NHS
North Lincolnshire
Clinical Commissioning Group

NHS North Lincolnshire Clinical Commissioning Group

Annual Report and Accounts 2022-23 (April 1 – June 30)

Accessibility Statement

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Calling us on: 01652 251000 or

Writing to us at: NHS North Lincolnshire Health and Care Partnership, Health Place, Wrawby Road, Brigg, North Lincolnshire, DN20 8GS

The accounts for the year ended June 30 2022 have been prepared by NHS North Lincolnshire Clinical Commissioning Group under section 232 (schedule 15,2(1)) of the National Health Service Act 2006 in the form which the Secretary of State has, within the approval of the Treasury, directed.

We are NHS North Lincolnshire CCG

NHS North Lincolnshire Clinical Commissioning Group (CCG) is responsible for planning and paying for healthcare services in the area. This is what we call 'commissioning'. Our ambition is to help local people live healthier lives and to make sure that when people do require health treatment, they receive the best possible standard of care.

If you are registered with a North Lincolnshire GP practice, we are responsible for commissioning most of your healthcare. This includes mental health care, maternity services, treatments you receive in hospital, urgent and emergency care and some community services.

We are clinically led, which means that local doctors, nurses and other healthcare professionals have a central role in the work of the CGG. Our clinicians see North Lincolnshire patients every day and understand what our local population needs, making them ideally placed to make decisions about local care.

Our CCG brings together all 19 local practices and other health professionals to plan and design services to meet the needs of local patients. The number of patients registered with our GP practices is around 183,500. For a full breakdown of our member practices, branch sites, patient list sizes and locality, please turn to the Accountability section of this report.

Where appropriate, we will jointly commission services with partners such as neighbouring North East Lincolnshire CCG or North Lincolnshire Council. The main health provider organisations that we have contractual arrangements for services are:

- Northern Lincolnshire and Goole NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Foundation Trust
- East Midlands Ambulance Service NHS Trust
- Yorkshire Ambulance Service NHS Trust

We also work closely with Healthwatch North Lincolnshire, the independent champion for local people who use health and social care services. We hold six Governing Body meetings and an Annual General Meeting each year, all of which are open to the public. For dates, times and venues, please contact us via the details below or visit our website:

We ceased to exist as an organisation on 30th June 2022, but you can contact us at:

NHS North Lincolnshire Health & Care Partnership,
Health Place,
Wrawby Road,
Brigg, North
Lincolnshire,
DN20 8GS

Tel: 01652 251000

A warm welcome

Welcome to the 2022, April 1 to June 30, Annual Report and Accounts for NHS North Lincolnshire Clinical Commissioning Group (CCG).

We hope this will provide an overview of our progress and performance during what has been another challenging period for our National Health Service.

As a result of the pandemic, demand on the system has never been so high. As expected, we are seeing huge pressures in our hospitals, GP practices, ambulance services, mental health services, community teams and care homes. But while it has been tough, North Lincolnshire can be proud of its response under the most severe pressure.

Working alongside our partners has been pivotal and we have seen some excellent collaboration between our local healthcare providers, North Lincolnshire Council and voluntary sector. We have worked extremely closely with our acute and community care providers, Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and mental health provider, Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH), to ensure patients are receiving the best and most timely care possible.

GP practices continue to do an incredible job. GPs are giving record breaking numbers of appointments every month to patients in North Lincolnshire. We have seen an increase in consultations by telephone, video or online, which has meant patients who don't always need to make a trip to see their GP, have not needed to.

By the time this report is published, the health and care landscape will look different. The Health and Care Bill which has gone through Parliament sets out plans to put Integrated Care Systems on a statutory footing, empowering them to better join up health and care services, improve population health and reduce health inequalities.

The proposals within this Bill mean that each ICS will be led by an NHS Integrated Care Board (ICB), an organisation with responsibility for NHS functions and budgets, and an Integrated Care Partnership (ICP), a statutory committee bringing together all system partners to produce a health and care strategy. When ICBs were legally established on 1 July 2022, Clinical Commissioning Groups (CCGs) were dissolved.

Even when the CCG ceases to exist as a statutory body, it is imperative to stress our Place will be paramount. North Lincolnshire has come too far for it not to be. Work has been under way throughout the year with the Health and Wellbeing Board, and other partners, to develop partnership arrangements. A baseline maturity assessment has been undertaken, showing movement to a 'maturing' partnership'. We already have strong partnerships, governance and underpinning strategies and plans and working arrangements, so the foundations have certainly been built for a bright future.

We would like to thank our CCG Governing Body members who have been critical in not only North Lincolnshire CCG's response to the pandemic but also the growth and development of the organisation and to our incredible team who have been unwavering in their commitment to the people of Northern Lincolnshire.

We want to thank all partners with a specific mention to our Governing Body lay members and the local voluntary sector for all the hard work they are doing.

A huge thanks must go to the public as well. And to those who continue to engage with our community groups. There has been a relaunch of the organisation's Patient and Community Assurance Group in a bid to make it more representative of the diverse population we serve in North Lincolnshire. We are delighted to see a number of new recruits join – including the chairman of the North Lincolnshire Multi-Faith Partnership.

Thank you for taking the time to read our report.
NHS North Lincolnshire CCG

Contents

PERFORMANCE REPORT

Stephen Eames CBE

Chief Executive (Accountable Officer)

22 June 2023

Performance Overview

The Accountable Officer's Performance Overview highlights our key programmes of work, service transformation and explains how we are working – with our partners and the residents of North Lincolnshire – to improve health outcomes.

This section includes key updates on:

- Joint strategic programmes
- Commissioning programme areas (unplanned care, planned care, cancer, maternity, children and young people and mental health)
- Integrated care in North Lincolnshire
- Primary care
- Engaging with people and communities
- Delivering safe, high-quality services
- Taking action on health inequalities and the local strategy for health and wellbeing

A detailed financial and performance analysis, and the sustainability report, will follow this.

Performance analysis

Humber and North Yorkshire Health and Care Partnership

Humber and North Yorkshire Health and Care 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. The Partnership comprises of NHS organisations, local councils, health and care providers and voluntary, community and social enterprise (VCSE) organisations.

Working across a large geographical area, which includes the cities of Hull and York, and large rural areas across East Yorkshire, North Yorkshire and Northern Lincolnshire, Humber and North Yorkshire Health and Care Partnership serves a population of 1.7 million people.

A key focus for the Partnership during the period of 1 April to 30 June 2022 was preparing for the introduction of the Health and Care Act 2022. This Act sees Integrated Care Boards (ICBs) established to take on NHS planning functions within each ICS.

During this period details were finalised for the ICB executive team and board members, which until 1 July 2022 were designate positions. Details of these can be found at www.humberandnorthyorkshire.icb.nhs.uk/board-members.

A new name was also introduced, with Humber and North Yorkshire Health and Care Partnership launched on 1 April 2022 to replace Humber, Coast and Vale. The new name was introduced to better reflect the geography of the region and provide an opportunity to refresh the Partnership's brand and identity.

Whilst much of the focus was on the introduction of the Health and Care Act, other programmes of work have continued and some of the key projects and achievements during this period are below:

Re-launch of the ORCHA App Store

April 2022 saw the re-launch of the ORCHA App Store to help support people with choosing the right self-care apps. Apps present a fantastic opportunity to provide valuable health information which can help not only improve the quality of healthcare, but also help people to live healthier lives. The market is awash with apps, though, and we have no ability to see whether what is being downloaded will actually improve our health or if our personal data will be stored safely.

For that reason, Humber and North Yorkshire Partnership have partnered with ORCHA (the Organisation for the Review of Care and Health Applications) to deliver hnyhealthapps.co.uk and help to overcome these challenges. ORCHA carry out independent and impartial reviews of health and care related apps, and the resultant information is clearly presented throughout this website.

Becoming the first ICS to receive Menopause Friendly Accreditation

Humber and North Yorkshire Health and Care Partnership became the first ICS to receive Menopause Friendly Accreditation, working together with partner organisations to support the collective workforce.

The ICS has developed a programme to raise awareness of the menopause, its symptoms, and ways of managing them, and implications on long term health, as well as support to have GP and workplace conversations. Line managers are now armed with the information and tools needed to have supportive conversations and around 50 menopause advocates across the partnership have undergone specific menopause training that they can share with others.

DadPad app launched to support new and dads-to-be

The DadPad app is an easy-to-use, freely downloadable resource now available for new dads and dads-to-be in the Humber and North Yorkshire area. The app can be downloaded from the App Store or Google Play and is packed with relevant information, as well as details on local support groups and service providers it aims to provide new fathers with guidance on how to develop the mindset, confidence and practical skills needed to meet their babies' physical and emotional needs.

Signing the NHS Smokefree Pledge

The NHS Long-Term Plan sets a target that by 2024 tobacco dependency treatment services will be available for all patients admitted to secondary care, maternity, and mental health settings.

The Humber and North Yorkshire Health and Care Partnership marked their dedication to this programme by signing The NHS Smokefree Pledge, committing to treating tobacco dependence and providing wider system support to reduce tobacco use. Each Trust will employ specialist teams offering highly effective and evidence-based treatments to patients upon admission, to help people manage their nicotine use whilst in hospital and offer everyone the opportunity to make a supported quit.

In addition to this, across the Humber and North Yorkshire Health and Care Partnership, funding has been obtained for a pilot scheme to offer an enhanced stop smoking service for staff. This will help those who smoke tobacco to manage their dependency at work and help to move towards a truly Smokefree NHS.

Engaging communities

We adhere to the statutory guidance set out by NHS England for "patient and public participation in commissioning health and care" and this is embedded into the methodology we use to deliver engagement.

This requires us to:

- Involve the public in governance.
- Explain public involvement in commissioning plans/business plans.
- Demonstrate public involvement in annual reports.
- Promote and publicise public involvement.
- Assess, plan, and take action to involve.
- Feedback and evaluate.
- Implement assurance and improvement systems.
- Advance equality and reduce health inequalities.
- Provide support for effective involvement.
- Hold providers to account.

In addition to being a statutory duty we believe that meaningful patient and public participation can help us to develop and deliver services that are safe, effective and efficient.
Our Engagement and Public Involvement Strategy sets out our principles for engagement. North Lincolnshire CCG:

- Will meet its statutory duties to involve, engage and consult the public.
- Will communicate via clear and concise means and transparently.
- Expects to be accountable for the way in which it involves, engages, and consults.
- Believes responding to feedback from the public is as important as receiving it
- Believes in consistency and coherence in engagement and communication but will vary its approach to reflect local circumstances and sensitivities.
- Will learn lessons from its engagement and communication activity and respond accordingly.
- Believes engagement and communication must be authentic by operating within the context of financial and operational realities.
- Will ensure effective links to tap into wider networks and groups – beyond just health.
- Will ensure that people who engage with us are fully supported to do so.

Developing our approach to involving communities

The communications and engagement team, while responding to the continued pandemic, has continued to work hard to improve not only public involvement, but the internal process that underpins strong public involvement.

We have a number of ways in which patients and the public can get more involved in our work. We are committed to working with the voluntary, community and faith sector to ensure that we hear from and respond to the most vulnerable members of our community. We consider these

groups when planning patient and public involvement and go out to hear their views in a way that is most suited to them.

Ways that people get involved include:

- **Our Lay Member for Patient and Public Involvement** – Our lay member represents the patient voice on the CCG Governing Body.
- **Healthwatch** – we regularly engage with Healthwatch North Lincolnshire and involve them in our work. We use insight provided by Healthwatch to inform our programmes of work.
- **Embrace Patient Network** – This initiative enables local people to sign up to be involved in shaping the future of local healthcare in a number of ways, such as taking part in focus groups, reviewing information before it goes to the general public, as well as receiving regular communication from the CCG. To join Embrace, please contact us or visit our website https://northlincolnshireccg.nhs.uk/tell-us-what-you-think/embrace/
- **The CCG website** – The "Tell us what you think" section of the website offers information on different ways patients can get involved with our work.
- **Programme-specific involvement** – We use local intelligence and relationships with the community and voluntary sector to ensure we speak with and involve the right people in our commissioning decisions, for example speaking to parents about their views on a proposed shared care pathway for neurodiversity needs.

Partnerships and networks

Local Authority

We continue to work in partnership with North Lincolnshire Council, and their public health team.

Providers

We work in partnership with our providers to deliver engagement across North Lincolnshire. Our providers include Northern Lincolnshire and Goole Hospitals NHS Foundation Trust and Rotherham, Doncaster and South Humber NHS Foundation Trust.

During quarter 1, the CCG has continued to meet with other public sector bodies on the North Lincolnshire Equality and Inclusion Forum virtually, to share best practice of engaging with those who experience the worst health outcomes. To help understand how well we are supporting or providing services fairly to all groups of people, the CCG continues to carry out equality monitoring of our membership of PCAG and Embrace and participation in our surveys.

Working with local people

Our goal is to put patients at the heart of everything we do, learning from their lived experiences, listening to their ideas and thoughts and designing and commissioning services which meet the needs of our diverse population.

On a wider system footprint, we continue to support engagement for various workstreams as a part of the Humber Acute Services Review, including engagement on maternity services and ophthalmology. The Humber Acute Services programme considers how our hospital services will be provided in the future, and we have continued to facilitate the involvement of North Lincolnshire representatives in the Citizen's Panel. More information about the review can be found here

From 1 April 2015 it has been a contractual requirement for all GP practices across England to establish and maintain a Patient Participation Group (PPG). Patient Participation Groups are the building blocks for engagement at GP practice level. Each GP practice has set up a group of patients interested in engaging with their work.

We have continued to see a strong attendance of our quarterly PPG Chairs Forum meeting, despite still doing it virtually for members' safety and convenience.

We have refocused these meetings to give members the chance to question a panel of CCG representatives about one or two subjects per meeting. Such subjects in the meetings this year have focused on primary care and general NHS access and promoting the vaccination programme. The meeting also provides an opportunity for members to talk about issues or promote work going on in their local practice or Primary Care Network.

How we have listened and responded

We have listened to views on a variety of services and used this insight to inform service development. Some of this engagement includes:

- Engagement on a neurodiversity pathway which involved in-depth telephone interviews with North Lincolnshire parents to understand their views on proposals for shared care. Crucially, feedback from the engagement led to a change in the proposal for shared care.

- Working with Healthwatch North Lincolnshire to engage those with lived experience of mental health to understand what outcomes patients might expect from a proposed mental health crisis house. It is planned to use the findings of focus groups to develop an outcome measure for the new service.

- We are increasingly working jointly with our partners on collaborative engagement exercises across North Lincolnshire. Engagement to gather views on current services for autistic children and adults in North Lincolnshire has taken place, and the findings will be used to help improve services and shape a refresh of the All Age Autism Plan for people with autism living in North Lincolnshire. The plan will outline the key priorities within North Lincolnshire as part of the ambition to make North Lincolnshire an autism friendly place to live well, be safe and prosperous.

Assuring our engagement plans

Our Patient and Community Assurance Group (PCAG) is responsible for overseeing our engagement work and assuring not only that we are carrying out our statutory duties to a high standard, but that we are responding effectively to the feedback we receive and using this to inform and influence our commissioning.

PCAG group members were recruited via our Embrace patient network and nominations from the local voluntary and community sector. In addition to Embrace members, we have representation on the group from Healthwatch North Lincolnshire, Cloverleaf Advocacy, North Lincolnshire Youth Council, Westcliff Community Works and the Humber and Wolds Rural Action group. Meetings are chaired by our CCG Lay Member for Patient and Public Involvement.

During quarter 1, we have continued to work hard to make the group more representative of the population we serve. The chair of the North Lincolnshire Multi-Faith Partnership and a college student have recently joined the group, with both already making invaluable contributions.

The Head of Strategic Commissioning is now a regular attendee of the group and gives a summary of commissioning projects and the engagement plans/activity associated with them.

We would like to thank all of our patient and public participants. We really appreciate the time people have given to find out about our work and give us their views.

Hopefully the information in this section shows what a difference public involvement makes and how it's helping us to get services right for people in North Lincolnshire.

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

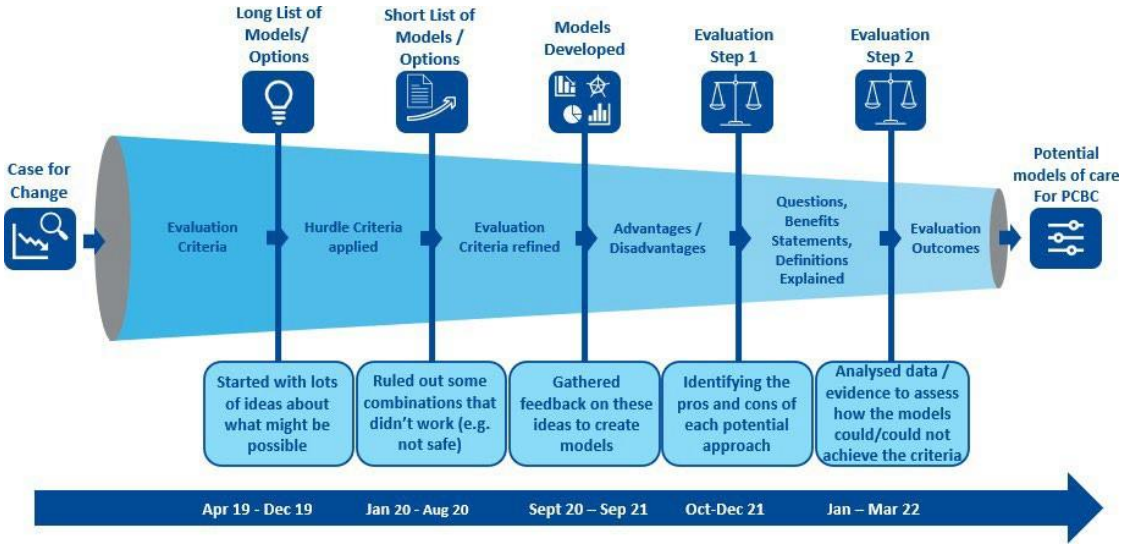
Throughout 2021-2022 we engaged with over 9,000 stakeholders, including:

- **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 on board 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 is continuing 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

Working in partnership with other NHS organisations across the Humber, we have made some significant progress through the Humber Acute Services Programme during 2021-22.

Interim Clinical Plan

Over the course of the year, the focus has been to put in place some important building blocks to establish joint services across the Humber. These building blocks include establishing joint clinical leadership working across both acute hospital trusts and the development of clinical strategies for each specialty – that help to address the health inequalities that exist within our communities, across a large and diverse geographical area.

Significant progress has been made despite the additional and ongoing pressures throughout the year caused by and responding to the Covid-19 pandemic. Some of the 2021-22 highlights include:

- **Joint clinical leadership** in place across most specialties, with significant progress in others
- **Launch of the Humber neurology service** in October 2021 – the first Humber-wide specialty operating jointly across both trusts that will provide improved equity of access to services across the Humber. This includes improved **triaging of neurology referrals** that allows patients to be immediately directed to the right sub-specialist clinics through a 'straight to test' pathway, minimising the overall number of appointments needed, and reducing overall waiting times
- **Using the learning from the successful application of the Connected Health Network** model to cardiology patients and exploring the potential for **implementing similar approaches across other specialties**
- **Working with the Elective Recovery Programme** to help people look after themselves and stay well – through the **waiting well initiative that focused on cardiology patients** who had experienced delays in accessing appointments, as a direct result of the Covid-19 pandemic
- **Transforming ophthalmic outpatient services** through the development of an Eye Electronic Referral System (EeRS) that will improve **patient access** to services, with improved quality and tracking of referrals into hospital and clinic appointments.
- Developing **a digital referral pathway for dermatology patients** that allows GPs to include digital images for review by specialist consultants, **transforming the referrals process** and **optimising capacity and waiting lists** by reducing inappropriate referrals and allowing more time to focus on those requiring acute interventions. Similar arrangements are also being explored for Ear, Nose and Throat referrals.
- Collaborative development of a **Consultant Led, Team Delivered service model for oncology** to address service pressures arising through increasing complexity of treatments, patient numbers and numbers of therapies offered to individual patients. This approach **makes best use of our resources, ensuring that patients are seen at the right time, in the right place, by the right person**, while optimising the consultant's availability to focus on the most clinically appropriate cases.

Improving quality

Delivering safe, high-quality services

Throughout the first quarter of 2022-2023 North Lincolnshire CCG continued its unrelenting passion and dedication to commissioning and delivering high quality, safe services for its local population.

During this time, we have continued to build on previous successes, continued our ambition to deliver against the 5 year Quality Strategy and ensured continuous quality improvement and system wide collaboration has been at the heart of our North Lincolnshire approach. The Quality Strategy embraced the fundamental principals of co-production, integration and utilising feedback and data intelligence to continually seek improvement against quality outcomes.

With the emphasis being on ensuring high quality services and continuous improvement, we were able to fulfil our statutory duty of improving the quality of care that is commissioned under section 14R of the Health and Social Care Act 2012.

Quality assurance

As a CCG we were committed to ensuring the highest levels of quality and safety for the services that we commission. As such we sought assurances from provider organisations and working collectively across the system where risks or areas for improvement were identified.

We monitored the quality of services across North Lincolnshire using quality oversight processes which measure impact and outcomes against the quality standards that are set nationally, and those that we have set locally. These standards include patient experience, patient outcomes and patient safety.

Robust oversight of service provision across the providers organisations has continued to be reported into the Quality, Performance and Finance Committee and into the Governing Body. In addition to the standard reporting workplan, other focused assurance work has also taken place across the first quarter including a focus deep dive on the urgent and emergency care pressures seeking system wide improvement opportunities and a detailed review of patient flow and discharge arrangements in North Lincolnshire. All identified learning and associated actions are continually monitored for progress and impact via the relevant forums.

Care homes

The continuing impact of the Covid-19 pandemic has remained challenging for the health and care system. The Care Home Oversight Group, established at the beginning of the pandemic to support our local care homes utilising a system wide partnership approach, has been maintained. This has enabled health and social care partners to come together twice a week, to share data and intelligence with the principal aim of supporting local care homes to prevent and/or manage any infectious outbreaks including Covid-19. This approach has continued to provide early identification of wider quality elements enabling bespoke support and actions to be instigated rapidly.

The CCG has remained instrumental in providing ongoing support, advice and training across all 58 care homes in North Lincolnshire. This has also included supporting the vaccination programme of both residents and staff within the care home sector. The outcome of these ongoing actions has resulted in a maintained improved prevention and outbreak management process across the care home sector and partnership support with a focus on improving outcomes for care home residents.

Infection, Prevention and Control

The CCG has been instrumental in supporting the Infection, Prevention and Control (IPC) agenda across North Lincolnshire throughout the last year, maintaining a clear focus on the continuing response to the Covid-19 pandemic, whilst also ensuring the wider IPC areas did not lose focus.

Environmental audits and IPC visits have continued to be undertaken during the quarter 1 by the nursing team across care homes and general practice surgeries to support prevention and reduce the risk of any increased transmission. Additionally, the nursing team has supported Covid-19 outbreak incident management meetings, facilitating supportive actions and recommendations to reduce the risk of reoccurrence.

The CCG have also continued to prioritise reducing Escherichia Coli (E-Coli) rates across North Lincolnshire. Continuation of a rolling programme of delivery of IPC sessions for primary care and care home IPC leads covering a variety of topics including:

- The role of the IPC Lead including IPC standards
- Reducing the chain of infection – best practice, hand hygiene and audits and PPE
- Prevention of urinary tract infections – to dip or not to dip
- Waste management – environmental cleaning
- Equipment cleaning
- Asepsis – specimen collecting, laundry and linen management

An additional training programme continues to be supported and includes the following topics;

- Oral care
- Catheter care
- Hydration
- Managing outbreaks of diarrhoea and vomiting in a care home setting
- Scabies: the condition, treatment and management
- Blood borne viruses.

The success of the above actions, as well as the wider IPC measures in relation to Covid-19, has resulted in the CCG E-Coli rates not exceeding the NHS England trajectory for the end of Quarter 1 for 2022/2023. The emphasis for the remainder of this year will be to sustain this improvement and continue to build on the current success. Furthermore, the quarter 1 position for clostridioides difficile infections was 5 against a trajectory of no more than 6 cases during this time frame. We had no MRSA cases during quarter 1 of 2022/2023.

Learning Disability Mortality Reviews (LeDeR)

NLCCG have continued to ensure high quality reviews have been allocated and completed within the required NHS England timeframes, with any learning alongside good practice is extracted and shared within the Humber LeDeR Panel meetings for discussion and wider sharing across the system and Humber area.

The 2021/2022 LeDeR Annual Report was published on the CCG's website along with an Easy Read version of the report by the required deadline set by NHS England of the 30th June 2022. This report, was the first publication of an ICS LeDeR Annual Report, incorporating the six CCG's within the Humber and North Yorkshire area, highlighting areas of good work as well as identified areas for learning and future collaborative working as an ICS.

Safeguarding

During Quarter 1, 2022-2023, North Lincolnshire CCG has fulfilled its safeguarding responsibilities effectively and in partnership with colleagues across the system. A consistent skilled workforce has maintained its commitment to working on a multi-agency basis with children's and adult social care safeguarding teams and thus maintaining statutory responsibilities under the Care Act 2015, and the Children Act 2004.

The CCG's commitment to safeguarding partnerships has enabled us to be a pivotal leader in

shaping the arrangements locally to ensure safe and robust arrangements were maintained during the first quarter of 2022/2023. In addition, the Safeguarding Executive and wider team have also ensured effective contribution to the safeguarding planning arrangements for the transition to the Integrated Care System during 2022.

The CCG's Safeguarding Executive Lead has continued as a statutory partner attending the Children's Multi-Agency Resilience and Safeguarding (C-MARS) Board to ensure critical leadership in the safeguarding arena. They remain pivotal in ensuring the effectiveness of the local safeguarding arrangements and continue as the C-MARS Senior Responsible Officer for scrutiny, assurance and training, as well as being the Executive Lead for the SAB's delivery of the protection and accountability core adult safeguarding principles. In addition, they are also a core member of the Strategic Domestic Abuse Board, the Corporate Parenting Board and represent at Community Safety Partnership.

The Designated Nurse for Safeguarding has continued a key role in overseeing the delivery of Board and partnership activity, as well as providing case support to both safeguard and promote families, children and adults in North Lincolnshire, to enable the best outcomes in line with all safeguarding principles and legal frameworks. In addition, the Designated Nurse for Safeguarding leads the C-MARS Safeguarding Practice Learning and Improvement Group and is the Chair for the Prevention and Proportionality group, which is committed to progressing priorities across the system with adults and children to ensure that learning is identified and shared to improve the outcomes for people. Quarter one has seen consideration, reflection and self-assessment of the reports from the national panel and the McAlister report, with benchmarking of our local arrangements. Locally, an independent scrutiny process has provided assurance we are safeguarding effectively within current arrangements.

The Named Doctor for Safeguarding has continued to lead a project across the Humber to introduce a safeguarding adult forensic examination pilot in response to a Safeguarding Adult Review. NHS England and the Faculty for Forensic and Legal Medicine are directly supporting this, with commitments from the Humber Local Authorities and Humberside Police.

Looked After Children

North Lincolnshire CCG continues to work in partnership with the North Lincolnshire Corporate Parenting Board and Multi-Agency Looked After Partnership with the increased capacity of the Designated Safeguarding Nurse for Looked After Children (LAC) and Care Leavers post. This additional designated capacity facilitates greater partnership collaboration with the local commissioned LAC service, through co-ordination and enhanced working with the Designated Doctor for LAC and the LAC Nursing Team. This has ensured the CCG remains fully involved and committed to promoting the health and welfare of Looked After Children across North Lincolnshire.

NHS funded care

North Lincolnshire CCG recognises the ongoing achievements delivered by its Continuing Healthcare service during the first quarter of 2022/2023. Continuing Health Care is aligned to our Nursing and Quality Directorate, with the Head of NHS Funded Care being responsible for the operational delivery in addition to strategic commissioning of commissioned care for all

age Continuing Health Care.

In line with the National Framework for Continuing Health Care and NHS Funded Nursing Care the service continues to exceed the national premium standards. The standard is measured by the completion of a full review and assessment within 28 days of receiving a positive checklist for an individual**.** This is monitored quarterly by NHS England with a compliance target set at 80% or above.

The Hospital Discharge Model, Discharge 2 Assess remains one of the North Lincolnshire priorities, in line with national policy ensuring timely, safe discharges for individuals who are medically optimised. North Lincolnshire NHS and partners have sought the views of our care home providers in North Lincolnshire to understand how we can better work together to improve the patients discharge experience. This work is ongoing and will support future partnership working between health, social care, and local providers.

The Continuing Healthcare team has continued to coordinate “FIT” testing and supplies of Personal Protective Equipment for individuals in receipt of aerosol generated procedures, ensuring the individual and the workforce remains safe. We would once again like to express our sincere thanks to the Humberside Fire and Rescue Service for supporting this critical initiative over the past two and a half years.

Mental health case management

The mental health case management service continues to improve patient outcomes by not only working in partnership but joint working. This is evidenced by timely reviews and commissioning visits attended by health, social care and our mental health trust. This allows for any areas of success and concern to be recognised and or addressed without delay.

Following the completion of Safe and Well reviews in 2021 / 2022 for individuals under the Transforming Care Programme, the service has provided assurance that all identified actions have now been completed. This has not only provided assurance for the Transforming Care Board but more importantly individuals and family members. The ongoing Commissioning and Quality Assurance visits confirm that individuals are in receipt of safe, quality and appropriate care and treatment.

In line with the local priorities NHS Funded Care will through its day to day practice continue to embed the following priorities

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience, and access
- value for money

The service will continue to build on the governance and assurance particularly in relation to the mental health pathways. This will in include the development of a Place, multi-agency All Age 117 After Care Policy.

Action to reduce health inequalities

During the first quarter of 2022/2023 the CCG has continued to support the workforce to operate safely across the partnership, to ensure the people of North Lincolnshire can access vital healthcare services. Throughout the past two years the Covid-19 pandemic has shone a light on health inequalities and highlighted how initially Covid-19 disproportionally affected ethnic minority staff, patients and wider communities, as well as those with disabilities. The CCG has therefore ensured a key focus has been maintained on supporting the health and wellbeing of employees and the wider community, minimising health inequalities where able.

Not only has the CCG embraced its equality duties and legal compliance but it has maintained its dedication and clear focus on driving change in line with the CCG equality objectives and harnessing the strength of our partnership. Working with our system partners we have continued to improve our understanding of the local population needs, shining a light on areas of inequality and utilising this intelligence in commissioning our services to reduce health inequalities across North Lincolnshire. The development of the North Lincolnshire Population Health Management and Prevention group will continue to drive this shared understanding, identifying areas for improvement and progressing actions across the system.

A partnership approach.

The CCG is a key member of the North Lincolnshire Health and Wellbeing Board, which is a partnership board and statutory committee of North Lincolnshire Council, established as part of the Health and Social Care Act 2012. This board has continued its focus on the inequalities agenda supporting integration and partnership working to improve the outcomes for our local population.

Local engagement and collaboration with system partners, including the voluntary sector, has strengthened, which has enabled increased and targeted support into some of our most vulnerable communities. Bespoke support has been wrapped around specific community groups such as care home residents, the homeless population and our local ethnic minority communities. An integrated approach to supporting our local population utilising a variety of methods has enabled many successes in areas such as Covid-19 outbreak management and uptake of the Covid-19 vaccination programme.

Commissioning to reduce health inequalities.

Our commissioning priorities are informed by the local Joint Strategic Needs Assessment. The Joint Strategic Needs Assessment (JSNA) provides a picture of the current and future health and wellbeing needs of the local population. In North Lincolnshire, the assessment of health and wellbeing forms part of a suite of documents which together create an integrated intelligence base about the place of North Lincolnshire. We use this information to prioritise our plans to ensure they focus on areas of greatest need. It helps us identify geographical areas or population groups who have greater need, enabling us to focus on these groups with the aim of reducing health inequalities.

Reducing health inequalities has continued to be a key focus with decisions informed by our local data and intelligence enabling us to target services at those with the greatest need. This has included targeted actions to support improved uptake and quality of annual health checks

for those people living with a learning disability or serious mental illness and championing the review of waiting lists against equality datasets across providers. Work has commenced, working alongside Primary Care Networks to implement a CVD prevention programme, with interventions targeted at those areas with highest prevalence of CVD. In addition the Northern Lincolnshire Women and Childrens Board also led on a health inequalities workstream focused on the quality outcomes and health inequalities gap of pregnant women and those postnatally, considering the wider determinants of health and the impact.

Health and wellbeing strategy

The North Lincolnshire Health and Wellbeing Board (HWBB) is a statutory committee of the council and is a partnership between key local organisations committed to working together to improve the health and wellbeing of the local population and reduce health inequalities. The CCG plays an active role within the HWBB, with representation from the CCG Chief Operating Officer and the Chair, reporting on local health issues and plans in addition to the submission of plans such as the Better Care Fund.

The Health and Wellbeing Board has continued its oversight of the implementation of the Joint Health and Wellbeing Strategy, which it approved in September 2021. This includes the continued work of the Population Health Management and Prevention Partnership, which has focused on reducing teenage pregnancy rates, improving supported self-management, better use health data to support Primary Care Networks address cardiovascular disease and improving the outcomes for people who are frail.

The North Lincolnshire Health and Wellbeing Board met once between 1st April and 30th June 2022 (on 28th June) and included on the agenda an update on the Joint Health and Wellbeing Strategy - Framework and Priorities and an update from the CCG on the Humber Operational Plan and North Lincolnshire Priorities 2021/22.

Health and Place plan

The Health and Care Integration Plan, 2019-24 was refreshed this year, to ensure this reflected the priorities and learning from the Covid-19 pandemic. This refreshed strategy, co-developed with Place partners was approved by the HWBB in June 2021 and covers the remaining period 2021-24. The plan shows how we intend to focus on transforming the lives of people of North Lincolnshire, through developing a sustainable, enabling integrated Health and Social Care system across all life stages and levels of need that empowers our local population, unlocks and builds community capacity.

Integrated commissioning

North Lincolnshire CCG works closely with North Lincolnshire Council to explore opportunities for integrated commissioning to improve the outcomes of North Lincolnshire residents and to get the best value from services on behalf of the Health and Wellbeing Board. Delivery of the integration agenda is through the Integrated Adults Partnership and the Integrated Children's Trust. This includes representation from key health and care commissioners, providers and

the voluntary sector. The CCG continues to jointly commission a number of services, such as the Carers Support Service which offers a range of support to residents who provide unpaid care for other people. During this year, the CCG and the council have worked together on a review of the carer strategy, identifying four key priorities and implementation plans. Delivery of the plan is monitored by the Integrated Adults Partnership.

The Integrated Adults Partnership and the Integrated Children's Trust both provided progress reports to the Health and Wellbeing Board during the year.

Unplanned care

We successfully developed an Urgent Care Service, delivered from the Emergency Department of Scunthorpe General Hospital. This model, developed in conjunction with Northern Lincolnshire and Goole NHS Foundation Trust and the local GP Federation, Safecare, enables suitable patients who do not meet the criteria for an Emergency Department to be diverted into a GP led service. This in turn creates capacity within the Emergency Department to deal with those presenting with critical illness or injury. Continued work to embed a Same Day Emergency Care model in the hospital has also reduced the number of people who require overnight care in a hospital bed. This has been a significant achievement during the Covid-19 pandemic when non-elective admissions have been high.

As Covid-19 numbers and hospital admissions have increased following a reduction in restrictions, we have continued close working with partners to ensure patients can be rapidly discharged from hospital once fit. This has included commissioning community care home beds to support the Discharge to Assess process. Discharge to Assess is the process by which patients are discharged from hospital (with additional support if required) and receive a full assessment of their ongoing care needs within their home setting. Pressures on health services have been challenging particularly over the last year, and this has been seen in the demand on ambulance services and emergency departments. The CCG has facilitated projects to support management of this demand and to reduce demand on ambulance services where clinically appropriate. This has resulted in an increase in the number of patients seen by an ambulance crew and managed without the need to convey to hospital.

Planned care

NLCCG has worked with NLaG and North East Lincolnshire CCG to develop and pilot the Connected Health Network (CHN) model, which represents a transformative change from the traditional model of patients being referred by primary care into secondary care. The traditional model is based on hand-offs from one service to another and waiting lists for patients.

The Connected Health Network operates across traditional boundaries, with GPs working in partnership with specialists to provide ongoing care and support to patients as an extension of primary care, avoiding a formal referral. In many cases, the patient does not need to be seen face to face, with the specialist clinician consulting virtually with a patient and using a shared administration resource, directly booking diagnostic tests and hospital based procedures. Early pilots of this model have resulted in 70% of patients on hospital follow-up being discharged to primary care, with a reduction in duplication of diagnostic tests due to the

shared access of the primary care record. This model is currently being rolled out across North and North East Lincolnshire across a number of specialties, with a plan to spread this model across the ICS.

Other successes have also supported the redesign of traditional outpatient pathways with increased use of advice and guidance to reduce the need for a hospital referral, increased use of virtual consultations and straight to test pathways to reduce the number of times a patient has to attend the hospital for an appointment and the introduction of patient initiated follow-up, where the patient has flexibility to arrange follow-up appointments for when they need them.

Cancer

The CCG, GP practices and NLaG have developed and implemented a new rapid diagnostic pathway. This is in line with the national directive for the establishment of rapid diagnostic centres as part of the NHS Long Term Plan to rapidly rule out cancer in those patients where the GP has concerns but the patient doesn't have typical symptoms of cancer.

Following a number of blood tests carried out in primary care, the patient is referred on a rapid diagnostic pathway for hospital-based tests and scans to rule out cancer. The introduction of this pathway for gastro-intestinal problems enables these patients to be rapidly assessed, without creating delays for patients on cancer pathways. This model will be expanded in 2022-23 to cover other conditions.

Maternity

North Lincolnshire CCG, as a member of the Humber and North Yorkshire Local Maternity System (LMS), provides support and oversight for our maternity and neonatal services across the area. A new Perinatal Safety, Quality and Assurance Group has been established to review any incidents that occur across the area and provides shared learning, recommendations for improvements to policies and procedures, and supports the implementation of those changes. A LMS wide procurement of a single maternity IT system to enable consistent data recording across all maternity units, alongside a patient app which will enable women to access their records and test results and provide access to advisory websites has been undertaken, with implementation in 2022-23.

We have continued working with our Maternity Voices Partnership colleagues to ask our families and staff about what is important to them and how we can encourage more joint working; this builds on the service user engagement undertaken in 2020-21. Work has continued to maintain the Maternity Continuity of Carer teams to support families; particularly those in minority ethnic communities and deprived populations. A number of breastfeeding initiatives were also delivered including the provision of breast pumps in neonatal units, development of a training course for midwives to reverse tongue-tie in babies, and purchase of books for children's centres to normalise breast feeding.

Mental health and learning disabilities

Children and young people

The CCG has continued to work locally and with Humber and North Yorkshire ICS partners to promote and ensure access to mental health support during the pandemic, in recognition of the impact of Covid-19 restrictions on the mental wellbeing of children and young people.

The CCG has increased its investment into services for people with eating disorders in response to an increased number of people coming forward with eating disorders during the pandemic. In addition, the CCG has supported work to reduce waiting lists through the expansion of services to tackle the increased waiting times caused by the reduction in face to face services during the early stages of Covid-19. We have also launched a new Mental Health Support Teams in schools (MHSTs) service which provides specialist mental health staff into schools to support those pupils with mental health issues by improving access to services through early identification of issues and promotion of emotional health and well- being across whole school communities. The teams will work alongside existing services such as Educational Psychologists and pastoral support to ensure a holistic approach within school settings. The MHSTs will work closely with Child and Adolescent Mental Health Services (CAMHS) in order to support transitions both in and out of the CAMHS service ensuring access to specialist services at the right time.

In conjunction with North Lincolnshire Council, the CCG has contributed to the development of an all-age autism plan for 2022-2026, co-produced with a wide range of partners and informed by user voice. The plan is awaiting formal approval and following this, implementation of the plan will be monitored by the SEND Standards Board, the Integrated Children's Trust and the Integrated Adults Partnership.

In conjunction with North Lincolnshire Council, we have further invested in the jointly commissioned specialist trauma service to ensure children who have experienced trauma through abuse or neglect can access timely specialist support.

Adult services

Work with wider partners across the Humber and North Yorkshire footprint continues to implement the Transforming Care plan, including development of community infrastructure and reducing avoidable hospital admissions for people with a learning disability. We have been able to expand the North East Lincolnshire employability scheme for people with a learning disability to North Lincolnshire to support people into training and employment. Despite the huge pressures in primary care, GP practices have managed to increase the proportion of patients with a learning disability who have received an annual health check within the last year.

The CCG has continued work with MIND North Lincolnshire to develop a crisis house to support people in mental health crisis to avoid hospital admission. The model has been developed with input from services users and whilst the launch has been delayed due to building work, the facility is scheduled to open in Spring 2022.

We have increased support for mental health in primary care through the development of a

Primary Care Network mental health team and appointment of mental health nurses into GP practices. This is improving access to mental health support in primary care and starting to increase the number of people with a mental health condition who receive an annual health check.

Frailty

The national Ageing Well programme focused on the development of new integrated models of community care to help increase community capacity to support more patients out of hospital – helping alleviate pressures on other parts of the health system and improve outcomes for patients. This programme focused on supporting our frail population and addressed three key priority areas:

- **Enhanced health in care homes** – enhanced support and better coordinated care, reablement and rehabilitation for care home residents through personalised care and support planning
- **Urgent community response** – rapid response to people in the community experiencing a health or social care crisis
- **Anticipatory care** – helping people with complex needs stay healthy and functionally able through personalised care and support planning.

The implementation of these workstreams is overseen by the Northern Lincolnshire Frailty Oversight Group which is led by frailty clinicians and includes representation from partners across the North Lincolnshire health and care system. The group has taken forward learning from the award-winning frailty service delivered from the team at the Jean Bishop Integrated Care Centre in Hull. This is led by Community Consultant Geriatricians, has agreed a consistent, system-wide approach to identification of frailty and commences risk stratification of the frail population to identify those patients who would benefit from the local frailty service, proactively managing their health to reduce the risk of hospitalisation.

The continued implementation of enhanced health in care homes means that now, every care home is aligned to a Primary Care Network. This enables people who are a resident in a care home to receive a weekly check from primary care and the wider multi-disciplinary care team including representatives from the care home, primary care and community services to identify early any healthcare needs and ensure these are addressed. A successful pilot has been under way in East PCN which provides an integrated support package coordinated by a lead nurse undertaking a holistic assessment of the needs of care home residents and person-centred care planning. Early feedback indicates that the pilot has delivered positive outcomes for care home residents and their carers through this joined-up and targeted approach.

In the latter part of 2021-22, North Lincolnshire has seen the mobilisation of a 2 hour Urgent Community Response service which provides an integrated health and/or social care response in a patient's own home or usual place of residence in the event of a crisis. The service is operational 8am-8pm, seven days per week and is supported by a GP who is part of the wider community unscheduled care team to provide senior decision making, following a successful pilot period during the pandemic. This service aims to reduce unnecessary attendance or admission to hospital, enabled by rapid access to senior clinical decision

making, and for the patient to remain in their own home where it is safe to do so. As the service evolves and embeds, opportunities will be sought to enhance the provision.

Over the next year the frailty workstreams will look to further integrate and optimise existing pathways and services by focusing on the enhancement of clinical leadership and collaborative working, facilitated by the Frailty Oversight Group and Integrated Care System Collaborative with the national operational guidance for the Ageing Well workstreams.

End of life

The Northern Lincolnshire End of Life Steering Group was established from July 2020 with senior representation from each organisation and delegated decision-making responsibilities. This group has continued to drive forward improvements in end of life care through improved integration of care. Significant progress has been made with the implementation of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment). This enables health professionals to create a personalised recommendation for clinical care in emergency situations where the person is not able to make decisions or express their wishes, including decisions where a patient does not wish to be resuscitated.

The implementation of Electronic Palliative Care Co-ordination Systems (EPaCCS) has continued with increased numbers of care plans being recorded on the system. EPaCCS record people's care preferences and important details about their care at the end of life. This information facilitates co-ordination of care between all health and care providers involved in caring for a patient at the end of life. It supports appropriate treatment decisions to allow more people to experience a 'good death', in the place that they wish and with the appropriate level of intervention.

We have adopted a standard competency framework for end-of-life care skills across all partners and have developed standard training for clinical practice/direct patient care; communications skills and symptom management including last days of life. This will be continued to be developed and mobilised during 2022-23 to ensure consistent, high-quality training and education for people involved in end-of-life care.

Primary care

There are four Primary Care Networks (PCNs) established in North Lincolnshire which operate under the Network Contract Directed Enhanced Service (DES), each having their own Clinical Director and PCN Manager to help develop and expand the networks and provide a more effective service for patients. As the PCNs continue to mature, the networks continue to recruit additional workforce as part of the Additional Roles Reimbursement Scheme to increase capacity to help meet patient demand. The 19 GP practices in North Lincolnshire serve a population of around 183,500 people.

PCN	Number of practices	Total patients (nearest 1,000)	Clinical Director
East Network	5	32,000	Dr Salim Modan
South Network	6	72,000	Dr Tehmina Mubarika & Dr Jane Widders
North Network	3	33,000	Dr Toby Blumenthal
West Network	5	44,000	Dr Pratik Basu & Dr Gary Armstrong

Member practices

Practice name sites and PCNs from which services are delivered.

North Primary Care Network
Central Surgery, King Street, Barton Upon Humber, DN18 5ER Winterton Surgery, Manlake Avenue, Winterton, DN15 9TA Bridge Street Surgery, Brigg, North Lincs, DN20 8NT
East Primary Care Network
Riverside Surgery, Barnard Avenue, Brigg, DN20 8AS The Killingholme Surgery, South Killingholme, DN40 3EL West Town Surgery, Barton Upon Humber, DN18 5PU Trent View Medical Practice, 45 Trent View, Keadby, DN17 3DR The Medical Centre, Victoria Road, Barnetby, DN38 6HZ
South Primary Care Network

Ashby Turn Primary Care Partners, The Link, DN16 2UT West Common Lane Teaching Practice, DN17 1YH Cedar Medical Practice, 275 Ashby Road, DN16 2AB Ancora Medical Practice, 291 Ashby Road, DN16 2AB The Surgery, Traingate, Kirton in Lindsey, DN21 4PQ Cambridge Avenue Medical Centre, Bottesford, DN16 3LG
West Primary Care Network
The Birches Medical Practice, Ironstone Centre, DN15 6HX The Oak Tree Medical Practice, Ironstone Centre, DN15 6HX Church Lane Medical Centre, Orchid Rise, DN15 7AN The Oswald Road Medical Centre, Oswald Road, DN15 7PG South Axholme Practice, The Surgery, Epworth, DN9 1EP

NHS 111 direct booking

NHS 111 direct booking in North Lincolnshire is now live for all practices and allows the 111 service to directly book into a GP appointment slot when appropriate to create a smoother process for patients who need to see a clinician.

Digital enabled care

Following significant change as a result of the Covid-19 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 a number of key programmes of work under way 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 a number of 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 under way looking at how we can provide supported digital access to those patients who normally wouldn't be able to access, 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 a 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 a number of exciting projects underway:

- We have implemented a clinical booking system which allows NHS 111 to book callers into urgent 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.

Performance analysis - how are we doing?

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. The CCG has internal processes in place to manage performance against a range of national and local indicators 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.

Operational and Constitutional Indicators

The NHS Oversight Framework 2022-23, published in June 2022, states this updated framework will take effect from 1 July 2022 and the existing oversight arrangements as set out in the System Oversight Framework 2021/22 apply until this date.
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.

The CCG's performance against the rights and pledges set out in the NHS Constitution and several identified areas of focus are reported to our Governing Body through a set of defined key indicators and associated targets.

The CCG achieved 9 of these 29 standards (see tables below). This shows the most recent position available to the CCG for each indicator at the time of writing, which is as of June 2022.

Performance has been achieved in the following:	
Cancer 2 Week Waiting Times Cancer 31 Day Subsequent Waits – Anti Cancer Drug Regimens Ambulance Category 4 90th centile IAPT % of patients moving to recovery Early intervention in psychosis % Of patients who wait 18 weeks or less to access IAPT services % Of patients who wait 6 weeks or less to access IAPT services MRSA Clostridiodes difficile	

Performance has not been achieved in the following:	
18 Week Referral to Treatment (Incomplete pathways) 52 Week Waiting Times Diagnostic 6 week waits 12 Hour Trolley Waits 4 Hour A&E Waiting Times (Trust wide National SITREP reporting) Breast Cancer 2 week wait Cancer 31 Day Wait – first definitive treatment Cancer 31 Day Subsequent Waits – Surgery Cancer 31 Day Subsequent Waits – Radiotherapy Cancer 62 Day Wait Referral to Treatment Times – first definitive referral from GP referral Cancer 62 Day Referral to Treatment Times – Screening Service Cancer 62 Day Waiting Time – Consultant decision to upgrade status Ambulance Category 1 Mean Waiting Time Ambulance Category 1 90th Centile Ambulance Category 2 Mean Waiting Time Ambulance Category 2 90th Centile Ambulance Category 3 90th Centile Mixed Sex Accommodation Cancelled operations: not offered another date within 28 days % Of people who have depression and receive psychological therapies (IAPT)	

COVID-19 and the ongoing wider system pressures has and continues to negatively impact on performance across provider organisations nationally, regionally, and locally. The indicators seeing the greatest impact relate to the following areas:

- 18 Week Referral to Treatment Times
- 52 Week Waits
- Diagnostics
- A&E performance – including 12-hour trolley breaches
- Some cancer indicators
- Ambulance response times

Performance challenges remain across a range of indicators including but specifically the following:

Referral to Treatment Times and 52 Weeks

Referral to Treatment times continue to fall below required standards, specifically at our two main local acute providers Northern Lincolnshire & Goole NHS Foundation Trust (NLaG) and Hull and East Yorkshire Hospitals NHS Trust (HEY).

The Q1 performance against the CCG level RTT waiting time standard improved slightly to 69.2% during Q1 2022/23, Although improved, the CCG level position remains below the national RTT performance standard of 92%. National reporting shows that the CCG position in relation to Incomplete RTT performance is above both the England and the Humber Coast and Vale ICS average.

Medicine and Surgical Divisions continue with their recovery plans with the focus being on the longest waiters and cancer patients. Additional capacity, which includes both the use of Goole District Hospital and the Independent sector, continues to be utilised and the Trust Consultants are continuing to provide additional sessions to increase clinical capacity. In addition, the Trust are supporting mutual aid opportunities across the Integrated Care System footprint to ensure equity of care to all.

The Trust continue with their robust risk stratification process, across all specialities, to monitor the risks and potential harm to patients who are waiting beyond 52 weeks for treatment or those waiting for outpatient reviews. Processes are in place to record, track and monitor risk stratification for all patients, at all points in the pathway. Assurance has been provided that where any harm is identified this is escalated and managed via the Serious Incident management process.

Six Week Diagnostic Waiting Times

Performance against the Diagnostic Waiting Time Standard deteriorated during Q1 22/23.

Extra capacity secured and delivered from Ironstone Centre continues to be utilised and, although Non-Obstetric Ultrasound continues to be the modality of concern, the Trust expect to see improvements over the coming months.

Demand and capacity planning for diagnostic services are a focus and business cases are being processed to consider increasing the workforce to support this.

A&E Four Hour Waits

CCG performance against the A&E 4 hour waiting time standard failed to achieve the national standard during Q1 22/23, the significant and sustained pressures in bed occupancy, patient demand and acuity have seen daily challenges within the EDs impacting performance in relation to long patient waits, 12-hour trolley breaches and ambulance handover delays which also continue to deteriorate.

The Trust have implemented a number of measures in relation to 12-hour trolley breaches, specifically, such as daily operational meetings to review ward zoning and patient movements to enable bed availability and senior second reviews conducted by Medicine Divisional Clinical Directors and Divisional Head of Nursing.

The Trust continue to maintain utilisation of Same Day Emergency Care (SDEC) above the national average at 40% and the Urgent Care Service (UCS) continues to provide improved patient experience and performance.

In addition to this the wider system continues to enact daily escalation meetings and has system wide improvement plans in place to support a collaborative approach to minimise the risk to patient safety. New initiatives continue to be developed, implemented, and overseen by the A&E Delivery Board and the ICS has developed an ethical framework to support the

risk management and decision making across the health and care system.

Cancer Waiting Times

The CCG has experienced difficulties with some of the pathways at various times during Q1 22/23.

All tumour sites are affected by increasing waiting times due to high demand and the availability of oncologists. The Trust are also experiencing challenges related to visiting consultant services and tertiary based staging scans, which affect the ability to transfer patients for treatment.

To mitigate some of the risks, 28- and 62-day performance is being reviewed and managed weekly and specific tumour site pathway reviews are being undertaken to identify any learning and opportunities for improvement. Within the colorectal pathway, the Clinical Nurse Specialist (CNS) straight to test model commenced in January 2022, at both Scunthorpe and Grimsby, and is impacting positively on the 28-day faster diagnosis performance.

Divisional trajectories at tumour site level are also being mapped for 2022/2023 to deliver a reduction in the backlog, increase faster diagnosis and improve performance against the 28 day and 62-day standards.

The joint transformation pathway work continues between NLaG and HUTH with a key focus being the identification of areas where pathways can be accelerated and to help with the transfer of patients.

Clinical harm reviews continue to be undertaken for all patients who wait more than 104 days and cancer surgery continues to be prioritised, in addition to the use of the independent sector to support timely access to surgery and diagnostics. Significant work continues with system partners to aid pathway improvements, and this will continue to be monitored by the Humber Cancer Board.

Ambulance Response Programme (ARP)

East Midlands Ambulance Service (EMAS) continues to be challenged by the demands on the service and the acuity of patients being conveyed. Performance therefore remains a significant concern across Northern Lincolnshire.

Due to the sustained pressures, EMAS continue to utilise their Capacity Management Plan (CMP), designed to ensure that at times of significant and potentially sustained pressure, the limited resources available are prioritised for the most clinically urgent cases. The CMP has four levels from one (normal operating) to 4 (extreme pressure). Actions designed to increase capacity, reduce demand, and reduce clinical risk are put in place when the triggers for each level have been reached.

EMAS continue with their monthly harm review process to identify if there have been any instances of actual or potential harm. This is reported monthly through the CCG forums and

additional quality oversight and improvement forums have been established during recent months. Across Northern Lincolnshire there is an EMAS improvement plan in place that links directly into the System Improvement Group. In addition to this, a specific action plan relating to reducing ambulance handover delays has been developed in April 2022, in response to the increase in the system pressures. These action plans will continue to be monitored and additional actions included as part of the current system oversight and improvement structures.

Joint working between EMAS and NLaG has continued in relation to the Same Day Emergency Care (SDEC) pathways to support non conveyance to ED where appropriate. A joint piece of work has also commenced, analysing EMAS pathways to promote any learning and provide ongoing support of the direct referral opportunities.

The CCG continues to work closely with the Trust and partners to improve EMAS performance in North Lincolnshire. It reviews the quality impact of performance challenges through the contract management process and via quality monitoring initiatives, including clinical site visits, thematic reviews of quality data (including incidents, complaints, and concerns) and the development of a joint EMAS improvement plan with partners. Key findings from these quality monitoring initiatives are included in the integrated Quality Performance and Finance Report, which is submitted to the Governing Body Meeting.

Dementia

The CCG's position in relation to percentage of dementia diagnosis rates is underachieving in Q1 22/23.

Performance against the 18-week referral to treatment target for dementia diagnosis has been maintained. Dementia diagnosis rates are shared with PCNs monthly and pathway discussions continue between primary and secondary care to address and challenges and the associated performance. A clinical workshop to consider pathway redesign is also in the process of being arranged.

Increasing Access to Psychological Therapies (IAPT)

The CCG achieved the required level of performance in all the IAPT standards during Q1 22/23, which the exception of, during June, the percentage of people who have depression and/or anxiety disorders who receive psychological therapies being slightly under the monthly trajectory.

Workforce challenges remain an area of concern for RDaSH in terms of turnover, vacancies, and sickness absence rates. This is reflected in the North Lincolnshire inpatient setting, both in terms of recruitment and staff absence. This has previously been reported as an extreme risk however, further to internal moderation, has been downgraded to a high risk with the following mitigations:

- Over recruitment to Healthcare Support Worker posts
- Recruitment to the Section 136 worker posts to reduce the impact of providing cover for the suite from inpatient services

- International nurses commencing in post
- Recruitment to vacant nursing posts
- Recruitment to the newly created reablement worker posts
- Revision of the minimum safe staffing numbers due to the increased acuity of patient presentation.

Oversight continues at the monthly quality forum between RDaSH and NLCCG.

Current performance positions

Detailed in the following are the current performance positions against the CCG's operational and constitutional targets, which form part of the reporting framework to its Governing Body.

Most are monitored monthly by the CCG's performance and quality teams and form part of its Integrated Governance Report (IGR). Deviation and off-track performance is reported and monitored as part of the report, which is received monthly by the Quality, Performance and Finance Committee (QPF) and Governing Body.

Corporate Performance Summary Dashboard

	Period	Actual	National Target	Variance	Annual Direction of Travel*	Period	Actual	National Target	Variance	Annual Direction of Travel*
Referral to Treatment pathways: incomplete	Jun-21	67.29%	92%	-13.7%	↑	Jun-22	68.58%	92%	-8.4%	↑
Number of >52 week Referral to Treatment in Incomplete Pathways	Jun-21	554	0	554	↓	Jun-22	442	0	442	↓
6 Week Diagnostic Waiting Times	Jun-21	38.72%	1%	37.7%	↑	Jun-22	30.11%	1%	29.1%	↑
A&E 4 Hour Wait	Jun-21	74.63%	95%	-15.4%	↓	Jun-22	63.30%	95%	-31.7%	↓
12 Hour Trolley Waits	Jun-21	0	0	0	⟷	Jun-22	502	0	502	↓
Cancer 2 Week Wait	Jun-21	96.0%	93%	3%	↓	Jun-22	93.1%	93%	0%	↓
Cancer 2 Week Wait: Breast Symptoms	Jun-21	88.9%	93%	-4.1%	↓	Jun-22	87.9%	93%	-5.1%	↓
Cancer 31 Day: First Definitive Treatment	Jun-21	95.5%	96%	-0.5%	↑	Jun-22	94.7%	96%	-1.3%	↓
Cancer 31 Day: Subsequent Treatment for Surgery	Jun-21	75.0%	94%	-19%	↓	Jun-22	50.0%	94%	-44%	↓
Cancer 31 Day: Subsequent Treatment for Anti Cancer Drug Regimens	Jun-21	100%	98%	2%	⟷	Jun-22	100%	98%	2%	⟷
Cancer 31 Day: Subsequent Treatment for Radiotherapy	Jun-21	100%	94%	6%	⟷	Jun-22	53%	94%	-41%	↓
Cancer 62 Day Referral to Treatment	Jun-21	52.8%	85%	-32%	↓	Jun-22	48.7%	85%	-36%	↓
Cancer 62 Day Referral to Treatment from NHS Screening Service	Jun-21	58.3%	90%	-32%		Jun-22	73.3%	90%	-17%	↑
Cancer 62 Day Referral to Treatment; Consultant upgrade of status	Jun-21	50%	90%	-40%	↑	Jun-22	50%	90%	-40%	⟷
Ambulance clinical quality: Category 1 - 7 Minute Mean	Jun-21	00:09:18	00:07:00	00:02:18	↓	Jun-22	00:12:44	00:07:00	00:05:44	↓
Ambulance clinical quality: Category 1 - 15 minute 90th centile response	Jun-21	00:17:56	00:15:00	00:02:56	↓	Jun-22	00:23:30	00:15:00	00:08:30	↓
Ambulance clinical quality: Category 2 - 18 Minute Mean	Jun-21	00:45:17	00:18:00	00:27:17	↓	Jun-22	01:46:23	00:18:00	01:28:23	↓
Ambulance clinical quality: Category 2 - 90th centile response	Jun-21	01:38:00	00:40:00	00:58:00	↓	Jun-22	04:19:04	00:40:00	03:39:04	↓
Ambulance clinical quality: Category 3 - 120 minute response	Jun-21	06:02:18	02:00:00	04:02:18	↓	Jun-22	10:40:27	02:00:00	08:40:27	↓
Ambulance clinical quality: Category 4 - 180 minute response	Jun-21	09:49:10	03:00:00	06:49:10	↓	Jun-22	No Data	03:00:00		
Dementia Diagnosis Rate	Jun-21	53.6%	66.7%	-13.10%	↓	Jun-22	51.5%	66.7%	-15.20%	↓
IAPT Entering Treatment Levels	Jun-21	2.2%	1.9%	0.3%	↑	Jun-22	1.8%	1.9%	-0.1%	↓
IAPT Recovery Rates	Jun-21	45.0%	50%	-5.0%	↑	Jun-22	50.0%	50%	0.0%	↑
IAPT <6 Week Waits	Jun-21	95.0%	75%	20.0%	↑	Jun-22	100.0%	75%	25.0%	↑
IAPT <18 Week Waits	Jun-21	100.0%	95%	5.0%	⟷	Jun-22	100.0%	95%	5.0%	⟷
Early Intervention Psychosis (1st Episode Psychosis) 2 Week Wait	Jun-21	100.0%	50%	50%	↑	Jun-22	100.0%	50%	50%	⟷
MRSA	Jun-21	0	0	0	⟷	Jun-22	0	0	0	⟷
C Difficile	Jun-21	1	2	-1	↑	Jun-22	2	2	0	↓

** Annual direction of travel gives the position in Jun 2021 compared to June 2022 (or where the indicator is quarterly, Q1 against Q1)*

Sustainable Development

Introduction

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

Sustainability is about the effective use of natural resources and behaving in a way that manages and minimises the impact we have on our environment. It requires us to pay particular attention to travel, facilities management and procurement. As a commissioner of healthcare services and as an employer, we recognise the need to minimise our impact on the environment.

During April-June 2022 and still under the influence of the Covid-19 pandemic the CCG continued with its agile working strategy, which gave staff the option to work from home full time or if required access to the building. The building continued to remain open to those staff that chose to come to work for whatever reason; this mirrored the previous year in the way of usage of utilities over the reporting period.

Governance

The CCG continued to use the Sustainability Impact Assessment (SIA) template, as this enabled the CCG to assess and anticipate the likely sustainability implications of all policies, strategies or service design/redesign. The template is embedded within the organisation's corporate templates that support decision making functions.

Travel

Travel was kept to an absolute minimum and therefore our carbon footprint was significantly reduced for a second year. Use of Microsoft Teams continued to enable business to carry on as normal without the requirement for travel. This has been another year of savings for the CCG.

Facilities management

NHS Property Services Limited (NHS PS) manages the building from which the CCG operates. We have a lease/rental agreement with NHS PS and all utility bills are shared on a proportionate basis across the building's occupants.

ACCOUNTABILITY REPORT

Stephen Eames CBE

Chief Executive (Accountable Officer)

22 June 2023

Accountability Report

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

It comprises three sections:

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

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

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

Corporate Governance Report

North Lincolnshire CCG Members' Report

The Members' Report contains details of our CCG member practices, our Governing Body membership, membership of the Integrated Audit and Governance Committee and where people can find Governing Body member profiles and the register of interests.

Our CCG membership

NHS North Lincolnshire CCG is a clinically led organisation that brings together local GP practices and other health professionals to plan and design services to meet local patients' needs. Our GP practices serve a population of around 183,500 people.

The CCG has nineteen member practices – including a number of branch surgeries.

Member practices

Practice name sites and PCNs from which services are delivered.

North Primary Care Network
Central Surgery, King Street, Barton Upon Humber, DN18 5ER Winterton Surgery, Manlake Avenue, Winterton, DN15 9TA Bridge Street Surgery, Brigg, North Lincs, DN20 8NT
East Primary Care Network
Riverside Surgery, Barnard Avenue, Brigg, DN20 8AS The Killingholme Surgery, South Killingholme, DN40 3EL West Town Surgery, Barton Upon Humber, DN18 5PU Trent View Medical Practice, 45 Trent View, Keadby, DN17 3DR The Medical Centre, Victoria Road, Barnetby, , DN38 6HZ
South Primary Care Network
Ashby Turn Primary Care Partners, The Link, DN16 2UT West Common Lane Teaching Practice, DN17 1YH Cedar Medical Practice, 275 Ashby Road, DN16 2AB Ancora Medical Practice, 291 Ashby Road, DN16 2AB The Surgery, Traingate, Kirton in Lindsey, DN21 4PQ Cambridge Avenue Medical Centre, Bottesford, DN16 3LG
West Primary Care Network
The Birches Medical Practice, Ironstone Centre, DN15 6HX The Oak Tree Medical Practice, Ironstone Centre, DN15 6HX Church Lane Medical Centre, Orchid Rise, DN15 7AN The Oswald Road Medical Centre, Oswald Road, DN15 7PG South Axholme Practice, The Surgery, Epworth, DN9 1EP

Our CCG Governing Body membership

NHS North Lincolnshire CCG's Governing Body meets in public on a bi-monthly basis. It has responsibility for leading the development of the CCG's vision and strategy – as well as providing assurance to the Council of Members with regards to the achievement of the CCG's objectives.

Residents and particular organisations are encouraged to attend these meetings to develop a better understanding of their NHS – both locally and nationally.

NHS North Lincolnshire CCG Governing Body Membership

Chair and Accountable Officer

Dr Faisel Baig, Chair. Membership dates: 1 April 2022 – 30 June 2022

Emma Latimer, Accountable Officer. Membership dates: 1 April 2022 – 30 June 2022

GP Board Members

Dr Salim Modan. Membership dates: 1 April 2022 – 30 June 2022

Dr Gary Armstrong. Membership dates: 1 April 2022 – 30 June 2022

Dr Pratik Basu. Membership dates: 1 April 2022 – 30 June 2022

Dr Hardik Gandhi. Membership dates: 1 April 2022 – 30 June 2022

Secondary Care Doctor

Dr James Woodard. Membership dates: 1 April 2022 – 30 June 2022

Lay Representatives

Erika Stoddart, Lay Member for Governance. Membership dates: 1 April 2022 – 30 June 2022

Janice Keilthy, Lay Member for Public and Patient Involvement. Membership dates: 1 April 2022 – 30 June 2022

Heather McSharry, Lay Member for Equality and Inclusion. Membership dates: 1 April 2022 – 30 June 2022

Governing Body Officer Members

Emma Sayner, Chief Finance Officer. Membership dates: 1 April 2022 – 30 June 2022

Alex Seale, Chief Operating Officer. Membership dates: 1 April 2022 – 30 June 2022

Helen Davis, Interim Director of Nursing and Quality and Executive Nurse. Membership dates: 1 April 2022 – 30 June 2022

Associated Members

Dr Satpal Shekhawat, Medical Director. Membership dates: 1 April 2022 – 30 June 2022

Directors of Public Health

Our committees

Five committees assist in the delivery of the statutory functions and key strategic objectives of the CCG.

- Integrated Audit and Governance Committee
- Planning and Commissioning Committee
- Quality, Performance and Finance Committee
- Primary Care Commissioning Committee
- Remuneration Committee
- Integrated Commissioning (Committees in Common)

For full details of committee functions, membership and attendance for 2022-23 please see the appendix section at the end of the Accountability section.

Register of interests

Information about our obligation to declare conflicts of interest can be found in the CCG's constitution.

For further information regarding the CCG's Conflict of Interest process please visit: https://northlincolnshireccg.nhs.uk/publications/lists-and-registers/

Access to Information

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	41
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 17 cases. The CCG did not provide all the information requested in 7 cases because an exemption was applied either to part of, or to the whole request. The exemptions applied were;

The information was accessible by other means.

Information requested related to personal data and compliance would breach the principles in Data Protection Legislation.

In 17 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://northlincolnshireccg.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://northlincolnshireccg.nhs.uk/publication-scheme/

Handling complaints

Ensuring that our patient and service user voice is heard is a fundamental principle within the CCG and this is never more important than when the experience of local health services fall short of expectations.

North Lincolnshire CCG recognise that every concern or complaint presents an opportunity to improve the quality and safety of the services it provides or commissions. The feedback received from complaints is a central part of our intelligence monitoring and helps to identify themes and trends.

Robust complaints procedures and policies are in place, for all local providers, to effectively manage complaints received. In accordance with the NHS Complaints Regulations, complaints processes and procedures are also in place at North Lincolnshire CCG for receiving, handling, investigating and resolving complaints relating to the actions of the CCG, its staff and services, as well as it's commissioned services. For further information regarding the CCG's complaints process please visit the CCG website at https://northlincolnshireccg.nhs.uk/

Personal data related incidents

The CCG recognises the importance of maintaining data in a safe and secure environment. It uses the Serious Incidents Requiring Investigation (SIRI) tool to assess any matters involving any potential data loss to the organisation.

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 Protection and Security Toolkit (DPST) and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the DPST. We have ensured all staff undertake annual information governance training, we maintain through our IG Team a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities and we provide regular IG training sessions and IG updates, including General Data Protection Regulation (GDPR) updates to staff through monthly staff meetings and staff briefings.

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

There were no significant personal data related incidents to report during the period 1st April to 30th June 2022.

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

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

Emergency Preparedness, Resilience and Response (EPRR)

The CCG is required to develop and maintain sufficient plans to ensure that the organisation and all commissioned services are well prepared to respond effectively to major incidents or emergencies. These plans serve to mitigate the risk to public and patients and ensure that critical functions can be maintained in the event of unforeseen disruption to services. Our key role and responsibilities in relation to EPRR include:

- Ensuring all contracts with commissioned provider organisations (including independent and third sector) contain relevant EPRR elements, including business continuity
- Monitoring compliance by each commissioned provider organisation with their contractual obligations in respect of EPRR and with applicable core standards
- Ensuring robust escalation procedures are in place so that if a commissioned provider has an incident the provider can inform the CCG 24 hours a day, seven days a week
- Ensuring effective processes are in place for the CCG to properly prepare for and rehearse incident response arrangements with local partners and providers
- Being represented at Strategic Health Gold Command response for Covid-19 and the LHRP. Providing a route of escalation for the LHRP in respect of commissioned provider EPRR preparedness
- Supporting NHS England in discharging its EPRR functions and duties locally, including supporting health economy tactical coordination during incidents.

We certify that the CCG has incident response plans in place, which are fully compliant with the NHS England EPRR Framework (2015).

The CCG regularly reviews and makes improvements to its EPRR plans, including business continuity. These plans provide assurance that the CCG has robust processes in place to meet its statutory duties.

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 Emma Latimer to be the Interim Accountable Officer of NHS North Lincolnshire CCG.

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

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

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

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

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

As the Accountable Officer, I 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 Lincolnshire CCGs

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.

Annual Governance Statement 2022-23

Introduction and Context

North Lincolnshire Clinical Commissioning Group (the CCG) is a body corporate established by NHS England on April 1, 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 health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such an extent as it considers necessary to meet the reasonable requirements of its local population.

As at April 1, 2022, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

North Lincolnshire CCG comprises 19 practices covering a population of about 183,593 (January 2022). The CCG operated for the period 1 April 2022 to 30 June 2022, whereupon it was succeeded by Humber and North Yorkshire Integrated Care Board.

It is served by one main acute provider, including community services (Northern Lincolnshire and Goole NHS Foundation Trust, NLAG), one specialist acute provider (Hull University Teaching Hospitals NHS Trust, HUTH) and one mental health provider (Rotherham, Doncaster and South Humber Foundation Trust, RDaSH). North Lincolnshire CCG is largely coterminous with the Local Authority (North Lincolnshire Council). For 2022-23 it had a total budget of £77,348.00.

The North Lincolnshire CCG area is geographically large and with more than half of its population living in rural areas. This creates distinct neighbourhoods and localities, each with their own unique characteristics and sense of identity, with different population profiles and needs. For example, the Scunthorpe North locality comprises mainly younger citizens, high levels of rented accommodation, with higher levels of Black and Minority Ethnic (BAME) residents than elsewhere in the CCG area. Whereas the Axholme locality comprises higher number of more affluent, older people, living in private accommodation, with a higher incidence of long-term conditions associated with the older population.

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 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 the Annual Governance Statement.

For fuller details of the Accountable Officer's personal responsibilities please refer to section 'Statement of Accountable Officers responsibilities' on page 29.

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.

North Lincolnshire CCG has a constitution that has been agreed by the Council of Members and approved by NHS England. It sets out the responsibilities and arrangements in place to commission services for the residents of North Lincolnshire. The constitution includes the Scheme of Delegation and Reservation, Authority to Act, Standing Orders and Prime Financial Policies. It identifies the governing principles, rules and procedures to ensure accountability and probity for the running of the CCG ensuring that decisions are taken in a transparent and open manner promoting the best interests for the people for whom we commission services.

The North Lincolnshire CCG Constitution includes provisions which regulate:

- Its membership and geographical area of coverage.
- The arrangements for the discharge of our functions and those of our Governing Body.
- The procedures we will follow in making decisions and securing transparency in decision making.
- Arrangements for discharging our duties in relation to registers of interests and managing conflicts of interests.

The Governing Body and committee structure introduction

The Governing Body has its functions identified as set out in the Constitution which has been agreed by member practices.

The CCG maintains a constitution and associated Standing Orders, Prime Financial Policies and Scheme of Delegation, all of which have been approved by the CCG membership and certified as compliant with the requirements of NHS England. Taken together these documents enable the maintenance of a robust system of internal control. The Scheme of Delegation defines those decisions that are reserved to the Council of Members and those that are the responsibility of its Governing Body (and its committees), CCG committees, individual officers and other employees. The Council of Members comprises representatives of the 19 member practices and has overall authority on the CCG's business.

The Governing Body has responsibility for leading the development of the CCG's vision and

strategy, as well as providing assurance to the Council of Members with regards to the achievement of the CCG's objectives. It has established committees to assist in the delivery of the statutory functions and key strategic objectives.

The following committees support the Governing Body:

- Integrated Audit & Governance Committee
- Quality, Performance & Finance Committee
- Planning & Commissioning Committee
- Primary Care Commissioning Committee
- Remuneration Committee
- Integrated Commissioning (Committees in Common)
- Executive Management Group

The Governing Body

During the period April to June 2022, the Governing Body met twice in public and was quorate on both occasions. Attendance figures for the Governing Body and other committees are attached at **Appendix 1.**
The Governing Body received and considered a number of items and reports but had a primary focus on the safe and robust management of the transition to the new Integrated Care Board.

The Governing Body is supported by a number of the strategic committees, which are set out below.

The Integrated Audit & Governance Committee

Chaired by the CCG Lay Member for Governance, and including additional lay representation, the committee met three times during the reporting period and was quorate at each meeting.

The committee is responsible for providing assurance to the Governing Body on processes operating within the organisation for risk, control and governance. It has delegated responsibility for oversight of risk management and internal control, internal audit, external audit, value for money whilst reviewing the findings of other significant assurance functions including counter fraud.

Highlights of its work include:

- Review of draft annual report and annual accounts
- Review of Counter Fraud and security work
- Monitoring the implementation of audit recommendations
- Regular updates on the controls and mitigations in relation to the risks during transition to the Integrated Care Board.
- Assurance with respect to the actions and response of the CCG to the COVID-19 pandemic.

Planning & Commissioning Committee

The Planning & Commissioning Committee met once and was quorate at that meeting.

The Planning & Commissioning Committee is chaired by a GP Board Member with delegated authority from the Council of Members. Its remit is to ensure the planning, commissioning and procurement of commissioning related business is in line with the commissioning strategy and organisational objectives.

Highlights of its work include:

- Service specification for Changing Lives Through Changing Minds
- Programme Delivery Group

The Quality, Performance & Finance Committee

The Quality, Performance and Finance Committee is chaired by the CCG Lay member for Patient & Public Involvement. The Committee met once during the reporting period and was quorate. The purpose of the Committee is to receive assurance regarding the continuing development, monitoring and reporting of quality, performance, and financial outcome metrics in relation to the Clinical Commissioning Group (CCG) quality improvement, financial performance and management plans.

Highlights of the work undertaken by the committee include:

- Oversight of the quality and performance indicators of local providers, including primary care, considering organisational responses to the COVID-19 pandemic and any associated improvement / recovery plans.
- Assurance with regards to the quality legacy transfer document to be submitted to the Integrated Care Board.

Primary Care Commissioning Committee

This is a committee with the principal purpose of commissioning primary medical services for the people of North Lincolnshire. It is chaired by the CCG Lay member for Patient & Public involvement and met once in 2022, with the meeting being quorate.

Highlights of work undertaken by the committee include:

- Primary Care Risk Register
- Primary Care Due Diligence
- Enhanced Access

The Remuneration Committee

The Remuneration Committee is chaired by the Lay Member for Patient & Public Involvement. The Group has delegated responsibility from the Governing Body for advising it on all aspects of salary not covered by Agenda for Change, arrangements for the termination of employment, monitoring and evaluating the performance of Governing Body members and approving human resources policies and procedures.

The Remuneration Committee met once during the reporting period and was quorate. Its work was focused on considering papers relevant to its terms of reference and, specifically, remuneration considerations and receipt of the annual performance appraisals of the CCG's Very Senior Manager (VSM) officers.

The Committee also engaged with the Remuneration Committees of NHS Hull CCG and NHS East Riding CCG with respect to those VSM officer posts that are shared across all three CCGs.

The CCG's use of the UK Corporate Governance Code

To ensure compliance with best Governance practice, the CCG also refers to the UK Corporate Governance code.

Though the CCG is not formally required to comply with the UK Corporate Governance Code provisions, it has used the principles of the Corporate Governance Code as a guide to improving corporate governance, including those aspects of the Code that are considered most relevant to the CCG and "best practice".

Using the principles of the UK Corporate Code to support "best practice" the CCG has:

- Reviewed declarations of interest and CCG compliance with statutory requirements
- Undertaken a continuous assurance mapping exercise against a range of CCG functions
- Reviewed counter fraud and security management arrangements
- Considered the Strategic Risk Register and receive appropriate assurance with regards to risk management and controls within the organisation
- Reviewed Very Senior Managers (VSM) roles, responsibilities remuneration and performance
- Reviewed Governing Body appointments and clinical leads

Discharge of statutory functions

Following establishment, the arrangements put in place by the CCG (and explained within the Corporate Governance Framework) and developed with extensive expert external legal input, have been reviewed to ensure compliance with all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the Scheme of Delegation.

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

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

Risk management arrangements and effectiveness

Arrangements for the identification, mitigation and management of risk play an integral role within the overall corporate CCG's governance functions.

As outlined in its Risk Management Strategy, North Lincolnshire CCG had adopted a risk management process where logical steps were taken to manage risks effectively. Following on from setting priorities, potential risks or opportunities are then identified and evaluated before a course of action is determined to address the identified risks. As few risks remain static and new issues are likely to emerge, it is essential that all risks captured were routinely monitored.

In addition, reporting of risk issues and in particular reporting and reflecting on any adverse events that do occur is essential to ensure that the CCG continuously improved its risk management activities. Risk management was embedded within the activities of North Lincolnshire CCG through the risk process. The assurance framework was reviewed by the Executive Management Team to ensure that the process was kept live and relevant.

Members of staff were able to report any concerns through an electronic desktop incident reporting process, which was actively encouraged and each incident was reviewed and investigated as applicable. Finally, the CCG was also committed to eliminating avoidable risks relating to either staff, patients, clients or other stakeholders.

In particular, North Lincolnshire CCG is committed to eliminating any form of discrimination and aims to commission services that are accessible, delivered in a way that respects the needs of each individual whilst being inclusive to everyone. The CCG remains fully committed to ensuring appropriate focus remains on this key programme of work and has an Equality and Inclusion Group that was accountable to the Quality, Performance and Finance Committee.

In addition, North Lincolnshire CCG actively engaged with public stakeholders for example:

- Partnership working with the Local Authority through the Health and Wellbeing Board and liaison with the Health Scrutiny Panel
- Maintenance of a Patient and Community Assurance Group
- Maintaining a Council of Members which is made up of a healthcare representative from each CCG member practice. The Council of Members participate and are engaged in the development of North Lincolnshire CCG Strategy and plans
- Governing Body meetings were held in public, save for where members resolve to take an item in private, allowing a transparent and public decision-making process
- Seeking assurance on our approach to patient and public involvement through working with local community members on our Patient and Community Assurance Group (PCAG)
- Engaging through Embrace, the CCG's patient engagement network comprising local people who are interested in being involved in CCG decision making
- Working closely with our local Healthwatch in jointly hosting the North Lincolnshire Patient Participation Group Chairs Forum
- Meeting with voluntary, community and social enterprise sector and faith groups

The CCG's capacity to handle risk

The Risk Management Strategy, updated in February 2022, was 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. Governance and internal control of the organisation was an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of

- Evaluate the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically

The CCG's Integrated Audit and Governance Committee has assured itself that the organisation has adequate arrangements in place for countering fraud and reviews the outcomes of counter fraud work.

North Lincolnshire CCG implemented anti-fraud prevention measures and counter fraud risks in compliance with NHS Protect Standards on countering fraud, bribery and corruption. To ensure compliance with the standards the CCG contracts with an external provider, Audit Yorkshire, who supply Local Counter Fraud Specialist (LCFS) services to the organisation via an annual fraud plan.

The Fraud Plan includes initiatives to promote fraud awareness, deterrence and prevention and also to investigate suspected cases of fraud, and if required, apply a range of potential sanctions including criminal, civil and disciplinary measures. Progress against the Internal Audit Plan was monitored at the Integrated Audit and Governance Committee. The Local Counter Fraud Specialist is directly responsible to the Chief Financial Officer and all fraud work was reported to the CCG Integrated Audit & Governance Committee. The CCG's policies had been updated to reflect counter fraud policy and the 2010 Bribery Act and GDPR as standard.

The key elements of the Risk Management Strategy are:

- To support the Governing Body in carrying out its duties effectively. The Integrated Audit and Governance Committee provides assurance (and the Quality Performance and Finance Committee additional assurance) that the risk registers and assurance framework are regularly reviewed and updated and that corresponding robust and adequately progressed risk treatment plans exist.

- That the Accountable Officer has overall accountability for ensuring that there is a sound system in place for the management of risk and is responsible for ensuring systems and processes are implemented to comply with the strategy.

All the CCG's risk registers were linked to the CCG's agreed risk appetites by risk type to support the effective management of risks across the organisation. Risk appetite was aligned to the following risk categories: reputation, compliance, financial, operational and strategic. The resultant heat maps allow the CGG Governing Body, committees and staff to more effectively focus resources and attention on key risks that are 'out of appetite'.

The CCG had previously undertaken governing body sessions on risk appetite to establish a clear corporate approach to risk taking, tolerances and control. Setting of risk appetite has driven organisational behaviours and allowed us to develop confidence, competence and resilience on an incremental basis. Risk is unavoidable but the CCG's risk appetite has been informed by experience and knowledge.

If the assessment of the risk is higher than the risk appetite, further action will be taken to reduce the likelihood and/or impact of the risk occurring. A more detailed consideration of the CCG's approach to risk appetite is set out in the Risk Assessment section below.

Risks to data security were managed through a suite of information governance policies and CCG staff have undertaken the Electronic Staff Record (ESR) Information Governance training – Data Security Awareness Level 1. Any data security incidents were reported through the CCG's incident reporting system and notified to the Information Governance Manager for investigation.

During quarter 1 of 2022/23, no significant data breaches have been reported by the CCG.

Risk Assessment

The CCG recognised the need for a robust focus on the identification and management of risks and therefore placed risk within an integral part of our overall approach to governance. Consequently, risk management was an explicit process in every activity the CCG and its staff take part in.
The CCG had a robust process for identification and mitigation of risks and where there have been serious incidents, responding to them quickly and ensuring that lessons learnt from them were implemented swiftly across the CCG.

The Risk Management Strategy reflects the risk management processes within the CCG and its responsibilities for management of risks. Those risks which were deemed to be a strategic risk have been allocated to the Strategic Risk Register and risk owners asked to identify assurances on control, gaps in control or and assurance and direct or Indirect influence on risk mitigation. The operational risks remained on the corporate register or directorate risk registers.

An Assurance Framework based upon Department of Health and "best practice" guidance has been in place throughout the year.

A key element of the framework is the Strategic Risk Register that provided a structure and process to enable the organisation to focus on the risks that might compromise the achievement of its strategic objectives.

The Strategic Risk Register mapped out the key controls to mitigate the risks and provides a mechanism to inform the Governing Body of the assurances received about the effectiveness of these controls. It is a dynamic tool and was reviewed at public meetings of the Governing Body and regularly by the Integrated Audit and Governance Committee. The Quality Performance and Finance Committee provided additional assurance.

The Strategic Risk Register provides an effective focus on strategic and reputational risk rather than operational issues and highlights any gaps in control and assurances. It provides the Governing Body with confidence that systems and processes are in place and that it operates in a way that is safe and effective.

The key risks on the assurance framework as of the end of May 2022 are highlighted in the table below:

Risk Description	Controls	Assurances	Risk Rating (Impact x likelihood)
If the CCG fails to develop alternative out of hospital provision in the right place the acute sector does not have a workforce or resources to deliver the forecast demand	Agreed Governing Body priority and overseen by Planning and Commissioning Committee. Part of the place plan in conjunction with NLC, Out of Hospital programme management in place reporting to programme delivery group. Continuing to seek opportunities for integration of provision to reflect changing needs of patients and reduce fragility of services	Delivery of programme plan is monitored through programme delivery group on a monthly basis.	5 x 3 = 15
There is a risk of harm to patients due to Failure of NL&G to meet all Control targets for Quality	Monthly Quality Review (QRM) meeting in place to oversee delivery of schedule 4 requirements and to enable a monthly assessment of quality impact against key performance indicators. QRM became a Commissioner only meeting in October 2020 due to a request via the provider as a consequence of demand from the Covid-19 pandemic, which was supported by NHSEI. Quality Board continues to meet bi-monthly which is Chaired by NHSEI. NL&G's clinical harm process and risk stratification model remains in place with regular updates and oversight via the relevant quality forums.	Assurance reporting and improvement actions by NL&G are submitted to the Quality Board, Commissioner Quality Review Meeting and internally into the Quality and Safety Committee which has Commissioned representation. Additionally, the CCG reports internally to the Quality Performance & Finance Committee and Governing Body and externally to the Local / Regional Quality Surveillance Group.	3 x 4 = 12

If the CCG fails to deliver its constitutional targets this may result in the CCG being assessed as inadequate.	Ensuring robust contract management of our key providers	Working with providers to address waiting times including transferring care to alternative providers for some specialities (where capacity is available). Monitored through Quality Performance & Finance Committee Social distancing requirements and infection Prevention and control guidance issued in April 22, which should support elective recovery	3 x 3 = 9
Risk of harm to patients due to EMAS failure to reach control standards	Regional meetings in place between EMAS and Commissioners regarding quality oversight and improvement plans, with direct links to the A&E Delivery Board. Agreed actions in place with regards to improving non-conveyance rates and use of alternative pathways across the system. Audit of long waiters continues, with a view to understand current risk of harm and any improvement opportunities.	Improved engagement with local EMAS team and Divisional General Manager. Assurance reporting to Quality Performance and Finance Committee, EMAS Quality Assurance Group and A&E Delivery Board. Local initiatives in place to reduce patient conveyance which is mapped to the A&E delivery board transformation plan.	5 x 3 = 15
If the Humber system cannot successful resolve the identified fragile specialties within the Trusts (NLAG & HUTH), the CCG may experience reputational damage as patients need to travel further to access treatment. This may also have a negative impact on patients in terms of accessibility and quality of healthcare	NLAG Trust plans to address fragile specialties. Humber Acute Services Review (HASR) plans to develop Humber wide options for engagement which will address fragile services as a priority	HASR options in development across a range of fragile specialties. To be completed Jan 21 for commencement of public engagement. NLAG Trust plans for outpatient transformation having some impact in reducing referrals and attendances.	4 x 3 = 12

Requirement for pump priming or additional investment into services prior to the mobilisation of ICB governance arrangements may compromise timely delivery of transformational change, impacting on service capacity and recovery and patient experience.	CCG shared understanding of financial risks and impacts of transformational change programmes. Risks identified and managed through Programme reporting and Programme Delivery Group	PDG reporting and project risk logs	4 x 3 = 12
Information Governance risks due to the inability to be able to access and share information within Share point with other ICS organisations	This is being picked up as part of the ICS Digital Transition Group which includes key partners and will help to provide assurance to the exec team once a solution has been established.	N3i and the NLC team have explored and identified a workaround and staff training will be provided. If the workaround doesn't operate as anticipated, we have a contingency in place to move NLCCG staff over to the ICS version of share point. The Exec team within the CCG are regularly updated on the latest developments.	4 x 4 = 16
Risk of delivery of the CCG/ICB and ICS financial performance targets in 2022/23 due to: 1) Recurrent commitments across the system which have been funded via non recurrent money during the covid pandemic (2020/21 to 2021/22) 2) Delivery of ERF baseline, risk that the 104% is not achieved resulting in a clawback of funding and/or income doesn't cover independent sector costs 3) Removal of Hospital Discharge Funding and the impact on hospital flow 4) Complexity of the financial regime as we transition from CCG's to the ICB 5) Inflationary pressures in excess of allocation received (e.g. increase in	Understand exit run rate Strong financial governance to manage discretionary spend Agree principles within the ICS to outline how we will work together (Financial Framework) and how prioritisation of investment will be managed Agree ERF risk share approach Financial risk to be understood across the organisation and system and reported monthly	Monthly reports to QP&F, Governing Body and NHS England (non ISFE). Monthly ICS meetings to look at the system wide position.	4 x 4 =16

national living wage, gas & electricity prices) 6) Challenging efficiency targets of 4% (on influenceable spend)			

Note: Covid-19 continued to be identified as an ongoing risk for the CCG throughout 2021-22. The CCG was an active member of the Humber area major incident arrangements, with executive director representation at the Strategic Co-ordinating Group meetings and senior officer representation at the Tactical Co-ordinating Group meetings led by the Local Resilience Forum. In addition, the CCG enacted its internal major incident and business continuity arrangements, with the CCG's Accountable Officer chairing a health services cell for the Humber area, (Health Gold Command).

The specific risks in relation to the impact of COVID-19 were subject to increased frequency of review in-year and reflected in the CCG's Strategic and Corporate Risk Registers, as appropriate. Each 'strategic' risk is owned by a lead director and is reviewed and was updated on a regular basis. The Integrated Audit & Governance Committee reviewed the Corporate Risk Register and Strategic Risk Register. The Corporate Risk Register identified the highest rated and 'Out of Appetite' operational risks faced by the CCG. The Governing Body reviews the Strategic Risk Register twice yearly. The Quality, Performance & Finance Committee reviews the Strategic Risk Register quarterly. The Executive Management Group reviews the Strategic Risk Register on a quarterly basis. This gave significant assurance that systems are were place and that there was a clear audit trail.

A Heads of Service Meeting, with representatives from each directorate, reviewed the CCG's Directorate Risk Registers. This meeting determined where the risks are appropriately assigned and do not overlap, key risks were identified and escalated if appropriate in line with the CCG's Risk Strategy. Individual Directorate Risk Registers are reviewed at directorate team meetings.

Other sources of assurance

Internal Control Framework

A system of internal control consists of a set of processes and procedures in the CCG 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 was based on a process to:

- Identify and prioritise risks to the achievement of the CCG's objectives.
- Consider the likelihood of those risks being realised.
- Measure the impact should they be realised.
- Manage them effectively.

The CCG's system of internal control has been in place for the year up to 31 March 2022 and up to the date of the approval of the Annual Report and Accounts.

Underpinning the prime financial policies, the CCG has detailed financial policies and a supporting Scheme of Delegation.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published in June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support the CCGs undertaking this task, NHS England has published a template audit framework.

Audit Yorkshire carried out an annual audit of conflicts of interest and the CCG has received high assurance. The audit report made some minor recommendations around noting when conflicts are notified at meetings and how these are recorded in line with current NHSE guidelines. These points have been addressed.

A link to the CCG's register of interests for the reader is provided here:
https://northlincolnshireccg.nhs.uk/publications/lists-and-registers/

Although the NHS England quarterly data collection on conflicts of interest by was stopped in the light of Covid-19 pandemic the obligations, the requirement on CCG's to manage conflicts, including the training elements, remains in place.

Data quality

Data was collated and managed by NHS East Riding of Yorkshire Clinical Commissioning Group on behalf of North Lincolnshire CCG. This is sourced from both national and local sources and forms part of the material routinely considered at the Governing Body, its committees and the Council of Members. Where possible, the data are triangulated from national systems and alternative sources to ensure accuracy. NHS East Riding of Yorkshire Clinical Commissioning Group had in place internal procedures and controls in order to ensure data presented was of the best quality possible. Any data issues noted in source data is reviewed and identified with the source provider.

Should data issues arise resulting from internal processes, a route cause analysis is undertaken, corrective actions put in place and ongoing learning identified.

The Primary Care Commissioning Committee also reviewed the range and quality of data regarding primary care and identified further improvements, and the CCG Governing Body received regular quality and corporate performance reports during the year which were refined following user feedback.

Information Governance

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

Data security risks are addressed through mapping all information assets for the CCG, identifying data owners and risk assessing all data flows, in and out, including security during transfers and at rest. The Information Technology environment has also been risk assessed to ensure that adequate security for information on the networks is in place.

North Lincolnshire CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have an information governance management framework that the CCG applies to the management of all information assets. The framework includes an Information Governance Subgroup which is a subgroup of the Integrated Audit & Governance Committee (IA&GC).

The CCG continued to develop information governance processes and procedures in line with the Data Security and Protection Toolkit (DSPT) and Senior Information Risk Officer (SIRO) guidance and ensuring it is embedded amongst CCG staff. The CCG has an appointed Data Protection Officer and Caldicott Guardian.

The CCG has ensured all qualifying staff members, including board members undertake annual information governance training (Data Security Awareness training Level 1) and have implemented a number of measures to ensure they are aware of their information governance roles and responsibilities.

There are policies and processes in place for information incident reporting and investigation of serious incidents.

The following information governance policies were reviewed and updated during 2021-22:

- Acceptable Computer Use Policy
- Confidentiality Audit Policy
- Confidentiality: Code of Conduct Policy
- Data Protection & Confidentiality Policy
- E-Mail Use Policy
- Information Security Policy
- Mobile Working Policy

- Records Management Policy
- Safe Haven Policy

Processes implemented allow the CCG to fulfil its requirements under the Freedom of Information Act and Data Protection Act relating to the protection, use and processing of Subject Access Requests.

The CCG has an incident reporting system for all staff and local general practices that encompasses information governance incidents allowing staff a single point of reporting.

The development of policies and the framework has allowed us to achieve a level two compliance with all the relevant information governance toolkit standards. The CCG has a trained Caldicott Guardian in place able to offer expert advice and support.

The CCG has included information risk within the CCG's Risk Management Policy and has processes in place to identify Information Asset Owners and Controllers. We have processes where the Information Asset Owners assess risks to assets in their areas and report to the SIRO annually.

The CCG uses an Integrated Performance dashboard to summarise its performance against mandatory information governance requirements. It is reviewed on a regular basis by the CCG Quality, Performance & Finance Committee.

The CCG continues to develop and enhance information risk assessment and management procedures as part of overall risk management and ongoing work is undertaken to fully embed an information risk culture throughout the organisation.

NHS Digital have revised the Data Security and Protection Toolkit submission deadline for 2021-22 to June 2022 and the CCG reported substantial compliance against the requirements of the toolkit. The CCG has had no lapses of data security incidents during 2021-22.

Business Critical Models

The CCG recognises the principles as reflected in the Macpherson Report as a direction of travel for business modelling in respect of service analysis, planning and delivery.

Key business critical models have been identified. In line with the Macpherson report we recognise and have identified that policy simulation (its impact on people and finances), forecasting, financial evaluation, allocation, workforce, procurement and planning are key areas where we use models.

Current quality assurance systems are in place to manage our business risks including:

- Business Intelligence reporting/financial reporting
- Customer feedback (e.g. patient complaints)
- Risk assessment (including risk registers and an assurance framework)
- Internal and external Audit
- Public and Patient Involvement and Engagement
- Third Party Assurance mechanisms (Service Auditor reports / NHS England/ EPRR / Business Continuity etc.)

The CCG can confirm that these quality assurance processes are used across our business critical areas as appropriate.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control).

This is achieved through a risk-based plan of work, agreed with management and approved by the Audit & Integrated Governance Committee, which aims to provide a reasonable level of assurance subject to any inherent limitations.

The Head of Internal Audit Opinion provided includes their opinion on the Assurance Framework, and the risk-based audit assignments across the critical business systems to inform the Annual Governance Statement.

The CCG has also conducted an assurance mapping exercise to identify the CCG's assurance landscape, and this continues to be further developed as systems, processes and partner relationships continue to evolve and embed.

The Head of Internal Audit Opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Governing Body takes into account in making its Annual Governance Statement.

Third party assurances

In developing the CCG Assurance Map and review of sources of assurance the CCG has considered services provided by service organisations and the assurance required as received by or via service auditor reports.

This specifically includes the NHS Business Services Authority, and Capita. Assurances on the effectiveness of the controls in place for these third parties are received in part from an annual Service Auditor Report from the relevant service. and I have been advised that such assurances have been provided for 2021 - 22.

Both the NHS Business Services Authority and Capita have received qualified opinions from their respective auditors on account of further assurance being required on the adequacy of a small number of controls.

In relation to NHS Business Services Authority, their service auditor reported that there were insufficient logical access controls in place to appropriately restrict access to the development and production area of the NHS hub for part of the reporting period and therefore controls were not suitably designed to achieve Control Objective 2 "Controls provide reasonable assurance that security configurations are created, implemented and maintained to prevent inappropriate access" during the period 1 April 2021 to 6 June 2021.

In relation to Capita, their service auditor identified a qualification relating to four out of 17 control objectives for the period 2021 – 22. These matters were identified in a small number of the sample cases reviewed by the auditor and relate to:

- controls regarding pension record updates and errors arising from pension uploading processes.
- controls in place to investigate and resolve errors arising from the ISFE GP payment file upload process.
- controls in place to ensure the timely revoking of accounts, as appropriate, on the Active Directory (AD), PCSE Online, UNIX, NHAIS or Ophthalmic Payments systems and user access reviews, and
- controls in place to ensure the timely revoking of accounts, as appropriate, on the ISFE, LPA, PCSE Online, POL and Active Directory (AD) systems and user access reviews.

As Accountable Officer I am advised that appropriate plans have been developed to strengthen the relevant controls during the forthcoming year by both organisations.
Additionally, the CCG has an assurance map which is monitored by the Integrated Audit & Governance Committee. The assurance map includes the identification of issues or concerns relating to third party service providers enabling the CCG to take actions as appropriate.

Control Issues

Introduction

Identification and mitigation/management of control issues is a key feature of sound risk management systems.
As of June 2022 (based on the most recently available information), the CCG was meeting 9 out of 29 of its constitutional and operational targets. Performance was below the required target in the following areas:

NHS NORTH LINCOLNSHIRE CCG PERFORMANCE		**Actual (YTD – June 2022) 62.7%**	**Target**
NHS NATIONAL REQUIREMENTS			
A&E waiting time - total time in the A&E department, SitRep data	2022-23	63.3% MONTH	95%
Commentary CCG performance against the A&E 4 hour waiting time standard failed to achieve the national standard during Q1 22/23, the significant and sustained pressures in bed occupancy, patient demand and acuity have seen daily challenges within the department impacting performance. Northern Lincolnshire and Goole NHS Foundation Trust have implemented a range of measures in relation to 12-hour trolley breaches, including daily operational meetings to review ward zoning and patient movements to enable bed availability as well as senior second reviews conducted by Medicine Divisional Clinical Directors and Divisional Heads of Nursing. Covid-19 continues to impact due to workforce sickness, isolation and general staff wellbeing, in addition to the impact of the physical capacity within the current A&E department localities.			

The benefits of the Urgent Care Service (UCS) are starting to be realised through the improvements in the 4-hour waiting time standard. The UCS at Scunthorpe General Hospital is providing improved patient experience and 99% performance against the 4-hour standard. The UCS at Diana, Princess of Wales Hospital Grimsby is also now operational and benefiting from the same positive performance.

System partners are working collaboratively to support the daily challenges being experienced in relation to patient flow and the subsequent impact on A&E departments and other providers. Access pathways are being streamlined and the discharge to assess initiative is being supported by daily operational calls to reduce specific challenges or barriers being experienced.

		Actual (Month – Jun 2022)	**Target**
RTT - The percentage of incomplete pathways within 52 weeks for patients on incomplete pathways at the end of the period.	2022-23	68.6%	92%

Commentary

Referral to Treatment (RTT) times continue to fall below required standards, specifically at our two main local acute providers Northern Lincolnshire & Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH). However, the CCG position in relation to incomplete RTT performance is above both the England and the Humber and North Yorkshire ICS average.

The Trust's active recovery plans focus on the longest waiters and cancer patients. Additional capacity in Goole District Hospital and the independent sector, continues to be utilised. Clinic capacity has been increased through additional sessions and in-sourcing of capacity. NLAG is providing mutual aid to other trusts owing to its underlying relatively stronger performance. While it is recognised that this may impact negatively on NLaG's performance, this approach is consistent with the collaborative principles of ensuring an equitable service across the Integrated Care System. The Trust continues with their robust risk stratification process, across all specialties, to monitor the risks and potential harm to patients who are waiting beyond 52 weeks for treatment or those waiting for outpatient reviews. Processes are in place to record, track and monitor risk stratification for all patients, at all points in the pathway. Assurance has been provided that where any harm is identified this is escalated and managed via the Serious Incident management process.

		Actual (YTD – Jun 2022)	**Target**
Access to services: Diagnostics	2022-23	30.1%	1%

Commentary

Performance against the Diagnostic Waiting Time Standard has deteriorated during Q1 22/23. Non-Obstetric Ultrasound remains the primary concern however the extra capacity secured and delivered from the Ironstone Centre in Scunthorpe continues to be utilised and the benefits are expected to be realised further over the coming months.

		Actual (MONTH – Jun 2022)	Target
Access to services - Cancer			
Cancer – 2 week wait for suspected cancer (breast cancer) (%)	2022-23	87.9%	93%
Cancer - 31 Day standard for diagnosis to first definitive treatment within 31 days (all cancers) (%) - Meeting target.	2022-23	94.7%	96%
Cancer 31 day waits: subsequent cancer treatments-surgery	2022-23	50.0%	94%
Cancer 31 day waits: subsequent cancer treatments-Radiotherapy	2022-23	53.1%	94%
Cancer 62 day waits: first definitive treatments following urgent GP referral for suspected cancer including 31 day rare cancers (%)	2022-23	48.7%	85%
Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.	2022-23	73.3%	90%
Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	2022-23	50.0%	90%

Commentary

The CCG has experienced difficulties with some of the pathways at different times during 2022/23. All tumour sites are being affected by increasing waiting times due to high demand and the availability of oncologists. Northern Lincolnshire and Goole NHS Foundation Trust are also experiencing challenges related to visiting consultant services and tertiary based staging scans, which affect the ability to transfer patients for treatment.

To mitigate some of the risks, 28- and 62-day performance is being reviewed and managed weekly and specific tumour site pathway reviews are being undertaken to identify any learning and opportunities for improvement. Within the Colorectal pathway, the Clinical Nurse Specialist (CNS) straight to test model commenced in January 2022, at both Scunthorpe and Grimsby, and is impacting positively on the 28-day faster diagnosis performance.

Divisional trajectories at tumour site level are also being mapped for 2022/23 to deliver a reduction in the backlog, increase faster diagnosis and improve performance against the 28 day and 62-day standards.

The joint transformation pathway work continues between NLaG and HUTH with a key focus being the identification of areas where pathways can be accelerated and to help with the transfer of patients.

Clinical harm reviews continue to be undertaken for all patients who wait more than 104 days and cancer surgery continues to be prioritised, in addition to the use of the Independent Sector to support timely access to surgery and diagnostics. Significant work continues with system partners to aid pathway improvements, and this will continue to be monitored by the Humber Cancer Board.

Full information regarding performance against the CCG's detailed targets and highlights of plans to support improved performance for the future are set out in the performance section of the CCG Annual Report. Following the pandemic being declared, the CCG has acknowledged it is not business as usual and new challenges and demands have presented, resulting in some changed practices. The CCG has demonstrated leadership through co-ordinating the local health economy response.

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

Introduction

Sound corporate governance has played a key role within the CCG's overall pursuit of improved economy, efficiency and effectiveness.

2022-23 Performance Apr-Jun

A summary of the CCG's Financial Performance in 2022-23 can be seen below:

Financial Duties	Target	Outturn RAG	RAG Explanation
Maintain expenditure within the agreed control total	Planned control total or better achieved	✔	The CCG's Expenditure matched allocation
Maintain Expenditure within the allocation cash limit	Cash drawdown less than cash limit	✔	The CCG has maintained expenditure within its cash allocation for Apr-Jun 2022/23
Ensure running costs do not exceed our agreed admin allocation	Expenditure less than or equal to allocation	✔	At Month 3 running cost spend matched the allocation
Ensure compliance with the better payment practice code (BPPC)	Greater than or equal to 95% by number/value	✔	Target achieved for Month 1-3 2022/23
Achievement of the Mental Health Investment Standard	Growth of 5.44% or greater	✔	The CCG achieved the Mental Health Investment Standard for Month 1-3 2022/23

Medium term financial strategy

The NHS Long Term Plan requires an integrated approach to strategic and operational planning, where systems are expected to bring together member organisations to develop a common set of principles. To support submission of the Humber Coast and Vale Long Term Plan the CCG produced a five-year financial plan which set out how we will allocate resources to deliver the requirements of the Long Term Plan including the commitment to increase investment in mental health, primary and community health services as a share of total NHS revenue spend across the five years from 2019-20 to 2023-24.

Governance arrangements to promote improvements in economy, efficiency and effectiveness

The Governing Body has overarching responsibility for ensuring that North Lincolnshire CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and

economically and in accordance with the Group's principles of good governance (its main function).
The CCG's constitution allows for the delegation of responsibility to ensure appropriate arrangements are in place for the CCG to fulfil this duty to the Integrated Audit & Governance Committee and requires that it undertakes functions as set out in its Terms of Reference as agreed by the Governing Body.
The Integrated Audit & Governance Committee receives regular reports on financial governance and reviews the Annual Accounts, Annual Governance Statement and Head of Internal Audit Opinion. The Governing Body receives a Finance Report from the Chief Finance Officer at every meeting, where open challenge takes place.
The Chief Finance Officer is a member of the Governing Body and is responsible for providing financial advice to the group and for ensuring financial control and accounting systems are in place. The role of Chief Finance Officer includes:

- Acting as the Governing Body's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged
- Making appropriate arrangements to support and monitor the CCG's finances.
- Overseeing robust audit and governance arrangements leading to propriety in the use of the CCG's resources
- Being able to advise the Governing Body on the effective, efficient and economic use of the CCG's allocation to remain within that allocation and deliver required financial targets and duties
- Producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England
- Acting as the Governing Body's lead officer for Business Intelligence

Delegation of functions

The CCG's Accountable Officer (AO) delegates responsibilities to support compliance with the standards set out in annex 3.1 of 'Managing Public Money' (July 2013 annexes revised July 2015). The annex identifies feedback from delegation chains as a key input to the governance statement. The CCG systems enable the AO to work with staff to make informed decisions about planned progress and take corrective action as appropriate. The CCG reviews a wide range of feedback from delegated functions including; assessing the use of resources, management of risks and budget management.

The CCG for example holds regular contract meetings, led by the CCG Chief Finance Officer, with third party providers who support the commissioning functions of the CCG. These meetings are used to set and review performance indicators, assess information captured from internal audit or ongoing risk evaluation and identify any issues/trends causing concern. An issue log identifies concerns and gives assurance that actions are being undertaken.
Feedback from the ongoing assessment of delegated functions is acted upon as appropriate. The Annual Governance Statement draws to a close by summarising external viewpoints on the CCG's governance arrangements, before ending with the Accountable Officer's personal review of the CCG's governance, risk management & Internal control arrangements.

Counter Fraud Arrangements

The Integrated Audit and Governance Committee (IAGC) has assured itself that the organisation has adequate arrangements in place for countering fraud and regularly reviews the outcomes of counter fraud work. The CCG has an accredited Local Counter Fraud Specialist (LCFS) in place to undertake work against the Counter Fraud Functional Standard; the LCFS resource is contracted in from Audit Yorkshire and is part of a wider Fraud Team resource with additional LCFS resource available as and when required. The Chief Finance Officer is accountable for fraud work undertaken and a Counter Fraud Annual Report (detailing counter fraud work undertaken against each requirement of the standard) is reported to the Integrated Audit and Governance Committee annually.

There is an approved and proportionate risk-based counter-fraud work plan in place which is monitored at each Integrated Audit and Governance Committee meeting. In line with the requirements of the Counter Fraud Functional Standard, which first became effective 1st April 2021 and are reviewed annually, the CCG completed an online Counter Fraud Functional Standard Return (CFFSR) to assess the work completed around anti-fraud, bribery and corruption work and assessed itself as an 'Green' rating for 2021/22. This self-assessment (CFFSR) detailing our scoring was approved by the Chief Finance Officer and Audit Committee Chair prior to submission.

Head of Internal Audit Opinion

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

The Head of Internal Audit concluded that:

The overall opinion for the period 1 April 2022 to 30 June 2022 provides **Significant Assurance**, that that there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently.

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

Audit Area	Outcome
Governance arrangements	It was confirmed that good governance arrangements were maintained in the period under review. The Governing Body continued to meet during this 3-month period, with meetings occurring on 14 April 2022 and 9 June 2022. All four sub-committees continued to meet and operated in line with their Terms of Reference and the CCG's Scheme of Reservation and Delegation. All meetings held in Quarter 1 of 2022-23 were quorate. The Governing Body meetings included consideration of key governance arrangements including a review of the ICS Governance Arrangements during the 3-month extension period to June 2022; Corporate Risk Register; Committee Annual Reports for the Quality,

	Performance and Finance Committee, the Planning and Commissioning Committee, Primary Care Commissioning Committee and the Internal Audit and Governance Committee annual report. It was 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 Declaration Register, Gifts and Hospitality Register and Healthcare Procurement 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. The Governing Body received and approved the Corporate and Strategic Risk Registers on 9 June 2022. Both documents were also presented to the Integrated Audit & Governance Committee on 8 June 2022, in line with their Terms of Reference. Review of the risk registers also continued to take place at the sub committees of the Governing Body.
Under the Transition Programme	Audit Yorkshire continued to support North Lincolnshire CCG in its work to transition to the Humber and North Yorkshire ICB. This included: Routine attendance at workstream meetings for oversight of the Due Diligence process, Governance, Finance, Information Governance, and the Shared Business Services project board, as well as the overarching Transition Board. This 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 Checklist'. 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. This work also sought to ensure that outstanding actions (as at 31 May 2022) had been appropriately identified and allocated to responsible officers for completion by 30 June 2022 or after 1 July 2022. An opinion of **Significant Assurance** was provided.
Financial Governance	We conducted focussed testing to confirm 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. Extensive work was undertaken to manage debtor and creditor balances in readiness for the transition to the ICB. Control accounts continued to be reconciled and appropriately approved, whilst controls over journals and user access to the financial ledger were maintained. With respect to the final financial plan for 2022/23 (incorporating Quarter 1), the forecast balanced position for North Lincolnshire CCG in Quarter 1 and the 9-month ICB Financial plan to March 2023 was presented to the Governing Body on 9 June 2022 where it was approved. This plan was subsequently submitted to NHSEI.

<table>
<tr><td></td><td>NHSEI received financial reports based on North Lincolnshire CCG's position against this draft budget so financial probity remained in place during Quarter 1 against what was known at that time.

Testing confirmed that the financial monitoring report for month 3 agreed to the trial balance which incorporated the initial allocations received and the forecast outturn as per the plan. During Quarter 1 the Integrated Audit and Governance Committee received updates on the financial position.</td></tr>
<tr><td>Outstanding Audit Recommendations and Risks</td><td>Work continued to track and update outstanding audit recommendations so that a final position was established for transfer to the Humber and North Yorkshire ICB.

The position for Quarter 1 as at 30 June 2022 was:

<table>
<tr><th>Overdue</th><th>Overdue with Revised Date</th><th>Not Yet Due</th><th>Implemented</th><th>Total</th><th>% Overdue</th></tr>
<tr><td>0</td><td>2</td><td>1</td><td>4</td><td>7</td><td>29%</td></tr>
</table>

These have been reported to the Humber and North Yorkshire ICB Internal Audit Committee.</td></tr>
</table>

Review of the effectiveness of Governance, Risk Management & Internal Control

As Accountable Officer, I have specific responsibility for reviewing the effectiveness of the system of internal control. In addition, as Accountable Officer I am also responsible for achieving the organisational objectives in the context of sound and appropriate business processes and reporting risks to the Governing Body.

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

The Strategic Risk Register provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principal objectives have been reviewed.

I have been advised on the implications of my review of the effectiveness of the system of internal control by the Governing Body, the Integrated Audit & Governance Committee and Quality, Performance & Finance Committee, and where appropriate a plan is in place to address weaknesses and ensure continuous improvement of the system.

In particular, my review is also informed by:

- External Audit providing progress reports to the Integrated Audit & Governance Committee and the Annual Completion Report within the CCG
- Internal Audit review of systems of internal control and progress reports to the Integrated Audit & Governance Committee, especially the Head of Internal Audit Opinion
- Assurance reports on risk and governance received from the Integrated Audit & Governance Committee
- Performance management systems

- Internal committee structure with delegated responsibility for risk identification, evaluation, control, review and assurance
- Review of the Strategic Risk Register action plans to address any identified weaknesses and ensure continuous improvement of the system is in place via the Assurance Framework and also via action plans embedded within the Risk Registers
- The Corporate Risk Register
- Assessment of the impact of the proposals set out in the Government's White Paper for the NHS.
-

In addition to myself, the systems and mechanisms set out within this Statement and other CCG officers have played a significant part in maintaining and reviewing the effectiveness of the system of internal control during April to June 2022 and have managed risks assigned to them. In particular:

The Governing Body:
This is responsible for providing clear commitment and direction for Risk Management within the organisation. The Governing Body delegates responsibility for oversight and independent assurance on risk management to the Integrated Audit & Governance Committee and delegates responsibility for operational and clinical risk management to the Quality, Performance & Finance Committee.

The Integrated Audit & Governance Committee:
As the Committee with overarching responsibility for risk management, it provides assurance to the Governing Body that appropriate risk management arrangements are in place across the organisation with specific responsibilities for financial risk management. It undertakes its own annual self-assessment of its effectiveness and reviews Internal and External Audits, the Assurance Framework, financial governance reports and the Register of Interests. The Committee is underpinned by various subgroups covering areas including health & safety, emergency planning and information governance.

The Quality Performance & Finance Committee:
Responsible for providing assurance to the Governing Body that appropriate clinical risk management, financial and performance arrangements are in place across the organisation. The Committee is underpinned by various subgroups covering areas including, infection control, quality in contracts and incident management.

Chief Finance Officer:
As Senior Responsible Officer for NHS finances across the CCG, the Chief Finance Officer is responsible for ensuring that the organisation complies with its statutory financial obligations to achieve financial targets and reports financial risks to the Governing Body.

Conclusion

With the exception of the internal control issues, I have outlined in my statement, my review confirms that the CCG has a system of internal controls that supports the achievement of its policies, aims and objectives that is "fit for purpose" and that these control issues either have been, or are being, mitigated and addressed.

ANNUAL GOVERNANCE REPORT APPENDIX 1

Meeting Attendances April 2022 – June 2022

NL CCG Governing Body - 01.04.22 - 30.06.2222

Date of meetings	Dr Faisel Baig - Chair	Emma Latimer Chief Officer	Alex Seale Chief Operating Officer	Emma Sayner Chief Finance Officer	Helen Davis Acting Director of Nursing and Quality	Dr Satpal Shekhawat - Associate Medical Director	Dr Hardik Gandhi GP Member	Dr Salim Modan GP Member	Dr Gary Armstrong GP Member	Dr Pratik Basu GP Member	Janice Keilthy, Lay Member, Patient & Public Involvement	Heather McSharry, Lay Member, Equality & Inclusion	Erika Stoddart, Lay Member Governance - Vice Chair	Dr James Woodard, Secondary Care Doctor
14.04.22	✓	✓	✓	x	x	✓	✓	✓	✓	✓	✓	✓	✓	x
09.06.22	✓	x	✓	✓	x	✓	✓	✓	x	✓	✓	✓	x	x

Primary Care Commissioning Committee - 01.04.22 - 30.06.22

Date of meetings	Janice Keilthy - Lay member Patient and Public Involvement	Heather McSharry Lay Member Equality & Inclusion VICE CHAIR	Emma Sayner - Interim Chief Finance Officer	Dr Andrew Lee - Chair of CoM	Dr Salim Modan - Clinical Lead - Primary Care	Dr Faisel Baig - Chair CCG	Helen Davis - Acting Director of Nursing & Quality	Alex Seale Chief Operating Officer	Dr Satpal Shekhawat - Associate Medical Director	Erika Stoddart Lay Member Governance
23.06.22	✓	x	x	✓	x	✓	✓	✓	✓	✓

Remuneration Committee 01.04.22 - 30.06.22

Date of meetings	Janice Keilthy Lay Member PPI - Chair	Dr Salim Modan - Vice Chair	Erika Stoddart - Lay Member Governance	Heather McSharry Lay Member Equality & Inclusion
16.05.22	✓	✓	✓	✓

Council of Members - 01.04.22 - 30.06.22

Date of meetings	Ancora	Ashby Turn	Barnetby Dr Ahmed	Bridge St	Cambridge Avenue	Cedars	Central	Church Lane	Market Hill	Oswald Rd	Riverside	South Axholme	Killingholme	The Birches	Kirton and Scotter	Trent View	West Common Lane	West Town	Winterton
28.04.22	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	x	✓	✓
26.05.22	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
23.06.22	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Planning & Commissioning Committee wef 01.04.22 - 30.06.22

Date of meetings	Dr Gary Armstrong (Chair)	Alex Seale Chief Operating Officer	Helen Davis Acting Director of Nursing & Quality	Rachel Stanton Interim Deputy Director of Nursing and Quality	Dr Faisel Baig	Dr Salim Modan	Dr Hardik Gandhi	Dr Pratik Basu	Dr Satpal Shekhawat Medical Director	Janice Keilthy Lay Member Patient & Public Involvement	Heather McSharry Lay Member Equality & Diversity	Jane Ellerton Head of Commissioning	Erica Ellerington Head of Primary Care Transformation
19.05.22	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	x

Quality Performance & Finance Committee wef 01.04.22 - 30.06.22

Date of meetings	Janice Keilthy Lay Member Patient & Public Involvement (Chair)	Heather McSharry Lay Member Equality & Inclusion Vice Chair	Helen Davis - Acting Director of Nursing and Quality	Rachel Stanton Interim Deputy Director of Nursing and Quality	Emma Sayner Chief Finance Officer	Jane Ellerton Senior Head of Strategic Commissioning	Dr Satpal Shekhawat Associate Medical Director	Louise Tilley Interim Deputy Chief Finance Officer	Alex Seale - Chief Operating Officer
03.05.22	✓	x	x	✓	x	x	✓	✓	✓

Integrated Audit & Governance Committee 01.04.22 - 30.06.22

Date of meetings	Erika Stoddart Lay Member Governance - Chair	Janice Keilthy Lay Member PPI - Vice Chair	Heather McSharry Lay Member Equality & Diversity
21.04.22 - Extraordinary meeting	✓	✓	✓
08.06.22 Ordinary meeting	x	✓	✓
08.06.22 - Extraordinary meeting	x	✓	✓

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The Remuneration Committee is a statutory requirement of any NHS organisation. As such the Remuneration Committee has been established in accordance with good governance and its role is reflected in the CCG's Constitution.

Members of the Remuneration Committee must be drawn from the Governing Body.

The Committee met once between 1st April and 30th June 2022; the meeting was quorate; membership and attendance details are shown in the table at Page 73.

Policy on the remuneration of senior managers

In determining the remuneration for Very Senior Manager (VSM) posts, the CCG consider the principles of national guidance, where available, as well as finding from local benchmarking and other external factors e.g., NHS Pay Review Body pay circulars and local organisational context.

Remuneration of Very Senior Managers

National advice received in September 2021 included a caveat that the CCG's Remuneration Committee may use its discretion to consider awarding non-consolidated pay awards. At its meeting in May 2022, the CCGs Remuneration Committee considered the pay and remuneration of its VSMs and approved non-consolidated pay awards for each of its VSMs which have been accounted for in the CCG Q1 Accounts for 2022-23 below.

The tables at Pages 76 to 78 below provide details of the CCG's Senior Managers remuneration, including salary and pension benefits.

Senior Manager Remuneration (including salary and pension entitlements) (subject to Audit)

Salary Table – for the 3 month period 1 April 2022 to 30 June 2022

Name and Title	(a)Salary (Bands of £5,000)	(b)Expense payments (taxable) to nearest £100*	(c)Performance pay and bonuses (bands of £5,000)	(d)Long term performance pay and bonuses (bands of £5,000)	(e)All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (Bands of £5,000)	(g) Full Year Equivalent Salary (Bands of £5,000)
	£000	£	£000	£000	£000	£000	£000
Gary Armstrong - GP Member	0-5					0-5	15-20
Faisel Baig - Chair	20-25					20-25	90-95
Pratik Basu - GP Member	5-10					5-10	30-35
Hardik Gandhi - GP Member	5-10					5-10	30-35
Janice Keilthy - Lay Member	0-5					0-5	5-10
Clare Linley - Strategic Lead Nursing and Quality ***	10-15					10-15	55-60
Heather McSharry - Lay Member	0-5					0-5	5-10
Salim Modan - GP Member	10-15					10-15	45-50
Alex Seale - Chief Operating Officer	25-30	1900	0-5	0	7.5-10	40-45	105-110
Satpal Shekhawat - GP Member / Associate Medical Director (AMD)	15-20					15-20	60-65
Erika Stoddart - Lay Member	0-5					0-5	5-10
Helen Davis - Interim Director of Nursing and Quality	20-25				10-12.5	35-40	90-95
Emma Latimer - Chief Officer*	10-15	200	0-5			10-15	150-155
Emma Sayner - Chief Finance Officer**	10-15	900	0-5		2.5-5	20-25	115-120
Dr James Woodard - Secondary Care Consultant	0-5					0-5	5-10

Notes

*Emma Latimer (from 01/11/2019 to 30/06/2022)) is currently in joint posts with North Lincolnshire CCG, Hull CCG and East Riding of Yorkshire CCG
The values above relate to NHS North Lincolnshire CCG, however Emma Latimers respective salary banding is £150-155k

** Emma Sayner (from 01/12/17) is currently in joint post with Hull CCG and North Lincolnshire CCG.
The values above are relate to NHS North Lincolnshire CCG, however Emma Sayners full salary banding is £115-120k

*** Clare Linley (from 19/07/2021) appointed to Strategic Lead - Nursing and Quality, employed by North Lincolnshire CCG and supporting Hull CCG, East Riding of Yorkshire CCG and North East Lincolnshire CCG.
The values above reflect the total salary

The CCG operates a performance related pay (PRP) element as part of the remuneration of those senior officers on Very Senior Manager (VSM) contracts. An entitlement to PRP is determined by performance against agreed objectives through the Personal Development Review (PDR) process. Furthermore, eligibility for PRP is also subject to the CCG's achievement of all of its statutory financial targets as well as due regard to any national guidance issued by NHS England with respect to such awards.

Individual VSM performance is assessed as falling in one of four bands, with Bands 1 and 2 being eligible for consideration of PRP, with a maximum award of 5% being paid to a Band 1 VSM and 3% to a Band 2 VSM. Bands 3 and 4 are not eligible for consideration of a performance award.

The Remuneration Committee scrutinises individual VSM officer performance against their annual objectives and recommends for the Governing Body's approval the performance band to be assigned against each VSM.

Salary Table – Year Ended 31 March 2022

Name and Title	(a)Salary (Bands of £5,000)	(b)Expense payments (taxable) to nearest £100*	(c)Performance pay and bonuses (bands of £5,000) #	(d)Long term performance pay and bonuses (bands of £5,000)	(e)All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (Bands of £5,000)
	£000	£	£000	£000	£000	£000
Gary Armstrong - GP Member	15-20	0	0	0	0	15-20
Faisel Baig - Chair	85-90	0	0	0	0	85-90
Pratik Basu - GP Member	30-35	0	0	0	0	30-35
Hardik Gandhi - GP Member	30-35	0	0	0	0	30-35
Janice Keilthy - Lay Member ***	10-15	0	0	0	0	10-15
Clare Linley - Director of Nursing & Quality **	55-60	0	5-10	0	70-72.5	135-140
Heather McSharry - Lay Member ***	10-15	0	0	0	0	10-15
Salim Modan - GP Member	45-50	0	0	0	0	45-50
Alex Seale - Chief Operating Officer ****	110-115	6,800	5-10	0	97.5-100	225-230
Satpal Shekawat - GP Member / Associate Medical Director (AMD)	60-65	0	0	0	0	60-65
Erika Stoddart - Lay Member ***	10-15	0	0	0	0	10-15
Emma Latimer - Chief Officer*	50-55	2,800	10-15	0-5	0-2.5	60-65
Emma Sayner - Chief Finance Officer*	55-60	3,600	15-20	0-5	10-15	85-90
Dr James Woodard - Secondary Care Consultant*	5-10	0	0	0	0	5-10
Penny Spring - Director of Public Health (up to 2 November 2020)*	0	0	0	0	0	0
Geoff Day - Director of Primary Care (up to 31 March 2021)*	0	0	0	0	0	0

Notes

*** The following 5 Senior Post holders are not paid directly by North Lincolnshire CCG:**

1) Emma Latimer - from 01/11/2017 - 31/10/2019 was in joint posts with North Lincolnshire CCG and NHS Hull CCG. From 01/11/2019 to 31/03/2021 Emma Latimer is in joint posts with North Lincolnshire CCG, Hull CCG and East Riding of Yorkshire CCG. The values above relate to NHS North Lincolnshire CCG, however Emma Latimer's respective salary banding is £150 - £155k

2) Emma Sayner (from 01/12/17) is currently in joint post with Hull CCG and North Lincolnshire CCG. The values above are relate to NHS North Lincolnshire CCG, however Emma Sayner's full salary banding is £115-120k.

3) Dr James Woodard - is remunerated via The University Hospitals Derby and Burton NHS Foundation Trust. The payment detail above relates only to his work for North Lincolnshire CCG.

4) Penny Spring - Employed by North Lincolnshire Council (NLC) and receives no remuneration from North Lincolnshire CCG.

5) Geoff Day - Employed by NHS England and Improvement and receives no remuneration from North Lincolnshire CCG.

** Clare Linley - (from 13/05/20) is in a joint post with North Lincolnshire CCG and Hull CCG. The values above relate to NHS North Lincolnshire CCG, however Clare Linley's full salary banding is £105-£110k

*** The salary banding includes a backdated pay award in respect of 2019/20. The salary banding excluding this would be £5-£10k

**** The salary banding includes a backdated pay award in respect of 2019/20. The salary banding excluding this would be £105-110k

Pension benefits at 30 June 2022

Name and Title	(a)Real increase in pension at pension age (bands of £2,500)	(b)Real increase in pension lump sum at pension age (bands of £2,500)	(c)Total accrued pension at pension age at 30 June 2022 (bands of £5,000)	(d)Lump sum at pension age related to accrued pension at 30 June 2022 (bands of £5,000)	(e)Cash Equivalent Transfer Value at 1 April 2022	(f)Real increase in Cash Equivalent Transfer Value	(g)Cash Equivalent Transfer Value at 30 June 2023	(h)Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Gary Armstrong - GP Member *	0	0	0	0	0	0	0	0
Faisel Baig - Chair *	0	0	0	0	0	0	0	0
Pratik Basu - GP Member *	0	0	0	0	0	0	0	0
Hardik Gandhi - GP Member *	0	0	0	0	0	0	0	0
Janice Keilthy - Lay Member *	0	0	0	0	0	0	0	0
Clare Linley - Strategic Lead Nursing and Quality *	0	0	0	0	0	0	0	0
Heather McSharry - Lay Member *	0	0	0	0	0	0	0	0
Salim Modan - GP Member *	0	0	0	0	0	0	0	0
Alex Seale - Chief Operating Officer	0-2.5	0-2.5	40-45	85-90	733	8	751	0
Satpal Shekhawat - GP Member / Associate Medical Director (AMD) *	0	0	0	0	0	0	0	0
Erika Stoddart - Lay Member *	0	0	0	0	0	0	0	0
Helen Davis - Interim Director of Nursing and Quality	0-2.5	0-2.5	20-25	40-45	327	7	340	0
Emma Latimer - Chief Officer +	0	0	0	0	0	0	0	0
Emma Sayner - Chief Finance Officer +	0	0	0	0	0	0	0	0
Dr James Woodard - Secondary Care Consultant **	0	0	0	0	0	0	0	0

NOTES

* These members have either left the NHS pension scheme or are not members of the NHS pension scheme for managers.
** No pension details are available to the CCG for these individuals as they are not paid through the CCG's payroll. Dr James Woodard is employed by The University Hospitals of Derby and Burton Foundation Trust.
+ For pension details related to these individuals please see NHS Hull CCG's Annual Report & Accounts 30 June 2022

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 Treasure published updated guidance on 27 April 2023; this guidance will be used in the calculation of the 2023-24 CETV figures.

The benefits and related CETVs do not allow for potential future adjustment for some eligible employees arising from the McCloud judgement.

PLEASE NOTE: COLUMNS (E) PLUS (F) DO NOT SUM TO EQUAL (G) DUE TO THE NATURE OF THE CALCULATION.

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

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

The CCG made no payments in respect of early retirement or for loss of office in the 3 month period 1 April 2022 to 30 June 2022.

Payments to past Directors (subject to Audit)

The CCG made no payments to past members in the 3 month period 1 April 2022 to 30 June 2022.

Fair Pay Disclosure

Percentage change in remuneration of highest paid director

1 April to 30 June 2022	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	-3.6%	-66.7%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	6.07%	0%

2021/22	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	5.42%	0%

In 2022/23 there has been no change in respect of highest paid director. The reduction of 3.6% was due to reduced benefit in kind. The performance pay was significantly reduced in 2022/23.

Pay ratio information

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

The banded remuneration of the highest paid director / member in NHS North Lincolnshire CCG in the reporting period 1 April 2022 and 30 June 2022 was £135-£140k (2021-22, £140-£145k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

1 April to 30 June 2022	25th percentile	Median	75th percentile
Total remuneration (£)	£40,588	£47,672	£69,615
Salary component of total remuneration (£)	£33,127	£43,806	£66,614
Pay ratio information	3.39	2.88	1.98
2021/22			

Total remuneration (£)	£32,225	£42,121	£67,640
Salary component of total remuneration (£)	£32,225	£42,121	£67,640
Pay ratio information	4.42	3.38	2.11

During the reporting period 1 April to 30 June 2022, 10 (2021-22, 10) employees received remuneration in excess of the highest-paid director / member. Remuneration ranged from £20k to £209k (2021-22 £20k-£209k).

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

Staff Report

CCG Staff numbers Quarter 1 2022 (senior managers)

Please see table below for information on number of senior managers by band and analysed by 'permanently employed' and 'other' staff for NHS North Lincolnshire CCG between 1 April 2022 and 30 June 2022.

Pay band	Total
Band 8a	8
Band 8b	5
Band 8c	2
Band 8d	1
Band 9	1
VSM	3
Governing body	14
Any other spot salary	18
Assignment category	**Total**
Permanent	62
Fixed term	3
Statutory office holders	8
Bank	1
Honorary	15

* Also included in other spot salary section

**Including apprentices/non agenda for change/GP/Lay Members etc

Gender composition for staff, Governing Body and Council of Members Qtr 1

Between 1 April 2022 and 30 June 2022, the gender composition of the NHS North Lincolnshire CCG Board and Council of Members was as follows:

	Female	Male
CCG Board (Governing Body)	7	7
CCG Membership (Council of Members)	3	16

The gender composition for NHS North Lincolnshire CCG employees at 30 June 2022 was as follows:

Pay band	Female	Male
Band 8a	7	1
Band 8b	3	2
Band 8c	2	

Band 8d	1	
Band 9	1	
VSM	3	
Governing body***	7	7
Any other spot salary	6	12
All other employees	39	4

*** Includes VSM staff

Sickness Absence Data

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

Absence	Total
Average sickness %	0.03%
Total number of FTE days lost	147

The CCG regularly reviews reasons for absence and all sickness is managed in line with the organisation's Attendance Management Policy which can be found at NHS North Lincolnshire CCG - Helping you build a healthy future.

Turnover

The average staff turnover for NHS North Lincolnshire CCG between 1 April 2022 and 30 June 2022 is below:

Turnover	Total
	0.04%

Average turnover rates within NHS North Lincolnshire CCG are low, therefore not giving any cause for concern. Ongoing work to improve staff engagement, health and wellbeing and organisational culture support the key commitments in the NHS People Plan in respect of staff retention.

Staff engagement, workforce health and wellbeing

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.

80% of NHS North Lincolnshire CCG's staff participated in the survey, which was above the average of 64% across the 6 CCGs. 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.

Below are details of further activities undertaken to support staff engagement and workforce health and wellbeing.

The HR and OD team have delivered regular updates at bi-weekly team briefings including; training opportunities, Wellness Action Plans & guides, national Health and Wellbeing Apps and useful websites to support wellbeing whilst staff continue to work predominately from home. A large number of staff have accessed 1:1 coaching support and training opportunities for those interested in becoming a qualified coach have also been offered.

NHS North Lincolnshire CCG provides support to physical and emotional wellbeing through management and self-referral to Occupational Health services, including the ability to access counselling sessions and access to colleagues who are trained Mental Health First Aiders. Staff and their immediate family members also have access to an Employee Assistance Programme; a support network that offers expert advice and compassionate guidance 24/7 covering a wide range of issues. Services include legal information, online CBT and bereavement support. In addition, staff also have access to a wellbeing portal which offers a virtual library of wellbeing information. The articles and self help guides available through this library provide support on a range of health and advisory issues as well as instant guidance to aid physical and mental health. A smartphone app is also available as part of the support which includes access to features such as a weekly mood tracker, mini health checks and breathing techniques.

NHS North Lincolnshire CCG have also run a quarterly morale tracker; a short survey designed to give a better insight into morale, staff experiences at work and their health and wellbeing. The survey supports an integral part of the People Promise – "we each have a voice that counts" and provides regular insight into the working experience of staff to support actions for improvement.

All staff have the opportunity to discuss and agree their own individual objectives as part of their annual Personal Development Review, when any relevant training and development needs are also identified.

Staff consultation

Recognising the benefits of partnership working, North Lincolnshire CCG is an active member of the Yorkshire and Humber SPF which is organised by the Human Resources Team. The forum works across the six Humber and North Yorkshire CCGs: East Riding of Yorkshire, Hull, North Lincolnshire North East Lincolnshire, North Yorkshire and Vale of York. The aim of the Partnership Forum is to provide a formal negotiation and consultation group for the CCGs and the Trade Unions to discuss and debate issues in an environment of mutual trust and respect. HR policies are reviewed, and job descriptions evaluated and banded in partnership with staff side colleagues.

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 on 1 July 2022, a formal consultation with Trade union representatives via the Humber, Coast & Vale Social Partnership Forum and staff of the 6 Humber Coast and Vale CCGs: Hull, East Riding of Yorkshire, North Lincolnshire, North East Lincolnshire, North Yorkshire and Vale of York. commenced 4 April 2022 and concluded on 6 May 2022. The consultation concerned the intent to transfer the employment of the staff from the 6 CCGs to the Humber and North Yorkshire Integrated Care Board (the ICB) together with proposed measures in connection with the transfer. The consultation did not cover 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 Practice "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.

A regular series of FAQ's were issued during the consultation period and staff invited to request either a formal or informal 1:1.

Recognising the potentially challenging time for staff, a number of services, resources and initiatives were in place to support staff to improve or maintain positive mental and physical wellbeing. These include: Employee Assistance Programme (EAP), Self-referral and line management referral to Occupational Health, first line mental health support through to targeted support offered by the Resilience Hub provided by mental health professions, 'Our People' app, local Humber Resources and Organisational Development Business Partnering team and Trade Union Representatives.

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Trade Union Facility Time

Not Applicable.

Diversity and Inclusion

As an employer the CCG recognises and values people as individuals and accommodates differences wherever possible by making adjustments to working arrangements or practices. Policies and processes in place to support this include:

- Staff Induction
- Dignity and Respect
- Attendance Management
- Recruitment and Selection
- Agile Working
- Menopause
- Flexible Working

The CCG has adopted an agile working policy which allows employees greater flexibility in how they manage their work and personal life and offers more choice in when and where employees undertake their role. This will benefit staff with various protected characteristics.

The CCG has also reviewed their Attendance Management policy in 2022 which now includes the provision of disability leave to help employees manage their disability and will be launched in the near future.
Our policies are available at NHS North Lincolnshire CCG - Helping you build a healthy future.

The CCG has continued to increase knowledge and support for people going through menopause and continued to promote the menopause policy. Numerous training events have been held educating both managers and employees on menopause and the CCG is working towards becoming a menopause friendly accredited organisation.

The HR team have run multiple recruitment and selection training sessions for employees to attend to raise awareness and knowledge on unconscious biases, equality legislation, improving diversity and positive action.

The CCG does not have any targets set in relation to diversity and inclusiveness.

Staff Policies

When transferring to the ICB 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 have been developed in consultation with Trade Union representatives. 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 been developing 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

Our policies are available at NHS North Lincolnshire CCG - Helping you build a healthy future.

Staff Numbers for the 3 month period 1 April 2022 to 30 June 2022 (subject to audit)

	01 April 22 - 30 June 22			2021-22		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**69.55**	**2.38**	**71.93**	**71.00**	**2.41**	**73.41**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

Staff Costs table for the 3 month period 1 April 2022 to 30 June 2022 (subject to audit)

	Admin			Programme			Total			01 Apr 22 - 30 Jun 22
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	
Employee Benefits										
Salaries and wages	505	7	**512**	413	22	**435**	918	29	**947**	
Social security costs	53	-	**53**	51	-	**51**	104	-	**104**	
Employer contributions to the NHS Pension Scheme	92	-	**92**	54	-	**54**	146	-	**146**	
Other pension costs	-	-	**-**	-	-	**-**	-	-	**-**	
Apprenticeship Levy	0	-	**0**	-	-	**-**	0	-	**0**	
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**	
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**	
Termination benefits	-	-	**-**	-	-	**-**	-	-	**-**	
Gross employee benefits expenditure	**650**	**7**	**657**	**518**	**22**	**540**	**1,168**	**29**	**1,197**	
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**	-	-	**-**	-	-	**-**	
Total - Net admin employee benefits including capitalised costs	**650**	**7**	**657**	**518**	**22**	**540**	**1,168**	**29**	**1,197**	
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**	
Net employee benefits excluding capitalised costs	**650**	**7**	**657**	**518**	**22**	**540**	**1,168**	**29**	**1,197**	

Expenditure on consultancy

North Lincolnshire CCG spend on consultancy in the 3 month period 1 April 2022 to 30 June 2022 is nil (£2k 2021-22)

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements.

For all off-payroll engagements as at 30 June 2022 for more than £245* per day:

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

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

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

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

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	3
Of which:	
No. not subject to off-payroll legislation(2)	0
No. subject to off-payroll legislation and determined as in-scope of IR35(2)	0
No. subject to off-payroll legislation and determined as out of scope of IR35(2)	3
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 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 (1)	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements. (2)	4

Exit packages, including special (non-contractual) payments.

The CCG had no exit packages, including special (non-contractual) payments or other departures during the 3 month period 1 April 2022 to 30 June 2022.

Parliamentary Accountability and Audit Report

NHS North Lincolnshire CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report on page 31. An audit certificate and report is also included in this Annual Report at page 32 of the Annual Accounts Section.

ANNUAL ACCOUNTS

Foreword to the Accounts

These accounts for the period ended 30th June 2022 have been prepared by the NHS North Lincolnshire Clinical Commissioning Group in accordance with the Department of Health Group Accounting Manual 2022/23 and NHS England SharePoint Finance Guidance Library.

Independent auditor's report to the Board of NHS Humber and North Yorkshire Integrated Care Board in respect of NHS North 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 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 17 (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.

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.

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 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 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 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

NHS North Lincolnshire CCG: Annual Accounts 01 April 2022 - 30 June 2022

CONTENTS **Page Number**

The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the three months to 30 June 2022

	Note	01 April 22 - 30 June 22 £'000	2021-22 £'000
Income from sale of goods and services	2	(103)	(420)
Other operating income	2	-	(16)
Total operating income		**(103)**	**(436)**
Staff costs	4	1,196	4,524
Purchase of goods and services	5	76,095	314,841
Depreciation and impairment charges	5	21	-
Provision expense	5	-	-
Other Operating Expenditure	5	138	519
Total operating expenditure		**77,450**	**319,884**
Net Operating Expenditure		**77,347**	**319,448**
Finance income		-	-
Finance expense		1	-
Net expenditure for the Year		**77,348**	**319,448**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**77,348**	**319,448**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of right-of-use assets		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Net (gain)/loss on assets held for sale		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net (gain)/loss on revaluation of other Financial Assets		-	-
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Total other comprehensive net expenditure		**-**	**-**
Comprehensive Expenditure for the accounting period		**77,348**	**319,448**

Statement of Financial Position as at 30 June 2022

	Note	30-Jun-22 £'000	2021-22 £'000
Non-current assets:			
Property, plant and equipment		-	-
Right-of-use assets	8	393	-
Intangible assets		-	-
Investment property		-	-
Trade and other receivables		-	-
Other financial assets		-	-
Total non-current assets		393	-
Current assets:			
Inventories		-	-
Trade and other receivables	9	1,321	685
Other financial assets		-	-
Other current assets		-	-
Cash and cash equivalents	10	24	12
Total current assets		**1,345**	697
Non-current assets held for sale		-	-
Total current assets		**1,345**	697
Total assets		**1,738**	697
Current liabilities			
Trade and other payables	11	(18,211)	(20,132)
Other financial liabilities		-	-
Other liabilities		-	-
Lease liabilities	8a.3	(81)	-
Borrowings		-	-
Provisions		-	-
Total current liabilities		**(18,292)**	(20,132)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(16,554)**	(19,435)
Non-current liabilities			
Trade and other payables		-	-
Other financial liabilities		-	-
Other liabilities		-	-
Lease liabilities	8a.3	(312)	-
Borrowings		-	-
Provisions		-	-
Total non-current liabilities		(312)	-
Assets less Liabilities		**(16,866)**	(19,435)
Financed by Taxpayers' Equity			
General fund		(16,866)	(19,435)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(16,866)**	(19,435)

The notes on pages 5 to 31 form part of this statement

The financial statements on pages 1 to 4 were approved by Humber and North Yorkshire ICB Board on 22 June 2023 and signed on its behalf by:

Chief Executive (Accountable Officer)
22 June 2023

Statement of Changes In Taxpayers Equity for the three months to 30 June 2022

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for the three months to 30 June 2022				
Balance at 01 April 2022	(19,435)	0	0	**(19,435)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(19,435)**	**0**	**0**	**(19,435)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23				
Total transition adjustment for initial application of IFRS 16	0			**0**
Net operating expenditure for the financial year	(77,348)			**(77,348)**
Net gain/(loss) on revaluation of property, plant and equipment		0		**0**
Net gain/(loss) on revaluation of right-of-use assets		0		**0**
Net gain/(loss) on revaluation of intangible assets		0		**0**
Net gain/(loss) on revaluation of financial assets		0		**0**
Total revaluations against revaluation reserve		**0**		**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(77,348)**	**0**	**0**	**(77,348)**
Net funding	79,917	0	0	**79,917**
Balance at 30 June 2022	**(16,866)**	**0**	**0**	**(16,866)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22				
Balance at 01 April 2021	(17,512)	0	0	**(17,512)**
Transfer of assets and liabilities from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(17,512)**	**0**	**0**	**(17,512)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22				
Net operating costs for the financial year	(319,448)			(319,448)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of right-of-use assets		0		
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve		0		**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(319,448)**	**0**	**0**	**(319,448)**
Net funding	317,525	0	0	317,525
Balance at 31 March 2022	**(19,435)**	**0**	**0**	**(19,435)**

The notes on pages 5 to 31 form part of this statement

Statement of Cash Flows for the three months to 30 June 2022

	Note	**30-Jun-22 £'000**	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(77,348)	(319,448)
Depreciation and amortisation	5	21	0
Impairments and reversals		0	0
Non-cash movements arising on application of new accounting standards		0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	9	(636)	235
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	11	(1,921)	1,684
Increase/(decrease) in other current liabilities		0	0
Provisions utilised		0	0
Increase/(decrease) in provisions		0	0
Net Cash Inflow (Outflow) from Operating Activities		**(79,884)**	(317,529)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Non-cash movements arising on application of new accounting standards		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(79,884)**	(317,529)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		79,917	317,525
Other loans received		0	0
Other loans repaid		0	0
Repayment of lease liabilities		(21)	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**79,896**	317,525
Net Increase (Decrease) in Cash & Cash Equivalents	10	**12**	(4)
Cash & Cash Equivalents at the Beginning of the Financial Year		**12**	16
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) for the accounting period		**24**	12

The notes on pages 5 to 31 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

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

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.

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

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022 on a going concern basis.

NHS North Lincolnshire Clinical Commissioning Group was disolved on 30 June 2022 having joined with NHS Humber and North Yorkshire Integrated Commissioning Board 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 **Movement of Assets within the Department of Health and Social Care Group**

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

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

1.4 **Pooled Budgets**

The clinical commissioning group has entered into a pooled budget arrangement with North Lincolnshire Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the Better Care Fund and a note to the accounts provides details of the income and expenditure.
The pool is hosted by North Lincolnshire Clinical Commissioning Group. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

1.5 **Operating Segments**

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

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.
The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

1.7.2 **Retirement Benefit Costs**

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

1.8 **Other Expenses**

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

1.9 **Leases**

Notes to the financial statements

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

1.9.1 **The Clinical Commissioning Group as Lessee**

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

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

1.10 **Cash & Cash Equivalents**

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

1.11 **Clinical Negligence Costs**

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

1.12 **Non-clinical Risk Pooling**

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

1.13 **Contingent liabilities and contingent assets**

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

1.14 **Financial Assets**

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

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

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

1.14.1 **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.

1.15 **Financial Liabilities**

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

1.15.1 **Other Financial Liabilities**

Notes to the financial statements

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.

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

1.17 **Losses & Special Payments (where reported in financial statements)**
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 clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

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

Vulnerable People Packages of Care
The primary basis for estimating the forecast level of expenditure not yet invoiced is recorded package costs in the Broadcare patient database. Analysis during 2022-23 (supported by similar analysis in previous financial years) has shown that due to peaks and troughs in the numbers of packages for individual months this basis can produce fluctuating expenditure trends which are difficult to justify. Therefore, the solution adopted to address this issue is summarised below:
* First a simple rolling annual trend is generated using moving averages
* Then the Broadcare based expenditure projection is adjusted for any relevant local intelligence
For Continuing Healthcare Packages, the following adjustments are also made:
* Pre panel packages are recorded on Broadcare at a nominal package value to reflect that on average only 1 in 5 will be found eligible.
*NHS England are responsible for legacy cases that were included in the risk pool, therefore an adjustment will be made to ensure all such cases are not reflected in the CCG estimates.
Prescribing
There is a delay of almost two months between the end of an accounting period and receipt of the Practice Prescribing Monitoring Document (PMD) showing the actual prescribing expenditure by GPs. As a result data for May and June prescribing expenditure was not available at the time of production of the annual accounts. An estimate of outstanding prescribing expenditure is therefore calculated using the forecast in the NHS BSA PMD prescribing reports and any relevant local intelligence.

1.19 **Adoption of new standards**
On 1 April 2022, the clinical commissioning group adopted IFRS 16 'Leases'. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.
Under IFRS 16 the group will recognise a right-of-use asset representing the group's right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

Impact assessment
The clinical commissioning group has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.
IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.
The group has utilised three further practical expedients under the transition approach adopted:
a) The election to not make an adjustment for leases for which the underlying asset is of low value.
b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.
The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.
As of 1 April 2022, the group recognised £0.414m of right-of-use assets and lease liabilities of £0.414m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was no impact to tax payers' equity.
The group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.
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	-155
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	1
Operating lease commitments discounted used weighted average IBR	-154
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	-330
Less: Short term leases (including those with <12 months at application date)	26
Less: Low value leases	0
Less: Variable payments not included in the valuation of the lease liabilities	44
Lease liability at 1 April 2022	-414

1.2 **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.
Financial impact for North Lincolnshire CCG is assesssed as immaterial.

2 Other Operating Revenue

	01 April 22 - 30 June 22 Admin	01 April 22 - 30 June 22 Programme	01 April 22 - 30 June 22 Total	2021-22 Total
	£'000	£'000	£'000	£'000
Income from sale of goods and services (contracts)				
Education, training and research	-	-	-	-
Non-patient care services to other bodies	-	6	**6**	175
Patient transport services	-	-	-	-
Prescription fees and charges	-	97	**97**	245
Dental fees and charges	-	-	-	-
Income generation	-	-	-	-
Other Contract income	-	-	-	-
Recoveries in respect of employee benefits	-	-	-	-
Total Income from sale of goods and services	**-**	**103**	**103**	**420**
Other operating income				
Rental revenue from finance leases	-	-	-	-
Rental revenue from operating leases	-	-	-	-
Charitable and other contributions to revenue expenditure: NHS	-	-	-	-
Charitable and other contributions to revenue expenditure: non-NHS	-	-	-	-
Receipt of donations (capital/cash)	-	-	-	-
Receipt of Government grants for capital acquisitions	-	-	-	-
Continuing Health Care risk pool contributions	-	-	-	-
Non cash apprenticeship training grants revenue	-	-	-	-
Other non contract revenue	-	-	-	16
Total Other operating income	**-**	**-**	**-**	**16**
Total Operating Income	**-**	**103**	**103**	**436**

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

	Education, training and research £'000	Non-patient care services to other bodies £'000	Patient transport services £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Income generation £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Source of Revenue								
NHS	-	-	-	-	-	-	-	-
Non NHS	-	6	-	97	-	-	-	-
Total	**-**	**6**	**-**	**97**	**-**	**-**	**-**	**-**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Patient transport services £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Income generation £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Timing of Revenue								
Point in time	-	-	-	-	-	-	-	-
Over time	-	6	-	97	-	-	-	-
Total	**-**	**6**	**-**	**97**	**-**	**-**	**-**	**-**

3.2 Transaction price to remaining contract performance obligations

North Lincolnshire CCG has no contract revenue expected to be recognised in future periods related to contract performance obligations.

4. Employee benefits and staff numbers

4.1.1 Employee benefits	**Total**		**01 April 22 - 30 June 22**
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**918**	**29**	**947**
Social security costs	**104**	**0**	**104**
Employer Contributions to NHS Pension scheme	**145**	**0**	**145**
Other pension costs	**0**	**0**	**0**
Apprenticeship Levy	**0**	**0**	**0**
Other post-employment benefits	**0**	**0**	**0**
Other employment benefits	**0**	**0**	**0**
Termination benefits	**0**	**0**	**0**
Gross employee benefits expenditure	1,167	29	1,196
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	1,167	29	1,196
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	1,167	29	1,196

4.1.1 Employee benefits	Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**3,310**	**235**	3,545
Social security costs	**360**	**0**	360
Employer Contributions to NHS Pension scheme	**618**	**0**	618
Other pension costs	**0**	**0**	0
Apprenticeship Levy	**1**	**0**	**1**
Other post-employment benefits	**0**	**0**	**0**
Other employment benefits	**0**	**0**	**0**
Termination benefits	**0**	**0**	**0**
Gross employee benefits expenditure	4,289	235	4,524
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	4,289	235	4,524
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	4,289	235	4,524

4.2 Average number of people employed

	01 April 22 - 30 June 22			2021-22		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**69.55**	**2.38**	**71.93**	**71.00**	**2.41**	**73.41**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

	01 April 22 - 30 June 22 Compulsory redundancies		01 April 22 - 30 June 22 Other agreed departures		01 April 22 - 30 June 22 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	1	2,833	1	2,833
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**1**	**2,833**	**1**	**2,833**

Analysis of Other Agreed Departures

	01 April 22 - 30 June 22 Other agreed departures		2021-22 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	1	2,833
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**-**	**-**	**1**	**2,833**

The CCG can confirm that there were no senior manager service contracts, exit packages or severance packages made during 01 Apr-22 - 30 Jun 22 .

There was no compensation for early retirement or loss of office or payments to past directors during 01 Apr 22 - 30 Jun 22

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

4.4 Pension costs

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

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

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

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

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

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

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

5. Operating expenses

		01 Apr 22 - 30 Jun 22 Total £'000	2021-22 Total £'000
	Purchase of goods and services		
	Services from other CCGs and NHS England	10	64
1*	Services from foundation trusts	40,973	154,765
	Services from other NHS trusts	7,436	28,139
	Provider Sustainability Fund	-	-
	Services from Other WGA bodies	-	-
2*	Purchase of healthcare from non-NHS bodies	8,675	50,287
	Purchase of social care	2,027	7,674
	General Dental services and personal dental services	-	-
3*	Prescribing costs	8,282	35,820
	Pharmaceutical services	-	-
	General Ophthalmic services	-	-
	GPMS/APMS and PCTMS	7,938	30,583
	Supplies and services – clinical	109	412
4*	Supplies and services – general	309	5,420
	Consultancy services	-	2
	Establishment	81	571
	Transport	4	85
	Premises	60	219
5*	Audit fees	47	47
	Other non statutory audit expenditure		
	· Internal audit services	-	-
	· Other services	-	-
	Other professional fees	140	709
	Legal fees	0	5
	Education, training and conferences	4	39
	Funding to group bodies	-	-
	CHC Risk Pool contributions	-	-
	Non cash apprenticeship training grants	-	-
	Total Purchase of goods and services	**76,095**	**314,841**
	Depreciation and impairment charges		
	Depreciation	21	-
	Amortisation	-	-
	Impairments and reversals of property, plant and equipment	-	-
	Impairments and reversals of right-of-use assets	-	-
	Impairments and reversals of intangible assets	-	-
	Impairments and reversals of financial assets	-	-
	· Assets carried at amortised cost	-	-
	· Assets carried at cost	-	-
	· Available for sale financial assets	-	-
	Impairments and reversals of non-current assets held for sale	-	-
	Impairments and reversals of investment properties	-	-
	Total Depreciation and impairment charges	**21**	**-**
	Provision expense		
	Change in discount rate	-	-
	Provisions	-	-
	Total Provision expense	**-**	**-**
	Other Operating Expenditure		
	Chair and Non Executive Members	138	499
	Grants to Other bodies	-	-
	Clinical negligence	-	-
	Research and development (excluding staff costs)	-	-
	Expected credit loss on receivables	-	-
	Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
	Inventories written down	-	-
	Inventories consumed	-	-
	Other expenditure	-	20
	Total Other Operating Expenditure	**138**	**519**
6*	**Total operating expenditure**	**76,254**	**315,360**

Explanatory Notes

1* Services from foundation trusts expenditure has increased during Apr-Jun 2022-23, mainly as a result of contract growth and inflation which has been applied in line with NHS Planning Guidance.

2* Purchase of healthcare from non-NHS bodies expenditure has reduced during Apr-Jun 2022-23, mainly as a result of:
- Scaling down of the Hospital Discharge Covid Programme included in 2021/22 £0.7m
- A reduction in Continuing Healthcare Spend to bring package costs back in line with 2020-21 and previous years

3* Prescribing costs have reduced during Apr-Jun 2022-23, mainly as a result of seasonal fluctuation with higher expenditure seen during the winter months (Oct- Mar)

4* Supplies and Services - general has reduced in Apr-Jun 2022-23, mainly as a result of the following expenditure in 2021/22 being non recurrent:
- Living Wage for Care Homes £1.1m paid
- Winter Access Funding £0.45m
- Lindsey Lodge Expansion Project £0.35m

5* Audit fees include £47k of expenditure in relation to the external audit fee which is inclusive of £8k value added tax, this value for 2022/23 April to June is the same as the full year position in 2021/22 as a full audit will be required for the closure of North Lincolnshire CCG.

6* The total operating expenditure for 2021-22 includes £4.28m in relation to Covid-19, there was no covid spend in 2022/23 April to June.

6.1 Better Payment Practice Code

Measure of compliance	01 Apr 22 - 30 Jun 22 Number	01 Apr 22 - 30 Jun 22 £'000	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	2,192	23,466	10,024	97,379
Total Non-NHS Trade Invoices paid within target	2,166	23,033	9,690	93,902
Percentage of Non-NHS Trade invoices paid within target	**98.81%**	**98.15%**	**96.67%**	**96.43%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	70	47,695	408	185,417
Total NHS Trade Invoices Paid within target	70	47,695	400	185,311
Percentage of NHS Trade Invoices paid within target	**100.00%**	**100.00%**	**98.04%**	**99.94%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	01 Apr 22 - 30 Jun 22 £'000	2021-22 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

7 Finance costs

	01 Apr 22 - 30 Jun 22 £'000	2021-22 £'000
Interest		
Interest on loans and overdrafts	-	-
Interest on lease liabilities	1	-
Interest on obligations under PFI contracts:		
· Main finance cost	-	-
· Contingent finance cost	-	-
Interest on obligations under LIFT contracts:		
· Main finance cost	-	-
· Contingent finance cost	-	-
Interest on late payment of commercial debt	-	-
Other interest expense	-	-
Total interest	**1**	**-**
Other finance costs	-	-
Provisions: unwinding of discount	-	-
Total finance costs	**1**	**-**

8 Leases

8.1 Right-of-use assets

01 Apr 22 - 30 Jun 22	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2022	-	-	-	-	-	-	-	-	-
IFRS 16 Transition Adjustment	-	414	-	-	-	-	-	-	414
Addition of assets under construction and payments on account				-					-
Additions	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Lease remeasurement	-	-	-	-	-	-	-	-	-
Modifications	-	-	-	-	-	-	-	-	-
Disposals on expiry of lease term	-	-	-	-	-	-	-	-	-
Derecognition for early terminations	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-
Cost/Valuation at 30 June 2022	**-**	**414**	**-**	**-**	**-**	**-**	**-**	**-**	**414**
Depreciation 01 April 2022	-	-	-	-	-	-	-	-	-
Charged during the year	-	21	-	-	-	-	-	-	21
Reclassifications	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Disposals on expiry of lease term	-	-	-	-	-	-	-	-	-
Derecognition for early terminations	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body									
Depreciation at 30 June 2022	**-**	**21**	**-**	**-**	**-**	**-**	**-**	**-**	**21**
Net Book Value at 30 June 2022	**-**	**393**	**-**	**-**	**-**	**-**	**-**	**-**	**393**

Revaluation Reserve Balance for right-of-use assets

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

8a Leases cont'd

8a.2 Lease liabilities

01 Apr 22 - 30 Jun 22	**01 Apr 22 - 30 Jun 22 £'000**	2021-22 £'000
Lease liabilities at 01 April 2022	-	-
IFRS 16 Transition Adjustment	414	-
Addition of Assets under Construction & Payments on Account	-	-
Additions purchased	-	-
Reclassifications	-	-
Interest expense relating to lease liabilities	1	-
Repayment of lease liabilities (including interest)	(21)	-
Lease remeasurement	-	-
Modifications	-	-
Disposals on expiry of lease term	-	-
Derecognition for early terminations	-	-
Transfer (to) from other public sector body	-	-
Other	-	-
Lease liabilities at 30 June 2022	**394**	-

8a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	30-Jun-22 £'000	2021-22 £'000
Within one year	(85)	-
Between one and five years	(318)	-
After five years	-	-
Balance at 30 June 2022	**(403)**	-
Effect of discounting	8	-
Included in:		
Current lease liabilities	(81)	-
Non-current lease liabilities	(312)	-
Balance at 30 June 2022	**(394)**	-

8a Leases cont'd

8a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

01 Apr 22 - 30 Jun 22	**01 Apr 22 - 30 Jun 22 £'000**	2021-22 £'000
Depreciation expense on right-of-use assets	21	-
Interest expense on lease liabilities	1	-
Expense relating to short-term leases	-	-
Expense relating to leases of low value assets	-	-
Expense relating to variable lease payments not included in the measurement of the lease liability	36	-
Income from sub-leasing right-of-use assets	-	-
Gain/(loss) from sale and leaseback transactions	-	-
Gain/(loss) resulting from COVID-19 related rent concessions	-	-

8a.5 Amounts recognised in Statement of Cash Flows

	01 Apr 22 - 30 Jun 22 £'000	2021-22 £'000
Total cash outflow on leases under IFRS 16	(21)	-
Total cash outflow for lease payments not included within the measurement of lease liabilities	(36)	-
Total cash inflows from sale and leaseback transactions	-	-

9. Trade and other receivables	Current 30-Jun-22 £'000	Non-current 30-Jun-22 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
NHS receivables: Revenue	58	-	183	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	-	-	-	-
NHS accrued income	12	-	-	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	57	-	397	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
1* Non-NHS and Other WGA prepayments	1,097	-	-	-
Non-NHS and Other WGA accrued income	28	-	29	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	-	-	-	-
VAT	3	-	10	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	66	-	66	-
Total Trade & other receivables	**1,321**	**-**	**685**	**-**
Total current and non current	**1,321**		**685**	
Included above:				
Prepaid pensions contributions	-		-	

Explanatory Note

1* At the 30 June 22, there was a balance on Non NHS and other WGA receivables due to:

- prepayment for Spire Healthcare due to undertrade based on April and May Activity £300k
- prepayment of July and August Personal Health Budgets to ensure prompt payment to service users whilst systems transition to working as an ICB £481k
- prepayment for IT licences due to annual fees charged at the beginning of the financial year £169k

9.1 Receivables past their due date but not impaired

	30-Jun-22 DHSC Group Bodies £'000	30-Jun-22 Non DHSC Group Bodies £'000	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
1* By up to three months	(4)	49	3	64
By three to six months	3	-	-	-
By more than six months	-	-	-	-
Total	**(1)**	**49**	**3**	**64**

1* The Credit Value of £4k relates to an NHS England Support Unit outstanding credit note

9.2 Loss allowance on asset classes

North Lincolnshire CCG has no loss allowances to report.

10 Cash and cash equivalents

	01 Apr 22 - 30 Jun 22 £'000	2021-22 £'000
Balance at 01 April 2022	12	16
Net change in year	12	(4)
Balance at 30 June 2022	**24**	**12**
Made up of:		
Cash with the Government Banking Service	24	12
Cash with Commercial banks	-	-
Cash in hand	0	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**24**	**12**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 30 June 2022	**24**	**12**
Patients' money held by the clinical commissioning group, not included above	-	-

Cash, bank and overdraft balances are recorded at current values.

	11. Trade and other payables	Current 30-Jun-22 £'000	Non-current 30-Jun-22 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
	Interest payable	-	-	-	-
	NHS payables: Revenue	13	-	149	-
	NHS payables: Capital	-	-	-	-
1*	NHS accruals	1,439	-	215	-
2*	NHS deferred income	72	-	-	-
	NHS Contract Liabilities	-	-	-	-
3*	Non-NHS and Other WGA payables: Revenue	3,213	-	2,097	-
	Non-NHS and Other WGA payables: Capital	-	-	-	-
4*	Non-NHS and Other WGA accruals	12,691	-	17,067	-
	Non-NHS and Other WGA deferred income	8	-	-	-
	Non-NHS Contract Liabilities	-	-	-	-
	Social security costs	50	-	46	-
	VAT	-	-	-	-
	Tax	52	-	46	-
	Payments received on account	-	-	-	-
	Other payables and accruals	673	-	512	-
	Total Trade & Other Payables	**18,211**	**-**	**20,132**	**-**
	Total current and non-current	**18,211**		**20,132**	

Explanatory Note

1* NHS accruals has increased by £1.2m as a result of the following items:
- 'Low Value Activity accrual of £437k - quarter 1 balance which was paid in July
- 'Block contract accrual of £792k to align the quarter 1 position to the final plan submission in June

2* At 30 Jun 22 there was a balance on NHS deferred income due to:
- Income received in advance for Office 365 licences from NHSE £72k

3* In the three months to the 30 June 22 Non-NHS and Other WGA payables: Revenue increased due to:

- Increased accruals for North Lincolnshire Council in respect of Domicillary Care Framework reimbursements £872k
- Accrual for Qtr 1 payment for Lindsey Lodge Hospice in respect of Lymphoedema Services £160k

4* In the three months to the 30 June 22 Non-NHS and Other WGA accruals decreased due to:
- a reduction in Continuing Healthcare accruals of £1.4m
- a reduction in accruals with North Lincolnshire Council for Hospital Discharge funding of £0.5m

12 Contingencies

North Lincolnshire CCG had no contingent liabilities in the three months to 30 June 2022 (None in 2021-22)

13 Financial instruments

13.1 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.

13.1.1 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.

13.1.2 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.

13.1.3 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.

13.1.4 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.

13.1.5 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.

13 Financial instruments cont'd

13.2 Financial assets

	Financial Assets measured at amortised cost 30-Jun-22 £'000	**Equity Instruments designated at FVOCI 30-Jun-22 £'000**	**Total 30-Jun-22 £'000**	**Financial Assets measured at amortised cost 2021-22 £'000**	**Equity Instruments designated at FVOCI** 2021-22 £'000	**Total** 2021-22 £'000
Equity investment in group bodies		-	-		-	**-**
Equity investment in external bodies		-	-		-	**-**
Loans receivable with group bodies	-		-	-		**-**
Loans receivable with external bodies	-		-	-		**-**
Trade and other receivables with NHSE bodies	70		70	3		**3**
Trade and other receivables with other DHSC group bodies	28		28	209		**209**
Trade and other receivables with external bodies	122		122	463		**463**
Other financial assets	-		-	-		**-**
Cash and cash equivalents	24		24	12		**12**
Total at 30 June 2022	**244**	**-**	**244**	**687**	**-**	**687**

13.3 Financial liabilities

	Financial Liabilities measured at amortised cost 30-Jun-22 £'000	**Other 30-Jun-22 £'000**	**Total 30-Jun-22 £'000**	**Financial Liabilities measured at amortised cost 2021-22 £'000**	**Other 2021-22 £'000**	**Total 2021-22 £'000**
Loans with group bodies	-		**-**	-		**-**
Loans with external bodies	-		**-**	-		**-**
Trade and other payables with NHSE bodies	255		**255**	142		**142**
Trade and other payables with other DHSC group bodies	1,197		**1,197**	222		**222**
Trade and other payables with external bodies	16,971		**16,971**	19,676		**19,676**
Other financial liabilities	-		**-**	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**	-		**-**
Total at 30 June 2022	**18,423**	**-**	**18,423**	**20,040**	**-**	**20,040**

14 Operating segments

North Lincolnshire CCG considers they only have one operating segment, namely the commissioning of healthcare services. The position in 2021/22 was the same.

15 Joint arrangements - interests in joint operations

CCGs should disclose information in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

Interests in joint operations

North Lincolnshire CCG are part of a pooled budget arrangement for the Better Care Fund (BCF) with North Lincolnshire Council.

The table below includes details of these arrangements, along with the financial values recognised in the CCG's accounts:

			Amounts recognised in Entities books ONLY 01 Apr 22 - 30 Jun 22				Amounts recognised in Entities books ONLY 2021/22			
Name of arrangement	Parties to the arrangement	Description of principal activities	Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pooled Budget - Better Care Fund (BCF)	North Lincolnshire CCG & North Lincolnshire Council	The integration of Health & Social Care so that people can manage their own health & wellbeing, to live independently in their community, for as long as possible.	0	0	0	**3,284**	0	0	0	13,277

16 Related party transactions

Details of related party transactions with individuals in the 3 month period 1 April 2022 to 30 June 2022 are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Faisel Baig				
CCG Chair				
Out of Hours GP - Core Care Links	165	0	0	0
Member of Safecare, North Lincs GP Federation	423	0	0	0
Spouse working as a salaried GP at Riverside Surgery	722	0	0	1
Chair, Scunthorpe Towns Fund Board (North Lincolnshire Council)	4,115	52	881	55
Emma Latimer				
Chief Officer				
Chief Officer - Hull CCG	66	0	0	0
Chief Officer - East Riding CCG	5	0	0	0
Emma Sayner				
Chief Finance Officer				
Chief Finance Officer - Hull CCG	66	0	0	0
Citycare Board Member	28	0	0	0
Alex Seale				
Chief Operating Officer				
Partner Govenor for Northern Lincolnshire & Goole NHS FT	32,931	0	0	0
Helen Davis				
Interim Director of Nursing & Quality				
Husband is employed by Northern Lincolnshire & Goole NHS FT	32,931	0	0	0
Dr Satpal Singh Shekhawat				
Associate Medical Director				
GP Partner at Kirton Lindsey Surgery (member of the South Primary Care Network), including MCATs p	635	0	0	0
Member of Safecare, North Lincs GP Federation	423	0	0	0
Dr Salim Modan				
GP Member				
Partner at Riverside Surgery (member of the East Primary Care Network)	722	0	0	1
Member of Safecare, North Lincs GP Federation	423	0	0	0
Director of the East Primary Care Network *				
Dr Hardik Gandhi				
GP Member				
Partner at Cedar Medical Practice (member of the South Primary Care Network)	296	0	0	0
Member of Safecare, North Lincs GP Federation and provides GP OOH Services under contract to Saf	423	0	0	0
Spouse works as a Consultant Obstetrician and Gynaecologist in Scunthorpe General Hospital (Northe	32,931	0	0	0
Director of the South Primary Care Network *				
Dr Pratik Basu				
GP Member				
Salaried GP (via Core Care Links) at the Birches Practice (member of the West Primary Care Network)	324	1	0	0
Salaried GP (via Core Care Links) at the Oak Tree Medical Centre Practice (member of the West Prima	165	0	0	0
Member of Safecare, North Lincs GP Federation	423	0	0	0
Director of the West Primary Care Network *				
Dr Gary Armstrong				
GP Member				
Partner at South Axholme Practice (member of West Primary Care Network)	912	0	0	0
Member of Safecare, North Lincs GP Federation	423	0	0	0
Director of the West Primary Care Network *				
Janice Keilthy				
Lay Member Patient & Public Involvement				
Director of Citizens Advice, Scunthorpe	60	0	0	0

* From 1 July 2019, each of the 19 North Lincolnshire General Practices became a member of a Primary Care Network (PCN). There are 4 PCN's (North, South, East and West) within North Lincolnshire. Whilst the PCN's have provided services for the CCG during 2020-21, all financial transactions have been conducted with the lead practice of each PCN and therefore these transactions are not separately reported in the table above.

Only relationships with a financial transaction are disclosed.

The Department of Health and Social Care (DHSC) and its related parties are deemed related parties of the entities within the Department Group. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the DHSC is regarded as the parent Department.

· NHS England

. NHS Trusts

Hull University Teaching Hospitals NHS Trust
East Midlands Ambulance Service NHS Trust
Leeds Teaching Hospitals NHS Trust
United Lincolnshire Hospitals NHS Trust
Yorkshire Ambulance Service NHS Trust

. NHS Foundation Trusts

Northern Lincolnshire & Goole NHS Foundation Trust
Rotherham Doncaster & South Humber NHS Foundation Trust
Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Northumberland, Tyne & Wear NHS Foundation Trust
Lincolnshire Partnership NHS Foundation Trust
Humber Teaching NHS Foundation Trust

· NHS Litigation Authority; and,
· NHS Business Services Authority.
· NHS Property Services

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with :

North Lincolnshire Council
HM Revenue and Customs
National Insurance Fund

15 Related party transactions cont'd

As members of the CCG, GP Practices are considered to be a related party and details of transactions with the practices in the 3 month period 1 April 2022 to 30 June 2022 are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Ancora Medical Practice	1,185	0	61	0
Cedar Medical Practice	296	0	0	0
Cambridge Avenue Medical Centre	466	0	0	0
Kirton Lindsey Surgery	635	0	0	0
Ashby Turn Primary Care Partners	385	1	0	0
West Common Lane Teaching Practice	261	0	0	0
Killingholme Practice	131	0	0	0
Riverside Surgery	722	0	0	1
West Town Surgery	105	0	0	0
Barnetby Medical Centre	279	0	0	0
Winterton Medical Practice	612	0	0	0
The Central Surgery Barton	1,108	0	17	0
Bridge Street Surgery	403	0	0	0
Trent View Medical Practice	606	0	0	1
The Birches Medical Practice	324	1	0	0
Market Hill 8 to 8 Centre	165	0	0	0
Church Lane Medical Centre	198	0	0	0
The Oswald Road Medical Surgery	409	0	23	0
South Axholme Practice	912	0	0	0

15 Related party transactions

Details of related party transactions with individuals in 2021/22 are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Faisel Baig				
CCG Chair				
Out of Hours GP - Core Care Links	692	0	0	0
Member of Safecare, North Lincs GP Federation	1,572	0	0	0
Spouse working as a salaried GP at Riverside Surgery	3,225	1	0	1
Chair, Scunthorpe Towns Fund Board (North Lincolnshire Council)	14,070	332	478	99
Emma Latimer				
Chief Officer				
Chief Officer - Hull CCG	570	107	66	0
Chief Officer - East Riding CCG	156	49	0	0
Emma Sayner				
Chief Finance Officer				
Chief Finance Officer - Hull CCG	570	107	66	0
Citycare Board Member	60	0	13	0
Alex Seale				
Chief Operating Officer				
Partner Govenor for Northern Lincolnshire & Goole NHS FT	128,626	0	0	0
Helen Davis				
Interim Director of Nursing & Quality				
Husband is employed by Northern Lincolnshire & Goole NHS FT	128,626	0	0	0
Dr Satpal Singh Shekhawat				
Associate Medical Director				
GP Partner at Kirton Lindsey Surgery (member of the South Primary Care Network), including MCATs p	3,075	2	0	1
Member of Safecare, North Lincs GP Federation	1,572	0	0	0
Dr Salim Modan				
GP Member				
Partner at Riverside Surgery (member of the East Primary Care Network)	3,225	1	0	1
Member of Safecare, North Lincs GP Federation	1,572	0	0	0
Director of the East Primary Care Network *				
Dr Hardik Gandhi				
GP Member				
Partner at Cedar Medical Practice (member of the South Primary Care Network)	1,002	1	0	1
Member of Safecare, North Lincs GP Federation and provides GP OOH Services under contract to Safe	1,572	0	0	0
Spouse works as a Consultant Obstetrician and Gynaecologist in Scunthorpe General Hospital (Norther	128,626	0	0	0
Director of the South Primary Care Network *				
Dr Pratik Basu				
GP Member				
Salaried GP (via Core Care Links) at the Birches Practice (member of the West Primary Care Network)	1,069	1	0	0
Salaried GP (via Core Care Links) at the Oak Tree Medical Centre Practice (member of the West Prima	692	1	0	1
Member of Safecare, North Lincs GP Federation	1,572	0	0	0
Director of the West Primary Care Network *				
Dr Gary Armstrong				
GP Member				
Partner at South Axholme Practice (member of West Primary Care Network)	3,359	4	0	0
Member of Safecare, North Lincs GP Federation	1,572	0	0	0
Director of the West Primary Care Network *				

Explanatory Note
* From 1 July 2019, each of the 19 North Lincolnshire General Practices became a member of a Primary Care Network (PCN). There are 4 PCN's (North, South, East and West) within North Lincolnshire. Whilst the PCN's have provided services for the CCG during 2021-22, all financial transactions have been conducted with the lead practice of each PCN and therefore these transactions are not separately reported in the table above.

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- NHS England

- NHS Trusts
  - Hull University Teaching Hospitals NHS Trust
  - East Midlands Ambulance Service NHS Trust
  - Leeds Teaching Hospitals NHS Trust
  - United Lincolnshire Hospitals NHS Trust
  - Yorkshire Ambulance Service NHS Trust

- NHS Foundation Trusts
  - Northern Lincolnshire & Goole NHS Foundation Trust
  - Rotherham Doncaster & South Humber NHS Foundation Trust
  - Doncaster & Bassetlaw Hospitals NHS Foundation Trust
  - Sheffield Teaching Hospitals NHS Foundation Trust
  - Northumberland, Tyne & Wear NHS Foundation Trust
  - Lincolnshire Partnership NHS Foundation Trust

- NHS Litigation Authority; and,
- NHS Business Services Authority.
- NHS Property Services

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with :

- North Lincolnshire Council
- HM Revenue and Customs
- National Insurance Fund

15 Related party transactions cont'd

As members of the CCG, GP Practices are considered to be a related party and details of transactions with the practices in 2021/22 are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Ancora Medical Practice	4,607	1	8	1
Cedar Medical Practice	1,002	1	0	1
Cambridge Avenue Medical Centre	1,659	1	0	1
Kirton Lindsey Surgery	3,075	2	0	1
Ashby Turn Primary Care Partners	1,636	1	0	1
West Common Lane Teaching Practice	1,027	1	0	0
Killingholme Practice	530	0	0	0
Riverside Surgery	3,225	1	0	1
West Town Surgery	473	0	0	0
Barnetby Medical Centre	1,058	0	0	0
Winterton Medical Practice	2,400	2	25	1
The Central Surgery Barton	4,093	1	29	1
Bridge Street Surgery	1,475	1	0	0
Trent View Medical Practice	2,317	2	0	1
The Birches Medical Practice	1,069	1	0	1
Market Hill 8 to 8 Centre	692	1	0	1
Church Lane Medical Centre	1,247	1	0	1
The Oswald Road Medical Surgery	1,738	1	10	1
South Axholme Practice	3,359	4	0	0

17 Events after the end of the reporting period

There is one non-adjusting post balance sheet event. This relates to 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 Integrated Care Boards (ICB) across England with ICBs taking on the commissioning functions of CCGs. The Bill was passed on 28th April 2022 and the functions, assets and liabilities transferred to Humber and North Yorkshire ICB on the 1st July 2022.

18 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:

	01 Apr 22 - 30 Jun 22 Target	**01 Apr 22 - 30 Jun 22 Performance**	2021-22 Target	2021-22 Performance
Expenditure not to exceed income	77,451	77,451	319,903	319,884
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	77,348	77,348	319,467	319,448
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	875	875	3,447	3,215

19 Losses and special payments

Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 01 Apr 22 - 30 Jun 22 Number	**Total Value of Cases 01 Apr 22 - 30 Jun 22 £'000**	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £'000
Administrative write-offs	-	-	-	-
Fruitless payments	-	-	1	20
Store losses	-	-	-	-
Book Keeping Losses	-	-	-	-
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total	**-**	**-**	**1**	**20**

Explanatory Note

The fruitless payment disclosed in 2021-22 relates to a one off payment for variation in rate between Continuing Health Care Standard Rate and Private Provider Health Care Rate. These amounts are reported on an accruals basis but excluding provisions for future losses.

19.1 Special payments

North Lincolnshire CCG had no special payments in the three months to 30 Jun 2022 (None in 2021-22)

20 Continuing Healthcare Retrospective Claims Accounting Treatment

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare claims accounted for by NHS England on behalf of the CCG is as follows:

	30-Jun-22 £000's	**2021/22 £000's**
Accrual	**0**	0
Provision	**0**	0
Contingent Liability	**171**	171
	171	171