NHS
North East Lincolnshire
Clinical Commissioning Group

Annual Report and Accounts

1 APRIL 2022 - 30 JUNE 2022

Formal sign-off of this Annual Report and Accounts is by Stephen Eames as Chief Executive of the Humber and North Yorkshire Integrated Care Board, the legal entity that has replaced the NHS North East Lincolnshire Clinical Commissioning Group (CCG). However, the content of the report covers and has been written by the responsible officers at the time the CCG existed.

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Overview

Welcome to the Annual Report and Accounts of NHS North East Lincolnshire Clinical Commissioning Group (CCG) for April-June 2022.

NHS organisations like North East Lincolnshire Clinical Commissioning Group (NEL CCG) have a duty to keep the public up to date with their activities by publishing an annual report and financial accounts at the end of each financial year. This report covers the period from the beginning of the financial year until the CCG's disestablishment on 1 July 2022.

The purpose of this section is to describe our responsibilities as commissioners and set out our activities in the three months since our Annual Report and Accounts for 2021/2022 and the transition to new health and care arrangements in England as a result of the Health and Care Act 2022.

Reducing the impact our organisation has on our environment is extremely important to us and we no longer routinely produce large, printed documents like the annual report and accounts. However, a printed copy will be provided on request. The information contained in the report will also be made available in other languages and in different formats such as audio, large print and Braille if needed.

For more information or to ask us for a copy of the report in a format you find more suitable to access please contact us at the address at the end of this section.

Who are we and what do we do?

CCGs, which ceased to exist after the date this report covers, are made up of GPs, other people who are employed in health or care and members of the public who do not work for the NHS. Their role is to look at what health and care support the local population needs and plan and buy those services.

Our CCG is led by GPs representing 24 practices who provide health services to families living in Grimsby, Cleethorpes, Immingham and rural North East Lincolnshire, supported by a team of non-clinical staff who carry out the day-to-day running of the organisation. We are accountable to our members, patients and our local communities and are overseen by NHS England and NHS Improvement, a single organisation that supports the NHS and helps us to improve care for patients.

CCGs are allocated a sum of money to spend on health services each year based on the overall health and wellbeing needs of the (just under) 160,000 people who live in our area. This money has to pay for a wide range of services. These are services such as life-saving emergency care, the treatment of acute physical and mental illnesses, routine family health care and managing long term health difficulties such as dementia, heart and breathing problems, diabetes, and their complications.

Our CCG is unique in England because we also commission care services for adults who need practical support due to illness, disability, or old age (Adult Social Care). The CCG receives funds from North East Lincolnshire Council (NELC) to pay for Adult Social Care.

The range of NHS services commissioned for our population is set out in the Health and Social Care Act 2012. The CCG and council have a strong and established partnership, the governance of which is underpinned by a s75 agreement, a statutory provision that governs arrangements between NHS organisations and local authorities allowing them to operate pooled budgets at a local level, as well as Integrated Commissioning arrangements.

These arrangements have enabled us to take a lead on making sure people in North East Lincolnshire benefit from services that are as joined-up as possible and take their needs as an individual into account. In 2018, the CCG moved into the Municipal offices. This was more than just an office move. This was about sharing working environments and facilities with not only different teams internally, but with people who have a different organisation on their payslip. This was embraced with enthusiasm and was an important step towards the CCG and Council working as a genuine "Union", focused together on our place and the people who live and work here.

The Union with NELC is part of the CCG's proud history of successful integrated working – integrated working with partner organisations, the VCSE sector and, importantly, with our communities. NEL CCG has created a legacy for the Borough. The national mandate contained in the Health and Care Act 2022 offers a unique opportunity to move ever closer to the seamless picture of health and care delivery which we have been working towards for many years.

As part of these changes, CCGs ceased to exist on July 1, and a new approach is seeing the North East Lincolnshire Health and Care Partnership bring services closer together to give patients a better experience and tackle inequalities by addressing the big challenges to people's health.

Like all other CCGs, we are not responsible for commissioning preventative or some very specialist health services.

The CCG has delegated responsibility for commissioning primary care services.

We continued to work with our partners in the Council and Public Health, and the organisations that provide health care, to understand local needs and decide how to best use the money allocated to us.

Planning and buying health and adult social care services together means we can use the total funds we receive to get the very best value for money. It also means we can make the way that services are delivered across health and social care much more "joined up" which helps us to make sure people do not experience wasteful and frustrating duplication of services and minimises the risk of people falling through gaps in services.

The CCG Constitution sets out the membership of the CCG and describes the rules and the internal controls (governance) that ensure quality. Patient safety, effectiveness of care and the experience of people who use commissioned services are at the heart of everything we do.

In the period from 1 April 2022 and 30 June 2022, the CCG was allocated £78m by NHS England. This includes £7.6m to support delegated Primary Care and £0.8 to pay for the management and operation of the organisation which leaves a total of £69.6m million to pay for health services.

The income to fund Adult Social Care is set by North East Lincolnshire Council as part of its annual resource and priorities process, and in the period April to June 2022 the CCG received £12 million.

How to get in touch with us

The CCG's former statutory functions are being carried out by the Humber and North Yorkshire Integrated Care Board (ICB) in North East Lincolnshire and we remain very keen to hear from the people who use local health or care services as well as their carers or families. The experiences they share with us can help us to improve future services.

You can contact the ICB in North East Lincolnshire in the following ways:

By post: HNY ICB, Municipal Building, Town Hall Square, Grimsby, DN31 1HU

By phone: Switchboard 0300 3000 400

By email: hnyicb-nel.askus@nhs.net

You can still visit our website for more information both about the CCG and about health and care in North East Lincolnshire. The webpages will inform when information on that page has been transferred to Humber and North Yorkshire Integrated Care Board (ICB)

Our social media has transferred to North East Lincolnshire Health and Care Partnership (HCP)

Follow us on Twitter

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Our plans and how we manage risks

As we worked towards the close down of the CCG, our plans naturally focussed on the ongoing management of the consequences of the COVID-19 pandemic to ensure services to patients continued in the best possible way

This included continuing to manage local delivery of the national vaccination programme for coronavirus and reinstating as many of the pre-COVID services as the capacity in health and care could allow

Having responded admirably to the challenges of the pandemic our local services adapted to include a range of care and services delivered remotely and online – we took the learning from this experience and included this effective way of working in the new arrangement our area has moved into.

Alongside the focus on COVID recovery we continued to respond to what local people needed while taking into account national ideas to improve the way the NHS works.

Development of the Integrated Care System

Integrated Care Systems (ICSs) are a partnership between the different organisations that provide health and care needs across an area, coordinate services and plan in a way that improves population health and reduces inequalities between different groups.

The Humber and North Yorkshire ICS grew from the Humber, Coast and Vale Health and Care Partnership. The area secured ICS status in April 2020, a year ahead of the requirement set out in the NHS Long Term Plan.

Humber and North Yorkshire Health and Care Partnership comprises of NHS organisations, local councils, health and care providers and voluntary, community and social enterprise (VCSE) organisations. Partnership is one of 42 Integrated Care Systems (ICSs) which cover England to meet health and care needs across an area, coordinate services and plan in a way that improves population health and reduces inequalities between different groups.

NHS Humber and North Yorkshire ICB is a statutory organisation accountable for NHS spend and performance for 1.7million people across a region of 1500 square miles. The ICB is a core member of the Humber and North Yorkshire Health and Care Partnership described above, alongside NHS providers, local councils, health and care providers and voluntary, community and social enterprise (VCSE) organisations. ICBs have taken on the NHS planning functions currently held by Clinical Commissioning Groups (CCGs), as well as some held by NHS England.

Managing Risks

The CCG adopts an integrated approach to risk management which enables consideration of the potential impact of all types of risks on processes, activities, stakeholders, and commissioned services. The CCG Risk Management Framework provides strategic direction and guidance on embedding the integrated risk management approach in all CCG business. Further analysis of the main risks can be found in the Risk Assessment section of the Annual Governance Statement.

Going Concern Basis

This Annual Report and Accounts have been prepared under a Direction issued by the NHS Commissioning Board under the National Health Service Act 2006 (as amended) on the going concern basis.

In addition:

Chief Executive (ICB): As Accountable Officer, the Chief Executive is accountable for achieving organisational objectives within an appropriate business framework.

Executive Director of Finance & Investment (ICB): As the Senior Responsible Officer for NHS finances, the Executive Director of Finance & Investment is accountable for compliance with Standing Financial Instructions to achieve financial balance.

Performance Analysis

Performance summary

Introduction

Clinical commissioning groups (CCGs) were established on 1 April 2013 and are clinically led organisations. NHS England has a statutory duty (under the Health and Social Care Act 2012) to conduct an annual assessment of every CCG. The approach to the 2020/21 assessment (latest available) was simplified due to the continued impact of Covid-19 and the change in priorities this has required to enable the CCG to respond. This means that CCGs will not be given an overall performance rating. Instead, a letter provides a narrative assessment of CCG performance.

In recent years it has become increasingly clear that the best way to manage NHS resources to deliver high quality, sustainable care is to focus on organising health at both system and organisation level and therefore from the 1st July 2022 CCGs were abolished and statutory integrated care systems (ICSs) were established to take over the CCGs commissioning functions

NHS Oversight Framework (existing framework)

The NHS System Oversight Framework reflects an approach to oversight that reinforces system-led delivery of integrated care, 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 Operational Planning Guidance.

This framework applies to all Integrated Care Systems (ICSs), Clinical Commissioning Groups (CCGs), NHS trusts and foundation trusts and gives a single set of oversight metrics, applicable to ICSs, CCGs, and trusts, which is used to flag potential issues and prompt further investigation of support needs with ICSs, place-based systems and/or individual trusts and commissioners.
These metrics align to the five national themes of the System Oversight Framework: quality of care, access, and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability.

NHS Oversight Framework (new framework from July 2022)

The NHS oversight framework for 2022/23, published in June 2022, states this updated framework will take effect from the 1st July 2022 and the existing arrangements as set out in the NHS System Oversight Framework will apply until after this date.

This new framework outlines NHS England's approach to NHS oversight for 2022/23 and is aligned with the ambitions set out in the NHS Long Term Plan and the 2022/23 NHS operational planning and contracting guidance. It also reflects the significant changes enabled by the Health and Care Act 2022 including the formal establishment of integrated care boards and the merging of NHS Improvement (comprising of Monitor and the NHS Trust Development Authority) into NHS England.

The new framework describes how the oversight of NHS trusts, foundation trusts and integrated care boards will operate. This supports our ambition for system-led delivery of integrated care in line with the direction of travel set out in the NHS Long Term Plan, Integrating care: next steps to building strong and effective integrated care systems across England and the government's white paper on integration – Joining up care for people, places and populations.

Oversight metrics

A set of oversight metrics has been published, applicable to integrated care boards, NHS trusts and foundation trusts, to support implementation of the framework. These will be used to indicate potential issues and prompt further investigation of support needs and align with the five national themes of the NHS oversight F=framework: quality of care, access, and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability.

North East Lincolnshire Place applicable measures from the above frameworks facing challenges in year include;

- Patients waiting more than 52 weeks to start consultant-led treatment was above plan figures.
- Proportion of patients meeting the faster cancer diagnosis standard was below national threshold.
- Elective activity levels are 4.5% below plan
- Antimicrobial resistance: appropriate prescribing of antibiotics trend is showing a deterioration

North East Lincolnshire Place applicable measures from the above frameworks seeing success in year include;

- Number of appointments in GP Practice exceeded plan figures.
- Number of people with severe mental illness receiving a full annual physical health check and follow -up interventions is above plan for Q1
- Number of people accessing IAPT services is above plan
- Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check is above plan for Q1

How we measure performance

Measuring our performance helps us to ensure our services are being delivered to a high-quality standard and providing value for money. Internal processes are in place to manage performance against a range of national and local indicators (see table below) including a mechanism to work with internal and external colleagues to identify areas of risk and implement action plans to mitigate these, this ensures improvements in performance are delivered. Throughout the year, reports are provided to our Governing Body setting out our performance against the agreed local and national measures. This Performance Report describes how, in partnership with our providers, we are meeting our commitment to ensure that the commissioning decisions and actions we take improve healthcare for the people of North East Lincolnshire and ensure patients receive the highest quality health and social care. These reports can be found on our website.

NHS Constitution Rights and Pledges NHS System Oversight Framework (existing) and NHS Oversight Framework (new July 2022)	We monitor our performance against the NHS constitution measures, NHS System Oversight Framework and the New NHS Oversight framework on an ongoing basis.
Financial performance	Our finance team monitors our financial performance on an ongoing basis. Our financial performance is reported to the Integrated Governance and Audit Committee and our Governing Body.
Provider performance including NHS Constitution standards	We measure the performance of our providers using contractually agreed schedules of key performance indicators and quality indicators. Where performance is below the required standard for measures, the provider is asked for an explanation including actions and timeframes to bring the performance or quality of care back up to the required standard. Performance is reported and monitored by the Integrated Governance & Audit Committee and our Governing Body via the Performance Report.
Better Care Fund (BCF)	The Better Care Fund (BCF) is intended to transform local health and social care services so that they work together to provide improved and joined up care and support. It is a government initiative, bringing existing resources from the NHS and local authorities into a single pooled budget. Performance against the pooled budget is monitored with local authority colleagues, through a sub-committee of the Health and Wellbeing Board. We are required to complete a quarterly return to show our progress on the BCF
Adult Social Care Outcomes Framework (ASCOF)	We monitor our performance against the Adult Social Care Outcomes Framework measures on an ongoing basis. Performance is reported and monitored by the Integrated Governance & Audit Committee and our Governing Body via the Performance Report.

Progress on NHS Constitution Targets

Measure	Latest Period	2022/23				Forecast Position	National Threshold
		Denominator	YTD Perf.	YTD Target	YTD Status		
Total time in A&E: four hours or less - Trust	Jul-22	51,701	62.56%	95.00%	✗	Not Met	95%
ARP Category 1 Mean Response Time – Calls from people with life-threatening illnesses or injuries - EMAS	Jul-22	N/A	00:09:41	00:07:00	✗	Not Met	00:07:00
ARP Category 1 90th centile response time – Calls from people with life-threatening illnesses or injuries - EMAS	Jul-22	N/A	00:17:37	00:15:00	✗	Not Met	00:15:00
ARP Category 2 Mean Response Time – Emergency calls - EMAS	Jul-22	N/A	01:09:00	00:18:00	✗	Not Met	00:18:00
ARP Category 2 90th centile response time – Emergency Calls - EMAS	Jul-22	N/A	02:33:42	00:40:00	✗	Not Met	00:40:00
ARP Category 3 90th centile response time – Urgent Calls - EMAS	Jul-22	N/A	09:04:45	02:00:00	✗	Not Met	02:00:00
ARP Category 4 90th centile response time – Less Urgent Calls - EMAS	Jul-22	N/A	08:03:27	03:00:00	✗	Not Met	03:00:00
Percentage of Patients waiting <6 weeks for a diagnostic test - CCG	Jul-22	7,219	78.24%	99.00%	✗	Not Met	99%
RTT - Incomplete Patients: % Seen Within 18 Weeks - CCG	Jul-22	17,766	66.66%	92.00%	✗	Not Met	92%
Cancers: two week wait - CCG	Jun-22	1,452	96.56%	93.00%	✓	Fully Met	93%
Cancers: two week wait (all breast symptoms excluding suspected cancer) - CCG	Jun-22	102	92.16%	93.00%	!	Fully Met	93%
Cancer 31 Days Diagnosis to Treatment (First definitive treatment) - CCG	Jun-22	218	88.07%	96.00%	✗	Almost Met	96%
Cancer 31 Days Diagnosis to Treatment (Subsequent surgery treatment) - CCG	Jun-22	43	69.77%	94.00%	✗	Not Met	94%
Cancer 31 Days Diagnosis to Treatment (Subsequent drug treatment) - CCG	Jun-22	83	95.18%	98.00%	!	Fully Met	98%
Cancer 31 Days Diagnosis to Treatment (Subsequent radiotherapy treatment) - CCG	Jun-22	76	63.16%	94.00%	✗	Fully Met	94%
Cancer 62 Days Referral to Treatment (GP Referral) - CCG	Jun-22	113	45.13%	85.00%	✗	Not Met	85%
Cancer 62 Days Referral to Treatment (Screening Referral) - CCG	Jun-22	10	60.00%	90.00%	✗	Not Met	90%
Cancer 62 Days Referral to Treatment (Consultant Upgrade) - CCG	Jun-22	4	25.00%	90.00%	✗	Not Met	N/A
Cancelled Operations offered binding date within 28 days - Trust	Q1 2022/23	113	20.35%	25.93%	✓	Fully Met	N/A
Numbers of unjustified mixed sex accommodation breaches - CCG	Jul-22	N/A	8	0	✗	Not Met	0
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period - CCG	May-22	385	92.2%	75.0%	✓	Fully Met	75%
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period - CCG	May-22	385	100.0%	95.0%	✓	Fully Met	95%
Psychosis treated with a NICE approved care package within two weeks of referral - CCG	May-22	20	75.0%	60.0%	✓	Fully Met	56%

Development and performance in-year

Reflecting upon our overall performance over the year, we have met a number of the national Health and Adult Social Care targets and also achieved many of the activity levels set out in our planning submissions. However, the continued coronavirus pandemic, reduction of hospital activity levels and the increased demand for NHS services in continues to be the most serious challenge that the NHS has ever experienced.

Planning submissions 2022-23

We are accountable for how we spend public money and in 2022/23 trajectories as outlined in the Operational Planning Guidance were set at an ICS level working with our Providers and where appropriate local planning trajectories were agreed at place level.

Although we had planned to meet all national planning standards and commitments in 2022/23, this has not been possible for some of our commissioned services. In the performance analysis that follows it will highlight the significant challenges over the previous quarter.

Some of the key challenges on planning measures for North East Lincolnshire have included:

- **Cancer 28 day waits (faster diagnosis standard) and other Cancer Waiting Times standards –**
  - **Issues** –
    - Management of complex unfit patients requiring significant work-up are causing delays
    - All tumour sites are affected by the increasing waiting times for oncology consultant appointments (62-day pathways) resulting in increased breaches of 62 days
    - Colorectal is a challenge but the teams are working to improve referrals in to ensure the right patients receive the diagnostics required
    - Notable increase in Urological Cancer referrals over last 3 months
    - UGI is a challenge, but the teams are working to improve referrals in to ensure the right patients receive the diagnostics required, we are reviewing the 28-day performance and RDC commencing at DPoW next week and SGH the week after
    - Medicine UGI and Lung tumour site pathways for 28-day performance continue to be challenged
    - Gynaecology Nursing capacity to support delivery of planned care
    - Breast Consultant capacity due to substantive vacancy (now appointed, start date of September 2022)
    - Upper GI and Head & Neck surgery is carried out in Hull which is currently causing significant delay
    - Covid Positive Patients
    - Request to test (14 days) - in order to meet 28-day Faster Diagnosis Standard, this needs to be reduced to 7 calendar days
    - HUTH have relocated Urology oncologist to Breast which is causing some risk to waiting times
    - Regionally and nationally, cancer services are struggling which impacts on us locally in terms of moving patients through the system.
  - **Actions taken –**
    - Additional Consultant Led Endoscopy Clinics to enable decision making at time of procedure - September 2022

- Urology service review completed with additional one stop clinics being introduced from September 2022 in collaboration with Radiology.
- Additional consultants business case approved in Urology - recruitment of additional cancer consultant. September 2022.
- The Cancer Transformation team has completed a pathway analysis on 100 patient pathways for Lung. Outputs of this analysis have identified several areas for improvement and discussions are continuing with HUTH
- Production of process maps for booking of patients to ensure optimum list utilisation, by end of July 2022.
- Review of current processes for coding of activity, end of August 2022.
- Review of Demand and Capacity, end of August 2022.

- **Referral to treatment waiting list & Number of 52+ week waits –**
  - **Issues –**
    - Theatre capacity affected by short notice sickness, issues with theatre estates and an influx of acute activity causing elective activity to be converted
    - Medicine vacancy rate; Gastroenterology: 33.3%, Cardiology: 75%, Dermatology: 28%
    - Gynaecology Nursing capacity to support delivery of planned care
    - Breast Consultant capacity due to substantive vacancy (now appointed, due to start September 2022)
    - Potential further COVID waves
    - Carry over of annual leave - clinician availability and summer peak
    - Ongoing management of high levels of acute activity impacting elective work
    - Theatre nurse staffing vacancy, retention and high sickness rates
    - Contracting agreements and funding for use of Independent Sector not yet agreed for 22/23
    - Removal of Waiting List Initiative additional sessions by NLaG clinicians. Along with a reduction to 2% activity from external providers
    - Increasing CT colon demand & limited capacity in July/August due to consultant leave, will impact 2ww performance
  - **Actions taken –** The local NHS hospitals continue to work with the independent sector hospitals to transfer some patients to them for treatment to help deliver the NHS activity. NLAG are also utilising an external provider called Medefer to review patients on waiting lists and also to review some new referrals, as well as Advice and Guidance requests. We are currently looking at ways to move to an “advice first” approach with GPs, to drive Advice & Guidance referrals by GPs for those clinically appropriate patients. There have also been some reviews undertaken by the hospital teams and the general practice teams of patients waiting on lists to check if they still require or are still suitable for treatment.

    NEL PCNs and speciality teams at the local Hospital are continuing to rollout the Connected Health Network model which entails primary care teams and secondary care teams working as a multi-disciplinary team to manage outpatient activity in a different way, reducing transactions between organisations and significantly reducing waiting times. Several specialities are

now live across 4 out of the 5 NEL PCNs, with roll out concentrating both on growth and future sustainability.

We continue to work with system partners to develop clinical pathways which support patients only being referred to acute providers when it is absolutely necessary, to free up capacity for those patients who need acute care.

- **Estimated diagnosis rate for people with dementia -**
  - **Issues –** Performance on this measure continues to deteriorate. It should be noted that the last 5 months performance on this measure has been below the lower process limit.
  - **Actions taken –** The Dementia Diagnosis numerator isn't changing or is changing minimally each month which isn't reflective of the work NAViGO are doing. NAVIGO have requested and received the Dementia Registers from Care Plus and the team are going to do some analysis and data quality checks. If we identify any that should be on the dementia register, then we will work with the PCN's to get them recorded.

Some of the key successes on planning measures for North East Lincolnshire in 2022/23 have included:

- Appointments in General Practice – A trajectory for this measure was set for 2022/23 and have achieved the monthly plan set for this measure.
- SMI People with severe mental illness receiving a full annual physical health check and follow up interventions – We have seen continued improvement on this measure and the 2022/23 trajectory for Q1 has been achieved at Place level.
- Learning disability registers and annual health checks delivered by GPs – We are above the Place level plan set for Q1 2022/23.

Other measures performance in 2022-23

We have also faced challenges on many other of the national measures as outlined below;

- **Antimicrobial resistance: appropriate prescribing of antibiotics in primary care** – we have seen a continued rise in this measure since April 2021 which coincides with the easing of all COVID restrictions, however it is worth noting that current levels of antibiotic prescribing are now back in line with pre-COVID levels but this will be continually monitored to ensure levels don't continue to rise.
- **A&E waiting times -**
  - **Issues** –
    - Pressure within the community in relation to demand for ambulance attendances
    - Rise in the number of patients being admitted with Covid-19 (specifically at DPOW)
    - High level of acuity with pressures within Resus
    - Inability to achieve Ambulance Handover targets due to patient flow within the hospital
  - **Actions taken –**
    - Daily review of medical and nursing staffing to ensure appropriate skill mix - ongoing
    - Work continues on the new build for both sites to increase footprint (DPoW due to open at the beginning of September 2022)
    - Discussions commencing in relation to funding of extra medical staff for the new build (DPoW due to open at the beginning of September 2022)

- Screen being installed in SDEC and SAU to enable "straight to" ambulance handover pathways to be implemented to support ED avoidance - ongoing
- Review of all Urgent Care Services across Northern Lincolnshire has commenced to look at reducing pressure across the system by ensuring that patients are seen at the right place, by the right person, first time - ongoing
- Bid submitted for funding for Virtual Ward Development across Northern Lincolnshire which will provide an alternative to urgent care attendance and acute care if successful, outcome anticipated in July 2022.

In contrast to the above we have seen some success in the national measures outlined below.

- Many of our adult social care measures continue to achieve the targets set such as permanent admissions to residential and nursing care, adults with learning disabilities who live in their own home or with their family, adults with learning disabilities in paid employment and people receiving self-directed support.

Our Quarter 1 2022-2023 Priorities

There are 9 high level priorities for NEL Place they are:

1 Community Diagnostic Hub
2 Accountable Teams
3 Therapies Review
4 Intermediate & Transitional Care
5 Domestic Abuse
6 Workforce
7 Tackle Elective backlog
8 Improve responsiveness of UEC & build community care capacity
9 Improve MH services and services to people with LD

Each priority has an SRO and Programme Lead assigned to progress the milestones and manage the risks and key performance indicators used to measure progress and achievements.

Financial information

The CCG's accounts have been prepared under a direction issued by the NHS Commissioning Board (NHS England) under the National Health Service Act 2006 (as amended).

There are significant financial challenges to the NHS, driven largely as we come out of the Covid-19 pandemic and the associated pressure on all areas of healthcare.

The financial regime imposed in 2022/23 has enabled systems to respond to the immediate pressures, as well as moving towards further restoring services, delivering recovery targets, and reducing waiting lists is likely to be substantial.

In 2022/23 (Quarter 1) the CCG has once again reported a balanced financial position despite the ongoing pressures faced.

Commissioning activity and service redesign

During 2021/2022 and into 2022/23 our commissioning activity has centred on responding to the requirements of the ongoing Covid pandemic and moving towards recovery for levels of pre-pandemic activity and service levels. We have also looked at how the system will operate differently in the new organisational arrangements and what this means for a different approach to service redesign and planning

In terms of key elements of commissioning and service redesign we have:

- Worked to develop primary care responses in terms of the Primary Care Networks and interfaces with secondary care, creating and piloting our Connected Health Networks which enable a more streamlined pathway for selected specialties which have drastically reduced waiting lists
- Worked with partners across the Humber as part of a joined-up approach to delivering End of Life care
- Accelerated our work on support for digital service delivery and home working arrangements for CCG staff
- Planned for the delivery of a clinical diagnostic hub within North East Lincolnshire
- Planned for and delivered the latter phases of the Covid vaccination programme

Our commissioning activities have taken place within the context of the ongoing pandemic and requirements to recover pre-pandemic activity levels. Future years' work will focus on delivering nationally mandated work and local priorities identified by our Health and Care Partnership.

Safe Transition from CCG to ICB

On the 1st of July 2022, the CCG will cease to exist, and all its NHS responsibilities will transition to the Humber and North Yorkshire Integrated Care Board (ICB). During the period (April – June) there has been a particular focus on ensuring a smooth / safe transition to the new arrangements.

The Council and CCG have reviewed the current Section 75 agreement, (the legal document which supports the Partnership Arrangements) to ensure that it continues to meet the partnerships aspirations going forward, with further development work continuing until 2023.

Over the last 2 years NEL place: the CCG; the Council; and the place providers, have been working closely together to establish the Health and Care Partnership and a Joint Committee. The Joint Committee has been meeting in shadow form as part of its development to ensure that NEL continues to have the right arrangements in place for partnership working across the NHS and the Council and for the continued delivery of integrated services for our population, with a renewed focus on addressing health inequalities. This work will continue at place as the CCG transitions into the ICB.

Covid 19 Vaccination Rollout

Our providers have continued to deliver covid vaccinations to our local population during 1st April to 30th June 2022. This has included the delivery of a Spring Booster to the following cohorts, and our providers worked hard to make sure they reached as many people as possible:

- people aged 75 and over
- people who live in a care home for older people
- people aged 12 and over who have a weakened immune system

The vaccination remains one of the best ways to protect ourselves and our loved ones from serious illness caused by Covid-19, and as we move into 2022/23, we are keeping open the offer of a first,

second or booster dose for people who have not yet come forward and are now well underway with our plans for the booster programme in Autumn 2022.

Digital Enabled Care

Following significant change because of the COVID pandemic, over the last 12 months we have seen a number of digital enhancements to benefit our population and professionals, to ensure that we continue to empower the best possible level of care.

We have several key programmes of work underway to ensure that our health and social care teams have access to the latest digital tools in their workplace:

- We believe that every patient should only have to tell their story once, so to ensure that each professional directly involved in a patient's care is fully informed to make decisions we have accelerated the deployment of our shared care record system – The Yorkshire and Humber Care Record.
  Across the Humber and North Yorkshire we have connected Hospital, Social Care, Primary Care and End of Life records, to allow health professionals to access a holistic view of patient care, when it is appropriate to do so.
- We have continued to replace older computers in GP Practices to ensure that practice teams have access to appropriate equipment and continue to sustain a high level of Digital Maturity.
- We have started to implement a secure clinician to clinician messaging solution to allow care professionals to seek advice from their peers.

We have worked hard to provide the appropriate solutions to empower patients to interact digitally with their care services:

- All practices have access to online and video consultation facilities.
- We have continued to develop the use of the NHS App to provide convenient access to GP services and to assist patients to manage their own care requirements.
- Over the last year we have added hospital records to the NHS App, for some of our population.
- We have continued to develop our online self-care app store and expanded it to cover a wider geography, this allows more of the local population to easily access suitable apps to support their wellbeing.

We recognise that digital solutions do not always provide the most accessible or appropriate method of communication for all patients, so to support access we have undertaken several programmes of work:

- We have worked with NHS England to develop a resource pack, to support patients to know how to best access their practices for digital, non-digital and face to face access. This work formed the basis for a national resource pack to be used nationally within general practice.
- We are actively working to ensure that all practice websites are as easy to use as possible.
- We have begun to provide Practices with systems to record the digital maturity of their patients, to ensure that they offer the most appropriate style of care to individuals.
- We recognise the importance of understanding the best access method for everyone, so we have a dedicated Digital Inclusion Network, to ensure that service accessibility is at the heart of everything we do.
- We have workstreams underway looking at how we can provide supported digital access to those patients who normally wouldn't be able to access it, for example tools for digital access within rural locations such as village halls.

Care Homes are an important element within our care community, providing proving residential care for a large number of our population.

We understand that a great deal of care needs to take place within care provider premises, and we are working hard to ensure that all Care Homes are connected to the wider care community:

- All our Care Homes are provided with access to a secure NHS Mail address.
- All have been provided with a connected tablet to allow access to video consultations, proxy medication ordering and other online health services from within a resident's room.
- We are working with our IT partners to look at how we can provide improved Wi-Fi access within care homes, allowing staff and visiting clinicians to remain fully connected to their systems.
- Our care community has developed a support team to support care homes to improve their digital maturity.
- We have developed a first of type Care Home IT Operating Model to outline the services and support required by providers, to ensure they receive the support required to allow digital access.

It is important that we support the reconfiguration of clinical services to ensure that patients are seen in the most appropriate location and to increase capacity within the care system and to support this we have several exciting projects underway:

- We have implemented a clinical booking system which allows NHS 111 (and 01472 256256 SPA in North East Lincolnshire) to book callers into Urgent Care and Primary Care settings and we are now developing this system further to allow any care provider to directly book into any other care provider. This will allow a quicker and easier experience for patients.
- We have supported the process to move diagnostic services into the community, increasing capacity within other local services.

Hospital at Home (H@H)

We know that we face challenges in our area for children who don't currently get the best possible start in life. One of the ways in which we are transforming this situation is through the Children's H@H service.

Due the hospital pressures during and after COVID we recognised that we needed to significantly increase the community nursing offer for children in North East Lincolnshire so towards the end of 2021 we launched the Children's H@H pilot.

The H@H service is a nurse-led service that takes referrals from A&E, the Paediatric Assessment Unit (PAU), Rainforest Ward and primary care. Children's community nurses assess poorly children at home and then advise and support parents / carers to care for their children in familiar surroundings where they are likely to recover more quickly and bounce back. The service and care is overseen by the consultant of the week and assisted using digital technology.

Since its inception at the end of November 2021 there has been a month on month increase in referrals to the service with the vast majority of children being managed at home successfully. The pilot has demonstrated that H@H reduces hospital admissions and attendances and reduces the burden on primary and secondary care.

Feedback from Nurses as well as parents has been extremely positive. Solutions like this will help us transform the way we support our children and families in the future. And in 2022/23 we are looking to further develop the service so that it can support more children, young people, and their families.

Hospital Discharge

The North East Lincolnshire system has worked collaboratively to respond to the hospital discharge guidance launched on 1st April 2022. We have worked with North Lincolnshire, East Riding and Lincolnshire to ensure efficient and effective discharges for all patients. North East Lincolnshire and North Lincolnshire have shared executive discharge arrangements to ensure a consistent Northern Lincolnshire approach. A self-assessment against the newly launched discharge guidance has led to an appreciation of the achievements to date as well as identifying areas for further improvement. These have been incorporated into our Northern Lincolnshire discharge improvement plan, to take us further on our discharge improvement journey.

A full North East Lincolnshire system wide multi-disciplinary team (MDT) approach consisting of social workers, nurses, therapists, mental health and primary care professionals has been used to ensure timely and safe discharges from hospital, ensuring suitable and effective care for those with ongoing health and care needs. On average there are 240 discharges of North East Lincolnshire residents per week across pathways 0,1,2 and 3. Roughly 91% of patients return home (pathway 0 and 1), 7% are discharged into a step down intermediate or discharge to assess placement (pathway 2), and 2% go into a longer-term placement/or back to their existing care home (pathway 3). Recent achievements have included:

- ✓ Further improved the proportion of people going home first
- ✓ Maintained timely discharge notifications with over a 1/3rd being prior to 12 noon
- ✓ Increased number of same day discharges - all discharge delay reasons are known and monitored
- ✓ Optimised the support at home and bed-based capacity offer to flexibly meet demand
- ✓ Strengthened contribution from the voluntary and community sector
- ✓ Improved patient length of stay

Cambridge Park enhanced recovery facility

In response to COVID-19 and the increased need for bed based intermediate care (step up and step down) and discharge to assess facilities, Cambridge Park was acquired, refurbished, and opened in May 2020. The service aims to provide rehabilitation, re-ablement, recovery and recuperation opportunities for adults in North East Lincolnshire. The service aims to promote faster recovery from illness, prevents unnecessary acute hospital admissions and premature admissions to long-term care, supports timely discharge from hospital and maximises independent living and regaining of function wherever possible. Multi-professional staff collaborate with individuals and their informal carers via an asset-based approach to ensure individuals achieve their goals and reach their optimum level of independence, health, and wellbeing. The service can currently support up to 38 people. Despite the increase in complexity of need presented to the service, 20% of people still managed to return home with no on-going care services. A further 19% have stepped down into intermediate care at home services and 7% of people required the same package of care or less, than prior to their admission to hospital. The remainder go on to need a new or increased package of care, short stay placement or specialist onward care provision (hospice/return to hospital).

Humber Acute Services Programme – Summary of Engagement

The Humber Acute Services programme is currently developing a range of potential clinical models (options) for the future delivery of core hospital services including:

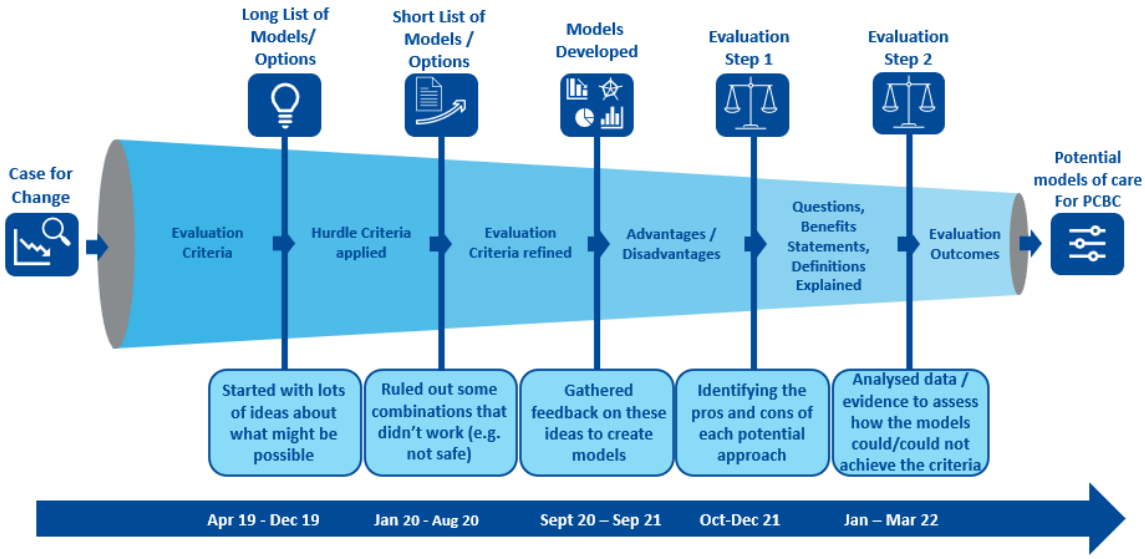
- Urgent and Emergency Care
- Maternity, Neonatal Care and Paediatrics
- Planned Care and Diagnostics

We engaged with over 9,000 stakeholders, including:

- **Current and future patients, staff, the public** and their representatives about what matters most to them when they need hospital care (around 4000 people took part, February to October 2021)
- **Women, birthing people, their partners and families** on where and how they would like to be cared for when giving birth (around 1150 people responded, June to July 2021)
- **People who had visited Emergency Departments** about their experiences and what could be done to help them access care in a different way (around 2000 people responded, July to August 2020)
- **People and communities who face additional barriers** to accessing care, their representatives and others working alongside them to find out how we can address the barriers they face.
- **Children, young people, their parents and carers** on what matters to them when receiving hospital care (around 300 people took part, November to December 2021)

Overall, people told us that being seen and treated quickly, being kept safe and well looked after and having enough staff with the right skills and experience were the most important things to them when thinking about their hospital care. For parents, carers and people using maternity services safety was the number one priority overall. For staff in our hospitals, addressing workforce shortages and having a better work-life balance were highlighted as key priorities.

Taking onboard the feedback and insights from patients, staff, service-users and other stakeholders, our clinical teams have continued to develop and refine the different potential scenarios for how services could be organised in the future. Different ideas have been added in and/or discounted at various stages, based on evidence and feedback from clinical teams and wider stakeholders, as summarised in the diagram below:



Our clinical design process has produced a range of possible scenarios, which could potentially address the issues and challenges within our hospital services. Evaluation of these potential scenarios began during February and March 2022, involving a wide range of stakeholders, and continued during spring 2022. This will support the development of a Pre-Consultation Business Case, which will be published later in 2022.

For more information on the Humber Acute Services Programme can be found at https://humberandnorthyorkshire.org.uk/our-work/humber-acute-services-review/

Humber Acute Services Programme - Process Update Q1 2022-2023

The Humber Acute Services programme is currently developing a range of potential clinical models (options) for the future delivery of core hospital services including:

Urgent and Emergency Care

Maternity, Neonatal Care, and Paediatrics

Planned Care and Diagnostics

Throughout 2022, we have continued to involve patients, members of the public, staff, and other key stakeholders in a variety of ways. This has included, sending regular staff, partner and stakeholder newsletters, publishing and promoting the findings from surveys, and responding to questions raised. Since the programme launched in 2018, we have engaged with over 12,000 people and are committed to ensuring this process of listening continues throughout all stages of the programme.

Over the next few months, the Humber Acute Services programme team will be updating and refining our Equalities Impact Assessment (EQIA) to help us understand how any future changes to hospital services may impact people and communities who already face disadvantages and health inequalities. The findings from all our engagement activities will be used to inform this process, ensuring that the views and perspectives of patients, public and staff are considered at every stage.

Finally, extensive stakeholder mapping has recently been undertaken to ensure we are engaging and listening to impacted communities, groups, and individuals. This exercise has resulted in exciting new relationships and networks being established. These new networks will provide invaluable support during formal public consultation.

For more information on the Humber Acute Services Programme please visit our website: https://humberandnorthyorkshire.org.uk/our-work/humber-acute-services-review/
For regular updates, please sign up to our stakeholder newsletter: https://bit.ly/signmeup123

Sustainable development

NHS North East Lincolnshire Clinical Commissioning Group is committed to commissioning health and social care services that meet the needs of the local population and are financially and environmentally sustainable.

The development of hybrid working.

Following the gradual progression back to working post COVID, work at home has still been the predominant method for most CCG staff. This reflects not only the new flexibility but builds on the work we had done for many years at reducing physical capacity to manage overhead costs in premises and the environmental costs of travel where not deemed necessary. This means less management costs and more funds available for front line services.

The organisation with colleague organisations is exploring how best to utilise digital working and those occasions where face to face is the most beneficial and delivers substantial benefits over a virtual meeting. This is being driven on a cost basis, personal flexibility basis and of course an environmental impact of contributing to net Zero position of the NHS. Alongside the significant increase in fuel costs this has been beneficial to cut down excess mileage.

The CCG is working on how this approach can be managed across its locality and on a wider Humber and North Yorkshire footprint.

While there will be an increased return to working in an office and having face to face meetings, the ability to not have to travel many miles for a meeting is supported by most staff as this saves time and increases productivity as staff are not on the road for many hours in the day travelling from one meeting to the next. This also must be recognised as part of the Net Zero plan to reduce unnecessary travel if we are to have an impact on the CCG carbon footprint.

We will continue to review and reduce office space across the area with Partnership organisations and will challenge them more significantly about how they are making efficiency gains from HQ buildings, sharing space and encouraging more flexible working where appropriate. The Health & Care Partnership is initiating a whole area premises review to look at the green agenda and the costs incurred from building occupation, which will develop into a new estates' strategy for 2023-28.

As we continued working from home for the majority of 2021-22, the savings identified last year will have continued and this was estimated at 115 tonnes of CO2. The level of reduced home to work travel of 2,312 miles per day and business miles reduction of around 50,000 miles, will be broadly at that level for the period.

Facilities Management

The Local Authority manages the buildings through Equans and we are a small part of the overall estate so we do not have details of our costs and usage outside of the overall building, which will be reported on through the Local Authority environmental returns.

Procurement

As part of the procurement process, the CCG considers social and environmental factors alongside financial factors in making decisions on the purchase of goods and the commissioning of services.

The CCG also consider the implications of the Social Value Act 2012 and generally, as we commission services rather than products, providers necessarily must look to try and recruit and source ancillary services locally, sustaining investment in the local economy.

Net Zero NHS Contracts - Decarbonisation

The new NHS Contracts have strengthened the commitment to a Net Zero NHS and all providers should have strategies and board level engagement to manage that impact and reduction. As a result of the proposed restructuring of the Commissioning Bodies in the NHS, the North East Lincolnshire Health Care Partnership has signed up to Net Green Zero and has set out a delivery plan for all local providers to sign up to.

The local providers include, Northern Lincolnshire and Goole NHS Foundation Trust, Care Plus Group, Navigo, Focus, NHS Property Services, North East Lincolnshire Council, St Andrews Hospice, St Hugh's Hospital, Core Care Links and the local GP Primary Care Networks.

The vision of the group is to lead and influence the North East Lincolnshire, Healthcare Care Partnership ambition to reach net zero carbon emissions in time for the deadlines set out by NHS England of 2040 for direct carbon emissions and 2045 for indirect (supply chain) emissions.

Sustainability

North East Lincolnshire CCG continually reviews its sustainability to generate ideas for reducing our carbon footprint and reducing waste. Alongside the agile working and travel impact identified above, the CCG has been paper light for many years as an agile organisation.

The CCG will work with Residential Care Homes to look at and understand the level of pharmaceutical waste. The changes to prescription ordering have a significant impact on waste and cost as the patient now must explicitly request items, they need rather than where a whole list of repeat items could be ordered by the pharmacy. This programme will have a significant impact on waste and efficiency.

Statutory duties

Engaging People and Communities

The NEL Commitment - Talking, Listening and Working Together co-produced by the CCG and council with local people and Voluntary, Community and Social Enterprise (VCSE) organisations sets out how people and communities will be involved in the planning and design of local services and solutions. This approach has been adopted by the NEL Health and Care partnership and will continue to be the foundation of our engagement and involvement activities at Place in North East Lincolnshire.

Between April and June 2022, the Accord community-led membership scheme continued to be the CCG's main vehicle for communicating with our 1300 members through a dedicated website, regular e-bulletins and a quarterly digital and hard copy newsletter which is mailed out to members who do not have access to digital technology. The Accord Steering Group provides a link between the wider membership base of Accord, and the CCG. Its role is to make sure Accord counts and the CCG values and makes appropriate use of the scheme.

Between April and June Accord members and stakeholders have been given the opportunity to have their say on a variety of service developments, including:

- Coproduction workshops to shape citizen engagement for NEL Place service development and activity
- Priorities for the Humber and North Yorkshire ICS Community Engagement Strategy

- Liberty Safeguards consultation (Department of Health and Social Care and Ministry of Justice)
- NEL Adult Services Strategy review
- Humber, Coast and Vale Keyworker Service development of 'Community of Experience' for all children and young people with a learning disability, autism or both, their families and carers
- NEL Community Diagnostic Centre

Accord members and stakeholders have also been provided with information about:

- Work of the Cancer Alliance, cancer awareness training and opportunities to become a cancer champion
- Recruitment for Community Lay member to proposed NEL Joint-Committee
- Notification of the transfer to the HNYICB as data controller for personal data relating to their membership of Accord

In March 2022, the Community Forum which was an integral part of the CCG's governance arrangements was disbanded in order to plan and prepare with community members for transition to the new ICS and Place arrangements. Having met on Teams for the last two years the final meeting of the Forum was in person, and this gave us an opportunity to thank our volunteers and acknowledge their contribution to health and care in NEL - several members having been involved from the very beginnings of the CCG decided now was the opportunity to step down and enjoy a well-earned break.

Originally the transition to the new arrangements was to take place from April 2022. This was extended to July 2022 so in order to maintain – as set out in the CCG constitution - the **"clear arrangements for community governance via the Community Forum that provides assurance to the CCG Governing Body that patient, service users, carers and the public are effectively engaged and involved in decisions made about health and social care services in North East Lincolnshire"**; an Interim Patient Assurance Group was established with Terms of Reference ratified by the CCG risk committee.

The role of the Interim Patient Assurance Group is to provide assurance and challenge to the CCG Governing Body that patient, service users, carers and the public are effectively engaged and involved in decisions made about health and social care services in North East Lincolnshire in keeping with the North East Lincolnshire Commitment and joint community engagement strategy – "Talking Listening and Working Together". The group comprised of members of the Accord Steering group and former members of the Community Forum who still wished to be involved post-transition, along with the PPI Lay member to link directly into the CCG Risk Committee. Two meetings were held on Teams between April and June with a further two post-transition. Members received information for the Place Director (designate) and the Engagement lead and had an opportunity to comment on the HNY ICS Community Engagement Strategy, developing HCP values and outcomes from community engagement to inform the citizen engagement model for NEL in the new arrangements.

Between April and July we held three co-production workshops at a local community venue, inviting Accord members and members and service users from partner organisation to join us to shape a model for citizen engagement for NEL Place. The workshops were facilitated by the CCG with the support of partners to facilitate discussion groups. Participants received information about the new health and care system which included a presentation from the CCG Clinical Director about how clinicians, service managers, partner providers and public health plan to work together and involve communities. At the final session we looked at all the outcomes from the previous meetings to determine what was important and needed to be included for citizen engagement to be effective. We then explored potential options to achieve this and arrived at a preferred option for us to take forward,

which was felt to provide a flexible and accessible engagement offer in keeping with the NEL Commitment – Talking, Listening and Working Together.

To assure that the thread of public and community involvement is woven into operational, strategic and governance arrangements across all levels of activity in NEL, a dedicated Community Lay member on the NEL Health and Care Joint Committee with a lead role in championing community engagement and public involvement was developed, with recruitment and selection taking place between May and July.

Reducing Health Inequalities

During 2021/22, NELCCG has continued to make good progress on addressing the health inequalities in our system, building on a robust track record of equality and inclusion practice which has been embedded in our commissioning activities for the past decade

Some highlights for the year include work in the following areas:

- **Population health management and the analysis of local data**
  Our local Business Intelligence teams working across the patch and with colleagues in the Humber have looked at dashboards to support practitioners with clinical cohort analysis and identification of at-risk patients and deeper engagement of those at risk of exclusion, including carers.

- **COVID 19 vaccination**
  For the vaccine sites we chose a site in the highly deprived area and the centre for those less likely to engage – homeless etc, (at Open Door). We also supported engagement with hard-to-reach groups utilising volunteers to go door to door promoting vaccinations.

- **Talking Listening Working Together**
  We have worked together as a group of organisations and individuals including statutory agencies, voluntary sector organisations and individual community activists to produce and deliver the “NEL commitment” which is an approach to engagement and involvement which enables all stakeholders to be part of identifying local issues and creating local solutions – in particular this has been applied to health and care issues and issues such as social isolation and low-level mental health problems.

- **Connect NEL**

  Alongside one of our key voluntary sector partners, Centre 4 we have supported the development of Connect NEL which seeks to connect individuals to community-based activities and services which are tailored and suited to their individual needs.

  The service consists of a helpline and staff who have access to a local database of grass roots community activities as well as more established interventions and who are trained to assess and advise service users on what may be appropriate for their needs/ Tis service is particularly valuable for underserved groups in order to link them into groups and activities which are helpful to tackle the inequalities they experience.

Improve Quality

Jan Haxby, Director of Quality and Nursing leads the NEL CCG Quality & Nursing Team. The Quality & Nursing team supports the commissioning and oversight of good quality NHS health and care services in North East Lincolnshire and provides leadership to help deliver some key strategic areas of care. The Quality team includes senior leadership for Quality and for Safeguarding adults and children and this includes commissioning of services for Children Looked After (CLA).

One of our significant roles is to seek routine assurances regarding the quality of health and social care services and the outcomes for service users, and to share this with our health and care commissioner or service lead colleagues to help inform their commissioning role or their oversight of health or care contracts. We seek assurances by working closely with our providers but also by gathering information and data through our systems and processes which we then analyse to inform our assessment of the quality of care or service that is provided. Where we have concerns, the CCG Quality team, or the contract lead, works at an enhanced level with the provider to support them to address any gaps in quality or in safeguarding arrangements. The work undertaken by the team helps to identify specific areas which require focused quality improvement, this is how we identify and inform our priorities for delivery.

We provide regular reporting to the CCG Governing Body and its sub-committees, and we also create quality reports and quality profiles that can be accessed by CCG colleagues, as well as sharing learning from our quality work through a regular Quality Bulletin.

During 2022 the CCG continued to hold Risk Committee meetings to facilitate a regular dialogue regarding risk, given that the Covid pandemic and the pressures across the health and care system where regularly impacting on the ability of health and care to deliver services. The Quality team reported quality-related matters to the Risk Committee via the Safety Review Group where detailed discussions were held to oversee delivery of key areas of quality focus including providers where there are concerns, and key strategic priorities.

Our approach to quality and safeguarding between 1 April 2022 and June 30 2022

The CCG Quality & Nursing team started the financial year with a vacant post due to a retirement and have sought to fill the role on an interim basis until full recruitment can take place.

The Quality & Nursing team's priorities were to continue with our main team role described above in respect of quality assurance and oversight but to also prioritise further system leadership and support to a number of quality improvement programmes identified through quality intelligence. One such example is the LEDER programme, and the quality team ensure there is a review of any death of a person with a learning difficulty so that any lessons can be learnt and shared.

Another example is the unexpected mortality numbers reflected in the reporting of the SHMI (Standardised Hospital Mortality Index). The SHMI has been higher than expected for many years but has continued to reduce over the last 12 months and is now in the "as expected" range. In this last quarter we have continued to undertake case note reviews and audits of records across all health and care providers to better understand where further improvements can be made.

The CCG safeguarding team have been working very closely with partner agencies to develop joint approaches to a number of safeguarding deliverables like training and policy. Quarterly GP Safeguarding Leads meetings, and Safeguarding in Health Forums, have continued to focus on areas we need to improve across health. This includes health assessments for Children Looked After (CLA) and we have provided increased staffing to ensure there is enough capacity in the health team to undertake assessments.

We have noted during 2022 that the numbers of suicides in NEL, and for some neighbouring areas, is significantly higher than in previous years. We are working with colleagues to gain a better understanding of this and to make sure the learning from the reviews into each suicide is reaching service planners and leaders of services.

NEL CCG continued to be an active partner in local multi-agency safeguarding arrangements across the Safeguarding Adults Board (SAB), the Local Safeguarding Children's Partnership (LSCP), Corporate Parenting Board and the Community Safety Partnership (CSP). The Designated Nurses chair the sub-groups which oversee the multiagency reviews for both the Children's and Adults

Boards, actively contributing and supporting the health contribution to these reviews. Our Named Doctors for safeguarding children and adults are also involved in several work areas like domestic homicide reviews and they raise any areas of concern to be addressed.

Finally, we have worked closely with colleagues from across the Humber and North Yorkshire & York to prepare our teams and our systems and approaches for the pending transition over to the ICB. This provides us with opportunities to review our current working arrangements and to share our good practice with others.

Principals of remedy – handling of complaints 1 April 2022 to 30 June 2022

The CCG adopted the six Principles for Remedy set out by the Parliamentary and Health Service Ombudsman in their revised Principles for Remedy in May 2010, to form part of its complaints handling procedure for healthcare and adult social care. These six principles are:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement.

The CCG has continued to demonstrate its compliance with these principles through the PALS and complaints reporting process to the Safety Review Group and on to the Quality Governance Committee. We have used themed intelligence reports which bring together the learning from the PALS and complaints we receive, the incidents and serious incidents we were notified of and the process we developed to understand and respond accordingly to any concerns raised through other routes. We also hold stakeholder meetings when concerns need to be shared and potentially escalated.

Through a unique agreement under Section 75 of the National Health Service Act 2006, North East Lincolnshire CCG delegated responsibility for some children's health service commissioning to North East Lincolnshire Council, and in turn, the Council delegated commissioning for adult social care to the CCG – both with the intention of facilitating a more integrated service response with better outcomes for the people of North East Lincolnshire.

Between 1 April and 30 June 2022, the CCG received 14 complaints; 8 of which were about NHS care, 5 of which were about adult social care and 2 were about both health and adult social care. Of the 14 complaints closed during this period; 4 were upheld, 4 were partially upheld, and 6 were withdrawn. This was either because the complainant changed their mind about pursuing a complaint, or with their agreement, a resolution was found to their concerns by a different route.

During the three months there has been an increase in complaints about NHS services with complaints covering primary, secondary and community services. Across both NHS and Adult Social Care, concerns about the quality of care provided was the most common reason for complaining.

Of the complaints concluded during April to June 2022, poor communication played a part both between staff and service users, their family and carers and also between the services themselves. Poor record keeping was also highlighted as playing a part.

Ombudsman investigations.

During the period 1st April – 30th June 2022, no health complaints were investigated by the Parliamentary and Health Services Ombudsman. The Local Government and Social Care Ombudsman (LGSCO) had two cases referred to it and the investigations are ongoing.

The CCG's Chief Operating Officer and Director of Quality and Nursing personally signed off all complaint responses and details of any remedies or service improvements were included within the responses. These were followed up with the provider(s) through an action plan to ensure all actions have been undertaken. Unfortunately, in view of the ongoing pressures from Covid-19 on providers, site visits remained limited, which hindered the further assurance checks to ensure learning from complaints has become embedded. Learning from PALS, Complaints, Incidents, and Serious Incidents was shared through the regular Bulletin to providers.

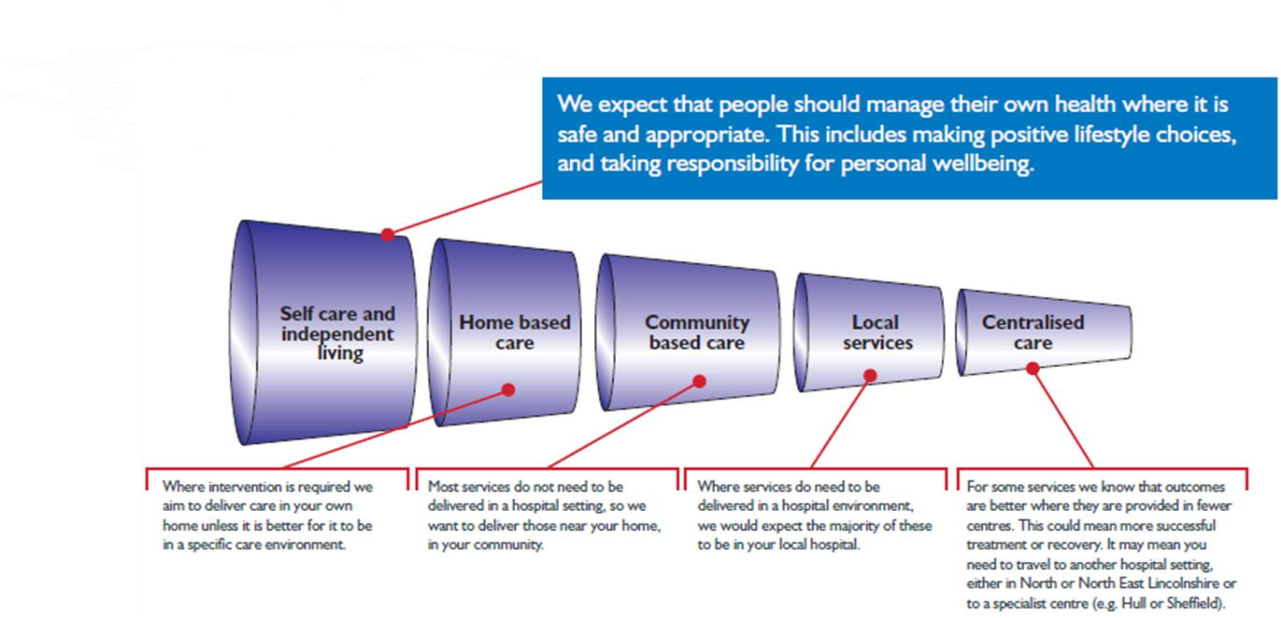
A joint annual report on health and social care complaints will be received by North East Lincolnshire Council Cabinet (consisting of elected members) for scrutiny. The functions historically carried out by the CCG will now be delivered by the Humber and North Yorkshire Integrated Health Board, which is working its partners at 'Place' to determine the new processes for quality monitoring and assurance.

Health and Wellbeing Strategy

We published our Union strategy (our partnership with the Local Authority in North East Lincolnshire) in July 2020 and we have used the strategy to continue to underpin our medium and long-term ambitions for the area. The strategy has also formed the backdrop for the work of our emerging Health and Care Partnership which was formed this year and will set the direction of travel for health and care in North East Lincolnshire within the upcoming new arrangements for system wide operation in the future.

We have formulated a Health and Care Partnership strategy which will shortly be ratified and sets out the transformational approach to individualising health and care for our population through intensive collaboration between local stakeholders. The strategy has been co-produced and work to operationalise the new ways of working is well underway.

As in previous years we are continuing to work towards moving health and care requirements more towards individuals taking responsibility for their own health and wellbeing and moving towards self-care and independent living in line with the model illustrated below:



We have continued to build on previous years' achievements with our social prescribing programme funded through a Social Impact Bond. We have also helped our local PCNs to recruit additional Social Prescribing link workers who now operate in a fully integrated way with our existing model to

optimise the impact of the service and help some of our most vulnerable residents to improve their health and wellbeing.

The approach we have taken in working closely in partnership with the Local Authority is reviewed on an ongoing basis by the Place Board (our Health and Wellbeing Board) to ensure a joined-up perspective on the relevant Health and Wellbeing needs of our local population.

We have also retained the improvements in access to primary care made during the pandemic in relation to remote working – enabling patients to access their GP practices from home via telephone and video consultations

As set out in the strategy we have worked to improve services for people with long term conditions, despite the challenges presented by the pandemic and worked to improve end of life care through more effective planning for end of life for each individual.

In terms of Mental health service provision, we have continued to improve our online offer for people isolated at home through physical health concerns, in particular related to Covid and the consequent increase in stress and anxiety.

This has been another very challenging year for the health and wellbeing agenda, but we have made some clear progress in selected areas and will continue to adapt to emerging needs and opportunities in this field of work.

Access to Information (FOI)

During the period from 1 April 2022 to 30 June 2022, the CCG processed the following requests for information under the Freedom of Information Act 2000 (FOIA):

FOI	2022/2023
Number of FOI requests processed	51
Percentage of requests responded to within 20 working days	100%
Average time (in days) taken to respond to an FOI request	14 days

The CCG provided the full information requested in 19 cases. The CCG did not provide all the information requested in 9 cases because an exemption was applied either to part of, or to the whole request. The exemptions applied were.

- The cost of providing the information exceeded the limits set by the FOIA.
- The information was accessible by other means.
- Information requested related to personal data and compliance would breach the principles in Data Protection Legislation.

In 23 cases, the CCG was unable to provide all the information requested, as it was either not held in full, or only partially held. Where the CCG did not hold the information, the applicant was redirected, where possible, to other organisation(s); that may hold the information.

The CCG did not receive any requests for an internal review of an FOI response provided during the Quarter.

The Section 45 Code of Practice under FOIA recommends that public authorities with over 100 Full Time Equivalent employees publish FOIA compliance statistics as part of their publication

schemes. As a matter of best practice the CCG publishes FOIA reports on a quarterly basis at the link below: https://www.northeastlincolnshireccg.nhs.uk/publication-scheme/what-are-our-priorities-and-how-are-we-doing/

Our publication scheme contains documents that are routinely published; this is available on our website: https://www.northeastlincolnshireccg.nhs.uk/freedom-of-information/publication-scheme/

Stephen Eames CBE
Chief Executive (Accountable Officer)
22 June 2023

Accountability Report

This section has been prepared by the Governing Body and provides an overview of GP practices who are members of the CCG, the composition of the Governing Body and other key points of interest.

Corporate Governance Report

Members' report

We are a clinically led organisation which brings together 24 local GP practices and other local health professionals to plan and design services to meet local patients' needs. During the reporting period 1st April – 30th June 2022 there was one merger between Clee Medical Centre and Dr Biswas-Saha, resulting in the closure of Blundell Park Surgery.

All our GP practices are members of a Primary Care Network (PCN). A PCN consists of groups of general practices working together with a range of local providers, (for example community services and social care) to provide co-ordinated health and social care to their local populations.

As from April 2022, there are now 5 PCNs in North East Lincolnshire as follows:

- Panacea
- Meridian
- Freshney Pelham
- Apollo
- Genesis

During the first quarter of 2022-23, the PCNs have been working towards the delivery of their key services which include:

- Early detection of cancer
- Enhanced Support to Care Homes
- Medication Reviews and Medicines Optimisation
- CVD Prevention and Diagnosis
- Tackling neighbourhood health inequalities
- Extended Access
- Social Prescribing

Each PCN employs additional roles to support their work, delivery their key objectives. The roles include the following: -

- Clinical Pharmacist
- Pharmacy Technicians
- Social Prescribing Link Workers
- Health and Wellbeing Coach
- Physician Associates
- First Contact Physiotherapists
- Dietitians
- Podiatrists
- Occupational Therapists
- Nursing Associate
- Trainee Nursing Associate
- Paramedics
- Mental Health Practitioners
- Advanced Practitioners

In addition, during April to June 2022 the PCNs in North East Lincolnshire delivered:

- Covid vaccines
- PCN Hubs with additional same day appointment slots for patients

Our member practices are listed below:

Practice	PCN Membership
Fieldhouse Medical Group	Freshney Pelham
Humberview Surgery	Freshney Pelham
Littlefield	Freshney Pelham
Pelham Medical Group	Freshney Pelham
Woodford Medical Centre	Freshney Pelham
Open Door Surgery	Meridian Health Group
Quayside Practice	Meridian Health Group
Roxton Practice	Meridian Health Group
Roxton at Weelsby View	Meridian Health Group
Birkwood Medical Centre	Panacea
Clee Medical Centre	Panacea
Greenlands Surgery	Panacea
Dr A Kumar	Panacea
Dr R Mathews	Panacea
Dr O Qureshi	Panacea
Dr A Sinha	Panacea
Dr P Suresh Babu	Panacea
Scartho Medical Practice	Genesis
Chantry Health Group	Genesis
The Lynton Practice	Genesis
Healing Surgery	Apollo
Beacon Medical Practice	Apollo
Raj Medical Practice	Apollo
Core Care Family Practice	Apollo

Governing Body member profiles

Our Governing Body is responsible for ensuring the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently, and economically and in accordance with the CCG's principles of good governance.

The membership comprises of members from our constituent practices, healthcare professionals, lay members, executive members, and local authority.

Current composition of the Governing Body

Clinical members

Dr Peter Melton	Clinical Chief Officer
Dr Ekta Elston	Medical director, Vice Chair Council of Members, GP representative
Vacant	Chair Council of Members, GP representative
Dr Jeeten Raghwani	GP representative
Dr Renju Mathews	GP representative
Dr Chris Hayes	Secondary care doctor

Lay members

Mark Webb	Chair
Philip Bond	Community engagement
Tim Render	Governance and audit

Officer representatives

Rob Walsh	Chief Executive (NEL CCG and NEL Council)
Helen Kenyon	Chief Operating Officer
Laura Whitton	Chief Finance Officer
Jan Haxby	Director of Quality/registered strategic nurse
Vacant	Director Public Health/Health and Wellbeing NELC
Jo Warner	Managing director focus independent adult social care work

Standing attendees

Joanne Hewson	Chief Operating Officer NEL Council

Individual Governing Body member profiles are available to view on our website

Register of interests

The management of conflicts of interest is embedded into the governance arrangements of the CCG. We maintain registers of interest, where a declaration is made, this is recorded clearly alongside how the conflict was managed. The registers are updated on an ongoing basis as interests arise or cease and when any changes require individuals to update their declarations.

The register for Governing Body members, member practice of the CCG and 'decision makers' can be found on the CCG website

Additional disclosures

Modern Slavery Act

NHS North East Lincolnshire CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2022 is published on our website

Personal data related incidents

The CCG has not reported any personal data related incidents to the Information Commissioners Office during the period April 2022 – June 2022.

Emergency Preparedness

Background

NHS England is responsible for emergency preparedness in the Yorkshire and Humber region including North East Lincolnshire. This regional management is administered through a Local Health Resilience Partnership (LHRP) attended by CCGs and NHS funded organisations. The basis of the LHRP is to seek assurance from NHS organisations that they meet the obligations of the national Emergency Preparedness, Resilience and Response (EPRR) Framework. The purpose of the EPRR Framework is to provide a set of standards for all NHS funded organisations in England to help with meeting the requirements of the Civil Contingencies Act 2004 (CCA 2004), the NHS Act 2006 as amended by the Health and Social Care Act 2012 (NHS Act 2006 (as amended)) and the NHS Standard Contract. The CCG is a Category 2 responder and has a key role in linking into NHS England in the event of a major incident and in a proportionate coordination role with local providers in the management of incidents depending on their nature. The Humber Local Resilience Forum (LRF) also exists, consisting of Local Authorities, Emergency Services, the NHS funded organisations that are Category 1 NHS responders, and this forum maintains an incident risk register, which, for this region, is biased towards industrial accidents and flooding. In contrast the EPPR Framework is biased towards health-related emergencies e.g. pandemic flu and on major service failure (any cause) of NHS providers.

2022/23 Core Standards Self-Assurance Process and Compliance

Due to the events of 2020, the NHS England Care Standards Self-Assessment process did not receive their tri-annual review and therefore not all standards reflect current best practice. NHS England have therefore removed a small number of standards to accommodate this year's assurance process until a full review can be undertaken.

The overall EPRR assurance rating for an organization is based on the percentage of core standards the organization assesses itself as being "fully compliant with" (see below). For the last 3 years, the CCG has been "substantially compliant" with the core standards. This year, there are only 29 applicable standards for CCGs. The CCG was assessed by the Emergency Planning and Resilience Manager as being fully compliant with the 28/29 of these standards and therefore the CCG has an

overall rating of substantial compliance. It is anticipated that as part of the CCG moving into ICS form all EPRR arrangements will be reviewed including training, exercising, planning and the auditing of the processes and business continuity management system (BCMS).

Covid-19 and other emergency planning work

NEL EPARG holds quarterly meetings to progress actions and plans alongside the training and exercising sessions.

The following sessions took place in 2021/22 with involvement from EPARG member organisations:

- Black Start Exercise
- Exercise Lemur
- Flooding Exercise involving the Environment Agency and Anglian Water
- Humber Cyber BCP
- Omicron Winter Exercise

Statement of Disclosure to Auditors

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

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report.

- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it

Stephen Eames CBE
Chief Executive (Accountable Officer)
22 June 2023

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

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

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

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

As the Accounting Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS North East Lincolnshire Clinical Commissioning Group'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.

I also confirm that:

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

Stephen Eames CBE
Chief Executive (Accountable Officer)
22 June 2023

Annual Governance Statement

Introduction and context

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

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

As at 1 April 2022 the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the Nation Health Service 2006 (as amended).

Scope of responsibility

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

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

Governance arrangements and effectiveness

The 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.

The CCG constitution sets out how the organisation will ensure it is well governed and accountable to both its GP member practices and its local population. No required changes were mandated to be made to the CCG's constitution during period April 2022 – June 2022 as such the CCG have not made any changes to their constitution during this period.

The Constitution and Governance handbook are available on the CCG website.

As a clinically led organisation, it is essential for there to be strong clinical representation on the Governing Body and on the committees of the CCG, and for any service redesign and/or transformation programmes to be clinically led. To encourage openness and inclusivity each Committee's membership shall include a minimum of one GP member representative.

The CCG and North East Lincolnshire Health & Care Partnership continues to work into shadow partnership arrangements with the establishment of a Professionals Forum whose membership is the clinical and professional leads from all partner organisations within NEL, including the GP Primary Care Networks. Please refer to the members report for list of practices within North East Lincolnshire

The CCG's Governing Body has ongoing requirement to review the CCG's governance arrangements to ensure they reflect the principles of good governance to which the Governing Body regularly review the CCG's governance arrangements. As the CCG transition to the Integrated Care Board (ICB) with effect from 1 July 2022 an independent audit review of the CCG governance arrangements was undertaken during the first quarter of 2022/23, to provide assurance that the CCG continues to maintain oversight of their statutory functions and performance,

Audit testing on the effectiveness of the governance arrangements in place within the CCG found good governance arrangements were maintained during this reporting period.

The Governing Body is supported by a robust committee structure, to assist in the delivery of the statutory functions and key strategic objectives of the CCG. All the committees have at least one Governing Body member, GP Representative, and Lay member as part of their membership and minutes of all committees are shared with the Governing Body.

The Governing Body continued to meet in public during the first quarter of 2022/23 with the meetings being broadcast on the CCG website as an opportunity for the public to join the meeting.

Meeting papers are available on our website.

Governing Body

The Governing Body met virtually twice in the 3 months to 30th June, with the meetings being broadcast on the CCG website as an opportunity for the public to join the meeting.

The Governing Body has statutory responsibility for:

- ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently, and economically and in accordance with the group's principles of good governance
- establishing a remuneration committee to determine the remuneration, fees, and other allowances payable to employees or other persons providing services to the group and the allowances payable under any pension scheme it may establish
- establishing an Audit committee, that will be called the Integrated Governance & Audit Committee, to ensure sound integrated governance and financial management arrangements are in place, and that those arrangements support the efficient, effective and economic delivery of the group's functions; those matters specified elsewhere in this constitution and in the scheme of reservation and delegation

The focus of the Governing Body during this period has been:

- Planning for 2022/23
- Ensuring a smooth close- down of the CCG, including the approval of the 2021/22 annual report & accounts
- Establishment of & transition to the new integrated care arrangements (ICB, Place Based)

The 'Risk committee', formed during COVID, has also continued to meet virtually on regular basis and report back to the entire Governing Body.

The May meeting was quorate; however the June meeting didn't meet quoracy, the minutes of the June meeting demonstrate appropriate action to be taken if decisions to be made.

Governing Body Members	Attendance (maximum of 2 meetings)
Mark Webb (Chair)	2
Dr Peter Melton	2
Dr Ekta Elston	1
Dr Renju Mathews	0
Dr Jeeten Raghwani	0
Dr Chris Hayes	1
Philip Bond	2
Tim Render	2
Rob Walsh	2
Helen Kenyon	1
Laura Whitton	2
Jan Haxby	1
Joe Warner	2

Our committees

During the first quarter of 2022/23 the following committees continued to meet to support the Governing Body with a focus primarily on any work that contributed to the close -down of the CCG and in readiness for the handover to the ICB. The Chair or in the absence of the Chair the Executive Lead of each committee approved the minutes of the final meetings as part of the transition.

- Integrated Governance and Audit Committee
- Primary Care Commissioning Committee
- Care Contracting Committee
- Quality Governance Committee

The Membership, Attendance and Activity Summary

Integrated Governance and Audit Committee

The Integrated Governance and Audit Committee is accountable to the CCGs Governing Body. It is responsible for providing an independent and objective view to the Governing Body for all matters pertaining to the CCGs functions and responsibilities, in particular: -

a) Economy, effectiveness, and efficiency
b) Governance arrangements, including compliance with those laws, regulations and directions governing the CCG.

It is also responsible with providing the Governing Body with an independent and objective view of:

a) The CCG's financial systems and financial information
b) All other responsibilities of the committee as set out in the CCG's scheme of reservations and delegation and the committees' terms of reference.

Performance highlights include (please note: this list is not exhaustive)

- Annual accounts
- Annual report and governance statement
- Performance reports
- NHSE assurance checklist
- NAO disclosure checklist
- Due diligence
- Risk management

The committee met twice during this report period and records show that all the meetings were quorate.

IG & Audit Committee Members	Attendance (maximum of 2 meetings)
Tim Render (Chair)	2
Dr Karin Severin	0
Councillor Margaret Cracknell	1
Joe Warner	2
Philip Bond	2
David Walker	0

Primary Care Commissioning Committee

The Primary Care Commissioning Committee functions as a corporate decision-making body for the management of the delegated functions for matters relating to primary care.

It is a committee comprising representatives of the following organisations:

- NHS North East Lincolnshire CCG (including lay member representation)
- NHS England
- North East Lincolnshire Council

The committee met once during this report period and records show that the meeting was quorate.

Primary Care Commissioning Members	Attendance (maximum of 1 meeting)
Mark Webb	1
Philip Bond	0
Laura Whitton	1
Dr Ekta Elston/Dr Anupman Sinha	0
Dr Renju Mathews	0
Councillor Stan Shreeve	1
Jan Haxby/Lydia Golby	1
Geoff Barnes	1

Care Contracting Committee

The Care Contracting Committee (CCC) is a Committee of the Governing Body that has been delegated the responsibility for ensuring that the market shape agreed by the Council of Members is achieved.

The Committee also oversees all procurement processes ensuring that they are enacting decisions taken by the Council of Members and that the CCG is compliant with external regulations and requirements including relevant procurement law. All the CCGs contracts except for those which relate solely to General Practice, for example, Primary Medical Contracts and General Medical Contracts. These will be managed by the CCG's Primary Care co-commissioning committee (PCCC).

The committee met three times during this reporting period. The meeting of 13th April 2023 was not quorate, but no decisions were made at this meeting.

Care Contracting Committee Members	Attendance (maximum of 3 meetings)
Helen Kenyon – Chief Operating Officer - Chair	3
Mark Webb – Lay member (Governing Body)	2
Bev Compton – Director of Adult Social Services	2
Christine Jackson – Head of Case Management Performance & Finance - focus	3
Laura Whitton – Chief Finance Officer	3
Jan Haxby – Director of Quality and Nursing	1
Dr Ekta Elston – Medical Director	0
Dr J Raghwani – GP representative	1

Quality Governance Committee

The Quality Governance Committee (QGC) is a committee of the CCG Governing Body that exists to:

- Oversee the Quality Governance arrangements within the CCG for arrangements around the commissioning of health and social care (see appendix one for an overview of the Triangle of Quality governance that the QGC has adopted as an operational definition of quality governance).
- Have oversight of the safety, effectiveness and experience of the services commissioned by the CCG.
- Provide a position statement to the CCG Governing Body on contracted services contemporaneous quality governance arrangements and quality indicators.
- Ensure a positive safety culture is embedded in the NHS and Social Care system we commission.
- Review quality benchmarking information and approve position statements on the analysis of this and the recommendations made to address variance.

The committee met twice during this reporting period and records show that all the meetings were quorate.

Quality Governance Committee Members	Attendance (maximum of 2 meetings)
Philip Bond – Community lay member representative	2
Bernard Henry – Community lay member representative	0
Nicola McVeigh – Chair of MIFS	1
Lydia Golby – Clinical representative (Chair)	2
Julie Wilburn – clinical representative	1
Zoe Wray – Quality & Experience team manager	1
Julie Wilson – Commissioning representative	2
Ryan Jewitt – Head of Nursing	2

As part of the CCG's governance arrangements, there is a requirement for "public and patient involvement". As part of transition to the Integrated Care Board, the Community Forum ceased on 31/03/2022. This has been replaced by the Interim Patient Assurance Group which will provide assurance and challenge to the CCG Governing Body that patient, service users, carers and the public are effectively engaged and involved in decisions made about health and social care services in North East Lincolnshire in keeping with the North East Lincolnshire Commitment and joint community engagement strategy – "Talking Listening and Working Together"

UK code of corporate governance

NHS bodies are not required to comply with the UK Code of Corporate Governance. However, compliance with relevant principals of the Code is considered good practice.

This Governance Statement is intended to demonstrate how the CCG had regard to the principles set out in the Code that are considered relevant to the CCG and best practice.

Discharge of the CCG's statutory functions

In light of recommendations of the 2013 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Audit Yorkshire supported the transition of statutory functions from the CCG to the Humber and North Yorkshire ICB. Work undertaken was in line with the requirements of the 'CCG Closedown & ICB Establishment Due Diligence process. A review of the final due diligence position and process provided an overall opinion of **Significant** assurance.

Risk management arrangements and effectiveness

A fundamental element of good governance is ensuring a clear and integrated approach to risk management. There is an agreed Risk Management Framework in place, which sets out the approach to risk management. The framework is designed as a guide to the CCG in its approach to risk management and provides a structural framework with clear definitions and responsibilities. It also identifies how to report risks and how risks are governed within the CCG.

Risk is evident in everything we do. The risk management framework is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

As part of the preparedness to transfer to the Integrated Care Board (ICB) the CCG has continued to ensure we are continuing to carry out our duties for Risk Management. During quarter 1 we continued to maintain both our Board Assurance Framework (BAF) and the Risk Register. Risks that may affect the ability of the CCG to meet its strategic commitments are recorded on the Board Assurance Framework and operational risks are recorded on the CCG Corporate Risk Register. Initially risks are subject to agreement by senior managers to ensure that the full consequences of the risk have been considered in relation to it actual impact on the CCG and enable effective risk mitigation. Significant risks are reported to the relevant committees.

The Governing Body owns and determines the content of the Board Assurance Framework (BAF), identifying the strategic risks to achieving the CCG's commitments and monitoring progress throughout the year. The BAF is presented to the Governing Body at least annually, to enable the Governing Body to review each of the risks, analyse the controls and assurances, clearly identify any gaps and the actions needed to address them.

To support the Governing Body in carrying out its duties in relation to risk management, the Board Assurance Framework and Risk Register are monitored by the Integrated Governance and Audit Committee at each of its meetings, which ensures robust and adequate progression of the risks are kept live and relevant. The controls, assurances and gaps in controls and assurance are scrutinised along with any actions required to work towards improving the potential risk. The Integrated Governance & Audit Committee informs and escalates any risk to the Governing Body as and when required.

The CCG has appropriate processes in place to identify, assess, report, control and monitor risks. Audit testing found that the risk management processes in place reflect the system of risk management outlined in the CCG's Risk Management Framework, confirming that the Board Assurance Framework and Risk Register have continued to be consistently presented to Integrated Governance & Audit Committee during 2022/23 in a timely manner.

The CCG actively involve Public Stakeholders in managing risks. These measures are in place to ensure that CCG decision making processes are transparent, to ensure that community engagement continues to be embedded in this process and, ultimately, to provide further assurance to the organisation.

Capacity to handle risk

The Accountable Officer remains ultimately accountable for ensuring sound systems for risk management are in place and implemented.

The Chief Finance Officer is responsible for governance and risk managed, supported by the Governance Team. Senior Leadership have a specific duty to ensure that appropriate mechanisms are in place within their areas of responsibility for identifying and highlighting new and emerging risks.

The CCG fully appreciates its statutory obligations towards risk management and the Governing Body, Senior Managers and staff work together to provide an integrated approach to the management of risk and in developing a culture of reporting risk, understanding, and challenging risk and providing opportunities for the analysis of risk and discussions on risk across the whole organisation.

Risk awareness is a key element of the CCG's approach to risk management, ensuring that all staff understand and can discharge their roles and responsibilities in relation to risk. Staff are supported as appropriate to their level authority and duties and there are relevant policies and procedures available with support from the governance team. Risk Management is embedded within the activities of the CCG through the risk process as follows: -

- CCG employees receive training in Equality and Diversity and Equality Impact Assessments are completed for all service proposal, service specification, strategy, policies so that the full impact on protected groups is identified and considered.
- The CCG has policies in place to encourage employees to highlight risks and report incidents and the Whistleblowing Policy highlights the importance the CCG places upon the open reporting culture.
- Staff and GPs are encouraged to report any concerns through the incident reporting system and each incident is reviewed and investigated as per the CCG incident management policy.

Risk assessment

All risks are assessed on the level of controls and assurances that are in place and are scored on the severity of consequence and likelihood of occurrence. Both assessments are scored on a 5 x 5 matrix and the product of the two gives a risk score that reflects the urgency and degree of action, if any, required for reducing or eliminating the risk. An escalation procedure is in place to ensure that risks are escalated initially to the risk manager and to the Integrated Governance & Audit Committee if required. The risk management framework sets out the management and assessment of risks.

A deep dive session to review risks was undertaking in May 2022, with the Chair of IG&A committee, Chief Finance Officer, Corporate Assurance Officer, and Service Support Officer to prepare for the closedown of the CCG and risks are updated to enable these to be clearly articulated to the ICB as the successor body.

The deep dive review identified a number of risks requiring a more focus review to reflect the current position and potential closures. Risk managers and assignees were asked to undertake the review and asked to pay particular attention to the risk description, internal controls, and risk ratings and agree any closures identified.

North East Lincolnshire Clinical Commissioning Group compared with neighbouring CCGs will have more operational risks on their risk register due to the partnership working with North East Lincolnshire Council in relation to the commissioning of Adult Social Care. As at quarter 1 2022/23 there were **three** Adult Social Care risks on the risk register.

As at quarter 1 the total risks held on both Board Assurance Framework and the Risk Register with a residual risk rating being assessed as high level (15+) was **ten** and are listed in the table below.

Risk Code	Risk Summary	Current Risk rating	Current Risk Trend	Control	
CCG-BAF.2002	Risks of failing areas of performance having detrimental impact on population health	16		**Assurance on Controls**	Regular reporting into the Governing Body and IG&A Committee.
				Positive Assurances	NHSE continue to acknowledge the CCG is taking an active leadership role to address the issues in relation to NLaG. NHSE's overall assessment of the CCG in the improvement and assessment framework was 'Good' 2020/21 Year end position of ASC targets was also positive. The CCG received the best available rating Patient & Community Engagement (Green Star).
				Gaps in controls	None
				Gaps in Assurances	None
CCG-BAF.3006	Covid-19	15		**Assurance on controls**	The Union Outbreak Control Steering Group updates the NEL Outbreak Management Plan. Covid-19 is a strategic risk for NELC and both CCG and NELC staff are involved in its mitigation.
				Positive Assurances	• Leadership Team • Senior Management Team (CCG) • HCV Strategic Group • Northern Lincolnshire A&E Delivery Board
				Gaps in controls	The CCG business continuity plan has now been reviewed, there are still some gaps. Staff absences have been mitigated significantly as a lot of restrictions have now been relaxed.
				Gaps in assurances	**None**

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
CCG-RR.2005	RTT Performance and overdue follow-ups	20		CCG-RR.2005a Performance Reporting	Robust performance reporting is produced for the Service Lead to act upon and is discussed at the Planned Care Board and monitored at OLT with escalation to CoM and Governing Body.
				CCG-RR.2005b Northern Lincolnshire Planned Care Board	A Planned Care Board chaired by the NL CCG Chief Executive has been established to ensure actions are taken to improve performance across NL and NEL which will feed into the NLAG Contract Transformation Board. Senior leadership is present at those meetings with clinically led planning to redesign services for optimum efficiency and effectiveness. Clinical engagement has been secured from both the Trust and the CCG in the service specific transformation Boards. Options put forward for some specialties to manage demand and outpatient transformation programme has been refreshed following Covid experience.
				CCG-RR.2005f Commissioning of additional activity from alternative providers	Alternative providers have been commissioned to provide additional capacity to help individuals access care more quickly and reduce the risk of clinical harm. This control is partially effective as there are not alternative providers for all specialities and there is no feasible alternative market for us to develop.
				CCG-RR.2005g Humber level waiting list management	It has been agreed that as a result of the impact of Covid the waiting lists of NLAG and Hull and the independent sector need to be managed as a single list during the remainder of this year, as a minimum, to ensure capacity that is available is being used for the highest risk/need patients.
CCG-RR.2017	Cancer waiting time performance	20		CCG-RR.2017a Performance Reporting	Robust performance reporting is produced for the Service Lead to act upon and is discussed at the Planned Care Board and monitored at OLT with escalation to CoM and Governing Body.
				CCG-RR.2017b Northern Lincolnshire Planned Care Board	A Planned Care Board chaired by the NL CCG Chief Executive has been established to ensure actions are taken to improve performance across NL and NEL which will feed into the NLAG Contract Transformation Board. Senior leadership is present at those meetings with clinically led planning to redesign services for optimum efficiency and effectiveness. Clinical engagement has been secured from both the Trust and the CCG in the service specific transformation Boards. Options put forward for some specialties to manage demand and outpatient transformation programme has been refreshed following Covid experience.
				CCG-RR.2017c Cancer Alliance	Provides a regional perspective and support with workforce, diagnostics, radiology etc.
				CCG-RR.2017d HASR	Working on a strategic plan for Hull and NLAG around provision of services to ensure improved delivery against national targets.
				CCG-RR.2017e Dedicated Cancer Clinical Lead	Working across primary care as the interface between primary and secondary care and advises and supports GPs on any cancer related issue.

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
CCG-RR.2020	Looked after children initial health assessment performance	20		CCG-RR.2020a Performance Report, monitoring, and escalation	CCG Designated Looked After Children's Nurse receives quarterly performance reports from the service provider. The CCG now consistently receives quarterly data and performance reports. This report is monitored by the Children looked after strategic group and Safety Review Group within the CCG and is escalated to the Clinical Governance Committee as required.
				CCG-RR.2020b Assurance Management by the Provider	CCG Designated Looked After Children's Nurse has assurance that the service provider raises individual issues with the Local Authority (e.g. Social Worker and Service Manager as they are identified) There is assurance that escalation takes place with Children's Social Care (CSC) direct but also through the CLA operational delivery group, the CLA strategic group, Corporate Parenting Board, within the CCG and the SCP.
				CCG-RR.2020c Quarterly position statement	CCG Designated Looked after Children's Nurse to report on a quarterly basis into the SRG escalating to the Clinical Governance Committee and the Governing Body as required. The governance and reporting structure is in place.
				CCG-RR.2020d Joint working with Children's Social Care to support process	CCG Designated Nurse and Senior Named Nurse support the work of CSC to improve the timeliness of notifications to the health team to improve data and performance around children entering care receiving their IHA within 28 days
CCG-RR.2004	Failure to achieve Accident and Emergency 4-hour targets	16		CCG-RR.2004c A&E Delivery Board	A&E delivery board established as part of a national requirement to ensure system wide ownership and delivery against the A&E target required.
				CCG-RR.2004d A&E delivery board winter plan	The winter plan includes initiatives in and out of hospital to support an agreed A&E 4 hour wait performance trajectory.
				CCG-RR.2004g UECN Talk before you walk task and finish group	Carrying out a regional review into 111 and links into integrated urgent care delivery including UTCs, direct booking and addresses any gaps that are currently resulting in people attending A&E that could be treated elsewhere.
				CCG-RR.2004h Primary Care Access Hubs	Establishment of 3 PCN Primary Care Access Hubs to divert 'UTC type' activity into Primary Care via 111
				CCG.RR-2004i Community Discharge Hub	Establishment of a Community Discharge Hub to ensure early patient discharge restoring flow within the acute site
				CCG-RR.2004j Missed Opportunities Audit	An audit by team of subject matter experts reviews all ambulance attendances within a chosen 24 hour period to understand any missed opportunities to access care via a different route and avoid an A&E attendance
				CCG-RR.2004k System Improvement Grp	A subgroup of AEDB has been established to oversee development of and performance against the System Improvement Plan

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
CCG-RR.2014	Management of deprivations of liberty safeguards under the Mental Capacity Act 2007	16		CCG-RR.2014a Well defined and managed MCA process adhering to national best practice	An online process through Systmone has been developed which allows for the systematic processing of applications, recording of decisions and evidence and offers process efficiencies. The framework recommended by ADASS as national practice has been applied.
				CCG-RR.2014b Quality assurance panel	Each case is reviewed by the QA panel to ensure legal compliance, appropriateness and consistent application of the legal tests in each case.
				CCG-RR.2014c Authorised signatories in place	Authorised signatories are trained in the requirements of the law and offer an independent view of each application. There are opportunities to feedback in relation to any issues either via the admin support team at focus or more directly to the MCA/DOLs lead in the CCG. Due to the upcoming retirement of one of the existing signatories, former signatories will be retrained to act as replacements
				CCG-RR.2014d Risk assessed/triaged case load	All cases are risk assessed and prioritised for approval. Work being undertaken with Navigo and Focus to try and prevent inappropriate applications and to prioritise existing ones more effectively
				CCG-RR.2014e BIA training and competency framework	High quality BIA training has been procured and the BIA competencies have been defined so that ongoing development of workers can be managed and their competency assessed and assured. This includes arrangements for supervision.
				CCG-RR.2014f MCA training	MCA training is being commissioned following an audit of care providers which revealed a number of gaps in training and concerns about the quality of the training offered. Focus are now providing this training. Focus have created a training lead post for MCA and Safeguarding and have successfully recruited to this as a job share. The post holders will work with the existing provider to develop a hand over training package and develop new offers to meet demand. MCA training has been reshaped and a new curriculum and format is now being offered. The feedback has been very positive, Unfortunately the demand has now increased as a result and there is now a backlog. Due to COVID training has been altered and online training is now being trialled. This control remains partially effect due to the demand in delivering the training. Online training for Level 1 has been trialled and there has been positive feedback. Focus are looking at how best to deliver online training and are reviewing the training offer. As a result of COVID all Level 1 training is now being offered through Zoom and work is ongoing to convert other MCA training into web deliverable programmes. These are being booked through Focus libris and are booking up quickly. The strategic group is reviewing recent court cases with a view to setting up a specific workshop to consider implications. All MCA training has now been converted to virtual and is booked via focus. Due to the number of COVID-19 outbreaks in care homes some staff booked on training are having to cancel or are not able to attend. This is putting more pressure on the training system as places are being rescheduled. Training continues to be offered online with more frequent dates and shorter duration in the anticipation that as the pandemic eases the uptake will return. Following an increased uptake of MCA/DoLS online training focus are developing new modules and video updates.

					FOCUS are putting on more training sessions and utilising other communications to get information out about the need for MCA compliance via newsletters and video briefings. They are also putting on more training sessions as where capacity to do so is available
				CCG-RR.2014g BIA forum and ongoing professional development	There is a monthly BIA forum which provides the opportunity to share practice and to learn from case law examples.
				CCG-RR.2014h Light touch approach for cases	We have implemented part of the light tough approach. Work continues to develop the light touch approach and pilot with urgent and discharge cases. As the light touch approach has not reduced the backlog it has been redeveloped to allow staff to test out skills that will be needed when the LPS comes into effect 1/4/22.
				CCG-RR.2014j Attendance at the regional BIA forum (ADASS)	Regular attendance at the regional forum provides the opportunity to share good practice and keep pace with national developments. It also provides independent training for BIAs to maintain their competence.
				CCG-RR.2014k MCA Strategic Network	The NEL MCA Strategic Forum, has now become a formal subgroup of the Safeguarding Adults Board to ensure spread of strategic development and commitment
				CCG-RR.2014l BIA and MHA capacity	Work is being carried out by the CCG and Focus to work up data on the impact of reducing the DoLS backlog to zero within 12 months. Presented to Cabinet Feb 19 with request for further work especially on DoLS. Work is ongoing to review a new option that would focus on certain risk categories. A training programme has been commissioned for BIA training and 10 NEL staff have been put forward. There continues to be pressure on the system to allow BIAs to partake of the duty rota, this is the reason as to why the risk remains partially effect. To help reduce some of the pressure Focus have identified that the present assessment budget has been exhausted and there is potential for an overspend if work continues in this financial year. Focus have looked at mitigating plans and funding and a paper is being developed for CCC to seek alternative ways to meet the assessment requirement. Focus are continuing to develop a light touch approach to assessment in line with guidance as well as the use of virtual assessments where possible. Focus are due to report on DoLS assessment activity, however because of COVID-19 it is not expected that the overall back log will have changed. Focus have reviewed activity and are now anticipating that there will be little reduction in the backlog. Due to LPS being delayed to 2022 this will also put pressure on the number of assessments that will need to be carried out as we are not able to rely on an "equivalent assessment" for a second year. Focus are looking at how much they are able to move towards the new LPS system without compromising the legality of the present process. Work to "pilot" an approach to DoLS that could align with LPS continues but this has been much slower as a result of the COVID-19 pandemic as Care Homes have found it difficult to spare extra time to input into the process. BIA training is continuing however the COVID pandemic has had an impact on the length of time this is taking. The Pandemic has also meant that pressure on staff to fulfil more activity in their substantive roles that there has been more pressure on the availability of BIAs. A scoping tool is being developed locally to identify the specific areas of pressure when the LPS comes into effect. The ICS is also looking at scoping the impact of LPS as it will become responsible for any CHC client who needs to have their deprivation of liberty authorised via the LPS.

					there is still no clarity from DHSC about the implementation date for the LPS. Work continues to ensure that should the 1st April 2022 date still happen the CCG are prepared. In light of the transfer of CCG functions to the ICB work has started to share NEL practice with NL CCG. The draft code for LPS and the Draft Regulations have now been released for consultation Work is being carried out in place, across northern Lincolnshire and the ICS to review them and to look at shared models to improve capacity or resilience. The CCG will be running a number of consultation events before submitting feedback both as a CCG/LA and as part of the ICS The CCG and the ICS are responding to the consultation on the code of practice as there are significant concerns over its apparent interpretation of present statute and case law. The outcome of the consultation and any potential legal challenge could dramatically affect the numbers of authorisations and assessments needed. The CCG is therefore intending to plan for the demand to remain high
				CCG-RR.2014m Monitoring of activity at DAC and Safeguarding Board	Help and support to develop and deliver a process for applications to the court of protection for deprivations in non-standard settings. Providing front-end legal advice to practitioners. Staff changes within NELC legal and the demand for CoP DoLS is putting pressure on the ability of the legal team to carry out work in a timely manner - discussions to mitigate this has started
CCG-RR.4026	Leavers processes are not consistently being followed which could pose security and financial risks for the CCG	16		CCG-RR.4026a Information asset reviews	Information Asset Register reviews are conducted at least annually. This is a requirement for compliance with the Data Security Protection Toolkit (DSPT)
				CCG-RR.2026b Leavers' process	There are various leavers processes Line Managers are required to follow to remove access to accounts when staff leave or change roles within the organisation i.e.: • Managers/pre post checklist • NHSmail Joiners/leavers process
				CCG-RR.2026c Security group reviews	Security reviews are conducted at least annually in-line with the annual IAR reviews, and any inconsistencies or errors are highlighted and corrected.
				CCG-RR.2026d Secondment agreement	When individuals go on secondment, they are likely to take their equipment /NHS mail account with them and may retain access to some CCG systems depending on the job role. Secondment must therefore be considered on a case-by-case basis. Access is being removed to shared mailboxes and w-drive where appropriate, but seconded staff members do need to remain on HQ distribution lists as they are members of staff and as such need to be kept updated on any changes within the organisation.

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
CCG-RR.2003	On-going failure to meet Clinical Handover time targets for EMAS patient delivery at DPoW A&E	15		CCG-RR.2003c EMAS Contract Management Meeting	This divisional monthly meeting addresses performance, quality and strategic issues. Commissioners can challenge EMAS and escalate any issues to the lead commissioner (Derby & Derbyshire CCG).
				CCG-RR.2003d EMAS recovery and restoration meeting	There is one meeting at the EMAS level and a further one is being established at the greater Lincolnshire level to maximise Executive time and ensure we achieve a greater level of traction and comparison with Lincolnshire and use of SPA and conveyance attendance. The purpose of this meeting is to compare the current data with the Covid data to understand the differences in numbers of conveyance of patients and the increasing trend in transporting patients taking place now.
				CCG-RR.2003e Northern Lincolnshire EMAS transformation Group	The Greater Lincolnshire EMAS Contract meeting, as conveyance puts pressure onto the system which leads to potentially longer handovers. This meeting has oversight of the NHS 111 First meeting to again look into the reduction of conveyance as first step to reduce handover delays. This group includes NEL AD Contracts lead, Lincs Dir of Commissioning and Lincs Head of Urgent care and EMAS Divisional manager Lincolnshire. This meeting then feeds into the EMAS Overall Contract performance discussions on monthly basis covering issue of performance delivery and improvement.
CCG-RR.3012	Inability to deliver ASC statutory duties on behalf of NELC within the allocated Budget in year	15		CCG-RR.3012b Monthly budget monitoring	The activity budgets are monitored through a joint commissioning finance meeting with focus and the CCG. Areas of concern are escalated to FPB on an exception basis Non activity budgets are monitored with individual budget holders.
				CCG-RR.3012c Financial Programme Board	Financial Programme Board has detailed oversight of the key budgets for adult social care specifically those for residential, nursing and domiciliary care and can therefore ensure that demand is being appropriately managed. The FPB also has oversight of a range of efficiency and improvement measures which have been designed to ensure best use is made of the budget and that we are planning expenditure in line with budget.
				CCG-RR.3012d Corporate Reporting process	The internal controls 3012a to 3012c all contribute to corporate reporting.
				CCG-RR.3012e CCG strategic oversight meeting	A fortnightly oversight meeting is held CCG representatives in attendance. This oversight group actively discuss measures to address the budget gap and ensure we make best use of available resources

Other sources of assurance

Internal control framework

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

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

The system of internal control within the CCG is based on an on-going process designed to identify and prioritise the risks. It is frequently the case that whilst the impact of the risk may remain the same as the original raw assessment, successful mitigating actions/internal controls will reduce the likelihood of the risk occurring.

The CCG has approved set of standing orders, standing financial instructions of which are published as appendices within the CCG constitution. The CCG also has prime financial policies, financial policies and procedures and a robust financial scheme of delegation.

Internal Audit will continue with their current system for managing recommendations to monitor any outstanding CCG recommendations assigned to a responsible manager until such time that they can be closed.

Conflict of interest management

As the part of the CCG's transition to the Integrated Care Board (ICB) our internal auditors undertook an audit testing during quarter 1 and confirmed that the CCG continues with their arrangements for managing conflict of interest during the transition period.

The CCG is required to publish any breaches in relation to the CCG's Conflicts of Interest Policy. Breaches registers can be found **here**

Data quality

The CCG recognise that good quality data is essential for the effective commissioning of services and underpins the delivery of high-quality care. The CCG has an in-house business intelligence (BI) team and BI is oversee by the Integrated Governance & Audit Committee.

It is also important to ensure that the data quality is of a high standard in order to comply with current data protection legislation, in particular the principle for "accurate and up to date". The CCG Governing Body, its committees and staff are aware of the importance of maintaining high standards of information governance and securing confidentiality of patients.

The data received by the Governing Body and its committees is continuously reviewed and the contents of reports are refreshed regularly to ensure that suitable information is available to the CCG.

Information governance

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

The CCG place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information by demonstrating compliance with the Data Security Protection Toolkit (DSPT). The CCG has a suite of approved Information Governance policies which outline mechanisms in place to ensure that risks to confidentiality and data security are effectively managed and controlled.

The CCG is committed to reporting, managing, and investigating information governance incidents. An Incident Reporting Policy is in place, this policy used by staff for recording, reporting, and reviewing of information governance (IG) and information security incidents/near misses. Staff are required to report information governance risks and incidents through the centralised incident reporting process

The CCG has published privacy notice on its website, which informs what personal information the CCG holds and processes, the legal basis for doing so and the purposes.

Business critical models

The main CCG business critical model is our plan (finance & performance) which is subject to NHS England assurance and audit review. The plan for 2022-23 was part of the overall ICB planning. The CCG maintains and organisational Information Asset Register (IAR) which identifies business critical, HR, Business Intelligence, and financial assets. Each asset has the required level of professional and management input and known as Information Asset Owners (IAO). Data flow mapping also forms part of the IAR, which provides an understanding of the flows of the information.

Third party assurances

Internal & External auditors have been appointed to provide the Governing Body with independent assurance of its process of internal control and to assure itself of the validity of this Governance Statement.

During the first 3 months of 2022/23, the CCG contracted with several external organisations for the provision of support services.

The CCG receives financial transaction and reporting services from the NHS Shared Business Services (SBS). Service auditor reports are received on an annual basis and gives assurance on this business arrangement.

The CCG receives financial transaction and reporting services from NHS Business Services Authority with regards to prescribing. Service auditor reports are received on an annual basis and gives assurance on this business arrangement.

The CCG receives financial transaction services from NHS Digital with regards to GP Payments. Service auditor reports are received on an annual basis and gives assurance on this business arrangement.

The CCG receives payroll services from the national NHS Electronic Staff Record (ESR), administered by Victoria Pay Services. Service auditor reports are also received on an annual basis and gives assurance on this business arrangement.

The CCG receives Individual Funding Request (IFR), Medicines Management, Non-Contract Activity support & Data Services for Commissioning Regional Offices support (DSCRO) from North East Commissioning Support (NECS).

Assurance is gained through regular contract monitoring and review meetings where outstanding issues are raised and resolved, and future improvements are discussed and agreed.

For each of the material systems where third parties handle transactions the CCG has gained assurance via the following:

- Work undertaken by Audit Yorkshire and internal auditors of North East Lincolnshire Council.
- Internal work undertaken by the CCG.
- Routine monitoring of contracts we have in place throughout the year.
- External assurance. (Please note Service Auditor Reports are only produced annually so not available for accounts to 30th June 2022)

Control issues

Reflecting on our performance for quarter one our system has performed well against a number of challenging targets. Although we had planned to meet all national planning standards and commitments in this reporting period, this has not been possible for some of our commissioned services. The performance analysis highlights the significant challenges identified over the previous quarter. Although concerns have been highlighted, we do not consider any a serious lapse in internal control.

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

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently, and economically in accordance with the NHS principles of good governance.

The 2022-23 planning process was undertaken for the full financial year at an individual CCG level amalgamated into an overall Humber & North Yorkshire Plan. Due to CCGs officially ending on 30 June 2022 plans were pro-rated to reflect quarter one.

The Chief Finance Officer provides routine reports to the Governing Body on financial performance, including performance against the organisation's statutory financial duties.

The CCG makes full use of internal and external audit function to ensure controls are operating effectively, to advise on areas of improvements and provide independent assurance. Audit reports, actions plans are discussed in detail at every Integrated Governance & Audit Committee which are summarised in the Head of Internal Audit Opinion Statement.

The CCG's rating for the Quality of Leadership (165a) as part of the CCG oversight framework are published here. There are no updates available for reporting period April 2022- June 2022 for CCGs.

Delegation of functions

The CCG's Accountable Officer (AO) delegates responsibilities within the organisation to control its business. The systems used to do this provide adequate insight into the business of the organisation and its use of resources to allow the AO to make informed decisions about progress against business plans and, if necessary, may also rely on information from the following:

- The Chief Finance Officer
- Senior Management Team
- Clinical Leads

The CCG operates a scheme of reservation and delegation (SoRD) which sets out the powers reserved by the GP membership, Governing Body, its committees, and other components of the CCG's decision-making architecture.

The CCG considers a wide range of feedback received through the delegation of functions both internally and externally (e.g., North East Lincolnshire Council, North of England Commissioning Support Unit) to the organisation. This extends to the use of resources, response to risks and the extent to which in-year targets (e.g., budgets) have been met.

Counter fraud arrangements

The CCG has a team of accredited Counter Fraud Specialists (LCFS) that are contracted to undertake counter fraud work proportionate to identified risks.

In March 2022, the NHS Counter Fraud Authority (NHSCFA) issued the most recent iteration of the Government Functional Standard GovS 013: Counter Fraud (Functional Standard), which was initially introduced in February 2021.

The standard outlines an organisation's corporate responsibilities regarding counter fraud and the key principles for action. In March 2021, the LCFS produced an annual counter fraud plan 2021/22 aligned to the standards, which was followed by a Quarter 1 2022/23 counter fraud plan. The Quarter 1 workplan is intended to provide the organisation a counter fraud provision and manage transitional risks prior to the introduction of the ICB. The plan was reviewed and approved at the June 2022 Integrated Governance & Audit Committee.
The CCG's Integrated Governance & Audit Committee reviews and approves the annual counter fraud plans, which identify the actions to be undertaken to promote an anti-fraud culture, prevent and deter fraud and investigate suspicions of fraud. The LCFS also produces an annual report for the CCG and regular progress reports for the review and consideration of the Chief Finance Officer and the Integrated Governance & Audit Committee.

The Chief Finance Officer for the CCG is proactively and demonstrably responsible for tackling fraud, bribery, and corruption and the LCFS regularly attends the Audit Committee. The CCG has also appointed an officer at the CCG as a Counter Fraud Champion to assist and support the work of the LCFS.

The LCFS completes an annual self-assessment of compliance against the NHSCFA's standards, which is reviewed and approved by the Chief Finance Officer and Integrated Governance & Audit Committee Chair prior to submission to the NHSCFA. The 2021/22 was completed and submitted to the NHSCFA in May 2022, which recognised the CCG as being '**green'** overall identifying that the organisation was fully compliant against 12 of the 13 requirements that make up the standard.

A summary of the return is included within the Annual Counter Fraud Report 2021/22, which was submitted to the CCG's June 2022 Integrated Governance & Audit Committee for review.

Head of internal audit opinion

Following completion of the planned audit work for quarter 1 for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's systems of risk management, governance, and internal control.

The Head of Internal Audit concluded that: -

Our overall opinion for the period 1st April 2022 to 30 June 20222 is

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

The audit programme at the CCG has been undertaken in the context of the imminent transition to Integrated Care Boards (ICBs). An element of internal audit work during 1st April to 30th June has been to support and provide assurance on this transition process.

The basis of Internal Audit's opinion was the assurances obtained from across the organisation's critical business systems; specifically audit reviews. The outcome from internal audit work for this reporting period is detailed in the table below.

Audit Area	Outcome
Governance arrangements	It was confirmed that good governance arrangements were maintained in the period under review. It was also confirmed that potential conflicts of interest continued to be recorded and reported in meetings in line with the statutory guidance for the Management of Conflicts of Interest. The Register of Interests, Register of Sponsorship, Gifts and Hospitality and Contracts Register all remained up to date during Quarter 1 of 2022/23.
Risk management	It can be confirmed that the CCG continued to maintain oversight of its risks throughout this period. As the responsible Committee the Integrated Governance and Audit Committee continued to maintain high level monitoring throughout the reporting period.
Transition Programme	A review of the final due diligence position and process as at 31st May 2022. The audit work was undertaken in readiness for the Accountable Officer letter sent on 1 June 2022 to the designate ICB Chief Executive, and NHS England and Improvement (NHSEI) Regional lead. An opinion of **Significant Assurance** was provided.
Financial Governance	Focussed testing confirmed that key financial controls continued to operate during this period. It was confirmed that approval of orders and invoices agreed to the Operational Scheme of Delegation. Control accounts continued to be reconciled and appropriately approved, whilst controls over journals and user access to the financial ledger were maintained. Testing also confirmed the Integrated Governance & Audit Committee continued to receive updates (by exception).

An assessment of Outstanding Audit Recommendations and Risks - Work continued to track and update outstanding audit recommendations so that a final position was established for transfer to the ICB.

The position for Quarter 1 as at 30 June 2022 detailed in the table below: -

Overdue	Overdue with Revised Date	Not Yet Due	Implemented	Total	% Overdue
0	2	0	0	2	100%

These have been reported to the Humber and North Yorkshire ICB Internal Audit Committee.

The outcomes demonstrates that the CCG has continued to maintain excellent internal control /governance during a period of significant change and challenge

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

In carrying out my duties as Accounting Officer for the ICB I have been supported and obtained assurances on the effectiveness of governance, risk management, the systems of internal controls and financial management at NHS North East Lincolnshire CCG, as the organisation's functions are transferred to NHS Humber and North Yorkshire Integrated Care Board (ICB). This is informed by the work of the internal auditors and the executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their quarter one letter.

The Board Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principle objectives have been reviewed.

Review of the Board Assurance Framework action plans to address any identified weaknesses, and ensure continuous improvement of the system, are in place via action plan embedded within the board assurance framework and the corporate risk register. Quarter one risk reports capturing key risks across the spectrum of corporate governance.

The Governing Body, Integrated Governance and Audit Committee and other sub-committees as necessary, has advised on the implications of the result of this review and plans to address any weaknesses and to ensure continuous improvement of the system are in place.

Conclusion

NHS North East Lincolnshire CCG's Governing Body, Integrated Audit & Governance Committee and Executive Officers are not aware of any issues of a material financial, operational or other nature which could be expected to impair the efficient operation of the business of NHS Humber and North Yorkshire Integrated Care Board.

Stephen Eames CBE
Chief Executive (Accountable Officer)
22 June 2023

Remuneration and Staff Report

The remuneration and Staff Report sets out the organisations remuneration policy very senior managers.

Remuneration Committee

The Remuneration Committee is a formal committee of the Governing Body whose members were appointed by the Governing Body.

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

The committee receives regular reports on:

- Governing Body tenure and remuneration
- Clinical Leads tenure and remuneration
- Very Senior Managers remuneration

In addition to its core business, the Remuneration Committee effectively oversaw the following key areas of work (please note: this list is not exhaustive):

- Provide annual assurance to the Governing Body on achievement of the Committee's Terms of Reference
- Work plan report
- HR Guidance for the new arrangements
- Agenda for Change Revised Pay Scales

The Remuneration Committee did not meet between 1 April 2022 and 30 June 2022, however the members did make two virtual decisions during this time period.

Senior managers' contracts and payments

The Chief Finance Officer and Chief Operating Officer Roles pay was in line with the national guidance entitled "Clinical Commissioning Groups Remuneration Guidance for Chief Officers" (where the senior manager also undertakes the Accountable Officer role and Chief Finance Officer's guidance)

Other very senior manager's (VSM) roles are appointed under the CCG Framework and all remuneration and Terms of Service are approved by the Remuneration Committee.

Salaries and allowances (Subject to Audit)

Pension related benefit is the increase in the annual pension entitlement determined in accordance with the HMRC method. This compares the accrued pension and the lump sum at age 60 at the end of the financial year against the same figures at the beginning of the financial year adjusted for inflation. The difference is then multiplied by 20 which represents the average number of years an employee receives their pension (20 years is a figure set out in the CCG Annual Reporting Guidance). **These figures do not represent actual cash payments.** It should be noted that the GP representative figures are affected by previous employments in non-practitioner roles which can lead to a distortion in the numbers.

*The CCG makes a financial contribution to North East Lincolnshire Council to the role of Chief Executive NELCCG/NELC as detailed in the table below

1 April to 30 June 2022-23 Name	Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) All pension related benefits (bands of £2,500) £000	(f) Total (a to e) (bands of £5,000) £000	Full year equivalent salary (bands of £5,000)
Dr P Melton	Clinical Chief Officer	20-25					20-25	85-90
Rob Walsh*	Chief Executive –NELCCG/NELC	5-10					5-10	30-35
Mark Webb**	Chair	5-10					5-10	20-25
Helen Kenyon	Chief Operating Officer	25-30				7.5-10	35-40	105-110
Jan Haxby	Director of Quality & Nursing	20-25				5.0-7.5	25-30	90-95
Laura Whitton	Chief Finance Officer	25-30				5.0-7.5	30-35	100-105
Philip Bond**	Lay Member Community Engagement	0-5					0-5	5-10
Dr Renju Mathews**	GP Representative	0-5					0-5	5-10
Dr Jeeten Raghwani**	GP Representative	0-5					0-5	5-10
Tim Render**	Lay Member Audit & Governance	0-5					0-5	10-15
Dr Chris Hayes**	Secondary Care Doctor	0-5					0-5	10-15
Joe Warner	Governing Body Social Care Representative	0-5					0-5	0-5

1 April to 30 June 2022-23 Name	Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) All pension related benefits (bands of £2,500) £000	(f) Total (a to e) (bands of £5,000) £000	Full year equivalent salary (bands of £5,000)
Stephen Pintus	Director of Public Health	0-5					0-5	0-5
Dr Ekta Elston	Vice Chair Council of Members/Medical Director	10-15				5.0-7.5	15-20	65-70

** CCG board member finished 30 June when CCG closed. Full year equivalent salary based on first quarter's salary.

2021-22 Name	Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) All pension related benefits (bands of £2,500) £000	(f) Total (a to e) (bands of £5,000) £000
Dr P Melton	Clinical Chief Officer	85-90					85-90
Rob Walsh*	Chief Executive –NELCCG/NELC	30-35					30-35
Mark Webb	Chair	20-25					20-25
Helen Kenyon	Chief Operating Officer	100-105				22.5-25	125-130
Jan Haxby	Director of Quality & Nursing	85-90					85-90
Laura Whitton	Chief Finance Officer	95-100				20-22.5	120-125
Philip Bond	Lay Member Community Engagement	5-10					5-10
Dr Renju Mathews	GP Representative	5-10					5-10
Dr Jeeten Raghwani	GP Representative	5-10					5-10
Tim Render	Lay Member Audit & Governance	10-15					10-15
Dr Chris Hayes	Secondary Care Doctor	10-15					10-15
Joe Warner	Governing Body Social Care Representative	0-5					0-5
Stephen Pintus	Director of Public Health	0-5					0-5
Dr Ekta Elston	Vice Chair Council of Members/Medical Director	65-70				2.5-5	65-70

Pension benefits (Subject to Audit)

It is important to note that the pension benefit figures for the GPs relate to their non-practitioner employment only and the pensionable pay figure is grossed up to reflect a whole-time equivalent post. The pension data used in these calculations has been provided by the Business Services Authority. Whilst this will include, the work undertaken in their capacity as a senior manager of the CCG it might also include other, non-practitioner work. These pension benefit figures will also include contributions made in previous employments in a non-practitioner role.

Certain members do not receive pensionable remuneration therefore there will be no entries in respect of pensions for certain Members. The CCG hasn't made any payments in respect of compensation on early retirement, the loss of office, or payments to past directors

Name and Title	(a) Real increase in pension at age 60 (bands of £2,500)	(b) Real increase in pension lump sum at aged 60 (bands of £2,500)	(c) Total accrued pension at age 60 at 30 June 2022 (bands of £5,000)	(d) Lump sum at age 60 related to accrued pension at 30 June 2022 (bands of £5,000)	(e) Cash Equivalent Transfer Value	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 30 June 2022	(h) Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Jan Haxby Director of Quality and Nursing	0-2.5	0-2.5	35-40	115-120	904	10	924	
Helen Kenyon Chief Operating Officer	0-2.5	0-2.5	45-50	95-100	841	9	860	
Laura Whitton Chief Finance Officer	0-2.5	0-2.5	35-40	90-95	819	10	838	
Dr Ekta Elston Vice Chair Council of Members/Medical Director	0-2.5	0-2.5	10-15	20-25	185	5	193	

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 an 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. 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 2023-24 CETV figures. The benefits and related CETVs do not allow for a future adjustment for some eligible employees arising from the McCloud judgment.

The method used to calculate CETVs has changed to remove the adjustment for Guaranteed Minimum Pension (GMP) on 8 August 2019. If an individual was entitled to a GMP, this will affect the calculation of the real increase in CETV which has been reported. This is more likely to affect individuals who are members of the 1995 Section and 2008 Section of the NHS Pension Scheme".

Real increase in CETV

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

Compensation on early retirement or for loss of office

Nil return for 2022/2023 – refer to **Note 4** of the Financial Statements.

Payments to past members

Nil return for 2022/2023 – refer to **Note 4** of the Financial Statements.

Pay Ratio (Subject to Audit)

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

The banded remuneration of the highest paid director in NELCCG in the financial year Q1 2022-23 was £30,000 - £35,000 (against full year 2021-22, £120,000 - £125,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Q1 2022-23	25th percentile	Median	75th percentile
Total remuneration (£)	£7,002	£8,905	£12,067
Salary component of total remuneration (£)	£7,002	£8,905	£12,067
Pay Ratio information	4.61	3.62	2.67
2021-22			
Total remuneration (£)	£25,067	£36,509	£47,339
Salary component of total remuneration (£)	£25,067	£36,509	£47,339
Pay Ratio information	4.89	3.36	2.59

In Q1 2022-23, no (2021-22, no) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £2,394 to £31,404 (1.63% against 2021/22 (full year 21.22: £8,856 to £103,361).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. NELCCG has not paid any non-consolidated performance-related pay or benefits-in-kind for the last 2 years.

The increase is mostly due to the percentage pay rise received by all employees.

Staff Report

Staff Composition

The CCG has a staffing establishment of 96.6 whole time equivalents, in its headquarters function, and has a formal arrangement in place to buy in a range of support services from a number of different providers at a cost of £0.33 Million in Q1 of 2022/23

The number of persons of each sex who were directors, (or equivalent) and employees of the company as detailed in the table below

Gender	Total (Female)	Total (Male)
Band 8a	8	2
Band 8b	9	4
Band8c	3	1
Band8d	1	1
Band9	0	0
VSM	4	0
Governing Body	1	8
Any other Spot Salary	2	2
All other Employees (including apprentice if applicable)	59	14

Staff Deployment

The CCG is keen to support staff development. There are a number of secondments ongoing, both internally and externally, providing opportunity for staff to expand their skills and knowledge. During the period 1 April 2022 to 30 June 2022 there has been a total of 12 secondments:

- Four employees seconded externally to partner agencies, other CCGs, or the ICS
- Eight employees seconded internally to higher banded posts.

Employee Benefits and Staff Numbers

2022-2023	ADMIN Permanent employees £'000	Other £'000	Total £'000	PROGRAMME Permanent employees £'000	Other £'000	Total £'000	TOTAL Permanent employees £'000	Other £'000	Total £'000
Employee benefits salaries and wages	700	32	**732**	272	-	**272**	972	32	**1,004**
Social security costs	81	4	**85**	32	-	**32**	113	4	**118**
Employer contributions to the NHS pension scheme	153	5	**157**	42	-	**42**	194	5	**199**
Other pension costs	-	-	**-**	-	-	**-**	-	-	**-**
Apprenticeship levy	1	-	**1**	-	-	**-**	1	-	**1**
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	-	-	**-**	-	-	**-**	-	-	**-**
Gross employee benefits expenditure	**935**	**41**	**975**	**347**	**-**	**347**	**1,281**	**41**	**1,322**
Less recoveries in respect of employee benefits (note 4.1.2)	(13)	-	**(13)**	(16)	-	**(16)**	(28)	-	**(28)**
Total – net admin employee benefits including capitalised costs	**922**	**41**	**963**	**331**	**-**	**331**	**1,253**	**41**	**1,293**
Less: employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**922**	**41**	**963**	**331**	**-**	**331**	**1,253**	**41**	**1,293**

2021-2022	ADMIN Permanent employees £'000	Other £'000	Total £'000	PROGRAMME Permanent employees £'000	Other £'000	Total £'000	TOTAL Permanent employees £'000	Other £'000	Total £'000
Employee benefits salaries and wages	2,774	132	**2,906**	1,139	-	**1,139**	3,913	132	**4,045**
Social security costs	300	16	**316**	122	-	**122**	422	16	**438**
Employer contributions to the NHS pension scheme	611	19	**630**	179	-	**179**	790	19	**809**
Other pension costs	-	-	**-**	-	-	**-**	-	-	**-**
Apprenticeship levy	6	-	**6**	-	-	**-**	6	-	**6**
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	-	-	**-**	-	-	**-**	-	-	**-**
Gross employee benefits expenditure	**3,691**	**167**	**3,858**	**1,440**	**-**	**1,440**	**5,131**	**167**	**5,298**
Less recoveries in respect of employee benefits (note 4.1.2)	(88)	-	**(88)**	(63)	-	**(63)**	(151)	-	**(151)**
Total – net admin employee benefits including capitalised costs	**3,603**	**167**	**3,770**	**1,377**	**-**	**1,377**	**4,980**	**167**	**5,147**
Less: employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**3,603**	**167**	**3,770**	**1,377**	**-**	**1,377**	**4,980**	**167**	**5,147**

Sickness Absence Data

The sickness absence data for NHS North East Lincolnshire CCG between 1 April 2022 and 30 June 2022 is below:

Absence	Total
Average sickness %	0.70%
Total number of FTE days lost	60.07

The CCG regularly reviews reasons for absence and all sickness absence is managed in line with the organisations Attendance Management policy. This policy enables managers to address sickness absence issues, both short and long-term, in a fair, consistent and equitable manner. It is recognised however that all cases must be dealt with on an individual basis because of differing circumstances. The CCG provide access to an Occupational Health Service through management referrals. For individual support, staff can access the Employee Assistance Programme, an internal Wellbeing Officer, or a bank of trained Mental Health First Aiders.

Staff Turnover percentages

	Q1 22.23		21.22
Average Headcount	113		109
Leavers	0		10
Turnover	0.00%		9.17%

Staff Policies - Diversity and Inclusion

As an employer the CCG recognises and values people as individuals and accommodates differences wherever possible by adjusting working arrangements or practices. Equal opportunities are key, and Equality Impact Assessments are conducted for all policies, which are scrutinised by the Equalities panel.

The People and Culture service have adopted the EACH model as their approach - treating employees as adults, thinking about them as consumers and understanding them as humans. This underpins all the workstreams of the People Strategy.

The CCG continued to exercise best practice in relation to updating policies and service developments undertaken throughout the year. This involved our active community engagement in assessing and feeding back on policies and proposals through our Equality Impact Assessment panel and specific involvement for communities of interest who may be affected by a particular proposal. All commissioning activity was undertaken within the context and constraints of recovery from COVID and the impact of the pandemic on the NHS and on our local population. Our well-established policies and procedures enabled us to comply with our Public Sector Duties under the Equality Act 2010 and we continued to engage positively with all sectors of our community albeit more via electronic events and conversations rather than face to face opportunities.

We continued to work closely with the local authority to deliver activities contributing to the implementation of our local health and wellbeing strategy. In particular we continued to work actively with our voluntary and community sector colleagues to agree the North East Lincolnshire commitment – our Talking Listening and Working Together approach to engagement and service development.

In terms of workforce, the CCG continued to build on the success of previous years and worked in a focussed way to target recruiting a more diverse workforce in response to the issues surfaced from previous WRES reports, resulting in more diverse groups taking up posts in the organisation which align to the identified proportion of diversity in the local population.

Trade Union Facility Time Section

NHS North East Lincolnshire Clinical Commissioning Group is not required to produce a Trade Union Facility Time return as they do not have any employee's that are trade union representatives.

Other employee matters

The CCG is a great place to work

The CCG strives to be an employer of choice, which is one of the four aims of the People Strategy for North East Lincolnshire (NEL) Union.

A staff engagement survey was carried out across the six Humber Coast and Vale CCGs in April 2022. The survey was designed to obtain anonymous feedback on staff experience of working for

the CCG over the previous 12 months. The questions covered the following areas together with the opportunity to provide feedback via a free text question:

- Your job
- Your team
- People in your organisation
- Your managers
- Your health, wellbeing and safety at work
- Your personal development
- Your organisation
- Your experience during the COVID-19 pandemic.

62% of NEL CCG's staff participated in the survey. The overall survey results for the CCG were generally positive and have been shared with both the Senior Leadership Team (SLT) and the Humber Social Partnership Forum (SPF). An action plan is currently being developed with the support of SPF. The areas for development and areas of strength together with the action plan will be shared with staff.

Staff turnover is currently at an average of 9.45%

The CCG holds full staff events on a quarterly basis. At these events, awards are given to nominated staff in recognition of hard work and commitment in the preceding quarter. With the anticipated abolishment of CCGs on 30 June 2022, the focus of the event held during quarter 1, was "farewell" to the CCG, recognising the overall achievements of the CCG since its inception. Additionally, the Union operate an annual staff recognition event, Leading Lights.

The CCG offers a number of employee benefits, including awards in recognition of long service. The CCG has a wide range of policies to support staff in throughout their employment lifecycle.

Workplace Health, Safety and Wellbeing

Staff health, safety and wellbeing is a high priority; both locally with an aim of the People Strategy being "Improve the health, safety and wellbeing of the workforce", and nationally with the commitment in the NHS People Promise of "We are safe and healthy".

The CCG have a great wellbeing offer. Within the Union there are dedicated Wellbeing staff who provide confidential support to employees and co-ordinate and promote a range of wellbeing activities. Further investment has been made in Mental Health First Aid with additional staff undertaking the accredited training to strengthen our provision.

The CCG provides an Occupational Health service, which includes a professional counselling service. This is accessed through management referral. In addition, staff are also able to access the Employee Assistance Programme, a confidential counselling and advice service

Staff are also able to access the Humber, Coast and Vale Staff Resilience Hub, a team of trained mental health professionals working with individuals and teams to develop and promote resilience. The Hub provides a range of resources, including advice and guidance, support groups and webinars.

North East Lincolnshire Clinical Commissioning Group (NEL CCG) recognises its responsibilities and duties under the Health & Safety at Work Act 1974 and is committed to ensuring so far as is reasonably practicable, the health, safety and welfare of its employees, visitors and other persons who may be affected by its activities.

NEL CCG will comply with legislation as a minimum and strive to improve performance on a continual basis by accepting best practice standards and the setting of performance targets in relation to the

management of health & safety. NEL CCG are supported by the Health and Safety team from North East Lincolnshire Council ensuring that there are robust arrangements in place for the management of health and safety across the organisation. In addition to this the CCG has its own in-house first aiders, DSE assessors, Mental Health First Aiders and a selection of staff trained in defibrillator usage. The CCG moved into NELC Municipal Offices in August 2018 and complies with NELC's procedures for the building.

Health and safety forms part of the mandatory e-learning schedule that needs to be undertaken by all staff and data screen assessment (DSE) is a part of this training schedule.

For the period 1 April 2022 to 1 June 2022 there were no incidents reported under the category of Health and Safety.

Staff consultation

Recognising the benefits of partnership working, NEL CCG is an active member of the Humber Social Partnership Forum (SPF). The aim of the SPF is to provide a formal negotiation and consultation group between the CCGs and Trade Unions to discuss and debate issues in an environment of mutual trust and respect.

The CCG has an Employee Advisory Group who are responsible for inputting into key decisions and policies for the CCG, engaging with their wider teams and representing their views.

Fortnightly staff briefings are held to keep staff updated and regular Q&A sessions take place with the Union leadership team.

Staff consultation - abolishment of CCGs and establishment of Integrated Care Boards

In anticipation of the abolishment of CCGs on 30 June 20022 and the establishment of the Integrated Care Boards (ICBs) on 1 July 2022 a formal consultation with Trade union representatives via the Humber, Coast & Vale Social Partnership Forum and staff, concerning the intent to transfer the employment of the 6 Humber Coast and Vale CCG's staff to the Humber and North Yorkshire Integrated Care Board (ICB) together with proposed measures in connection with the transfer commenced 4 April 2022 and concluded 6 May 2022. The consultation related to the transfer of employment only and did not cover consultation on structures for the ICB.

The following cohorts will transfer into the ICB:

- All permanent CCG employees
- All CCG employees on a Fixed Term Contracts that go beyond 30 June 2022
- Agency Work arrangements that go beyond 30 June 2022*
- Secondments into the CCG that go beyond 30 June 2022**

*Novation of contract, not transfer of employment

**Secondment will transfer into the ICB, continue to be employed by substantive employer

Employees will transfer on their existing terms and conditions of service, with staff below board level covered by an employment commitment and will lift and shift into the new organisation. Post transfer as a result of several sender organisations coming together, there may be a change to job titles, functions, roles to align with the way place partnership of the ICB is going to work, with any changes being discussed on an individual 1:1 basis. Consultation with staff not covered by the employment commitment commenced prior to transfer and any staff in place at transfer date will also form part of the transfer scheme, transferring into the ICB either in a new designate role or in a displaced position.

The legal mechanism for the transfer of staff from the CCG to the ICB was a statutory transfer order made by NHS England, ensuring the protection of employees' substantive terms and conditions of

employment. The process followed the legal requirement of the Transfer of Undertaking (Protection of Employment) Regulations (TUPE) and the Cabinet Office Statement of Practise "Staff Transfer in Public Sector" (COSOP). The Trade Union Colleagues and the Designate ICB Executives have been working in partnership to ensure a safe transfer of staff.

It is the intention of the ICB to have a single suite of employment policies for all newly appointed staff or those who change their contract with the ICB following transfer. These will be developed in consultation with Trade Union representative. For exiting employees, it is the intention of the ICB to have a suite of non-contractual policies and procedures . In partnership with SPF, the HR team has developed a single suite of non-contractual policies. Following an extensive comparison of each CCG's policies it was proposed the policy with the most up to date best practice be adopted by the remaining CCGs. Staff were invited to provide feedback on how the policies varied from their current CCG policies and whether they were in in agreement with the proposed policies applying to them. In line with TUPE, existing staff will transfer with their existing contractual policies.

During the comparison of policies, the HR team identified there were both contractual and non-contractual policies due for review across all 6 CCGs. A full review of these policies took place and were updated to ensure they reflected up to date best practice. Staff were invited to feedback and comment on the content of these polices. All feedback and views on the content of these policies was incorporated into the policy, where appropriate. These policies are listed below:

- Managing Work Performance Policy
- Disciplinary Policy
- Redeployment Policy
- Induction and Probation
- Recruitment and Selection
- Flexible Working

Included in the measures were two items relating to NEL CCG staff only:

- Annual Leave year will run from 1 April to 31 March, an adjustment will be made to bring employees on a different holiday in line.
- NEL CCG staff only are currently in receipt of an Agile Working Payment, this will cease upon transfer.

A regular series of FAQ's were issued during the consultation period and staff invited to request either a formal or informal one: one.

Recognising the potentially challenging time for staff, staff were reminded of the wide range of support available.

Talent and Development

The Union offer a Talent and Leadership Academy, an in-house leadership programme available to all staff. The Union also offer a coaching programme, providing access to a trained pool of coaches to support with individual development or for staff to train to become a coach themselves.

Staff can access a range of short courses and learning programmes, both through ESR and Learn-NEL, the council's new learning management system. A Learning Agreement has been signed with Unite and UNISON, allowing staff access to a range of courses through their online learning platforms.

Off-payroll engagements (Subject to Audit)

Off payroll engagements are any and all engagements for the services of an individual where payment is not made through payroll, and therefore after the deduction of income tax and national insurance. This therefore includes all payments to GP practices as well as payments to individuals who claim to be self-employed and are therefore paid through accounts payable.

Off-payroll engagements as of 30 June 2022, for more than £245 per day are as follows:

Table One - Off-payroll engagements longer than six months

Number of existing engagements as of 30 June 2022	6
Of which, the number that have existed:	
For less than 1 year at the time of reporting	0
For between 1 and 2 years at the time of reporting	0
For between 2 and 3 years at the time of reporting	0
For between 3 and 4 years at the time of reporting	1
For 4 or more years at the time of reporting	5

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

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

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	6
***Of which**:*	
No. not subject to off-payroll legislation	6
No. subject to off-payroll legislation and determined as in-scope of IR35	0
No. subject to off-payroll legislation and determined as out of scope of IR35	0
the number of engagements reassessed for compliance or assurance purposes during the year	6
Of which: no. of engagements that saw a change to IR35 status following review	0

Table 3 - For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility between 01 April 2022 and 30 June 2022:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed 'board members and/or senior officers with significant financial responsibility', during the financial year. This figure should include both on-payroll and off-payroll engagements	20

Expenditure on consultancy

Further details in relation to expenditure on consultancy can be found in **note 5** in the Financial Statements

Exit packages and severance payments

Further details in relation to Exit Packages can be found in **Note 4.3** in the Financial Statements.

Parliamentary Accountability and Audit Report

NHS North East Lincolnshire Clinical Commissioning Group is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report as per the table below.

Contingent liabilities	Note 31
Losses and special payments	Note 45
Gifts	Not applicable
Fees and charges	Note 5

An audit certificate and report are also included in the annual accounts of this Annual Report and Accounts.

Stephen Eames CBE
Chief Executive (Accountable Officer)
22 June 2023

Annual Accounts

Foreword to the accounts

NHS NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

These accounts for the period April 2022 – June 2022 have been prepared by NHS North East Lincolnshire Clinical Commissioning Group under section 232 (schedule 15.3(1) of the National Health Service Act 2006 in the form which the Secretary of State has, within the approval of the Treasury, directed.

Stephen Eames CBE
Chief Executive (Accountable Officer)
22 June 2023

Independent auditor's report to the Board of NHS Humber and North Yorkshire Integrated Care Board in respect of NHS North East Lincolnshire Clinical Commissioning Group

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of NHS North East Lincolnshire Clinical Commissioning Group ('the CCG') for the three-month period ended 30 June 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2022/23 as contained in the Department of Health and Social Care Group Accounting Manual 2022/23, and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to Clinical Commissioning Groups in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 and of its net expenditure for the three-month period then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been properly prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

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

Emphasis of Matter – transfer of the CCG's functions to the NHS Humber and North Yorkshire Integrated Care Board

We draw attention to note 1.1 (going concern) and note 38 (events after the reporting period) of the financial statements which highlight that, following the Health and Care Act 2022, the CCG's functions transferred to the NHS Humber and North Yorkshire Integrated Care Board from 1 July 2022. Given services will continue to be provided by another public sector entity, the financial statements are prepared on a going concern basis. Our opinion is not modified in respect of this matter.

Conclusions relating to going concern

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

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

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

Other information

The Accountable Officer is responsible for the other information. The other information 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, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit Committee, the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the CCG which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in December 2021.

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

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the three-month period ended 30 June 2022.

We have nothing to report in this respect.

We will report the outcome of our work on the CCG's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Responsibilities of the Accountable Officer

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

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

We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves

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

We have nothing to report in this regard.

Opinion on regularity

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

Responsibilities of the Accountable Officer for the financial statements

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

The Accountable Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2022/23 and prepare the financial statements on a going concern basis, unless the CCG is informed of the intention for dissolution without transfer of services or function to another entity. The Accountable Officer is responsible for assessing each year whether or not it is appropriate for the CCG to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

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

We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice and as required by the Local Audit and Accountability Act 2014.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the CCG, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, and significant one-off or unusual transactions.

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

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Health and Social Care Act 2012; and
- the other information published together with the audited financial statements in the Annual Report for the financial period for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Use of the audit report

This report is made solely to the Board of the NHS Humber and North Yorkshire Integrated Care Board in respect of NHS North East Lincolnshire Clinical Commissioning Group, 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 Board of the NHS Humber and North Yorkshire Integrated Care Board, 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 Board of the NHS Humber and North Yorkshire Integrated Care Board, as a body, for our audit work, for this report, or for the opinions we have formed.

Certificate

We certify that we have completed the audit of NHS North East Lincolnshire Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Mark Kirkham, Partner
For and on behalf of Mazars LLP

5th Floor
3 Wellington Place
Leeds
LS1 4AP
29 June 2023

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

	Note	3 months to 30 June 2022 £'000	2021-22 £'000
Income from sale of goods and services	2	(14,628)	(54,928)
Other operating income	2	(117)	(294)
Total operating income		**(14,745)**	**(55,222)**
Staff costs	4	1,322	5,298
Purchase of goods and services	5	91,450	364,844
Depreciation and impairment charges	5	9	-
Provision expense	5	-	2
Other Operating Expenditure	5	(31)	457
Total operating expenditure		**92,750**	**370,601**
Net Operating Expenditure		**78,005**	**315,379**
Finance expense		0	166
Net expenditure for the Year		**78,005**	**315,545**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**78,005**	**315,545**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Remeasurement of the defined pension liability / asset		(236)	(4,172)
Total other comprehensive net expenditure		**(236)**	**(4,172)**
Comprehensive Expenditure for the year		**77,769**	**311,373**

The notes on pages 82 to 104 form part of this statement

Statement of Financial Position as at 30 June 2022

	Note	30-Jun-22 £'000	2021-22 £'000
Non-current assets:			
Right-of-use assets	13a	97	-
Trade and other receivables	17	-	-
Total non-current assets		**97**	**-**
Current assets:			
Trade and other receivables	17	9,478	10,940
Cash and cash equivalents	20	535	28
Total current assets		**10,013**	**10,968**
Total assets		**10,110**	**10,968**
Current liabilities			
Trade and other payables	23	(20,337)	(25,396)
Lease liabilities	13a	(35)	-
Provisions	30	(238)	(238)
Total current liabilities		**(20,610)**	**(25,633)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(10,500)**	**(14,665)**
Non-current liabilities			
Trade and other payables	23	-	(233)
Lease liabilities	13a	(62)	-
Total non-current liabilities		(62)	(233)
Assets less Liabilities		**(10,562)**	**(14,898)**
Financed by Taxpayers' Equity			
General fund		(7,766)	(11,866)
Other reserves		(2,796)	(3,032)
Total taxpayers' equity:		**(10,562)**	**(14,898)**

The notes on pages 82 to 104 form part of this statement

The financial statements on pages 80 to 81 were approved by the Humber & North Yorkshire ICB Board on 22nd June 2023 and signed on its behalf by:

Stephen Eames
Chief Executive (Accountable Officer)
22nd June 2023

Statement of Changes In Taxpayers Equity for the 3 months ended 30 June 2022

	General fund £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2022-23			
Balance at 01 April 2022	(11,866)	(3,032)	**(14,898)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(11,866)**	**(3,032)**	**(14,898)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23			
Net operating expenditure for the financial year	(78,005)		**(78,005)**
Movements in other reserves	0	236	236
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(78,005)**	**236**	**(77,769)**
Net funding	82,105	0	**82,105**
Balance at 30 June 2022	**(7,766)**	**(2,796)**	**(10,562)**

	General fund £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22			
Balance at 01 April 2021	(6,566)	(7,204)	**(13,770)**
Transfer of assets and liabilities from closed NHS bodies	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(6,566)**	**(7,204)**	**(13,770)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22			
Net operating costs for the financial year	(315,545)		(315,545)
Movements in other reserves	0	4,172	4,172
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(315,545)**	**4,172**	**(311,373)**
Net funding	310,245	0	310,245
Balance at 31 March 2022	**(11,866)**	**(3,032)**	**(14,898)**

The notes on pages 82 to 104 form part of this statement

Statement of Cash Flows for the year ended 30 June 2022

	Note	3 months to 30 June 2022 £'000	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year	44	(78,002)	(315,443)
Depreciation and amortisation	5	9	-
Other Gains & Losses		-	166
(Increase)/decrease in trade & other receivables	17	1,462	(2,561)
Increase/(decrease) in trade & other payables	23	(5,058)	7,811
Provisions utilised	30	-	(47)
Increase/(decrease) in provisions	30	-	2
Net Cash Inflow (Outflow) from Operating Activities		**(81,589)**	(310,072)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		-	(166)
Net Cash Inflow (Outflow) from Investing Activities		-	(166)
Net Cash Inflow (Outflow) before Financing		**(81,589)**	(310,238)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		82,105	310,245
Repayment of lease liabilities		(9)	-
Net Cash Inflow (Outflow) from Financing Activities		**82,096**	310,245
Net Increase (Decrease) in Cash & Cash Equivalents	20	**507**	7
Cash & Cash Equivalents at the Beginning of the Financial Year		**28**	**21**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**535**	**28**

The notes on pages 82 to 104 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Clinical Commissioning Groups (CCG's) 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 CCG's, 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 CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG 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 the going concern basis. 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 for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.
NHS North East Lincolnshire CCG was dissolved on 30 June 2022 having joined with NHS Humber and North Yorkshire Integrated Care Board with effect from 1 July 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 **Pooled Budgets**

The CCG has entered into a pooled budget arrangement in accordance with section 75 of the NHS Act 2006. Under the arrangement, the CCG 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.

1.4 **Operating Segments**

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

1.5 **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 CCG will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The CCG 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 CCG to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the CCG 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. Other sources include:
- S75 Partnership Agreement
- Contribution from clients towards cost of social care
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 CCG 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.

1.6 **Employee Benefits**

1.6.1 **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.

1.6.2 **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 CCG 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.

Notes to the financial statements

1.6.2 **Local Government Pensions**

Some employees are members of the Local Government Pension Scheme (LGPS), which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the CCG's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. The interest earned during the year from scheme assets is recognised within finance income. Re-measurements of the defined benefit plan are recognised in the Income and Expenditure reserve and reported as an item of other comprehensive [income / net expenditure].

1.7 **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.

1.8 **Grants Payable**

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

1.9 **Property, Plant & Equipment**

1.9.1 **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 CCG;
- 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.

1.9.2 **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 Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would

- 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.

1.9.3 **Subsequent Expenditure**

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

1.10 **Intangible Assets**

1.10.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the

- When it is probable that future economic benefits will flow to, or service potential be provided to, the CCG;
- 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.

Notes to the financial statements

1.10.2 **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.

1.10.3 **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 CCG expects to obtain economic benefits or service potential from the asset. This is specific to the CCG 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 CCG 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.

1.11 **Leases**

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

1.11.1 **The CCG 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

The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the ‘Depreciation, amortisation and impairments’ policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.11.2 **The CCG 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.

Notes to the financial statements

1.12 **Cash & Cash Equivalents**

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

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

1.13 **Provisions**

Provisions are recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the CCG will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 3.27% (2021-22: 0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 3.20% (2021-22:0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 3.51% (2021-22 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 3.00% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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 CCG 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.

1.14 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the CCG 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 CCG.

1.15 **Non-clinical Risk Pooling**

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

1.16 **Carbon Reduction Commitment Scheme**

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

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

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

Allowances acquired under the scheme are recognised as intangible assets.

1.17 **Contingent liabilities and contingent assets**

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

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

Notes to the financial statements

1.18 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

1.18.1 **Financial Assets at Amortised cost**

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

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

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

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

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

1.18.4 **Impairment**

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

The CCG 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 CCG 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 CCG does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

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

1.19 **Financial Liabilities**

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

1.19.1 **Financial Guarantee Contract Liabilities**

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

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

1.19.2 **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 CCG's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.19.3 **Other Financial Liabilities**

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

1.20 **Value Added Tax**

Most of the activities of the CCG 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.

Notes to the financial statements

1.21 **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 CCG not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

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

1.22.1 **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 CCG's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- Bad Debt Provision
- Local Government Pension Scheme as advised by the actuaries Hymans Robertson LLP

1.22.2 **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.
- Prescribing - The full year is estimated on the spend for 10 months

1.23 **Gifts**

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

1.24 **Adoption of new standards**

On 1 April 2022, the CCG 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 CCG 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.

Notes to the financial statements

1.24 **Adoption of new standards**

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.

	Total £000
Operating lease commitments at 31 March 2022	0
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	0
Operating lease commitments discounted used weighted average IBR	0
Add: Finance lease liabilities at 31 March 2022	0
Add: Peppercorn leases revalued to existing value in use	0
Add: Residual value guarantees	0
Add: Rentals associated with extension options reasonably certain to be exercised	(106)
Less: Short term leases (including those with <12 months at application date)	0
Less: Low value leases	0
Less: Variable payments not included in the valuation of the lease liabilities	-
Lease liability at 1 April 2022	(106)

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

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

2 Other Operating Revenue

	3 months to 30 June 2022			2021-22
	Admin	Programme	Total	Total
	£'000	£'000	£'000	£'000
Income from sale of goods and services (contracts)				
Other Contract income	387	14,213	**14,600**	54,777
Recoveries in respect of employee benefits	12	16	**28**	151
Total Income from sale of goods and services	**399**	**14,229**	**14,628**	**54,928**
Other operating income				
Charitable and other contributions to revenue expenditure: non-NH	-	117	**117**	294
Total Other operating income	**-**	**117**	**117**	**294**
Total Operating Income	**399**	**14,346**	**14,745**	**55,222**

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

3 months to 30 June 2022	Recoveries in respect of employee benefits	Partnership Agreement *	Private Client Revenue *	Other Contract income	Total
	£'000	£'000	£'000	£'000	£'000
Source of Revenue					
NHS	-	-	-	-	-
Non NHS	28	11,959	2,604	37	14,628
Total	**28**	**11,959**	**2,604**	**37**	**14,628**

2021-22	Recoveries in respect of employee benefits	Partnership Agreement *	Private Client Revenue *	Other Contract income	Total
		£'000	£'000	£'000	£'000
Source of Revenue					
NHS	-	-	-	-	-
Non NHS	151	45,333	9,277	167	54,928
Total	**151**	**45,333**	**9,277**	**167**	**54,928**

3 months to 30 June 2022	Recoveries in respect of employee benefits	Partnership Agreement *	Private Client Revenue *	Other Contract income	Total
	£'000	£'000	£'000	£'000	£'000
Timing of Revenue					
Point in time	28	-	-	19	47
Over time	-	11,959	2,604	18	14,581
Total	**28**	**11,959**	**2,604**	**37**	**14,628**

2021-22	Recoveries in respect of employee benefits	Partnership Agreement *	Private Client Revenue *	Other Contract income	
	£'000	£'000	£'000	£'000	£'000
Timing of Revenue					
Point in time	151	-	-	126	277
Over time	-	45,333	9,277	41	54,651
Total	**151**	**45,333**	**9,277**	**167**	**54,928**

* This income in the above tables relates specifically to adult social care

3.2 Transaction price to remaining contract performance obligations

There is no contract revenue expected to be recognised in the future periods (related to contract performance obligations not yet completed at the reporting date).

4. Employee benefits and staff numbers

4.1.1 Employee benefits	**Total**		**3 months to 30 June 2022**
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	972	32	1,004
Social security costs	114	4	118
Employer Contributions to NHS Pension scheme	194	5	199
Apprenticeship Levy	1	-	1
Gross employee benefits expenditure	**1,281**	**41**	**1,322**
Less recoveries in respect of employee benefits (note 4.1.2)	(28)	-	(28)
Total - Net admin employee benefits including capitalised costs	**1,253**	**41**	**1,294**
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	**1,253**	**41**	**1,294**

4.1.1 Employee benefits	Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	3,913	132	4,045
Social security costs	422	16	438
Employer Contributions to NHS Pension scheme	790	19	809
Apprenticeship Levy	6	-	6
Gross employee benefits expenditure	**5,131**	**167**	**5,298**
Less recoveries in respect of employee benefits (note 4.1.2)	(151)	-	(151)
Total - Net admin employee benefits including capitalised costs	**4,980**	**167**	**5,147**
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	**4,980**	**167**	**5,147**

4.1.2 Recoveries in respect of employee benefits			**3 months to 30 June 2022**	2021-22
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(23)	-	(23)	(122)
Social security costs	(2)	-	(2)	(13)
Employer contributions to the NHS Pension Scheme	(3)	-	(3)	(16)
Total recoveries in respect of employee benefits	**(28)**	**-**	**(28)**	**(151)**

4.2 Average number of people employed

	3 months to 30 June 2022	2021-22
Permanently Employed Number	**97.9**	96.8
Other	**1.5**	1.7
Total	**99.4**	98.5

The CCG had no staff engaged on capital projects during 3 months to 30 June 2022 (2021/22 : NIL).

4.3 Exit packages agreed in the financial year

There were no exit packages in 3 months to June 2022 (2021/22 : NIL).

4.4 Pension costs

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

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

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

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

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

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

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

4.4.3 Local Government Pension Scheme

The CCG has admitted body status within the Local Government Pension Scheme in respect of former council employees and new employees performing social care functions. The scheme provides members with defined benefits related to pay and service. The costs of the employers contributions is equal to the contributions paid to the funded pension scheme for these employees.

The contributions rate is determined by the Funds Actuary based on triennial actuarial valuations : the last formal valuation was carried out at 31st March 2019. With effect from 1st April 2020, the employers contribution rate reduced to 29.9%, along with a small monthly supplementary payment.

The Local Government Scheme is accounted for as a defined benefits scheme :

- The liabilities of The East Riding of Yorkshire pension scheme attributable to the CCG are included in the balance sheet on an actuarial basis using the projected unit method i.e. an assessment of the future payments that will be made in relation to retirement benefits earned to date by employees, based on assumptions about mortality rates, employee turnover rates, etc. and projections of projected earnings for current employees.
- Liabilities are discounted to their value at current prices, using a discount rate based on the Corporate bond yield curve which is constructed based on the constituents of the iBoxx £ Corporates AA index and using the UBS delta curve fitting methodology.
- the principle assumptions used by the independent qualified actuaries in updating the latest valuations of the Fund for IAS 19 purposes were:

	30 June 2022	*31 March 2022*
	% p.a.	*% p.a.*
Pension Increase rate	***2.70%***	*3.20%*
Salary Increase rate	***3.60%***	*4.10%*
Discount Rate	***3.85%***	*2.70%*

	30-Jun-22		*31st March 2022*	
Mortality Assumptions	***Males Years***	***Females Years***	Males Years	Females Years
Current Pensioners	***21.1***	***24.0***	*20.8*	*23.5*
Future Pensioners**	***21.9***	***25.5***	*22.0*	*25.3*

** Figures assume members aged 45 as at the last formal valuation date

Sensitivity Analysis	**30-Jun-22**		31st March 2022	
Change in assumptions at year ended 31 March 2022	**Approximate % increase to Employer liability**	**Approximate monetary amount £'000**	Approximate % increase to Employer liability	Approximate monetary amount £'000
0.1% decrease in Real Discount Rate	**1%**	**454**	2%	670
1 year increase in member life expectancy	**4%**	**1,248**	4%	1,526
0.1% increase in the Salary Increase Rate	**0%**	**11**	0%	9
0.1% increase in the Pension Increase Rate	**1%**	**448**	2%	657

The change in the net pensions liability is analysed into seven components:

- Current service cost; the increase in present liabilities expected to arise from employee service in the current period (allocated to the revenue accounts of services for which the employees worked in the Income and Expenditure Account).
- Past service cost; the increase in liabilities arising from current year decisions whose effect relates to years of service earned in earlier years.
- Interest cost; the expected increase in the present value of liabilities during the year as they move one year closer to being paid.
- Expected return on assets; is based on the long term future expected investment return for each asset class at the beginning of the period.
- Gains/losses on settlements and curtailments; the cost of the early payment of pension benefits if any employee has been made redundant in the previous financial year.
- Actuarial gains and losses; changes in actuarial deficits or surpluses that arise because events have not coincided with the actuarial assumptions made for the last valuation (experience gains and losses) or the actuarial assumptions have changed.
- Contributions paid to the East Riding Pension fund; cash paid as employer's contributions to the pension fund.

The estimated Employers Contributions payable in the year to 31 March 2023 will be approximately £64,000

The above information relates to the LGPS annualised calculation used for the actuarial pension valuation.

Employer Membership Statistics *(This is the latest information provided, information is only provided when a valuation takes place)*

	31-Mar-22 Number	***31-Mar-19 Number***
Actives	3	4
*Deferred pensioners**	209	237
Pensioners	235	211
Total	447	452

* Deferred pensioners include undecided leavers & frozen refunds.

The membership numbers do not affect any calculations and are provided purely for information purposes only.

5. Operating expenses

	3 months to 30 June 2022			2021-22
	Admin	**Programme**	**Total**	Total
	£'000	**£'000**	**£'000**	£'000
Purchase of goods and services				
Services from other CCGs and NHS England	19	90	109	415
Services from foundation trusts	-	31,855	31,855	123,435
Services from other NHS trusts	-	4,469	4,469	17,217
Purchase of healthcare from non-NHS bodies*	-	23,194	23,194	92,810
Purchase of social care	-	14,922	14,922	56,760
Prescribing costs	-	6,943	6,943	29,263
GPMS/APMS and PCTMS*	-	9,033	9,033	36,385
Supplies and services – clinical	-	2	2	6
Supplies and services – general	97	250	347	6,278
Consultancy services	3	38	41	181
Establishment*	24	193	217	906
Transport	-	-	-	-
Premises	28	16	44	180
Audit fees**	50	-	50	50
Other non statutory audit expenditure				
· Internal audit services	13	-	13	53
· Other services	-	-	-	-
Other professional fees	9	158	167	628
Legal fees	2	34	36	171
Interest (Local Government Pension Scheme)	-	253	253	807
Expected return on Assets (Local Government Pension Scheme)	-	(252)	(252)	(721)
Education, training and conferences	1	6	7	20
Total Purchase of goods and services	**246**	**91,204**	**91,450**	**364,844**
Depreciation and impairment charges				
Depreciation	-	9	9	-
Total Depreciation and impairment charges	**-**	**9**	**9**	**-**
Provision expense				
Provisions	-	-	-	2
Total Provision expense	**-**	**-**	**-**	**2**
Other Operating Expenditure				
Chair and Non Executive Members	25	-	25	98
Grants to Other bodies	-	-	-	389
Expected credit loss on receivables	-	(56)	(56)	(99)
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-	-	-
Other expenditure	-	-	-	68
Total Other Operating Expenditure	**25**	**(56)**	**(31)**	**457**
Total operating expenditure	**271**	**91,157**	**91,428**	**365,303**

* In the Operating expenses table above, the figures for 2021-22 include the following COVID related costs - Purchase of Healthcare from Non NHS bodies £3m, GPMS/APMS & PCTMS £432k & Establishment £16k

** External audit fees includes VAT

6.1 Better Payment Practice Code

Measure of compliance	**3 months to 30 June 2022 Number**	**3 months to 30 June 2022 £'000**	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	3,004	43,074	39,803	194,640
Total Non-NHS Trade Invoices paid within target	2,936	42,998	39,261	192,871
Percentage of Non-NHS Trade invoices paid within target	**97.74%**	**99.82%**	**98.64%**	**99.09%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	60	36,126	290	142,039
Total NHS Trade Invoices Paid within target	59	36,126	286	141,998
Percentage of NHS Trade Invoices paid within target	**98.33%**	**100.00%**	**98.62%**	**99.97%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998
The CCG had no late payment of commercial debt for the year ending 30 June 2022 (31 March 2022: £NIL).

7 Income Generation Activities
The CCG did not undertake any income generation activities as at 30 June 2022 (31 March 2022: £NIL).

8. Investment revenue
The CCG had no investment revenue as at 30 June 2022 (31 March 2022: £NIL).

9. Other gains and losses
The CCG had no gains/(losses) as at 30 June 2022 (31 March 2022: £166k).

10. Finance Costs
10.1 Finance costs
The CCG had no finance costs as at 30 June 2022 (31 March 2022: £NIL).

10.2 Finance income
The CCG had no finance income as at 30 June 2022 (31 March 2022: £NIL).

11. Net gain/(loss) on transfer by absorption
The CCG has no recognised gain or loss on transfer by absorption in the Statement of Comprehensive Net Expenditure.

12. Property, plant and equipment
The CCG had no plant, property or equipment as at 30 June 2022 (31 March 2022: £NIL).

13a Leases

13a.1 Right-of-use assets

3 months to 30 June 2022	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2022	-	-
IFRS 16 Transition Adjustment	106	106
Cost/Valuation at 30 June 2022	**106**	**106**
Depreciation 01 April 2022	-	-
Charged during the year	9	9
Depreciation at 30 June 2022	**9**	**9**
Net Book Value at 30 June 2022	**97**	**97**

13a.2 Lease liabilities

	3 months to 30 June 2022 £'000	2021-22 £'000
Lease liabilities at 01 April 2022	-	-
IFRS 16 Transition Adjustment	106	-
Lease remeasurement	(9)	-
Lease liabilities at 30 June 2022	**97**	-

13a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	3 months to 30 June 2022 £'000	2021-22 £'000
Within one year	(35)	-
Between one and five years	(62)	-
After five years	-	-
Balance at 30 June 2022	**(97)**	**-**
Effect of discounting	-	-
Included in:		
Current lease liabilities	(35)	-
Non-current lease liabilities	(62)	-
Stephen Eames	**(97)**	**-**
Balance at 30 June 2022		

2022-23	3 months to 30 June 2022 £'000	2021-22 £'000
Depreciation expense on right-of-use assets	9	-
Interest expense on lease liabilities	-	-

13a.5 Amounts recognised in Statement of Cash Flows

	3 months to 30 June 2022 £'000	2021-22 £'000
Total cash outflow on leases under IFRS 16	(9)	-

14. Intangible non-current assets
The CCG had no intangible Assets as at 30 June 2022 (31 March 2022: £NIL).

15. Investment property
The CCG had no investment property as at 30 June 2022 (31 March 2022: £NIL).

16. Inventories
The CCG had no inventories as at 30 June 2022 (31 March 2022: £NIL).

17.1 Trade and other receivables

	Current 3 months to 30 June 2022 £'000	**Non-current 3 months to 30 June 2022 £'000**	Current 2021-22 £'000	Non-current 2021-22 £'000
NHS receivables: Revenue	158	-	923	-
NHS prepayments	29	-	-	-
NHS accrued income	143	-	21	-
Non-NHS and Other WGA receivables: Revenue	3,020	-	3,181	-
Non-NHS and Other WGA prepayments	2,585	-	2,068	-
Non-NHS and Other WGA accrued income	1,744	-	1,399	-
Expected credit loss allowance-receivables	(2,062)	-	(2,118)	-
VAT	67	-	88	-
Other receivables and accruals	3,794	-	5,378	-
Total Trade & other receivables	**9,478**	**-**	**10,940**	**-**
Total current and non current	**9,478**		**10,940**	
Included above:				
Prepaid pensions contributions	-		-	

17.2 Receivables past their due date but not impaired

	3 months to 30 June 2022 DHSC Group Bodies £'000	**3 months to 30 June 2022 Non DHSC Group Bodies £'000**	2021-22 DHSC Group Bodies (re-stated) £'000	2021-22 Non DHSC Group Bodies (re-stated) £'000
By up to three months	59	208	53	208
By three to six months	25	195	-	193
By more than six months	-	259	-	259
Total	**84**	**662**	**53**	**660**

17.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies	**Other financial assets**	**Total**
	£'000	**£'000**	**£'000**
Balance at 01 April 2022	(2,118)	-	**(2,118)**
Financial assets that have been derecognised	168	-	**168**
Other changes	(112)	-	**(112)**
Total	**(2,062)**	**-**	**(2,062)**

Receivable provisions relate to 2 main areas:
- Debtors ledger income
- House Sale income, which is collected from clients for residential & nursing care where there is no charge on the property.

General aged debt provision has not been reviewed at 30th June 2022 due to shorter reporting period.

18. Other financial assets
The CCG had no other financial assets as at 30 June 2022 (31 March 2022: £NIL).

19. Other current assets
The CCG had no other current assets as at 30 June 2022 (31 March 2022: £NIL).

20 Cash and cash equivalents

	3 months to 30 June 2022 £'000	2021-22 £'000
Balance at 01 April 2022	28	21
Net change in year	507	7
Balance at 30 June 2022	**535**	**28**
Made up of:		
Cash with the Government Banking Service	535	28
Cash and cash equivalents as in statement of financial position	**535**	**28**
Balance at 30 June 2022	**535**	**28**
Patients' money held by the clinical commissioning group, not included above	-	-

21. Non-current assets held for sale

The CCG had no non-current assets held for sale as at 30 June 2022 (31 March 2022: £NIL).

22. Analysis of impairments and reversals

The CCG had no impairments or reversals recognised in expenditure during in period April - June 2022 (2021-22: £NIL).

23 Trade and other payables	**Current 3 months to 30 June 2022 £'000**	**Non-current 3 months to 30 June 2022 £'000**	Current 2021-22 £'000	Non-current 2021-22 £'000
NHS payables: Revenue	17	-	113	-
NHS accruals	688	-	101	-
NHS deferred income	-	-	2	-
Non-NHS and Other WGA payables: Revenue	480	-	2,022	-
Non-NHS and Other WGA accruals	15,719	-	17,549	-
Non-NHS and Other WGA deferred income	1,961	-	1,873	-
Social security costs	71	-	63	-
Tax	53	-	52	-
Other payables and accruals	1,348	-	3,620	233
Total Trade & Other Payables	**20,337**	**-**	**25,395**	**233**
Total current and non-current	**20,337**		**25,628**	

Other payables include £294k outstanding pension contributions at 30 June 2022 (31 March 2022: £311k).

24. Other financial liabilities

The CCG had no other financial liabilities as at 30 June 2022 (31 March 2022: £NIL).

25. Other liabilities

The CCG had no other liabilities as at 30 June 2022 (31 March 2022: £NIL).

26. Borrowings

The CCG had no borrowings as at 30 June 2022 (31 March 2022: £NIL).

27. Private finance initiative, LIFT and other service concession arrangements

The CCG had no private finance initiative, LIFT or other service concession arrangements that were excluded from the Statement of Financial Position a as at 30 June 2022 (31 March 2022: £NIL).

28 Finance lease obligations

See Note 13a

29 Finance lease receivables

See Note 13a

30 Provisions

	Current 3 months to 30 June 2022 £'000	**Non-current 3 months to 30 June 2022 £'000**	Current 2021-22 £'000	Non-current 2021-22 £'000
Continuing care	238	-	238	-
Total	**238**	**-**	**238**	**-**
Total current and non-current	**238**		**238**	

	Continuing Care £'000	**Other £'000**	**Total £'000**
Balance at 01 April 2022	**238**	**-**	**238**
Balance at 30 June 2022	**238**	**-**	**238**
Expected timing of cash flows:			
Within one year	238	-	**238**
Balance at 30 June 2022	**238**	**-**	**238**

31. Contingent Liabilities

The CCG had no contingent liability as at 30 June 2022.

32. Commitments

32.1 Capital commitments

The CCG had no contracted capital commitments not otherwise included in these financial statements as at 30 June 2022 (31 March 2022: £NIL).

32.2 Other financial commitments

The CCG had no non-cancellable contracts (which were not leases, private finance initiative contracts or other service concession arrangements) as at 30 June 2022 (31 March 2022: £NIL).

33 Financial instruments

33.1 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.

33.1.1 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.

33.1.2 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.

33.1.3 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.

33.1.4 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.

33.1.5 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.

33 Financial instruments cont'd

33.2 Financial assets

	Financial Assets measured at amortised cost 3 months to 30 June 2022 £'000	Financial Assets measured at amortised cost 2021-22 £'000
Trade and other receivables with NHSE bodies	278	809
Trade and other receivables with other DHSC group bodies	2,971	4,238
Trade and other receivables with external bodies	1,816	477
Other financial assets	3,794	5,378
Cash and cash equivalents	535	28
Total at 30 June 2022	**9,394**	**10,930**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 3 months to 30 June 2022 £'000	Financial Liabilities measured at amortised cost 2021-22 £'000
Trade and other payables with NHSE bodies	131	149
Trade and other payables with other DHSC group bodies	6,402	7,075
Trade and other payables with external bodies	10,469	12,561
Other financial liabilities	1,348	3,620
Total at 30 June 2022	**18,350**	**23,405**

34 Operating segments

3 months to 30 June 2022	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Health	78,537	(532)	**78,005**	3,434	(14,934)	**(11,500)**
Adult Social Care	15,860	(15,860)	**-**	12,688	(5,737)	**6,951**
Total	**94,397**	**(16,392)**	**78,005**	**16,122**	**(20,671)**	**(4,549)**

2021-22	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Health	317,546	(2,001)	**315,545**	3,386	(20,482)	**(17,096)**
Adult Social Care	59,525	(59,525)	**-**	7,582	(5,384)	**2,198**
Total	**377,071**	**(61,526)**	**315,545**	**10,968**	**(25,866)**	**(14,898)**

35 Joint arrangements - interests in joint operations

35.1 Interests in joint operations

The CCG has a pooled budget with North East Lincolnshire Council . The pool is hosted by NHS North East Lincolnshire CCG and forms part of the overall integrated health & social care budget that the CCG has responsibility for.

Under the arrangement funds are pooled under Section 75 of the National Health Service Act 2006 for the provision of Adult Social Care and Better Care Fund expenditure within North East
The tables below provides a summary of the income and expenditure in the financial year.

Adult Social Care Partnership Agreement

	3 months to 30 June 2022 £'000	2021-22 £'000
NELC Allocation	11,959	45,333
Other Contributions*	3,901	14,192
Total Social Care Expenditure	(15,860)	(59,525)
Total	**-**	**-**

*Other Contributions, includes £1.3m funding from the Health Better Care Fund Allocation. This is an internal recharge between the Health & Adult Social Care Operating Segments and as such is not reflected as Income & Expenditure on the SOCNE.

Better Care Fund	3 months to 30 June 2022 £'000	2021-22 £'000
Underspend b/f	**4,460**	**3,703**
In Year Allocations:		
BCF - Health	3,499	13,244
BCF - Local Authority	805	3,221
IBCF - Local Authority	2,015	7,822
Sub Total	**10,779**	**27,990**
In Year Spend :		
IBCF spend	(2,015)	(7,327)
BCF - Health & Adult Social Care	(3,448)	(13,244)
BCF - Disabled Facilities Grant	(697)	(2,959)
Sub Total	**(6,160)**	**(23,530)**
Total	**4,619**	**4,460**

35.2 Interests in entities not accounted for under IFRS 10 or IFRS 11
The CCG has no interests in entities not accounted for under IFRS10 or IFRS 11.

36. NHS Lift investments
The CCG had no NHS LIFT investments as at 30th June 2022 (31 March 2022: £NIL).

37 Related party transactions

The Department of Health & Social Care is regarded as a related party. During the year the CCG has had a significant number of material transactions (greater than £1 million) with entities for which the Department is regarded as the parent Department. This includes

· **NHS England (including commissioning support units);**

· **NHS Foundation Trusts**
Northern Lincolnshire & Goole Hospitals NHS Foundation Trust

· **NHS Trusts;**
East Midlands Ambulance Service NHS Trust
Hull University Teaching Hospital NHS Trust

· **NHS Business Services Authority.**

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with North East Lincolnshire Council in respect of the provision of adult social care.

Note that these amounts in the following table are for the full year, although some of the individuals worked for the CCG for part of the year.
As the CCG took on responsibility for delegated primary care payments made to GP's in relation to their GP core contract are included below.

The amounts shown in the following table relate to the total payments to the related party mentioned, and not amounts that the individual is responsible for.

Details of related party transactions with individuals are as follows:

	3 months to 30 June 2022			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Christopher Hayes				
Governing Body Member Secondary Care Doctor				
Consultant Cardiologist at York Hospital NHS Trust	-	-	8	-
Dr Ekta Elston				
Medical Director/Council of Members Vice Chair				
A PMS contract is held between Roxton Practice and NEL CCG	2,256	-	164	(219)
Partner GP at The Roxton Practice, Immingham	1,911	-	164	(219)
Roxton Practice and The Roxton at Weelsby View are members of 360 Care Limited	183	-	57	-
Roxton Practice and The Roxton at Weelsby View are members Meridian PCN. Funding is received via Roxton Practice Immingham	345	-	246	-
Service level agreement between Roxton Practice and Illumina Diagnostics Ltd	232	-	74	-
Dr Jeeten Raghwani				
Governing Body GP Representative				
GP Principal Greenlands Surgery, Stirling Medical Centre & Greenlands New Waltham	112	-	4	(20)
Medical Director for Care Plus Group	6,515	-	553	(3)
Greenlands Surgery is a member of Panacea PCN. Funding is received via Dr Mathews	354	-	289	-

Details of related party transactions with individuals are as follows:	3 months to 30 June 2022			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Peter Melton				
Accountable Officer/GP Clinical Chief Officer				
PMS contract held between Roxton Practice and NEL CCG	2,256	-	164	(219)
Roxton practice is a member of 360 Care Limited & wife is employed by 360 Care Limited	183	-	57	-
GP Principal The Roxton Practice, Immingham	1,911	-	164	(219)
Director and registered manager of Illumina Diagnostics Ltd	232	-	74	-
Roxton Practice and The Roxton at Weelsby View are members Meridian PCN. Funding is received via Roxton Practice Immingham	345	-	246	-
Helen Kenyon				
Chief Operating Officer				
Sue Rogerson is a personal friend who is a director of an independent consultancy company, SJW Solutions in Partnership. Sue, via SJW Solutions in Partnership has and does work for the ICS and therefore locality including working directly with the CCG	34	-	7	-
Jan Haxby				
Director of Quality/Registered Strategic Nurse				
Daughter works as a registered nurse in critical care in Hull University Teaching Hospital NHS Trust	2,520	-	32	-
Joe Warner				
Social Care Representative				
Chief Executive - Focus Adult Social Care Social Enterprise	1,836	-	202	(2)
Rob Walsh				
Chief Executive NELCCG/NELC				
Chief Executive - North East Lincolnshire Council	1,502	(4,488)	800	(3,893)
Tim Render				
Governance & Audit (Lay Member)				
Independent Chair Audit & Governance Committee for North East Lincolnshire Council	1,502	(4,488)	800	(3,893)
Dr Renju Mathews				
Governing Body GP Representative				
Director – Rutreb Limited	2	-	2	-
Dr Mathews' Practice is a member of 360 Care Ltd	183	-	57	-
Dr Mathews' Practice is member of Panacea PCN. Funding is received via Dr Mathews	354	-	289	-
GP – Cromwell Primary Care Centre, Cromwell Road & Stirling Medical Centre, Grimsby	380	-	37	(33)
Philip Bond				
Patient & Public Involvement (Lay Member)				
Registered carer under the Carers Support Service which receives some funding from NELCCG	130	-	33	-
David Walker				
Governance & Audit (Lay Member)				
Employed by St Andrews Hospice as fundraising coordinator	159	-	19	-
Chair of Humbercare Fundraiser	70	-	-	-
Member practice				
Beacon Medical Primary Care Centre	518	-	68	(44)
Beacon Medical Primary Care Centre is member of Apollo PCN. PCN funding goes to a lead practice and for Apollo this is Beacon Medical Primary Care Centre	147	-	79	-
Birkwood Medical Centre	473	-	191	(98)
Blundell Park Surgery	3	-	-	-
Chantry Health Group	257	-	18	(32)
Clee Medical Centre	572	-	50	(47)
Core Care Family Practice	114	-	25	(34)
Dr A Kumar	137	-	9	(17)
Dr A Sinha	215	-	27	(37)
Dr O Z Qureshi Surgery	160	-	22	(17)
Dr P Suresh-Babu	92	-	7	(16)
Dr R Mathews	380	-	33	(33)
Dr R Mathews is a member of Panacea PCN. PCN funding goes to a lead practice and for Panacea this is Dr R Mathews	354	-	289	-
Greenlands & New Waltham Surgery	112	-	4	(20)
Fieldhouse Medical Group	589	-	69	(195)
Healing Health Centre	94	-	12	(20)
Humberview Surgery	177	-	5	(15)
Humberview Surgery is member of Freshney Pelham PCN. PCN funding goes to a lead practice and for Freshney Pelham this is Humberview Surgery	232	-	392	-
Littlefield Surgery	231	-	34	(38)
Open Door	140	-	15	-
Pelham Medical Group	354	-	37	(34)
Quayside Medical Centre	97	-	17	-
Raj Medical Centre	460	-	65	(154)
Scartho Medical Centre	575	-	32	(116)
Scartho Medical Centre is member of Genesis PCN. PCN funding goes to a lead practice and for Genesis this is Scartho Medical Centre	157	-	94	-
The Lynton Practice	168	-	21	(17)
The Roxton Practice (Immingham)	1,911	-	164	(219)
The Roxton Practice is a members of Meridian PCN. PCN funding goes to a lead practice and for Meridian this is The Roxton Practice, Immingham	345	-	246	-
Woodford Medical Centre	384	-	41	(38)
DHSE Related Parties				
Leeds Teaching Hospital NHS Trust	165	-	1	-
Lincolnshire Partnership NHS Foundation Trust	34	-	39	-

Details of related party transactions with individuals are as follows:	2021 / 2022			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Christopher Hayes				
Governing Body Member Secondary Care Doctor				
Consultant Cardiologist at York Hospital NHS Trust	30	-		(112)
Dr Ekta Elston				
Medical Director/Council of Members Vice Chair				
A PMS contract is held between Roxton Practice and NEL CCG	7,962	-	318	(236)
An APMS contract is held between Roxton Practice (Roxton at Weelsby View) and NEL CCG	58	-		-
Partner GP at The Roxton at Weelsby View, Weelsby View, Grimsby	58	-		-
Partner GP at The Roxton Practice, Immingham	6,537	-	318	(236)
Roxton Practice and The Roxton at Weelsby View are members of 360 Care Limited	743	-	66	-
Roxton Practice and The Roxton at Weelsby View are members Meridian PCN. Funding is received via Roxton Practice Immingham	1,425	-	209	-
Service level agreement between Roxton Practice and Illumina Diagnostics Ltd	757	-	87	-
Dr Jeeten Raghwani				
Governing Body GP Representative				
GP Principal Greenlands Surgery, Stirling Medical Centre & Greenlands New Waltham	429	-	16	(19)
Medical Director for Care Plus Group	23,368	(14)	927	-
Greenlands Surgery is a member of Panacea PCN. Funding is received via Dr Mathews	2,632	-	358	-
Dr Peter Melton				
Accountable Officer/GP Clinical Chief Officer				
APMS contract held between Roxton at Weelsby View and NEL CCG	58	-		-
PMS contract held between Roxton Practice and NEL CCG	7,962	-	318	(236)
Roxton practice is a member of 360 Care Limited & wife is employed by 360 Care Limited	743	-	66	-
GP Principal at Roxton at Weelsby View, Weelsby View, Grimsby	58	-		-
GP Principal The Roxton Practice, Immingham	6,537	-	318	(236)
Director and registered manager of Illumina Diagnostics Ltd	757	-	87	-
Roxton Practice and The Roxton at Weelsby View are members Meridian PCN. Funding is received via Roxton Practice Immingham	1,425	-	209	-
Helen Kenyon				
Chief Operating Officer				
Sue Rogerson is a personal friend who is a director of an independent consultancy company, SJW Solutions in Partnership. Sue, via SJW Solutions in Partnership has and does work for the ICS and therefore locality including working directly with the CCG	101	-	15	-
Jan Haxby				
Director of Quality/Registered Strategic Nurse				
Daughter works as a registered nurse in critical care in Hull University Teaching Hospital NHS Trust	10,017	-	14	-
Joe Warner				
Social Care Representative				
Chief Executive - Focus Adult Social Care Social Enterprise	6,735	-	182	(19)
Rob Walsh				
Chief Executive NELCCG/NELC				
Chief Executive - North East Lincolnshire Council	9,633	(8,764)	611	(5,391)
Stephen Pintus				
Director of Public Health NELC				
Director of Public Health – North East Lincolnshire Council- Retired 16.07.21	9,633	(8,764)	611	(5,391)

37. Related party transactions *(continued)*

Details of related party transactions with individuals are as follows:	2021 / 2022			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Tim Render				
Governance & Audit (Lay Member)				
Independent Chair Audit & Governance Committee for North East Lincolnshire Council	9,633	(8,764)	611	(5,391)
Dr Renju Mathews				
Governing Body GP Representative				
Director – Rutreb Limited	5	-	2	-
Dr Mathews' Practice is a member of 360 Care Ltd	743	-	66	-
Dr Mathews' Practice is member of Panacea PCN. Funding is received via Dr Mathews	2,632	-	358	-
GP – Cromwell Primary Care Centre, Cromwell Road & Stirling Medical Centre, Grimsby	906	-	52	(32)
Philip Bond				
Patient & Public Involvement (Lay Member)				
Registered carer under the Carers Support Service which receives some funding from NELCCG	322	-	65	-
David Walker				
Governance & Audit (Lay Member)				
Employed by St Andrews Hospice as fundraising coordinator	743	-	12	-
Chair of Humbercare Fundraiser	284	-	-	-
The CCG is a clinically led organisation representing 25 member practices. The funding paid to member practices has been listed below :				
Beacon Medical Primary Care Centre	1,702	-	161	(44)
Birkwood Medical Centre	1,614	-	148	-
Blundell Park Surgery	292	-	18	-
Chantry Health Group	916	-	44	(34)
Clee Medical Centre	1,933	-	200	(47)
Core Care Family Practice	432	-	28	(34)
Dr A Kumar	550	-	29	(16)
Dr A Sinha	585	-	56	(37)
Dr O Z Qureshi Surgery	591	-	40	(17)
Dr P Suresh-Babu	330	-	16	-
Dr R Mathews	906	-	52	(32)
Dr R Mathews is a member of Panacea PCN. PCN funding goes to a lead practice and for Panacea this is Dr R Mathews	2,632	-	358	-
Greenlands & New Waltham Surgery	429	-	16	(19)
Fieldhouse Medical Group	2,177	-	138	(195)
Healing Health Centre	338	-	14	(20)
Humberview Surgery	550	-	101	(14)
Humberview Surgery is member of Freshney Pelham PCN. PCN funding goes to a lead practice and for Freshney Pelham this is Humberview Surgery	1,275	-	262	-
Littlefield Surgery	852	-	71	(38)
Open Door	539	-	24	-
Pelham Medical Group	1,302	-	69	(34)
Quayside Medical Centre	359	-	26	-
Raj Medical Centre	992	-	106	-
Roxton at Weelsby View	58	-	-	-
Scartho Medical Centre	2,080	-	144	(116)
The Lynton Practice	643	-	39	(17)
The Roxton Practice (Immingham)	6,537	-	318	(236)
The Roxton Practice is a members of Meridian PCN. PCN funding goes to a lead practice and for Meridian this is The Roxton Practice, Immingham	1,425	-	209	-
Woodford Medical Centre	1,306	-	105	(38)
DHSE Related Parties				
Leeds Teaching Hospital NHS Trust	667	-	17	-
Lincolnshire Partnership NHS Foundation Trust	12	-	18	-

38 Events after the end of the reporting period

There are two non-adjusting post balance sheet event:
a) The Health and Social Care Bill that was introduced into the House of Commons on 6th July 2021. The Bill allows for the establishment of ICBs across England. ICBs will take on the commissioning functions of CCGs. The Bill was passed on 28th April 2022 and the intention is that the CGG functions, assets and liabilities will therefore transfer to an ICB on the 1st July 2022.
b) As a result of the above event the Local Government Pension Scheme has transferred back to North East Lincolnshire Council. This relates to the non-current asset in the Statement of Financial Position and note 42.

39 Third party assets

The CCG held no third party assets as at 30 June 2022 (31 March 2022: £NIL).

40 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 months to 30 June 2022 Target	3 months to 30 June 2022 Performance	2021-22 Target	2021-22 Performance
Expenditure not to exceed income	78,538	78,537	317,546	317,546
Revenue resource use does not exceed the amount specified in Directions	78,006	78,005	315,546	315,546
Revenue administration resource use does not exceed the amount specified in Directions	847	470	3,399	2,920

It should be noted that the table above only relates to NHS funding. The CCG also receives £12m from North East Lincolnshire Council via the Partnership Agreement. This is a pooled budget arrangement under Section 75 of the National Health Service Act 2006, see note 35.

In Q1 of 2022/23, the CCG received revenue resource of £78,006k from NHS England.

41. Analysis of charitable reserves
The CCG held no charitable reserves as at 30 June 2022 (31 March 2022: £NIL).

42. FRS Accounting Information - Pensions

The disclosures in this note relate to the East Riding Pension Fund (the Fund). The CCG participates in the Local Government Pension Scheme. The Local Government Pension Scheme is a defined benefit scheme based on final pensionable salary.

In accordance with International Accounting Standards- IAS 19 Employee Benefits disclosure of certain information concerning assets, liabilities, income and expenditure related to pension schemes is required. The accounts need to reflect the assets values on the basis of the present value of any economic benefits available in the form of refunds from the plan or reductions in future contributions to the plan. As there were no active members after 30/6/22 refunds or changes to future contributions are not possible and hence the net asset is disclosed as a nil value in the statements.

The actuaries report states that the market value of the assets of the Pension fund as at 30 June 2022 was £39.3 million (31 March 2022 was £37.9 million).

Assets	**Value at 30-June-2022 £000**	**Value at 31-March-2022 £000**
Equity Securities	4,718	4,597
Debt Securities	3,460	5,150
Private Equity	2,874	2,163
Real Estate	4,483	4,410
Investment Funds & Unit Trusts	23,297	20,556
Cash & Cash Equivalents	505	1,053
Total	**39,337**	**37,929**

Funding Position
The following amounts, needed for reconciliation to the balance sheet, were measured in accordance with the requirements of

Fair Value	**30-June-2022 £000**	**31-March-2022 £000**
Fair Value of Employer Assets	39,337	37,929
Present Value of Funded Obligations	(31,193)	(38,162)
Net Asset/(Liability)	**8,144**	**(233)**

Recognition in the profit or loss	**30-June-2022 £000**	**31-March-2022 £000**
Current service cost	18	80
Interest Cost	253	807
Expected Return on Employer Assets	(252)	(721)
Past Service Cost / (Gain)	0	0
Losses / (Gains) on Curtailments and Settlements	0	0
Total	**19**	**166**

42. FRS Accounting Information - Pensions *(Continued)*

Reconciliation of defined benefit obligation	30-June-2022 £000	31-March-2022 £000
Opening Defined Benefit Obligation	38,162	40,839
Current Service Cost	18	80
Interest Cost	253	807
Contribution by Members	3	12
Actuarial Losses/(Gains)	(256)	(1,026)
Past Service Costs / (Gains)	0	0
Losses / (Gains) on Curtailments	0	0
Estimated Benefits Paid	(6,987)	(2,550)
Closing Defined Benefit Obligation	**31,193**	**38,162**

Reconciliation of fair value of employer assets	30-June-2022 £000	31-March-2022 £000
Opening Fair Value of Employer Assets	37,929	36,536
Expected Return on Assets	252	721
Contributions by Members	3	12
Contributions by the Employer	16	64
Actuarial Gains/(Losses)	1,393	1,622
Estimated Benefits Paid	(256)	(1,026)
Total actuarial gain (loss)	**39,337**	**37,929**

Amounts for the current and previous accounting periods	30-June-2022 £000	31-March-2022 £000
Fair Value of Employer Assets	39,337	37,929
Present Value of Defined Benefit Obligation	(31,193)	(38,162)
Surplus / (deficit)	8,144	(233)
Experience Gains/(Losses) on Assets	1,393	1,622
Experience Gains/(Losses) on Liabilities	6,987	2,550

Cumulative Statement of Recognised Gains / Losses	30-June-2022 £000	31-March-2022 £000
Actuarial Gains and Losses	1,393	1,622
Effect of Surplus Recovery Through Reduced Contributions	6,987	2,550
Actuarial Gains / (Losses) recognised in STRGL	8,380	4,172
Cumulative Actuarial Gains and Losses	7,465	(915)

43. Losses & Special Payments

In 2022/23 there were no losses. In 2021/22 there was £168k of receivables written off relating to 390 Adult social care invoices.

The CCG had no special payment cases during 2022/23 (2021/22 : None)

44. Cash Flow Workings

	£'000
Net operating costs for the financial year (per SOCNE)	(78,005)
Pension charge	3
Net operating costs for the financial year per cash flow	**(78,002)**

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