Annual Report and Accounts

2020-2021

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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 the 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 2020 and 31 March 2021, including highlighting notable achievements and challenges.

The Overview is a summary that can be read as a document on its own. However, greater detail about our performance, the way we make decisions and our structure and staffing is available in the rest of the Annual Report. The Annual Accounts for the year 2020-2021 are presented at the end.

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

This year our Annual Report and Accounts was prepared as North East Lincolnshire took its first steps out of the UK's third Lockdown. This has been a series of tough social measures aimed at suppressing a second wave of coronavirus infections, hospitalisations and, sadly, deaths to give the NHS the opportunity to push out the unprecedented national COVID vaccination programme. Achieving the ambitious vaccination target will without doubt save many, many lives. It will also accelerate the restoration of elective and cancer care, support health and care staff to recover after working under a Level 4 Critical Incident for such an extended period of time and allow our population to spend quality time with family, friends and work colleagues again, taking part in the activities essential to their physical, emotional and mental health wellbeing. We are extremely proud of the health and care staff and volunteers who have enthusiastically risen to the challenge of rolling out the COVID vaccines in North East Lincolnshire. As of the end of March, more than 82,000 doses had been administered to adults in the Borough.

While the CCG is an NHS organisation led by family doctors and other clinicians, we also work closely with North East Lincolnshire Council under an arrangement we call the Union to make the most of the total money that is available to us to improve the health, care and support services that enable local communities to enjoy a good quality of life, recover from ill health as near home as possible, make healthier choices about their lives and stay active, engaged and independent for as long as they can. Much of this work is about how we can support local people to do more for themselves and for each other as communities. Together we recently launched Livewell, a bright, accessible new website that aims to make it easy for people to find the advice, information and support they need without going around the houses. There's also information on what to do if you're concerned about someone else's wellbeing, interactive sections on living with dementia or a sensory

impairment and a link into the new social prescribing portal for North East Lincolnshire which puts people in touch with practical support to help them overcome emotional or social difficulties that have come about as a result of health conditions.

During the past 12 months, working with other organisations has been more important than ever to manage the pandemic in our area and lessen the impact as much as possible on local people. The CCG has been part of the Humber-wide emergency response to COVID through the Local Resilience Forum (LRF) working with the local authorities, police, fire and port authority since the start of the crisis, and later part of the local authority led recovery work.

Alongside the organisations that provide health and care in North East Lincolnshire, the CCG is part of the NEL Health and Care Executive which has met weekly throughout the last 12 months to plan and manage the response. To reduce the spread of COVID-19, some local health services had to be suspended to reduce footfall in clinical settings and risky face-to-face contact. Working as a system meant we could identify and take action to prevent harm from unintended consequences as much as possible.

Areas that worked well included:

- rapid rollout of digital solutions to support the delivery of essential services via remote working in the majority of cases, which helped to limit spread of the virus.

- working as an integrated system and embracing a digital 1st approach meant we were able to quickly implement innovative solutions to problems which could normally take years to fix.

- reducing the risk to people living in care home or receiving support at home by supporting providers through access to Personal Protective Equipment (PPE), testing symptomatic patients in homes and people returning to a home after a stay in hospital, providing digital solutions to support remote GP consultations, moving staff from other organisations to tackle shortages due to staff self-isolating and system wide support on hand to help care homes with any other emerging issues.

- a collective response to sourcing PPE such as face masks, goggles, gloves and aprons and distributing across the health and care providers as needed to ensure no one ran out.

- early recognition of the mental health impact of COVID19 on staff and the wider population which led to the establishment of an 24/7 all-age mental health support line, which can be accessed by all.

- system planning in relation to staffing and an agreement as to where staff would be deployed should the pandemic impact significantly locally.

- agreement to quickly bring online extra community capacity in partnership across the CCG, Council and Care Plus Group, and the other partners to support step down from hospital, and step up from community, including support to care homes, where needed.

While many positives and better ways of working, such as those highlighted above, have come out of the pandemic, it is very clear that life has changed irrevocably for many people as a result.

We also must not forget that COVID-19 will be with us for a long time to come and the impact of the pandemic will be far reaching. As it becomes clearer what our “new normal” will look 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, against a challenging backdrop, the CCG has once again been rated “Good” by NHS England, 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 CCG received its third Green Star (the highest rating possible) this year for how it meets its duty to involve the public in health and care issues and this is something we remain very proud of.

On behalf of the CCG Governing Body and the Union Board, we are delighted to present our Annual Report and Accounts for 2020/2021. 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 NELCCG/NELC

Mark Webb
CCG Lay Chair

Who we are and what 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 26 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.

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

The CCG has delegated responsibility for commissioning primary care services.

We 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 2020/2021, the CCG was allocated £301.5 million by NHS England. This includes £28.5 million to support delegated Primary Care and £3.5 million to pay for the management and operation of the organisation which leaves a total of £269.5million 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 2020/2021 the CCG received £46.5 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 North East Lincolnshire CCG in the following ways:

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

By phone: 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 year 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 managing 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 our future delivery.

Alongside the focus on COVID recovery we will continue to respond to what local people need and reflect the work set out in both the Union strategic plan. What we do in North East Lincolnshire also has to take into account national ideas to improve the way the NHS works.

We plan to continue to work with our statutory partners across Humber Coast and Vale and to contribute to the creation of the Integrated Care System which will co-ordinate care in an even more integrated way in our geographical area.

This will support the different organisations who work together to either plan or deliver health and care in an area (the health and care system) to continue to deliver high-quality care to their communities but in a way that is much less legally bureaucratic, more accountable and more joined up. This will be done by bringing the NHS, local government and partners closer together to provide for the needs of their communities as a whole. this has come at a unique point in time when organisations in North East Lincolnshire have never worked so closely together as we continue to tackle COVID-19 in our community. Over the last 25 years, we have an established track record of working together to improve health outcomes and reduce inequalities by making the most of our shared experience and efficiencies. The new organisational arrangements will support our ambition to embed this integration at the heart of our system.

We will work with organisations across the Humber, Coast and Vale area to tackle the big issues that cause problems for people living in North East Lincolnshire. Working with different health, care

and voluntary organisations will help us see where we can be more efficient and spend our limited financial resources to the best advantage, as well as making sure our population gets the best possible clinical care. The Humber Coast and Vale Integrated Care System is made up of six NHS CCGs and six local authority boundaries representing our communities here in North East and North Lincolnshire alongside Hull, East Riding, York and Scarborough and Ryedale. Working together like this will let us share resources in areas where we are currently stretched, providing a better service to patients. Support services such as finance can be shared to make things more efficient and save money. You can find out more by visiting the Humber Coast and Vale website.

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 risk

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 Statemen

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 Office: As Accountable Officer, the Clinical Chief Officer is accountable for achieving organisation 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 Appraisal

Performance summary

CCG Assurance Framework

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 latest year-end assessment available at the time of this report is 2019/20 and North East Lincolnshire CCG was rated as 'Good'. The 2020/21 year-end assessment will be available from July on NHS England.

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 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 Delivery and Assurance 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 and 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

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	Feb-21	112,051	81.49%	82.77%		Fully Met	95%
ARP Category 1 Mean Response Time – Calls from people with life-threatening illnesses or injuries - EMAS	Jan-21	N/A	00:07:10	00:07:00		Almost Met	00:07:00
ARP Category 1 90th centile response time – Calls from people with life-threatening illnesses or injuries - EMAS	Jan-21	N/A	00:12:42	00:15:00		Fully Met	00:15:00
ARP Category 2 Mean Response Time – Emergency calls - EMAS	Jan-21	N/A	00:23:03	00:18:00		Not Met	00:18:00
ARP Category 2 90th centile response time – Emergency Calls - EMAS	Jan-21	N/A	00:46:53	00:40:00		Not Met	00:40:00
ARP Category 3 90th centile response time – Urgent Calls - EMAS	Jan-21	N/A	02:38:38	02:00:00		Not Met	02:00:00
ARP Category 4 90th centile response time – Less Urgent Calls - EMAS	Jan-21	N/A	03:00:58	03:00:00		Not Met	03:00:00
Percentage of Patients waiting <6 weeks for a diagnostic test - CCG	Jan-21	8,360	57.76%	89.72%		Not Met	99%
RTT - Incomplete Patients: % Seen Within 18 Weeks - CCG	Jan-21	13,340	65.70%	77.25%		Not Met	92%
Cancers: two week wait - CCG	Jan-21	3,591	95.02%	93.00%		Fully Met	93%
Cancers: two week wait (all breast symptoms excluding suspected cancer) - CCG	Jan-21	288	95.49%	93.00%		Fully Met	93%
Cancer 31 Days Diagnosis to Treatment (First definitive treatment) - CCG	Jan-21	666	96.70%	96.00%		Fully Met	96%
Cancer 31 Days Diagnosis to Treatment (Subsequent surgery treatment) - CCG	Jan-21	150	84.00%	94.00%		Fully Met	94%
Cancer 31 Days Diagnosis to Treatment (Subsequent drug treatment) - CCG	Jan-21	293	99.66%	98.00%		Fully Met	98%
Cancer 31 Days Diagnosis to Treatment (Subsequent radiotherapy treatment) - CCG	Jan-21	225	96.89%	94.00%		Fully Met	94%
Cancer 62 Days Referral to Treatment (GP Referral) - CCG	Jan-21	328	68.60%	69.41%		Almost Met	85%
Cancer 62 Days Referral to Treatment (Screening Referral) - CCG	Jan-21	26	61.50%	90.00%		Not Met	90%
Cancer 62 Days Referral to Treatment (Consultant Upgrade) - CCG	Jan-21	10	80.00%	90.00%		Fully Met	N/A
Cancelled Operations offered binding date within 28 days - Trust	Q3 2019/20	452	1.99%	11.01%		Fully Met	N/A
Numbers of unjustified mixed sex accommodation breaches - CCG	Feb-20	N/A	1	0		Not Met	0
Proportion on CPA discharged from inpatient care who are followed up within 7 days - CCG	Q3 2019/20	108	99.07%	95%		Fully Met	95%
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	Dec-20	1,375	94.6%	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	Dec-20	1,375	98.9%	95.0%		Fully Met	95%
Psychosis treated with a NICE approved care package within two weeks of referral - CCG	Nov-20	70	92.9%	60.0%		Fully Met	56%

Development and performance in-year

CCGs are accountable for how they spend public money. Reflecting upon our overall performance over the year, we have continued to meet or exceed national targets in some areas such as certain cancer and mental health waiting times measures. We have also continued to meet our targets across several of the Adult Social Care measures. However, the coronavirus pandemic and the increased demand for NHS services in 2020/21 has been the most serious challenge that the NHS has ever experienced. Although we had planned to meet all national planning standards and commitments in 2020-21, this has not been possible for some of our commissioned services due to the current pandemic and a number of our measures have had revised targets for September 2020 to March 2021 due to the COVID-19 pandemic as directed by the phase three response to COVID-19 guidance issued by NHS England. 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:

- A&E waiting times have continued to be particularly challenging for North East Lincolnshire in 2020/21. Our year-to-date performance for the Trust up to February 2021 was 81.49% against our agreed trajectory of 82.77%. Attendances have continued to increase up to (and exceeding in some cases) our pre-COVID levels with very high acuity and challenges to patient flow presented by the high numbers of COVID positive patients and zoning requirements. The HCE and AEDB have oversight of management of the risk to A&E throughout the pandemic and a whole system response to managing this and other risks is in place. Locally some of the actions taken include:

    - A system wide discharge event was repeated in January 2021 supported by ECIST with a view to restoring flow within the Trust and Community Beds, allowing recovery of performance. Following this a community discharge hub has now been established to ensure the benefits to patient flow are embedded in day-to-day operations.
    - The regional Think 111 First Task and Finish group ensures improvements are embedded across the System and we continue to monitor the impact on A&E attendances and waiting times performance.
    - Locally 3 Primary Care Access Hubs are being established to divert ‘UTC type’ activity away from A&E into Primary Care via 111.

- A number of the cancer treatment waiting times measures are currently below the trajectories set. We continue to be actively involved in system wide work being undertaken by the HCV Cancer Alliance and ICS and plans are fully aligned to those of the National Cancer Policy Programme. The CCG continues to have input to the Humber Cancer Board, Regional Primary Care Strategy Group, and HCV CA System Board. Locally some of the actions being taken include:

    - Trust Cancer Restoration Plan in line with national guidance to restore demand, reduce waiting times and ensure sufficient capacity to manage future increased demand for follow up care.
    - Rapid Diagnostic Centre
    - PTL Lung Cancer Awareness Events held in North and North East Lincolnshire.
    - Colorectal recovery plan in place to reduce the backlog of this speciality

- Referral to treatment waiting times have continued to decline over the year due to the COVID-19 impact. The proportion waiting less than 18 weeks is approximately 13% lower than the same time in the previous year and the number waiting over 52 weeks is 673 (previous year at the same time the number was 5) and these numbers are on a significantly lower referral rate due to COVID-19 impact. The Trust have been utilising the Independent sector for

ophthalmology and the expectation is that they will continue to support them over the forthcoming year and funding may be given for extending capacity. However, there is a concern that more referrals which were delayed will come into the Trust which would impact on backlogs and waiting times further.

- Proportion of people who have depression and/or anxiety disorders who receive psychological therapies – COVID-19 has impacted this measure and performance follows the national picture of reduced number of referrals and self-presentations. Future planned better integration with Primary Care and national communications are expected to help improve referrals.

- Proportion of people with a learning disability on the GP register receiving an annual health check, performance on this measure has continued to be below the target set. A task & finish group has been set up, using lines of influence where possible to encourage Primary Care pick up of this activity, early signs indicate that performance on this measure has significantly improved in the period January to March 2021 although there is significant risk to measure through re-prioritisation of primary care e.g. towards COVID vaccinations.

- People with a severe mental illness receiving a full annual physical health check and follow-up interventions, whilst the activity was not ceased during COVID response, Primary Care capacity has been impacted and re-prioritised and continues to be such. We continue to encourage practices and PCNs to pick this up, especially working with our Mental Health Provider to develop a supportive approach. We are anticipating an improvement but not to the level of achievement.

- Reliance on inpatient care for people with a learning disability and/or autism care:

  - Commissioned by CCG, lockdown and COVID restrictions have directly impacted this measure resulting in an in-patient admission and the continued requirements of Covid response are likely to slow discharge. Further transfers out of hospital settings are planned unless further restrictions are implemented.
  - Commissioned by NHSE, lockdown and restrictions have adversely impacted planned discharge in that the provider identified pulled out, so a new plan has been developed. Due to the complexity of the case this is likely to result in yearend position not being achieved.

Some of the key successes for the CCG in 2020/21 have included:

- Cancer waiting times, both the two-week wait measures and three of the four 31 day wait measures continue to be achieved.

- Several of our hospital activity measures that had revised targets for September 2020 to March 2021 due to the COVID-19 pandemic have been achieved such as referrals, elective spells and non-elective spells.

- 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 and people receiving self-directed support.

Our 2020-2021 objectives

The challenges of the global pandemic impacted significantly across the health and care system, including for the CCG. In terms of our corporate plan for the financial year 2021, we were forced to suspend work in a number of areas in order to respond effectively to the needs and constraints of

COVID-19. These actions and priorities have been reviewed and revisited for 2021/22 and relevant workstreams will be picked up and pursued in the coming months.

Financial information

North East Lincolnshire CCG is in its eighth year of operation and this report covers the year ending 31 March 2021.

The financial performance in this year has built on the excellent performance of previous years, despite continued pressures on health and social care funding. As part of the NHS response to COVID a different finance regime has been in place during 2020/21. In the first half of the year (months 1-6) a retrospective non-recurrent allocation adjustment equal to the overall year to date variance was enacted. As such all CCG's have reported a breakeven position. Two key elements of this revised finance regime were 1) Centrally mandated fixed value contract arrangements with NHS providers and 2) a claims process for additional costs linked to COVID. In the second half of the year (months 7-12) the Humber Coast & Vale Integrated Care System, which North East Lincolnshire CCG is part of, was issued with an allocation envelope and there was a requirement for the system to breakeven. This requirement was achieved. Mandated payments to NHS providers continued and there was a claims process in relation to hospital discharge funding

The CCG has a range of statutory and operational duties and all these have been met as below:

Statutory Duties

Revenue resource use does not exceed the amount specified in Directions (Reported Surplus = £8.147m)	Achieved
Revenue administration resource use does not exceed the amount specified in Directions	Achieved
Capital resource use does not exceed the amount specified in Directions	Achieved

Operational Duties

Manage cash within the 1.25% of monthly drawdown or <£0/25m, whichever is the greater	Achieved
Partnership Agreement (planned to break even)	Achieved
Meet the "Better Payment Practice Code" (95%)	Achieved

Statutory Financial Duty

There are statutory (legal) financial duties for the Clinical Commissioning Groups as follows:

- **Revenue resource use does not exceed the amount specified in Directions (Reported Surplus equals £8.147m)**
  This duty requires the CCG to achieve an in-year surplus equivalent to no less than 1% of its health allocation. The CCG's total health allocation for 2020-21 was £301.544m which includes £8.147m (2.7%) of the CCG's accumulated surplus.

  There were a number of significant pressures in year, despite this, as shown in the Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2021, this duty was met precisely.

- **Revenue administration resource use does not exceed the amount specified in Directions**
  This duty requires the CCG not to spend in excess of its Running Cost Allocation. This allocation for 2020/21 was £3.454m with the CCG spending £3.298m on running costs.

- **Capital resource use does not exceed the amount specified in Directions**
  The CCG received £168k NHS capital resource in 2020/21. The CCG spent £166k

Administrative Financial Duties

There are a number of administrative financial duties applied to all CCGs in the same way as all other NHS organisations. Although these are not statutory duties, they are critically important in determining the performance and financial health of the organisation. Therefore, performance is rigorously monitored internally and externally.

- **Manage cash with 1.25% of monthly drawdown**
  The CCG is required to have a cash balance at the end of each month that is no greater than 1.25% of the cash drawn down in that month.

- **Partnership Agreement (planned breakeven)**
  Under the Partnership Arrangements the CCG has with NELC with regard to Adult Social Care, the CCG achieved its planned break-even position. There were a number of significant pressures in year, despite this, as shown in note 34 Operating Segments and note 35 Joint Arrangements this duty was met.

- **Better Payment Practice Code**
  The Better Payment Practice Code states that 95% of invoices should be paid within 30 days of receipt of goods or a valid invoice (whichever is later). Performance is measured in terms of both numbers of invoices and value of invoices. For 2020/2021 the CCG, on average, paid 98.9% of invoices by number and 99.7% of invoices by value in compliance with the code

Conclusion

North East Lincolnshire Clinical Commissioning Group has fulfilled all its statutory and administrative financial duties in its eighth year of existence. The consistent excellent performance is a credit to all the staff and members of the organisation.

This has given the organisation a strong basis from which to tackle the significant financial risks and pressures that continue to face us.

The CCG has a number of financial duties under the National Health Service Act 2006 (as amended). Please refer to finance performance duties note 40 within the annual accounts.

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.

Accommodation and travel changes in year

The CCG consolidated further into the Municipal offices in year, saving on running costs and impact of the CCG HQ building in terms of revenue and environmental costs, by bringing the Continuing Healthcare team into the building before Covid Lockdown and the work at home order.

The CCG has worked for many years with Agile Technology and as at the start of the first lockdown the CCG staff switched 100% to working at home using the MS Team platform with a by-product of reducing the face-to-face travel requirements for its staff, for business meetings and the home to work mileage.

The CCG prior to COVID, operated at a staff to desk ratio of 50%. This means more staff were encouraged to work at home or in flexible spaces reducing the environmental impact. With the advent of Covid and through a subsequent staff survey, a preference has been expressed post-Covid lockdowns, to continue to utilise a significant proportion of time working from home on the agile platforms. The expected level requested by staff was 2 days in the office 3 days at home.

We know while this will save home to work and business miles, there may be an uplift in home energy costs from greater working at home which may not be offset in the short term by reducing energy in buildings which are currently open for staff.

However, as we review and reduce office space across the CCG and council then it will allow greater savings which will benefit towards the NHS Net Zero targets. The cultural effect of less home to work travel and business mileage will probably have a more significant effect on reducing carbon emissions than more work at home. We are working with the Local Authority energy partner Engie on reviewing this.

We will also promote energy saving strategies to staff at home, regarding sourcing green energy, insulation and updating home heating and move to low energy lighting.

For mileage last year due to COVID on home to work travel we estimate a saving of 2,312 miles per day. Now due to agile staffing we would not have come in every day, so estimating that for 3 days per week, we will have saved 333,000 miles over the last year.

Based on estimates of 250 grammes per average mile this would equate to a carbon reduction of around 98,000 kilos.

Total business mileage for 2019/20 was 56,883 miles but in 2020-21 this has been effectively nil. The use of MS Teams for longer journeys will be insisted upon going forward with monthly meetings replaced maybe by quarterly face to face meetings to maintain relationships. The elimination of this travel would equate to another saving of 17,000kg of carbon.

Therefore in 2020-21 the CCG has seen an approximate reduction in travel production of carbon of 115,000 kg (115 Tonnes) of CO_2.

Facilities Management

The Local Authority manages the buildings through Engie 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.

The Provider must maintain and deliver a Green Plan, approved by its Governing Body, provide an annual summary of progress on delivery of that plan to the Co-ordinating Commissioner.

Within its Green Plan the Provider must quantify its environmental impacts and publish in its annual report quantitative progress data, covering as a minimum greenhouse gas emission in tonnes, emissions reduction projections and an overview of the Provider's strategy to deliver those reductions, including action to reduce air pollution from fleet vehicles, transitioning as quickly as reasonably practicable to the exclusive use of low and ultra-low emission vehicles.

Additionally, to adapt the Provider's premises and the way services are delivered to mitigate risks associated with climate change and severe weather, reduce single use plastic products and waste, and reduce waste and water usage through best practice efficiency standards and adoption of new innovations.

A number of early steps will be taken to decarbonise under the strategy and the CCG and providers must work to these headings to meet the target.

1. **Our care:** By developing a framework to evaluate carbon reduction associated with new models of care being considered and implemented as part of the NHS Long Term Plan.

2. **Our medicines and supply chain**: By working with our suppliers to ensure that all of them meet or exceed our commitment on net zero emissions before the end of the decade.

3. **Our transport and travel**: By working towards road-testing for what would be the world's first zero-emission ambulance by 2022, with a shift to zero emission vehicles by 2032 feasible for the rest of the fleet.

4. **Our innovation**: By ensuring the digital transformation agenda aligns with our ambition to be a net zero health service and implementing a net zero horizon scanning function to identify future pipeline innovations.

5. **Our hospitals**: By supporting the construction of 40 new 'net zero hospitals as part of the government's Health Infrastructure Plan with a new Net Zero Carbon Hospital Standard.

6. **Our heating and lighting**: By completing a £50 million LED lighting replacement programme, which, expanded across the entire NHS, would improve patient comfort and save over £3 billion during the coming three decades.
7. **Our adaptation efforts**: By building resilience and adaptation into the heart of our net zero agenda, and vice versa, with the third Health and Social Care Sector Climate Change Adaptation Report in the coming months.

8. **Our values and our governance**: By supporting an update to the NHS Constitution to include the response to climate change, launching a new national programme for a greener NHS, and ensuring that every NHS organisation has a board-level net zero lead, making it clear that this is a key responsibility for all our staff.

The targets to achieve being:

- for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032

- for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

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 has continued to work with Residential Care Homes to look at and understand the level of pharmaceutical waste. The changes to prescription ordering will have a significant impact on waste and cost as the patient has to explicitly request items they need rather than as now where a whole list of repeat items could be ordered by the pharmacy, whether the patient needs them or not. This programme will have a significant impact on waste and efficiency.

Statutory duties

Engaging People and Communities

The CCG and council's joint Commitment of Talking, Listening and Working Together has been the bedrock of our Engagement and Involvement activity this year. The Commitment sets out how people and communities will be involved in the planning and design of local services and solutions so that we make every conversation count in North East Lincolnshire

The Covid19 pandemic meant that we had to think very differently in order to meet our duty to involve and continue to talk, listen and work together with patients, public and stakeholders which we were able to do with the support of our Community Forum and Accord Steering group and with NEL Voluntary, Community and Social Enterprise (VCSE) Forum

Accord

Accord is the CCG's community membership scheme. The purpose of Accord is to provide local people with opportunities to influence decisions about local health and social care services.

People with an interest in health and social care who are registered with a GP in North East Lincolnshire can join and currently there are 1,500 registered members.
Accord has its own dedicated website and members receive regular e-bulletins providing links to local, regional and national health and care engagement opportunities and updates about the outcomes of previous engagement activity.

Members also receive a quarterly Accord newsletter, which is available online, hard copy and audio.

This year Accord members and stakeholders have been given the opportunity to have their say on a number of service developments these have included:

- Adult Social Care consultations including Care Homes Expenses, Direct Payments and Liberty Protection Safeguards surveys
- Humber, Coast and Vale 'Hospitals of the Future' survey
- Northern Lincolnshire End of Life strategy
- Consultations carried out by Northern Lincolnshire and Goole NHS Foundation Trust including Trust priorities and Accident and Emergency department capital build plans
- Surveys and consultation on behalf of partners such as the Office of the Police and Crime Commissioner, Environment Agency, Healthwatch and Local Authority
- Accessing GP Services during Covid19 (Humber)

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

Accessing GP services during COVID 19 engagement

Over the summer the four Humber CCGs', including North East Lincolnshire CCG, launched a survey to find out the views of patients on the changes which were made to Primary Care services in response to the Covid pandemic.

A number of changes were made to Primary Care services in North East Lincolnshire at the start of the pandemic with patients being assessed over the phone or digitally, and only being asked to attend in person when necessary. Over 7500 patients responded to the survey, with over 1900 of these being from North East Lincolnshire.

The full findings report and recommendations was received by the Primary Care Commissioning Committee in March and our focus in 2021/22 will be to develop and implement an action plan in response to what people told us about their experiences.

The Accord Steering group

The Accord steering group provides a link between the wider membership base of Accord. The role of the steering group is to make sure Accord counts and the CCG values and makes appropriate use of the scheme. The group quickly mobilised to meet virtually at the onset of lockdown and continue to do so throughout the year.

Steering Group achievements over the year included:

- Developing and contributing to the content for the Accord newsletter
- Reviewing Accord communications to ensure they are 'reader friendly'
- Planning and evaluating a series of online public and stakeholder engagement digital engagement meetings on Zoom
- Meeting with and commenting on service plans such as the End of Life Strategy, Commissioning intentions and capital build plans for Diana Princess of Wales Hospital

In 2021/22, the group will continue their work to "make sure Accord counts" and explore ways to build on the success of this years' digital engagement.

Public Engagement Events

The CCG held four public and stakeholder digital engagement events over the course of the year. These meetings were held on Zoom following consultation with Accord members on their preferred platform for ongoing digital engagement with the CCG during the pandemic. These events were hosted by the Chair of the CCG and involved health and care leaders and clinicians from the CCG, public health, hospital and mental health trusts. Topics for discussion were chosen by the Accord Steering group and participants were invited to post questions in the chat function which were answered by the presenters either directly into the chat function or live during the questions and answer segment of the meeting.

Participants are invited to carry out a live poll at the end of the session to evaluate their experience of the event.

The videos of these meetings and any subsequent follow up questions and answers are then placed on the CCG website.

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 accessible to people with communication difficulties or language needs, or how people experiencing any form of disadvantage or vulnerability can access services.

This year we recruited new members of the community from protected characteristics groups and reviewed and refreshed our equality impact assessment processes and the role of the panel.

The Community Forum

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

Members of the Community Forum 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.

This year we recruited to a new Primary Care Community Lead role. New Community Leads receive a comprehensive induction and support as well as annual 1-1's with the Chair. Community members all completed their mandatory online training.

The Community Forum meets monthly. Face-to-face meetings were not possible during lockdown, so the CCG worked to enable all members to access meetings on Microsoft Teams. There were a few teething troubles at the start however the Forum was able to meet every month from May through to March 2021. Meetings were well attended, and all were quorate. A representative from the CCG Leadership team attends each meeting as does the CCG Engagement Lead and CCG administrative support.

Minutes from Community Forum meetings are also received by the Governing Body along with an annual assurance report presented by the Chair who attends governing body meetings.

Collectively the forum highlights for 2020/21 include:

- Considered and commented on key CCG response to the Covid19 pandemic including recovery plans, PPE, infection rates, care homes and the vaccination roll out
- Received information and commented upon CCG corporate plan, commissioning intentions, finance, quality and performance
- Received information and commented upon presentations by guest speakers including mental health, adult social care, equality and diversity, children and young people, primary care, out of hospital plans and cancer.
- Received quarterly CCG Engagement activity reports to monitor CCG performance against the Engagement strategy
- Discussed and contributed to the CCG response to the White Paper on the Future of the NHS
- Gave feedback to the CCG about community perceptions and views in relation to local Covid 19 communications from their extensive social networks.

The focus for the Forum in this year will be to shape the patient and public involvement and assurance arrangements at Place building on established and developing good practice.

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

This year has been the most challenging for the CCG, however, as a result of previous work done to embed public involvement and engagement into the governance structures and planning, the CCG has been able draw on that experience in even the most trying of times.

The CCG developed a system of triangles some years ago, with a triangle consisting of a Clinical Lead, an administrator, and a lay member. The purpose of the triangle was to ensure any planning and governance had lay input. Examples of work schemes included Planned Care, Women and Children's services etc. The lay member of the triangle attended a Community Forum which was held on a monthly basis and the Forum has a key role in the planning, development, and delivery of CCG services. Benefits of this level of involvement and engagement are key to the future progression of CCG initiatives not just over the coming year but into the future as well. The role of the Forum is to provide lay challenge.

During the pandemic, the Forum has held meetings virtually through Microsoft Teams, a significant achievement given the number of people attending the virtual meetings. The Forum is supported through the Engagement team of the CCG. In order to ensure the Forum also has a strong voice at the highest level, the Chair of the CCG has a position on the CCG Board.

In addition to the Forum, the CCG has a public membership of around 2500, administered by CCG staff, but led by a Board of Members, known as the Steering Group. The community membership is called Accord and has developed in the last 5 years to become a key part of the CCG operation.

As with the Community Forum, the Steering Group has met virtually and over the last few months there has been a keen focus to reinvigorate the membership and involve the general public, by holding virtual events for members. Despite the pandemic, these events have involved speakers from the Hospital Trust, GPs and other healthcare professionals. They have drawn attendances of well over 50 people and involved Q and A sessions. The sessions have built on a series of events held in previous years to ensure our local community is still involved in what is happening at the CCG level.

Moving to my own involvement as Lay Member, I have been involved at the highest of levels in CCG work. The CCG share a CEO and staff with the Local Authority, and I am one of four CCG Board members who serve on a Union Board together with four Elected Councillors to oversee key healthcare issues within our local area. We have met at least twice virtually to discharge our responsibilities.

In addition to the Union Board and CCG Board, it was decided early in the pandemic to form a CCG Risk Committee to ensure all healthcare issues arising from COVID 19 were addressed. The Risk Committee consists of the CCG Board Lay Chair, the Non-Executive Director who is Audit Committee Chair, The CCG/LA CEO and myself as Lay Member, supported by key officers.

The Committee took on further responsibility as many more formal Committees were suspended due to COVID. I am able to say as a result that Lay representation was embedded at the highest level of CCG operation.

In more normal times, my Lay role involves serving as Vice Chair to the Primary Care Commissioning Committee and also the Integrated Governance and Audit Committee. I am also a member of the Clinical Safety Committee.

COVID has had a major impact in public involvement but I am able to say that in my opinion the CCG discharges its duty of public engagement and involvement extremely effectively. Rather than wait for the end of lockdowns and tiers, the CCG responding by embracing virtual meetings and the use of Microsoft Teams.

Public involvement has featured not only in the emergency committees established through Lay Member representation but impressively through its Public membership bodies, the Community Forum and Accord. Rather than wait until 'normal' times returned, both of those bodies continued by holding their meetings through Teams. The Accord Steering Group should be applauded for continuing to hold wider public events virtually, so ably supported by CCG Engagement staff.

The CCG has an excellent reputation for the highest levels of public engagement and as Lay Member with a responsibility for Lay and Public Involvement I am able to confirm the CCG has discharged not only its legal responsibilities but also responsibilities to our local community.

Reducing Health Inequalities

During 2020/21, NELCCG has made 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 primary care data**
  PCNs and the CCG have looked at potential dashboards to support practices and/or PCNs 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)

- **Tackling social isolation and mental health**
  Joint working groups (CCG/LA/VCSE) set up to develop and co-produce 'Art of the Possible' initiatives dealing with:

  - How can we work together to tackle social isolation in NEL?

  - Why are people who experience poor mental health living shorter lives than those that do not?

  - How can we prevent people in NEL developing life limiting health conditions before their time?

- **Digital Transformation – enabling ourselves to target vulnerable groups**
  During our response to the initial phase of the Covid-19 pandemic digital transformation was a key aspect of supporting us as a Partnership with other CCGs ensuring we could provide access to services. We recognise that for some groups this may have also created greater inequalities. Across the Partnership we are looking to embed these new ways of working as well as consider further options however we are doing more work around digital inclusion and focusing on digital and health literacy, targeted at communities likely to be at risk of worsening health inequalities

  We are working across the Partnership on:

  - Ensuring that we are monitoring and acting on the new data sets for digital pathways Developing a Humber-wide, strength-based community approach to developing Health Hubs – focusing on digital and health literacy, targeted at communities likely to be at risk of worsening health inequalities.

- **Mental Health and Wellbeing**

  a) The LiveWell platform was launched in response to the Covid-19 first wave to support people's mental health so IAG offers clear advice of where to go for help and support and access to an online wellbeing check-in

b) During COVID-19 the IAG offer on LiveWell has been extended to children, young people and families to support their family life wellbeing. (https://livewell.nelincs.gov.uk/children-and-young-people-and-families/)

Improve Quality

Jan Haxby, Director of Quality and Nursing leads the NEL CCG Quality & Nursing Team. The main role of the team is to support the commissioning of good quality NHS health and care services in North East Lincolnshire and to provide nursing leadership.

Our main role requires us to seek routine assurances regarding the quality of health and social care services and the outcomes for service users, and to share this with CCG colleagues, for example commissioner/service leads, to help inform their commissioning role. 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 quality. Where we have concerns, the CCG Quality teamwork at an enhanced level with the provider to support them to address any gaps in quality. The delivery of the Team's role 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 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.

Prior to the start of 2020/2021 financial year, the Quality & Nursing team's priorities were to continue with our main team role, but to also prioritise the following work-

1. Improve system safety and the safety culture in North East Lincolnshire through:
    - the development of a system-wide Infection Prevention & Control strategy
    - Implement the requirements of the National Patient Safety Strategy regarding incidents
2. Build on existing Safeguarding Partnership arrangements to:
    - alongside partners, strengthen the NEL strategic plans for domestic abuse
    - develop a service specification for the children looked after (children in care) health arrangements
3. Establish permanent arrangements in NEL for the national Child Death processes.
4. Continue to drive improvements in care identified from reviews of patients who die within 30 days of hospital discharge.
5. Develop the Nursing profession and hear the voice of nurses:
    - Improve networking between nursing provider teams
    - Promote professional nursing standards by working with senior nurses in nursing provider teams
6. Develop working relationships and aligned working with quality teams in our neighbouring CCGs.

The impact of the Covid-19 pandemic has negatively impacted upon the teams' ability to achieve all the priorities we set ourselves for 2020/21, and in some instance, progress has been delayed. However, due to the Covid-19 pandemic the Quality & Nursing team were required to undertake other roles and functions to support our providers, for example, in Wave 1 of the Covid-19 pandemic, delivering training to care homes for infection prevention and control (IPC) and the use of personal and protective equipment (PPE) for staff.

Our achievements under the 2020/2021 priorities include:

Priority 1 is about having safe services across NE Lincolnshire. During 2020 we engaged with key stakeholders across Northern Lincolnshire to establish a commitment to develop a system-wide Infection Prevention and Control Strategy for 2020-2025. In order to develop this we worked with stakeholders to understand through data and intelligence the current/emerging areas for focused improvement activity and developed a joint strategy to address the outcomes we want to attain. The draft strategy was completed but progress paused during 2020 in light of the Covid-19 pandemic and this document is awaiting final agreements and sign-off by all partners.

The CCG were required to identify a named Patient Safety Specialist within the organisation, and who has commenced engagement with the national Patient Safety network. The pilot of the new national incident framework has changed therefore the timescales with regards to the review of our systems and processes against the new framework has moved to next financial year, 2021/22.

We continue to share learning with our providers through our Quality Matters bulletin, which identifies themed areas of learning and promotes good professional standards.

Priority 2 is about continuing to grow the safeguarding partnership arrangements in NEL. The CCG produces a Safeguarding Annual Report each year and the full report for 2020/21 will be due for completion in quarter 1 of 2021.

Domestic Abuse is one of the biggest drivers of safeguarding activity within NE Lincolnshire and is agreed as a priority by the three locality statutory Safeguarding Boards. The Local Safeguarding Children Partnership, Safeguarding Adult Board and Community Safety Partnership collaborated to strengthen the strategic leadership and the financial commitment to this agenda through the newly developed North East Lincolnshire (safeguarding) Tri-Board. During 2020, multi-agency partners have contributed to the revision of the NEL Domestic Abuse Strategy 2021-2024 which included stakeholder consultation forums, and the strategy is now agreed through each of the 3 statutory safeguarding boards.

The number of children within the care system in NEL has been higher than the England and regional average for many years and the CCG has been required to provide increasing capacity into the Children Looked After (CLA) Health service to enable them to continue to assess and meet the health needs of children who are looked after by the local authority. The CLA health service is commissioned by the CCG from Northern Lincolnshire & Goole NHS Foundation Trust (NLaG) and during 2020, work has been underway between CCG and NLG colleagues to develop the service specification and key performance indicators, which is currently in draft form and being consulted on. The specification aims to offer clear and defined direction on how the service provides and meets statutory requirements in relation to the health of children looked after and how the service contributes to multi-agency/partnership working.

Priority 3 refers to the work required of all CCGs and Public Health teams nationally to fully implement and embed arrangements for the review of all child deaths. The national Child Death Review process was revised in 2018. Along with North Lincolnshire CCG and Public Health team, NEL CCG and NEL Public Health - as the 4 Child Death Review statutory partners - operate on a Northern Lincolnshire footprint to deliver the statutory arrangements through quarterly Executive Partners Meetings.

During 2020, we have been working with local providers to ensure the effective delivery of our local arrangements, and the operational local processes for the Child Death Review Panels have been further developed. In addition, NEL has established substantive arrangements to fulfil the posts of the Child Death Review Manager and Child Death Review Administrator.

Priority 4 refers to the work the CCG has been involved in for a number of years, working alongside the hospital provider (NLaG) and others like Care Plus Group, to understand the high Summary Hospital-level Mortality Indicator (SHMI), and to work collectively to address any quality issues identified through this work. During 2020 we have seen a significant improvement in the overall SHMI, which measures the actual death rate in a hospital compared to the expected death rate. We think this improvement is attributable mostly to work undertaken that reviewed how patients are coded upon admission to hospital in accordance with their needs and presenting symptoms.

During 2020 we have continued to review the case notes of patients who have died within 30 days of discharge from hospital, to identify potential for improvements in care. Themed areas of focus have included end of life care, clinical support provided to care homes, and strengthening the working between staff both in and out of hospital. The action plan for this work is due to be reviewed during 2021 and will identify any new themes.

Priority 5 was about strengthening nursing leadership and hearing the experience of the nurse workforce. We have made limited progress in this area due to the Covid-19 pandemic and the need to support other areas of work. One such piece of other work is described above regarding offering infection prevention and control training to care homes at the height of the Covid-19 pandemic, but another piece of work was to create a new recruitment agency that focuses on identifying the skills of people who are unemployed or furloughed due to the Covid-19 pandemic, and matching those skills with the workforce gaps being experienced and the roles required by our providers, particularly when providers were struggling for staff due to the impact of Covid-19. These roles were defined by our NEL health and social care providers to ensure the recruitment agency could offer much needed workforce.

We also established a new senior nurse meeting during 2020 to support networking between providers and peer support and which was helpful during periods of high Covid related activity and pressure on services. As needed, we have engaged with individual providers to support them at times of surge, including team members working directly into providers to offer leadership and capacity support.

We have also engaged with the strategic work being undertaken across the region to improve and increase the nursing profession; the initial focus has been on General Practice Nursing.

Priority 6 is about working closely with other CCG quality and nursing teams where it makes sense to do so and during 2020/21 we have built on our existing close working with the quality and nursing team in NL CCG, and have strengthened our working also with Hull and East Riding CCGs. We have agreed to work together and lead a number of quality and nursing agendas on behalf of each other where it is appropriate to do so. This has helped with clear and transparent communication and with aligning working practices and approaches. Increasingly, as the ICS develops, we will work jointly on a bigger footprint and we have started to include North Yorkshire & York in our more recent conversations about our strategic approaches to quality and nursing leadership.

This coming year, during 2021/22, as well as the main role of the team, we will be focusing on the following priorities: -

- Improve system safety and the safety culture in North East Lincolnshire
- developing the quality & nursing leadership arrangements including safeguarding leadership as part of the new emerging ICS arrangements – Nurse leadership will be very important as new models of care emerge.
- continue to focus on sustaining the progress made with regards to strategic agendas like domestic abuse and children looked after.

Further work on the priorities to refine the above and identify other priorities will take place in the next few months.

Principals of remedy – handling of complaints 2020-2021.

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 Experience Review Group and on to the Clinical 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. An appointed lay person from the local community works closely with the Customer Care Team, seeking the views of those who have used the complaints process to look at where the process can be refined and improved.

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 46 complaints; 23 of which were about NHS care, 16 of which were about adult social care and 7 were about both health and adult social care. Of the 28 complaints closed during 2020/21; 4 were upheld, 16 were partially upheld, 8 were not upheld and 11 were withdrawn.

Ombudsman investigations
No complaints were investigated by the Parliamentary and Health Services Ombudsman. The Local Government and Social Care Ombudsman carried out one investigation, the outcome of which was the complaint was not upheld, and consequently, no recommendations were made.

The CCG's Chief Operating Officer and Director of Quality and Nursing personally sign 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, the Covid-19 Pandemic restrictions prevented the further assurance checks to ensure learning from complaints has become embedded normally done during site visits to providers.

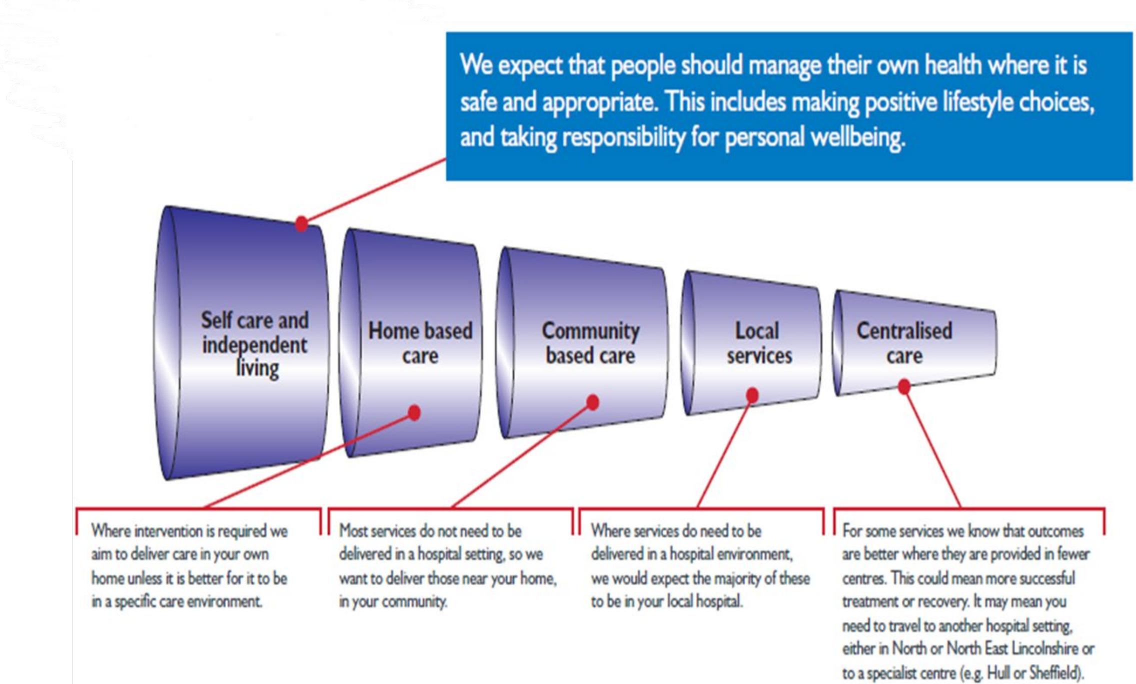
Learning from PALS, Complaints, incidents, and serious incidents is shared through a regular Bulletin to providers, and we meet regularly with stakeholders like the Care Quality Commission and Healthwatch to share information and intelligence, although again these meetings have been affected by the Covid-19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

A joint annual report on health and social care complaints is received by North East Lincolnshire Council Cabinet (consisting of elected members) for scrutiny.

Health and Wellbeing Strategy

We published our Union strategy (our partnership with the Local Authority in North East Lincolnshire) in July 2020 and as well as responding to all the needs and requirements of Covid, we have used the strategy to continue to underpin our medium and long term ambitions for the area.

This has included working 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:



Notably in this regard we 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 Social Prescribing link workers who have been integrated into 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 has also been aligned with and considered 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 made real strides in improving access to primary care 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 improved 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.

Admissions to urgent and emergency care have reduced as a result of the pandemic and we are looking to learn the lessons from this experience to enable us to keep these levels low into the future and continue to relieve pressure on our acute services

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

Commissioning activity and service redesign

During 2021/22 our commissioning activity has centred on responding to the COVID pandemic and responding to emerging issues. This has also formed the focus of service redesign which has been required to repurpose and adapt to the needs and constraints of operating in a COVID-safe way.

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

- Worked to reshape primary care delivery to reduce face to face consultations and offer more phone and video-based consultations
- Moved to a system of hot and cold sites to cater for patients who still require face to face contact but who may or may not have a COVID infection
- Worked with partners across the Humber as part of the Local Resilience Forum to ensure a co-ordinated approach to the operational needs of managing service adaptation to COVID-related delivery
- Accelerated our work on support for digital service delivery and home working arrangements for CCG staff
- Planned for and delivered the first phases of the COVID vaccination programme
- Planned for and begun to reinstate services as appropriate across the system in acute and community care
- For each of the service areas and pathways we have reviewed and adapted them to take account of COVID-related constraints and implications

Our commissioning activities have been responsive to the pandemic and can now focus on moving ahead with priorities and transformation which picks up pre-pandemic needs, post-pandemic needs and gets the organisation back on track for delivery against the NHS Long Term Plan

Access to Information (FOI)

During the period from 1 April 2020 to 31 March 2021, the CCG processed the following requests for information under the Freedom of Information Act 2000 (FOIA):

FOI	2020/2021
Number of FOI requests processed	199
Percentage of requests responded to within 20 working days	100%
Average time (in days) taken to respond to an FOI request	14 days

The CCG provided the full information requested for 88 requests. The CCG did not provide all the information requested in 48 cases because an exemption was applied either to part of, or to the whole request. The exemptions applied were.

- The information was accessible by other means,
- The cost of providing the information exceeded the limits set under FOIA,

- Information requested related to personal data or would constitute a breach of confidentiality.

In 63 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 received 1 request for an Internal Review of an FOI response provided during this year in Quarter Two. The review concluded the information held by the CCG had been appropriately provided and the correct exemptions applied and explained in full.

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
10 June 2021

Accountability Report

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

Corporate Governance Report

Members report

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

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

During the reporting period 1 April 2020 – 31 March 2021 the following changes took place:

- Drs Chalmer & Meier's and The Roxton Practice merged on 3 April 2020, delivering services at Immingham and Weelsby View Health Centre. The result of the above change is that the CCG now has 25 member practices, which is a reduction from the 26 reported in the 2019-2020 Annual Report

All our GP practices are members of a Primary Care Network (PCN) (group of practices) and there are three PCNs within North East Lincolnshire which were first formed in April 2019. The PCNs were self-selected, based on working with like-minded practices and having common interests

Our member practices are:

- Beacon Medical Primary Care Centre
- Birkwood Medical Centre
- Blundell Park Surgery
- Chantry Health Group
- Clee Medical Centre
- Core Care Family Practice
- Dr A Kumar
- Dr A Sinha
- Dr O Z Qureshi Surgery
- Dr P Suresh-Babu
- Dr R Mathews
- Greenlands & New Waltham Surgery
- Fieldhouse Medical Group
- Healing Health Centre
- Humberview Surgery
- Littlefield Surgery
- Open Door
- Pelham Medical Group
- Quayside Medical Centre
- Raj Medical Centre
- Roxton at Weelsby View
- Scartho Medical Centre
- The Lynton Practice
- The Roxton Practice (Immingham)
- Woodford Medical Centre

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
Steve Pintus	Director of Public Health
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 2020-2021:

Dr Sudhakar Allamsetty	Chair of Council of Members, GP representative Aug 2019 – 04 Jan 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

Details and a summary of work of all committees, is set out in our Annual Governance Statement

Register of interests

The CCG have arrangements in place to ensure that conflicts of interest are appropriately managed with transparency and proportionality. Our Standard of Business Conduct and Managing Conflicts of Interest Policy provides guidance and outlines the process in place for maintaining registers 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. Governing Body Members, Committee members, employees and member practices are asked to complete a declaration of interest form to identify any potential conflicts of interest. 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.

Prior to each Governing Body and committee meeting, members are required to declare any conflicts of interest in the agenda items for consideration and these are formally recorded in the minutes.

Any request for historical information must be submitted to the CCG's Chief Finance Officer.

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 2021 is published on our website

Personal data related incidents

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

The CCG has not reported any personal data related incidents to the Information Commissioners Office during 2020/21.

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.

2020/21 Process due to Covid-19 Pandemic

The CCG is active in the LHRP forum and the EPRR assurance process. In October 2020 North East Lincolnshire completed the annual mandatory self-assessment against the EPPR requirements recording a “substantial” compliance level with the requirements. This was a slightly different process to previous years due to the NHS dealing with the Covid-19 Pandemic; and NHS England set out a different process for 2020/21 assurance streamlined to allow providers to focus on delivering the Covid-19 response. Instead of completing a full assessment of itself against the Core Standards including a deep dive which is usually changed every year, CCG’s were instead asked to submit a statement of compliance addressing the 3 following main areas:

1. progress made by organisations that were reported as partially or noncompliant in the 2019/20 process

2. the process of capturing and embedding the learning from the first wave of the COVID-19 pandemic

3. inclusion of progress and learning in winter planning preparations

CCGs were also asked the following questions:

- That where relevant your EPRR assurance action plans have been reviewed in order to improve your level of compliance against the 2019/2020 EPRR Assurance Core Standards, and where you have previously reported partial or non-compliance as your overall assurance rating that you provide an updated assurance level following review and delivery of your ongoing action plans.

- That you have undertaken, or plan to undertake, a formal review process on your response to the COVID-19 pandemic to date, and have associated plans to ensure that the lessons and recommendations from that review are embedded as part of your ongoing EPRR work programme, and

- That you have reviewed your response to the COVID-19 pandemic and taken steps to embed key lessons and actions in your planning for winter and associated system response arrangements.

The CCG worked with NAViGO, NLaG and Care Plus Group who are Category 1 providers in order to provide assurance for the North East Lincolnshire area.

North East Lincolnshire CCG Submission for 2020/21

In 2019/20, the CCG reported that it was fully compliant with 42 out of 43 of the core standards and partially compliant with 1 (infectious disease). The update from the CCG submitted was as follows:

Infectious disease outbreaks were extensively exercised last year with a recommendation that a document is finalised, or an MOU, for North East Lincolnshire partners encompassing arrangements for PGD sign off and payment in line with the DPH Principles on Managing Infectious Diseases. This document has not been formally drafted due to mobilisation of the Covid-19 response. It is felt that this document is still required, but the following documents have been drafted amongst many others to support infectious disease response:

- Northern Lincolnshire Standard Operating Procedure for Swabbing for Covid-19
- North East Lincolnshire SOP for Management of Covid-19 Outbreaks in Health and Social Care Settings
- North East Lincolnshire System Resilience Plan.

The CCG also participated in and holds actions for the North East Lincolnshire Council Local Outbreak Management Plan specifically centred around Covid-19. This standard ought to remain partially compliant for now pending finalisation of the generic infectious disease document but this pandemic has proven that NEL does have the resource and able partnership working to respond to an infectious disease outbreak.

After a review of the core standards the CCG confirmed it remains fully compliant with the other 42 standards. The assurance rating for 20/21 would remain “Substantially Compliant”.

Covid-19 and other Emergency Planning Work

The majority of emergency planning work this year has of course been taken up responding to the Covid-19 Pandemic. Emergency Planning and Clinical Staff across NEL worked together to ensure:

- Creation of a centralised PPE store for NEL ensuring ample access to PPE including FFP3 masks and appropriately trained individuals. This service played a crucial part in getting PPE to our frontline health and social care staff, particularly during the early stages of the pandemic when PPE stores were short. The service continues to run, albeit with less users due to the Department of Health and Social Care Portal expanding its criteria on those who can register for free PPE.
- Creation of a Pillar 1 swabbing service in conjunction with Northern Lincolnshire and Goole Foundation Trust, Care Plus Group and North Lincolnshire CCG. The service allowed for local swabbing of health and social key workers with results being held locally at our Covid Co-ordination Hub (CHUB). CHUB also supported testing in care homes and difficult to reach settings whilst the national programmes were being rolled out.

The CCG participated in various exercises as well as dealing with the Covid-19 pandemic:

- Comms testing
- Outbreak scenario testing with local partners
- Concurrent emergencies exercises
- Winter planning exercise
- Cyber incident exercise

The CCG continued its work to gather intelligence on EU Exit following a deal being agreed in Winter 2020 by communicating out key messages for the NHS to providers, conducting webinars for Primary Care and co-ordinating an assurance collection exercise for all providers including adult social care. Work also continued reviewing the emergency plans in place for instances of arrivals of undocumented migrants in NEL ports, particularly considering Covid-19 and any other infection control procedures.

The CCG has this year collaborated with the 3 other Humber CCG's (Hull CCG, North Lincolnshire CCG and East Riding of Yorkshire CCG) to review and redesign the "Director-on-call Pack" for use in on-call incidents and emergencies; and the CCG's internal business continuity plan has been reviewed and strengthened for 2021 with approval of the final document granted in March 2021.

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
10 June 2021

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 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 Accounting 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
Accountable Officer
10 June 2021

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 2020 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).

During 2020-21 the CCG has continued to work alongside the other 3 CCGs in the Humber as part of the development of the Humber Partnership within the Humber Coast & Vale Integrated Care System. The development of the Humber Partnership will be a key component of the Integrated Care System (ICS) as we implement the changes recently announced as part of the White Paper.

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 has reviewed its constitution, which sets out how the organisation will ensure well governed and accountable to both its GP member practices and its local population. This has been updated in line with the NHS England revised model Constitution. A governance handbook has been produced, the purpose of this handbook is to bring together a range of documents, which support the Constitution and good governance. The Constitution and 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. 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 Governing Body has responsibility for ensuring good governance arrangements as well as its main functions. The Scheme of Delegation sets out those decisions that are reserved to the membership, its Governing Body, its committees, individual officers, and other employees.

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 audit review provided **significant** assurance on the effectiveness of the governance arrangements in place within the CCG. To further strengthen the arrangements the auditors made one moderate recommendation in relation to the assurances being provided to the Governing Body from the Sub-Committees.

As part of the CCG's commitment to openness and transparency, meetings of the Governing Body are held regularly in public, and members of the public are encouraged to attend any of our meetings that are held in public. Governing Body meeting papers are available on our website. The Governing Body's forward plan is a key mechanism by which governance oversight is appropriately timed and transparency and maintained in a way that does not create unnecessary governance processes.

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 has a detailed work programme. These terms of reference are reviewed annually and amended in respect of the evolving needs of the CCG. All committees have at least one Governing Body, 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, each committee provides a committee annual effectiveness self-assessment report to the Governing Body which summarises key discussions and discussions made throughout the year.

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 CCG structure, terms of reference and brief description for each committee are published on the CCG's website.

During 2020-21 and as a result of the COVID 19 Pandemic the CCG put temporary revised governance arrangements in place, which were in line with the NHS England Reducing the Burden guidance.

During the first phase of the pandemic, a special Emergency Powers oversight meeting (COVID Risk Committee) was established (April 2020). The terms of reference covered:

- reviewing COVID 19 decisions
- raise challenge where required but also endorse decisions
- to safeguard all (CCG leaders, the CCG itself and the community)

Membership of the committee is the CCG Lay Chair, Governing Body Lay members, Joint Chief Executive, and Chief Finance Officer. Whilst there is no Clinical Representation on the Committee the notes & actions will be copied into the Clinical Chief Officer.

The meeting took place weekly until August when it then started to meet fortnightly. The minutes of the meeting are circulated to the Governing Body.

All other committee meetings stopped meeting (either physically or virtually) from April 2020 until August 2020. During this period decision making was either via:

- The risk committee
- Chairs Action (Where an urgent decision (< 7days) is required to be made)
- Virtually (Where a decision is required within the period but is not urgent)

The scheme of delegation remained unchanged

Upon the recommencement of all Committee meetings, a number of changes were made to the way they were structured and designed so as to create more focussed, effective meetings.

All meetings have been held on a virtual basis during the year. The CCG has fully embraced virtual working and the roll out of new technology such as MS Teams to support remote working and maintain business continuity.

As part of the review of each committee, we maintain a record of attendance of the committee's membership (see below).

The Membership, Attendance and Activity Summary

The 2020-21 membership and attendance summary of the Council of Members, Governing Body and Governing Body committees is given below.

Council of Members

Members' attendance

Members	Attendance (maximum of 3 meetings)
Beacon Medical Primary Care Centre	0
Birkwood Medical Centre	3
Blundell Park Surgery	0
Chantry Health Group	2
Clee Medical Centre	2
Core Care Family Practice	0
Dr A Kumar	0
Dr A Sinha	2
Dr O Z Qureshi Surgery	2
Dr P Suresh-Babu	0

Members	Attendance (maximum of 3 meetings)
Dr R Mathews	2
Greenlands & New Waltham Surgery	0
Fieldhouse Medical Group	1
Healing Health Centre	0
Humberview Surgery	0
Littlefield Surgery	0
Open Door	2
Pelham Medical Group	0
Quayside Medical Centre	2
Raj Medical Centre	0
Roxton at Weelsby View	3
Scartho Medical Centre	1
The Lynton Practice	0
The Roxton Practice (Immingham)	3
Woodford Medical Centre	0
Executive Director with responsibility for ASC strategic commissioning	3

Governing Body

Members' attendance

Members	Attendance (maximum of 3 meetings)
Mark Webb (Chair)	3
Dr Peter Melton	2
Dr Ekta Elston	3
Dr Sudhakar Allamsetty (left January 2021)	2
Dr Renju Mathews	2
Dr Jeeten Raghwani	3

Members	Attendance (maximum of 3 meetings)
Dr Chris Hayes	2
Philip Bond	3
Tim Render	3
Rob Walsh	3
Helen Kenyon	3
Laura Whitton	3
Jan Haxby	2
Steve Pintus	3
Joe Warner	3
Anne Hames – standing attendee	3
Joanne Hewson – standing attendee	0

Risk Committee

Members' attendance

Members	Attendance (maximum of 25 meetings)
Mark Webb	23
Dr Peter Melton (in attendance)	13
Philip Bond	25
Tim Render	24
Rob Walsh	21
Laura Whitton	24

Union Board

Members' attendance

Members	Attendance (maximum of 2 meetings)
Mark Webb	2
Dr Peter Melton	1
Philip Bond	2
Dr Sudhakar Allamsetty (left January 2021)	1
Councillor Philip Jackson	2
Councillor Margaret Cracknell	2
Councillor John Fenty (left December 2020)	1
Councillor Ian Lindley	1

Community Forum

Members' attendance

Members	Attendance (maximum of 11 meetings)
Anne Hames (Chair)	11
Albert Bennett	11
Jean Cross	8
Eveline Dawson	11
Diane Edmonds	10
Christine Foreman	11
Bernard Henry	11
Marie Linford	8
Terry Simco	10
Pam Taylor	10
David Walker	9
Peter Vickers (commenced July 2020)	8

Integrated Governance & Audit Committee

Members' attendance

Members	Attendance (maximum of 5 meetings)
Tim Render (Chair)	5
Dr Karin Severin	1
Councillor Margaret Cracknell	4
Joe Warner	5
Philip Bond	5
David Walker (joined September 2020)	2

Primary Care Commissioning Committee

Members' attendance

Members	Attendance (maximum of 2 meetings)
Mark Webb	2
Philip Bond	2
Laura Whitton	2
Dr Ekta Elston/Dr Anupman Sinha	2
Dr Sudhakar Allamsetty/Dr Renju Mathews (left January 2021)	0
Steve Pintus	2
Councillor Margaret Cracknell	2
Jan Haxby/John Berry	2

Remuneration Committee

Members' attendance

Members	Attendance (maximum of 1 meeting)
Mark Webb (Chair)	1
Tim Render	1
Dr Sudhakar Allamsetty (left January 2021)	0
Dr Jeeten Raghwani	1

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, which provides assurance to the Integrated Governance & Audit Committee and Governing Body that strategic and operational risks are being managed and where necessary escalated. 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.

NHS North East Lincolnshire CCG defines its risk within the two categories as per below:

- Strategic Risks – relate to the delivery of the organisation's strategic objectives. They have the highest probability for external impact.
- Operational Risks – relate to the organisations day-to-day business delivery, whilst they may have some external impact, operational risks mostly affect internal functions and services.

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 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 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. This ensures that the process is maintained and act on behalf of the Governing Body to ensure that mitigation plans are in place to manage the risks identified.

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 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.

It was agreed for a Governing Body workshop to take place during 2020/21 to review the risk management arrangements and effectiveness. However, due to the impact of the COVID 19 pandemic this has been put on hold and will be developed in 2021/22 as part of the wider integration in strategic and operational planning, as we focus on the support and recovery of the pandemic

The internal audit review provided **significant** assurances that there is an effective risk management process in place together with effective system of internal controls to manage the principle risks identified by the organisation.

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.

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 taken into account.

- 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.

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. Annual risk awareness sessions continue to take place with risk managers and assignees to ensure continued effective risk management and appropriate controls are in place, and mitigating actions are progressed and monitored.

The impact of the COVID 19 pandemic has resulted in the CCG facing significant risks and the CCG's capacity to respond and support our partner organisation to manage the adverse effects of the pandemic on our local population. The CCG's governance arrangements have been rearranged and moved to a more focussed streamlined approach and decision-making model. This includes the creation of the Risk Committee to enable regular focussed discussions pertinent to impact of COVID both directly and indirectly.

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. The risk management strategy sets out the management and assessment of risks.

Each risk has a risk assignee and risk manager. The assignee has the operational oversight of the risk and the manager is the senior manager of the risk area. The risks are regular reviewed and updated on a regular cycle by the risk assignee and annually with the risk managers.

2020-21 has been a challenging year for the CCG working under different circumstances, priorities, and pressures. However, during the year the all risks continued to be updated on a regular basis. With effect from February 2021, our approach to risk management and assessment of risks has been moved to a more integrated approach across performance and CCG priorities with single monitoring and reporting via the CCG's Operating Leadership Team (OLT), with exception reports to the Integrated Governance & Audit Committee. The new approach was approved by the Integrated Governance & Audit Committee in March 2021. This will reduce the burden on the individuals and allowing the wider organisational oversight, with only one update on a more streamlined timeframe with a triangular approach and the opportunity to link the areas together. This process will be reviewed, and deep dive session is planned for the autumn.

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 2020/21 there were **four** Adult Social Care risks on the risk register.

The total risks held on both Board Assurance Framework and the Risk Register at the end of 2020/21 with a residual risk rating being assessed as high level (15+) was **six** opposed to **fourteen** as at 2019/20.

There are currently no principal risks on the Board Assurance Framework rated at 15 or above as at end of Quarter 4

The North East Lincolnshire CCG principal risks on the Risk Register (a risk rating of 15 and above) are listed in the table below:

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.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.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.

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
					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.
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

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
				CCG-RR.2004j Missed Opportunities Audit	An audit by team of subject matter experts review 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.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.
				CCG-RR.2014d Risk assessed/triaged case load	All cases are risk assessed and prioritised for approval. Work being undertaken with Navigo and Focus to try and prevent inappropriate applications and to prioritise existing ones more effectively
				CCG-RR.2014e BIA training and competency framework	High quality BIA training has been procured and the BIA competencies have been defined so that ongoing development of workers can be managed and their competency assessed and assured. This includes arrangements for supervision.
				CCG-RR.2014f MCA training	MCA training is being commissioned following an audit of care providers which revealed a number of gaps in training and concerns about the quality of the training offered. Focus are now providing this training. Focus have created a training lead post for MCA and Safeguarding and have successfully recruited to this as a job share. The post holders will work with the existing provider to develop a hand over training package and develop new offers to meet demand. MCA training has been reshaped and a new curriculum and

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
					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 trialed. 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
				CCG-RR.2014g BIA forum and ongoing professional development	There is a monthly BIA forum which provides the opportunity to share practice and to learn from case law examples.
				CCG-RR.2014h Light touch approach for cases	We have implemented part of the light tough approach. Work continues to develop the light touch approach and pilot with urgent and discharge cases
				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

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
				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
				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

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
					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
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	Lydia Golby and Eddie McCabe are the CCG representatives on this 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 with Bev Compton, Helen Kenyon, Laura Whitton, Eddie McCabe, Rachel Brunton and Nic McVeigh 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.

Significant 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 "**significant assurance**" has been provided. To further strengthen the arrangements the auditors made five minor recommendations, these have all now been implemented.

NHS England issued guidance in April 2020 to reduce burden and release capacity to manage the COVID 19 Pandemic the collection of the conflict of interest self-certification returns has been paused until further notice.

During 2020/21 the CCG has not recorded any breaches in relation to the CCG's Conflicts of Interest Policy.

The CCG achieved above the 90% compliance level required for conflict of interest training for 2020/21.

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.

All the organisation's main providers are required under their contract to have good quality data that is compliant with national standards. Monitoring data quality is achieved through formal contract

monitoring arrangements. Where required local standards are agreed and reviewed on an annual basis.

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). Due to the COVID 19 Pandemic our DSPT was submitted May 2021. 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 audit of the Data Security and Protection Toolkit (DSPT) provided an opinion of **"High"** assurance demonstrating a high level of compliance in relation to the evidence to support the CCG's submission of its DSPT self-assessment.

The CCG has worked with the Data Protection Officer to ensure that following the end of the Brexit transition period on 31 December 2020, when the UK became a third country for the purposes of data transfers with the EU / EEA, the CCG remained compliant with its data protection obligations and any data flows with the EU / EEA including hosting would continue. This included confirming if any personal data was processed outside of the UK, and if so, obtaining the relevant assurances from its system suppliers that handle and process personal data to ensure ongoing compliance and the continuation of data flows if the UK was not granted an Adequacy Decision, e.g. the use of standard contractual clauses.

In December 2020, as part of the trade deal, the EU agreed to delay transfer restrictions for at least four months, which can be extended to six months (known as the bridge). In February 2021, the European Commission published its draft decisions on the UK's adequacy under the EU's GDPR and Law Enforcement Directive. In both cases, the European Commission has found the UK to be adequate.

The Information Governance Steering Group oversees and drives the broader Information Governance Agenda, the implementation of the Clinical Commissioning Group's (CCG's) Information Governance Framework, including identifying lines of accountability and to ensure that information governance practices and procedures are embedded throughout the CCG. The group reports to the Integrated Governance & Audit Committee and provides assurances that effective information governance best practice mechanisms are in place within the organisation.

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.

We ensure all staff undertake the annual information governance training (Data Security Awareness) and continued to maintain a 100% compliance rate. In additional to the mandatory training the SIRO, Caldicott Guardian and Information Asset Owner completed 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.

We will continue to develop information governance processes and procedures in line with the requirements of the law, the DSPT and the national information governance agenda.

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 and 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.

The CCG contracted with a number of 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 e.g. Service Auditor reports.
- Work undertaken by AuditOne, AuditYorkshire 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 20/21:

- NHS Shared Business Services Limited - ledger and financial systems due to manual credit requests on the sales ledger not being authorised by the appropriate client user.
- NHS Business Services Authority – prescription payments process due to controls not suitably designed or operating effectively in respect of payments made to the correct, valid contractors, completeness of prescriptions scanned against prescription declared by pharmacies and access to the system being appropriately restricted.
- Electronic Staff Records – controls not suitably designed to provide assurance that security configurations are created, implemented, and maintained to prevent inappropriate access.
- Capita Business Services Limited due to controls around ensuring cheque payments received are recorded completely and accurately and ensuring logical access by internal Capita staff is restricted to authorised individuals.

The CCG however has got local controls in place to mitigate these.

I have been advised that adequate assurances have been provided for 2020/21 for the other services bought by the CCG.

Control issues

No significant control issues have been identified during 2020-21. However, an internal audit review of Local Government Ombudsmen (LGO) Decisions an opinion of limited assurance was given. The audit found that "strong systems were in place for horizon scanning of decisions made by the LGO which may have an impact on adult social care practices and that a selection of these decisions are discussed further at the CCG/Social Work Practice (SWP) meetings. However, it is not always clear how the information provided is taken forward, whether there are actions put in place as a result of these discussions, and if any actions that are stated are subsequently checked to ensure they are implemented and if any have an impact on working practices and processes. In addition, similar arrangements do not currently exist with the other CICs in the area Care Plus Group or NAVIGO"

There were five actions identified of which two remain outstanding and these will be implemented by November 2021 and will be monitored and overseen by the CCG's Integrated Governance & Audit Committee.

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, Union Board 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 2020-21 due to COVID. As we move out of the pandemic and

into 2021-22 we will be carrying out an assessment as part of the planning of the benefits efficiencies as a direct result of the different ways of working during COVID so that this can be continued as we move back to business as usual.

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 of 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. The latest data available is for 2019-20 quarter four of which the CCG is rated as **"Green"**

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

North East Lincolnshire Council and the North East Lincolnshire Clinical Commissioning Group continue to work very closely together to deliver health services in North East Lincolnshire. As this relationship has developed, both organisations looked forward to the next stage to consider how they could be better equipped to deal with the on-going challenges faced by local government and the NHS and the development of the Integrated Care System.

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

Counter fraud arrangements

The CCG has a team of accredited Counter Fraud Specialists (LCFSs) that are contracted to undertake counter fraud work proportionate to identified risks. In January 2020, the NHS Counter Fraud Authority (NHSCFA) issued Standards for Commissioners – fraud, bribery and corruption to LCFSs and Chief Finance Officers. The standards outlined an organisation's corporate responsibilities regarding counter fraud and the key principles for action. The work plans for 2020/21 followed the format of the standards and described the tasks and outcomes that informed anti-fraud activity.

The standards are as follows:

- Strategic governance – this sets out the requirements in relation to the strategic governance arrangements of the organisation to ensure that anti-fraud measures are embedded at all levels across the organisation.

- Inform and Involve – this sets out the requirements in relation to raising awareness of fraud risks against the NHS and working with NHS staff and the public to publicise the risks and effects of fraud against the NHS.

- Prevent and Deter – this sets out the requirements in relation to discouraging individuals who may be tempted to commit fraud against the NHS and ensuring that opportunities for fraud to occur are minimised.

- Hold to Account – this sets out the requirements in relation to detecting and investigating fraud, prosecuting those who have committed frauds, and seeking redress.

The CCG's counter fraud arrangements are in compliance with NHS Counter Fraud Authority's Standards for Commissioners: fraud, bribery and corruption. These arrangements are underpinned by the appointment of accredited local counter fraud specialists, the introduction of a CCG-wide countering fraud and corruption policy and the nomination of the Chief Finance Officer as the executive lead for counter fraud.

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.

It should be noted that at the end of July 2020 the NHSCFA issued a circular concerning the publication by the Cabinet Office of the Government Functional Standard GovS 013: Counter Fraud (Functional Standard). The circular outlined the NHSCFA's plans for the Functional Standard to be introduced across the NHS, detailing the intended arrangements and timescales. On 29 January 2021, the NHSCFA rolled out new counter fraud requirements for NHS-funded services in relation to the Functional Standard. All NHS bodies will be expected to work towards covering all 13 requirements by the end of 2021/22. Organisations were issued a Functional Standard Return in March 2021 and will need to submit this by the deadline of the end of May 2021. As with the previous SRT, this process should be overseen by the organisation's Chief Finance Officer and Integrated Governance and Audit Committee Chair in line with the organisation's existing approach to counter fraud assurance. The counter fraud work plan for 2021/22 will be designed to align to the requirements of the new standard.

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.

From 1st April 2020 to 30th September 2020 Audit One provided the CCG's internal audit services. For completeness, and as has been reported to the Audit Committee, the outcome of these completed audits is listed in the table below. The results of these audits will not feature in our formal Head of Audit Opinion for 2020/21.

In addition, 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. The outcome of the completed audits is listed in the table below to support a more comprehensive view of the CCG's system of internal control

The Head of Internal Audit concluded that: -

Our overall opinion for the period 1 October 2020 to 31 March 2021 is: Significant assurance can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.

During the year internal auditors issued the following audit reports:

AUDIT WORK COMPLETED BY AUDIT YORKSHIRE

Governance and Risk Management Arrangements	Significant
Conflicts of Interest	Significant
Key Financial Controls	High
Data Security and Protection Toolkit	High

The following audits, which have been reported separately by the service providers are noted here for completeness in providing an overall view of the CCG's internal control system. Work completed by AuditOne or North East Lincolnshire Council have not been considered and the opinion is therefore based solely on the work undertaken by Audit Yorkshire.

AUDIT WORK COMPLETED BY AUDITONE

Primary Care Commissioning	Full
Financial and Strategic Planning including QIPP	Substantial
Continuing Healthcare Hospital Discharge Scheme	Substantial

AUDIT WORK COMPLETED BY NORTH EAST LINCOLNSHIRE COUNCIL (Section 75 Agreement)

Local Government Ombudsmen Decisions	Limited – two actions remain outstanding. These will be implemented by November 2021 and monitored and overseen by the Integrated Governance and Audit Committee
Safeguarding	Substantial
Single Point of Access	Satisfactory
Infection Control	Satisfactory

Internal Audit had planned to provide assurance on delivery of the implementation of the Adult's strategy, but the pandemic has delayed its launch, and thus an in-depth audit has not been carried out in 2020/21. High level discussions, however, have confirmed that some progress has been made on the key themes contained within the action plan. Specifically, a significant amount of work has been carried out in building relationships between partners and creating a common approach to areas such as access to Information and Advice

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.

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 on 11 February 2021, 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

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. No significant control issues have been identified in year that have an impact on the effectiveness of the CCG. The issue raised as a result of internal audit have been identified in the control issue section of this statement.

Dr Peter Melton
Clinical Chief Officer
10 June 2021

Remuneration and Staff Report

Remuneration Report

Remuneration committee members

The Remuneration Committee is a formal committee of the Governing Body whose members were appointed by the Governing Body. In 2020/21 members and attendees were:

Members	Attendance (maximum of 1 meeting)
Mark Webb (Chair)	1
Tim Render	1
Dr Sudhakar Allamsetty (left January 2021)	0
Dr Jeeten Raghwani	1

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

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

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 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

2019-20 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				0-2.5	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				15-17.5	115-120
Jan Haxby	Director of Quality & Nursing	85-90				10-12.5	95-100
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	10-15				30-32.5	45-50
Dr Chris Hayes	Secondary Care Doctor	5-10					5-10
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	45-50				2.5-5	45-50

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	0.0-2.5	35-40	95-100	801	26	852	-
Helen Kenyon Chief Operating Officer	0-2.5	0.0-2.5	40-45	95-100	745	24	796	-
Laura Whitton Chief Finance Officer	0-2.5	0.0-2.5	35-40	90-95	721	26	773	-
Dr Ekta Elston Vice Chair Council of Members/Medical Director	5-7.5	10-12.5	10-15	20-25	91	75	177	-

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 2020/2021 – refer to **Note 4** of the Financial Statements.

Payments to past members

Nil return for 2020/2021 – refer to **Note 4** of 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.

Pay multiples (Subject to Audit)

Year	**2020/21**	**2019/20**
Band of highest paid director's total remuneration (£'000)	120-125	120-125
Median total	30,811	30,511
Ratio	4.0	4.0

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

The banded remuneration of the highest-paid director, in North East Lincolnshire Clinical Commissioning Group in the financial year 2020-21 was £120,000 - £125,000. (2019-20 £120,000 - £125,000). This was 4.0 times (2019-20 4.0 times) the median remuneration of the workforce, which was £30,811 (2019-20 £30,511).

In 2020-21, no (2019-20, no) employees received remuneration in excess of the highest-paid director as per the remuneration table. Remuneration ranged from £8,856 to £103,361 (2018-19 £8,040 to £102,308).

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

Off-payroll engagements

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 2021, for more than £245 per day and that last longer than 6 months are as follows:

Table one: Off-payroll engagements longer than six months

Number of existing engagements as of 31 March 2021	37
Of which, the number that have existed:	
For less than 1 year at the time of reporting	16
For between 1 and 2 years at the time of reporting	4
For between 2 and 3 years at the time of reporting	5
For between 3 and 4 years at the time of reporting	3
For 4 or more years at the time of reporting	9

Where the reformed public sector rules apply, entities must complete Table 2 for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021 for more than £245 per day and that last for longer than 6 months:

Table 2: New off-payroll engagements

Number of new engagements, or those that reached 6 months in duration, between 1 April 2020 and 31 March 2021	16
of which	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	16
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	21
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility

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	22

Staff Report

a) Staff Composition

The CCG has a staffing establishment of 95.4 whole time equivalents in its headquarters function and has formal arrangements in place to buy in a range of support services from a number of different providers at a cost of £1.71 Million in 2020/21.

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

Gender	Total (Female)	Total (Male)
Band 8a	5	1
Band 8b	6	3
Band 8c	3	1
Band 8d	1	1
Band 9	0	0
VSM	4	0
Governing Body	1	8
Any other spot salary	2	2
All other employees (including apprentice if applicable)	63	15

b) Staff Deployment

- Two short term secondments have taken place in 2020/2021; one Band 8A and one Band 8b. One of these secondments is still ongoing.
- The average length of secondment is 5.5 months (this includes the total length of secondment for the individual who is still on secondment).
- Average length of time on secondment in 2020/21 is 2.5 months

c) Expenditure on consultancy

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

d) Employee Benefits and Staff Numbers

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**

2019-2020	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	2,923	136	**3,058**	553	0	**553**	3,476	135	**3,611**
Social security costs	311	15	**326**	55	0	**55**	366	15	**381**
Employer contributions to the NHS pension scheme	583	18	**601**	132	0	**132**	715	18	**733**
Other pension costs	0	0	**0**	0	0	**0**	0	0	**0**
Apprenticeship levy	3	0	**3**	0	0	**0**	3	0	**3**
Other post-employment benefits	0	0	**0**	0	0	**0**	0	0	**0**
Other employment benefits	0	0	**0**	0	0	**0**	0	0	**0**
Termination benefits	0	0	**0**	0	0	**0**	0	0	**0**
Gross employee benefits expenditure	**3,820**	**168**	**3,988**	**740**	**0**	**740**	**4,560**	**168**	**4,728**
Less recoveries in respect of employee benefits (note 4.1.2)	(8)	0	**(8)**	(35)	0	**0**	(43)	0	**(43)**
Total – net admin employee benefits including capitalised costs	**3,812**	**168**	**3,980**	**705**	**0**	**705**	**4,517**	**168**	**4,685**
Less: employee costs capitalised	0	0	**0**	0	0	**0**	0	0	**0**
Net employee benefits excluding capitalised costs	**3,812**	**168**	**3,980**	**705**	**0**	**705**	**4,517**	**168**	**4,685**

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 a second 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 strong 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.

With the majority of staff working from home during the pandemic, line mangers have undertaken 1:1 Wellbeing conversations with staff to focus on individual needs and provide appropriate support. Wellbeing surveys have been undertaken across the Union to identify wider needs and inform resource planning. 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

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 Health & 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 we also have a selection of staff trained in defibrillator usage. The CCG moved into NELC Municipal Offices in August 2018 and comply with NELC's procedures for the building.

Health and safety is a part of the mandatory e-learning schedule that needs to be undertaken by all staff and data screen assessment (DSE) is part of this training schedule. For the period April 2020 to March 2021 there were 0 incidents reported under the category of Health and Safety.

Policies that support equal treatment in employment and occupation

As an employer the CCG recognises and values people as individuals and accommodates differences wherever possible by making adjustments to 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.

Staff Consultation

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 and A sessions take place with the Union leadership team.

Talent and development

The Union offer a Talent and Leadership Academy, an in-house leadership programme available to all staff, which is currently in its fourth year of operation. 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 NELC's online learning platform. A Learning Agreement has been signed with Unite and UNISON, allowing staff access to a range of course through their online learning platforms.

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.

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
10 June 2021

Annual Accounts

Foreword to the accounts

NHS NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

These accounts for the year ended 31 March 2021 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
10 June 2021

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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 Lincolnshire Clinical Commissioning Group ('the CCG') for the year ended 31 March 2021, 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 2020/21 as contained in the Department of Health and Social Care Group Accounting Manual 2020/21, 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 2021 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 2020/21; 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.

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 2020/21 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, and significant one-off or unusual transactions.

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

- discussing with management and the 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 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 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 statement and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the NAO in April 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.

mazars

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 2021.

We have not completed our work on the CCG’s arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in April 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2021.

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

Responsibilities of the Accountable Officer

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

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

We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources, and issued our assurance statement to the group auditor in respect of the CCG's consolidation schedules.

Mark Kirkham

Partner
For and on behalf of Mazars LLP

5th Floor
3 Wellington Place
Leeds
LS1 4AP

10 June 2021

Statement of Comprehensive Net Expenditure for the year ended 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Income from sale of goods and services	2	(52,604)	(55,271)
Other operating income	2	(134)	(104)
Total operating income		**(52,738)**	**(55,375)**
Staff costs	4	5,075	4,728
Purchase of goods and services	5	340,108	331,292
Provision expense	5	83	(128)
Other Operating Expenditure	5	869	329
Total operating expenditure		**346,135**	**336,221**
Net Operating Expenditure		**293,397**	**280,846**
Other Comprehensive Expenditure			
Remeasurement of the defined pension liability / asset		3,508	(1,866)
Sub total		**3,508**	**(1,866)**
Comprehensive Expenditure for the year		**296,905**	**278,980**

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

The notes on pages 83 to 103 form part of this statement

Statement of Financial Position as at 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Non-current assets:			
Property, plant and equipment	13	166	-
Total non-current assets		166	-
Current assets:			
Trade and other receivables	17	8,379	7,363
Cash and cash equivalents	20	21	41
Total current assets		8,400	7,404
Total current assets		**8,400**	7,404
Total assets		**8,566**	7,404
Current liabilities			
Trade and other payables	23	(17,750)	(14,658)
Provisions	30	(283)	(271)
Total current liabilities		**(18,033)**	(14,929)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(9,467)**	(7,525)
Non-current liabilities			
Trade and other payables	23	(4,303)	(788)
Total non-current liabilities		**(4,303)**	(788)
Assets less Liabilities		**(13,770)**	(8,313)
Financed by Taxpayers' Equity			
General fund		(6,566)	(4,617)
Other reserves		(7,204)	(3,696)
Total taxpayers' equity:		**(13,770)**	(8,313)

The notes on pages 83 to 103 form part of this statement

The financial statements on pages 81 to 82 were approved by the Governing Body on 10th June 2021 and signed on its behalf by:

Dr Peter Melton
Accountable Officer
10th June 2021

Statement of Changes In Taxpayers Equity for the year ended 31 March 2021

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)**
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 expenditure 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)**

Changes in taxpayers' equity for 2019-20	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2019	(7,771)	-	(5,562)	**(13,333)**
Transfer of assets and liabilities from closed NHS bodies	-	-	-	**-**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2020	**(7,771)**	**-**	**(5,562)**	**(13,333)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20				
Net operating costs for the financial year	(280,846)	-	-	(280,846)
Movements in other reserves	-	-	1,866	1,866
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(280,846)**	**-**	**1,866**	**(278,979)**
Net funding	284,000	-	-	284,000
Balance at 31 March 2020	**(4,617)**	**-**	**(3,696)**	**(8,313)**

The notes on pages 83 to 103 form part of this statement

Statement of Cash Flows for the year ended 31 March 2021

	Note	**2020-21 £'000**	2019-20 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(293,390)	(281,015)
(Increase)/decrease in trade & other receivables	17	(1,017)	(757)
Increase/(decrease) in trade & other payables	23	2,926	(1,879)
Provisions utilised	30	(71)	(366)
Increase/(decrease) in provisions	30	83	(128)
Net Cash Inflow (Outflow) from Operating Activities		**(291,469)**	(284,145)
Cash Flows from Investing Activities			
Net Cash Inflow (Outflow) from Investing Activities		**-**	-
Net Cash Inflow (Outflow) before Financing		**(291,469)**	(284,145)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		291,448	284,000
Net Cash Inflow (Outflow) from Financing Activities		**291,448**	284,000
Net Increase (Decrease) in Cash & Cash Equivalents	**20**	**(20)**	(145)
Cash & Cash Equivalents at the Beginning of the Financial Year		**41**	186
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		**21**	41

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups (CCG) 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 2020-21 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

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

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

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

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

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Gorup are outside the scope of IFRS 3 BusinessCombinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of apsorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Pooled Budgets

The CCG has entered into a pooled budget arrangement under 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,
• The CCG’s share of the income from the pooled budget activities.
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:
• As per paragraph 121 of the Standard the CCG will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The CCG is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the CCG to reflect the aggregate effect of all contracts modified before the date of initial application.

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

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

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

The CCG's main sources of revenue are:
• S75 Partnership Agreement
• Contribution from clients towards cost of social care

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 **Retirement Benefit Costs**

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

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

1.9 **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.

1.10 **Property, Plant & Equipment**

1.10.1 **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.

1.10.2 **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.

Notes to the financial statements

1.11 **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's cash management.

1.12 **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 as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.02% (2019-20: 0.51%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.18% (2019-20: 0.55%) 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 1.99% (2019-20: 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 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the CCG has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 **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.

1.14 **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.

1.15 **Climate Change Levy**

Expenditure is recognised in line with the levy charged, based on the chargeable rates for energy consumption per the rates detailed in the Climate Change Levy guidance. https://www.gov.uk/guidance/pay-climate-change-levy

1.16 **Contingent liabilities and contingent assets**

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

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.17 **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.

1.17.1 **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.

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

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

Notes to the financial statements

1.17.3 **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.

1.17.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the CCG recognises a loss allowance representing the expected credit losses on the financial asset.
The CCG adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).
HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The CCG therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the CCG does not recognise allowances for stage 1 or stage 2 impairments against these bodies.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.18 **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.

1.18.1 **Financial Guarantee Contract Liabilities**

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

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

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

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

1.18.3 **Other Financial Liabilities**

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

1.19 **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.

1.20 **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).

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

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

1.21.1 **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'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

1.21.2 **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

1.22 **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 2020-21. 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 – The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

2 Other Operating Revenue

	2020-21 Admin	2020-21 Programme	2020-21 Total	2019-20 Total
	£'000	£'000	£'000	£'000
Income from sale of goods and services (contracts)				
Other Contract income	1,443	51,071	**52,514**	55,228
Recoveries in respect of employee benefits	23	67	**90**	43
Total Income from sale of goods and services	**1,466**	**51,138**	**52,604**	**55,271**
Other operating income				
Charitable and other contributions to revenue expenditure: non-NHS	-	134	**134**	99
Other non contract revenue	-	-	**-**	5
Total Other operating income	**-**	**134**	**134**	**104**
Total Operating Income	**1,466**	**51,272**	**52,738**	**55,375**

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

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	£'000
Source of Revenue						
NHS	-	-	-	-	-	-
Non NHS	-	90	42,696	9,538	280	52,604
Total	**-**	**90**	**42,696**	**9,538**	**280**	**52,604**

2019-20	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	-	-	-	-	20	20
Non NHS	-	43	45,678	9,254	276	55,251
Total	**-**	**43**	**45,678**	**9,254**	**296**	**55,271**

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	£'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**

2019-20	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	-	43	-	-	20	63
Over time	-	-	45,678	9,254	276	55,208
Total	**-**	**43**	**45,678**	**9,254**	**296**	**55,271**

* 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		2020-21
	Permanent Employees	**Other**	**Total**
	£'000	**£'000**	**£'000**
Employee Benefits			
Salaries and wages *	3,803	134	3,937
Social security costs *	393	16	409
Employer Contributions to Pension schemes *	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**

	Total		2019-20
	Permanent Employees	**Other**	**Total**
	£'000	**£'000**	**£'000**
Employee Benefits			
Salaries and wages	3,476	135	3,611
Social security costs	366	15	381
Employer Contributions to NHS Pension scheme	715	18	733
Apprenticeship Levy	3	-	3
Gross employee benefits expenditure	**4,560**	**168**	**4,728**
Less recoveries in respect of employee benefits (note 4.1.2)	(43)	-	(43)
Total - Net admin employee benefits including capitalised costs	**4,517**	**168**	**4,685**
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	**4,517**	**168**	**4,685**

* In the Employee benefits table for 2020-21 the totals include the following COVID related costs - Salary and wages £80.7k, Social Security costs £7.8k and Employers Contribution to NHS Pension scheme £9.5k

4.1.2 Recoveries in respect of employee benefits

			2020-21	2019-20
	Permanent Employees	**Other**	**Total**	**Total**
	£'000	**£'000**	**£'000**	**£'000**
Employee Benefits - Revenue				
Salaries and wages	(74)	-	**(74)**	(36)
Social security costs	(8)	-	**(8)**	(3)
Employer contributions to the NHS Pension Scheme	(8)	-	**(8)**	(4)
Total recoveries in respect of employee benefits	**(90)**	**-**	**(90)**	(43)

4.2 Average number of people employed

	2020-21 Permanently employed Number	2020-21 Other Number	2020-21 Total Number	2019-20 Permanently employed Number	2019-20 Other Number	2019-20 Total Number
Total	**93**	**2**	**95**	**88**	**2**	**90**
Of the above: **Number of whole time equivalent people engaged on capital projects**	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

	2020-21 Compulsory redundancies		2020-21 Other agreed departures		2020-21 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Total	**-**	**-**	**-**	**-**	**-**	**-**

	2019-20 Compulsory redundancies		2019-20 Other agreed departures		2019-20 Total	
	Number	£	Number	£	Number	£
£10,001 to £25,000	-	-	1	21,088	1	21,088
Total	**-**	**-**	**1**	**21,088**	**1**	**21,088**

Analysis of Other Agreed Departures

	2020-21 Other agreed departures		2019-20 Other agreed departures	
	Number	**£**	Number	£
Early retirements in the efficiency of the service contractual co	-	-	1	21,088
Total	**-**	**-**	**1**	**21,088**

These tables report the number and value of exit packages agreed in the financial year. Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where CCG has agreed early retirements, the additional costs are met by CCG and not by the Local Government Pension Scheme and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 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 was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced 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.

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 2021 % p.a.	*31 March 2020 % p.a.*
Pension Increase rate	*2.9%*	*1.9%*
Salary Increase rate	*3.8%*	*2.8%*
Discount Rate	*2.0%*	*2.3%*

	31st March 2021		31st March 2020	
Mortality Assumptions	*Males Years*	*Females Years*	Males Years	Females Years
Current Pensioners	*21*	*23.7*	**20.9**	**23.3**
Future Pensioners**	*22.2*	*25.5*	**21.8**	**24.8**

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

Sensitivity Analysis	**31st March 2021**		31st March 2020	
Change in assumptions at year ended 31 March 2021	**Approximate % increase to Employer liability**	**Approximate monetary amount £'000**	Approximate % increase to Employer liability	Approximate monetary amount £'000
0.5% decrease in Real Discount Rate	**9%**	**3,733**	9%	2,930
0.5% increase in the Salary Increase Rate	**0%**	**48**	0%	34
0.5% increase in the Pension Increase Rate	**9%**	**3,630**	9%	2,891

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 2022 will be approximately £61,000
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 Number	*31-Mar-16 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

	2020-21 Admin £'000	2020-21 Programme £'000	2020-21 Total £'000	2019-20 Total £'000
Purchase of goods and services				
Services from other CCGs and NHS England	46	360	406	430
Services from foundation trusts	-	119,518	119,518	121,077
Services from other NHS trusts	-	17,217	17,217	16,912
Purchase of healthcare from non-NHS bodies *	-	78,527	78,527	77,755
Purchase of social care	-	55,327	55,327	53,085
Prescribing costs	-	29,691	29,691	28,064
GPMS/APMS and PCTMS *	-	33,647	33,647	31,445
Supplies and services – clinical	-	6	6	7
Supplies and services – general *	193	3,220	3,413	451
Consultancy services	22	227	249	236
Establishment *	98	1,050	1,148	803
Transport	-	0	0	6
Premises	101	61	162	143
Audit fees	47	-	47	43
Other non statutory audit expenditure				
· Internal audit services	-	38	38	54
Other professional fees	61	590	651	606
Legal fees	3	26	29	50
Interest (Local Government Pension Scheme)	-	751	751	944
Expected return on Assets (Local Government Pension Scheme)	-	(733)	(733)	(880)
Education, training and conferences	3	11	14	61
Total Purchase of goods and services	**574**	**339,534**	**340,108**	**331,292**
Depreciation and impairment charges				
Total Depreciation and impairment charges	**-**	**-**	**-**	**-**
Provision expense				
Provisions	-	83	83	(128)
Total Provision expense	**-**	**83**	**83**	**(128)**
Other Operating Expenditure				
Chair and Non Executive Members	117	-	117	105
Grants to Other bodies	-	563	563	-
Expected credit loss on receivables	-	189	189	223
Other expenditure	-	-	-	1
Total Other Operating Expenditure	**117**	**752**	**869**	**329**
Total operating expenditure	**691**	**340,369**	**341,060**	**331,493**

* In the Operating expenses table above, the figures for 2020-21 include the following COVID related costs - Purchase of Healthcare from Non NHS bodeis £6.3m, GPMS/APMS & PCTMS £512k, Supplies & services - general £370k & Establishment £83k

Included within other professional fees are non-audit services of £10k 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.

6.1 Better Payment Practice Code

Measure of compliance

	2020-21 Number	2020-21 £'000	2019-20 Number	2019-20 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	38,765	180,035	39,384	167,355
Total Non-NHS Trade Invoices paid within target	38,323	179,230	38,458	165,614
Percentage of Non-NHS Trade invoices paid within target	**98.86%**	**99.55%**	**97.65%**	**98.96%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	667	138,698	2,090	141,475
Total NHS Trade Invoices Paid within target	656	138,635	2,078	140,833
Percentage of NHS Trade Invoices paid within target	**98.35%**	**99.95%**	**99.43%**	**99.55%**

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 2021 (31 March 2020: £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 2021 (31 March 2020: £NIL).

9. Other gains and losses
The CCG had no other gains and losses as at 31 March 2021 (31 March 2020: £NIL).

10.1 Finance costs
The CCG had no finance costs as at 31 March 2021 (31 March 2020: £NIL).

10.2 Finance income
The CCG had no finance income as at 31 March 2021 (31 March 2020: £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 2021 (31 March 2020: £NIL).

13. Property, plant and equipment

2020-21	Equipment £'000	Total £'000
Cost or valuation at 01 April 2020	-	-
Additions purchased	166	166
Cost/Valuation at 31 March 2021	**166**	**166**
Depreciation 01 April 2020	-	-
Depreciation at 31 March 2021	**-**	**-**
Net Book Value at 31 March 2021	**166**	**166**
Purchased	166	166
Total at 31 March 2021	**166**	**166**
Asset financing:		
Owned	166	166
Total at 31 March 2021	**166**	**166**

Revaluation Reserve Balance for Property, Plant & Equipment
There is no revaluation reserve for Property, Plant & Equipment

13.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Equipment	5	5

14. Intangible non-current assets
The CCG had no intangible Assets as at 31 March 2021 (31 March 2020: £NIL).

15. Investment property
The CCG had no investment property as at 31 March 2021 (31 March 2020: £NIL).

16. Inventories
The CCG had no inventories as at 31 March 2021 (31 March 2020: £NIL).

17.1 Trade and other receivables	Current 2020-21 £'000	Non-current 2020-21 £'000	Current 2019-20 £'000	Non-current 2019-20 £'000
NHS receivables: Revenue	199	-	153	-
NHS prepayments	2	-	358	-
NHS accrued income	20	-	158	-
Non-NHS and Other WGA receivables: Revenue	2,801	-	3,145	-
Non-NHS and Other WGA prepayments	2,095	-	2,095	-
Non-NHS and Other WGA accrued income	1,281	-	1,256	-
Expected credit loss allowance-receivables	(2,385)	-	(2,678)	-
VAT	50	-	87	-
Other receivables and accruals	4,316	-	2,789	-
Total Trade & other receivables	**8,379**	**-**	**7,363**	**-**
Total current and non current	**8,379**		**7,363**	
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 £4,316k in relation to the adult social care partnership agreement (2019/20: £2,789k).

17.2 Receivables past their due date but not impaired

	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000	2019-20 DHSC Group Bodies £'000	2019-20 Non DHSC Group Bodies £'000
By up to three months	(26)	(120)	(96)	(226)
By three to six months	(55)	(310)	(9)	(159)
By more than six months	-	(197)	-	(224)
Total	**(81)**	**(627)**	**(105)**	**(609)**

17.3 Loss allowance on asset classes	2020-21 Trade and other receivables - Non DHSC Group Bodies £'000	2020-21 Other financial assets £'000	2020-21 Total £'000	2019-20 Non DHSC Group Bodies £'000
Balance at 01 April 2020	(2,678)	-	**(2,678)**	(2,636)
Amounts written off	544	-	**544**	179
Financial assets that have been derecognised	417	-	**417**	556
Other changes	(668)	-	**(668)**	(777)
Total	**(2,385)**	**-**	**(2,385)**	**(2,678)**

Receivable provisions relate to 2 main areas:
- Debtors ledger income
- House Sale income which is collected from clients for residential & nursing care

	2020-21 Lifetime expected credit loss rate %	2020-21 Gross carrying amount £'000	2020-21 Lifetime expected credit loss £'000	2019-20 Lifetime expected credit loss £'000
Receivables are provided against at the following rates:				
NHS debt & Adult Social Care -0 - 6 Months	-	1,522	621	709
7 - 9 Months	25	189	88	40
10 -12 Months	50	79	54	104
1 - 2 years	75	340	265	277
Over 2 years	100	1,357	1,357	1,548
Total expected credit loss	**250**	**3,487**	**2,385**	2,678

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 2021 (31 March 2020: £NIL).

19. Other current assets
The CCG had no other current assets as at 31 March 2021 (31 March 2020: £NIL).

20 Cash and cash equivalents

	2020-21	2019-20
	£'000	£'000
Balance at 01 April 2020	41	186
Net change in year	(20)	(145)
Balance at 31 March 2021	**21**	**41**
Made up of:		
Cash with the Government Banking Service	21	41
Cash and cash equivalents as in statement of financial position	**21**	**41**
Balance at 31 March 2021	**21**	**41**
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 2021 (31 March 2020: £NIL).

22. Analysis of impairments and reversals
The CCG had no impairments or reversals recognised in expenditure during 2020-21 (2019-20: £NIL).

23 Trade and other payables	**Current 2020-21 £'000**	**Non-current 2020-21 £'000**	Current 2019-20 £'000	Non-current 2019-20 £'000
NHS payables: Revenue	188	-	405	-
NHS accruals	120	-	1,132	-
NHS deferred income	5	-	-	-
Non-NHS and Other WGA payables: Revenue	542	-	243	-
Non-NHS and Other WGA payables: Capital	166	-	-	-
Non-NHS and Other WGA accruals	14,795	-	12,321	-
Non-NHS and Other WGA deferred income	844	-	38	-
Social security costs	62	-	54	-
Tax	56	-	46	-
Other payables and accruals	972	4,303	419	788
Total Trade & Other Payables	**17,750**	**4,303**	**14,658**	**788**
Total current and non-current	**22,053**		**15,446**	

Other payables include £230k outstanding pension contributions at 31 March 2021 (31 March 2020: £238k).

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 2021 (31 March 2020: £NIL).

25. Other liabilities
The CCG had no other liabilities as at 31 March 2021 (31 March 2020: £NIL).

26. Borrowings
The CCG had no borrowings as at 31 March 2021 (31 March 2020: £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 2021 (31 March 2020: None).

28. Finance lease obligations
The CCG had no finance lease obligations as at 31 March 2021 (31 March 2020: None).

29. Finance lease receivables
The CCG had no finance lease receivables as at 31 March 2021 (31 March 2020: None).

30 Provisions

	Current 2020-21 £'000	**Non-current 2020-21 £'000**	Current 2019-20 £'000	Non-current 2019-20 £'000
Legal claims	0	-	50	-
Continuing care	179	-	97	-
Other	104	-	124	-
Total	**283**	**-**	**271**	**-**
Total current and non-current	**283**		**271**	

	Legal Claims £'000	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2020	**50**	**97**	**124**	**271**
Arising during the year	1	82	-	**83**
Utilised during the year	(51)	-	(20)	**(71)**
Balance at 31 March 2021	**0**	**179**	**104**	**283**
Expected timing of cash flows:				
Within one year	0	179	104	**283**
Balance at 31 March 2021	**0**	**179**	**104**	**283**

Other provisions relate:
• Section 117 reimbursement of client contributions (previous years)

31. Contingent Liabilities

The CCG had no contingent liability as at 31 March 2021.

32. Commitments

32.1 Capital commitments

The CCG had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2021 (31 March 2020: £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 2021 (31 March 2020: £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 2020-21 £'000	Financial Assets measured at amortised cost 2019-20 £'000
Trade and other receivables with NHSE bodies	128	173
Trade and other receivables with other DHSC group bodies	4,097	4,325
Trade and other receivables with external bodies	77	213
Other financial assets	4,316	2,789
Cash and cash equivalents	21	41
Total at 31 March 2021	**8,639**	**7,541**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2020-21 £'000	Financial Liabilities measured at amortised cost 2019-20 £'000
Trade and other payables with NHSE bodies	293	191
Trade and other payables with other DHSC group bodies	7,533	7,407
Trade and other payables with external bodies	7,986	6,504
Other financial liabilities	972	419
Total at 31 March 2021	**16,784**	**14,521**

34 Operating segments

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)**

2019-20	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Health	282,495	(1,649)	**280,846**	2,780	(11,728)	**(8,948)**
Adult Social Care	59,453	(59,453)	**-**	4,623	(3,989)	**634**
Total	**341,948**	**(61,102)**	**280,846**	**7,404**	**(15,717)**	**(8,313)**

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

	2020-21 £'000	2019-20 £'000
NELC Allocation	42,696	45,678
Other Contributions*	14,366	13,775
Total Social Care Expenditure	(57,062)	(59,453)
Total	**-**	-

NELC Allocation includes the Partnership Agreement and an adjustment for grants (£3.8m) which the CCG is deeemed to be acting as Agent in 2020/21.

*Other Contributions, includes £4.5m 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	2020-21 £'000	2019-20 £'000
Underspend b/f	**2,996**	**1,882**
In Year Allocations:		
BCF - Health	12,625	12,033
BCF - Local Authority	3,662	3,139
IBCF - Local Authority	7,822	7,042
Winter Pressures - Local Authority *	-	780
Sub Total	**27,105**	**24,876**
In Year Spend :		
IBCF spend	(7,822)	(7,042)
Winter Pressures Expenditure	-	(780)
BCF - Health & Adult Social Care	(12,625)	(12,033)
BCF - Disabled Facilities Grant	(2,955)	(2,025)
Sub Total	**(23,402)**	**(21,880)**
Total	**3,703**	**2,996**

* Funding for Winter Pressures - Local Authority received separately in 19/20 for £780k . In 20/21 this is part of the IBCF - Local Authority figure of £7,822k

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 2021 (31 March 2020: £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
Sheffield Teaching Hospital 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:	**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	-

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**
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
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.

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
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

Details of related party transactions with individuals are as follows:

	2019 / 2020			
	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	162	-	11	-
Dr Ekta Elston				
Medical Director/Governing Body/Council of Members Vice Chair				
Partner GP at The Roxton Practice, Immingham	4,835	-	190	103
Partner GP at The Roxton at Weelsby View, Grimsby	329	-	1	-
Health Education England – GP Training Programme Director for Northern Lincolnshire	-	36	-	20
Roxton Practice and The Roxton at Weelsby View are members of 360 Care Limited	501	-	30	-
Roxton Practice and Roxton at Weelsby View are members of Meridian Primary Care Network (PCN). PCN funding goes to a lead practice and for Meridian this is The Roxton Practice, Immingham	622	-	9	-
Roxton Practice and The Roxton at Weelsby View are members Meridian Health Group Federation. Payments are made to Meridian Health Group Ltd	238	-	-	-
Dr Jeeten Raghwani				
Governing Body GP Representative				
GP Principal Greenland's Surgery, Stirling Medical Centre & Greenland's New Waltham	387	-	2	-
Greenland's Surgery is a member of 360 Care Limited	501	-	30	-
Greenland's Surgery is a member of Pegasus at Panacea PCN. PCN funding goes to a lead practice and for Pegasus at Panacea this is Clee Medical Centre	525	-	4	-
Greenland's surgery is a member of the Meridian Health Group Federation. Payments are made to Meridian Health Group Ltd.	238	-	-	-
Dr Peter Melton				
Accountable Officer/GP Clinical Chief Officer				
GP Principal - Roxton at Weelsby View, Grimsby	329	-	1	-
GP Principal - The Roxton Practice, Immingham	4,835	-	190	103
Roxton practice is a member of 360 Care Limited & wife is employed by 360 Care Limited	501	-	30	-
Roxton Practice and Roxton at Weelsby View are members of Meridian PCN. PCN funding goes to a lead practice and for Meridian this is The Roxton Practice, Immingham	622	-	9	-
Roxton Practice and Roxton at Weelsby View are members of the Meridian Health Group Federation. Payments are made to Meridian Health Group Ltd.	238	-	-	-
Dr Sudhakar Allamsetty				
Chair of Council of Members/Vice Chair Governing Body				
GP Partner at Scartho Medical Centre	2,042	-	90	111
Scartho Medical Centre is member of Panacea Federation	326	-	-	-
Scartho Medical Centre are a member of Meridian Health Group Federation. Payments are made to Meridian Health Group Ltd	238	-	-	-
Scartho Medical Centre is member of Phoenix at Panacea PCN. PCN funding goes to a lead practice and for Phoenix at Panacea this is Clee Medical Centre	502	-	4	-
Helen Kenyon				
Chief Operating Officer				
Friend is a director of an independent consultancy company, SJW Solutions in Partnership.	113	-	-	-
Jan Haxby				
Director of Quality/Registered Strategic Nurse				
Daughter works as a newly qualified nurse in DPoW Hospital medical unit in NLaG	119,493	76	463	22
Joe Warner				
Social Care Representative				
Chief Executive - Focus Adult Social Care Social Enterprise	6,361	-	61	-
Mark Webb				
Governing Body chair (Lay Member)				
Trustee on the board for Centre 4 a community services centre, who provides meeting and office space for NHS providers and CCG	5	-	-	4
Phillip Bond				
Patient & Public Involvement (Lay Member)				
Cousin is employed in a senior position at NLaG	119,493	76	463	22
Registered carer under the Carers Support Service which receives some funding from NELCCG	407	-	-	-
Rob Walsh				
Chief Executive NELCCG/NELC				
Chief Executive - North East Lincolnshire Council	3,829	11,450	187	2,879
Governor, Grimsby Institute of Further and Higher Education	1	-	-	-

37. Related party transactions *(continued)*

Details of related party transactions with individuals are as follows:

	2019 / 2020			
	Payments to Related Party £'000	**Receipts from Related Party £'000**	**Amounts owed to Related Party £'000**	**Amounts due from Related Party £'000**
Stephen Pintus				
Director of Public Health NELC				
Director of Public Health – North East Lincolnshire Council	3,829	11,450	187	2,879
Tim Render				
Governance & Audit (Lay Member)				
Independent Chair Audit & Governance Committee for North East Lincolnshire Council	3,829	11,450	187	2,879
Dr Renju Mathews				
Governing Body GP Representative				
Director – Rutreb Limited	9	-	2	-
Dr Mathews' Practice is a member of 360 Care Ltd	501	-	30	-
GP – Dr Mathews Practice, Cromwell Road, Grimsby	559	-	33	32
Practice is a member of the Panacea Collaborative	326	-	-	-
Dr Matthew's practice is member of Pegasus at Panacea PCN. PCN funding goes to a lead practice and for Pegasus at Panacea this is Clee Medical Centre	525	-	4	-

The CCG is a clinically-led organisation representing 26 member practices. The funding paid to member practices has been listed below.

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Beacon Medical Primary Care Centre	1,638	-	75	44
Beacon Medical Primary Care Centre is member of Concorde PCN. PCN funding goes to a lead practice and for Concorde this is Beacon Medical Primary Care Centre	488	-	28	-
Birkwood Medical Centre	1,624	-	188	95
Blundell Park Surgery	337	-	8	-
Chantry Health Group	911	-	2	32
Clee Medical Centre	1,901	-	83	44
Clee Medical Centre is member of Pegasus at Panacea PCN. PCN funding goes to a lead practice and for Pegasus at Panacea this is Clee Medical Centre	525	-	4	-
Core Care Family Practice	405	-	-	-
Dr Chalmers & Meier	1,039	-	25	124
Dr A Kumar	527	-	1	-
Dr A Sinha	696	-	42	37
Dr O Z Qureshi Surgery	515	-	1	-
Dr P Suresh-Babu	268	-	21	-
Dr R Matthews	559	-	1	32
Greenland's & New Waltham Surgery	387	-	2	-
Fieldhouse Medical Group	2,225	-	6	-
Healing Health Centre	316	-	1	-
Humberview Surgery	302	-	8	14
Humberview Surgery is member of Freshney Pelham PCN. PCN funding goes to a lead practice and for Freshney Pelham this is Humberview Surgery	644	-	13	-
Littlefield Surgery	864	-	1	37
Open Door	477	-	10	-
Pelham Medical Group	1,192	-	65	32
Quayside Medical Centre	317	-	11	-
Raj Medical Centre	705	-	51	-
Roxton at Weelsby View	329	-	1	-
Scartho Medical Centre	2,042	-	90	111
Scartho Medical Centre is member of Phoenix at Panacea PCN. PCN funding goes to a lead practice and for Phoenix at Panacea this is Clee Medical Centre	502	-	4	-
The Lynton Practice	592	-	1	-
The Roxton Practice (Immingham)	4,835	-	190	103
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	622	-	9	-
Woodford Medical Centre	1,312	-	10	-

38 Events after the end of the reporting period
There were no events after the end of the reporting period.

39 Third party assets
The CCG held no third party assets as at 31 March 2021 (31 March 2020: None).

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:

	2020-21 Target	**2020-21 Performance**	2019-20 Target	2019-20 Performance
Expenditure not to exceed income	295,064	295,064	282,495	282,495
Capital resource use does not exceed the amount specified in Directions	168	166	24	-
Revenue resource use does not exceed the amount specified in Directions	293,397	293,397	280,846	280,846
Revenue administration resource use does not exceed the amount specified in Directions	3,454	3,298	3,803	3,341

It should be noted that the table above only relates to NHS funding. The CCG also receives £46.5m 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 2020/21, the CCG received revenue resource of £301,544k 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 2021 (31 March 2020: None).

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 2021 was £36.5 million (31 March 2020 was £32.3 million).

Assets	**Value at 31-March-2021 £000**	**Value at 31-March-2020 £000**
Equity Securities	3,280	2,970
Debt Securities	4,722	4,328
Private Equity	2,051	1,647
Real Estate	4,341	3,917
Investment Funds & Unit Trusts	21,179	18,507
Cash & Cash Equivalents	963	934
Total	**36,536**	**32,303**

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-2021 £000**	**31-March-2020 £000**
Fair Value of Employer Assets	36,536	32,303
Present Value of Funded Obligations	(40,839)	(33,091)
Net Asset/(Liability)	**(4,303)**	**(788)**

Recognition in the profit or loss	**31-March-2021 £000**	**31-March-2020 £000**
Current service cost	49	101
Interest Cost	751	944
Expected Return on Employer Assets	(733)	(880)
Past Service Cost / (Gain)	0	0
Losses / (Gains) on Curtailments and Settlements	0	0
Total	**67**	**165**

Reconciliation of defined benefit obligation	**31-March-2021 £000**	**31-March-2020 £000**
Opening Defined Benefit Obligation	33,091	39,650
Current Service Cost	49	101
Interest Cost	751	944
Contribution by Members	11	11
Actuarial Losses/(Gains)	(896)	(866)
Past Service Costs / (Gains)	0	0
Losses / (Gains) on Curtailments	0	0
Estimated Benefits Paid	7,833	(6,749)
Closing Defined Benefit Obligation	**40,839**	**33,091**

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

Reconciliation of fair value of employer assets	31-March-2021	31-March-2020
	£000	£000
Opening Fair Value of Employer Assets	32,303	36,827
Expected Return on Assets	733	880
Contributions by Members	11	11
Contributions by the Employer	60	355
Actuarial Gains/(Losses)	4,325	(4,904)
Estimated Benefits Paid	(896)	(866)
Total actuarial gain (loss)	**36,536**	**32,303**

Amounts for the current and previous accounting periods	31-March-2021	31-March-2020
	£000	£000
Fair Value of Employer Assets	36,536	32,303
Present Value of Defined Benefit Obligation	(40,839)	(33,091)
Surplus / (deficit)	(4,303)	(788)
Experience Gains/(Losses) on Assets	4,325	(4,904)
Experience Gains/(Losses) on Liabilities	(7,833)	6,749

Cumulative Statement of Recognised Gains / Losses	31-March-2021	31-March-2020
	£000	£000
Actuarial Gains and Losses	4,325	(4,904)
Effect of Surplus Recovery Through Reduced Contributions	(7,833)	6,749
Actuarial Gains / (Losses) recognised in STRGL	(3,508)	1,845
Cumulative Actuarial Gains and Losses	(5,087)	(1,579)

43. Losses & Special Payments

In 2020/21 there were no losses of minor equipment. In 2019/20 there were 2 losses of minor equipment at a value of £710.

The CCG had no special payment cases during 2020/21 (2019/20: None)

44. Cash Flow Workings

	£'000
Net operating costs for the financial year (per SOCNE)	(293,397)
Pension charge	7
Net operating costs for the financial year per cash flow	**(293,390)**

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