices Paid within target	254	107,097	478	410,701
Percentage of NHS Trade Invoices paid within target	**100.00%**	**100.00%**	**100.00%**	**100.00%**

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

The NHS Clinical Commissioning Group made no payments under the Late Payment of Commercial Debts (Interest) Act 1998 during the 3 month period end to 30 June 2022.

8. Property, plant and equipment

3 month period end to 30 June 2022	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2022	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Cost/Valuation at 30 June 2022	-	-	-	-	-	-	-	-	-
Depreciation 01 April 2022	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-	-	-	-
Depreciation at 30 June 2022	-	-	-	-	-	-	-	-	-
Net Book Value at 30 June 2022	-	-	-	-	-	-	-	-	-
Purchased	-	-	-	-	-	-	-	-	-
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 30 June 2022	-	-	-	-	-	-	-	-	-
Asset financing:									
Owned	-	-	-	-	-	-	-	-	-
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 30 June 2022	-	-	-	-	-	-	-	-	-

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2022	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
Balance at 30 June 2022	-	-	-	-	-	-	-	-	-

8.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	2	5
Furniture & fittings	5	10

NHS Morecambe Bay Clinical Commissioning Group - 3 month accounts to 30 June 2022

9a. Leases

9a.1 Right-of-use assets

3 month period end to 30 June 2022	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2022	-	-	-	-	-	-	-	-	-
IFRS 16 Transition Adjustment	-	-	-	-	-	-	-	-	-
Addition of assets under construction and payments on account				-					-
Additions	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Lease remeasurement	-	-	-	-	-	-	-	-	-
Modifications	-	-	-	-	-	-	-	-	-
Disposals on expiry of lease term	-	-	-	-	-	-	-	-	-
Derecognition for early terminations	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-
Cost/Valuation at 30 June 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Depreciation 01 April 2022	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Disposals on expiry of lease term	-	-	-	-	-	-	-	-	-
Derecognition for early terminations	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body									
Depreciation at 30 June 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net Book Value at 30 June 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Revaluation Reserve Balance for right-of-use assets

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2022	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
Balance at 30 June 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

9a. Leases cont'd

9a.2 Lease liabilities

3 month period end to 30 June 2022	**3 month period end to 30 June 2022 £'000**	Full year accounts 2021-22 £'000
Lease liabilities at 01 April 2022	-	-
IFRS 16 Transition Adjustment	-	-
Addition of Assets under Construction & Payments on Account	-	-
Additions purchased	-	-
Reclassifications	-	-
Interest expense relating to lease liabilities	-	-
Repayment of lease liabilities (including interest)	-	-
Lease remeasurement	-	-
Modifications	-	-
Disposals on expiry of lease term	-	-
Derecognition for early terminations	-	-
Transfer (to) from other public sector body	-	-
Other	-	-
Lease liabilities at 30 June 2022	**-**	-

9a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	3 month period end to 30 June 2022 £'000	Full year accounts 2021-22 £'000
Within one year	-	-
Between one and five years	-	-
After five years	-	-
Balance at 30 June 2022	**-**	**-**
Effect of discounting	-	-
Included in:		
Current lease liabilities	-	-
Non-current lease liabilities	-	-
Balance at 30 June 2022	**-**	**-**

9a. Leases cont'd

9a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

3 month period end to 30 June 2022	**3 month period end to 30 June 2022 £'000**	Full year accounts 2021-22 £'000
Depreciation expense on right-of-use assets	-	-
Interest expense on lease liabilities	-	-
Expense relating to short-term leases	-	-
Expense relating to leases of low value assets	-	-
Expense relating to variable lease payments not included in the measurement of the lease liability	-	-
Income from sub-leasing right-of-use assets	-	-
Gain/(loss) from sale and leaseback transactions	-	-
Gain/(loss) resulting from COVID-19 related rent concessions	-	-

13a.5 Amounts recognised in Statement of Cash Flows

	3 month period end to 30 June 2022 £'000	Full year accounts 2021-22 £'000
Total cash outflow on leases under IFRS 16	-	-
Total cash outflow for lease payments not included within the measurement of lease liabilities	-	-
Total cash inflows from sale and leaseback transactions	-	-

9a. Leases cont'd

9a.6 Revaluation

	3 month period end to 30 June 2022 £'000	Full year accounts 2021-22 £'000
The major constituents of the upward revaluation are as follows:-		
Previously charged to the Statement of Comprehensive Net Expenditure and now reversed:		
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
Other [balancing figure to get to annual total]	-	-
Total	**-**	**-**
Credited to the Revaluation Reserve:		
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
Other [balancing figure to get to annual total]	-	-
Total	**-**	**-**
The major constituents of the downward revaluation are as follows		
Charged to the Statement of Comprehensive Net Expenditure:		
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
Other [balancing figure to get to annual total]	-	-
Total	**-**	**-**
Charged to the Revaluation Reserve:		
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
[Detail major items]	-	-
Other [balancing figure to get to annual total]	-	-
Total	**-**	**-**

NHS Morecambe Bay Clinical Commissioning Group - 3 month accounts to 30 June 2022

10. Inventories

	Drugs	Consumables	Energy	Work in Progress	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 01 April 2022	-	-	-	-	405	-	**405**
Additions	-	-	-	-	(16)	-	**(16)**
Inventories recognised as an expense in the period	-	-	-	-	-	-	**-**
Write-down of inventories (including losses)	-	-	-	-	-	-	**-**
Reversal of write-down previously taken to the statement of comprehensive net expenditure	-	-	-	-	-	-	**-**
Transfer (to) from -Goods for resale	-	-	-	-	-	-	**-**
Balance at 30 June 2022	**-**	**-**	**-**	**-**	**389**	**-**	**389**

11.1 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	22	-	1,924	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	-	-	-	-
NHS accrued income	22	-	3,272	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	220	-	582	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	142	-	134	-
Non-NHS and Other WGA accrued income	100	-	219	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	-	-	-	-
VAT	33	-	2	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	-	-	-	-
Total Trade & other receivables	**539**	**-**	**6,133**	**-**
Total current and non current	**539**		**6,133**	
Included above:				
Prepaid pensions contributions	-		-	

The great majority of trade is with NHS England and Improvement. As NHS England and Improvement is funded by Government to provide funding to NHS Clinical Commissioning Groups to commission services, no credit scoring of them is considered necessary.

11.2 Receivables past their due date but not impaired

	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	-	39	1,924	444
By three to six months	37	88	-	37
By more than six months	4	11	-	77
Total	**41**	**138**	**1,924**	**558**

The NHS Clinical Commissioning Group did not hold any collateral against receivables outstanding at 30 June 2022.

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12. Cash and cash equivalents

	3 month period end to 30 June 2022	Full year accounts 2021-22
	£'000	£'000
Balance at 01 April 2022	61	13
Net change in year	541	48
Balance at 30 June 2022	**602**	**61**
Made up of:		
Cash with the Government Banking Service	602	61
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**602**	**61**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 30 June 2022	**602**	**61**

13. 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
Interest payable	-	-	-	-
NHS payables: Revenue	3,088	-	4,869	-
NHS payables: Capital	-	-	-	-
NHS accruals	1,616	-	909	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	5,530	-	9,514	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	11,169	-	19,984	-
Non-NHS and Other WGA deferred income	-	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	61	-	59	-
VAT	-	-	-	-
Tax	54	-	56	-
Payments received on account	-	-	-	-
Other payables and accruals	2,707	-	1,995	-
Total Trade & Other Payables	**24,225**	**-**	**37,386**	**-**
Total current and non-current	**24,225**		**37,386**	

Other payables include £469k outstanding pension contributions at 30 June 2022 (31 March 2022: £682k).

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14. 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
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	-	-
Continuing care	3,165	-	3,165	-
Other	-	-	-	-
Total	**3,165**	**-**	**3,165**	**-**
Total current and non-current	**3,165**		**3,165**	

	Pensions Relating to Former Directors £'000	Pensions Relating to Other Staff £'000	Restructuring £'000	Redundancy £'000	Agenda for Change £'000	Equal Pay £'000	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**3,165**	**-**	**3,165**
Arising during the year	-	-	-	-	-	-	-	-	-	**-**
Utilised during the year	-	-	-	-	-	-	-	-	-	**-**
Reversed unused	-	-	-	-	-	-	-	-	-	**-**
Unwinding of discount	-	-	-	-	-	-	-	-	-	**-**
Change in discount rate	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	-	-	-	-	-	**-**
Balance at 30 June 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**3,165**	**-**	**3,165**
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	-	3,165	-	**3,165**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 30 June 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**3,165**	**-**	**3,165**

The Continuing care provision has arisen from claims by Lancashire County Council and Cumbria County Council in respect of CHC packages of care which the Local Authorities have paid for but for which the individual patients did not have an assessment within the 28 day timescale specified in the national CHC Framework. Whilst in principle the NHS Clinical Commissioning Group accepts liability for the issue and acknowledges a failure to follow the guidance on timescales for assessments, the interpretation of some aspects of the guidance is being discussed with the Local Authorities and therefore it has not been possible to transact a financial remedy prior to the end of the 3 month period end to 30 June 2022. The NHS Clinical Commissioning Group has therefore adopted a prudent approach and based the provision on case lists and estimated costs provided by the Local Authorities. It is anticipated that this issue will be resolved some time in the 2022-23 financial year.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the NHS Clinical Commissioning Group. However the legal liability remains with the NHS Clinical Commissioning Group. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of the NHS Clinical Commissioning Group as at 30 June 2022 is £0.

15. Contingencies

The NHS Clinical Commissioning Group had no contingent liabilities as at 31 March 2022. Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the NHS Clinical Commissioning Group. However the legal liability remains with the NHS Clinical Commissioning Group. The total value of legacy NHS Continuing Healthcare contingent liabilities accounted for by NHS England on behalf of the NHS Clinical Commissioning Group as at 30 June 2022 is £0.

16. Financial instruments

16.1 Financial risk management

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

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

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

16.1.1 Currency risk

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

16.1.2 Interest rate risk

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

16.1.3 Credit risk

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

16.1.4 Liquidity risk

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

16.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

16. Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost 3 month period end to 30 June 2022 £'000	Equity Instruments designated at FVOCI 3 month period end to 30 June 2022 £'000	Total 3 month period end to 30 June 2022 £'000
Equity investment in group bodies	-	-	-
Equity investment in external bodies	-	-	-
Loans receivable with group bodies	-	-	-
Loans receivable with external bodies	-	-	-
Trade and other receivables with NHSE bodies	22	-	22
Trade and other receivables with other DHSC group bodies	104	-	104
Trade and other receivables with external bodies	238	-	238
Other financial assets	-	-	-
Cash and cash equivalents	602	-	602
Total at 30 June 2022	**966**	**-**	**966**

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost 3 month period end to 30 June 2022 £'000	Other 3 month period end to 30 June 2022 £'000	Total 3 month period end to 30 June 2022 £'000
Loans with group bodies	-	-	**-**
Loans with external bodies	-	-	**-**
Trade and other payables with NHSE bodies	688	-	**688**
Trade and other payables with other DHSC group bodies	4,161	-	**4,161**
Trade and other payables with external bodies	19,260	-	**19,260**
Other financial liabilities	-	-	**-**
Private Finance Initiative and finance lease obligations	-	-	**-**
Total at 30 June 2022	**24,109**	**-**	**24,109**

17. Operating segments

The NHS Clinical Commissioning Group considers that it has only one segment; commissioning of healthcare services.

NHS Morecambe Bay Clinical Commissioning Group - 3 month accounts to 30 June 2022

18. Joint arrangements - interests in joint operations

CCGs should disclose information in relation to joint arangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

18.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	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			
			Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Lancashire County Council Better Care Fund/iBCF	Lancashire County Council, Morecambe Bay CCG, Fylde & Wyre CCG, Chorley and South Ribble CCG, Greater Preston CCG, East Lancashire CCG, West Lancashire CCG	Better Care Fund services	0	0	2,444	(3,624)	0	0	7,610	(11,412)
Cumbria County Council Better Care Fund/iBCF	Cumbria County Council, Morecambe Bay CCG	Better Care Fund services	0	0	0	(2,469)	0	0	0	(9,415)

19. Related party transactions

The NHS Clinical Commissioning Group's Governing Body Members were asked to disclose any material transactions that they or their family (or any business that they own or control) have had with any local health-related body during the 3 month period end to 30 June 2022.

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr G Jolliffe (CCG Clinical Chair) ***see note above:**				
- GP employee, Cumbria Health On Call (CHOC)	957	0	0	0
- Spouse is employed as HCA at Risedale Surgery	268	0	0	0
- Daughter is employed in Pharmacy at University Hospitals of Morecambe Bay NHS Foundation Trust	73,728	0	507	0
Dr A Knox (Governing Body GP Member) ***see note above:**				
- GP Partner, Ash Trees Surgery	1,064	0	0	0
Dr J Hacking (Governing Body GP Member) ***see note above:**				
- GP Partner, Park View Surgery, Milnthorpe	218	0	0	0
- Member of Morecambe Bay Primary Care Collaborative	0	0	0	0
- Spouse is a Biomedical Scientist employed by University Hospitals of Morecambe Bay NHS Foundation Trust	73,728	0	507	0
Dr L Dixon (Governing Body GP Member) ***see note above:**				
- GP Partner, Bridgegate Medical Centre	384	0	0	0
Dr R Keith (Governing Body GP Member) ***see note above:**				
- GP Partner, Lancaster Medical Practice	2,492	0	0	0
- Shareholder of Morecambe Bay Primary Care Collaborative	0	0	0	0
Dr S Arun (Governing Body GP Member) ***see note above:**				
- GP Principle, Norwood Medical Centre	354	0	0	0
- Spouse is a GP at Abbey Road Surgery	248	0	0	0
- Spouse is Chief Executive Officer for Morecambe Bay Primary Care Collaborative	0	0	0	0
Mr J Hawker (Chief Officer 01/09/2018 - 31/03/2019) ***see note above:**				
- Spouse is the Director of Commissioning for NHS Wirral CCG	0	0	0	0
Mr A Harrison (Chief Finance Officer 01/08/2020 - 31/03/2021) ***see note above:**				
- Chief Finance Officer, NHS Blackpool Clinical Commissioning Group	60	0	30	(8)
- Chief Finance Officer, NHS Fylde and Wyre Clinical Commissioning Group	90	0	0	(9)

The Department of Health and Social Care is regarded as a related party. During the year the NHS Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department, including:

University Hospitals of Morecambe Bay NHS Foundation Trust	73,728	0	507	0
Lancashire & South Cumbria NHS Foundation Trust	11,631	0	1,919	(22)
Blackpool Teaching Hospitals NHS Foundation Trust	1,134	0	13	0
North West Ambulance Services NHS Trust	5,772	0	40	0
Wrightington, Wigan and Leigh NHS Foundation Trust	783	0	5	0
Manchester University NHS Foundation Trust	800	0	6	0
Lancashire Teaching Hospitals NHS Foundation Trust	3,399	0	31	0
Mersey Care NHS Foundation Trust	79	0	1	0
East Lancashire Hospitals NHS Trust	306	0	2	0
North Cumbria Integrated Care NHS Foundation Trust	908	0	825	0

In addition, the NHS Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies, including:

Lancashire County Council	1,768	(2,458)	1,313	(35)
Cumbria County Council	45	0	2,705	(68)

20. Events after the end of the reporting period

The Clinical Commissioning Group did not have any events after the end of the reporting period to disclose that would have a material effect on the statements as at June 2022.
The Health and Care Act received Royal Assent on 28 April 2022. The Act confirmed the establishment of Integrated Care Boards across England. As a result of this, the Clinical Commissioning Group was wound up on 30 June 2022 and the NHS Lancashire and South Cumbria Integrated Care Board was formed on 1 July 2022. As explained in Note 1, the Clinical Commissioning Group's accounts were still prepared on a going concern basis due to the continued provision of its commissioning functions by the NHS Lancashire and South Cumbria Integrated Care Board.

21. Losses and special payments

21.1 Losses

The NHS Clinical Commissioning Group had no losses cases during the 3 month period end to 30 June 2022 (2021-22: £nil).

21.2 Special payments

The NHS Clinical Commissioning Group made no special payments during the 3 month period end to 30 June 2022 (2021-22: 1 / £nil).