NHS
North East Lincolnshire
Clinical Commissioning Group

Annual Report and Accounts

2021-2022

Contents

Performance Report

Overview

Welcome to the Annual Report and Accounts of NHS North East Lincolnshire Clinical Commissioning Group (CCG) for 2020/2021.

NHS organisations like North East Lincolnshire Clinical Commissioning Group (NEL CCG) have a duty to keep the public up to date with their activities by publishing an annual report and financial accounts at the end of each financial year.

The purpose of this section is to describe how we plan and buy health and care services on behalf of the people of North East Lincolnshire (commissioning) and what our responsibilities as commissioners are. It also briefly tells the story of the previous 12 months between 1 April 2021 and 31 March 2022, including highlighting notable achievements, challenges and risks going forward.

The Overview is a summary that can be read as a document on its own. Greater detail about our organisation's performance, the way we make decisions, and our structure and staffing are available in the full Annual Report document. The Financial Statements for the year 2021-2022 are presented at the end of that document.

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

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

Welcome from our Chair and Clinical Chief Officer

We would like to open our Annual Report and Accounts by once again saying how proud we are of the health and care staff in North East Lincolnshire who have continued to work tirelessly for the past 12 months to maintain services for patient and community amid the ongoing COVID-19 pandemic and other challenges.

At the time of writing, the UK is marking the 2nd anniversary of the first national Lockdown when ways of working and daily life had to change almost overnight for most people, particularly the most vulnerable in our communities who had to take extreme measures to shield from the virus. The Government has now removed all domestic restrictions as we move into a phase of learning to live alongside COVID but there is no room for complacency. We are currently seeing another rapid rise in infections in North East Lincolnshire, and front-line health and care staff are still working in PPE to protect patients and reduce the impact of sickness absence on already stretched services.

Latest figures show more than 112,400 people in the Borough have had at least two COVID vaccinations. We are delighted so many members of our communities have elected to protect themselves and those around them and our thanks go to the staff and volunteers who continue to make this possible. Uptake of the first booster vaccination is good as we move into offering the Spring Booster to people aged 75 and over and younger people who have a weakened immune system due to a particular health condition or have their immune system suppressed by medication or treatment.

The COVID-19 pandemic was the most sustained Level 4 critical incident the NHS has dealt with. During the past 12 months, working with other organisations has continued to be vital to manage the pandemic in our area and lessen the impact as much as possible on local people and families. The CCG has worked closely with North East Lincolnshire Council to support our communities, businesses and care sector to follow COVID safety guidelines in a fast-changing environment and continues to do so as our area begins to recover from the impact the necessary restrictions have had on people's physical and mental wellbeing and the local economy.

Health and care organisations have worked as a single system in North East Lincolnshire throughout the pandemic. This has enabled us to identify and take action to prevent as much harm as possible from unintended consequences of restrictions on local health services that were needed to reduce footfall in clinic settings and lessen the serious risk of transmitting COVID through face-to-face contact. There are still challenges to overcome around elective care and some cancer targets which will be addressed later in this report.

This approach and our long history of working together with our partners has enabled great strides to be taken in North East Lincolnshire as our system begins to transform to meet challenges set out in the Government's Health and Care Bill. As part of these changes, CCGs will cease to exist, and a new approach will see the North East Lincolnshire Health and Care Partnership bring services closer together to give patients a better experience and tackle inequalities by addressing the big challenges to people's health.

This will support local health and care systems to continue to deliver high-quality care but in a way that is less bureaucratic, more accountable, and more joined up, by bringing the NHS, local government and partners together to provide for the needs of their communities as a whole.

We also must not forget that COVID-19 will be with us for a long time to come and the impact of the pandemic is already far reaching. As it becomes clearer what our "new normal" looks like and how all our lives will adapt around the continued presence of the virus, the CCG and its partners must now build on what we have learned during the height of the pandemic to transform the delivery of care and support, to accelerate the restoration of those services that had to be suspended or reduced to keep patients safe and meet the needs of those fighting the terrible effects of the virus. We also must manage the increasing demand on mental health services and NEL CCG remains committed to delivering the Mental Health Investment Standard.

While we believe the developing arrangements hold a lot of opportunity for our system and people living in our area, we know there are areas where our local health and care system needs to make improvements in both the short and long terms and we must drive these positive changes forward.

Our Annual Report addresses in detail some of the difficulties that we and our partners face and these are set out in our Performance Report along with what we are doing as a local system and a wider health and care partnership to address them. Some of our challenges are national ones and are faced by organisations across the country. We also need to address these at a local level and ensure that people of all ages continue to have access to safe, quality and caring services and live within communities that support them to enjoy the best wellbeing possible through access to a decent job, a decent place to live and the prospects a decent education bring.

We continue to work with neighbouring CCGs in North Lincolnshire, the East Riding of Yorkshire and Hull as well as organisations in our wider region to plan those services that fortunately fewer patients need or need less often, such as hospital treatment for very serious illnesses or critical injuries.

All of this is underpinned by the NEL Commitment to involving local people in our plans and supporting our communities to play the most active role possible in the way we make decisions. The NEL Commitment will become the standard for involvement for the North East Lincolnshire Health and Care Partnership.

Community involvement has been the backbone of the CCG since its inception and the Community Forum has been a vital part of our governance arrangements providing assurance, challenge, and a community perspective for the last ten years.

As the CCG is disbanded, the 'legal duty to involve' will sit with the Integrated Care Board for Humber Coast and Vale. Most CCG staff will continue to work at Place focussing on NEL plans and priorities.

With the retirement of several of our community forum members after so many years of great service to the local NHS, the Community Forum in its current form will discontinue after March 31st. We would like to place on record here our gratitude for its enormous contribution to local health and care. The role of community members appointed to the Forum was unique to those in other CCG areas working alongside clinicians and CCG staff in service triangles, formal committees and working groups.

On behalf of the CCG Governing Body and the Union Board, we are delighted to present our Annual Report and Accounts for 2021/2022. Once again would like to place on record our sincere thanks to our entire team, including clinicians, support staff, managers, community members and our partners in the local health and care system and beyond for their continued support over the past 12 months.

Dr Peter Melton – Clinical Chief Officer

Rob Walsh – Chief Executive

Mark Webb – Chair

Who are we and what do we do?

CCGs are made up of GPs, other people who are employed in health or care and members of the public who do not work for the NHS. Together they look at what the local population needs and plan and buy those services. Our CCG is led by GPs representing 25 practices who provide health services to families living in Grimsby, Cleethorpes, Immingham and rural North East Lincolnshire, supported by a team of non-clinical staff who carry out the day-to-day running of the organisation. We are accountable to our members, patients and our local communities and are overseen by NHS England and NHS Improvement, a single organisation that supports the NHS and helps us to improve care for patients.

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

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

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

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

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

As part of these changes, CCGs will cease to exist, and a new approach will see the North East Lincolnshire Health and Care Partnership bring services closer together to give patients a better experience and tackle inequalities by addressing the big challenges to people’s health.

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

The CCG has delegated responsibility for commissioning primary care services.

During 2021/22 we continued to work with our partners in the Council and Public Health, as well as with a panel of knowledgeable volunteers from the local community (known as the Community Forum) and the organisations that provide health care, to understand local needs and decide how to best use the money allocated to us.

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

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

In 2021/2022, the CCG was allocated £323.7 million by NHS England. This includes £30.2 million to support delegated Primary Care and £3.4 million to pay for the management and operation of the organisation which leaves a total of £290.1 million to pay for health services.

The income to fund Adult Social Care is set by North East Lincolnshire Council as part of its annual resource and priorities process, and in 2021/2022 the CCG received £47.9 million.

How to get in touch with us

We are always keen to hear from the people who use health or care services in North East Lincolnshire as well as their carers or families. The experiences they share with us can help us to improve future services.

You can contact the CCG in the following ways:

By post: NHS North East Lincolnshire Clinical Commissioning Group, Municipal Building, Town Hall Square, Grimsby, DN31 1HU

By phone: Switchboard 0300 3000 400

By email: nelccg.askus@nhs.net

Visit our website for more information about the CCG

Follow us on Twitter

Follow us on Facebook

We are also active on Instagram, look for nhs_nelccg.

What we want to achieve and how we manage risks

Our plan for the coming months before the CCG is disbanded will naturally focus on the ongoing management of the consequences of the COVID-19 pandemic and ensuring that services to patients continue in the best possible way

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

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

Alongside the focus on COVID recovery we will continue to respond to what local people need. What we do in North East Lincolnshire also has to take into account national ideas to improve the way the NHS works.

Development of the Integrated Care System

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

The Humber, Coast and Vale Health and Care Partnership was established in 2016 and comprises 28 organisations from the NHS, local councils, health, and care providers and voluntary, community and social enterprise (VCSE) organisations. In April 2020, Integrated Care System (ICS) status was secured, a year ahead of the requirement set out in the NHS Long Term Plan.

The Health and Care Bill currently going through Parliament sets out plans to now put ICSs 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 are legally established, Clinical Commissioning Groups (CCGs) will be dissolved.

It was originally expected that these changes would come in to effect in April 2022. However, to allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for new statutory arrangements to take effect and Integrated Care Boards (ICBs) to be legally and operationally established.

In Humber, Coast and Vale we are well developed with our plans and anticipate being operating in shadow form from 1 April 2022 under the new name of Humber and North Yorkshire.

Humber and North Yorkshire

NHS England guidance states that each ICB name should reflect the geographical area that it covers, and in Humber, Coast and Vale, the name will be revised to NHS Humber and North Yorkshire Integrated Care Board (ICB). We have also decided to take a consistent approach and apply the name of Humber and North Yorkshire to the ICS and ICP.

We plan to adopt the name of Humber and North Yorkshire Health and Care Partnership as the name of the ICS once ICB shadow arrangements are implemented from 1 April 2022.

Integrated Care Board

Subject to the passing of the Health and Care Bill, ICBs will be directly accountable for NHS spend and performance within each ICS. They will take on the NHS planning functions currently held by Clinical Commissioning Groups (CCGs), as well as some held by NHS England.

Ahead of its establishment, NHS Humber and North Yorkshire ICB has appointed Sue Symington as Designate Chair and Stephen Eames CBE as Designate Chief Executive, and arrangements are well underway to agree all board appointments. Most of the things we do, however, will aim to deliver the best care we can locally, shaped around what the people in our area really need.

Managing Risks

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

Going Concern Basis

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

In addition:

Clinical Chief Officer: As Accountable Officer, the Clinical Chief Officer is accountable for achieving organisational objectives within an appropriate business framework.

Chief Finance Officer: As the Senior Responsible Officer for NHS finances, the Chief Finance Officer is accountable for compliance with Standing Financial Instructions to achieve financial balance.

Performance Analysis

Performance summary

Introduction

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

In recent years it has become increasingly clear that the best way to manage NHS resources to deliver high quality, sustainable care is to focus on organising health at both system and organisation level.

NHS System Oversight Framework

The NHS System Oversight Framework for 2021/22 replaces the NHS Oversight Framework for 2019/20, which brought together arrangements for provider and CCG oversight in a single document.

The NHS System Oversight Framework reflects an approach to oversight that reinforces system-led delivery of integrated care, in line with the vision set out in the NHS Long Term Plan, the White Paper – Integration and innovation: Working together to improve health and social care for all and aligns with the priorities set out in the 2021/22 Operational Planning Guidance.

This framework applies to all Integrated Care Systems (ICSs), Clinical Commissioning Groups (CCGs), NHS trusts and foundation trusts and gives a single set of oversight metrics, applicable to ICSs, CCGs and trusts, which is used to flag potential issues and prompt further investigation of support needs with ICSs, place-based systems and/or individual trusts and commissioners.

These metrics align to the five national themes of the System Oversight Framework: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability.

CCG applicable NHS System Oversight Framework measures facing challenges in year include:

- Overall size of the waiting list was above H1 and H2 plan figures.
- Patients waiting more than 52 weeks to start consultant-led treatment was above H1 and H2 plan figures.
- Cancer people waiting longer than 62 days was below national threshold.
- Percentage meeting faster diagnosis standard was below national threshold.
- Number of people with a learning disability on the GP register receiving an annual health check was below our H1 and H2 plan figures.

CCG applicable NHS System Oversight Framework measures seeing success in year include:

- Number of appointments in GP Practice exceeded H1 and H2 plan figures.
- Antimicrobial resistance: appropriate prescribing of antibiotics and broad-spectrum antibiotics in primary care – performance of 8.36% against target of 11.30%.
- Elective activity levels have been restored in line with H1 and H2 plan figures.
- E. coli bloodstream infections, performance for year was 95 which is a considerable improvement over previous year.

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

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

Progress on NHS Constitution Targets

RAG Key: x in red circle = not achieved ! in amber circle = may not be achieved tick in green circle = achieved

Measure	Latest Period	2020/21				Forecast Position	National Threshold
		Denominator	YTD Perf.	YTD Target	YTD Status		
Total time in A&E: four hours or less - Trust	Mar-22	148,191	63.26%	95.00%	✗	Not Met	95%
ARP Category 1 Mean Response Time – Calls from people with life-threatening illnesses or injuries - EMAS	Mar-22	N/A	00:08:48	00:07:00	✗	Not Met	00:07:00
ARP Category 1 90th centile response time – Calls from people with life-threatening illnesses or injuries - EMAS	Mar-22	N/A	00:15:49	00:15:00	✗	Almost Met	00:15:00
ARP Category 2 Mean Response Time – Emergency calls - EMAS	Mar-22	N/A	00:47:30	00:18:00	✗	Not Met	00:18:00
ARP Category 2 90th centile response time – Emergency Calls - EMAS	Mar-22	N/A	01:41:58	00:40:00	✗	Not Met	00:40:00
ARP Category 3 90th centile response time – Urgent Calls - EMAS	Mar-22	N/A	06:49:03	02:00:00	✗	Not Met	02:00:00
ARP Category 4 90th centile response time – Less Urgent Calls - EMAS	Mar-22	N/A	06:11:03	03:00:00	✗	Not Met	03:00:00
Percentage of Patients waiting <6 weeks for a diagnostic test - CCG	Mar-22	7,751	83.83%	99.00%	✗	Not Met	99%
RTT - Incomplete Patients: % Seen Within 18 Weeks - CCG	Mar-22	16,476	71.23%	92.00%	✗	Not Met	92%
Cancers: two week wait - CCG	Mar-22	5,696	96.82%	93.00%	✓	Fully Met	93%
Cancers: two week wait (all breast symptoms excluding suspected cancer) - CCG	Mar-22	420	89.52%	93.00%	!	Almost Met	93%
Cancer 31 Days Diagnosis to Treatment (First definitive treatment) - CCG	Mar-22	942	94.37%	96.00%	!	Almost Met	96%
Cancer 31 Days Diagnosis to Treatment (Subsequent surgery treatment) - CCG	Mar-22	177	82.49%	94.00%	✗	Not Met	94%
Cancer 31 Days Diagnosis to Treatment (Subsequent drug treatment) - CCG	Mar-22	312	99.04%	98.00%	✓	Fully Met	98%
Cancer 31 Days Diagnosis to Treatment (Subsequent radiotherapy treatment) - CCG	Mar-22	270	95.19%	94.00%	✓	Fully Met	94%
Cancer 62 Days Referral to Treatment (GP Referral) - CCG	Mar-22	464	59.05%	85.00%	✗	Not Met	85%
Cancer 62 Days Referral to Treatment (Screening Referral) - CCG	Mar-22	95	80.00%	90.00%	✗	Not Met	90%
Cancer 62 Days Referral to Treatment (Consultant Upgrade) - CCG	Mar-22	19	57.89%	90.00%	✗	Not Met	N/A
Cancelled Operations offered binding date within 28 days - Trust	Q4 2021/22	280	21.43%	21.43%	✓	Fully Met	N/A
Numbers of unjustified mixed sex accommodation breaches - CCG	Mar-22	N/A	13	0	✗	Not Met	0
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period - CCG	Feb-22	1,740	97.1%	75.0%	✓	Fully Met	75%
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period - CCG	Feb-22	1,740	99.7%	95.0%	✓	Fully Met	95%
Psychosis treated with a NICE approved care package within two weeks of referral - CCG	Mar-22	60	86.7%	60.0%	✓	Fully Met	56%

Development and performance in-year

Reflecting upon our overall performance over the year, we have met a number of the national Health and Adult Social Care targets and also achieved many of the activity levels set out in our planning submissions. However, the coronavirus pandemic, reduction of hospital activity levels and the increased demand for NHS services in 2021/22 continues to be the most serious challenge that the NHS has ever experienced, as such along with all NHS organisations this has had a detrimental impact on the CCGs performance.

H1 and H2 Planning submissions 2021-22

CCGs are accountable for how they spend public money and in 2021/22 trajectories as outlined in the Operational Planning Guidance were set in two 6 months intervals to allow for changes and demand in the ongoing coronavirus pandemic.

Although we had planned to meet all national planning standards and commitments in 2021/22, this has not been possible for some of our commissioned services due to the current pandemic. In the performance analysis that follows it will highlight the significant challenges over the previous year.

Some of the key challenges for the CCG have included:

Cancer Waiting Times

- **Issues** - A number of factors are impacting on our ability to meet the national standards. Positron Emission Tomography (PET) CT waiting times, workforce challenges affecting access to consultant oncology appointments in many tumour sites, inability to transfer Inter-Provider Transfers by Day 38 as many of the tertiary diagnostics are also used for staging required before treatment can be agreed and access to local diagnostics (endo and radiology). National screening programmes were halted during COVID, and this has also impacted on performance in terms of backlogs since screening recommenced. It should be noted that cancer standards are not being met either regionally or nationally.
- **Actions taken regionally -** We continue to work closely with the Integrated Care System (ICS) and Cancer Alliance on regional solutions to address the issues outlined above and are actively engaged with both NLaG and HUTH in terms of their joint Cancer Transformation Programme. This includes continuing to work towards single services across the Humber for Lung, head and neck, upper GI and skin (tumour sites particularly under pressure). The Northern Lincolnshire Transformation Operational Board have oversight of the cancer agenda, including monthly updates on performance, risk, mitigating actions and escalation at ICS level.
- **Actions taken locally -** Locally, in 2021 the emphasis has been the work undertaken with Primary Care to implement the Cancer Primary Care DES aimed at early identification of cancer and the establishment of the national Rapid Diagnostic service. We have also participated in the CA Primary Care Strategy Clinical Group to streamline cancer pathways between NLaG and HUTH which will improve the patient journey/timeline and offer a more consistent equitable service. Some of the key highlights for Northern Lincolnshire in 2021 include national funding awarded to roll out Lung Health Checks across Northern Lincolnshire and regional funding obtained to provide dermascopes/cameras to all practices in Northern Lincolnshire.
- **Key local priorities for 2022 -** Continue to contribute to the Cancer Transformation programme (NLaG/HUTH), roll out of Lung Health Checks in October 2022, reduction in the number of Cancer patient DNAs, reduction in the number of cancers first diagnosed in A&E and continue to support/increase uptake of the national screening programme campaigns, working with the public, primary care and PHE.

Diagnostic waiting times

- **Issues -** Diagnostic services have continued to experience challenges during 2021/22, with some tests being delivered outside of the 6 weeks. Factors affecting this include difficulties in recruitment meaning that there is less capacity available and a build-up of cases due to the inability to see all patients at times during the Covid pandemic.
- **Actions taken -** NHS hospital providers have worked with local independent sector organisations to increase their capacity within certain diagnostic tests, such as non-obstetric ultrasound and echocardiography, and the CCG has made activity available on a regular basis through use of additional providers within the area. The local system is now working together to develop a business case for a community diagnostic centre, as part of a national programme. This centre will provide routine tests in a community setting, providing more capacity within the area and enabling the hospital to focus on inpatient and emergency testing. The detail of this will be further developed over the next 6 months.

Referral to treatment waiting times and waiting list

- **Issues -** There has continued to be a challenge in 2021/22 in being able to deliver against the national waiting times requirements. The main factors affecting this include difficulties in recruitment to some specialties, affecting the number of staff within the service and therefore the capacity available; a build-up of cases due to the inability to see all patients and/or operate at times during the Covid pandemic; and pressures on emergency care meaning that not as many staff or beds have been available to deliver planned care.
- **Actions taken -** The local NHS hospitals have worked with some of the local private (independent sector) hospitals to transfer some patients to them for treatment to help deliver the NHS activity. There have also been some reviews undertaken by the hospital teams and the general practice teams of patients waiting on lists to check if they still require or are still suitable for treatment. Our primary care networks and the local hospital specialist teams for some specialties have started to work together in a more joined up way to discuss and manage patients who might need hospital outpatient care, often avoiding the need for referral into the hospital. In the areas where this has been tried, it has reduced transactions between the organisations and significantly reduced waiting times. This is now a way of working that we are looking to roll out more widely to more specialities and primary care networks, which will help to tackle waiting lists.

LD receiving an annual health check

- **Issues -** The various levels of pandemic response and mixed messages and subsequent clarifications in issued guidance has contributed to a mixed picture in meeting this target across NEL. A more system type response has supported Primary Care in delivering this activity, but data and recording issues appear to continue to be a significant factor in attaining this target.
- **Actions taken -** Continue feedback to practices on their attainment. Continue work with ICS and NHSE/D re: MHSDS recording inaccuracies. LD Wellbeing Team supporting people to attend practices.

Some of the key successes on planning measures for the CCG in 2021/22 have included:

- Appointments in General Practice – A trajectory for this measure was set for 2021/22 and reviewed halfway through the year, we have achieved the target set for this measure for every month apart from April 2021 and our latest year-to-date position (up to February 2022) shows we are above target too.
- Several of our hospital activity measures have met the target set for 2021/22 such as elective spells, non-elective spells, consultant led first outpatient attendances and consultant led follow-up outpatient attendances.

Other CCG measures performance in 2021-22

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

A&E waiting times

- **Issues -** Exit block from Emergency Department (ED) due to lack of patient flow causing long delays for patients in ED. Implications of COVID19 (zoning segregation, PPE, awaiting swab results, staff sickness and isolation) creating challenges and delays for patient pathway through the ED. Medical staffing vacancies, sickness, and isolation resulting in over reliance on locum/agency doctors and junior skill mix. Nurse staffing vacancies, sickness and isolation resulting in unfilled nursing shifts and over reliance on agency nurses with less ED experience. Lack of clinical cubicle capacity to see incoming patients and hold patients awaiting admission. There is also a risk of 12-hour breaches occurring due to a lack of bed availability and patient flow out of the Emergency Department. Risk of harm to patients kept in ECC for more than 12 hours.
- **Actions taken -** The A&E Delivery Board are well sighted on the performance challenges across the urgent care pathway. High patient acuity, increased covid cases and resulting bed closures both within acute and community settings have severely impacted on patient flow and performance. The System Improvement Group was established to manage the programme of work to improve performance and manage risk across the system. This includes initiatives to reduce ambulance conveyance by transferring all appropriate Category 3 and 5 calls to the local Clinical Assessment Service for a community response. The development of the Community Urgent Care Team (CUCT) to deliver 2-hour urgent community response supports this initiative and recruitment is underway to ensure CUCT is equipped to meet the requirements of the National Specification. We are ensuring urgent primary care needs are met via Primary Care Hubs and GP Out of Hours access to prevent patients defaulting to Emergency Department (ED). The Urgent Care Service is co-located with ED to ensure all appropriate patients are seen in that service and the patient pathway is streamlined to ensure patients who do not need an ED 'majors' response are seen within the 4 hour target. Access pathways to Same Day Emergency Care (SDEC) have been reviewed and improvements identified to ensure Ambulance crews and GPs can directly refer to SDEC bypassing ED. Further UCS triage staff have access to directly refer suitable patients out of ED to Urgent Primary Care services. Much work has been undertaken on patient discharge pathways and the improvements to flow resulting from this programme to deliver improvements to ED performance particularly in respect of ambulance handovers and 12-hour Decision to Admit breaches.

ARP & Handover

- **Issues -** Activity continues to increase and handover performance has been significantly impacted by pressures across the system. There is a risk that calls waiting in the community have not received clinical assessment within the appropriate timescale. The increase in call volumes is compounded by the delays in handover at

hospital sites across the EMAS service area. Delays in response to patients waiting in community increases the risk of duplicate calls which has a further impact on call handling times. Handover delays at acute sites across the EMAS service area are impacting significantly on service performance, clinical safety and staff wellbeing.

- **Actions taken -** Support from the local Clinical Assessment Service (CAS) remains in place, in particular transfers of Category 3 and 5 calls to CAS. Where appropriate this can trigger a Community Urgent Care Team (CUCT) response. Support from CUCT to review patients awaiting a Category 2 response in community has been developed to support EMAS in the management of uncovered calls. Work is underway to improve the uptake of direct referral from EMAS into the Haven team to support end of life care for patients to remain at home where appropriate. EMAS have recruited additional HALO posts to support the safe management of ambulance patients queuing at acute sites. EMAS and NLaG are working together to ensure welfare needs of crews awaiting handover at acute sites are met. The existing Ambulance Handover Improvement Plan is being refreshed by the A&E Delivery Board for submission to NHSEI in March 2022. The plan details actions including reducing inappropriate conveyances by increasing hear and treat/see and treat and making handover process as efficient and clinically safe as possible. New ambulance handover process with digital triage in place. New ED/AAU build in development. New EMAS patient self-handover SOP in place. Further review and revision of direct EMAS to SDEC pathway to increase usage and improve successful referral rate. Further the System Improvement Plan identifies a number of workstreams which will contribute to overall performance improvement across the urgent care pathway, detail of this programme included above within the A&E Waiting times actions.

Proportion of people who have depression and/or anxiety disorders who receive psychological therapies

- **Issues -** The impact of lockdowns and social restrictions through the pandemic response has added to the challenge raised through the 'ambitions tool'.
- **Actions taken -** A comprehensive range of initiatives has been implemented with a good level of response, and we are working with the appropriate regional and national networks to maintain and further develop that improvement.

Dementia diagnosis

- **Issues -** Operational challenges in line with the various levels of pandemic response over the year have proven frustrating in ensuring restoration of the previous excellent rate of dementia diagnosis in NEL Perceptions of restricted access to main lines of referrer (e.g. Primary Care) and backlog of access to scanning diagnostics has resulted in a slower return to target rates than anticipated this year. Progress towards the target continues to be made.
- **Actions taken -** Implement reparation plan utilising SDF and SR funding, increased support for people to access diagnosis pathway and post diagnosis and work with HCV to support diagnostics access.

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

- Antibiotics prescribing in Primary Care – We have continued to meet the threshold set for both reduction in the number of antibiotics prescribed and the deduction in the proportion of broad-spectrum antibiotics prescribed.
- Cancer waiting times, one of the two week wait measures and three of the two of the 31 day wait measures continue to be achieved.
- Good progress has been made on the mental health targets with IAPT waiting times, IAPT Recovery and First Episode Psychosis treatment with NICE recommended

package of care within two weeks of referral all above their respective national standards.

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

Our 2021-2022 objectives

The Corporate Business Plan is split into 6 main themes:

1 Out of Hospital / Avoiding Admissions
2 In Hospital / Hospital Transformation
3 Discharge and Onward Care
4 Quality and Safety
5 Medicines Optimisation
6 Covid Recovery

The Corporate Business Plan comprises more than 64 projects and initiatives, each of which has milestones and key performance indicators used to measure progress and achievements. The areas of work described below are headline achievements for the organisation which reflect a cumulative achievement of these projects and initiatives.

To support the transformation of Out of Hospital care the following priorities for action in 2021/22 were identified and a targeted progress was made against each of them:

Objective	Work Areas
Strategic Developments	• Primary care – development of primary care networks
System Resource	• Digital enabling for care homes • Embedding primary care digital response
Overarching Health & Care Priorities	• Support to vulnerable within the community • Support to care home • Transformation of CMHT and alternative for crisis • Urgent and emergency care transformation • Elective care & outpatient care transformation • Maternity system transformation

Financial information

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

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

The financial regime imposed in 2021/22 has enabled systems to respond to the immediate pressures, however the financial pressure that will be faced as we move towards further restoring services, delivering recovery targets, and reducing waiting lists is likely to be substantial.

In 2021/22 the CCG has once again reported a balanced financial position despite the ongoing pressures faced.

Commissioning activity and service redesign

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

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

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

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

Covid 19 Vaccination Rollout

It has been another extremely busy year for our providers who have been delivering covid vaccinations to our local population. We have had 7 community pharmacies and 4 primary care centres offering vaccinations throughout 2021/22. The programme has expanded significantly since it began in late December 2020, and during 2021/22 it has provided vaccinations to people in age groups aged 12 and over, and 5- to 11-year-olds who have an increased risk from Covid-19. There are now 116,667 [71.88%] of people aged 5 and over in North East Lincolnshire who have had 2 doses of the covid vaccination, and 90,725 [80.59% of eligible individuals] who have had both doses and a booster. We know that there are some people who are unable to get out to a vaccination site, so our providers have worked jointly with our community nursing teams to ensure that people in Care Homes and those who are unable to get out of their own home have been able to have their vaccinations. Our providers have also held 'pop-up' clinics in other places within our communities to make them even more accessible; this has included supermarkets, markets, community centres and some large work places.

The providers within our vaccination programme have had to respond rapidly when new cohorts have been announced and when there has been a need for a big increase in the numbers being vaccinated to help tackle the Omicron variant. For example, just before Christmas 2021, our providers pulled out all the stops to increase the numbers of booster vaccinations, and on the busiest day 3255 people received their vaccination, which was 3 times more than the daily average in the weeks before that.

The vaccination remains one of the best ways to protect ourselves and our loved ones from serious illness caused by Covid-19, and as we move into 2022/23, we are planning to be able to keep open the offer of a first, second or booster dose for people who have not yet come forward, as well as preparing for a booster programme in Autumn 2022.

Digital Enabled Care

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

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

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

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

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

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

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

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

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

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

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

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

Hospital Discharge

The North East Lincolnshire system worked collaboratively to respond to the hospital discharge guidance launched in March 2020 and has adapted to meet the hospital discharge policy and national guidance. We have worked with North Lincolnshire, East Riding and Lincolnshire to ensure efficient and effective discharges for all patients. North East Lincolnshire and North Lincolnshire have shared executive discharge arrangements to ensure a consistent Northern Lincolnshire approach. The system has been recently commended for its partnership working and will present the model as part of the national lunch and learn sessions.

A full North East Lincolnshire system wide multi-disciplinary team (MDT) approach consisting of social workers, nurses, therapists, mental health and primary care professionals has been used to ensure timely and safe discharges from hospital, ensuring suitable and effective care for those with ongoing health and care needs. On average there are 240 discharges of North East Lincolnshire residents per week across pathways 0,1,2 and 3. Roughly 92% of patients return home (pathway 0 &1), 5% are discharged into a step down intermediate or discharge to assess placement (pathway 2), and 3% go into a longer-term placement/or back to their existing care home (pathway 3). Discharge performance improved over the COVID-19 outbreak but faltered during the Omicron outbreak due to the workforce pressures in the system. Achievements have included:

- ✓ Significantly increased proportion of people going home first
- ✓ Increased number of discharge notifications prior to 12 noon
- ✓ Increased number of same day discharges - all discharge delay reasons are known and monitored
- ✓ Increased volume of support at home and bed-based capacity to meet demand
- ✓ Strengthened contribution from the voluntary and community sector
- ✓ Established Northern Lincolnshire arrangements for a shared designated setting
- ✓ Improved patient length of stay

Cambridge Park enhanced recovery facility

In response to COVID-19 and the increased need for bed based intermediate care (step up and step down) and discharge to assess facilities, Cambridge Park was acquired, refurbished, and opened in May 2020. The service aims to provide rehabilitation, re-ablement, recovery and recuperation opportunities for adults in North East Lincolnshire. The service aims to promote faster recovery from illness, prevents unnecessary acute hospital admissions and premature admissions to long-term care, supports timely discharge from hospital and maximises independent living and regaining of function wherever possible. Multi-professional staff collaborate with individuals and their informal carers via an asset-based approach to ensure individuals achieve their goals and reach their optimum level of independence, health, and wellbeing. The service can currently support up to 35 people out of a maximum of 52 bed spaces. NEL CCG has been working with the provider (Care Plus Group) throughout 2021/2022 to increase the staffing capacity, skills mix and competencies to ensure the service can cater for 50 individuals and is working to offer an enhanced model of intermediate care to respond to the increasing complexity of needs for those discharging from hospital. Despite the increase in complexity of need presented to the service, 12% of people still managed to return home with no on-going care services. A further 25% have stepped down into intermediate care at home services and 10% of people required the same package of care or less, than prior to their admission to hospital. The remainder go on to need a new or increased package of care, short stay placement or specialist onward care provision (hospice/return to hospital).

Humber Acute Services Programme – Summary of Engagement

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

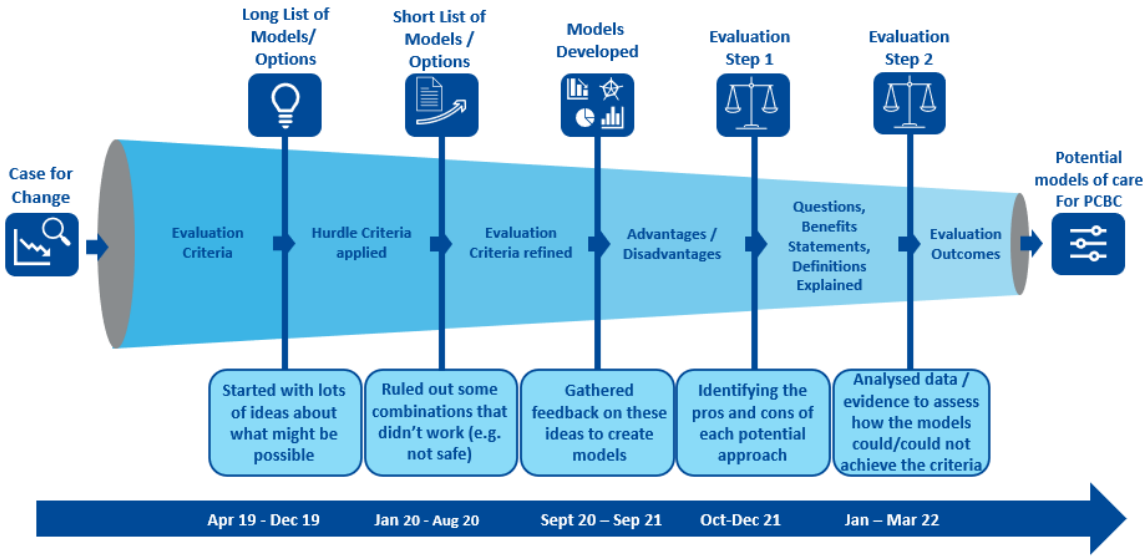
- Urgent and Emergency Care
- Maternity, Neonatal Care and Paediatrics
- Planned Care and Diagnostics

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 in 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 ENT 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 consultant's availability to focus on the most clinically appropriate cases.

Core Hospital Services

Throughout the year we have undertaken extensive engagement with patients, the public, staff and other stakeholders. This has helped us gather views and perspectives from people who use hospital services and those who might be impacted by any changes to them.

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.

The feedback and insights gathered have helped to influence the thinking around possible scenarios for the future, as our clinical teams have continued to develop and refine the different potential scenarios based on all the available evidence and stakeholder feedback.

Building Better Places

Alongside the work to design potential new ways of organising services and providing care, we have continued to develop plans for new and improved buildings to provide services from in the future. Work has also been undertaken in parallel to ensure its possible to quickly move forward on building work as soon as plans for the future shape of services have been agreed and the necessary funding is in place.

An Expression of Interest has been submitted to be part of the national New Hospitals Programme. A total of £720 million is being sought to rebuild and refurbish our hospitals on both sides of the Humber. If successful in securing the funding, the investment will be used to build a brand-new hospital in Scunthorpe, with the remainder of the funding used to create new facilities at Hull Royal Infirmary, the Diana, Princess of Wales Hospital in Grimsby and Castle Hill Hospital in Cottingham.

An announcement on the outcome of our bid is expected later in 2022.

Sustainability of Care Homes

The second year of the COVID-19 pandemic has continued to make delivery of care difficult for our residential and social care providers. The national approach to ensuring sustainability has been via DHSC grants and the CCG and council have benefitted from additional funding to meet additional pressures within the system. These funding streams have included infection control, rapid testing, workforce retention, omicron measures and hospital discharge funding. These funds total in excess of £12m over the course of the pandemic and have helped providers to meet the costs of new policy requirements in relation to infection control measures as well as providing funds to cover the cost of additional staffing, overtime and recruitment to meet safe care, and flow through the health and social care system. Early in the pandemic, funding was also needed to sustain providers during the period where there was a loss of income from reduced demand for social care, most notably within the residential care section of the market. Local evidence suggests that in addition to unprecedented levels of inflation, providers are experiencing further, on-going costs. There has been significant workforce attrition because of the pandemic, with workers leaving the sector permanently due to a combination of exhaustion, generally poorer working conditions and wages than comparable roles in retail or hospitality. Despite this additional support 4 providers have decided to either scale back their provision or have chosen to close. By using the CCG's Market Intelligence and Failing Services protocol all these closures were supported with all residents being able to find accommodation with other providers.

As a result of our previous work on cost of care it was identified optimum occupancy levels for long term sustainability were expected to be in the region of 90%. However overall occupancy stood at 73% in January 2021. In comparison in January 2022 there were 1085 residents compared to 1112 in January 2021 (Laing Buisson care cost benchmarking tool). Unsurprisingly occupancy levels across providers have been variable during the last year due to the impact of the pandemic and as of January 2022, the occupancy level stands at 77%, even with the reduction in the numbers of providers. North East Lincolnshire currently has a total of 1397 beds compared to 1541 in January 2021, equating to a 9% reduction in capacity. North East Lincolnshire has a higher proportion of residential care bed users than comparable councils, which may be reflective of our lower use and access to rehabilitation and re-ablement services. We aspire to reduce the number of short stay placements leading to long stay and this is one of the Health Care Partnership priorities, as such our overall requirement may reduce still further. This is a consideration in our residential strategy

Locally, public health colleagues have suggested that residency levels will not recover to that of pre-pandemic levels for at least 18 months. If this happens, we should expect to see 1183 (based on January 2020 figures) residents across 1397 beds, placing our average occupancy levels at 85%. This would indicate that further reshaping of the market would be necessary to ensure that most providers achieve the desired 90% level. In addition to the funding the CCG has also supported providers with additional PPE, IT equipment to allow video contact, observational equipment and training to ensure that staff are able to support residents through the ongoing pandemic. Ahead of the commencement of the Primary Care Networks Directed Enhanced Service for care homes, the CCG also delivered a wraparound package of enhanced community nursing support. As we move out of the acute phase of the pandemic work is already being planned for supporting providers to deliver homely remedies and further work will be undertaken to deliver more digital support and equipment.

Sustainable development

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

Continued development of agile working in response to the COVID pandemic and the development of hybrid working.

The CCG has worked for many years with Agile Technology and at the start of the first lockdown the CCG staff switched 100% to working at home.

As COVID progressed into its second year, the CCG, and colleagues it works with across the region and whole country, embraced the benefits of digital working and improved productivity. Work at home was still predominant for most CCG staff, but as we have become to come out from the pandemic, the organisation is exploring how best to utilise digital working and those occasions where face to face is the most beneficial. This means developing protocols and systems about how you have hybrid working and hybrid meetings. The CCG is working on how this approach can be managed across its locality and on a wider Humber and North Yorkshire footprint.

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

We continue to review and reduce office space across the CCG and council allowing greater savings which will benefit towards the NHS Net Zero targets.

As we continued working from home for the majority of 2021-22, the savings identified last year compared to 2019-20 will have continued and this was estimated at 115 tonnes of CO2. This was from reduced home to work travel of 2,312 miles per day and business miles reduction of around 50,000 miles.

Facilities Management

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

Procurement

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

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

Net Zero NHS Contracts - Decarbonisation

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

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

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

The objectives for the NEL HCP Environment Group will be to:

- Provide a strategic forum for advising on the development of ICP Partnership plans for achievement of the overarching NHS net zero target of 2040
- Focus on all aspects of the triple aims – improving population health, providing better care for all patients, and ensuring sustainability now and for generations to come
- To be a guiding clinical and professional mind and provide constructive challenge and advice across the Partnership
- To actively champion the work of the sustainability programme across the HCP Partnership but also programmes of work within their own organisations and influence, highlighting opportunities, synergies within and without their roles
- Develop an approach, values and ethos which enable proactive and adaptive responses for a sustainable and climate resilient 21st century health and care system

Sustainability

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

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

Statutory duties

Engaging People and Communities

The CCG and Council's joint commitment to Talking, Listening and Working Together has continued to be the foundation of our approach to our engagement and involvement activities in North East Lincolnshire this year. The Commitment, developed with local people and Voluntary, Community and Social Enterprise (VCSE) organisations, was adopted in 2020, setting out how people and communities will be involved in the planning and design of local services and solutions.

The continued impact of the Covid19 pandemic has meant that we have had to take a very different approach to meet our statutory duty to involve, and our commitment to Talking, Listening and Working Together with patients, public and stakeholders. This has been possible, with the continued support of our Community Forum and Accord Steering Group members, and the North East Lincolnshire (VCSE) Forum.

ACCORD

Accord is the CCG's community membership scheme. Its purpose is to provide local people with opportunities to influence decision making about local health and care services.

There are currently 1300 Accord members; these are people with an interest in health and social care, and who are registered with a GP Practice in North East Lincolnshire. Accord has its own dedicated website, and members receive regular email bulletins which provide links to local, regional, and national health and care engagement opportunities, updates on the outcome of previous engagement activities, and important news about local services.

All our members receive a quarterly Accord newsletter, which is produced online and in hard copy.

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

- Adult Social Care surveys including the Micro-Commissioning Policy survey and Adult Day Services Review.
- Humber, Coast and Vale 'Your Birthing Choices' survey and workshops, and 'What Matters to You' staff survey.
- Surveys and consultations on behalf of our partners such as Healthwatch and Local Authority. These surveys included the local Pharmaceutical Needs Assessment and Covid19 impact survey.

The CCG publishes information about how patient and public involvement has influenced our decision making on our website, and links to these reports are sent to Accord members and stakeholders in the Accord email bulletin.

Review of Adult Day Services in North East Lincolnshire

In December the CCG launched its review of Day Services for adults in North East Lincolnshire; a series of surveys for users of the service, carers, staff, and the public, to give their views on the current service and how it could look in the future.

The survey questions were co-designed with members of the Community Forum, Healthwatch and a local carer, and then produced in an Easy Read format; this helped to ensure that the surveys were accessible to people – including those with a communication difficulty. The CCG also worked with Healthwatch North East Lincolnshire, who helped people to complete the survey over the phone and answered any queries.

The surveys also sought to find out the views of service users and their carers on the potential for more Day services to be based in community settings, rather than the current model which is predominantly centre based.

Over 200 responses were received during a 5-week period, with a significant number of these being paper surveys. A findings report will be published during 2022/23 which will help to shape the development of options for the future delivery of Day services in the borough and inform any future consultation.

Independent Advocacy Service

During the summer, the CCG brought together a 'People's Panel' to take a leading role in the re-procurement of an Independent Advocacy Service for the area. The Panel was made up of several Accord members and a Community Forum representative; its role was to provide a community perspective on the bids received from organisations interested in providing the service.

Panel members met a few times to evaluate the tenders received, and then to interview each organisation and come to a consensus on an interview score. As part of this process, the Panel worked together to set several scenarios that each of the bidding organisations would need to present a solution to during their interview with the Panel.

Their input has helped to ensure that the successful organisation will provide a service which is suited to the population of North East Lincolnshire and is focused on the needs of the user.

The Accord Steering Group

The Accord Steering Group provides a link between the wider membership base of Accord, and the CCG. Its role is to make sure Accord counts and the CCG values and makes appropriate use of the scheme. During 2020/21 they quickly adapted to meeting virtually due to Covid19 and continued to meet in this format during 2021/22.

The Steering Group's achievements during the year included:

- Developing and contributing to the content of the Accord newsletter
- Planning and evaluating a series of online public and stakeholder engagement meetings on Zoom, including:
    - 'Caring for our Communities 2021' which focused on Adult Services including Care Homes and Extra Care Housing
    - 'Getting Better Together 2021' which included updates on the development of local integrated care arrangements
- Commenting on service plans and developments such as the North East Lincolnshire Primary Care Action Plan and capital build plans at Grimsby's Diana Princess of Wales Hospital

In 2022/23, the group will continue their work to 'make sure Accord counts', working with the CCG and the NEL Health and Care Partnership to develop an engagement model for our new Place based arrangements as part of the Humber, Coast and Vale (HCV) Integrated Care Board.

Public Engagement Events

Over the course of the year, the CCG held three digital engagement events for the public, patients, and stakeholders. These meetings were held on Zoom following consultation in 2020 with Accord members on their favoured platform for digital engagement with the CCG during the pandemic.

These events were hosted by the Lay Chair of the CCG and included updates from health and care leaders at the CCG, Local Authority, hospital, and mental health Trusts. Topics for discussion were identified by our Accord Steering Group members and participants were invited to post questions in the Zoom 'Q&A' function, which were answered by the presenters either directly via a typed response or live during the Question-and-Answer segment of the meeting.

To aid in the future development of these sessions, participants were invited to complete a live poll to evaluate their experience of the event. The feedback from these polls has been used by the Accord Steering Group to help shape plans for future sessions.

The videos of these meetings and any subsequent follow up questions and answers are then placed on the CCG website with a link to this emailed to all participants.

Community Equality Impact Assessment Panel

The Equality Impact Assessment Panel is made up of community members who meet regularly to review and discuss CCG plans and policies to raise awareness of any potential barriers for people with protected characteristics. This might be around how information will be accessed to people with communication difficulties or language needs, or how people experiencing any form of disadvantage or vulnerability can access services.

Statement from Patient and Public Involvement (PPI) Board Lay Member

I opened last year's 'Statement' by commenting that 2019/2020 had been the most challenging year for the CCG. How wrong could I be? Few could have foreseen the impact the Covid pandemic would continue to have or the longevity of the pandemic. Nevertheless, the CCG had established governance structures that enabled it not only to fulfil its statutory functions but also to support the initiatives already in place to ensure that healthcare was delivered effectively in North East Lincolnshire.

The decision, several years ago, to enshrine in law the union of the CCG and the Council has served the local community well. It enabled the CCG and Council to have a CEO with responsibility over both, and for staff to be appointed under the wider union. It meant that decisions could be made that considered all aspects of healthcare, from one viewpoint.

Throughout the period 2020/2021, the majority of meetings were held over Microsoft Teams. As a lay member, I formed the opinion that this was an effective way of conducting business. Staff members, in particular, must have saved on travel times and meetings I attended seemed more focused. Several CCG Board members live out of area and their travel time too will have been saved. It is my hope that consideration is given in future, that a form of hybrid meeting be held to enable the CCG or whatever its successor may call itself, to continue to function effectively.

Moving to my involvement as a member of the public appointed to the Board to ensure there was lay scrutiny at Board level, it is perhaps worth detailing the Committees I serve on, in addition to the CCG Board itself.

The CCG delegated most of its decision making and scrutiny to a Risk Committee consisting of the CCG Chair, the lay Audit Chair, myself, the Finance Director and the CEO of the combined bodies. We met virtually every fortnight over Microsoft Teams, conducting urgent business on a virtual email basis between meetings. This proved a very effective way of holding to account with staff members attending to brief as and when needed.

During the period in question the CCG did hold a couple of full CCG meetings, but Board members were kept fully appraised.

I sat, as Vice Chair, on the Primary Care Commissioning Committee and as a lay Board member on the Information Governance & Audit Committee, the Quality Governance Committee and the Union Board. Those committees met occasionally during the year and all minutes of those meetings are available on the web. Several of those meetings were also 'live streamed' for public consumption. Unfortunately, as with 'live' meetings in previous years, there was little public interest.

There was further participation by lay members in the Community Forum (detailed elsewhere in the Annual report) which met monthly and also with the ACCORD Steering Group. Accord is the public membership body of CCG with over 2000 members. Online events have been held promoting healthcare during 2020/2021 despite Covid, which have been well attended and received.

Having been involved (more closely than otherwise through the Risk Committee) at a high level with the CCG I am able to confirm the CCG has discharged its responsibilities. The CCG has an excellent reputation for public engagement, and it has been my privilege to serve our local community as a Board member. So many serve our local community in differing roles on a voluntary basis. I would like, on behalf of the CCG, to acknowledge the huge role those volunteers have played and congratulate my colleagues on the Board, for ensuring our community has been well served.

Reducing Health Inequalities

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

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

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

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

- **Connect NEL**

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

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

Improve Quality

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

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

helps to identify specific areas which require focused quality improvement, this is how we identify and inform our priorities for delivery.

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

During 2021 the CCG continued to hold Risk Committee meetings to replace some of the usual Committees stood-down because of the Covid-19 pandemic which included the Clinical Governance Committee. The Quality team reported quality-related matters to the Risk Committee via the Safety Review Group where detailed discussions were held to oversee delivery of key areas of quality focus including providers where there are concerns, and key strategic priorities.

As was the case in 2020, the impact of the Covid-19 pandemic has negatively impacted upon the teams' ability to achieve all the priorities we set ourselves for 2021/22, and in some instance, progress has been delayed. Due to the Covid-19 pandemic the Quality & Nursing team were required to support the operational delivery of the Discharge to Assess pathway by providing full time nursing leadership and this has significantly affected the team's capacity during 2021/22.

Our approach to quality and safeguarding during 2021/22.

At the start of 2021/2022 financial year, the Quality & Nursing team's priorities were to continue with our main team role described above in respect of quality assurance and oversight but to also prioritise further system support to the covid-19 pandemic response, and to some challenging objectives in respect of clinical effectiveness, safety and service user improvement across our health and social care system, some of which are described below.

We delivered on the local requirements of the National Patient Safety Strategy in-year, and we set up the mechanisms to ensure we are horizon scanning, assessing, and planning for the attainment of key objectives locally informed by the National strategy.

The covid-19 pandemic has been a key factor in the challenges to our local health and social care workforce. To combat this and provide support into our health and social care community we led a project to enhance the support offered by nurses to our care and nursing homes. We received extremely positive feedback from staff working in our care and nursing homes on the support offer delivered locally.

The CCG safeguarding team worked very closely with partner agencies to respond to the challenges arising from the continuation of the COVID-19 pandemic. Quarterly GP Safeguarding leads meetings and Safeguarding in Health Forums continued on-line and quarterly safeguarding bulletins were shared with all practice staff and wider health colleagues to highlight key safeguarding messages.

We provided senior leadership for a number of strategic workstreams across Northern Lincolnshire including End of Life and Unexpected Mortality. Both workstreams saw successes in their programmes of delivery and will continue to be a focus during 2022/23.

We developed a draft Infection Prevention and Control strategy for Northern Lincolnshire with key stakeholders. However, we placed this on hold to support the release of resource to respond to the covid-19 pandemic, recognising that the work we would undertake to support our system would also help to deliver elements of the strategy we had drafted with partners.

One of our achievements this financial year was the establishment of intravenous antibiotic services in community. We are particularly proud of this achievement because it is has been a local aspiration for a number of years and will help our community to avoid admission to hospital, bringing care closer to home/in the home.

Within the year we implemented a Customer Care and Incident electronic management system which enabled us to triangulate intelligence with ease and refined our ability to process information and analyse it to form recommendations. During 2021/2022 the Customer Care Team also reviewed our complaints policy and process for health and care. The process was refined to refocus the teams resources and improve efficiency and quality. Our early outcomes of the change have seen improvement in the length of the process from start to finish.

NEL CCG continued to be an active partner in local multi-agency safeguarding arrangements across the Safeguarding Adults Board (SAB), the Local Safeguarding Children's Partnership (LSCP), Corporate Parenting Board and the Community Safety Partnership (CSP). Throughout 2021-22 the LSCP completed it's first Safeguarding Practice Review and commenced a further review within the year. The CSP commenced 4 Domestic Homicide Reviews (DHR's) during 2021-22 and the SAB completed 3 Safeguarding Adult Reviews. The Designated Nurses chair the sub-groups which oversee the multiagency reviews for both the Children's and Adults Boards, actively contributing and supporting the health contribution to these reviews. The Safeguarding Team supports the dissemination of learning and oversight of health-related actions arising from these reviews through seven-minute briefing documents, enabling a succinct overview of the case and salient learning points to be shared in a timely way.

Separate annual reports are available for both the CCG safeguarding arrangements and for our arrangements with regards to the health of Children Looked After (CLA). Both safeguarding arrangements and the needs of children looked after are statutory functions and a priority for the CCG with some challenging workstreams associated with these agendas.

Principals of remedy – handling of complaints 2021-2022

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

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

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

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

During the past year, the CCG received 47 complaints; 18 of which were about NHS care, 27 of which were about adult social care and 2 were about both health and adult social care. Of the 58 complaints closed during 2020/21; 4 were upheld, 21 were partially upheld, 17 were not upheld and

16 were withdrawn. This was either because the complainant changed their mind about pursuing a complaint, or with their agreement, a resolution was found to their concerns by a different route.

There has been an increase in adult social care complaints, predominantly in relation to care at home services. Due to additional pressures in the health system during the pandemic, our service providers have struggled to maintain usual levels of staff capacity due to the restrictions imposed by COVID infection control measures and higher than usual turnover rates with staff. Our providers have struggled to recruit and retain staff during this very difficult period leading to issues with the quality of service delivered. Government support in the form of grant funding, and financial contributions from the NHS have been distributed to providers to ensure that a more attractive rate of pay can be offered, enabling some providers to offer the national minimum wage uplift earlier than required. We have also been working to support the sector with an active recruitment drive. However it is expected that staff shortages will remain whilst there is on-going pressure to deliver complex care as a result of pandemic conditions.

Over the last 12 months the main themes coming from complaints are:

- In both health and adult social care complaints, poor communication played a part both between staff and service users, their family and carers and also between the services themselves
- In adult social care complaints, there were missed opportunities to manage service user's expectations when home care agency staff are running late or unable to attend calls
- In health complaints, there was a lack of explanation to service users about changes being made to some local services

In response to these themes, the CCG acknowledges that in the last 12 months both health and social care services have been extremely busy and under pressure and this has often had an impact on their ability to always respond as they would like.

That said, one of the local providers recognised the importance of keeping families better informed when their loved ones are in hospital and introduced Family Liaison Assistants to relay information between the two.

Regarding improving communication between services, the pressures of COVID has meant that services have had to work more closely together and changes to IT services during the last 12 months have meant that information can be more easily shared between providers.

Feedback on the missed opportunities has been provided to home care agencies help inform their working practices.

When the CCG publishes its annual complaints report later in the year, a copy will be shared with local providers to share the learning from the complaints and PALS enquiries received by the CCG.

Ombudsman investigations.

No health complaints were investigated by the Parliamentary and Health Services Ombudsman.

The Local Government and Social Care Ombudsman (LGSCO) carried out six investigations, the outcomes of which were two of the complaints were upheld, two were not upheld, and the remaining two are still ongoing. The LGSCO made a number of recommendations in relation to the two upheld complaints. In the first case it was to offer an apology and reconsider two items of disability related expenditure (DRE) and in the second case the recommendations were for the CCG offer an apology, waive the remaining care home fees and make a redress payment for upset and inconvenience. All six cases had been considered by the CCG's Charging Appeals Panel as part of local resolution. As a result of the LGSCO's observations and findings, changes were made to how the Panel considers

DRE items and also to make the explanation of the findings of the Panel clearer in the decision letter to the appellant.

The CCG's Chief Operating Officer and Director of Quality and Nursing personally signs off all complaint responses and details of any remedies or service improvements are included within the response. These are followed up with the provider(s) through an action plan to ensure all actions have been undertaken. Unfortunately, in view of the ongoing pressures from Covid-19 on providers, site visits remained on hold, which prevented the further assurance checks to ensure learning from complaints has become embedded.

Learning from PALS, Complaints, incidents, and serious incidents is shared through a regular Bulletin to providers, and we meet regularly with stakeholders like the Care Quality Commission and Healthwatch to share information and intelligence, although again these meetings have been affected by the ongoing Covid-19 situation.

A joint annual report on health and social care complaints is received by North East Lincolnshire Council Cabinet (consisting of elected members) for scrutiny, and also by the Quality Governance Committee for the CCG Governing Body.

What is planned for 2022/23 - Key Challenges and Opportunities ahead in 2022-23.

The NHS will continue during 2022/23 to develop itself through the new arrangements within the ICS, and quality including patient safety, will need to be at the forefront of those arrangements during this time of transition.

As the ICS develops, the model of Quality within health and care will change and we will progress discussions with Quality leads from across our health and care sector and in line with thinking from the ICS to design, develop and grow our arrangements in NEL. Working in collaboration and partnership has always been our approach to delivering our role but as we move forward those partnership arrangements will need to expand to ensure we are working with and in an aligned way across the ICS footprint. This may mean we amend or develop the way in which we approach quality control, quality improvement or quality planning, and new leadership models from the ICB and from the 6 different Places that make up the Humber & North Yorkshire ICS will all influence this.

The NHS is under unprecedented pressure due to the impact of Covid-19 and the NHS waiting backlog, and a focus on patient safety during this time will be paramount, with system partners needing to work together to help ensure this happens. This will continue to be a significant focus for us during 2022/23.

The clinical and the care workforce, including nurses, midwives, allied health professionals and care staff are what help us achieve quality outcomes for users of our health and care services and also has to be a focus for 2022/23, where we know we have significant risks from vacancies and retainment of our workforce.

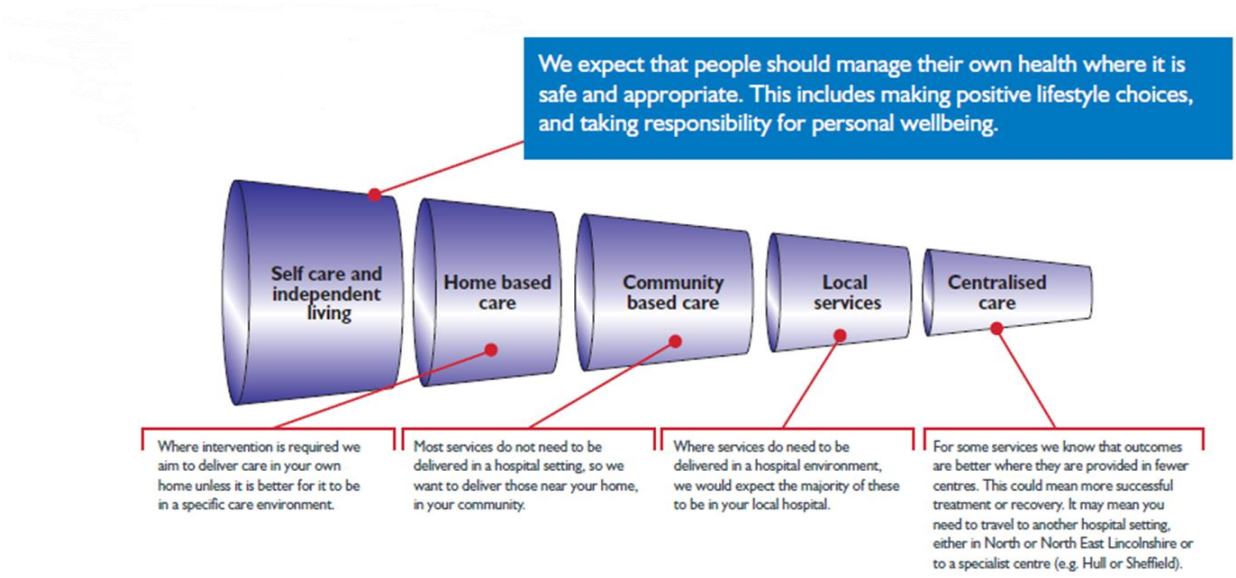
Another key priority for 2022/23 is to support effective and timely information sharing from Primary Care into multi-agency safeguarding systems for adults and children. we aim to recruit new Safeguarding Lead Nurses for Primary Care to actively support information sharing and improved safeguarding practice across GP practices.

Further priority areas for quality and for safeguarding will emerge as we progress forward into the new ICS arrangements.

Health and Wellbeing Strategy

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

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



We have continued to build on have built on previous years' achievements with our social prescribing programme funded through a Social Impact Bond. We have also helped our local PCNs to recruit additional Social Prescribing link workers who now operate in a fully integrated way with our existing model to optimise the impact of the service and help some of our most vulnerable residents to improve their health and wellbeing.

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

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

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

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

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

Access to Information (FOI)

During the period from 1 April 2021 to 31 March 2022, the CCG processed the following requests for information under the Freedom of Information Act 2000 (FOIA):

FOI	2021/2022
Number of FOI requests processed	194
Percentage of requests responded to within 20 working days	100%
Average time (in days) taken to respond to an FOI request	15 days

The CCG provided the full information requested in 86 cases. The CCG did not provide all the information requested in 35 cases because an exemption was applied either to part of, or to the whole request. The exemptions applied were:

- The cost of providing the information exceeded the limits set by the FOIA.
- The request was a repeat request and the information had already been provided.
- The information was accessible by other means.
- The information was exempt as compliance would prejudice law enforcement.
- Information requested related to personal data and compliance would breach the principles in UK GDPR.

In 73 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 year.

The Section 45 Code of Practice under FOIA recommends that public authorities with over 100 Full Time Equivalent employees publish FOIA compliance statistics as part of their publication schemes. As a matter of best practice the CCG publishes FOIA reports on a quarterly basis at the link below: https://www.northeastlincolnshireccg.nhs.uk/publication-scheme/what-are-our-priorities-and-how-are-we-doing/

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

Dr Peter Melton
Clinical Chief Officer
16 June 2022

Accountability Report

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

Corporate Governance Report

Member's report

We are a clinically led organisation which brings together 25 local GP practices and other local health professionals to plan and design services to meet local patients' needs.

During the reporting period 1st April 2021-31st March 2022 there were no mergers or changes to GP practice structures.

All our GP practices are members of a Primary Care Network (PCN) (group of practices). A PCN consists of groups of general practices working together with a range of local providers, (for example community services and social care) to provide coordinated health and social care to their local populations. The 3 PCNs in North East Lincolnshire during 2021/22 were:

- Panacea
- Meridian
- Freshney Pelham

Over the past year the PCNs have been working towards their key services which include:

- Early detection of cancer
- Enhanced Support to Care Homes
- Structured Medication Reviews
- Identifying patients at risk of CVD
- Tackling health inequalities
- Extended Access
- Chronic and Complex

In addition during 2021/22 the PCNs in North East Lincolnshire delivered:

- Covid and flu vaccine programmes
    - Covid vaccine delivery for all North East Lincolnshire patients
    - Care home resident and staff
- PCN Hubs with additional same day appointment slots for patients

Our member practices are listed below

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

Governing Body member profiles

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

Mark Webb taking the role of Lay Chair, leads the Governing Body. The membership comprises of members from our constituent practices, healthcare professionals, lay members, executive members and local authority.

Current composition of the Governing Body

Clinical members

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

Lay members

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

Officer representatives

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

Standing attendees

Anne Hames	Community Forum chair
Joanne Hewson	Chief Operating Officer NEL Council

Resignations were received from the following Governing Body members during 2021-2022:

Stephen Pintus -	Director Public Health/Health and Wellbeing NELC resigned from the Governing Body – June 2021.

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

Our committees

The following committees assist in the delivery of the statutory functions and key strategic objectives of the CCG to support our Governing Body.

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

The Annual Governance Statement includes the details of membership and summary of the committees.

Register of interests

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

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

Additional disclosures

Modern Slavery Act

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

Personal data related incidents

The CCG has not reported any personal data related incidents to the Information Commissioners Office during 2021/22.

Emergency Preparedness

Background

NHS England is responsible for emergency preparedness in the Yorkshire and Humber region including North East Lincolnshire. This regional management is administered through a Local Health Resilience Partnership (LHRP) attended by CCGs and NHS funded organisations.

The basis of the LHRP is to seek assurance from NHS organisations that they meet the obligations of the national Emergency Preparedness, Resilience and Response (EPRR) Framework.

The purpose of the EPRR Framework is to provide a set of standards for all NHS funded organisations in England to help with meeting the requirements of the Civil Contingencies Act 2004 (CCA 2004), the NHS Act 2006 as amended by the Health and Social Care Act 2012 (NHS Act 2006 (as amended)) and the NHS Standard Contract.

The CCG is a Category 2 responder and has a key role in linking into NHS England in the event of a major incident and in a proportionate coordination role with local providers in the management of incidents depending on their nature.

The Humber Local Resilience Forum (LRF) also exists, consisting of Local Authorities, Emergency Services, the NHS funded organisations that are Category 1 NHS responders, and this forum maintains an incident risk register, which, for this region, is biased towards industrial accidents and flooding. In contrast the EPPR Framework is biased towards health-related emergencies e.g. pandemic flu and on major service failure (any cause) of NHS providers.

2021/22 Core Standards Self-Assurance Process and Compliance

The NHS England Care Standards Self-Assessment process was not rolled out last year due to the unprecedented demand on the system, however this year it has returned with some of the previous mechanisms to the process, but also acknowledging the previous 18 months and the changing landscape of the NHS.

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

The overall EPRR assurance rating for an organization is based on the percentage of core standards the organization assesses itself as being "fully compliant with" (see below). For the last 3 years, the CCG has been "substantially compliant" with the core standards.

The last full submission of the core standards was in 2019/20 due to the scaled down process being applied for 2020/21. In that last submission there were 43 standards applicable to CCG's. This year, there are only 29 applicable standards for CCG's. The CCG was assessed by the Emergency Planning and Resilience Manager as being fully compliant with the 28/29 of these standards and therefore the CCG has an overall rating of substantial compliance.

It was assessed as being "partially compliant" with standard 53. It is anticipated that as part of the CCG moving into ICS form all EPRR arrangements will be reviewed including training, exercising, planning and the auditing of the processes and business continuity management system (BCMS). If this is not considered, the lead will consult with the relevant managers regarding the audit plan for the CCG/ICS to review whether or not the BCMS needs more independent audit.

Covid-19 and other emergency planning work

In 2020, we were unable to report the exercises completed as the assurance process was scaled down due to the Covid-19 Pandemic. Key exercises included the below, with a significant focus on Covid-19:

- Humber Directors of Public Health Covid-19 Outbreak Scenario
- LRF Concurrent Emergencies Exercise
- NELC (North East Lincolnshire Council) and NELCCG Covid-19 Outbreak Exercise
- NHSE HCV (Humber Coast and Vale) Winter and Covid-19 Exercise
- Northern Lincolnshire and Goole (NLaG) Concurrent Incident Covid-19 and Winter Pressures Exercise
- Internal Communications Cascade

In June 2021, the NEL EPARG met for its first meeting of the financial year. The group, as per it's Terms of Reference, holds quarterly meetings to progress actions and plans alongside the training and exercising sessions.

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

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

Statement of Disclosure to Auditors

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

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

Dr Peter Melton
Clinical Chief Officer
16 June 2022

The Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Dr Peter Melton Clinical Chief Officer to be the Accountable Officer of NHS North East Lincolnshire Clinical Commissioning Group.

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

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

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

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

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

As the Accounting Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS North East Lincolnshire Clinical Commissioning Group's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I also confirm that:

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

Dr Peter Melton
Clinical Chief Officer
16 June 2022

Annual Governance Statement

Introduction and context

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

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

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

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

The CCG constitution sets out how the organisation will ensure it is well governed and accountable to both its GP member practices and its local population. No required changes were mandated to be made to the CCG's constitution during 2021/22 as part of either the transitional arrangement to the new Integrated Care Arrangements (due to come into place in 2022/23) or the impact of the continued response to the COVID 19 pandemic, as such the CCG have not made any changes to their constitution during this period.

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

As a clinically led organisation, it is essential for there to be strong clinical representation on the Governing Body and on the committees of the CCG, and for any service redesign and/or transformation programmes to be clinically led. To encourage openness and inclusivity each Committee's membership shall include a minimum of one GP member representative. There are 25 practices that collectively form the members of NHS North East Lincolnshire Clinical Commissioning Group. These are listed in the members report

The CCG's Governing Body has ongoing requirement to review the CCG's governance arrangements to ensure they reflect the principles of good governance to which the Governing Body regularly review the CCG's governance arrangements. These arrangements have been supported

by an independent audit review of the CCG governance arrangements to provide assurance on the effectiveness of the governance arrangements in place that support the Governing Body in delivering its agreed aims and objectives and these arrangements remained in place during the COVID 19 pandemic.

The Risk Committee that was formed at the start of the pandemic, continued to meet regularly during 2021/22. Its role as an "emergency" decision making committee was stood down in April 2021, but it continued to act as an assurance touchpoint on (1) the response to COVID, (2) high level risks, (3) development of the ICB / NEL place arrangements

The audit review on the effectiveness of the governance arrangements in place within the CCG provided **High** assurance, with no recommendations. The Audit acknowledged that the NHS continues to face significant challenges from the COVID 19 pandemic and NELCCG have made some internal governance changes to reduce the burden and focus on the priorities as outlined in the updated "reducing the burden" guidance issued in December 2021.

The Governing Body is supported by a robust committee structure. Each committee has a set of terms of reference describing its membership and the scope of its authority and detailed workplan. An annual review of the terms of reference for all the statutory committees has been undertaken and was presented to and approved by the Governing Body in November 2021. For committees, such as the Integrated Governance and Audit Committee and Primary Care Commissioning Committee where the agenda changes little year on year, a pragmatic approach was adopted to continue to use the previous year's workplans. Work Plans for all other committees (Remuneration Committee, Care Contracting Committee, Quality Governance Committee), have been reviewed and updated.

All committees have at least one Governing Body member, GP Representative, and Lay member as part of their membership and minutes of all committees are shared with the Governing Body.

On an annual basis, usually at the end of the financial year, committees provide an annual effectiveness self-assessment report to the Governing Body which summarises key discussions and discussions made throughout the year.

The CCG has continued to meet in public with the meetings for Governing Body and Primary Care Commissioning Committee being broadcast on the CCG website as an opportunity for the public to join the meeting. Meeting papers are available on our website.

As part of the CCG's governance arrangements, there is a requirement for "public and patient involvement". The CCG undertakes this via the Community Forum. Community contacts, who are drawn from the CCG's Accord membership scheme, can contribute to the CCG's governance arrangements through positions on, committees or working groups, where they sit as equal partners with health professionals to influence service improvements.

The Membership, Attendance and Activity Summary

The 2021-22 membership and attendance summary of the Council of Members, Governing Body and Governing Body committees is given below.

Council of Members

The CCG is a membership organisation comprising all of the GP member practices across North East Lincolnshire. The Council of Members consists of one representative from each practice, to ensure that the CCG includes all GP practices in the area. In addition, there is representation of Adult Social Care (ASC) via the Executive Director (CCG Chief Operating Officer) with responsibility for ASC strategic commissioning and the ASC advisor to the Board are both members of the Council of Members. In order to engage the local GPs in the business of the CCG during the pandemic, the Council of Member meetings were held virtually, and it was also agreed that they would be

incorporated as part of Primary Care protected learning sessions to ensure business could be conducted in the most time efficient way; more latterly, it was agreed that CoM would be held during part of the Primary Care Network Clinical Directors meeting, with the invitation offered out to all members, with members having the option to give responsibility for their vote to their Primary Care Network Clinical Director if they wished. The Chair also agreed that meetings would only be held as and when formal business, as set out in the scheme of reservation and delegation was required of them. There has only been a requirement for one formal meeting of CoM during 2021/22.

Concurrent with this, the CCG and local health and care partners have begun to transition into shadow partnership arrangements (the North East Lincolnshire Health and Care Partnership), this includes the establishment of a Professionals Forum whose membership is the clinical and professional leads from all partner organisations within NEL, including the GP Primary Care Networks. Service change discussion and oversight which historically would have taken place at CoM has become the focus for this forum. This alongside the regular Primary Care Network Clinical Directors and CCG engagement forum, has meant that the clinical leadership and engagement in service change during 2021/22 has been strengthened.

The formal work of the COM, as required in the scheme of delegation, has reduced during 2021/22, due to the delayed planning timelines as a result of the Winter pressures from Covid. When it has met, CoM has been engaged in a number of changes affecting the way health care will be delivered, including changes that will be brought about as part of the Government's White Paper on the future of health and care. CoM have heard about, and provided comments on, the following:

- Potential developments included as part of the Humber Acute Services Review, including how our local hospitals across the Humber are working together within some specialties to deliver safe and sustainable services for the future
- The Humber Coast and Vale Out of Hospital work stream, which oversees and supports the development and expansion of community-based services; and
- What the new ways of working could be for the forthcoming changes to the way in which the NHS is structured (subject to parliamentary approval) in relation to the Humber Coast and Vale Integrated Care System, and how this could affect the CCG arrangements locally.

During this time, they have also been supporting the work of the local Primary Care Networks.

Members' attendance

PCN	Attendance
Freshney Pelham (Comprising Fieldhouse Medical Group, Humberview Surgery, Littlefield Surgery, Pelham Medical Group, Woodford Medical Centre)	1
Meridian Health Group (Comprising Open Door Surgery, Quayside Practice, Roxton Practice, Roxton at Weelsby View)	1
Panacea (Comprising Beacon Medical Practice, Birchwood Medical Centre, Chantry Health Group, Clee Medical Centre, Core Care Family Practice, Dr B Biswas-Saha, Dr A Kuma, Dr R Mathews, Dr O Z Qureshi, Dr A Sinha, Dr P Suresh Babu, Greenlands Surgery, Healing Partnership, Lynton Practice, Raj Medical Practice, Scartho Medical Practice)	1
Executive Director with responsibility for ASC strategic commissioning	1

Governing Body

Throughout the last year the NHS again experienced many challenges as we moved into the second year of a global pandemic. The Governing Body met virtually four times in the last year, with the meetings being broadcast on the CCG website as an opportunity for the public to join the meeting. A focus of the Governing Body has been to discuss the new arrangements of the Integrated Care System, and the Place Based arrangements, including the arrangements for the transition. From the outset, the Governing body formed a 'Risk committee' who met virtually on regular basis and reported back to the entire Governing Body to ensure they were kept abreast of all developments throughout the pandemic.

The mission of NHS North East Lincolnshire Clinical Commissioning Group is delivering to the people of North East Lincolnshire the best possible independent healthy living through joined up solutions. The Governing Body promotes good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

The Governing Body has statutory responsibility for:

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

The Governing Body received regular reports on the following standing items:

- Finance Report, including the approval of the annual disclosure statements
- Quality Report
- Safeguarding Report
- Covid – 19 Pandemic Update
- Previous minutes of the sub-committee meetings

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

- Annual Remuneration Committee self-assessment
- Annual Quality Governance Commissioning Committee self-assessment
- Annual Integrated Governance & Audit Committee self-assessment
- Business Continuity Plan
- Social Prescribing
- End of Year Assessment Update
- Terms of Reference – Statutory Governing body committees
- Information Governance Framework
- EPRR Assurance Report
- 2021/22 System Seasonal Plan
- Community Forum Assurance
- Equality and Diversity Report
- Planning / Recovery Planning

- 2021/22 Operational Plan Assurance Report
- Whistleblowing Case
- Feedback from the IG&AC

The September AGM reported on positive developments, performance, and clinical priorities over the year.

Members' attendance

Members	Attendance (maximum of 4 meetings)
Mark Webb (Chair)	4
Dr Peter Melton	3
Dr Ekta Elston	3
Dr Renju Mathews	2
Dr Jeeten Raghwani	3
Dr Chris Hayes	3
Philip Bond	4
Tim Render	3
Rob Walsh	4
Helen Kenyon	3
Laura Whitton	4
Jan Haxby	4
Steve Pintus (retired June 2021)	0
Joe Warner	4
Anne Hames – standing attendee (non-voting)	4
Joanne Hewson – standing attendee (non-voting)	2

Community Forum

The Community Forum is an essential part of the CCG's governance arrangements, existing to provide the CCG Governing Body with assurance that patients, service users, carers, and the public are being effectively engaged and involved in the decisions which are made about health and social care services in North East Lincolnshire.

Community Forum members are appointed to a specific Community Lead role with a service area, committee or working group, working as equal partners with service and clinical leads from the CCG. The purpose of appointing Community Leads into these positions is to create a framework whereby there is assurance that the public have a direct say in what services are commissioned and drive the commissioning strategy of the CCG.

The Community Forum meets monthly, however during the pandemic face-to-face meetings have not been possible, so these meetings have been held on Microsoft Teams for the past two years. This enabled the Forum to meet every month during 2021/22, with the meetings being well attended and all were quorate. Each meeting is attended by a member of the CCG Leadership Team, alongside the CCG Deputy Engagement Lead and CCG administrative support. Service and Clinical Leads from the CCG and partners attend to update the Forum on the latest developments and projects.

The CCG Governing Body receives the minutes from Community Forum meetings, along with an annual assurance report which is presented by the Chair who attends Governing Body meetings.

Community Forum highlights for 2021/22 include:

- Receiving quarterly CCG Engagement Activity reports to monitor CCG performance against the 'Talking, Listening and Working Together' Engagement Strategy.
- Giving feedback to the CCG about community perceptions and views regarding access to Primary Care services during the Covid Pandemic.
- Discussed and contributed to discussions regarding the future of the Community Forum, and the future approach to engagement at Place as part of the wider Integrated Care Board.
- Considered and commented on the CCG response to the Covid19 pandemic including recovery plans, infection rates, and the vaccination roll out.
- Received information and commented upon presentations by speakers including Primary Care, Mental Health, Adult Social Care, Equality and Diversity, hospital discharge and Humber Acute Services.

As a result of the CCG responsibilities being transferred to the HCV Integrated Care Board, the Community Forum held its final meeting in March 2022, where their enormous contribution to health and care services in the area was recognised.

Several long serving members of the Forum have decided to take this opportunity to retire from their roles; a decision which they made in 2021, when it was planned that CCG's would be disbanded in April 2022. However, the remaining five members are now working with the North East Lincolnshire Health and Care Partnership and the Accord Steering Group to develop a new model for health and care engagement in the area.

With the transition to the new arrangements at HCV having been put back to July 2022, and the CCG continuing to hold the legal 'duty to involve', the assurance role of the Community Forum will be discharged during the transition period by establishing an Interim Patient Assurance Group.

The Group will comprise of five members of the Accord Steering Group and five former Community Forum members and will be facilitated by the CCG Patient and Public Involvement Lay Member who will also provide a link into the CCGs Risk Committee and Governing Body.

Members' attendance

Members	Attendance (maximum of 11 meetings)
Anne Hames (Chair)	11
Albert Bennett	11
Jean Cross (left 31 March 2022)	07
Eveline Dawson (left 31 March 2022)	09
Diane Edmonds	09
Christine Foreman (left 30 April 2021)	01
Bernard Henry	10
Marie Linford (left December 2021)	06
Terry Simco (left 31 March 2022)	11
Pam Taylor	10
David Walker	07
Peter Vickers	08

Statutory Committees

Integrated Governance & Audit Committee

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

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

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

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

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

- Delivery of the committees annual workplan
- Focus on the following key system changes & the management of the risk associated with them
  - Transitional arrangements linked to the establishment of the Humber & North Yorkshire ICB
  - Development of the NEL place based arrangements (NEL Health & Care Partnership)

The committee met 5 times during 2021/22 and records show that all the meetings were quorate.

Members' attendance

Members	Attendance (maximum of 5 meetings)
Tim Render (Chair)	5
Dr Karin Severin	0
Councillor Margaret Cracknell	5
Joe Warner	5
Philip Bond	5
David Walker	3

Primary Care Commissioning Committee

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

It is a committee comprising representatives of the following organisations:

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

During the reporting period, the committee held virtual meetings throughout the year, receiving both quality and finance data reports regarding primary care and taking decisions where these were required.

A decision was made by the Chair to cancel the February meeting there was only one paper that required a decision, this was shared virtually for consideration/approval. A virtual decision log is held to record virtual decisions.

Members' attendance

Members	Attendance (maximum of 4 meetings)
Mark Webb	4
Philip Bond	4
Laura Whitton	3
Dr Ekta Elston/Dr Anupman Sinha	0
Dr Renju Mathews	0
Steve Pintus (left 17 July 2021)	1
Councillor Margaret Cracknell	4
Jan Haxby/John Berry (left 28 February 2022)/Lydia Golby	4
Derek Ward (joined March 2022)	0

Remuneration Committee

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

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

The committee receives regular reports on:

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

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

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

In 2020/21 members and attendees were:

Members	Attendance (maximum of 1 meeting)
Mark Webb (Member) (Chair)	1
Tim Render (Member)	1
Dr Sudhakar Allamsetty (Member) (left January 2021)	0
Dr Jeeten Raghwani (Member)	1
Rob Walsh (in attendance)	1
Laura Whitton (in attendance)	1
Rachael Adams (HR representative) (in attendance)	1

Governing Body Committees

Risk Committee

The Governing Body began to meet regularly in 2021/22, however, the Risk Committee continued to meet regularly, to update its members on the standard items of Covid 19 Infections update; the Covid-19 Vaccination Programme Update; and the Integrated Care System (ICS) Update

The committee were also updated on system planning; system pressures; Recovery Plans; Social Prescribing update; Whistleblowing Report; SEND inspections' Oncology Service update; Mental Capacity Act 2005 (MCA) and Liberty Protection Safeguards (LPS) – Risk issue; Hull University Teaching Hospital, Covid19 nosocomial infections and declared Serious Incident and Implications of delayed start of the Integrated Care Board (ICB) for formal reporting and decision-making in the CCG.

The following reports are presented at each meeting:

- NE Lincs COVID-19 Tracking Report
- Summary of Current Covid-19 Epidemiology
- Vaccination Programme Report

Members' attendance

Members	Attendance (maximum of 19 meetings)
Mark Webb	18
Rob Walsh	13
Philip Bond	16
Tim Render	15
Laura Whitton	16
Dr Peter Melton (Attending as clinical representative)	15

Quality Governance Committee

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

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

During 2021/22 four Quality Governance Meetings took place all of which were quorate

Members	Attendance (maximum of 4 meetings)
Jan Haxby – Clinical representative	3
Dr Ann Spalding – GP representative	4
Dr Ekta Elston – GP representative	1
Philip Bond – Community lay member representative	4
Bernard Henry – Community lay member representative	2
Nicola McVeigh – Chair of MIFS	3
Lydia Golby – Clinical representative	4
John Berry (left February 2022) – Clinical representative	1
Julie Wilburn – clinical representative	3
Zoe Wray – Quality & Experience team manager	2
Julie Wilson – Commissioning representative	2
Ryan Jewitt (joined August 2021) – Commissioning representative	2

Care Contracting Committee

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

The Committee also oversees all procurement processes ensuring that they are enacting decisions taken by the Council of Members and that the CCG is compliant with external regulations and requirements including relevant procurement law.

The Committee oversees all the CCGs contracts except for those which relate solely to General Practice, for example, Primary Medical Contracts and General Medical Contracts. These will be managed by the CCG's Primary Care co-commissioning committee (PCCC).

During 2021/22 ten CCC meetings were held, and all were quorate.

Members	Attendance (maximum of 10 meetings)
Helen Kenyon – Chief Operating Officer - Chair	9
Mark Webb – Lay member (Governing Body)	10
Bev Compton – Director of Adult Social Services	7
Christine Jackson – Head of Case Management Performance & Finance - focus	7
Laura Whitton – Chief Finance Officer	10
Jan Haxby – Director of Quality and Nursing	7
Dr Ekta Elston – Medical Director	3
Anne Hames (left February 2022) – Community representative	8
Dr J Raghwani – GP representative	9

Proposed Changes for 2022-23

CCGs will be dissolved on the passing of the Health & Care Bill through parliament and NHS Integrated Care Boards (ICBs) will be created. This is scheduled to come into effect on the 1 July 2022. Place-based partnerships, co-terminus with local authority administrative boundaries, will form a key part of these new arrangements alongside 4 provider collaboratives (Acute, Mental Health, Community & Primary Care)

The Council and the CCG in North East Lincolnshire have had a strong partnership over a number of years staring with the creation of the Care Trust Plus in 2007 and continuing under the "Union" arrangements, with shared leadership and governance arrangements, combined resources and integrated teams operating across the health and care system – underpinned by a Section 75 Agreement entered into under the National Health Service Act 2006. This provides a strong and credible foundation for NEL place to build upon to respond to the challenges and the opportunities presented by the Health & Care Bill, and a Health & Care Joint Committee is expected to be formally in place once the new statutory arrangements come into place.

UK code of corporate governance

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

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

Discharge of the CCG's statutory functions

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

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

Risk management arrangements and effectiveness

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

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

The CCG risks are maintained one either the Board Assurance Framework (BAF) or the Risk Register. Risks that may affect the ability of the CCG to meet its strategic commitments are recorded on the Board Assurance Framework and operational risks are recorded on the CCG Corporate Risk Register. Initially risks are subject to agreement by senior managers to ensure that the full consequences of the risk have been considered in relation to it actual impact on the CCG and enable effective risk mitigation. Significant risks are reported to the relevant committees.

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

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

An internal audit review of our risk management arrangements took place during 2021-22 which was part of a wider review, including Governance arrangements. The internal audit review provided

"**High**" assurances that the CCG has an effective framework in place for providing assurance to the Governing Body on the management of risk, including the Board Assurance Framework reported at Governing Body and the Board Assurance Framework and Corporate Risk Register reported at the Integrated Governance and Audit Committee meetings. These include a summary that highlights the number of risks, any changes, plus new and closed risks. Testing of a sample of meeting minutes of the Integrated Governance and Audit Committee found that both the Board Assurance Framework and Corporate Risk Register had been regularly reported and reviewed.

The CCG has appropriate processes in place to identify, assess, report, control and monitor risks, including the recording of risks on the CCG's Pentana system. Audit testing found that the risk management processes in place reflect the system of risk management outlined in the CCG's Risk Management Framework. The Strategic Risk Register and Corporate Risk Register are regularly updated, monitored, and reviewed.

The CCG does not have a specific 'Risk Appetite Statement' which describes the CCG's attitude towards risk and their tolerances etc. However, the Risk Management Framework makes reference to Risk Appetite and details domains for different aspects of risk and the subsequent severity levels in a separate appendix.

The risk management process is supported by aligned policies and procedures, including business continuity, counter fraud, and standard of business conduct

The CCG actively involve Public Stakeholders in managing risks, this is done, through the community forum and lay membership of the CCG's committees. These measures are in place to ensure that CCG decision making processes are transparent, to ensure that community engagement continues to be embedded in this process and, ultimately, to provide further assurance to the organisation.

Unfortunately, the proposed Governing Body workshop for September 2021 was cancelled, with plans to review/link Strategic Objectives to both the BAF and Risk Register. However, the pandemic and the impending transition to the Integrated Care Board (ICB) impacted on the ability to complete this work and it will therefore be picked up as part of the CCG's transition into the ICB.

In addition, the CCG has produced a high-level Place Based Strategy which includes a 'North East Lincolnshire Health and Care Governance and Operating Model'. This has been presented to and approved by the Governing Body, the Health and Care Partnership and the Union Board.

Capacity to handle risk

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

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

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

The CCG's Governing Body is responsible for overseeing the risks identified within the organisation and for gaining assurance that the CCG is addressing risks that are considered as strategic and obtaining assurance to satisfy itself that the CCG is fulfilling its organisational responsibilities and

public accountability. The Governing Body uses the Board Assurance Framework and exception reports from its committees to assist achievement of its goals and provides a clear commitment and direction for risk management within the CCG.

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

- CCG employees receive training in Equality and Diversity and Equality Impact Assessments are completed for all service proposal, service specification, strategy, policies so that the full impact on protected groups is identified and considered.

- The CCG has policies in place to encourage employees to highlight risks and report incidents and the Whistleblowing Policy highlights the importance the CCG places upon the open reporting culture.

- Staff and GPs are encouraged to report any concerns through the incident reporting system and each incident is reviewed and investigated as per the CCG incident management policy.

Risk assessment

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

2021-22 has been another challenging year for the CCG working under different circumstances, priorities, and pressures. It was evident that we needed to re-consider our approach to risk management. Risk management become a more integrated approach covering performance and CCG priorities with a single monitoring reporting via the CCG Operational Leadership Team and reporting to the Integrated and Audit Committee. However, due to the further pressures namely in relation to COVID 19 this approach has been put on hold. However, risks continue to be monitored using the 3-month systematic approach.

It was agreed at the Integrated Governance & Audit Committee in December for the Chair, Chief Finance Officer and Corporate Assurance Officer to undertake a deep dive risk review and define the risks associated with the transition/ developments of the Integrated Care Board and the Health Care Partnership and how these will be managed.

North East Lincolnshire Clinical Commissioning Group compared with neighbouring CCGs will have more operational risks on their risk register due to the partnership working with North East Lincolnshire Council in relation to the commissioning of Adult Social Care. As at Quarter 4 2021/22 there were **three** Adult Social Care risks on the risk register.

As at quarter 4, the total risks held on both Board Assurance Framework and the Risk Register at the end of 2021/22 with a residual risk rating being assessed as high level (15+) was **nine** opposed to **six** as at 2020/21 and are listed in the table below.

Risk Code	Risk Summary	Current Risk rating	Current Risk Trend	Control	
CCG-BAF.3006	Covid-19	15		**Assurance on controls**	All working groups on Covid-19 have action plans which are regularly updated. The Union Outbreak Control Steering Group meets monthly and updates the NEL Outbreak Management Plan. Covid-19 is a strategic risk for NELC and both CCG and NELC staff are involved in its mitigation. CCG Covid 19 Risk committee oversees the work undertaken and decisions made as part of the covid response on behalf of the Governing Body
				Positive Assurances	• Leadership Team • NEL Covid 19 outbreak control steering group • Senior Leadership Team (CCG) • HCV Strategic Group • Northern Lincolnshire A&E Delivery Board • Risk committee • Humber Health Cell
				Gaps in controls	The CCG business continuity plan has been reviewed, but there are still some gaps in support from NELC IT including an out of hours number to call for issues. The CCG relies heavily on IT solutions as a fully agile workforce. Test and trace can cause absences to health and care staff due to contact tracing Staff absences can surge with Covid-19 spread, particularly in schools. For example, when the schools returned in September 2021, there was a surge in staff absence associated with children being sent home and staff needing to be off for childcare, or due to positive cases resulting from school spread. This has been mitigated slightly as a lot of restrictions in schools have now been relaxed.
				Gaps in assurances	None

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

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

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

				ongoing professional development	
				CCG-RR.2014h Light touch approach for cases	We have implemented part of the light tough approach. Work continues to develop the light touch approach and pilot with urgent and discharge cases. As the light touch approach has not reduced the backlog it has been redeveloped to allow staff to test out skills that will be needed when the LPS comes into effect 1/4/22.
				CCG-RR.2014j Attendance at the regional BIA forum (ADASS)	Regular attendance at the regional forum provides the opportunity to share good practice and keep pace with national developments. It also provides independent training for BIAs to maintain their competence.
				CCG-RR.2014k MCA Strategic Network	The NEL MCA Strategic Forum, has now become a formal subgroup of the Safeguarding Adults Board to ensure spread of strategic development and commitment
				CCG-RR.2014l BIA and MHA capacity	Work is being carried out by the CCG and Focus to work up data on the impact of reducing the DoLS backlog to zero within 12 months. Presented to Cabinet Feb 19 with request for further work especially on DoLS. Work is ongoing to review a new option that would focus on certain risk categories. A training programme has been commissioned for BIA training and 10 NEL staff have been put forward. There continues to be pressure on the system to allow BIAs to partake of the duty rota, this is the reason as to why the risk remains partially effect. To help reduce some of the pressure Focus have identified that the present assessment budget has been exhausted and there is potential for an overspend if work continues in this financial year. Focus have looked at mitigating plans and funding and a paper is being developed for CCC to seek alternative ways to meet the assessment requirement. Focus are continuing to develop a light touch approach to assessment in line with guidance as well as the use of virtual assessments where possible. Focus are due to report on DoLS assessment activity, however because of COVID-19 it is not expected that the overall back log will have changed. Focus have reviewed activity and are now anticipating that there will be little reduction in the backlog. Due to LPS being delayed to 2022 this will also put pressure on the number of assessments that will need to be carried out as we are not able to rely on an "equivalent assessment" for a second year. Focus are looking at how much they are able to move towards the new LPS system without compromising the legality of the present process. Work to "pilot" an approach to DoLS that could align with LPS continues but this has been much slower as a result of the COVID-19 pandemic as Care Homes have found it difficult to spare extra time to input into the process. BIA training is continuing however the COVID pandemic has had an impact on the length of time this is taking. The Pandemic has also meant that pressure on staff to fulfil more activity in their substantive roles that there has been more pressure on the availability of BIAs. A scoping tool is being developed locally to identify the specific areas of pressure when the LPS comes into effect. The ICS is also looking at scoping the impact of LPS as it will become responsible for any CHC client who needs to have their deprivation of liberty authorised via the LPS. there is still no clarity from DHSC about the implementation date for the LPS. Work continues to ensure that should the 1st April 2022 date still happen the CCG are prepared. In light of the transfer of CCG functions to the ICB work has started to share NEL practice with NL CCG. The draft code for LPS and the Draft Regulations have now been released for consultation Work is being carried out in place, across northern Lincolnshire and the ICS to review them and to look at shared

					models to improve capacity or resilience. The CCG will be running a number of consultation events before submitting feedback both as a CCG/LA and as part of the ICS
				CCG-RR.2014m Monitoring of activity at DAC and Safeguarding Board	The risks are monitored as part of the strategic plan and reviewed on a regular basis by the Chair (Jan Haxby NELCCG) and via the Safeguarding Adults Operational Leadership Group. The NEL MCA Strategic Forum has now become a formal subgroup of the Safeguarding Adults Board to ensure spread of strategic development and commitment. Work programme presented to SAB and agreed
				CCG-RR.2014n Joint working with NELC legal team	Help and support to develop and deliver a process for applications to the court of protection for deprivations in non-standard settings. Providing front-end legal advice to practitioners. Staff changes within NELC legal and the demand for CoP DoLS is putting pressure on the ability of the legal team to carry out work in a timely manner - discussions to mitigate this has started

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
CCG-RR.4026	Leavers processes are not consistently being followed which could pose security and financial risks for the CCG	16		CCG-RR.4026a Information asset reviews	Information Asset Register reviews are conducted at least annually. This is a requirement for compliance with the Data Security Protection Toolkit (DSPT)
				CCG-RR.2026b Leavers' process	There are various leavers processes Line Managers are required to follow to remove access to accounts when staff leave or change roles within the organisation i.e.: • Managers/pre post checklist • NHSmail Joiners/leavers process
				CCG-RR.2026c Security group reviews	Security reviews are conducted at least annually in-line with the annual IAR reviews, and any inconsistencies or errors are highlighted and corrected.
				CCG-RR.2026d Secondment agreement	When individuals go on secondment, they are likely to take their equipment /NHS mail account with them and may retain access to some CCG systems depending on the job role. Secondment must therefore be considered on a case-by-case basis. Access is being removed to shared mailboxes and w-drive where appropriate, but seconded staff members do need to remain on HQ distribution lists as they are members of staff and as such need to be kept updated on any changes within the organisation.
CCG-RR.2003	On-going failure to meet Clinical Handover time targets for EMAS patient delivery at DPoW A&E	15		CCG-RR.2003c EMAS Contract Management Meeting	This divisional monthly meeting addresses performance, quality and strategic issues. Commissioners can challenge EMAS and escalate any issues to the lead commissioner (Derby & Derbyshire CCG).
				CCG-RR.2003d EMAS recovery and restoration meeting	There is one meeting at the EMAS level and a further one is being established at the greater Lincolnshire level to maximise Executive time and ensure we achieve a greater level of traction and comparison with Lincolnshire and use of SPA and conveyance attendance. The purpose of this meeting is to compare the current data with the Covid data to understand the differences in numbers of conveyance of patients and the increasing trend in transporting patients taking place now.
				CCG-RR.2003e Northern Lincolnshire EMAS transformation Group	The Greater Lincolnshire EMAS Contract meeting, as conveyance puts pressure onto the system which leads to potentially longer handovers. This meeting has oversight of the NHS 111 First meeting to again look into the reduction of conveyance as first step to reduce handover delays. This group includes NEL AD Contracts lead, Lincs Dir of Commissioning and Lincs Head of Urgent care and EMAS Divisional manager Lincolnshire. This meeting then feeds into the EMAS Overall Contract performance discussions on monthly basis covering issue of performance delivery and improvement.

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
CCG-RR.3012	Inability to deliver ASC statutory duties on behalf of NELC within the allocated Budget in year	15		CCG-RR.3012b Monthly budget monitoring	The activity budgets are monitored through a joint commissioning finance meeting with focus and the CCG. Areas of concern are escalated to FPB on an exception basis Non activity budgets are monitored with individual budget holders.
				CCG-RR.3012c Financial Programme Board	Financial Programme Board has detailed oversight of the key budgets for adult social care specifically those for residential, nursing and domiciliary care and can therefore ensure that demand is being appropriately managed. The FPB also has oversight of a range of efficiency and improvement measures which have been designed to ensure best use is made of the budget and that we are planning expenditure in line with budget.
				CCG-RR.3012d Corporate Reporting process	The internal controls 3012a to 3012c all contribute to corporate reporting.
				CCG-RR.3012e CCG strategic oversight meeting	A fortnightly oversight meeting is held CCG representatives in attendance. This oversight group actively discuss measures to address the budget gap and ensure we make best use of available resources

Other sources of assurance

Internal control framework

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

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

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

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

Throughout the year a series of audits continue to be undertaken to review the effectiveness of governance systems. The finalised reports and agreed action plans from these audits are submitted to the Integrated Governance and Audit Committee. All audit reports contain action plans of work required as a result of the review findings. All actions are assigned to a responsible manager to complete within the designated timescales.

High assurance has been given, that the system of internal control has been effectively designed to meet the organisation's objectives, and that controls are being consistently applied.

Conflict of interest management

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

Our internal auditors have independently reviewed the organisation's arrangements for managing conflict of interest and an overall opinion of "**High assurance**" has been provided. This demonstrates that there are effective arrangements in place to manage conflicts of interest in how the CCG conducts its business, they are acting fairly and transparently and in the best interests of their patients and local populations, through managing conflicts of interest as part of their day-to-day activities.

The CCG is required to publish any breaches in relation to the CCG's Conflicts of Interest Policy. Breaches register for the period December 2020 - November 2021 and be found **here**

Management of conflict-of-interest module one training is mandatory for

- CCG Governing Body Members
- members of formal CCG committees and sub-committees
- Primary Care Commissioning Committee members
- clinicians involved in commissioning or procurement decisions
- CCG governance leads
- anyone involved or likely to be involved in taking a procurement decision(s)

The CCG achieved the required levels of training for 2021-22 at 92.9%. which is above the required target level of 90%.

Data quality

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

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

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

Information governance

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

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

The Information Governance Steering Group provides assurance to the Integrated Governance & Audit Committee, that the CCG is compliant with relevant & mandatory legislation and that effective information governance best practice mechanisms are in place within the organisation.

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

The CCG undertakes reviews of the CCG information asset and data flow register (at least annual) it is the responsibility of the Information Asset Owners (IAOs) to manage information risks to the assets within their control. We have also carried out numerous Data Protection Impact Assessments (DPIA's) across all relevant areas a summary report is available on the CCG website.

The CCG has published privacy notice on its website, which informs what personal information the CCG holds and processes, the legal basis for doing so and the purposes. This notice was reviewed within year to ensure its accuracy

With the establishment date for the Integrated Care Board delayed until 1 July 2022 the CCG are required to submit a DSPT by 30 June 2022. However, CCGs are not required to submit a DSPT audit for 2021-22.

The CCG submitted there DSPT on 26 May 2022.

Training

We ensure all staff undertake the annual Data Security Awareness Training. The SIRO, Caldicott Guardian and Information Asset Owner also complete specialist training. We continue to provide staff with a series of briefings and information governance handbook is available to all staff to ensure they remain aware of their information governance roles and responsibilities in relation to confidentiality, data protection and information security.

As cyber security is probably one of the biggest risks to us as an organisation and remote working demands a greater focus on cyber safety. To help raise awareness, we have introduced cyber security training to be completed by 30 June 2022 and various communications and awareness has been circulated to staff.

BREXIT EU Exit

On 28 June 2021 the EU Commission adopted Adequacy Decisions for the UK under the EU's GDPR and Law Enforcement Directive, determining that the UK provides adequate protection for personal data transferred from the EU to the UK under the EU GDPR. This means that most personal data can continue to flow from the EU and the EEA without the need for additional safeguards. The adequacy decisions do not cover data transferred to the UK for the purposes of immigration control, or where the UK immigration exemption applies. For this kind of data, different rules apply, and the EU sender needs to put other transfer safeguards in place. However, this should not have any real impact on the CCG.

Adequacy decisions are made for a maximum of four years, and the EU's Adequacy Decisions for the UK will therefore expire on 27 June 2025 unless extended. Please note that Adequacy Decisions can end earlier, as the Commission will monitor developments in the UK on an ongoing basis to ensure that the UK continues to provide an equivalent level of data protection. Also, EU data subjects or an EU data protection authority can initiate a legal challenge to adequacy decisions, through The Court of Justice of the European Union who would then have to decide whether the UK did provide essentially equivalent protection.

Prior to the EU's UK Adequacy Decision, the CCG had reviewed its processing of personal and special category data, to determine what data flows it has with the EU / EEA including the hosting of systems, to ensure that appropriate safeguards were or could be put in place in the event of the UK not getting an adequacy decision.

Going forward the CCG will need to continue to identify and document any transfers of personal data to the EU/EEA or other third country transfers to ensure that they are lawful and covered by Adequacy Decisions, Appropriate Safeguards or a Derogation and be prepared if any current Adequacy Decisions are challenged or not renewed.

Business critical models

The main CCG critical model is our long-term financial model, the output of which is subject to NHS England assurance and audit review. As part of this process, and to provide effective risk management, there is a range of business-critical models in place. The CCG maintains and organisational Information Asset Register (IAR) which identifies business critical, HR, Business Intelligence, and financial assets. Each asset has the required level of professional and management input and known as Information Asset Owners (IAO). Data flow mapping also forms part of the IAR, which provides an understanding of the flows of the information.

Business continuity plans are in place and regularly reviewed to ensure that controls are in place and any risks are mitigated appropriately.

Third party assurances

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

During 2021/22 the CCG contracted with several external organisations for the provision of support services.
This specifically includes:

Organisation	Service
North East Commissioning Support (NECS)	• Individual Funding Request (IFR) • Medicines Management • Non-Contract Activity Support • Data Services for Commissioning Regional Offices (DSCRO) support
N3i	• GP information management and technology services • Specialist Information Governance
North East Lincolnshire Council	• Human Resources • Corporate IT • Adult Social Care Support Services (notably finance)

Other bought in support services include payroll services from Northumbria Healthcare NHS Foundation Trust.

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

- External assurance eg. Service Auditor reports
- Work undertaken by Audit Yorkshire and the internal auditors of North East Lincolnshire Council.
- Internal work undertaken by the CCG
- Routine monitoring of the contracts we have in place throughout the year.

There were a number of qualified Service Auditor Reports in 2021/22:

- **NHS SBS shared Business Services Limited –** controls related to performing annual inspection of fire alert and water detecting systems did not operate effectively during the period 1st April 2021 to 31st March 2022
- **NHS Business Services Authority -** controls were not in place to provide appropriate periodic review of user access, and in a number of instances the controls related to timely removal of leavers' access to applications and the network did not operate effectively. As a result, controls were not suitably designed and did not operate effectively during the period 1 April 2021 to 31 March 2022 to achieve the control objective

- **Capita Business Services** – provide a range of payment and pension administrative services under the PCSE contract. It was identified that a number of primary and secondary

controls were not operating effectively, and these exceptions have resulted in the non-achievement of certain key control objectives.

The outcome of Internal Audit reviews of key systems (including any control weaknesses) is summarised elsewhere in this Annual Governance Statement.

Where it is possible to do so, the CCG has local mitigation and control measures in place to address the weaknesses summarised above.

Control issues

Reflecting on our performance for 2021/22 our system has performed well against a number of challenging targets. Although we had planned to meet all national planning standards and commitments in 2021/22, this has not been possible for some of our commissioned services due to the current pandemic. The performance analysis highlights the significant challenges identified in year. Although concerns have been highlighted, we do not consider any a serious lapse in internal control

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

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

The CCG have robust financial procedures, controls, effective financial management, and financial planning arrangements in place. The CCG has produced an annual financial plan, in line with NHS England's planning guidance. The Chief Finance Officer provides routine reports to the CCG's Integrated Governance & Audit Committee, and the Governing Body on financial performance, including performance against the organisation's statutory financial duties.

Whilst the CCG recognises the need to achieve cost reductions through the delivery of savings from the Quality, Innovation, Productivity and Prevention (QIPP) programme. Work on specific QIPP programmes has been restricted in 2021-22 due to COVID. As we move out of the pandemic and back to business as usual in 2022-23, there will be a requirement to refocus on QIPP alongside embedding the transformative ways of working that took place during COVID.

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

The Integrated Governance & Audit Committee reviews the CCG's annual accounts prior to formal approval by the Governing Body.

The CCG's rating for the Quality of Leadership (165a) as part of the CCG oversight framework are published here. There are currently no in year updates available for 2021-22

Delegation of functions

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

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

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

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

Counter fraud arrangements

The CCG has a team of accredited Local Counter Fraud Specialists (LCFSs) that are contracted to undertake counter fraud work proportionate to identified risks. In January 2021, the NHS Counter Fraud Authority (NHSCFA) rolled out new counter fraud requirements for NHS-funded services in relation to the Government Functional Standard GovS 013: Counter Fraud (Functional Standard). From April 2021 all NHS services were required to provide assurance against the Functional Standard. This should be overseen by the organisation's accountable board member and audit committee/governing body and in line with the organisation's existing approach to assurance against counter fraud requirements. The work plan for 2021/22 followed the requirements of the standard and described the tasks and outcomes that informed anti-fraud activity.

There are 12 components within the Functional Standard which are sub divided as:

- Governance which outlines how the organisation supports and directs counter fraud, bribery and corruption work undertaken to create a strategic organisation-wide response when combatting fraud, bribery and corruption.

- Counter Fraud Bribery and Corruption Practices, which outline the organisations operational counter fraud activities undertaken during the year when detecting and combatting fraud.

The CCG's counter fraud arrangements are underpinned by the appointment of accredited LCFSs, the CCG-wide countering fraud and corruption policy, the nomination of the Chief Finance Officer as the executive lead for counter fraud and a Counter Fraud Champion at a strategic level, providing access to relevant staff groups, and encouraging staff to engage with fraud awareness initiative.

The CCG's Integrated Governance and Audit Committee reviews and approves an annual counter fraud work plan identifying the actions to be undertaken to create an anti-fraud culture, deter, prevent, detect and, where not prevented, investigate suspicions of fraud. The counter fraud team also produces an annual report for each organisation and regular progress reports for the review and consideration of the Chief Finance Officer and the Integrated Governance and Audit Committee.

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 a 'Green' rating for 2021/22. This self-assessment (CFFSR) detailing our scoring was approved by the Chief Finance Officer and Integrated Governance & 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 systems of risk management, governance, and internal control.

The Head of Internal Audit concluded that: -

Our overall opinion for the period 1st April 2021 to 31 March 2022 is

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

In addition to work undertaken by AuditYorkshire, NHS North East Lincolnshire CCG also receives an internal audit service from North East Lincolnshire Council's Internal Audit team for adult social care audits, as defined within a Section 75 Agreement. these are reported through the CCG's Integrated Governance & Audit Committee and where appropriate contribute to the CCG's Head of Internal Audit Annual Opinion.

The range of individual opinions arising from risk-based audit assignments, contained within risk-based plans that have been reported throughout the year.

Core & Risk Based Reviews Issued

We have issued to date:

4 **high** assurance opinions:	Governance and Risk Management Arrangements Conflicts of Interest Contract Management Budgetary Controls and Reporting & key Financial Controls *
0 **significant** assurance opinions:	
0 **limited** assurance opinions:	
0 **low** assurance opinions:	
2 reviews without an assurance rating	Mental Capacity Act – Benchmarking exercise on readiness Recommendation Tracking – Benchmarking exercise

*Draft Report Only

Follow Up

A total of 12 Internal Audit recommendations have been live during 2021/22 (this includes recommendations from previous years' reports that were still live as at 1 April 2021).

During the course of the year, we have undertaken work to track the implementation of Internal Audit Recommendations. The Recommendation clear up summary 2021/22 was as follows:

Overdue	Overdue with Revised Date	0	Implemented	Total	% Overdue
1	1	2	10	12	8%

We can conclude that the organisation has made good progress with regards to the implementation of recommendations. The vast majority of recommendations are implemented on a timely basis. There is one recommendation that is overdue in comparison to the original agreed action date.

The following audits, which have been reported separately by the service provider (North East Lincolnshire Council) are noted here for completeness in providing an overall view of the CCG's internal control system. These are not, however, included in our formal Opinion.

As in 2020/21 the focus of audit work has had to be realigned due to the impact of the Pandemic, in particular providing continued assurance on Infection Control Grants to care providers. We also provided assurance that the required Better Care Fund 2021/22 submission had been drafted using the standard templates and guidance.

The table below shows final reports issued

1 **substantial** assurance opinions:	Adult Social Care Debt Management
2 **Satisfactory** assurance opinions:	Adult Social Care Performance Management Direct payments (Prepaid Cards)
1 **limited** assurance opinions:	Rest and Reablement (Cambridge Park) 3 actions identified all due to be implemented by April 2023

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

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

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

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

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

Throughout the year a programme of audits has been undertaken to review the effectiveness of governance systems. The report from these audits are submitted to the Integrated Governance & Audit Committee. All audit reports contain action plans of work required because of the findings. All actions are assigned to a senior manager with responsibility to complete within the selected timescales.

There is a formal process in place to follow up on outstanding actions, progress against outstanding actions are reported in regular progress reports to the Integrated Governance & Audit Committee, with specific attention drawn to any actions where the target date has been put back, or where no update has been received from officers within the CCG.

The integrated governance and audit annual report, was presented to the Governing Body in February 2022, detailing the outcomes of the review of the effectiveness of the committee. The report assured the members of the effective governance arrangements of the organisation, and specifically that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently, and economically and in accordance with the group's principals of good governance.

Conclusion

With the exception of control issues that I have outlined in this statement, my review confirms that NHS North East Lincolnshire Clinical Commissioning Group overall has a sound internal control framework which includes robust governance and risk management systems that support the achievement of its policies, aims and objectives. We continue to put in place mitigating actions to address those risks that have been identified; no other significant control issues have been identified in year.

Dr Peter Melton
Clinical Chief Officer
16 June 2022

Remuneration and Staff Report

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

Details of our Remuneration Committee's membership, highlights and number of meetings, and individual attendance during 2021-22 are detailed are provided within our Annual Governance Section.

Senior managers' contracts and payments

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

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

Salaries and allowances (Subject to Audit)

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

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

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

2021-22 Name	Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) All pension related benefits (bands of £2,500) £000	(f) Total (a to e) (bands of £5,000) £000
Stephen Pintus	Director of Public Health	0-5					0-5
Dr Ekta Elston	Vice Chair Council of Members/Medical Director	65-70				2.5-5	65-70

2020-21 Name	Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) All pension related benefits (bands of £2,500) £000	(f) Total (a to e) (bands of £5,000) £000
Dr P Melton	Clinical Chief Officer	85-90					85-90
Rob Walsh*	Chief Executive –NELCCG/NELC	30-35					30-35
Mark Webb	Chair	20-25					20-25
Helen Kenyon	Chief Operating Officer	100-105				22.5-25	125-130
Jan Haxby	Director of Quality & Nursing	85-90				17.5-20	105-110
Laura Whitton	Chief Finance Officer	95-100				20-22.5	120-125
Philip Bond	Lay Member Community Engagement	5-10					5-10
Dr Renju Mathews	GP Representative	5-10					5-10
Dr Jeeten Raghwani	GP Representative	5-10					5-10
Tim Render	Lay Member Audit & Governance	10-15					10-15
Dr Sudhakar Allamsetty	Vice CCG Chair/Chair of Council of Members	15-20					15-20
Dr Chris Hayes	Secondary Care Doctor	10-15					10-15
Joe Warner	Governing Body Social Care Representative	0-5					0-5
Stephen Pintus	Director of Public Health	0-5					0-5
Dr Ekta Elston	Vice Chair Council of Members/Medical Director	65-70				122.5-125	185-190

Pension benefits (Subject to Audit)

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

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

Name and Title	(a) Real increase in pension at age 60 (bands of £2,500)	(b) Real increase in pension lump sum at aged 60 (bands of £2,500)	(c) Total accrued pension at age 60 at 31 March 2020 (bands of £5,000)	(d) Lump sum at age 60 related to accrued pension at 31 March 2020 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2019	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2020	(h) Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Jan Haxby Director of Quality and Nursing	0-2.5	15.0-17.5	35-40	115-120	852	36	904	
Helen Kenyon Chief Operating Officer	0-2.5	0-2.5	45-50	95-100	796	27	841	
Laura Whitton Chief Finance Officer	0-2.5	0-2.5	35-40	90-95	773	29	819	
Dr Ekta Elston Vice Chair Council of Members/Medical Director	0-2.5	0-2.5	10-15	20-25	177	0	185	

Cash equivalent transfer values

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

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

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. The benefits and related CETVs do not allow for a potential future adjustment arising from the McCloud judgment.

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

Real increase in CETV

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

Compensation on early retirement or for loss of office

Nil return for 2021/2022 – refer to **Note 4** of the Financial Statements.

Payments to past members

Nil return for 2021/2022 – refer to **Note 4** of the Financial Statements.

Pay Ratio (Subject to Audit)

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

The banded remuneration of the highest paid director in NELCCG in the financial year 2021-22 was £120,000 - £125,000 (0% change against 2020-21, £120,000 - £125,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2021-22	25th percentile	Median	75th percentile
Total remuneration (£)	£25,067	£36,509	£47,339
Salary component of total remuneration (£)	£25,067	£36,509	£47,339
Pay Ratio information	4.89	3.36	2.59
2020-21			
Total remuneration (£)	£24,251	£31,739	£44,926
Salary component of total remuneration (£)	£24,251	£31,739	£44,926
Pay Ratio information	5.05	3.86	2.73

In 2021-22, no (2020-21, no) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £9,575 to £103,361 (6.57% against 2020/21: £8,856 to £103,361).

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

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

Staff Report

Staff Composition

The CCG has a staffing establishment of 95.7 whole time equivalents, in its headquarters function, and also has a formal arrangement in place to buy in a range of support services from a number of different providers at a cost of £1.42 Million in 2021/22.

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

Gender	Total (Female)	Total (Male)
Band 8a	6	2
Band 8b	9	4
Band8c	3	1
Band8d	1	1
Band9	0	0
VSM	4	0
Governing Body	1	8
Any other Spot Salary	2	2
All other Employees (including apprentice if applicable)	60	14

Staff Deployment

The CCG is keen to support staff development. There are a number of secondments ongoing, both internally and externally, providing opportunity for staff to expand their skills and knowledge. In the 2021/22 year there has been a total of 10 secondments:

- Four employees seconded externally to partner agencies or other CCGs
- Five employees seconded internally to higher banded posts
- One individual on secondment into NEL CCG from a partner agency

Employee Benefits and Staff Numbers

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

2020-2021	ADMIN Permanent employees £'000	Other £'000	Total £'000	PROGRAMME Permanent employees £'000	Other £'000	Total £'000	TOTAL Permanent employees £'000	Other £'000	Total £'000
Employee benefits salaries and wages	2,933	144	**3,137**	810	-	**810**	3,803	144	**3,947**
Social security costs	308	16	**324**	85	-	**85**	393	16	**408**
Employer contributions to the NHS pension scheme	599	18	**618**	108	-	**108**	707	18	**726**
Other pension costs	-	-	**-**	-	-	**-**	-	-	**-**
Apprenticeship levy	4	-	**4**	-	-	**-**	4	-	**4**
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	-	-	**-**	-	-	**-**	-	-	**-**
Gross employee benefits expenditure	3,905	178	4,082	**1,003**	-	**1,003**	**4,907**	**178**	**5,085**
Less recoveries in respect of employee benefits (note 4.1.2)	(23)	-	**(23)**	(67)	-	**(67)**	(90)	-	**(90)**
Net employee benefits including capitalised costs	**3,881**	**178**	**4,059**	**936**	-	**936**	**4,817**	**-**	**4,995**
Less: employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**3,881**	**178**	**4,059**	**936**	-	**936**	**4,817**	**178**	**4,995**

Sickness Absence Data

The sickness absence data for NHS North East Lincolnshire CCG between 1 April 2021 and 31 March 2022 is below:

Absence	Total
Average sickness %	1.85%
Total number of FTE days lost	632.25

The CCG regularly reviews reasons for absence and all sickness absence is managed in line with the organisations Attendance Management policy. This policy enables managers to address sickness absence issues, both short and long-term, in a fair, consistent and equitable manner. It is recognised however that all cases must be dealt with on an individual basis because of differing circumstances. The CCG provide access to an Occupational Health Service through management

referrals. For individual support, staff can access the Employee Assistance Programme, an internal Wellbeing Officer, or a bank of trained Mental Health First Aiders.

Staff Turnover percentages

	21.22		**20.21**
Average Headcount	109		107
Leavers	10		8
Turnover	9.17%		7.48%

Staff Policies - Diversity and Inclusion

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

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

During 2021/22 the CCG continued to exercise best practice in relation to updating policies and service developments undertaken throughout the year. This involved our active community engagement in assessing and feeding back on policies and proposals through our Equality Impact Assessment panel and specific involvement for communities of interest who may be affected by a particular proposal. All commissioning activity was undertaken within the context and constraints of recovery from COVID and the impact of the pandemic on the NHS and on our local population. Our well-established policies and procedures enabled us to comply with our Public Sector Duties under the Equality Act 2010 and we continued to engage positively with all sectors of our community albeit more via electronic events and conversations rather than face to face opportunities.

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

In terms of workforce, 2021/22 the CCG built on the success of previous years and worked in a focussed way to target recruiting a more diverse workforce in response to the issues surfaced from previous WRES reports, resulting in more diverse groups taking up posts in the organisation which align to the identified proportion of diversity in the local population

Trade Union Facility Time Section

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

Other employee matters

The CCG is a great place to work

The CCG strives to be an employer of choice, which is one of the four aims of the People Strategy for North East Lincolnshire (NEL) Union. In the most recent staff survey, 79% of staff responded that they would recommend the CCG as a place to work. Staff turnover is consistently low, currently at an average of 5%.

When asked what makes the CCG a great place to work, the overriding response was **"the people"**. Staff spoke about colleagues going the extra mile, stepping in to support with work when needed and showing care for each other.

The CCG holds full staff events on a quarterly basis. At these events, awards are given to nominated staff in recognition of hard work and commitment in the preceding quarter. Additionally, the Union operate an annual staff recognition event, Leading Lights.

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

Workplace Health, Safety and Wellbeing

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

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

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

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

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

NEL CCG will comply with legislation as a minimum and strive to improve performance on a continual basis by accepting best practice standards and the setting of performance targets in relation to the management of health & safety. NEL CCG has commissioned a Health and Safety service from North East Lincolnshire Council ensuring that there are robust arrangements in place for the management of health and safety across the organisation. In addition to this the CCG has its own in-house first aiders, DSE assessors, Mental Health First Aiders and a selection of staff trained in defibrillator usage. The CCG moved into NELC Municipal Offices in August 2018 and complies with NELC's procedures for the building.

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

For the period April 2021 to 31 March 2022 there were no incidents reported under the category of Health and Safety.

Staff consultation

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

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

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

With the development of the ICB, regular briefing sessions have been taking place, both locally and jointly across the Humber Coast and Vale system. A joint staff survey is currently being developed to be distributed across the six CCGs in the system.

Talent and Development

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

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

Off-payroll engagements (Subject to Audit)

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

Off-payroll engagements as of 31st March 2022, for more than £245 per day are as follows:

Table One - Off-payroll engagements longer than six months

Number of existing engagements as of 31 March 2022	6
Of which, the number that have existed:	
For less than 1 year at the time of reporting	0
For between 1 and 2 years at the time of reporting	0
For between 2 and 3 years at the time of reporting	0
For between 3 and 4 years at the time of reporting	1
For 4 or more years at the time of reporting	5

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

For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245 per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	6
***Of which**:*	
No. not subject to off-payroll legislation	6
No. subject to off-payroll legislation and determined as in-scope of IR35	0
No. subject to off-payroll legislation and determined as out of scope of IR35	0
the number of engagements reassessed for compliance or assurance purposes during the year	6
Of which: no. of engagements that saw a change to IR35 status following review	0

Table 3 - For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility between 01 April 2021 and 31 March 2022:

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

Expenditure on consultancy

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

Exit packages and severance payments

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

Parliamentary Accountability and Audit Report

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

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

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

Dr Peter Melton
Clinical Chief Officer
16 June 2022

Annual Accounts

Foreword to the accounts

NHS NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

These accounts for the year ended 31 March 2022 have been prepared by NHS North East Lincolnshire Clinical Commissioning Group under section 232 (schedule 15.3(1) of the National Health Service Act 2006 in the form which the Secretary of State has, within the approval of the Treasury, directed.

Dr Peter Melton
Clinical Chief Officer
16 June 2022

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Independent auditor's report to the Governing Body of NHS North East Lincolnshire Clinical Commissioning Group

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of NHS North East Clinical Commissioning Group ('the CCG') for the year ended 31 March 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 2021/22 as contained in the Department of Health and Social Care Group Accounting Manual 2021/22, and the Accounts Direction issued by the NHS Commissioning Board 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 31 March 2022 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22; 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 Integrated Care Board

We draw attention to notes 1.1 (Going Concern) and 38 (Events after the end of the reporting period) of the financial statements, which highlight that the Health and Care Act 2022 gained Royal Assent on 28 April 2022. As disclosed in notes 1.1 and 38 of the financial statements, it is the intention that the CCG's functions will transfer to a new 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 2021/22 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 were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates.

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 Integrated Governance and 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 Integrated Governance and 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 Integrated Governance and 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 year ended 31 March 2022. We have nothing to report in this respect.

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 December 2021.

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 year 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 members of the Governing Body of NHS North East Lincolnshire CCG, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG 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 Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Certificate

We certify that we have completed the audit of NHS North East Lincolnshire CCG 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

Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Income from sale of goods and services	2	(54,928)	(52,604)
Other operating income	2	(294)	(134)
Total operating income		**(55,222)**	**(52,738)**
Staff costs	4	5,298	5,075
Purchase of goods and services	5	364,844	340,108
Provision expense	5	2	83
Other Operating Expenditure	5	457	869
Total operating expenditure		**370,601**	**346,135**
Net Operating Expenditure		**315,379**	**293,397**
Finance expense		166	-
Net expenditure for the Year		**315,545**	**293,397**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**315,545**	**293,397**
Other Comprehensive Expenditure			
Remeasurement of the defined pension liability / asset		(4,172)	3,508
Sub total		**(4,172)**	**3,508**
Comprehensive Expenditure for the year		**311,373**	**296,905**

Please refer to note 40 for further analysis of the CCG's position

The notes on pages 100 to 119 form part of this statement

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Property, plant and equipment	13	-	166
Total non-current assets		-	166
Current assets:			
Trade and other receivables	17	10,940	8,379
Cash and cash equivalents	20	28	21
Total current assets		10,968	8,400
Total current assets		**10,968**	8,400
Total assets		**10,968**	8,566
Current liabilities			
Trade and other payables	23	(25,395)	(17,750)
Provisions	30	(238)	(283)
Total current liabilities		**(25,633)**	(18,033)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(14,665)**	(9,467)
Non-current liabilities			
Trade and other payables	23	(233)	(4,303)
Total non-current liabilities		**(233)**	(4,303)
Assets less Liabilities		**(14,898)**	(13,770)
Financed by Taxpayers' Equity			
General fund		(11,866)	(6,566)
Other reserves		(3,032)	(7,204)
Total taxpayers' equity:		**(14,898)**	(13,770)

The notes on pages 100 to 119 form part of this statement

The financial statements on pages 98 to 99 were approved by the Governing Body on 16th June 2022 and signed on its behalf by:

Dr Peter Melton
Accountable Officer
16th June 2022

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

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

Changes in taxpayers' equity for 2020-21	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2020	(4,617)	-	(3,696)	**(8,313)**
Transfer of assets and liabilities from closed NHS bodies	-	-	-	**-**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	**(4,617)**	**-**	**(3,696)**	**(8,313)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21				
Net operating costs for the financial year	(293,397)	-	-	(293,397)
Movements in other reserves	-	-	(3,508)	(3,508)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(293,397)**	**-**	**(3,508)**	**(296,905)**
Net funding	291,448	-	-	291,448
Balance at 31 March 2021	**(6,566)**	**-**	**(7,204)**	**(13,770)**

The notes on pages 100 to 119 form part of this statement

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(315,443)	(293,390)
Other Gains & Losses		166	-
(Increase)/decrease in trade & other receivables Increase/(decrease) in trade &	17	(2,561)	(1,017)
other payables Provisions utilised	23	7,811	2,926
Increase/(decrease) in provisions	30	(47)	(71)
	30	2	83
Net Cash Inflow (Outflow) from Operating Activities		**(310,072)**	(291,469)
Cash Flows from Investing Activities			
Net Cash Inflow (Outflow) from Investing Activities		**(166)**	-
Net Cash Inflow (Outflow) before Financing		**(310,238)**	(291,469)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		310,245	291,448
Net Cash Inflow (Outflow) from Financing Activities		**310,245**	291,448
Net Increase (Decrease) in Cash & Cash Equivalents	**20**	**7**	(20)
Cash & Cash Equivalents at the Beginning of the Financial Year		**21**	41
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		**-**	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**28**	21

Notes to the financial statements

1 **Accounting Policies**

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

1.1 **Going Concern**

These accounts have been prepared on a going concern basis .

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021. The Bill will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs. The Bill was given Royal Assent and became an Act of Parliament on the 28th April 2022. The intention is that all the CCG functions, assets and liabilities will therefore transfer to an ICB on the 1st July 2022.

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

Where a 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 postion has therefore been drawn up at 31 March 2022 on a going concern basis.

1.2 **Accounting Convention**

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

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

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

1.3.1 **Critical accounting judgements in applying accounting policies**

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

• Bad Debt Provision

• Local Government Pension Scheme as advised by the actuaries Hymans Robertson LLP

1.3.2 **Sources of estimation uncertainty**

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

• Prescribing - The full year figure is estimated on the spend for the first 10 months of the year

1.4 **Pooled Budgets**

The CCG has entered into a pooled budget arrangement in accordance with section 75 of the NHS Act 2006. The CCG accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. If the CCG is in a “jointly controlled operation”, the CCG recognises:

•The assets the CCG controls;

•The liabilities the CCG incurs;

•The expenses the CCG incurs; and,

If the CCG is involved in a “jointly controlled assets” arrangement, in addition to the above, the CCG recognises:

•The CCG’s share of the jointly controlled assets (classified according to the nature of the assets);

•The CCG’s share of any liabilities incurred jointly; and,

•The CCG’s share of the expenses jointly incurred.

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 CCG.

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:

• The CCG is not required to disclose information regarding performance obligations that are part of a contract that has an original expected duration of one year or less,

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

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

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

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.At the year end, the CCG accrues income relating to performance obligations satisfied in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued in the same manner as other revenue.

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

Payment terms are standard reflecting cross government principles.

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

The CCG’s main sources of revenue are:

- S75 Partnership Agreement
- Contribution from clients towards cost of social care

Notes to the financial statements

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**

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

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

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

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

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.

1.8.1 **Grants Payable**

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

1.8.2 **Value Added Tax**

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

1.9 **Property, Plant & Equipment**

1.9.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the CCG;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.9.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.9.3 **Subsequent Expenditure**

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

1.10 **Cash & Cash Equivalents**

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

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

1.11 **Provisions**

Provisions are recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the CCG will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate.:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

1.12 **Clinical Negligence Costs**

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

1.13 **Non-clinical Risk Pooling**

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

1.14 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

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

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

1.15 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

1.51.1 **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.

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

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

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

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

1.15.4 **Impairment**

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

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

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

Notes to the financial statements

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

1.16 **Financial Liabilities**

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

1.16.1 **Financial Guarantee Contract Liabilities**

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

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

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

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

1.16.3 **Other Financial Liabilities**

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

1.17 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the CCG not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.18 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.
● IFRS 16 Leases – IFRS 16 Leases has been deferred until 1 April 2022, but CCGs will still need to provide adequate disclosure on the impact of the new standard. HM Treasury have issued application guidance which will assist entities in assessing the impact and this can be found at IFRS_16_Application_Guidance_December_2020.pdf (publishing.service.gov.uk).

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The CCG will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the CCG will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the CCG's incremental borrowing rate. The CCG's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the CCG will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

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

2 Other Operating Revenue

	2021-22 Admin	2021-22 Programme	2021-22 Total	2020-21 Total
	£'000	£'000	£'000	£'000
Income from sale of goods and services (contracts)				
Other Contract income	1,537	53,240	**54,777**	52,514
Recoveries in respect of employee benefits	88	63	**151**	90
Total Income from sale of goods and services	**1,625**	**53,303**	**54,928**	52,604
Other operating income				
Charitable and other contributions to revenue expenditure: non-NHS	-	294	**294**	134
Other non contract revenue	-	-	**-**	-
Total Other operating income	**-**	**294**	**294**	134
Total Operating Income	**1,625**	**53,597**	**55,222**	52,738

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

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

2020-21	Non-patient care services to other bodies	Recoveries in respect of employee benefits	Partnership Agreement *	Private Client Revenue *	Other Contract income	Total
	£'000		£'000	£'000	£'000	£'000
Source of Revenue						
NHS	-	-	-	-	-	-
Non NHS	-	90	42,696	9,538	280	52,604
Total	**-**	**90**	**42,696**	**9,538**	**280**	**52,604**

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

2020-21	Non-patient care services to other bodies	Recoveries in respect of employee benefits	Partnership Agreement *	Private Client Revenue *	Other Contract income	
	£'000		£'000	£'000	£'000	£'000
Timing of Revenue						
Point in time	-	90	-	-	280	370
Over time	-	-	42,696	9,538	-	52,234
Total	**-**	**90**	**42,696**	**9,538**	**280**	**52,604**

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

3.2 Transaction price to remaining contract performance obligations

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

4. Employee benefits and staff numbers

4.1.1 Employee benefits

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

	Total 2020-21		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	3,803	134	3,937
Social security costs	393	16	409
Employer Contributions to NHS Pension scheme	707	18	725
Apprenticeship Levy	4	-	4
Gross employee benefits expenditure	**4,907**	**168**	**5,075**
Less recoveries in respect of employee benefits (note 4.1.2)	(90)	-	(90)
Total - Net admin employee benefits including capitalised costs	**4,817**	**168**	**4,985**
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	**4,817**	**168**	**4,985**

* In the Employee benefits table for 2021-22 the totals include the following COVID related costs - Salary and wages £49.3k, Social Security costs £5.6k and Employers Contribution to NHS Pension scheme £6.3k

4.1.2 Recoveries in respect of employee benefits

	Permanent Employees £'000	Other £'000	2021-22 Total £'000	2020-21 Total £'000
Employee Benefits - Revenue				
Salaries and wages	(122)	-	**(122)**	(74)
Social security costs	(13)	-	**(13)**	(8)
Employer contributions to the NHS Pension Scheme	(16)	-	**(16)**	(8)
Total recoveries in respect of employee benefits	**(151)**	**-**	**(151)**	(90)

4.2 Average number of people employed

	2021-22	2020-21
Permanently Employed Number	**96.8**	93
Other	**1.7**	2
Total	**98.5**	95

The CCG had no staff engaged on capital projects during 2021/22 (2020/21 : NIL).

4.3 Exit packages agreed in the financial year

There were no exit packages in 2021/22 (2020/21 Nil).

4.4 Pension costs

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

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

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

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

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

4.4.3 Local Government Pension Scheme

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

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

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

	31 March 2022	***31 March 2021***
	% p.a.	***% p.a.***
Pension Increase rate	***3.20%***	*2.85%*
Salary Increase rate	***4.10%***	*3.75%*
Discount Rate	***2.70%***	*2.00%*

	31st March 2022		**31st March 2021**	
Mortality Assumptions	***Males Years***	***Females Years***	Males Years	Females Years
Current Pensioners	***20.8***	***23.5***	*21.0*	*23.7*
Future Pensioners**	***22.0***	***25.3***	*22.2*	*25.5*

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

Sensitivity Analysis	**31st March 2022**		31st March 2021	
Change in assumptions at year ended 31 March 2022	**Approximate % increase to Employer liability**	**Approximate monetary amount £'000**	Approximate % increase to Employer liability	Approximate monetary amount £'000
0.1% decrease in Real Discount Rate	**2%**	**670**	9%	3,733
0.1% increase in the Salary Increase Rate	**0%**	**9**	0%	48
0.1% increase in the Pension Increase Rate	**2%**	**657**	9%	3,630

The change in the net pensions liability is analysed into seven components:
• Current service cost; the increase in present liabilities expected to arise from employee service in the current period (allocated to the revenue accounts of services for which the employees worked in the Income and Expenditure Account).

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

The estimated Employers Contributions payable in the year to 31 March 2023 will be approximately £64,000
The above information relates to the LGPS annualised calculation used for the actuarial pension valuation.

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

	31-Mar-19	***31-Mar-16***
	Number	***Number***
Actives	4	4
*Deferred pensioners**	237	286
Pensioners	211	167
Total	452	457

* Deferred pensioners include undecided leavers & frozen refunds.
The membership numbers do not affect any calculations and are provided purely for information purposes only.

5. Operating expenses

	2021-22 Admin £'000	2021-22 Programme £'000	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services				
Services from other CCGs and NHS England	62	353	415	406
Services from foundation trusts	-	123,435	123,435	119,518
Services from other NHS trusts	-	17,217	17,217	17,217
Purchase of healthcare from non-NHS bodies *	-	92,810	92,810	78,527
Purchase of social care	-	56,760	56,760	55,327
Prescribing costs	-	29,263	29,263	29,691
GPMS/APMS and PCTMS *	-	36,385	36,385	33,647
Supplies and services – clinical	-	6	6	6
Supplies and services – general	178	6,100	6,278	3,414
Consultancy services	23	158	181	250
Establishment *	92	814	906	1,148
Transport	-	-	-	0
Premises	100	80	180	162
Audit fees	50	-	50	47
Other non statutory audit expenditure				
· Internal audit services	53	-	53	38
Other professional fees	17	611	628	651
Legal fees	6	165	171	29
Interest (Local Government Pension Scheme)	-	807	807	751
Expected return on Assets (Local Government Pension Scheme)	-	(721)	(721)	(733)
Education, training and conferences	7	13	20	14
Total Purchase of goods and services	**588**	**364,256**	**364,844**	**340,108**
Depreciation and impairment charges				
Total Depreciation and impairment charges	**-**	**-**	**-**	**-**
Provision expense				
Provisions	-	2	2	83
Total Provision expense	**-**	**2**	**2**	**83**
Other Operating Expenditure				
Chair and Non Executive Members	99	-	99	117
Grants to Other bodies	-	389	389	563
Expected credit loss on receivables	-	(99)	(99)	189
Other expenditure	-	68	68	-
Total Other Operating Expenditure	**99**	**358**	**457**	**869**
Total operating expenditure	**687**	**364,616**	**365,303**	**341,060**

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

Included within other professional fees are non-audit services of £9k in respect of Mental Health Investment Standard assurance that NHSE requires CCGs to obtain from an independent reporting accountant, to demonstrate their investment in mental health expenditure rises at a faster rate than their overall published programme funding.

NE Lincolnshire CCG are the host for the humber coast and vale CCG's for primary care digital IT costs. In 2021-22 a larger proportion was centrally funded by revenue

6.1 Better Payment Practice Code

Measure of compliance	2021-22 Number	2021-22 £'000	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	39,803	194,640	38,765	180,035
Total Non-NHS Trade Invoices paid within target	39,261	192,871	38,323	179,230
Percentage of Non-NHS Trade invoices paid within target	**98.64%**	**99.09%**	**98.86%**	**99.55%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	290	142,039	667	138,698
Total NHS Trade Invoices Paid within target	286	141,998	656	138,635
Percentage of NHS Trade Invoices paid within target	**98.62%**	**99.97%**	**98.35%**	**99.95%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998
The CCG had no late payment of commercial debt for the year ending 31 March 2022 (31 March 2021: £NIL).

7 Income Generation Activities
The CCG does not undertake any income generation activities.

8. Investment revenue
The CCG had no investment revenue as at 31 March 2022 (31 March 2021: £NIL).

9. Other gains and losses

	2021-22 £'000	2020-21 £'000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	(166)	-
Total	**(166)**	**-**

Two items of ophthalmology equipment were donated to both Northern Lincolnshire and Goole Hospitals NHS Foundation Trust & Hull University Teaching Hospital NHS Trust in 2021/22 financial year.

10.1 Finance costs
The CCG had no finance costs as at 31 March 2022 (31 March 2021: £NIL).

10.2 Finance income
The CCG had no finance income as at 31 March 2022 (31 March 2021: £NIL).

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

12. Operating Leases
The CCG had no operating leases as at 31 March 2022 (31 March 2021: £NIL).

13. Property, plant and equipment
The CCG had no plant, property or equipment as at 31 March 2022 (31 March 2021: £166k).

14. Intangible non-current assets
The CCG had no intangible Assets as at 31 March 2022 (31 March 2021: £NIL).

15. Investment property
The CCG had no investment property as at 31 March 2022 (31 March 2021: £NIL).

16. Inventories
The CCG had no inventories as at 31 March 2022 (31 March 2021: £NIL).

17.1 Trade and other receivables	**Current 2021-22 £'000**	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS receivables: Revenue	923	-	199	-
NHS prepayments	-	-	2	-
NHS accrued income	21	-	20	-
Non-NHS and Other WGA receivables: Revenue	3,181	-	2,801	-
Non-NHS and Other WGA prepayments	2,068	-	2,095	-
Non-NHS and Other WGA accrued income	1,399	-	1,281	-
Expected credit loss allowance-receivables	(2,118)	-	(2,385)	-
VAT	88	-	50	-
Other receivables and accruals	5,378	-	4,316	-
Total Trade & other receivables	**10,940**	**-**	**8,379**	**-**
Total current and non current	**10,940**		**8,379**	
Included above:				
Prepaid pensions contributions	-		-	

The majority of trade is with NHS England and North East Lincolnshire Council. As both are funded by Government, no credit scoring is considered necessary.

Other receivables is £5,378k in relation to the S75 adult social care partnership agreement (2020/21: £4,316k).

17.2 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	**2021-22 Non DHSC Group Bodies £'000**	**2020-21 DHSC Group Bodies £'000**	**2020-21 Non DHSC Group Bodies £'000**
By up to three months	(53)	(208)	(26)	(120)
By three to six months	-	(193)	(55)	(310)
By more than six months	-	(259)	-	(197)
Total	**(53)**	**(660)**	**(81)**	**(627)**

17.3 Loss allowance on asset classes	**2021-22 Trade and other receivables - Non DHSC Group Bodies £'000**	**2021-22 Other financial assets £'000**	**2021-22 Total £'000**	**2020-21 Non DHSC Group Bodies £'000**
Balance at 01 April 2021	(2,385)	-	**(2,385)**	(2,678)
Amounts written off	168	-	**168**	544
Financial assets that have been derecognised	652	-	**652**	417
Other changes	(553)	-	**(553)**	(668)
Total	**(2,118)**	**-**	**(2,118)**	**(2,385)**

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

	2021-22 Lifetime expected credit loss rate %	**2021-22 Gross carrying amount £'000**	**2021-22 Lifetime expected credit loss £'000**	**2020-21 Lifetime expected credit loss £'000**
Receivables are provided against at the following rates:				
NHS debt & Adult Social Care -0 - 6 Months	0	2,571	364	621
7 - 9 Months	25	207	62	88
10 -12 Months	50	91	52	54
1 - 2 years	75	380	304	265
Over 2 years	100	1,336	1,336	1,357
Total expected credit loss		**4,585**	**2,118**	2,385

General Aged debt relating to Adult social care follows the matrix outlined above. Some items of debt may be individually assessed and provided for if appropriate.

18. Other financial assets
The CCG had no other financial assets as at 31 March 2022 (31 March 2021: £NIL).

19. Other current assets
The CCG had no other current assets as at 31 March 2022 (31 March 2021: £NIL).

20 Cash and cash equivalents

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	21	41
Net change in year	7	(20)
Balance at 31 March 2022	**28**	**21**
Made up of:		
Cash with the Government Banking Service	28	21
Cash and cash equivalents as in statement of financial position	**28**	**21**
Balance at 31 March 2022	**28**	**21**
Patients' money held by the clinical commissioning group, not included above	-	-

21. Non-current assets held for sale
The CCG had no non-current assets held for sale as at 31 March 2022 (31 March 2021: £NIL).

22. Analysis of impairments and reversals
The CCG had no impairments or reversals recognised in expenditure during 2021-22 (2020-21: £NIL).

23 Trade and other payables	**Current 2021-22 £'000**	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS payables: Revenue	113	-	188	-
NHS accruals	101	-	120	-
NHS deferred income	2	-	5	-
Non-NHS and Other WGA payables: Revenue	2,022	-	542	-
Non-NHS and Other WGA payables: Capital	-	-	166	-
Non-NHS and Other WGA accruals	17,549	-	14,795	-
Non-NHS and Other WGA deferred income	1,873	-	844	-
Social security costs	63	-	62	-
Tax	52	-	56	-
Other payables and accruals	3,620	233	972	4,303
Total Trade & Other Payables	**25,395**	**233**	**17,750**	**4,303**
Total current and non-current	**25,628**		**22,053**	

Other payables include £311k outstanding pension contributions at 31 March 2022 (31 March 2021: £230k).

Other non-current other payables relate to the Local Government Pension Scheme.

24. Other financial liabilities
The CCG had no other financial liabilities as at 31 March 2022 (31 March 2021: £NIL).

25. Other liabilities
The CCG had no other liabilities as at 31 March 2022 (31 March 2021: £NIL).

26. Borrowings
The CCG had no borrowings as at 31 March 2022 (31 March 2021: £NIL).

27. Private finance initiative, LIFT and other service concession arrangements
The CCG had no private finance initiative, LIFT or other service concession arrangements that were excluded from the Statement of Financial Position as at 31 March 2022 (31 March 2021: £NIL).

28. Finance lease obligations
The CCG had no finance lease obligations as at 31 March 2022 (31 March 2021: £NIL).

29. Finance lease receivables
The CCG had no finance lease receivables as at 31 March 2022 (31 March 2021: £NIL).

30 Provisions

	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
Continuing care	238	-	179	-
Other	-	-	104	-
Total	**238**	**-**	**283**	**-**
Total current and non-current	**238**		**283**	

	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2021	**0**	**179**	**104**	**283**
Arising during the year	(0)	106	-	**106**
Utilised during the year	-	(47)	-	**(47)**
Reversed unused	-	-	(104)	**(104)**
Balance at 31 March 2022	**-**	**238**	**-**	**238**
Expected timing of cash flows:				
Within one year	-	238	-	**238**
Balance at 31 March 2022	**-**	**238**	**-**	**238**

31. Contingent Liabilities

The CCG had no contingent liability as at 31 March 2022.

32. Commitments

32.1 Capital commitments

The CCG had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2022 (31 March 2021: £NIL).

32.2 Other financial commitments

The CCG had no non-cancellable contracts (which were not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2022 (31 March 2021: £NIL).

33 Financial instruments

33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

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

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

33.1.1 Currency risk

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

33.1.2 Interest rate risk

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

33.1.3 Credit risk

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

33.1.4 Liquidity risk

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

33.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

33.2 Financial assets

	Financial Assets measured at amortised cost 2021-22 £'000	Financial Assets measured at amortised cost 2020-21 £'000
Trade and other receivables with NHSE bodies	809	128
Trade and other receivables with other DHSC group bodies	4,238	4,097
Trade and other receivables with external bodies	477	77
Other financial assets	5,378	4,316
Cash and cash equivalents	28	21
Total at 31 March 2022	**10,930**	**8,639**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	Financial Liabilities measured at amortised cost 2020-21 £'000
Trade and other payables with NHSE bodies	149	293
Trade and other payables with other DHSC group bodies	7,075	7,533
Trade and other payables with external bodies	12,561	7,986
Other financial liabilities	3,620	972
Total at 31 March 2022	**23,405**	**16,784**

34 Operating segments

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

2020-21	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Health	295,064	(1,667)	**293,397**	2,328	(13,314)	**(10,986)**
Adult Social Care	57,062	(57,062)	**-**	6,238	(9,022)	**(2,784)**
Total	**352,126**	**(58,729)**	**293,397**	**8,566**	**(22,336)**	**(13,770)**

35 Joint arrangements - interests in joint operations

35.1 Interests in joint operations

The CCG has a pooled budget with North East Lincolnshire Council . The pool is hosted by NHS North East Lincolnshire CCG and forms part of the overall integrated health & social care budget that the Under the arrangement funds are pooled under Section 75 of the National Health Service Act 2006 for the provision of Adult Social Care and Better Care Fund expenditure within North East Lincolnshire. The tables below provides a summary of the income and expenditure in the financial year.

Adult Social Care Partnership Agreement

	2021-22 £'000	2020-21 £'000
NELC Allocation	45,333	42,696
Other Contributions*	14,192	14,366
Total Social Care Expenditure	(59,525)	(57,062)
Total	**-**	**-**

NELC Allocation includes the Partnership Agreement and an adjustment for grants (£2.6m) which the CCG is deeemed to be acting as Agent in 2021/22.

*Other Contributions, includes £4.8m funding from the Health Better Care Fund Allocation. This is an internal recharge between the Health & Adult Social Care Operating Segments and as such is not reflected as Income & Expenditure on the SOCNE.

Better Care Fund	2021-22 £'000	2020-21 £'000
Underspend b/f	**3,703**	**2,996**
In Year Allocations:		
BCF - Health	13,244	12,625
BCF - Local Authority	3,221	3,662
IBCF - Local Authority	7,822	7,822
Sub Total	**27,990**	**27,105**
In Year Spend :		
IBCF spend	(7,327)	(7,822)
BCF - Health & Adult Social Care	(13,244)	(12,625)
BCF - Disabled Facilities Grant	(2,959)	(2,955)
Sub Total	**(23,530)**	**(23,402)**
Total	**4,460**	**3,703**

35.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

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

36. NHS Lift investments
The CCG had no NHS LIFT investments as at 31 March 2022 (31 March 2021: £NIL).

37. Related party transactions

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

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

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

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

· **NHS Business Services Authority.**

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

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

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

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

37. Related party transactions *(continued)*

Details of related party transactions with individuals are as follows:	2021 / 2022			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Rob Walsh				
Chief Executive NELCCG/NELC				
Chief Executive - North East Lincolnshire Council	9,633	(8,764)	611	(5,391)
Stephen Pintus				
Director of Public Health NELC				
Director of Public Health – North East Lincolnshire Council- Retired 16.07.21	9,633	(8,764)	611	(5,391)
Tim Render				
Governance & Audit (Lay Member)				
Independent Chair Audit & Governance Committee for North East Lincolnshire Council	9,633	(8,764)	611	(5,391)
Dr Renju Mathews				
Governing Body GP Representative				
Director – Rutreb Limited	5	-	2	-
Dr Mathews' Practice is a member of 360 Care Ltd	743	-	66	-
Dr Mathews' Practice is member of Panacea PCN. Funding is received via Dr Mathews	2,632	-	358	-
GP – Cromwell Primary Care Centre, Cromwell Road & Stirling Medical Centre, Grimsby	906	-	52	(32)
Philip Bond				
Patient & Public Involvement (Lay Member)				
Registered carer under the Carers Support Service which receives some funding from NELCCG	322	-	65	-
David Walker				
Governance & Audit (Lay Member)				
Employed by St Andrews Hospice as fundraising coordinator	743	-	12	-
Chair of Humbercare Fundraiser	284	-	-	-
The CCG is a clinically led organiisation representing 25 member practices. The funding paid to member practices has been listed below :				
Beacon Medical Primary Care Centre	1,702	-	161	(44)
Birkwood Medical Centre	1,614	-	148	-
Blundell Park Surgery	292	-	18	-
Chantry Health Group	916	-	44	(34)
Clee Medical Centre	1,933	-	200	(47)
Core Care Family Practice	432	-	28	(34)
Dr A Kumar	550	-	29	(16)
Dr A Sinha	585	-	56	(37)
Dr O Z Qureshi Surgery	591	-	40	(17)
Dr P Suresh-Babu	330	-	16	-
Dr R Mathews	906	-	52	(32)
Dr R Mathews is a member of Panacea PCN. PCN funding goes to a lead practice and for Panacea this is Dr R Mathews	2,632	-	358	-
Greenlands & New Waltham Surgery	429	-	16	(19)
Fieldhouse Medical Group	2,177	-	138	(195)
Healing Health Centre	338	-	14	(20)
Humberview Surgery	550	-	101	(14)
Humberview Surgery is member of Freshney Pelham PCN. PCN funding goes to a lead practice and for Freshney Pelham this is Humberview Surgery	1,275	-	262	-
Littlefield Surgery	852	-	71	(38)
Open Door	539	-	24	-
Pelham Medical Group	1,302	-	69	(34)
Quayside Medical Centre	359	-	26	-
Raj Medical Centre	992	-	106	-
Roxton at Weelsby View	58	-	-	-
Scartho Medical Centre	2,080	-	144	(116)
The Lynton Practice	643	-	39	(17)
The Roxton Practice (Immingham)	6,537	-	318	(236)
The Roxton Practice is a members of Meridian PCN. PCN funding goes to a lead practice and for Meridian this is The Roxton Practice, Immingham	1,425	-	209	-
Woodford Medical Centre	1,306	-	105	(38)
DHSE Related Parties				
Leeds Teaching Hospital NHS Trust	667	-	17	-
Lincolnshire Partnership NHS Foundation Trust	12	-	18	-

37. Related party transactions (continued)

Details of related party transactions with individuals are as follows:	2020 / 2021			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Christopher Hayes				
Governing Body Member Secondary Care Doctor				
Consultant Cardiologist at York Hospital NHS Trust	28	-	-	-
Dr Ekta Elston				
Medical Director/Council of Members Vice Chair				
Health Education England – GP Training Programme Director for Northern Lincolnshire	-	(251)	-	(72)
Partner GP at The Roxton at Weelsby View, Weelsby View, Grimsby	219	-	107	-
Partner GP at The Roxton Practice, Immingham	5,968	-	222	-
Roxton Practice and The Roxton at Weelsby View are members of 360 Care Limited	384	-	39	-
Roxton Practice and The Roxton at Weelsby View are members Meridian PCN. Funding is received via Roxton Practice Immingham	1,089	-	51	-
Dr Jeeten Raghwani				
Governing Body GP Representative				
GP Principal Greenlands Surgery, Stirling Medical Centre & Greenlands New Waltham	351	-	22	(19)
Medical Director for Care Plus Group	22,582	-	252	-
Greenlands Surgery is a member of Panacea PCN. Funding is received via Dr Mathews	2,194	-	77	-
Dr Peter Melton				
Accountable Officer/GP Clinical Chief Officer				
Roxton practice is a member of 360 Care Limited & wife is employed by 360 Care Limited	384	-	39	-
GP Principal at Roxton at Weelsby View, Weelsby View, Grimsby	219	-	107	-
GP Principal The Roxton Practice, Immingham	5,968	-	222	-
Roxton Practice and The Roxton at Weelsby View are members Meridian PCN. Funding is received via Roxton Practice Immingham	1,089	-	51	-
Dr Sudhakar Allamsetty				
Chair of Council of Members/Vice Chair Governing Body				
GP Partner at Scartho Medical Centre	2,155	-	72	-
Scartho Medical Centre is member of Panacea PCN. Funding is received via Dr Mathews	640	-	77	-
Clinical Director for Panacea PCN. Funding is received via Dr Mathews	2,194	-	56	-
Helen Kenyon				
Chief Operating Officer				
Sue Rogerson is a personal friend who is a director of an independent consultancy company, SJW Solutions in Partnership. Sue, via SJW Solutions in Partnership has and does work within the locality and may work with NHS/Social Care including potentially	109	-	12	-
Jan Haxby				
Director of Quality/Registered Strategic Nurse				
Daughter works as a registered nurse in DPoW Hospital medical unit in North Lincolnshire and Goole Hospital (NLaG)	118,511	(49)	-	(38)
Daughter works as a registered nurse in critical care in Hull University Teaching Hospital NHS Trust, Hull	9,785	-	14	-
Joe Warner				
Social Care Representative				
Chief Executive - Focus Adult Social Care Social Enterprise	6,716	-	58	-
Rob Walsh				
Chief Executive NELCCG/NELC				
Chief Executive - North East Lincolnshire Council	10,361	(8,175)	325	(4,351)
Stephen Pintus				
Director of Public Health NELC				
Director of Public Health – North East Lincolnshire Council	10,361	(8,175)	325	(4,351)
Tim Render				
Governance & Audit (Lay Member)				
Independent Chair Audit & Governance Committee for North East Lincolnshire Council	10,361	(8,175)	325	(4,351)

37. Related party transactions *(continued)*

Details of related party transactions with individuals are as follows:

	2020 / 2021			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Renju Mathews				
Governing Body GP Representative				
Director – Rutreb Limited	6	-	-	-
Dr Mathews' Practice is a member of 360 Care Ltd	384	-	39	-
GP – Cromwell Primary Care Centre, Cromwell Road, Grimsby	640	-	56	-
Practice is a member of the Panacea Collaborative	2,194	-	77	-
Philip Bond				
Patient & Public Involvement (Lay Member)				
Registered carer under the Carers Support Service which receives some funding from NELCCG	441	-	-	-
The CCG is a clinically-led organisation representing 25 member practices. The funding paid to member practices has been listed below.				
Beacon Medical Primary Care Centre	1,655	-	95	(44)
Birkwood Medical Centre	1,724	-	237	-
Blundell Park Surgery	294	-	11	-
Chantry Health Group	924	-	40	-
Clee Medical Centre	1,870	-	108	-
Core Care Family Practice	447	-	20	-
Dr Chalmers & Meier (ceased 03/04/20 as merged with The Roxton Practice, payment in relation to 2019/20)	1	-	-	-
Dr A Kumar	570	-	25	-
Dr A Sinha	700	-	36	-
Dr O Z Qureshi Surgery	569	-	41	-
Dr P Suresh-Babu	304	-	22	-
Dr R Mathews	640	-	77	-
Dr R Mathews is a member of Panacea PCN. PCN funding goes to a lead practice and for Panacea this is Dr R Mathews	2,194	-	56	-
Greenlands & New Waltham Surgery	351	-	22	(19)
Fieldhouse Medical Group	2,211	-	145	(195)
Healing Health Centre	332	-	12	-
Humberview Surgery	340	-	16	-
Humberview Surgery is member of Freshney Pelham PCN. PCN funding goes to a lead practice and for Freshney Pelham this is Humberview Surgery	1,009	-	172	-
Littlefield Surgery	838	-	73	(38)
Open Door	503	-	15	-
Pelham Medical Group	1,229	-	51	-
Quayside Medical Centre		-	12	-
Raj Medical Centre	877	-	77	-
Roxton at Weelsby View	219	-	107	-
Scartho Medical Centre	2,155	-	72	-
The Lynton Practice	599	-	-	-
The Roxton Practice (Immingham)	5,968	-	222	-
The Roxton Practice is a members of Meridian PCN. PCN funding goes to a lead practice and for Meridian this is The Roxton Practice, Immingham	1,089	-	51	-
Woodford Medical Centre	1,306	-	97	(38)
DHSE Related Parties				
Leeds Teaching Hospital NHS Trust	650	-	-	-
Lincolnshire Partnership NHS Foundation Trust	7	-	-	-

38 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 6 July 2021. The Bill allows for the establishment of Integrated Care Boards (ICB) across England. ICBs will take on the commissioning functions of CCGs. The Bill was passed on 28th April 2022 and the intention is that the CCG functions, assets and liabilities will therefore transfer to an ICB on the 1st July 2022 (2020-21 none).

39 Third party assets

The CCG held no third party assets as at 31 March 2022 (31 March 2021: £NIL).

40 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2021-22 Target	**2021-22 Performance**	2020-21 Target	2020-21 Performance
Expenditure not to exceed income	317,546	317,546	295,064	295,064
Capital resource use does not exceed the amount specified in Directions	-	-	168	166
Revenue resource use does not exceed the amount specified in Directions	315,546	315,546	293,397	293,397
Revenue administration resource use does not exceed the amount specified in Directions	3,399	2,920	3,454	3,298

It should be noted that the table above only relates to NHS funding. The CCG also receives £47.9m from North East Lincolnshire Council via the Partnership Agreement. This is a pooled budget arrangement under Section 75 of the National Health Service Act 2006, see note 35.

In 2021/22, the CCG received revenue resource of £323,693k from NHS England, including £8,147k relating to cumulative surplus. In the table above the revenue resource does not include this element of cumulative surplus.

41. Analysis of charitable reserves

The CCG held no charitable reserves as at 31 March 2022 (31 March 2021: £NIL).

42. FRS Accounting Information - Pensions

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

In accordance with International Accounting Standards- IAS 19 Employee Benefits disclosure of certain information concerning assets, liabilities, income and expenditure related to pension schemes is required.

The actuaries report states that the market value of the assets of the Pension fund as at 31 March 2022 was £37.9 million (31 March 2021 was £36.5 million).

Assets	**Value at 31-March-2022 £000**	**Value at 31-March-2021 £000**
Equity Securities	4,597	3,280
Debt Securities	5,150	4,722
Private Equity	2,163	2,051
Real Estate	4,410	4,341
Investment Funds & Unit Trusts	20,556	21,179
Cash & Cash Equivalents	1,053	963
Total	**37,929**	**36,536**

Funding Position

The following amounts, needed for reconciliation to the balance sheet, were measured in accordance with the requirements of IAS19:

Fair Value	**31-March-2022 £000**	**31-March-2021 £000**
Fair Value of Employer Assets	37,929	36,536
Present Value of Funded Obligations	(38,162)	(40,839)
Net Asset/(Liability)	**(233)**	**(4,303)**

Recognition in the profit or loss	**31-March-2022 £000**	**31-March-2021 £000**
Current service cost	80	49
Interest Cost	807	751
Expected Return on Employer Assets	(721)	(733)
Past Service Cost / (Gain)	0	0
Losses / (Gains) on Curtailments and Settlements	0	0
Total	**166**	**67**

Reconciliation of defined benefit obligation	**31-March-2022 £000**	**31-March-2021 £000**
Opening Defined Benefit Obligation	40,839	33,091
Current Service Cost	80	49
Interest Cost	807	751
Contribution by Members	12	11
Actuarial Losses/(Gains)	(1,026)	(896)
Past Service Costs / (Gains)	0	0
Losses / (Gains) on Curtailments	0	0
Estimated Benefits Paid	(2,550)	7,833
Closing Defined Benefit Obligation	**38,162**	**40,839**

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

Reconciliation of fair value of employer assets	31-March-2022	31-March-2021
	£000	£000
Opening Fair Value of Employer Assets	36,536	32,303
Expected Return on Assets	721	733
Contributions by Members	12	11
Contributions by the Employer	64	60
Actuarial Gains/(Losses)	1,622	4,325
Estimated Benefits Paid	(1,026)	(896)
Total actuarial gain (loss)	**37,929**	**36,536**

Amounts for the current and previous accounting periods	31-March-2022	31-March-2021
	£000	£000
Fair Value of Employer Assets	37,929	36,536
Present Value of Defined Benefit Obligation	(38,162)	(40,839)
Surplus / (deficit)	(233)	(4,303)
Experience Gains/(Losses) on Assets	1,622	4,325
Experience Gains/(Losses) on Liabilities	2,550	(7,833)

Cumulative Statement of Recognised Gains / Losses	31-March-2022	31-March-2021
	£000	£000
Actuarial Gains and Losses	1,622	4,325
Effect of Surplus Recovery Through Reduced Contributions	2,550	(7,833)
Actuarial Gains / (Losses) recognised in STRGL	4,172	(3,508)
Cumulative Actuarial Gains and Losses	(915)	(5,087)

43. Losses & Special Payments

In 2021/22 there was £168k of receivables written off relating to 390 Adult social care invoices.

The CCG had no special payment cases during 2021/22 (2020/21 : None)

44. Cash Flow Workings

	£'000
Net operating costs for the financial year (per SOCNE)	(315,545)
Pension charge	102
Net operating costs for the financial year per cash flow	**(315,443)**

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