NHS
Lincolnshire
Integrated Care Board

ANNUAL PUBLIC MEETING

The former NHS Lincolnshire CCG will be holding its final Annual Public Meeting (APM) on Monday, 26th September 2022 at 4.30 pm. The Annual Public Meeting is being held as part of the CCGs statutory commitments prior to the establishment of NHS Lincolnshire Integrated Care Board (ICB) on 1st July 2022.

The meeting will be held virtually as a Live Event on Microsoft Teams and a recording posted on the ICB website after the meeting for those who were unable to attend.

AGENDA

1.	Introduction – ICB Chair	Sir Andrew Cash, OBE Interim Chair NHS Lincolnshire Integrated Care Board (ICB)	4.30 pm
2.	Minutes of the NHS Lincolnshire Clinical Commissioning Group (CCG) Annual Public Meeting held in September 2021	Dr Gerry McSorley, (ICB Non-Executive Director (former Acting Chair of NHS Lincolnshire CCG)	4.40 pm
3.	Chief Executive's presentation: • Reflections of the last 18 months • Current position and forward look • Presentation of the NHS Lincolnshire CCG Annual Report and Accounts 2021/22	Mr John Turner, Chief Executive, NHS Lincolnshire ICB	4.45 pm
4.	Questions from Members of the Public	Sir Andrew Cash and Mr John Turner	5.20 pm
5.	Closing Comments	Sir Andrew Cash	5.55 pm

NHS
Lincolnshire
Clinical Commissioning Group

MINUTES OF THE NHS LINCOLNSHIRE CLINICAL COMMISSIONING GROUP ANNUAL PUBLIC MEETING HELD VIRTUALLY ON WEDNESDAY, 22ND SEPTEMBER 2021 AT 5.00 PM

PRESENT:	Mr Sean Lyons	CCG Chair
	Dr Majid Akram	GP and Clinical Lead, South Locality
	Dr David Boldy	Secondary Care Doctor
	Mrs Fenella Chambers	Non-Executive Director
	Mr Jim Connolly	Non-Executive Director
	Mr Graham Felston	Non-Executive Director
	Dr James Howarth	GP and Clinical Lead, East Locality
	Mr Matt Gaunt	Director of Finance and Contracting
	Mrs Janet Inman	Non-Executive Director
	Ms Sue Liburd	Non-Executive Director
	Dr Gerry McSorley	Non-Executive Director
	Mr Pete Moore	Non-Executive Director
	Dr John Parkin	GP and Clinical Lead, West Locality
	Mr John Turner	Chief Executive
IN ATTENDANCE:	Mrs Jules Ellis-Fenwick	CCG Corporate Secretary/Manager
	Mrs Sarah Fletcher	Chief Executive, Healthwatch
	Mrs Sarah-Jane Mills	Chief Operating Officer, West Locality
	Mrs Clair Raybould	Chief Operating Officer, South West Locality
	Professor Derek Ward	Director of Public Health
	Mrs Sandra Williamson	Chief Operating Officer, East Locality
APOLOGIES:	Dr Dave Baker	GP and Clinical Lead, South West Locality
	Mr Pete Burnett	Interim STP Programme Director
	Mr Martin Fahy	Director of Nursing and Quality
	Mr Andy Rix	Chief Operating Officer, South Locality
	Cllr Sue Woolley	Chair of the Health and Wellbeing Board

A number of members of the public, stakeholders and CCG staff joined the meeting through the Live Event link published on the CCG website. It is not possible to identify those individuals unless they chose to publish their details via the Question and Answer facility available during the meeting.

APM21/01 WELCOME AND INTRODUCTIONS

Mr Lyons opened by the meeting by introducing himself as the Lincolnshire CCG Chair.

Mr Lyons extended a warm welcome to everyone who had joined the meeting which is being held via Microsoft Teams as a Live Event in light of COVID Infection prevention and control requirements.

This was the second Annual Public Meeting of the Lincolnshire CCG since it was established on 1st April 2020. Clearly the last 18 months has been a very challenging period for everyone across the country, county and the NHS due to the coronavirus pandemic, which is still requiring the CCG's undivided attention and effort.

Nonetheless, the CCG was pleased to be able to hold its APM, albeit virtually, and would encourage members of the public to ask questions through the Question and Answer facility. The aim was to have as open and free flowing discussion as possible and the aim was to respond to the questions during the meeting, including those that had been submitted beforehand using the proforma provided on the CCG website.

In terms of the Board members, Mr Lyons requested that they remained 'muted' during the meeting and adopt the usual discipline of 'hands 'up during the meeting or the meeting chat facility, which will be monitored throughout.

Mr Lyons advised that he wanted to take the opportunity to recognise the hard work and enormous effort by the CCG staff to support the response to the pandemic and highlight just how fantastically well local health and care, voluntary, community and public sector organisations have worked together over the last year and indeed who remained wholly focused on supporting people's lives. The CCG Board was incredibly proud to be associated with such hard working and professional members of staff in the NHS and its partners who have worked tirelessly to support communities and patients on a daily basis. The benefits of partnership working have never been as closely evident as during the pandemic, and this boded well for the proposed national development of Integrated Care Systems which will result in much closer working between the CCG, the wider NHS and public sector partners in the near future.

Mr Lyons advised that he would like to take the opportunity to extend his sincere thanks and appreciation to the CCG Board members for their hard work and support over the past year; not forgetting Mr Murray Macdonald who was a Non-Executive Director up until the end of June 2021 and also Dr Andrew Doddrell who was the East Locality Clinical Lead until the end of December 2020.

At this stage Mr Lyons provided a briefing on the agenda for the meeting, the first item of which was to present the minutes of the Lincolnshire CCG's Annual Public Meeting held in 2020.

APM21/02 MINUTES OF THE LINCOLNSHIRE CCG'S ANNUAL PUBLIC MEETING

The minutes from the Lincolnshire CCG Annual Public Meeting held in September 2020 were presented.

Mr Lyons advised that the minutes were presented for information having previously been received by both the CCG Members' Forum and approved by the Board back in December 2020.

The Board agreed to:

- **Note the minutes.**

APM21/03 DISCUSSION THE WORK UNDERTAKEN BY THE CCG OVER THE PAST YEAR AND HIGHLIGHT OF KEY PRIORITIES FOR THE FUTURE

Mr Turner provided a presentation which set out the background to the CCG and its role. A review of the year was then provided including the response to COVID-19. The following points were highlighted:

- Vaccination Programme, including National Delivery Model Design
- COVID-19 Vaccination Numbers
- Review of the year: Further Challenges
- Review of the year - Achievements
- Current position and the next six months
- The Future – Key Priorities

The Board agreed to:

- **Note the presentation.**

APM21/04 2020/21 FINANCE REVIEW, INCLUDING PRESENTATION OF THE LINCOLNSHIRE CCG ANNUAL REPORTS 2020/21

Mr Gaunt provided a presentation which included a review of the CCG's finances in 2020/21, including presentation of the Lincolnshire CCG Annual Reports 2020/21.

The following points were highlighted:

- Financial Performance 2020/21
- How we spent our funding in 2020/21
- Financial Context 2020/21 and looking ahead
- Annual Reports and Accounts 2020/21

The Board agreed to:

- **Note the presentation.**

APM21/05 QUESTIONS FROM MEMBERS OF THE PUBLIC

Mr Lyons advised that, as previously indicated, a number of questions had been received prior to the meeting and these would be responded to in the first instance.

Mr John Bradwell – Sleaford Medical Group (PPG)

Question: I am concerned that during the past 16 months there was little interaction with the previous CCG to develop the Lincs CCG. There were no emails or information distributed. So, there was a complete absence of the CCG listening to the concerns of GP surgery representatives.

I would like to hear the dates of when the consultations been completed to determine the CCG groupings. This is especially relevant in the south of the county.

Will the representative in the future be from the PCN or still remain with the PPG.

Response: Mr Turner advised that in the lead up to the four CCGs becoming one, PPG representative workshops were held in September 2019 to discuss what was important to them and what worked well in the four CCG patient councils. Their biggest area of concern was that PPG representatives wanted meetings to keep their locality focus.

Following the development of the single CCG in April 2020, the model of patient involvement was remodelled and built on the feedback to develop 'patient councils' at an even more local level on a PCN locality basis. This model of engagement was agreed at the CCG's internal Quality and Patient Experience Committee (QPEC), demonstrating the organisations commitment to improve this vital service.

Wider discussion on this model was delayed due to team redeployment to support the response to COVID-19. However, the team continued to communicate with PPGs on a number of occasions. PPG representative meetings have since been held as follows:

<u>PPG Event: 22nd June 2021 – introducing the new model of patient councils.</u>

Topics covered included:

- Setting the scene – 4 CCGs into 1
- Approach to engagement in Lincolnshire
- Primary Care Networks

- Covid-19 Vaccination Programme
- Actions & next steps

From this meeting it was clear that PPGs would welcome a more detailed discussion about the approach to engagement and model of Patient Councils and so a further meeting was arranged.

PPG Event: 15th July 2021 – detailed discussion on new model of patient councils

Topics covered included:

- Previous PPG engagement in the 4 CCGs
- Shaping PPG engagement in the 1 CCG
- Our new model of PPG engagement
- Actions & next steps

This meeting identified a clear desire to amend the model and retain four Patient Councils in Lincolnshire. However, this was only the view of those attending the meeting and so the CCG asked the wider PPG groups and membership for their thoughts.

Further events and engagement have taken place as follows:

26th July – 4 week engagement
Overview of previous model of engagement and Patient Councils and current proposed approach sent to all PPGs for their feedback and views. Feedback has been collated and was currently being reviewed.

PPG Event: planned for mid-October to provide feedback on all PPG views and agree a model of engagement and Patient Councils going forward. This will include the role of all PPG members and where they fit into the model and ensure PCN involvement.

The CCG recognised that during the pandemic, it has not been able to engage with the PPGs or Patient Councils as would have happened previously. The CCG has endeavoured to keep in contact as much as possible, with regular stakeholder updates at the start of the pandemic and COVID update communications as well as information and surveys from other organisations such as Healthwatch. The CCG has also invited involvement in engagements such as the Pulse Check survey as well as local engagements such as proposed changes to Stackyard, Lakeside and Spilsby GP Practices.

Mr Turner advised that Mr Martin Fahy, Executive Lead for public engagement, had sent his apologies for the meeting and suggested that if there were any points that had not been satisfactorily answered or needed clarification, Mr Bradwell was welcome to contact the CCG and a fuller response could be provided.

Question Mr Alan Bowling

Please explain what actions have been undertaken to remove the temporary A&E operating restrictions at Grantham and District Hospital and restore it to 24 hour A&E operations.

Response: Mr Turner advised that Grantham Hospital A&E Department had been operating under reduced hours since August 2016. Further temporary changes were made as a result of the pandemic but the model had now reverted back to the previously reduced hours. It is proposed that a formal public consultation exercise around a number of NHS service changes in Lincolnshire, including Urgent & Emergency Care in Grantham, is conducted.

The CCG Board will be considering a paper on this at its next meeting on 29 September 2021 and, should the proposals be agreed by the Board, a comprehensive public consultation process will commence with immediate effect.

Question Mr Alan Bowling

Has AskmyGP been dictated as the primary route for GP contact by the NHS, and how do those without internet access seek GP appointments when phones are not answered?

Response: AskmyGP has not been dictated as the primary contact route for access to GPs. GP practices have been asked to offer an unspecified digital platform(s) alongside other methods of access. It should be noted that digital platforms have been in use for some time at many practices but that the pandemic has accelerated this. Work is being undertaken with patient groups such as Healthwatch to try and make digital platforms as easy to use and as beneficial to patients as possible.

Patient demand for GP services is now at pre-pandemic levels, if not higher. In terms of those contacting their GP, almost half receive care on same day. Of the total care that Lincolnshire practices give (either on the day or later), approximately two thirds is conducted on a face to face basis and one third via a range of virtual channels.

One of the positives over the last 18 months is that general practice has evolved into a truly multi-disciplinary team. A triage system has been introduced which has allowed patients to be seen by the most appropriate professional for their needs. This was initially an edict from NHSE for pandemic infection control. The use of digital platforms has enabled triaging to take place easily and remotely for patients. For those who prefer not to use a digital platform, or are unable to, practices are still accessible via phone and the same method of triage will apply.

The CCG and general practice recognise that digital options are not for everyone. The overriding message is that general practice is open, and digital platforms are there as an alternative for those who wish to use this option. Every contact made with the practice is still seen and dealt with by a professional.

With regards to phone access, the CCG is working with GP practices to ensure that all phone systems can cope with the current increase in demand and, in the case of any outdated phone systems, are working to update these if necessary. Additionally, it is envisaged that as the use of digital platforms increases, this will reduce demand on phones and free up capacity for those who wish to contact the practice by this method. Practices will continue to utilise phone systems as those people who are least likely to use a digital option are primarily the most vulnerable members of society.

The NHS in Lincolnshire, and indeed across the county, is facing severe pressures with regard to demand and capacity, with general practice the first point of call for many patients. Lincolnshire as a system struggles to recruit in all aspects of healthcare and whilst this continues to be an ongoing issue, strategies are being discussed in terms of how to attract and retain workforce.

Questions and Comments received through the Questions and Answers Facility

Question: Mr Barrie Church

Is the budget £1.3billion pounds, or million as shown on the presentation slide?

Response: It was confirmed this was an error; it should be billion.

Question/comments: Mr Barrie Church

It has to be remembered that in Stamford area we rely greatly on the two Peterborough vaccination centres. There is a need for CCG to understand that Stamford is different from other areas.

Response: Mr Turner advised that prior to working across Lincolnshire, his role centered on the south of the county and he was aware that a significant number of people in the south, including those in the Deepings, Spalding and Bourne as well as those in Stamford, look to Peterborough for their services.

Mr Turner added that the CCG has regular liaison with NWAFT around healthcare provision for Lincolnshire patients, particularly those in the south. This situation is not unique and the CCG recognises that in the Long Sutton area, the population also looked to Kings Lynn for services; the north of the county also looked to Grimsby and Scunthorpe and in the west of the county some people looked to Newark and Nottingham.

As a result of this the CCG and the Integrated Care System placed as much importance on out of county healthcare provision as it does to services in Lincolnshire.

Question: Mr Barrie Church

Mr Turner said ICS starts next year but slide showed 2021?

Response: Lincolnshire became a designated ICS from 1st April 2021 which was stated on the slide. It will become a statutory ICS Body from 1st April 2022 subject to passage and approval through Parliament of the Health and Social Care Bill.

Question: Mr Barrie Church

What is the actual commissioning budget as it states £1.330m on one of the first slides but later on it states allocated £1,344.8m shouldn't this in fact be £1.330bn or £1,344.8bn.

Response: Mr Gaunt confirmed that the correct figure was £1,344.8 billion.

Question: Mr Barrie Church

How do all the stats on waiting lists and elective work stand up when Stamford hospitals are not controlled by Lincs?

Response: All waiting lists are monitored, and patients tracked, in the same way irrespective of their chosen provider and there is the same level of engagement with out of county providers as there is with Lincolnshire providers.

Comment: Ms Sarah Connery, Acting Chief Executive, LPFT

Just a thank you to all of our GP colleagues across Lincolnshire for all of their hard work and commitment to the Lincolnshire population over this very difficult time.

The Board agreed to:

- **Note the questions received and CCG responses.**

APM21/06 CCG CHAIR – CLOSING COMMENTS

The CCG Chair thanked everyone for joining and participating in the meeting. The meeting was closed at 6.35 pm

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Chair Signature

Date

NHS
Lincolnshire
Clinical Commissioning Group

Annual Report and Accounts

2021/22

Improving Lincolnshire's Health and Wellbeing

Contents

Statement by the CCG Chair and Chief Executive

Chair and Chief Executive Foreword

We welcome you to the second Annual Report for NHS Lincolnshire Clinical Commissioning Group, which covers the period between 1st April 2021 and 31st March 2022. This Annual Report has been prepared in accordance with the National Health Service Act 2006 (as amended 2012) Directions by NHS England, in respect of Clinical Commissioning Groups' Annual Reports.

The 23rd March 2022 marked two years since the Government announced the first national lockdown in response to coronavirus. As in 2020/21, the CCG's focus throughout 2021/22 has been dominated by the response to the COVID-19 pandemic with the UK having endured several more national lockdowns as new variants emerged, all of which has continued to bring unprecedented challenges to the health and wellbeing of our population and had a profound effect on all our lives, livelihoods and on the health and care system.

Everyone in our community has been affected by the COVID-19 pandemic; some of us have lost loved ones, colleagues and friends, and we would like to take this opportunity to acknowledge their loss and extend our deepest sympathy.

We would also like to reiterate our heartfelt thanks and appreciation to all our colleagues and staff across the NHS, local government, the care sector, and all partners in Lincolnshire for all of their hard work, support and contribution throughout this exceptionally difficult year. We are very proud to be associated with everything that has been done and achieved.

As we write this forward, the NHS in Lincolnshire is totally focused on supporting the full recovery of services and the backlogs in patient care and services This includes Primary Care services, Mental Health, Learning Disabilities and Autism services, Urgent & Emergency Care, Elective Care, Cancer services, along with all other aspects of patient care and services. In February 2022 the Government published the NHS Delivery Plan for tackling the COVID-19 backlog of elective care in the NHS. The Lincolnshire system focus is now on full recovery across all services with providers currently restoring services paused during the peak of Omicron along with planning for recovery. Whilst elective recovery is a significant focus due to the size and complexity of people waiting for elective and cancer care, in tandem there is a strong focus of recovery across primary care, community and mental health services and cancer services that equally have backlogs of care to address.

Looking back over 2021/22, from both a national and local perspective, there can be no doubt that the Vaccination and Booster programme was a major focus for the NHS with over 120 million doses administered across the UK, saving countless lives and reducing pressure on the NHS. With the emergence of the Omicron variant an urgent and immediate acceleration of the Booster Vaccine Programme was enacted in December 2021, and a revised target of offering all eligible aged 18 and over a Booster vaccine by 1st January 2022 was confirmed on the 13th December.

The NHS in Lincolnshire, including PCNs, and GP Practices, responded at pace to ensure that all those eligible were offered a booster vaccination and there was a collective effort across the NHS coupled with excellent support from partners particularly local government, the care sector and the voluntary sector to ensure sufficient capacity and profile to enable people to come forward for their booster vaccine. In Lincolnshire, we are extremely proud that the impressive pace and rollout of the local vaccination programme compared well with other areas across the country, and we thank everyone involved for their support. It has been a truly tremendous effort.

The pandemic also shone a bright light on health inequalities within Lincolnshire. As a result we put in place a range of actions to seek to ensure that these were not further exacerbated, and have established with Public Health, Local Government and other partners an approach to tackling health inequalities as a core purpose of our work.

Although our primary focus was on the response to the pandemic, a significant piece of work has taken place on the review of four of Lincolnshire NHS services and in September 2021 the CCG Board approved the Acute Services Review (ASR) Pre-Consultation Business Case, which underpins four Lincolnshire NHS service change proposals relating to Orthopaedics, Urgent & Emergency Care, Acute Medical Beds and Stroke Services. The Board agreed to proceed to a period of public consultation which launched on the 30th September 2021 and ran for 12 weeks until 23 December 2021. The feedback from the consultation was subject to a detailed analysis. The outcome formed a key part of the Decision Making Business Case which was presented to the CCG Board in May 2022. Further information is included under the Key Achievements section of this report.

Prior to the Coronavirus pandemic, Lincolnshire was already leading the way with embracing digital technology within general practice, and the pandemic has accelerated the way our PCNs and general practices use technology to provide safer and more efficient ways of delivering primary care. We recognise that moving to a digital way of working is not a good fit for all, and our attention will remain focused on ensuring that any changes are reflective of that so as not to disadvantage any particular groups of patients.

Primary care colleagues are seeing record numbers of patients compared to pre COVID-19 levels. GP practices are open as they have been throughout the pandemic but are working differently in order to meet the rise in demand and protect the most vulnerable when they are attending appointments. 47% of patients who contact their GP are seen on the same day. Overall, two thirds of all patient contacts in Lincolnshire are face-to-face, one third through digital virtual consultations.

Supported and funded by the CCG, Healthwatch Lincolnshire, with the assistance of three local doctors (who sit on the CCG Board), have been working on a website called Digi-Health to provide information for Lincolnshire patients about the digital services available to them, and how they can support their surgeries to gain the most effective access.

There were some changes on the CCG Board over the past year with Mr Sean Lyons, CCG Chair, leaving on 31st December 2021 to take up a new joint role as Chair of North Lincolnshire and Goole Hospitals NHS Trust and Hull University Teaching Hospitals NHS Trust. Dr Gerry McSorley, the CCG's Deputy Chair, was confirmed as the CCG Acting Chair from the 1st January 2022.

Two of the CCG Non-Executive Directors, namely Mr Murray MacDonald and Mr Jim Connolly, also left to take up new roles as Non-Executive Directors for Lincolnshire Community Health Services NHS Trust (LCHS). We would like to take this opportunity to thank Sean, Murray and Jim for their invaluable contribution to the CCG during their time with us and welcome Mr Graham Felston, Non-Executive Director, who commenced with the CCG on the 1st July 2021.

As we move into 2022/23 there will be significant changes to the NHS structure, and this will result in the establishment of statutory Integrated Care Systems from 1st July 2022. These ICSs will be made up of two new components: the Integrated Care Partnership, and the Integrated Care Board (ICB). The ICB will incorporate within it all of the CCG's current responsibilities and staff, and the CCG will be disestablished on 30th June 2022.

ICS's will exist to achieve four aims:

- Improve outcomes in population in health and healthcare;
- Tackle inequalities in outcomes, experience and access;
- Enhance productivity and value for money;
- Help the NHS support broader social and economic development.

The ICP operates as a forum to bring partners – local government, NHS and others together across the ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for their population.

Lincolnshire only has one upper tier local authority, namely Lincolnshire County Council, and as such willl only have one ICP called the Lincolnshire Integrated Care Partnership.

We would like to end our report by paying tribute to and thanking all our staff, colleagues, partners in acute care, social care, community care, primary care, the care home sector, as well as that of our wider partners in the public and voluntary care sector for their tireless and unwavering response over the last 12 months. Their level of resilience, hard work and continued commitment has been truly remarkable.

We hope that you find this Annual Report of interest. If you have any comments or questions you would like to raise, please do not hesitate to contact us either via email or telephone as per the details specified on the back of this report.

Thank you

Dr Gerry McSorley, Acting CCG Chair

Mr John Turner, Chief Executive (Accountable Officer)

Performance report

Overview

The purpose of the overview is to give a brief summary of the CCG, its purpose and activities, demographic profile, how we work in the health system, and with whom we have contracts. It also summarises our performance against key targets, risks to achieving our strategic objectives and what our main challenges have been this year. We have provided more detail on all these areas later in the report.

Who we are

NHS Lincolnshire CCG is a body corporate established by NHS England on 1 April 2020 under the Health and Social Care Act 2012.

NHS Lincolnshire Clinical Commissioning Group (CCG) is responsible for commissioning, or buying, the majority of healthcare services for the population of Lincolnshire. Those services include planned care, cancer care, emergency care, mental health, learning disability and Autism, maternity services, and community and GP services for our 808,267 registered patients across 84 GP practices. We commission services from a wide range of providers in and outside of Lincolnshire (further information is set out on the next page).

An illustration of the geographical area covered by Lincolnshire CCG is detailed below.

In 2021 the CCG Chair was Mr Sean Lyons. Dr Gerry McSorley replaced Mr Lyons from 1st January 2022 as Acting CCG Chair. Our Accountable Officer (Chief Executive) is Mr John Turner, who has overall responsibility for managing the work of the CCG.

The work of the CCG is overseen by a Governing Body (referred to as 'the Board') which includes Four Locality Clinical Leads (all of whom are local GP's), Lay Members (referred to as 'Non-Executive Directors'), Director of Finance and Contracting, Director of Nursing and Quality, Secondary Care Doctor and CCG Executive Officers who ensure that we commission safe and effective healthcare services within our budget. The CCG Committee Structure is included in the Annual Governance Statement on page 60.

Purpose and Activities of the CCG

The CCG commissioning budget in 2021/22 was £1502.7m and the organisation employs nearly 380 staff.

The CCG understands the significant and varied health needs and profiles of communities across Lincolnshire.

The core purpose of the CCG is to:

- Improve the health of the people of Lincolnshire
- Reduce health inequalities
- Improve quality of care

The services we commission or buy are:

- Planned hospital care
- Rehabilitative Care
- Urgent and emergency care
- Most community health services
- Primary Care
- Mental health and learning disability services

On 1st April 2021 Lincolnshire became a Designate ICS. As a key partner in the developing Integrated Care System (ICS), we work closely with local hospital Trusts, mental health Trusts, local authorities, district councils, the voluntary sector and others to help achieve the best possible outcomes for local people.

We involve local patients, carers, the public and organisations such as Healthwatch Lincolnshire to help us better understand local need and commission high-quality care that is safe, effective and focused on the patient experience – as set out in the NHS Constitution and the CCG Constitution.

CCGs are accountable to the Secretary of State for Health, although NHS England has responsibility for the other third of the NHS healthcare spend (for example, dental services and some specialised hospital services). Read more about the NHS structure here:

The majority of dental, pharmaceutical, optometry and some vaccination services are commissioned by NHS England.

General Practice (GP) services are commissioned by the CCG under delegated agreement from NHS England.

Our main partners and providers

We commission services from a number of local organisations, including:

- United Lincolnshire Hospitals NHS Trust (ULHT)
- Lincolnshire Partnership NHS Foundation Trust (LPFT)
- Lincolnshire Community Health Services NHS Trust (LCHS)
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLAG)
- North West Anglia NHS Foundation Trust (NWAFT)
- East Midlands Ambulance Service NHS Trust (EMAS)
- All GP practices in Lincolnshire

NHS 111 - the local provider of NHS 111 is Derbyshire Health United.

Non-Emergency Transport Services are provided by Thames Ambulance Services Limited (TASL).

We work closely with local councils to ensure that health and social care services are as effective as possible. The council also employs Public Health specialists who promote healthy lifestyles and prevention of ill health.

There are seven District Councils in Lincolnshire:

- Boston Borough Council
- East Lindsey District Council
- City of Lincoln Council
- North Kesteven District Council
- South Holland District Council
- South Kesteven District Council
- West Lindsey District Council

Other key partners include:

Public Health

We have continued our close working with Public Health colleagues based within Lincolnshire County Council on a number of areas including the development of the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and social prescribing, which are referred to later in the report.

A member of the Public Health team regularly attends CCG Board meetings to further enhance collaborative working.

Further information on Lincolnshire County Council and Public Health Lincolnshire can be found here:

Homepage – Lincolnshire County Council

Healthwatch Lincolnshire

Healthwatch Lincolnshire is the independent consumer champion for health and social care in Lincolnshire, putting patients at the heart of health and social care services. Their role is to give local people a voice to influence and challenge how health and social care services are provided locally. Healthwatch provide the CCG with regular feedback from patients on their experiences of accessing NHS services, and assist the CCG to carry out surveys and consultations when we are making key decisions about the services we commission.

Representatives from Healthwatch regularly attend and participate in Board, Primary Care Commissioning Committee and Quality and Patient Experience Committee meetings.

Find out more about Healthwatch Lincolnshire here: www.healthwatchlincolnshire.co.uk

Health and Wellbeing Board

The CCG also works closely with the Health and Wellbeing Board which is a forum that brings together key leaders from the NHS, public health and care systems to work together to improve the health and wellbeing of the people of Lincolnshire and reduce health inequalities.

Board members collaborate to understand communities' needs, agree priorities and encourage commissioners to work in a more joined up way, and the Board has a duty to encourage integrated working for the purpose of advancing the health and wellbeing of the people of Lincolnshire.

The Chair of the Health and Wellbeing Board regularly attends and participates in the CCG Board meetings and the CCG Chief Executive is the Vice Chair of the Health and Wellbeing Board.

Further details can be found here: www.lincolnshire.gov.uk/health-wellbeing/health-wellbeing-board

Voluntary Centre Services (VCS)

The VCS supports volunteers and voluntary and community organisations across Lincolnshire, and will often provide assistance to the CCG to ensure the voluntary/third sector are informed about local health services, and involved in any key decisions we make about the services we commission.

Primary Care Networks

Primary Care Networks (PCN) are now a well-established part of the local health and care architecture. There are 15 PCNs in Lincolnshire meaning that everyone living in Lincolnshire will be able to access greater provision of proactive, personalised and coordinated care in their local community.

When they were first introduced in July 2019, PCNs built on the services provided by GP practices to provide extended services for people living in their local communities. To enable these developments an additional 151 additional staff were appointed to new roles for example clinical pharmacists, social prescribing and First contact practitioners (physiotherapists).

As PCNs have developed, colleagues are increasingly working with other organisations and communities to promote and drive the development of services that best reflect the needs of their local population. These arrangements are the foundation of integrated care and are at the heart of improving the health of people.

During the last 12 months, in addition to the introduction of new roles, PCNs have established stronger links with care homes and developed a more co-ordinated approach to providing multi-disciplinary support for residents.

In addition to progressing local service developments, the PCNs in Lincolnshire were the backbone of the COVID-19 vaccination programme. Each of the 15 PCNs were involved in delivering local vaccinations so that their patients were protected against the vaccine as soon as was practically possible.

In the coming year PCNs will continue to work with partners and local people to understand local issues to continue to provide the personalised care valued by patients.

Our Vision and Priorities

Our vision and priorities shape who we are, how we work and help us to make the right decisions of behalf of people in Lincolnshire.

Our goal is to ensure that everyone living in Lincolnshire has the best possible health and wellbeing they can. To achieve this, we work alongside our health and care partners to provide people with access to quality healthcare and reduce the health inequalities that exist today.

In 2021 the Board agreed a new strapline and Purpose Statement:

Improving Lincolnshire's Health and Wellbeing

Delivering high quality, people-centred healthcare that tackles health inequalities across Lincolnshire communities through a collaborative, insight-led approach.

This statement is underpinned by six key themes which were agreed in 2021 with executive leadership for each of the actions.

The Board purpose statement and supporting themes have acted as a guide to the way in which the CCG has worked throughout 2021/22, and it is anticipated will become a key building block of our Integrated Care System (ICS).

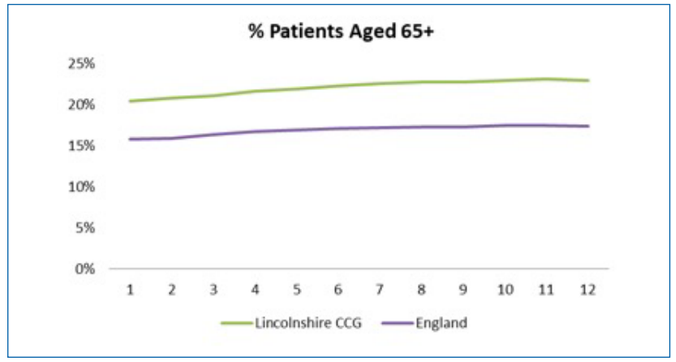
Social, community and human rights issues

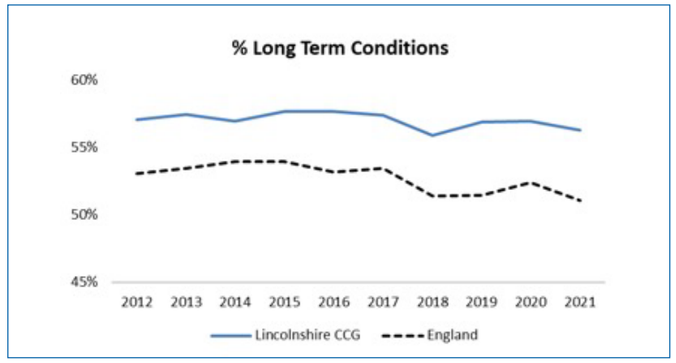
The CCG places a high priority on ensuring that it discharges its obligations as a good corporate citizen and takes into account its responsibilities towards serving and meeting the needs of local people, including safeguarding their human rights.

We ensure equality and diversity run through our work as described in detail in our section on Equality and Diversity.

Key issues and risks

The population represented by Lincolnshire CCG has a higher level of complex health issues such as diabetes, coronary heart disease, and Chronic Obstructive Pulmonary Disease (COPD) than the national average. Similarly the percentage of our population over the age of 65 and index of deprivation continue to be above the average in England. The COVID-19 pandemic has starkly exposed these existing inequalities, and whilst they are key to our planning, they also continue to place pressure on the majority of our services.





The key issues and risks to the organisation achieving its objectives are described in the Annual Governance Statement of this report.

Going Concern

The CCG has adopted a 'Going Concern' approach in the preparation of its annual financial statements. This follows the interpretation in the Government Accounting Manual of Going Concern in the public sector.

In summary this interpretation provides that where a body can show anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that function in published documents (such as financial allocation plans), there is sufficient evidence of Going Concern. The only exception to this approach would be for public sector organisations which are classed as trading bodies. CCGs being funded by direct allocation through NHSE England are not trading bodies.

However, the CCG will only continue to be in existence until the 30th June 2022, after which all CCGs in the country will be legally dissolved.

The CCG will be replaced by NHS Lincolnshire Integrated Care Board with effect from the 1st July 2022.

Performance Summary - Chief Executive

2021/22 has clearly been an incredibly challenging year for the NHS as a whole due to the continued effects of the COVID-19 pandemic, and this has been echoed for us as a CCG. The COVID-19 pandemic needed an unprecedented and co-ordinated emergency response, and some non-essential services were temporarily suspended due to the immediate pressures. Much of this has impacted on performance throughout 2021/22, as we are now seeing extra demands on health services, whether from disrupted routine operations, higher mental health needs and increased demand for emergency care - even new conditions such as 'Long COVID'.

As we begin to manage living with COVID-19 we are beginning to be able to see significant strides in our recovery plan as a result of protecting elective capacity in COVID-19 secure areas. As a result we have a lower than national average total number of patients waiting to be seen or treated in our acute providers and the amount of patients waiting the longest time for care, but we also recognise that we still have a big recovery challenge ahead to get waiting lists down to pre-pandemic levels.

Performance Analysis

NHS Constitutional Targets

The NHS Constitution sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. NHS Lincolnshire CCG seeks compliance with the Constitution in conjunction with our healthcare providers by setting plans to deliver and requiring providers to provide remedial action plans where standards are not delivered. As many services were stopped, paused or operated at much reduced capacity in 2020 due to the pandemic, Lincolnshire performance, like many other areas, is affected. The CCG is monitoring performance to inform restoration and recovery plans post COVID-19 as part of the National COVID-19 Restore Agenda, which moves away from a focus on Constitutional standards to the expectation of a focus on cancer and clinical urgency and so therefore the performance below needs to be seen in that context.

The assessment of performance for each target is based on the following:

- Achieved - Performance at or above the standard
- Underachieved - Performance between the standard and the lower threshold (determined nationally)
- Not achieved - Performance below the lower threshold

Indicator	Standard	2020/21 or latest period
A&E Waiting Time	< 4 Hours	Not Achieved
Ambulance Category One	90% < 15 Mins (life threatening)	Not Achieved
Ambulance Category Two	90% < 40 Mins (emergency calls)	Not Achieved
Ambulance Category Three	90% < 2 hours (urgent calls)	Not Achieved
Ambulance Category Four	90% < 3 hours (less urgent calls)	Not Achieved
Referral To Treatment	< 18 Weeks	Not Achieved
Diagnostic Test Waiting Time	< 6 Weeks	Not Achieved
Cancer- All Suspected Cancers	< 2 Weeks	Not Achieved
Cancer- Asymptomatic Breast Cancer	< 2 Weeks	Not Achieved
Cancer- First Treatment From Decision	< 31 Days	Not Achieved
Cancer- Subsequent Surgery	< 31 Days	Not Achieved
Cancer- Subsequent Chemotherapy	< 31 Days	Achieved
Cancer- Subsequent Radiotherapy	< 31 Days	Achieved
Cancer- To First Definitive Treatment	< 62 Days	Not Achieved
Cancer- First Treatment From Screening Service Referral	< 62 Days	Not Achieved
Cancer- First Treatment From Consultant Upgrade	< 62 Days	Not Achieved

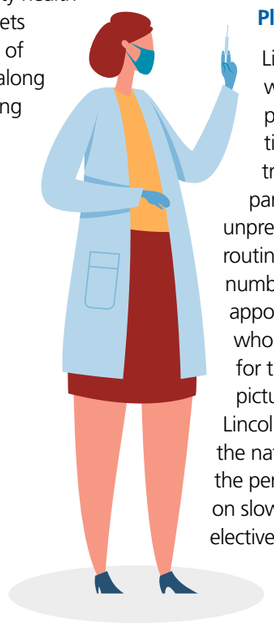
How We Report Performance

A CCG Integrated Performance Report is tabled at the Board and Quality Patient Experience Committee (QPEC) meetings and provides comprehensive up to date detail of performance against all the CCG constitutional standards and targets across urgent care, cancer, planned care, mental health, primary care, and a chapter on further key quality measures e.g. mortality rates, hospital infections and learning disability health checks. The report sets out causes for areas of underperformance along with key actions being taken to improve performance.

This monthly report is available to the public on the NHS Lincolnshire CCG website.

COVID-19 Recovery

Following the urgent response to the COVID-19 pandemic and subsequent restarting of services that were temporarily shut down to reduce demand during the first wave, the recovery continues to focus on accelerating the return to near-normal levels of non-COVID health services. More information on this is available on the NHS England website.



Planned Care

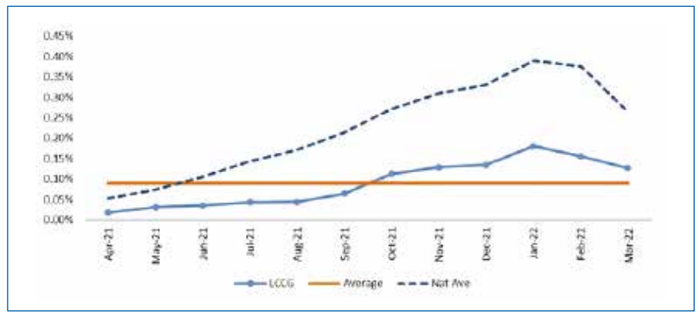
Lincolnshire CCG works with a wide range of providers to improve the time patients wait for treatments. The COVID-19 pandemic has caused unprecedented disruption to routine services, with record numbers of patients waiting for appointments as well as those who have waited over a year for treatment nationally. This picture has been reflected in Lincolnshire, which has followed the national trend. In 2021/22, the performance focus has been on slowing the increase of the elective waiting list size, along with reducing the number of patients having to wait 104 weeks (two years) for treatment.

As expected, the total waiting list size for Lincolnshire patients at all hospitals has significantly increased and the latest reported figure stands at 93,087. However, the total elective activity is above plan and there are signs that this is beginning to stabilise.

We have continued to strengthen our oversight of patients waiting over 104 weeks with our main acute providers, which we are also seeing has stabilised, and as a result of this work the percentage of our waiting list has remained significantly under the national average (0.13% compared to 0.33%).

Total Waiting List

Percentage of patients waiting over 104 weeks



The Elective Activity Coordination Hub (EACH) was launched in August 2021 to manage new patient referrals and to support patients accessing the most appropriate service to meet their needs.

The EACH also supports the transfer of clinically suitable patients on current waiting lists to alternative providers where waiting times will be shorter as well as linking in with out of county providers to offer support for Lincolnshire patients to 'wait well'. Providers do, however, still experience patients wishing to delay their treatment until after COVID or who are reluctant to travel to alternative sites where wait times may be quicker.

Most diagnostic modalities have restored to greater than pre-COVID capacity and are managing well to support increased demand. Both CT and MRI are above national and peer averages. Funding to implement a new Community Diagnostic Centre has been approved by NHSEI, which will also increase capacity for diagnostic procedures.

Emphasis in 2021/22 has also been placed on increasing both Advice and Guidance to GPs to reduce patient referrals where appropriate, and in providing more virtual appointments to prevent unnecessary patient journeys and utilise clinical time more efficiently.

The system has also been engaged in the Midlands Elective Delivery Programme, both sharing and learning from best practice for certain specialties, to ensure we are maximising opportunities to deliver best clinical outcomes and experience for patients.

The community Optometrist Triage Assessment and Treatment Service has been reprocured leading to both an increase in provision and greater geographical coverage of the county to improve patient access and experience. There has also been an increase in Low Vision service providers. In addition, the system has engaged with the Midlands Eyecare Transformation Programme with a view to implementation of an Electronic Eyecare Referral service.

The Lincolnshire Community Pain Management service provider raised the profile of pain by undertaking a week-long peloton across the county to increase awareness across the community.

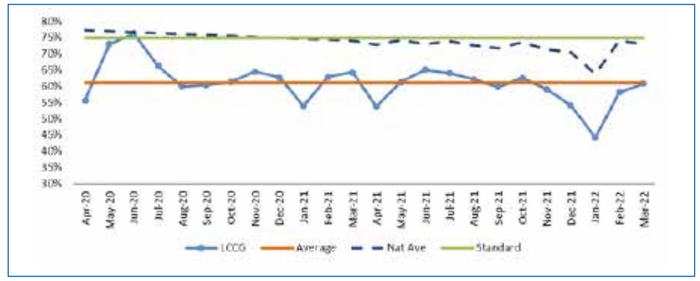
The Lincolnshire system has worked in collaboration to design new clinical guidelines, pathways and supporting referral forms for Dermatology. As part of the outpatient improvement work, the Dermatology Advice & Guidance service was revised, providing a new enhanced specialist advice service for Primary Care. In order to support practices using the new guidelines and the improved A&G service, the system secured funding from NHS digital to obtain dermatoscopic equipment for Lincolnshire GP Practices. ULHT has since seen A&G requests more than double from previous years with a 6-month average of 24 requests per month in 19/20, 79 requests p/m in 20/21 and 130 requests p/m for 21/22. February 2022 saw the highest number of requests of 156. The service has provided a consistent average response rate of 97% within 48hrs since implementation of the enhanced A&G service, which is an increase on the previous average of 72%. Dermatology A&G requests now equate to over 20% of the dermatology outpatient appointments compared to a baseline of 10% 6 months prior.

Patients receiving treatment for cancer within 62 days of an urgent GP referral (CCG)

Cancer

There are nine cancer standards monitored looking at time to be seen, diagnosis and treatment; details of the performance against each of these standards are shown in the constitutional standards at the beginning of the performance analysis. The key standard is that patients should begin their first treatment for cancer following an urgent GP referral for suspected cancer within 62 days. Nationally the achievement level has declined from 73.9% in 2020/21 to 67% in December 2021, and this performance deterioration is mirrored in Lincolnshire, where currently 47.3% of patients are treated within 62 days compared with 62.6% in 2021. This is against a standard of 85%.

Faster Diagnosis Standard



There is a new Faster Diagnosis Standard (FDS), which is a new performance standard being introduced to ensure patients who are referred for suspected cancer have a timely diagnosis. The standard is for 75% of patients to be told their cancer diagnosis outcome within 28 days - the chart above demonstrates how the CCG has performed against this standard so far. The FDS will work alongside the delivery of the 62-day referral to treatment cancer waiting times standard, including the standard to reduce waiting times, through improved analysis and pathway improvements of faster diagnosis.

Improvement work within the cancer pathway has been slow to progress over the last year due to the sheer size of the backlog following COVID-19 and the redeployment of many key staff members across the system. The backlog position is beginning to show signs of improvement with the backlog of patients over 62 days at 538 in December 2021. Work is ongoing both locally and regionally to address these backlogs. Colorectal cancer pathways account for 56% of the backlog, however, that backlog has been reduced by 20% since the beginning of January, due to additional capacity being put in place through ad hoc and new permanent clinics.

The Living with Cancer (LWC) programme was also severely impacted by the COVID pandemic, however, remaining staff in ULHT continued to support people LWC by completing Holistic Needs Assessments and support from the Macmillan Information Centres and other support mechanisms were moved on-line. Restore and Recovery plans were developed in May 2020 2020, and re-plan options presented at Board level in September 2020. Successful bids to the Macmillan COVID Response Fund, Health Education England and the Estates and Technology Transformation Fund have resulted in the capacity to deliver a re-planned programme, focussing on implementation of the NHS personalised care model, addressing health inequalities, using existing assets, workforce development and digitalisation.

Achievements

- Living With Cancer Community Cancer Care Co-ordinators integrated with all Lincolnshire Neighbourhood Working Teams who act as a point of contact for patients, their carers' and the wider healthcare team.
- Two LWC co-production groups (one county wide and one on the East Coast) established who are actively co-producing elements of the Living With Cancer programme.
- Rapid Diagnostic non-specific symptoms pathway has gone live. This will enable those with non-specific cancer symptoms to be referred into secondary care for appropriate tests to identify cancers earlier.
- Rapid diagnostic pathways have gone live for both haematuria and testicular cancer.
- Breast Pain Pathway has gone live, this will ensure patients who are experiencing breast pain alone are no longer referred into secondary care under a cancer referral, ensuring the right patients get to the right place at the right time.
- Cervical Screening text message roll out to encourage patients to come forward for screening.
- State-of-the-art robotic surgery system launched in Lincolnshire to help people access less invasive cancer treatments quicker for prostate and colorectal surgery. Previously patients had to travel outside of Lincolnshire for their care as there has previously been no such system in the county's hospitals.
- Dermatology spot clinics have been launched across Lincolnshire in sites across the community, providing care closer to home for patients
- Cancer team have worked with our health inequalities team, United Lincolnshire Hospitals NHS Trust and Active Lincolnshire to establish an appropriate location for the Fighting Fit Programme to best serve the population of Lincolnshire. This is a collaboration with Lincoln City Football Club to promote exercise for patients living with cancer. This commenced in in April 2022 in Mablethorpe. Fighting Fit | Cancer Rehabilitation | Charity | Lincolnshire (lincolncityfoundation.com)

Urgent Care

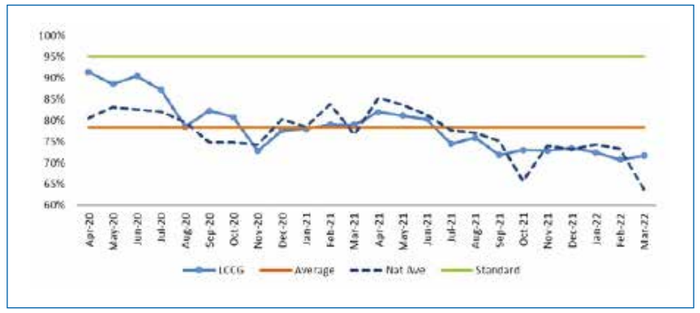
The Lincolnshire system has continued to experience significant pressure within urgent care throughout 2021/22, with January into February seeing a prolonged period of internal critical incident and escalation to major incident within ULHT. It is fair to say that the pressures experienced across the system have presented a greater challenge than we have seen in previous years. As well as an ever-increasing volume of patients being seen and treated, patients are presenting with more complex illnesses and co-morbidities.

Delivery of urgent care targets, in particular the delivery of the four-hour accident and emergency (A&E) target have been compromised as a consequence of the COVID response and there continues to be challenges with the delivery of the current national 4-hour standard.

There has also been an ongoing deterioration in the number of people waiting more than 12 hours in the department, and the number of ambulance handover delays has also increased.

However, the challenges we are experiencing are shared nationally; many areas continue to see rising attendances and an impact on their performance levels as well. For the constitutional 4-hour A&E target, Lincolnshire performance has consistently remained close to the national performance; the latest reported percentage of patients being seen within 4 hours was 72.5% compared to 74.3% nationally.

A&E admission, transfer, discharge within 4 hours (LCCG)

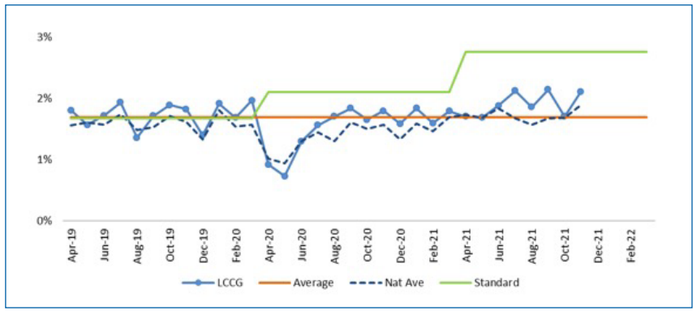


Mental Health

Improving Access To Psychological Therapies

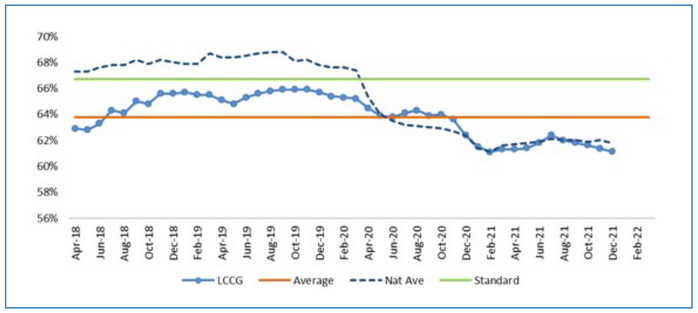
The Improving Access to Psychological Therapies (IAPT) programme began in 2008 and has transformed the treatment of adult anxiety disorders and depression in England. IAPT is widely-recognised as the most ambitious programme of talking therapies in the world and in the past year alone more than one million people accessed IAPT services for help to overcome their depression and anxiety, and better manage their mental health.

There is a continued focus on expanding services so more people can access them. The IAPT service aim was to achieve a 25% target access rate by April 2022, however, this is now thought to be more likely to be 23%. The service continues to have a high number of trainees which impacts on current capacity. Trainees are due to qualify in March 2022 and 13 in September 2022, which further support long term improvement.



Dementia Diagnosis Rate

As mentioned earlier in this report, people registered to GP practices in Lincolnshire CCG have a higher than average incidence of long standing health conditions. Early diagnosis of dementia ensures that people can be signposted to the services available to help them manage their conditions and enables people to plan ahead while they are still able to make important decisions on their care and support needs. The benefits to the patient in diagnosing dementia are far reaching and increase the earlier in the patient's journey they are diagnosed. As of February 2022, 60.9% of Lincolnshire patients had a diagnosis against an estimated prevalence of 66.7% standard; performance has declined from last year due to the impact of the pandemic and has followed the national trend.



The pandemic has undoubtedly impacted the DDR (dementia diagnosis rate) in Lincolnshire and nationally, this is partly due to people not presenting to their GP with memory concerns and as a consequence less diagnoses being made and also due to the number of deaths of the over 65 population. Primary care resources being redirected to the COVID-19 vaccination programme arguably has also had an impact. However, prior to the pandemic Lincolnshire was not achieving the national target, with variation across localities and Primary Care Networks. For example the South West locality was significantly underperforming at 58.9% (March 2020) whereas the West locality was over performing at 71% (March 2020). Previous drives to improve DDR across the county have clearly helped increase the DDR but they have not been sustained.

A new local primary care dementia pathway for over 65s has been developed by primary care in conjunction with the Lincolnshire Local Medical Committee (LMC), Lincolnshire Partnership Foundation Trust (LPFT) and other care providers. It is for over 65 year olds presenting with symptoms suggestive of dementia and is intended to act as a guide to navigate the practitioner through the patient journey from presenting symptoms, to diagnosis and post-diagnostic care and support.

The CCG Clinical Dementia Lead stepped down in August 2021, plans are in place to identify a new clinical lead and an area of focus will be the implementation of the primary care pathway including delivery of education sessions across the system.

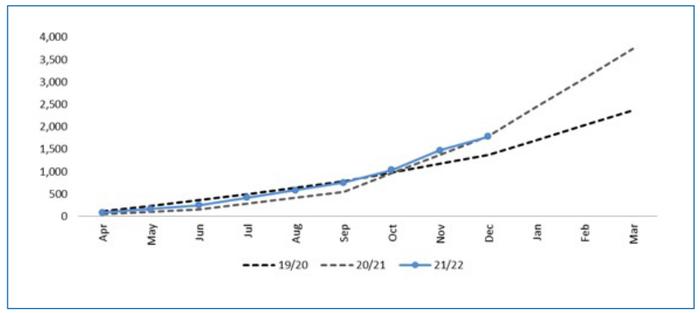
The pathway also incorporates the new Memory Service Referral Form which has a clearly defined criteria for referral which aims to improve getting the right patients to the clinic. This should improve the conversion to diagnosis rate. The referral form has recently been updated to identify patients who may be suitable to be seen on the digital pathway. Lincolnshire are piloting a digital pathway to improve people's access to memory assessment, offer greater flexibility of appointment times and improved waiting time to diagnosis. Benefits of the pathway include:

- A new fully digital pathway developed using consultants with extensive experience of remote consultations within the Memory Assessment and Management Service (MAMS).
- Provides an additional route of service delivery to expand and compliments the existing MAMS pathway.
- The service is 'boundaryless' and can be accessed/delivered to anyone within the county based on choice and meeting access requirements.
- The service will target waits and reduce length of time to a diagnosis (target is 6 weeks from referral to diagnosis).

The Joint Lincolnshire Dementia Strategy 2018 – 2021 (health and care) committed to look at how the process for people with learning disabilities to get dementia assessments could be improved, the importance of this has been highlighted through the health inequalities work that commenced in 2021. The Learning Disability (LD) annual health check template now includes a pre-assessment Dementia Screening questionnaire for people with learning disabilities, this has been promoted through primary care and further education will be provided to support the identification and assessment of people with LD and dementia.

Admiral Nurse Service

In June 2019 LCC launched a two-year proof of concept for the Admiral Nurse Service (ANS). The LCC's grant agreement was due to end with St Barnabas on 31st May 2021, but in order for the proof of concept to be given the opportunity to evidence impact LCC extended the proof of concept to March 2022 and Lincolnshire CCG agreed to joint fund this. The proof of concept ended on 31 March 2022 and St Barnabas have made the decision to charitably fund the service and continue to work with Dementia UK from April 2022. The service will continue to work with LCCG, LCC and the wider system.



Multi-agency Dementia Service Review (DSR)

The CCG and LCC commissioned a comprehensive multi-agency review of dementia services across Lincolnshire in July – November 2021. The report has highlighted several gaps in the current service provision and outlines a number of recommendations with regards to interventions that could be introduced to mitigate these gaps. The purpose of the DSR was to gain a better understanding of the current pathway for dementia, understand what is important to people living with dementia, and identify any gaps in provision and potential improvements in the pathway for people with dementia, their families and carers. The recommendations from the review will be incorporated into the new Lincolnshire Joint Dementia Strategy.

Learning Disability Annual Health Checks

Annual Health Checks support people with a Learning Disability stay well by helping to find health problems earlier and giving time to agree on the right care. The CCG has worked closely with primary care and system partners to refocus efforts on improving access to Annual Health Checks for people with a Learning Disability since 2020/21.

A dedicated CCG team was tasked with supporting improved performance by linking with system stakeholders and GP practices, providing direct support to practices and developing real time performance monitoring. An additional 1,789 annual health checks were delivered in 2020/21 when compared to the previous year, meaning the CCG achieved the national target of 80% of people registered with their practice as having a Learning Disability receiving a Health Check.

This success has continued into 2021/22, where the CCG, where the last reported figures in quarter 3 match 2020/21 performance almost exactly.

Key Achievements

Listed below is a summary of the CCG's key achievements in 2021/22.

Vaccination Programme

The NHS in Lincolnshire has faced one of its biggest challenges in its history in the planning and delivery of the Covid 19 Vaccination Programme whilst ensuring people can still access NHS services. But we have succeeded in this challenge, ensuring that the Lincolnshire population is well protected through the delivery of a robust and rapid vaccination programme. The strong Lincolnshire partnership approach within the NHS and with colleagues in in local government, the care sector, and the voluntary sector is an impressive hallmark of the programme and was only made possible by the continued dedication and hard work of NHS staff, volunteers, and partners across the county.

In Lincolnshire, as of 1st March 2022, we have administered 1,684,003 vaccines, that includes 616,670 first doses, 584,143 second doses and 483,190 booster doses. Of the most vulnerable population, currently 94.8% of all those eligible (3 months from 2nd dose) over 80s have been vaccinated with a first, second and booster dose, as have 97.9% of 75–79-year-olds, 98% of 70–74-year-olds and 98% of all Clinically Extremely Vulnerable (CEV) people aged 16-69. In addition, over 90% of our eligible housebound population and those living in care homes have received their booster vaccination. We are proud to report that we met the accelerated booster campaign target to offer all eligible people aged 18 and over a booster vaccine by 1st January 2022. The overall Lincolnshire position for booster vaccination uptake compares favourably with the national average and Lincolnshire has achieved the third highest uptake within the Midlands region.

We continue to encourage the population of Lincolnshire to book an appointment for first, second or booster vaccinations via the National Booking System or by calling 119. This is supplemented with regular pop-up walk-in sessions across the county. It is never too late to come forwards for a vaccination and we will happily vaccinate those requiring first, second or booster doses without judgement.

Vaccination of 12-15 year olds with a Clinically Extremely Vulnerable health condition (as defined by the JCVI) commenced prior to the 'healthy' 12 -15 programme during late summer 2021. The 'healthy' 12-15 programme commenced through a school service offer at the end of September 2021. Across Lincolnshire we have 89 schools in total, 67 mainstream schools and 22 special schools, and all schools received a visit by the end of November 2021 (in line with target), with some requiring multiple visits to ensure all pupils are offered vaccination where parental consent has been received. An offer through our mass vaccination centres remains with appointments bookable via the National Booking System. To date 64.8% of 12–15-year-olds have received a first dose and Lincolnshire has the highest vaccination uptake in this cohort in the Midlands region.

As part of the Government's plan to 'Live with Covid' further eligible cohorts have been confirmed by the JCVI for a Spring booster. This includes the extension of the 5-11 cohort for all children rather than those just 'at risk', as well as a further dose (5th dose) for those aged over 12 who are immunocompromised. Those aged 75 years and over and those living in older adult care homes will also be eligible for a further booster dose and plans are well developed to ensure continued access across Lincolnshire and further plans are in development to grow and improve our vaccination services for Autumn 2022 and beyond.

The COVID-19 Vaccination Programme in the county and the country has been a significant success to date, and Lincolnshire has performed well in comparison to other systems. It has been an amazing effort and we are grateful for the continued hard work and support from all our staff, partners, and volunteers for their contribution.

Urgent Care

One of the CCG's key aims for the year was to ensure people with an urgent or emergency care need were supported to access the right part of the system for their clinical need without an avoidable delay by signposting patients and colleagues to the right pathway at the right time.

The vision has been getting a clinical assessment for patients, at a location that was clinically appropriate and close to home to support them getting the right care for their needs. Throughout the year, people were encouraged to call NHS 111 First to enable them to be allocated a timed arrival slot into the most appropriate service including in General Practice, at an Urgent Treatment Centre or if necessary, the Emergency Department or other alternative services. The NHS 111 First initiative has been operating in Lincolnshire throughout 21/22 and has included a new booking system between NHS 111 and ED, enabling patients to be booked into an arrival slot. This work was led through the NHS 111 First project, as well as working collaboratively across the wider Lincolnshire system with Derbyshire Health United as the CCG's NHS 111 provider and Lincolnshire Community Health Service who provides our clinical assessment service to ensure there was capacity in the system to manage demand.

Our initial response to the pandemic also required us to focus on preparing for large numbers of COVID-19 patients needing hospital care and respiratory support, which meant we needed to create the maximum possible inpatient and critical care capacity. To do this, we worked with partners to urgently discharge all hospital in patients who were medically fit to leave. Often we had to make difficult decisions to postpone non-urgent treatments and operations, while ensuring emergency admissions, cancer treatment and other clinically urgent care could continue unaffected. This approach enabled us to treat people with COVID-19 and deliver critical services during the peak periods of the pandemic. However, it has also inevitably resulted in significantly increased waiting times for elective diagnostics, treatments and surgeries and our focus, now that we are past the most recent wave of COVID-19, is to accelerate the restoration and recovery of elective care for our population.

Throughout the year, the Urgent and Emergency Care Programme delivered a number of key changes including:

- NHS 111 First
- Increased access to the Urgent Treatment Centres (UTCs), as an alternative to ED.
- An increase in the number of GP practices able to offer direct booking.
- Reduced ambulance conveyance to Emergency Departments by increasing the use of hear and treat and see and treat
- Emergency Departments (EDs) able to fully implemented electronic bookings and commence taking bookings.
- Same Day Emergency Care (SDEC) pathways established for acute medicine, acute surgery and frailty.
- Same day specialty clinics developed to support 'on the day' appointments for patients.
- Development of discharge policy to support implementation of a discharge to access process to for timely discharges and preventing admissions.
- Implementation of the Frailty Virtual Ward
- Commissioning of a High Intensity User Service
- Implementation of a two-hour Community Crisis Rapid Response for patients.

Emergency Planning, Resilience and Response (EPRR)

The annual EPRR self-assessment against a set of core standards provides an assurance that NHS organisations are working to meet their EPRR statutory duties and obligations. The CCG was able to declare substantial compliance against the EPRR Core Standards however this is a reduction from full compliance in 2020/21. This reflects the NHS's continued response to COVID-19 and the operational demands of restoring services.

The CCG has completed work to restore full compliance through a review of policies and procedures including the CCG on-call handbook; EPRR position statement and through work with the Local Health Resilience Partnership. The pandemic and concurrent emergency exercises has developed, tested and rehearsed all of these actions, along with the wider spectrum of requirements within the EPRR core standards. This enables the CCG to be in a strong position ahead of the 2022-23 requirements.

CCG COVID-19 System Vaccination and Operation Centre (CCG Incident Response)

For the past two years, the CCG has demonstrated its ability and commitment to deliver its responsibilities through both mobilisation of the COVID-19 response centre and its active role in the county-wide response.

The CCG has always been an active partner in pandemic planning and response and is fully aware of its role in the pandemic plan. Scenario planning has been an important part of preparation and response. The System Vaccination Operations Centre (SVOC) was established to ensure that the CCG was able to both deliver its responsibilities and support swift and considerable system level change in the COVID-19 response. Key CCG teams came together through nominated individuals and dealt at pace with the challenges that the organisation faced. The SVOC is managed via the EPRR function of the CCG, which is delivered by the urgent care team and continues to be covered by a core team and its scope is of all incident related issues

Integrated Care System

Following the publication of the government Health and Care Bill in 2021, the Lincolnshire NHS System has been preparing for the transition to the new NHS architecture. The Bill has a significant impact on Clinical Commissioning Groups as they will be dissolved and replaced with an Integrated Care Board (ICB). The Lincolnshire CCG has been preparing for the transition to the Lincolnshire Integrated Care Board to ensure it has the capacity to discharge the statutory functions conferred on it.

The Lincolnshire ICB Board is taking shape, with Sir Andrew Cash OBE appointed as the Designated Interim ICB Chair, Mr John Turner has been appointed to the Chief Executive Officer role and Mr Martin Fahy and Mr Matt Gaunt will take up the Director of Nursing and Director of Finance roles, respectively. All the remaining CCG staff will transfer across to the ICB from the 1st July 2022.

Up until the 1st July 2022, the CCG will be continuing to develop the ICB Constitution, policies and governance arrangements in conjunction with NHS partners and the local authority. NHS reconfigurations do not capture the imagination of the public but the expectation is that the changes being made will strengthen integrated care in the county and the development of Provider Collaboratives. These are partnership arrangements involving the NHS Trusts and Foundation Trust, local authority and Primary Care Alliance in Lincolnshire working at scale across the county, with a shared purpose and effective decision-making arrangements, and focus on the health of the population will lead to improvements in the public's health and care outcomes over the coming years.

Public Consultation on four NHS services in Lincolnshire

On the 29th September 2021, the NHS Lincolnshire CCG Board were asked to:

- Approve the Acute Services Review (ASR) Pre-Consultation Business Case (PCBC), which underpins four Lincolnshire NHS service change proposals relating to Orthopaedics, Urgent & Emergency Care, Acute Medical Beds and Stroke Services; and
- Agree to proceed to a period of public consultation on the four Lincolnshire NHS service change proposals set out within the PCBC, and for that public consultation to run from 30th September to 23rd December 2021.

The NHS Lincolnshire CCG Board approved the ASR PCBC and agreed to proceed to a period of public consultation. The public consultation on the four Lincolnshire NHS services launched on the 30th September 2021. It ran for 12 weeks until 23 December 2021 and was widely promoted via stakeholder organisations, leaflet deliveries to households across Lincolnshire, posters and leaflets in GP practices and public locations, online and traditional media coverage and advertisement, and to United Hospitals Lincolnshire NHS Trust (ULHT) and Lincolnshire Community Health Services NHS Trust (LCHS) service users, among others.

Throughout the consultation the CCG, supported by partner organisations, has undertaken a comprehensive, wide ranging public consultation exercise across the whole county in line with best practice. The exercise was informed by discussion with, and advice provided by, the Consultation Institute.

The key aim was to give as many people as possible the opportunity to get involved and share their views in a way that suits them.

The CCG commissioned an independent organisation, Opinion Research Services (ORS) prior to the launch of the consultation to conduct the analysis of the quantitative and qualitive feedback received and provide a report to inform the further refinement of the service proposals.

The final detailed report written by ORS was presented to the CCG in June. This allowed the detailed work to be undertaken to consider the feedback, identifying the impact of any changes to progress, ahead of the report being finalised and allow the Decision-Making Business Case (DMBC) to be developed.

The Decision-Making Business Case (DMBC) was finalised in May 2022 and the CCG Board received the DMBC at its meeting held on 25th May to make a final decision on the proposed service changes.

Spending Review:

These were the priorities set nationally for the NHS, which we addressed in our system plan:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention.
- Delivering the NHS COVID-19 vaccination programme and continuing to meet the needs of patients with COVID-19.
- Building on what we have learned during the pandemic to transform the delivery of services.
- Maximising elective activity, taking full advantage of the opportunities to transform the delivery of service.
- Restoring full operation of all cancer service.s
- Expanding and improve mental health services.
- Expanding and improve services for people with a learning disability and/or autism.
- Delivering improvements in maternity care, including responding to the recommendations of the Ockenden review.
- Restoring and increasing access to primary care services.
- Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities
- Transforming community services and improve discharge.
- Ensuring the use of NHS 111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments.

Financial Performance

The annual accounts of the CCG have been prepared in accordance with the National Health Service Act 2006 (as amended) Directions by the NHS Commissioning Board, in respect of Clinical Commissioning Groups' annual accounts. The accounts have been prepared on a 'going concern' basis to show the long-term commitment to healthcare services. This is described at note 1.1 to the accounts. This is described at note 1.1 to the accounts. The annual accounts are detailed in full from page 86 in this report.

The level of accuracy used in financial reporting for the CCG is informed by the materiality concept. A transaction can be considered to be material by the impact it has on the financial duties of the CCG, but also the reputational and legal implications for the CCG and its internal and external stakeholders. Where judgements and estimates have been made in the preparation of the financial statements, the concept of materiality has been used. However, it should be noted that the concept of materiality has not been applied to disclosures required by law and accounting guidance - precise figures have been used for these disclosures.

CCGs are set a Revenue Resource Limit (RRL) by NHS England that represents the maximum that can be spent in the year. This is used to inform the financial plan for the year. The CCG agreed a plan with NHS England to deliver a £5.1m over-spend against its in-year RRL as there were urgent investments which could not be deferred in areas such as elective recovery, mental health and diagnostic services. The actual outcome for the year was only a £2.4m deficit at 31st March 2022, so a £2.7m favourable variance against the plan. The improvement came mostly from one-off benefits where expenditure estimates from the previous year were not as high as expected.

Hence, it should be noted that the CCG failed to meet its financial breakeven duty in 2021-22. However, the wider Lincolnshire NHS system (including the CCG and NHS providers) did make a surplus against target in 2021-22. The financial outlook for 2022-23 is challenging, and a recovery support programme will be needed for the Lincolnshire system. The CCG has a financial plan with a £3.25m deficit for 2022/23 as part of a breakeven position for the Lincolnshire healthcare system.

Summary Headline Financial Information

NHS Lincolnshire CCG's delivery of its financial targets for 2021/22 as follows:

	2020/21 £000	2021/22 £000
Revenue Resource Limit	1,344,833	1,516,316
Net Operating Expenditure	1,344,809	£1,518,737
Surplus/(deficit)	24	(2,421)

The CCG managed its administration functions within the allocated Running Costs Allowance of £15.3 million.

Cash payments were also managed within the Maximum Cash Drawdown limit as allocated by NHS England.

The CCG is an approved signatory to the Prompt Payment Code.

This initiative was devised by the Government with The Institute of Credit Management (ICM) to tackle the crucial issue of late payment and to help small businesses.

Suppliers can have confidence in any company that signs up to the code that they will be paid within clearly defined terms, and that there is a proper process for dealing with any payments that are in dispute.

Approved signatories undertake to: pay suppliers on time; give clear guidance to suppliers and resolve disputes as quickly as possible; and, encourage suppliers and customers to sign up to the code.

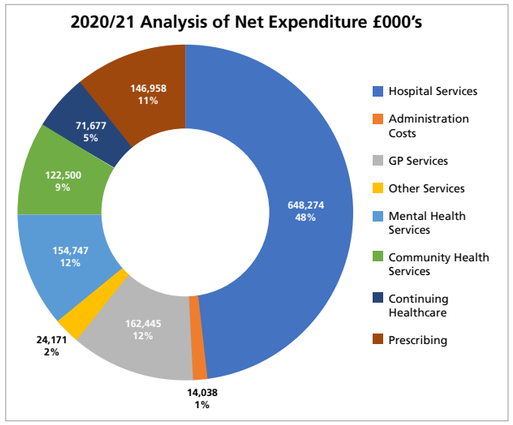
In the NHS, performance is measured by the Better Payment Practice Code which requires the CCG to pay at least 95% of valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The CCG is fully compliant with the code, with around 99% of non-NHS invoices paid within 30 days. Full details are given in Note 6 to the accounts.

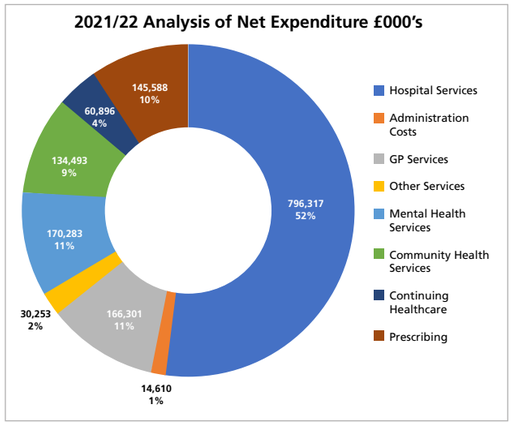
The operating expenditure of the CCG can be split into two types:

Programme – this is expenditure on the purchase of healthcare. The CCG overspent against its programme allocation. It spent 99.04% of its total resources on programme expenditure.

Administration – costs that are not for the purchase of healthcare, but relate to the direct running costs of the CCG. The CCG underspend on its running cost allocation. The CCG spent 0.96% of its total resources on administration expenditure.

Analysis of the CCG's expenditure can be seen in the pie charts below.





The changes in Programme and Administration expenditure from 2020/21 to 2021/22 are shown in the table below.

Expenditure type	2020/21 £000	2021/22 £000	Value change £000	Percentage change	Explanation
Programme	1,330,772	1,504,131	173,359	12%	More investment to restore and develop services following the pandemic.
Administration Costs	14,038	14,606	568	4%	Associated increase in costs to deliver increased services.
Total	1,344,810	1,518,737	173,927	11%	

They have also been some relatively minor changes to the assets and liabilities of the CCG over the last year. These are presented and explained in the table below.

	31 Mar 22 £000	31 Mar 21 £000	Explanation of Movements
Total assets	11,447	8,175	Increase in amounts due to the CCG relating to lower performance in non NHS elective contracts.
Total liabilities	(78,596)	(77,251)	Increase in provisions for possible amounts needed to settle contract queries.
"Total equity"	(67,149)	(69,076)	

Improving Health, Reducing Health Inequalities and Prevention

This section explains how the CCG in 2021/22 discharged its duty under Section 14T of the National Health Service Act 2006 (as amended) to have regard to the need to reduce inequalities.

Joint Strategic Needs Assessment

The Lincolnshire Health and Wellbeing Board is the forum where councillors, commissioners the CCG, local authority and communities work together with other partners to improve the health and wellbeing of the local population and reduce health inequalities. Among its key responsibilities is the production of the local JSNA. By drawing on both 'hard' data (i.e. statistics) and 'soft' data (i.e. the views of local people and professionals), the JSNA highlights who Lincolnshire's priority groups are in relation to health and social care need. The JSNA aims to establish a shared, evidence-based consensus on the key local priorities across health and social care.

In response to the NHS Long Term Plan, the CCG, along with system partners, set out plans last year in the System Five Year Plan to take a systematic population health approach to reducing health inequalities and addressing unwarranted variation in care.

The JSNA has been used to inform Lincolnshire's NHS Long Term Plan 2019 – 24, which sets out the plans across four core ambitions, including prevention. The Lincolnshire NHS Long Term Plan shows the overall profile of the health and wellbeing of the Lincolnshire population, identifying those conditions that are causing the greatest ill health and mortality, for example, cardiovascular disease and musculoskeletal. Deprivation and high disease prevalence, for example Chronic Respiratory disease and Cardiovascular disease are recognised as key challenges affecting some of the CCG population as well as one the main risk factors, for example, smoking and physical inactivity.

As a rural and coastal county, Lincolnshire faces:

- Specific challenges around deprivation, homelessness, an increasingly frail and elderly population, as well as an increasing migrant population
- A series of interlinked challenges, including sparsity, poor transport and digital infrastructure compared to urban counterparts, contributing to social isolation
- With people having to travel further to access services and many communities have limited or no mobile phone and broadband coverage.

The information below provided by East Midlands Academic Health Science Network (AHSNs) - provides a snapshot of the health inequalities for Lincolnshire which is currently being used to help inform the design and delivery of transformational innovation and interventions.

Impact of COVID-19

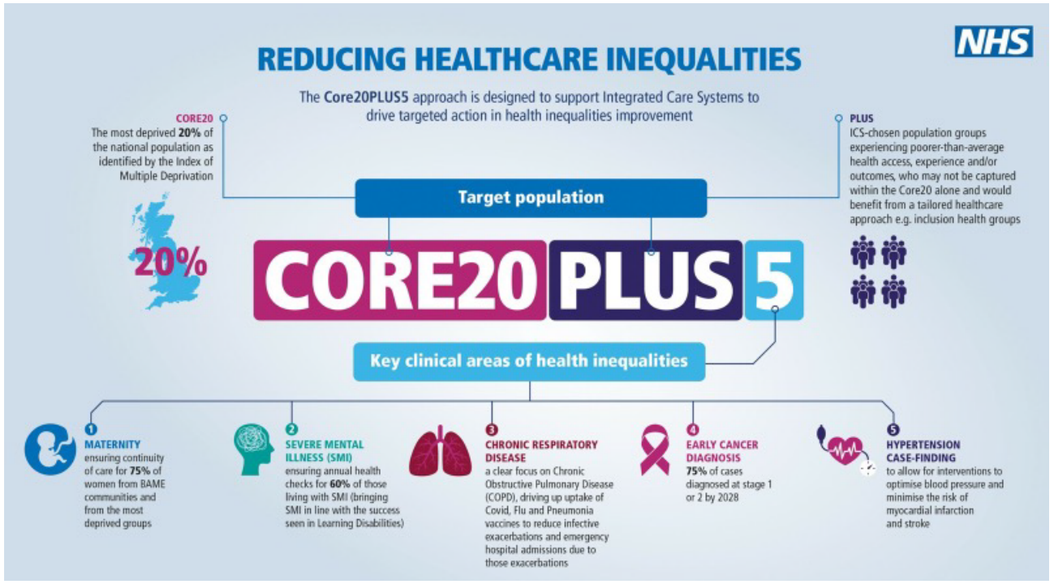
During this last year, the COVID-19 pandemic has exacerbated existing inequalities – both in terms of the harm caused by the virus itself and the wider social and economic impact of the pandemic. Like nearly every health condition, it has become increasingly clear that COVID-19 has had a disproportionate impact on many who already face disadvantage and discrimination.

The impact of the virus has been particularly detrimental on people living in areas of greatest deprivation, on people from Black, Asian, and Minority Ethnic communities, older people, men, those who are obese and who have other long-term health conditions, people with a learning disability and other inclusion health groups, those with a severe mental illness and those in certain occupations. COVID-19 risks further compounding inequalities which had already been widening.

Our focus has been around service provision and supporting patients and staff to maintain their health and wellbeing during the pandemic. We have looked at issues around access, experience, and effectiveness (in relation to services, information, and support) during this period, putting in actions to alleviate and address negative impact and support patients and staff through this difficult period.

Nationally, NHS England and NHS Improvement has outlined an approach to support the reduction of health inequalities at both national and system level – see below infographic.

The approach – 'Core20PLUS5' defines a target population cohort and identifies '5' focus clinical areas for accelerated improvement. This approach has been embedded within our Health Inequalities and Prevention Programme.



Within Lincolnshire our Core20PLUS5 population are:

- The 20% most deprived communities as identified by the Index of Multiple Deprivation (IMD) – 120k patients, 15% of Lincolnshire population.
- Plus - Black, Asian plus Ethnic Minorities communities (101k patients, 13% of Lincolnshire), with the largest Ethnic minorities group group being "any other white background" (8.2%) - a significant proportion of this group is people from an Eastern European background. ICS locally determined population groups (evidence and insight based) experiencing poorer-than-average health access, experience, and/ or outcomes who may not be captured within the Core20PLUS5 alone and would be benefit from a tailored health care approach – key groups identified for Lincolnshire include travellers, homeless, rural and coastal communities, farming and military families.

The effectivenessof the response depends on a system approach, recognising the need for action by all partners across the whole range of factors that influence and determine inequalities. It will also depend on our ability to become increasingly sophisticated and systematic in the way that we use data and insight to build our understanding of our population's health and wellbeing needs – with a view to understanding how need varies between groups and at different levels of our system, as well as what groups and communities are impacted most by inequalities. With this in mind, we have in place a system-wide Health Inequalities and Prevention Programme Board between the NHS in Lincolnshire and local authority with wider partners to reduce the avoidable inequity in people's health across the county.

Vision: To increase life expectancy and quality of life for people living in Lincolnshire and reduce the gap between the healthiest and least healthy populations within our county.

- Opportunity: to capitalise upon the legacy of COVID-19, which has amplified inequity, and understand how NHS services are accessed or not and improve how they are delivered. We must reverse the widening gap in health outcomes and life expectancy in the county.

Intention: To designate clear and specific actions for the county's NHS, Local Authority and wider partners to work together to deliver improvement. Our ultimate objective is to look after all of Lincolnshire's public with equally high standards, before, during and after they need a healthcare intervention.

- Our ambition: a year on year improvement in addressing health inequalities by narrowing the gap in healthcare outcomes within Lincolnshire.

Approach: The Lincolnshire Framework for Action will be integral, embedding our principle of improving the lives of those with the worst health outcomes fastest.

- Governance: Lincolnshire Health Inequalities and Prevention Programme will lead, through its membership from across the county's entire health and care system, reporting into the developing ICS structure, supported by the county's Health and Wellbeing Board. Local area Reference Groups will feed in local stakeholder intelligence and Health Inequalities Partnership group will be established in 2022/23.

For 2021/22, the Health Inequalities Programme has had an immediate focus on implementation of the framework Core20PLUS5 and a wider role to shape and strengthen the longer term, system-wide approach to health inequalities as part of the development of the Integrated Care Board and Integrated Care Partnership.

Our work is informed by the development of regional strategies for inequalities and prevention.

Along with other NHS organisations, the CCG has identified a named Executive Board Member responsible for tackling inequalities as well as a CCG Board Non-Executive lead. Each PCN (Primary Care Network) has identified a Health Inequalities lead and through the PCN Alliance a nominated PCN system lead for Health Inequalities has been agreed.

Working relationships between the CCG and Lincolnshire County Council are close and continue to be formally recognised through a number of mechanisms including the following:

- The CCG Chief Executive is a member of the Health and Wellbeing Board (Vice Chair)
- The CCG Chief Executive is a member of the Better Lives Lincolnshire Leadership Team (BLLET) which is made up of senior representatives from the third (or voluntary) sector, the NHS, social care providers and the County and District Councils.
- One of BLLET's role's is to take an integrated approach to tackling health, wellbeing and health inequalities challenges in Lincolnshire and improving health in our county.
- The CCG's Director of Operations and Director of Finance are members of the Joint Commissioning Oversight Group (JCOG).

Actions to address inequalities

We have regard to the need to reduce inequalities between patients in accessing health services for our local population.

We understand our local population and local health needs, through using the Joint Strategic Needs Assessments (JSNAs) and the collation of additional supporting data, including local health profiles, as well as qualitative data through local engagement initiatives, which aim to engage hard to reach groups.

We work in partnership with local NHS Trusts as well as local voluntary sector organisations and community groups, to identify the needs of the diverse community we serve to improve health and healthcare for the local population.

We seek the views of patients, carers and the public through individual feedback/input, consultations, working with other organisations and community groups, attendance at community events and engagement activity including patient surveys, focus groups and Healthwatch.

As the local commissioners of health services, we seek to ensure that the services that are purchased on behalf of our local population reflect their needs. We appreciate that to deliver this requires meaningful consultation and involvement of all our stakeholders.

We aim to ensure that comments and feedback from our local communities are captured and, where possible, give local people the opportunity to influence local health services and enable people to have their say using a variety of communication methods enabling them to influence the way NHS health services are commissioned.

We aim to tackle health inequalities at three levels and will take a place-based approach which requires partnership working in local neighbourhoods:

- Wider determinants: Actions to improve 'the causes of the causes' such as increasing access to good work, improving skills, housing and the provision and quality of green space and other public spaces and Best Start in Life initiatives.
- Prevention: Actions to reduce the causes, such as improving health lifestyles – for example, stopping smoking, a healthy diet and reducing harmful alcohol use and increasing physical activity.
- Access to effective Treatment, Care and Support: Actions to improve the provision of and access to healthcare and the types of interventions planned for all – for example ensuring health literacy is supportive, ensuring there are health inequalities impacts for all commissioned services.

Mental Health Transformation Programme which support Health Inequalities

The Mental Health Transformation programme utilises local data and is working towards a population health management approach. For example, the county faces specific challenges around homelessness, and to enable and engage most effectively with and provide for these population groups we have now embedded our Holistic Health for the Homeless Team within the City of Lincoln. This is a systemic team which works as part of the wider Integrated Place based teams to provide support for our homeless cohort. The learning we are gleaning from this work is helping us to diversify and work in other areas such as Boston.

A core element of our Integrated Place -based Teams modelling has been to embed specialist older adult provision in areas of highest need. These roles work as part of the wider Multi-Disciplinary Team (MDT) to provide specialist input and links into our existing Older Adults service.

We are expanding this work further to focus on rural parts of our county, supporting people from Eastern European and agricultural communities. Working with the voluntary care sector we are developing a project which will enable us to address some of the issues that have been highlighted by these communities, such as: integration, isolation, employment, and housing; all of which contribute to people experiencing poor mental health and other associated health problems.

Through local discussions it has been identified that a large challenge with supporting these communities is being able to connect with them, establishing trusted relationships that enable people to identify what is available, and feel safe to access help. This project will therefore respond in two ways, providing a peer support role that will be a link to the communities, undertaking peer design and development work, and providing targeted intervention and support to individuals linking with the 'Team Around Adults' and the mental health liaison roles within our substance misuse services.

Local Maternity and Neonatal Services (LMNS) work to tackle Health Inequalities

The Core20PLUS5 identifies key clinical service priority around continuity of carer. The LMNS team have completed the equity and equality assessment and work has commenced on developing the model for continuity of carer. We currently have Continuity of Carer teams in place in Gainsborough and Sleaford, covering the whole pathway (antenatal, delivery and post-natal). Our Wolds team has commenced booking women onto the Continuity of Carer pathway and next steps will be to establish teams in Boston English to Speakers of Other Languages (ESOL) patients, predominantly expected to be Eastern European – Lithuanian. We will also be establishing our Skegness Team in 22/23 – a coastal area with one of the highest deprivation levels within the county.

Demonstrating due regard in decision making

An Equality Impact Analysis (EIA) and Health Impact Assessment (HIA) is completed on all CCG commissioning decisions and policies to ensure access and inclusion for protected and marginalised groups and communities.

All service re-designs, business cases and project initiation documents (PIDs), new services and procurement exercises undergo a process of EIA. As part of the planning process for 2022/23 the Lincolnshire system will be rolling out the use of the Health Equity Assessment Template (HEAT) and will be embedding this within ICS project management and governance arrangements in 2022/23.

The Clinical Policy Sub-group (a sub-committee of the QPEC) reviews all clinical policy decisions including service specifications and considers their impacts on equality and the general duty.

Further information on Equality Impact Assessments is detailed under the Equality and Diversity section of the Annual Report.

Joint Health and Wellbeing Strategy (JHWS)

This section provides examples of how the CCG in 2021/22 contributed to the delivery of the Lincolnshire Health and Wellbeing Strategy as required under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007.

For many years, the NHS and Local Authority have worked in close partnership with partners to tackle health inequalities. All organisations have an important role to play, whilst the CCG has a legal duty to respond to inequalities in the health of its populations, both in terms of access to services and outcomes on life expectancy. No one organisation can do this in isolation.

The Health Inequalities programme will require involvement of all NHS organisations, local authority and wider partners to work together if we are to achieve real and lasting improvements for people living with Lincolnshire.

The JHWS for Lincolnshire aims to inform and influence decisions about the commissioning and delivery of health and care services in Lincolnshire so that they are focused on the needs of the people who use them and tackle the factors that affect everyone's health and wellbeing.

The local authority Director of Public Health attends the CCG Board meetings and provides updates on key issues. Through our work with them, and active engagement at the Health and Wellbeing Boards, we have confirmed the CCG's contribution to the delivery of the Joint Health and Wellbeing Strategy.

As may be expected, the focus of our activity this year has been our joint response to the pandemic and latterly the delivery of the vaccination programme across Lincolnshire.

- This section also provides an example of how the CCG discharged its duty under Section 14T of the National Health Service Act 2006 (as amended) to have regard to the need to reduce inequalities.

COVID Vaccination Programme which supports Health Inequalities

Significant work has been undertaken to date to increase vaccination uptake in rural and high deprivation areas. This has included specific activities including language translation (culturally competent) and pop-up vaccination sites.

Our COVID-19 vaccination work has included tailored approaches to support uptake of specific health inclusion groups. For example, homeless, traveller community and population groups where analysis shows uptake is lower than average (ethnicity/deprivation).

We have developed a Health Inclusion Strategy for COVID vaccinations, which targets low uptake in areas of greatest deprivation and ethnic groups with lower uptake than the whole population (significantly lower vaccination uptake by 'White Other' ethnicity, particularly Eastern European communities) and uses learning to date, as well as data dashboards, to monitor progress and tailor responses to increase uptake.

This will be further developed to support our focus on wider vaccination services (for example flu, pneumonia) in reducing inequalities in access and outcomes, and to continue to adopt culturally competent approaches to increasing vaccination uptake in groups that have a lower than overall average.

Refugees

The CCG is part of the Lincolnshire Refugee Resettlement Partnership and works in collaboration with the Local Authority to support the Vulnerable Persons Resettlement Scheme.

In 2021, Lincolnshire welcomed a number of Afghan families as part of the first phase of the resettlement programme for refugees. In 2022, support was provided to Ukranian refugees arriving in Lincolnshire as a result of the conflict in their country.

Homelessness

The Homelessness Act 2002 requires housing authorities to take a long-term strategic approach to preventing and managing homelessness. Councils are required to carry out regular reviews of the homelessness situation in local authority areas, taking account of the activities and services available to prevent and tackle homelessness, in addition to taking account of relevant national and regional policies, and to develop a strategy based on the findings of these.

Lincolnshire's Homelessness Strategy 2017 – 2021 sets out how the seven Lincolnshire housing authorities, together with a range of partners, aim to prevent and tackle homelessness. This is a combined strategy between the seven Lincolnshire district authorities who, although managing very diverse housing and homelessness pressures and needs, have committed to working to common goals to prevent homelessness across Lincolnshire.

Lincolnshire's Homelessness Strategy is supported by the Lincolnshire Rough Sleeping Strategy 2019-2021.

The intention was to review and merge both documents in 2021 but this has been delayed in light of the required response to deal with the COVID-19 pandemic.

Sustainable Development and Estates

Greener NHS and Green Plan

The CCG is working with provider Trusts to take forward the Greener NHS agenda. To support the NHS net zero ambition, each Trust and Integrated Care System should have a Green Plan which sets out their aims, objectives, and delivery plans for carbon reduction. The providers were asked to have agreed signed off plans by 14th January 2022. We are working towards having a system plan, based on the strategies of member organisations ready in the first quarter of 2022.

To support the work a Lincolnshire Greener NHS Group has been established which feeds into the Lincolnshire Strategic Infrastructure and Investment Group (LSIIG). Baseline carbon footprint data has been gathered and is based on the 2019/20 information. The total estimated emissions were the equivalent to 329.4 tonnes of CO2. This took account of the energy used at Bridge House and at Cross O'Cliff and an estimate of the emissions from 324,697 of business and leased car mileage.

The Green Plan cover several prescribed headings:

- Workforce and Leadership
- Sustainable models of care
- Digital transformation
- Travel and Transport
- Estates and Facilities
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation to mitigate the risks of climate change

The CCG and the local NHS are also working with District and County Council partners regarding their sustainability and green agendas. Lincolnshire County Council launched its Green Masterplan at the Lincolnshire Climate Summit in October 2021. This included three principles:

- Don't waste anything
- Consider wider opportunities
- Take responsibility and pride

These were discussed and supported by the Lincolnshire Greener NHS Group on 25th October 2021.

LSIIG agreed with the recommendation and they have been endorsed by Chief Executives across the system and will be part of the ICS plan.

There was an all staff briefing regarding the Greener NHS as part of the CCG's regular Monday morning briefings and information and communication shared regularly including around the COP26 summit in November 2021.

Some of the key national messages include:

Caring for our planet is caring for our patients Climate change poses a major threat to our health. Tackling climate change through reducing harmful carbon emissions will improve health and save lives. Here in the UK, air pollution is the single greatest environmental threat to human health, accounting for 1 in 20 deaths. Reducing emissions will mean fewer cases of asthma, cancer and heart disease.

In Lincolnshire, we recognise the links between the Green Agenda and Health Inequalities, and are taking these into our planning and local discussions.

This work includes our supply chain and by 2030, the NHS will no longer purchase from suppliers that do not meet or exceed the NHS commitment to net zero.

CCG - Sustainability

The CCG is aware of its responsibilities as an environmentally responsible commissioner and has adopted the following principles:

- Energy: by reducing total consumption
- Consumables: by encouraging all of our staff to reduce their use of paper to move towards electronic documents where possible.
- Procurement: by taking account of the Procurement for Carbon Reduction Tool.
- Travel: Due to the COVID-19 pandemic and the associated lockdown arrangements and social distancing requirements, a large majority of CCG employees have continued to work from home in 2021/22. This itself has significantly reduced the amount of travel for CCG staff and meetings, including the Board, which have all taken place on a virtual basis in 2021/22. There has also been a significant reduction in the use of paper.

Information on the CCG's use of energy and water is detailed at the below for the period 1 April 2021 to 31 March 2022.

	Bridge House	COC
	£	£
Utilities - Gas	N/A	18,796
Utilities - Electricity	6,833	45,775
Water	555	2,770
Total spend	7,388	67,342

NHS Woodland Lincolnshire – Tree for me!

The NHS in Lincolnshire has worked under extremely difficult and testing circumstances during the pandemic and we thought it fitting to recognise the amazing work that every one of our staff have undertaken to support the people that we serve in Lincolnshire. We wanted to recognise and thank every one of our staff in a sustainable and fitting way and one that supports the environment in our beautiful county.

In October 2021 the CCG announced the development of NHS Woodland Lincolnshire that recognises the work of all our staff but also allows our patients, service users and co-workers to reflect on the events of recent times and the strength and determination of the NHS to demonstrate new growth and resilience.

The ***NHS in partnership with the Woodland Trust*** will be planting trees across the county in 2022 in places such as GPs surgeries, vaccination centres, hospitals, hospices and key NHS locations. We know that planting a single tree has benefits for people, wildlife and the environment, and trees make communities happier, healthier places to be which supports the ambition of all of our NHS teams.

Staff members will be given the opportunity to own their very own tree, a Tree for ME! which could be planted on their own property - either in a pot, on a balcony, their garden or a place special to them or their family and friends. There will be a choice of one of three indigenous to the UK that have been selected in collaboration with the Woodland Trust, to support natural wild life and provide sustainable tree coverage to Lincolnshire. The trees will provided as a small sapling.

Estates

NHS Lincolnshire CCG has an established Primary Care Estates Group which meets monthly, to support routine management of reimbursed primary care premises and the development of primary care estate including oversight of financial reimbursement under the Premises Costs Directions. The Group has supported a number of estates developments including the development of a business case for a new surgery to be built at Spilsby, which was approved by the Primary Care Commissioning Committee during 2021/22.

The CCG has engaged with Community Health Partnerships (CHP), who have been commissioned by NHS England to support the national development of a framework and guidance for primary care estates developments. During 2021/22 the CCG has worked with its member practices on a data gathering programme to ensure a baseline of consistent data was collected for every NHS reimbursed GP practice. This has supported the further enhancement of the SHAPE Place Atlas (Strategic Health Asset Planning and Evaluation). SHAPE is accessible to commissioners and Primary Care Networks (PCNs) to support strategy development and investment requests.

The CCG has secured funding to continue to work with CHP during 2022/23 to support PCNs in developing their PCN Estates strategies, which will support GP practices to deliver high quality services to patients from suitable, good quality estate, aligning to the recommendations in NHS England's Premises Policy Review.

In October 2021 Abbey Medical Practice made a temporary move to 63 Monks Road, Lincoln so that work can begin on expanding their existing premises. The £1.5m project will see a full refurbishment of the existing building with a two storey extension which will create an additional five clinical rooms, plus addition admin, and office space and utility areas. This has been part funded through a successful bid made to the NHSE Estates and Technology Transformation Fund (ETTF) programme. Work is expected to be completed by Spring 2023. The refurbished premises will not only support delivery of GP services, but will also enable additional services to be provided that will meet local population needs.

In September 2021, work was completed at Welton Family Health Centre, which saw the adjacent former library building being converted into additional surgery space. An adjoining corridor was created and within the new extension there are five additional clinical rooms, a GP education room, additional patient toilets, and a separate reception area. The additional space creates the capacity needed to manage the growing practice list and also enables capacity for additional services to be provided to benefit local patient need.

Improvement in Quality

Quality Governance

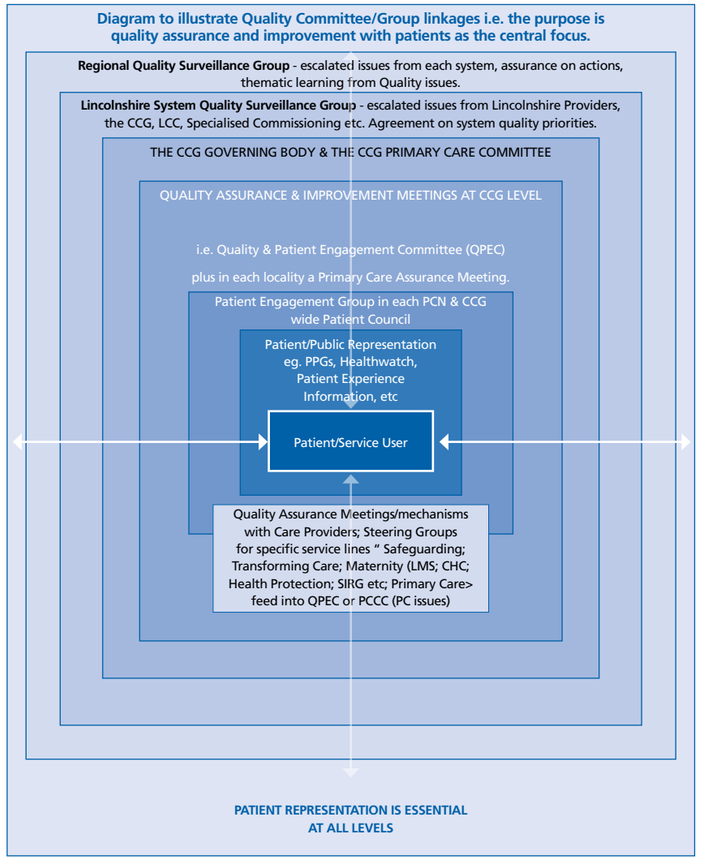
During 2021/22 the CCG continued to discharge Duties under Section 14R of the NHS Act 2006 to improve the quality of NHS services for the population of Lincolnshire. The CCG continued with adapted processes to monitor and improve the quality of care, in view of the continued response to the Covid 19 pandemic and the necessity for some staff to remain redeployed assisting in other areas of the system frontline clinical response to the pandemic. The most notable redeployment of staff was the significant contribution to the successful delivery of the expansive Covid 19 Vaccination Programme across the system for the Lincolnshire population.

Established incident reporting and quality surveillance mechanisms, including regular dialogue with provider Quality Leads, CCG Clinical Leads, GP leaders, CCG teams and also reinstated quality contracting/ governance meetings with and within our main providers, enables ongoing daily awareness of any serious or significant incidents or safeguarding issues occurring across the system, with relevant follow up instigated.

The Quality and Patient Engagement Committee (QPEC) is the sub-committee to the CCG Governing Body which receives assurance that, despite any process changes and workforce limitations, CCG Officers are appropriately discharging the duties to ensure the quality of all commissioned services for the people of Lincolnshire. QPEC has continued to meet bi-monthly during 21/22 to seek this assurance, escalating any priority issues for action by the Governing Body.

The system Quality Surveillance Group (now renamed the System Quality Group) has also continued to meet regularly in 21/22 to ensure a shared understanding across system partners of the quality risks within the system and that appropriate actions have been enacted to address any concerns. The main purpose of this forum being to ensure that quality improvement support is given from system partners as needed and also assurance to all the organisation Quality Leads represented, that required improvement actions are being addressed effectively either by individual organisations or collaboratively where necessary.

The Lincolnshire System Ethics Committee, established at the outset of the COVID-19 pandemic, has also continued to meet in 2021, albeit less frequently than in the early months of the pandemic, when there were many areas for ethical consideration, largely relating to potential capacity constraints and patient and staff wellbeing and safety issues. This Committee, chaired by the Bishop of Grantham, has continued to consider and make recommendation on any system wide ethical issues/ dilemmas, as the pandemic has progressed.



Quality Assurance

Despite the CCG staffing limitations caused by COVID due to staff redeployment, the CCG has continued to assure and improve quality through the domains of patient safety, clinical effectiveness and patient experience. This was achieved by continued surveillance of all 'hard' and 'soft' quality data sources for our providers including performance and quality metric compliance; CQC standards compliance; the nature of complaints and incidents reported; what patient surveys and concerns told us, including via Healthwatch; and also what we, the CCG, observed ourselves through quality reviews and quality visits. Understandably, because of the infection prevention and control limitations due to the pandemic the team have undertaken, like 2021, a significantly reduced number of quality visits this year, with reactive face to face visits only when indicated by the gravity of the quality concern.

Where significant quality concerns have been identified, the CCG Quality Team has worked with the provider to ensure problems are being addressed and to ensure improvement is demonstrated.

Quality Priorities 2021/22

Health Protection

An overriding focus for all organisations in 2021/22, primarily as a consequence of the pandemic, has continued to be ensuring Infection Prevention and Control with safe environments of care for patients and staff. The CCG has assisted with this through the work of its Health Protection Team.

The Health Protection Team works on behalf of the CCG to ensure good health protection systems and processes are in place for NHS commissioned providers, member General Practices and to support the wider public health of the population. The work of this team

covers three work streams: Infection Prevention and Control (IPC); Communicable Disease Control; and Vaccinations and Immunisation and, therefore in 2021/22 the work of this team has continued to be of paramount importance due to the demands of the pandemic.

At the start of the financial year 2021/22, the CCG was already immersed in the COVID-19 response. The Senior Health Protection Nurse (HPN) was on maternity leave and there were three vacant posts in the team. Two Senior Health Protection Nurses were recruited and one Health Protection Administrator and the Senior HPN returned from maternity in January 2022 and took up the Health Protection Lead Nurse role.

Most of the core Health Protection functions i.e. assurance reporting and support visits were postponed in line with local and national postponement of 'business as usual'. NB. Infection rate surveillance was maintained, and assurance visits did still occur, if necessary, where there were any particular IPC concerns requiring direct observation for follow up. Support to specific non COVID-19 infection outbreaks was also given when needed.

There has been re-planning for Health Protection service provision from January 2022, now a full team is in place - and regular provider visits have been scheduled in order to return to more regular reporting and assurance.

The team continued to support the Influenza and Covid vaccination campaigns and extensive training was delivered in Infection Prevention and Control and the use of Personal Protective Equipment to mass vaccination sites.

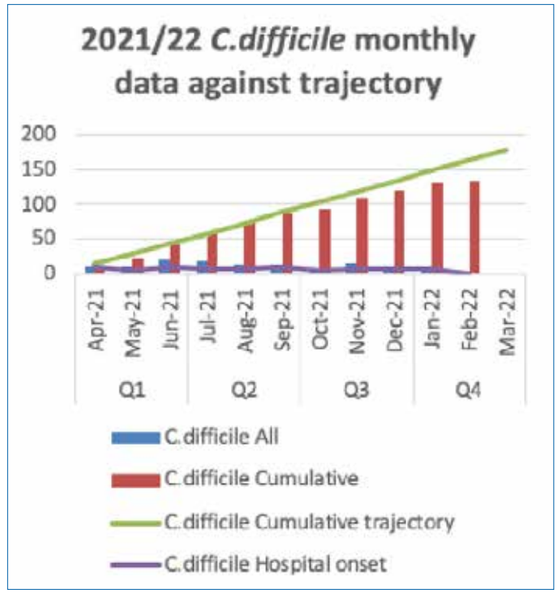
The team has increased resource to manage both the expected demand and the unexpected remit of the Health Protection function i.e. communicable disease outbreaks. There has been a significant Avian Influenza outbreak in Lincolnshire, spanning several months and affecting a number of farms. This dominated the activity of the team in both December 2021 and January 2022 and the response required is expected to continue well into the second half of 2022.

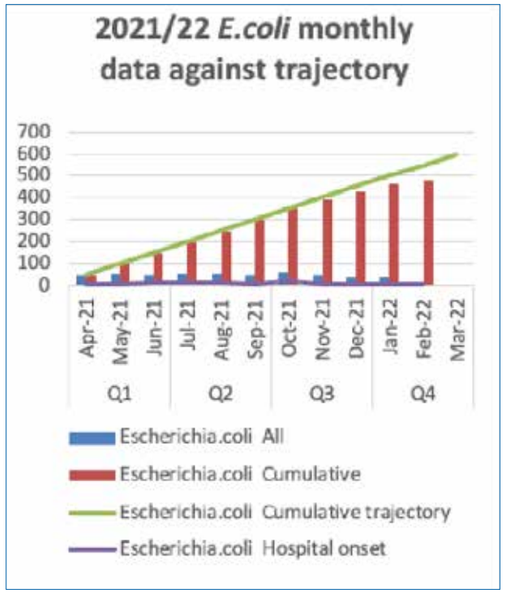
CCG attributed Healthcare Associated Infections:

Organism	C.difficile			MRSA			MSSA		
Year	**2019/20**	**2020/21**	**2021/22*/ trajectory**	**2019/20**	**2020/21**	**2021/22***	**2019/20**	**2020/21**	**2021/22***
CCG	166	156	134/163	12	7	5	135	149	139
Hospital Onset	-	76	79	-	2	1	-	27	28

Organism	Escherichia.coli			Pseudomonas			Klebsiella spp.		
Year	**2019/20**	**2020/21**	**2021/22*/ trajectory**	**2019/20**	**2020/21**	**2021/22***	**2019/20**	**2020/21**	**2021/22***
CCG	584	527	481/550	63	81	52	129	154	141
Hospital Onset	-	63	90	-	19	18	-	34	41

*figures given for 2021/22 consist of data up to and including February 2022 and is, therefore not a complete fiscal year





Due to the COVID pandemic, the figures provided for 2020/21 may not be an accurate reflection, so the figures for 2019/20 have been included in this report for reference.

The system is currently under trajectory for C.difficile and E.Coli. It is likely that the system will remain under trajectory once the figures for March 2022 have been collated.

As we have been in business continuity, there has not been the usual oversight of Gram Negative Bloodstream Infection (GNBSI) and therefore, the reduction plans have not been scrutinised. It is anticipated that this will be a focus for 2022/23 and may result in a decline in cases.

Note: hospital onset figure includes hospitals where Lincolnshire patients have been treated out of county, so does not reflect the case numbers for ULHT.

Addressing Capacity Constraints

The third wave of covid infection from Autumn 2021 brought staffing constraints to many Lincolnshire health and care services, either due to illness or isolation requirements. This, in addition to known recruitment and retention challenges, caused capacity issues across most services at some stage in 2021/22. There has also been increased pressure on Urgent and Emergency services, particularly since the Autumn 2021 too. This has been caused by a combination of factors, including patients making more contact with services post 'lockdowns'; patients waiting longer for elective procedures; workforce and physical capacity constraints e.g. bed capacity; increases in people holidaying in the county as unable to travel overseas. Bed capacity constraints within the three main acute Trusts that serve Lincolnshire have caused long waits in Emergency Departments (EDs) and significant long handover delays from ambulance to Emergency Departments (EDs).

All very long waits and delays are subject to harm reviews to help ensure that although patient experience may have been compromised that there has been no or at most minimal impact on patient safety.

Lincolnshire Community Health Services (LCHS) like many services as described above, has faced significant operational and staffing challenges. However, they have continued to deliver services of a high standard and showed their ability to respond to changes and challenges in a dynamic way.

The LCHS Executive Team has continued to lead on system work to ensure effective Urgent and Emergency Care system provision, good discharge and patient flow processes in our hospitals, and that there is effective, high quality and accessible palliative and end of life care (POEL) when required. CCG Nursing and Quality team members contributed significantly to this work throughout 21/22 leading on important programmes of work within these areas e.g. Discharge & Flow Cell; POEL Board; NHS 111 First.

LCHS is working with partners to help with the transformation of services. This work will focus on more collaborative approaches to delivering community services to patients in a more effective way. They are developing closer working relationships with their partner Primary Care Networks which will allow for better care delivered in the local community (at place). LCHS has also worked on supporting the patient flow challenges through secondary care. One way they have achieved this is by creating community hospital capacity which can easily be offered to an acute Trust as a 'step down' discharge option whilst a patient awaits a residential or community care package.

Lincolnshire Partnership Foundation Trust (LPFT) was also affected by the pandemic in 2021/2022, particularly over the winter with staffing pressures necessitating a ward closure. LPFT also have had recruitment and retention challenges, particularly within its nursing and medical workforce. There have been positive developments in this area in 2021/2022 with successful international recruitment. LPFT activity levels and waiting lists have increased most likely as a consequence of the pandemic. There has also beeen an increase seen in suicides and self- harming behaviour in children and working age adults.

Work has continued supported by the CCG to increase community Mental Health and Learning Disability provision and to thereby reduce the need for 'Out of Area' service provision and in-patient Learning Disability beds. Waiting list backlogs resultant from Covid 19 lockdowns and suspension of services have been another area of recovery focus during 2021/22. CCG staff have worked with United Lincolnshire Hospitals NHS Trust (ULHT) and others to ensure elective and cancer service delivery is as effective and available as possible given the limitations resultant from the pandemic. Inevitably despite best efforts, this does mean many patients are waiting much longer than normal for procedures in some areas. This is under constant review so mitigating actions can be progressed to address. As in urgent and emergency care any very long delays are subject to a harm review process to ensure patient safety, and work continues to eliminate any unacceptable delays. It is recognised, however, that any delay is frustrating and worrying for patients with implications for ongoing health, which necessitates this to be a continuing area of focus for improvement by the CCG, then Integrated Care Board and partners going forward.

The success of the COVID-19 vaccination has been positive for care homes in 2021/2022 with residents much less affected than was seen in the first year of the pandemic. Irrespective it has remained a very busy and challenging time for care home staff, who equally have been affected by staffing constraints due to covid illness, plus recruitment and retention issues. Domiciliary care has equally been as adversely affected and this has created significant difficulties at times sourcing home care for patients needing this on discharge from hospitals.

The CCG has continued to work with the Local Authority, Lincolnshire Care Association (LINCA), Primary Care Networks (PCN) and all other relevant system partners to ensure a network of support is available for care homes and domiciliary care providers. CCG Safeguarding Leads have also continued with their regular input to the Care Home & Domiciliary Service Quality Review Meeting led by the Local Authority with partner agencies which considers in detail any specific provider concerns for follow up, to ensure appropriate support and improvement occurs.

Staff Wellbeing

Extensive health and wellbeing support has continued to be made available for all health and care staff, with LPFT leading on this work. This recognises the difficult and intense working environment for health and care colleagues during the pandemic and provides a wide menu of support tools and interventions for staff to continue to access to aid physical and psychological good health.

Patient Safety

In 2021/22 there has been a continued commitment by the CCG and providers of healthcare to Lincolnshire patients, in the investigation and learning of lessons following the identification of adverse incidents and serious incidents. This has been achieved through a variety of mechanisms, building upon work initiated pre and during year one of the COVID-19 pandemic.

Collaborative review and discussion of serious incident investigations with representation from the main healthcare providers, and the CCG, has provided a positive forum to share learning across different healthcare organisations. Within the forum, discussions regarding care pathways have taken place, sharing of good practice, and the sharing of assessment and investigation tools. Through this collaborative forum, further development work is scheduled for 2022/23 to support a system-based implementation of new initiatives including the Patient Safety Incident Response Framework (PSIRF).

Also continued work has been undertaken in 2021/22 in relation to identification of mechanisms to share incident themes to support learning and development in specific patient pathways. This has included (but not limited to) sharing incident information in relation to urgent and emergency care, safe patient discharge and end of life care. These are key areas for further development work in 2022/23, acknowledging that there continue to be incidents reported in relation to interfaces of care provision from secondary care to primary and community services. The aim will be to inform pathway/service developments as appropriate.

During 2021/22, collaborative working with the Mass Vaccination Team has continued in relation to incident management and broader quality initiatives.

A particular area identified by ULHT, through audit and via care interface concerns reported, is the need for the system to continue work on improving the quality of Recommended Summary Plans for Emergency Care and Treatment (ReSPECT). ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides healthcare professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment.

This year a clinical project manager has been appointed within the Palliative and End of Life team to further drive this work forward, and is currently auditing and developing improvement plans with care home providers. St Barnabas Hospice also continues to help to support staff across community organisations, including within care homes, with effective completion of the process.

Some of the CCG's providers are under an enhanced level of surveillance and support from the CCG and other partners because of previous regulator and/ or CCG performance and quality concerns. For these providers the CCG Quality Leads attend Quality Review Meetings with the provider at a frequency indicated by the level of concern. They also undertake, where relevant, quality visits to seek assurance on progress with actions or any other quality/ safety concerns. Direct support is given to the organisation where required to facilitate quality improvement.

It is particularly pleasing to note the improvements demonstrated by ULHT at their most recent CQC re-inspection in October and November 2021.

The inspection report indicated that the CQC recognised the widespread improvements the Trust has made in the quality and safety of services since the last inspection in 2019. The CQC commented that this was particularly impressive against the COVID backdrop. Positive comments were also made about the Trust having a strong cohesive team with collective leadership at Board level.

As a result of the inspection, the overall Trust CQC rating remains 'Requires Improvement', however, within the individual service and domain scores there is significant improvement and the Trust has been moved out of the CQC Special Measures assurance regime.

Other areas of note for ULHT are :

The first patient at ULHT has undergone an operation using a state of the art robotic surgery system. This follows an investment of more than £3.2m by the Trust to bring this technology to the county for the benefit of urology and colorectal cancer patients

The first undergraduate medical students from the University of Lincoln Medical School will start their attachments in the Trust during February. This will consist of 80 third year medical students.

Maternity

Post the Ockenden Report (Dec 2020) which reviewed Maternity Care at Shrewsbury & Telford NHS Trust (SaTH), and identified several problems with Maternity Care at that Trust, all Maternity Services serving Lincolnshire families have positively responded to the Ockenden Review (Part 1) giving assurance that the issues that occurred at SaTH are mitigated. A further request for actions from maternity services is expected as a second stage of the Ockenden Review, although this has been delayed until later in 2022.

The Lincolnshire Local Maternity and Neonatal Services Network (LMNS) continues to work very proactively with ULHT to drive improvements in maternity and neonatal care. Further information is provided in the communication and engagement section of this report. The CCG and a LMNS representative also attend the ULHT monthly Maternity and Neonatal Oversight Meeting to receive assurance on the quality of maternity services, and this includes consideration of progress with an overarching improvement plan which encompasses all previously identified areas for improvement. Good progress with this plan has been evidenced in 2021/22.

Safeguarding

The pandemic has brought many safeguarding challenges both nationally and to the population of Lincolnshire. There has been a significant increase in cases of domestic abuse. Children and young people have had limited or no-access to school resulting in some of them being less visible to support services, which has increased their anxiety, feelings of isolation and reduced opportunities for them to reach out to their community for help and support.

Vulnerable members of the community have also experienced significant effects including social isolation, lack of community support and, for some, may have been living in an environment that is not conducive to positive health and wellbeing.

Individuals suffering domestic abuse, exploitation and mental health difficulties have not always been able to access face to face support from their GP due to covid restrictions, therefore making it difficult for them to disclose their experiences in a safe environment, giving rise to an increase in "hidden harm". Care home residents have been significantly affected by the restrictions, including separation from their family and those close to them.

Lincolnshire CCG has a wide range of statutory duties in relation to safeguarding its population, however this has become more bespoke during the pandemic. The expert CCG team has continued throughout to give advice and directly manage complex safeguarding cases. They provide training, support and guidance to other professionals either with specific safeguarding responsibilities or support with individual and organisational safeguarding issues.

The team provides advice and expertise to ensure that safeguarding implications are considered at every step of the commissioning process and obtain assurance that providers of care are doing the same.

The safeguarding team is fully immersed in the work of the local Safeguarding Children (LSCP) and Adult Boards (LSAB) with its inter-agency partner, to include contribution to Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews in addition to supporting strategic and operational board meetings and executive meetings associated sub groups. The CCG also supports development of the Safeguarding Board priorities and local and national policy.

The team gains assurance against key safeguarding themes from all levels of health providers, such as hospitals and care homes, to ensure compliance levels for staff training, support robust practices to ensure staff are able to report concerns and share information in a timely and responsive way to ensure positive safeguarding outcomes for individuals who have contact with their services. The Designate Nurse and Doctor for the CCG maintained weekly contact, with provider and Local Authority safeguarding lead practitioners to provide both peer support and to identify any safeguarding themes or trends that were emerging as a direct impact of the pandemic.

In addition, the Designate Dr attended much more frequent LSCP executive board meetings and LSAB exec meetings during wave 1 & 2 of the pandemic to ensure that any safeguarding issues were identified, addressed and mitigated.

Safeguarding Level three Training for Children and for Adults to general practice staff and CCG staff was maintained through online training. The feedback from participants in the training as always was very positive. General Practitioner Safeguarding Forums also continued virtually. The Team also continued to support general practice regarding domestic abuse and their engagement with the multi-agency risk assessment conference (MARAC) process.

There have been many Government led safeguarding initiatives to support people to access services during the pandemic. The CCG Safeguarding Team has been pivotal in implementing those initiatives across Lincolnshire to improve outcomes for our population.

Children and Young People

It is recognised that the COVID-19 has had a huge impact on our children and young people. Isolation during lockdown away from supportive peer groups, home schooling, dealing with infection, prevention and control measures, and the pressures around exams and uncertainty have all taken their toll. Referrals to the Healthy Minds programme and into the Child and Adolescent Mental Health Service (CAMHS) have greatly increased for anxiety, self-harm and eating disorders/disordered eating. Additional investment has been agreed to address the increased demand and employ more staff to increase capacity and reduce waiting times. The CCG works closely with Lincolnshire County Council, who commission CAMHS on its behalf and are working together on the implementation of Mental Health Support Teams (MHST) which will further expand the lower acuity support for children and young people, leaving CAMHS to focus on those that need higher level clinical support.

Another possible effect of the lockdown was the early appearance of respiratory illnesses normally associated with the winter months occurring in August 2021, and as a result it was predicted that a huge increase may be seen over the winter. Surge planning was put in place to cope with this demand which fortunately wasn't needed.

Lincolnshire Community Health Services NHS Trust's Children's Rapid Response Respiratory Service was a finalist in the Health Service Journal Value Awards 2021. The service provides specialist assessment, treatment and management of children aged 0-19 years, with complex physical disabilities with additional respiratory problems, in the community. The service proactively targets all children at risk with early specialist respiratory physiotherapy assessment, preventative daily chest management plans and training for families, carers and schools for day-to-day management of their child's chest problems. Rapid response is provided to these children when they are acutely unwell with a chest infection to prevent hospital admissions.

Transformation work has continued in areas such as child diabetes, asthma and epilepsy, with greater focus being given to the transition from children to adult services. The CCG taking a lead has worked with partners to deliver the COVID 19 vaccination programme to school aged children in line with recommendations from the Joint Committee on Vaccination and Immunisation (JCVI).

offering alternative arrangements to meet the needs of CYP with SEND. In Lincolnshire, therapy, nursing and community paediatric services have continued using virtual platforms or by wearing appropriate personal protective equipment and this has been the catalyst for new ways of working with parents and carers reporting increased satisfaction in being able to access clinical support more readily in some cases.

As schools reopened, there have been some challenges in responding to the differing national guidance from NHSE and the DfE. This differing guidance resulted in partners having different expectations regarding local health provision restoration. The DCO team has worked in partnership across the system to ensure full understanding is shared across the networks to effect the safe return to educational settings.

The DCO team has delivered on a number of high impact projects including the development of the SEND Education Programme for Clinicians; the Sensory Processing Disorder Programme; and the Special Schools Health Strategy development.

Special Educational Needs and Disability (SEND)

The Designated Clinical Officer (DCO) for Children and Young People (CYP) with Special Educational Needs and Disability has continued to deliver on all statutory functions.

SEND Legislation (SEND Code of Practice 2015) outlines that CCGs must:

1. Work with the local authorities to contribute to the online Local Offer of services available
2. Commission services jointly for CYP (up to age 25) with SEND, including those with Education Health and Care Plans (EHCP) and have mechanisms in place to ensure practitioners and clinicians will support the integrated EHCP needs assessment process.
3. Support the Extended Powers of Tribunal process.

The Government Minister for SEND has sent open letters throughout the pandemic and has noted the impact on CYP and their families. This was initially a result of the Prioritisation within Community Health Services document (NHSE/I April 2020). The document did not refer to SEND legislation or requirements but did identify segmentation in therapy and community paediatrics, with the need to prioritise only urgent care needs and to stop medium and lower priority work. This had a direct impact on CYP with SEND, as provider services ceased non-urgent home visits and school interventions were ceased due to school closures. Feedback from CYP and their families have reported that they felt there was a lack of clear communication of what the local provision was at that time, adding to the increased pressures that families were experiencing already. Services eventually were reinstated via phased business continuity plan

General Practice

The Quality of general practice provision has continued to be assured through the work of CCG Locality Primary Care Quality Assurance Groups and constituent CCG locality linked staff. There is then escalation reporting of any areas of concern to the Primary Care Quality Oversight Group and ultimately to the Primary Care Commissioning Committee. At these groups there is careful consideration for each practice of wide- ranging quality indicators including any incidents, complaints, Healthwatch and regulator feedback. Any concerns are followed up directly with the practice for improvement action as needed. Increasingly this follow up is in conjunction with the associated Primary Care Network (as Primary Care Networks develop they will gradually take greater staged responsibility for the quality of care delivery in their local area). The Quality Governance role development of Primary Care Networks is being supported by the aligned CCG Quality officers in conjunction with the CCG Locality Heads of Transformation and teams.

Activity levels for general practice and primary care services in general have remained very significantly increased – normal workload plus backlog after 'lockdowns'; positive COVID cases and long COVID patients needing ongoing care and awaiting elective procedures; and because of the additional workload associated with delivery of the COVID-19 vaccination and influenza vaccination programmes. This includes most recently the successful work to ensure the majority of Lincolnshire residents had received the COVID booster vaccination by end of 2021.

General practice has ensured safe service access in 2021/22 by ensuring maintenance of safe Infection Prevention and Control practices and appropriate access routes, be this via telephone or video consultation routes or via face to face appointments where indicated.

The increase of positive COVID cases in the community over winter 21/22 brought significant workforce pressures with staff illness or staff isolating. Although this situation has now improved, some practices remain affected by staff absences either due to Covid or for other reasons. Business continuity plans have been activated in several of our practices to ensure safe staffing levels e.g use of locums; sharing staff and facilities across practices. CCG locality staff monitor this situation on a daily basis, ensuring support is offered if required.

Patient feedback through Healthwatch does continue to raise some access concerns for some Practices. Where several concerns are raised, these are followed up directly with the practice to ensure any improvements required. Regular communication is also being shared with the public regarding the different routes for service access, including virtual contact & consultations being undertaken routinely now by general practice when it is appropriate to do so.

Beacon Medical Practice, Skegness was supported in 2021 by the CCG, Local Medical Committee and other partners with quality improvement actions following an inadequate CQC rating. It is pleasing to report progress to a good rating from the CQC following CQC re-inspection in August 2021.

Lakeside Medical Practice in Stamford has also been supported this year by the CCG and Local Medical Committee to make improvements after a CQC overall inadequate rating post inspection in June 2021. The practice has recently had a further CQC inspection in early March 2022 and has been rated as Requires Improvement.

CCG support to workforce development and additional roles within Primary Care and General Practice has continued to ensure continued workforce sustainability and good quality multi-disciplinary care provision. For example, the work to develop primary care nursing, increase primary care nurse training and opportunities continues in conjunction with the Lincolnshire Universities and the Lincolnshire Training Hub as nurses play a key role in patient care provision within primary care.

New nursing associate roles have started to become well embedded within general practice and offer an additional career pathway in addition to healthcare support workers, practice nurses and nurse practitioner roles. Advanced clinical practitioner roles have also expanded and whilst these roles are attractive to nurses, they are also open to other registered health professionals.

Continuing Healthcare

The CCG Continuing healthcare (CHC) service started 2021/22 in a strong position and has maintained this in relation to the mandatory NHSE performance indicators around eligibility decisions being made within 28 days. Furthermore, the service has continued to ensure that eligibility assessments for hospital discharge were completed within the 4-week target. During the first half of the year, the clinical team continued to compete assessments and reviews via the Microsoft Teams platform. Whilst this was a viable solution during the COVID-19 pandemic, the option posed significant challenges for completing the eligibility assessments. The key issues were around reviewing evidence, assessing capacity and inclusion of individuals within the process.

Since November 2021, the CHC team have facilitated all eligibility assessments face to face whenever possible, and this has been received positively by individuals, their families and providers. Complaints related to the assessments reduced and we have received positive feedback.

During the winter months, CHC supported the discharge teams to ensure patients awaiting a CHC package of care were placed as quickly as possible. The team attending daily discharge meetings have developed good working relationships with the discharge teams. This has enabled patents to be placed on the correct pathway for discharge in a timelier manner.

The team have focused on further improving the quality of data being entered into the dedicated CHC computer system. High quality data is essential to ensure production of accurate reporting and financial forecasting.

The CHC team has worked hard through the year to improve access to personal health budgets for all individuals. The clinical team have concentrated on ensuring packages of care are personalised for individuals, and that they are fully involved in decisions made about them (where possible). The team also procured a new direct payment support service which will provide comprehensive support to individuals with a direct payment.

Patient, Public and Stakeholder Engagement

Engaging people and communities

Our commitment

The CCG is fully committed to involving patients, the public, partners and key stakeholders in the development of services and ensuring they are at the heart of everything we do. We understand that partnership working is key to empowering patients to have more choice and control over their own health. Through these partnerships, we can better understand the health needs of our population, resulting in improved health outcomes.

Legal Duty for Involvement

As outlined in section 14Z2 of the NHS Act 2006 (as amended 2012), the CCG has discharged its public involvement duty by having in place provisions for involving the public in the planning of commissioned services; and the development and consideration of proposals for changes in the commissioning arrangements which would have an impact on service delivery and decisions which would have an impact on services. By listening to local people and co-producing with those who represent them, we can improve the decisions we make and make sure we are considering the health needs of Lincolnshire residents.

The CCG wants to continuously improve and develop how we can involve our communities. It is important to us that the public sees how their feedback has helped to shape local services and how much we value all feedback and engagement. This is regularly published for members of the public to read. How we do this is set out in our Communication and Engagement Strategy, and our values are outlined in our Constitution.

Structures, Governance and assurance information

Good communications and engagement are a priority for us, and a strong framework, with clear structures and assurance processes, plays a key role in making sure that patients and communities are central to our decision-making.

- Our CCG Constitution clearly states our guiding principles about public involvement and is available to view on our website.
- Our engagement function is part of the CCG's Nursing and Quality Team and is led by the Director of Nursing and Quality, which ensures that patients and the public are at the heart of CCG decision making.
- Reports on our engagement and outcomes of this are reported to QPEC and to our Primary Care Commissioning Committee (PCCC) if it is regarding a GP surgery.
- Updates from the Non-Executive Directors and escalation of engagement feedback if required are reported into our Board meetings.
- We also welcome assurance on specific projects from our patients and public.
- Our Voluntary Executive Team and Stakeholder Board allows open discussion of our plans, and challenge to ensure we meet statutory requirements and our aims and values. It ensures that we have the time and expertise to plan, monitor and evaluate its communications and engagement activity.
- Regular reports to CCG Committees share an overview of current patient experience and key engagement activity.

Working with Partners and Communities

The NHS has a responsibility to ensure that patients are informed of anything that could affect their health – this was particularly relevant during the pandemic and our COVID vaccination programme. We have continued to work closely with Healthwatch, local authorities, community champions and representatives from the community and voluntary sector.

Patient feedback and data

The NHS has access to a wealth of information to support and shape engagement.

The CCG uses data from the Health and Social Care Information Centre (HSCIC) and the Joint Strategic Needs Assessment (JSNA), produced by Public Health, gives all organisations in Lincolnshire information about the health needs of the population. This helps us to target engagement with communities and populations experiencing the greatest need or barriers and make commissioning decisions based on local population health needs.

Several national surveys are published annually. The findings within these highlight areas that we need to consider more closely. We also use a range of data and patient feedback from stakeholders and providers, patient experience feedback, complaints, and comments. We monitor social media (such as Twitter and Facebook) responding and acting where appropriate and use these mechanisms to obtain feedback. This type of feedback again enables us to identify themes and local concerns.

Seeing the impact of participation

Despite the challenges of the COVID-19 pandemic in 2021/22, we have continued to involve our patients, public and stakeholders. Some examples of our engagement activities include:

- Undertook a formal public consultation on proposed changes to four of Lincolnshire's NHS services.
- Developed and recruited our CCG Involvement Champions.
- Supported and worked with our Patient Participation Groups and re-established the county-wide Patient Council meetings.
- Supported a programme of change in primary care, including Practice Mergers consultation on new premises and Primary Care Network changes.
- Undertaken a consultation on the re-procurement of the patient transport service in Lincolnshire.
- Significantly grown our social media presence, including Facebook and Twitter because of the COVID vaccination programme.
- Significantly increased our stakeholder database contacts and local community groups and networks.
- Established the Citizen's Panel and set up Qualtrics – our engagement database.
- Engaged children and young people with special educational needs.
- Engaged the Local Maternity Neonatal System.

How we reach diverse, potentially excluded and disadvantaged groups

The engagement team, working as key members within the Inclusion and Health Equalities Vaccination team, have continued during the year to communicate and engage with the population of Lincolnshire in relation to COVID-19 vaccinations.

This work has included targeting areas of the county with lower up take of vaccinations. We have visited workplaces, community centres, colleges, football stadiums, the University, markets and high street locations to provide further information and guidance regarding the COVID-19 vaccine.

We produced promotional material in a range of different languages and used methods including billboards, targeted fliers to households and businesses, videos and social media.

The distribution of the vaccination messages has been vitally important, and we have worked in partnership with translators, local trusted community leaders, faith leaders, community groups, local organisations, and our Lincolnshire Resilience Forum.

We have continued to be support by our existing networks including the HHH team (Holistic Health for Homeless,) District Councils, YMCA, Nomad, Rough Sleeper Team, Intervention Team, Primary Care Networks and Faith networks across the county.

To help us involve people digitally we continue to recruit to our Citizen Panel which now has over 750 members. The panel has been set up to be a group that is representative of our Lincolnshire population, allowing us to identify and target all demographics including those less likely to get involved such as people with caring responsibilities, in full-time employment and living in rural locations.

The panel gives us an exciting opportunity to gain insight into our population's views on various topic and its aim is to research current services in Lincolnshire, test appetites for change and explore how the population feels about the current provision of services.

The work of the Citizen Panel helped build the CCG's knowledge and confirm the approach with regards to on-going programmes of work such as personalisation. The first survey released last year, has helped us understand the importance of communities and gathered views on people's relationships with health and care professionals, and the way their care is planned and delivered.

How we involve patients and the public

This year the CCG have successfully recruited our first intake of CCG Involvement champions, who are volunteers from a variety of backgrounds from across the whole of Lincolnshire. The aim of the programme is to help the CCG hear the voices of our diverse population, with the champions acting as a point of contact between the CCG and the group or the community they are a part of. So far, the Champions have helped the CCG to share information on our four NHS Services Consultation, promoting participation to their community groups and contacts. The champions have also helped to share our communications about the COVID-19 vaccination pop up clinics and events.

The engagement team have continued to support primary care through several practice re-procurements and Primary Care Network changes; to ensure stronger and more resilient services for our patients.

This has included:

- A public consultation on the merger of Newark Road Surgery and Portland Medical Practice in Lincoln
- The re-procurement of the Sidings Practice in Boston
- The re-procurement of Cliff House Medical Centre in Lincoln

To support the Citizens' Panel and other engagement across the system we use Qualtrics, a stakeholder and engagement software that coordinates engagement with our communities across the CCG and Provider Trusts, reducing duplication. This has enabled us to significantly increase the range of stakeholders, local community groups and networks including those that fall under protected characteristics and seldom heard groups.

During 2021/22 we also commenced our programme of engagement in the development of Community Diagnostic Centres (CDC). The aim of the first survey was to understand what is most important to the public when providing CDCs, what they feel are the benefits and also their main concerns. Feedback from this engagement will inform the CDC project group and help shape the principles for the future CDCs. From this, a programme of further engagement and patient experience will commence.

How we enable and support those who want to get involved

The CCG has reinstated regular involvement with our primary care patient representatives following a pause of our Patient Council due to staff re-deployment to support the COVID -19 response. Our county-wide patient participation group meetings have been held online and work has included sharing our consultations and engagement, and offering support to our member practices in re-establishing their PPG meetings. As agreed with patient representatives, our focus for work over the next year will be to re-establish the four locality Patient Council meetings once the membership increases.

Together with our NHS providers, ULHT, LPFT and LCHS, we established a regular engagement bulletin that is sent out via our engagement and stakeholder software, Qualtrics. In this we publish a range of the latest opportunities for people to get involved in, such as surveys, questionnaires, focus groups, public consultations, meetings and events and the latest news for our stakeholders and patients.

Learning and best practice

During 2021/22 we undertook a formal consultation on proposed changes to four of Lincolnshire's NHS services, Orthopaedic surgery across Lincolnshire, Urgent and emergency care at Grantham and District Hospital, Acute Medical beds at Grantham and District Hospital, and Stroke services across Lincolnshire. Our consultation was undertaken over 12 weeks and activities reached a wide range of stakeholders including patients, their carers, families, public, staff, stakeholders and hard to reach groups, ensuring our methods and approaches were inclusive and tailored to the people we wanted to reach so that they can have their say.

Our planning of consultation activities was informed by the Equality Impact Assessments undertaken to ensure that all voices in our community had an opportunity to be heard as we recognise the importance of proactive and targeted engagement with seldom heard groups such as younger people, travellers, economically disadvantaged, disabled people, people with mental health issues and minority ethnic groups.

Our consultation process has been guided, advised and assessed by The Consultation Institute through their Quality Assurance role by providing feedback on the consultation plan, consultation document and summary. All feedback received during our consultation has been collated, analysed and reported by an independent organisation to demonstrate transparency and objectivity. The final decision on the consultation will be made in Spring 2022 and the outcome will then be communicated widely with the residents and stakeholders in Lincolnshire.

Better Births has continued to co-produce maternity services in Lincolnshire, alongside women and families, despite some challenges due to the pandemic. Some of our key work that has captured views and helped shaped our programme has included:

- We continued to listen and act on feedback during the pandemic. Through listening the team were able to ensure that access to Midwifery and Health Visiting remained open through the local Children Centres, reducing the need to travel to the hospital, providing care closer to home.
- The significant development of the Lincolnshire Maternity Voices Partnership, which now includes Neonatal Parent Voices and Lincolnshire Military Maternity Voices, in addition to Lincolnshire Maternity Voices.
- Use of social media including live question and answer sessions via Facebook, with up to 10,000 views.
- Improved engagement with military families which has told us that our services are hard to navigate. In response to this, we are currently recruiting to a Military Care Navigator role, which is a dedicated role to support and signpost Military families throughout their pregnancy journey.
- Continued work with our travelling community to ensure that our maternity documentation and information meets their needs
- Promoting the "Dad Pad" app to dads and families in Lincolnshire. The app is the essential guide for new dads, developed with the NHS, to give dads the knowledge and practical skills to help give their baby the best possible start in life.
- We are working towards the ambition of the long-term plan and are in the process of recruiting dedicated maternity staff to support women who want to stop smoking during pregnancy.
- Development of the Local Maternity Neonatal System meeting membership to include service users across the county ensuring that co-production is continued throughout our governance and is present in everything we do.
- The work of Lincolnshire Maternity Voices remains strong. The Committee consists of service users, service user representatives, midwives, doctors and commissioners. We work together to review and contribute to the development of local maternity services and we are an independent body, reporting to Lincolnshire Maternity and Neonatal System.

Lincolnshire Young Voices (LYV) is a jointly supported (local Authority and CCG) widening participation group for children and young people with special educational needs and disabilities (SEND).

The aim of Lincolnshire Young Voices is to enable, listen and act upon the young persons voice around the provision of services in the county. LYV are group of young people who 'have a lot to say' about improving services for children and young people (aged 0-25yrs) with special educational needs and disability and their families in Lincolnshire, and are Experts by Experience.

COVID-19 impacted on the ability to deliver on several work streams detailed in the LYV Service Delivery Plan. However, the group undertook a few audits of professional agencies such as Children's Centres around communication, approachability and sensory environment. The group are now working in collaboration with several key stakeholders to develop online training resources for use across the system by professionals involved with CYP with SEND and this is called 'A Rough Guide to Not Putting Your Foot in it!'

The training programme is being developed collaboratively as a web-based training resource for staff working with CYP with SEND in collaboration with Lincolnshire Young Voices (LYV) using the voice of the SEND community and national best practice to inform and guide the development of a learning resource to improve professional practice and support CYP with SEND to live their best lives. It has been designed for use as part of an induction/ mandatory training programmes and on-going development to support the improvement of staff knowledge and skills. It is intended to improve the lived experience of CYP with SEND, address health inequalities and improve access to services by using the lived experience of service users and experts by experience. Their work has been recognised nationally and the co-chairs will be chairing the SEND National Conference later in 2022.

The Designated Clinical Officer (DCO) for children and young people with special educational needs and disabilities has attended various virtual engagements events and developed strong relationships with the Lincolnshire Parent Carer Forum (LPCF) which is funded by the DfE.

Coralie Cross, Chair of LPCF says:

'LPCF work very closely with the Designated Clinical Officer for CYP with SEND in the CCG. This has been demonstrated through the co-production of the Sensory Processing Difficulties project. The mutually supportive relationship, focussed on improving experiences for families, has enabled the LPCF team to play a "critical friend" role during the formulation of the project and also to take an active role in ensuring that the workshops were as accessible to parents as possible. Our open, positive relationship with the DCO is further enhanced by his regular attendance at signposting events for parents during 2020-21 and also during our recently successful Week of SEND. LPCF appreciate the support and close working relationship we have with the Designated Clinical Officer.

Social Media and engaging with the local population

LET'S GET SOCIAL

The CCG strongly supports the use of social media as a positive communication channel to provide members of the public, GP practices and other stakeholders with information about what we do and the services we commission. We use social media to provide opportunities for genuine, open, honest and transparent engagement with stakeholders; giving them a chance to participate and influence decision making. Social media is a great opportunity for us to listen and have conversations with a wide and diverse range of people, especially with hard to reach groups. It not only allows us to make announcements, e.g. health news, service information, upcoming events, it allows people to respond to whatever we post and encourage conversation and feedback to improve the ongoing development of our services.

Unlike other methods of promotion, social media encourages two-way communications in real time. Our strategy is focused on increasing proactive staff input and public engagement, supporting both national campaigns and CCG priorities to inform, engage, educate and inspire. Throughout the COVID-19 pandemic our online channels of communication have become more important than ever, to provide fast updates on a rapidly changing environment to inform and engage with our local population.

We are now working as a system across our local NHS to review our social media strategy, the channels we use and how we can work better together in Lincolnshire to inform, engage and grow our audiences as we move into an Integrated Care System. Our most engaging posts are by far those that are people-centred, stories. As part of our ongoing social media strategy, we will work on more people-centred content and grow our audience with the help of key stakeholders and influencers.

FACEBOOK / NHSLincsCCG

We use Facebook to share news, health campaigns, signpost to local services and have two-way discussions with the public to gain feedback from patients on our services, their wider care or their own individual health. Many of our GP practices are also using Facebook as a way of communicating with their patients and keeping them up to date on practice news, events and healthcare advice. As of 31 March 2022 we had 2,595 followers to our page, which opened in 2020. Between 1 April 2021 and 31 March 2022, we shared 2,031 posts, with a total reach of 2.2 Million and received over 28,395 post engagements (including 4,795 likes, 9,843 shares and 3,676 post comments).

TWITTER @ NHSLincsCCG

Our community of followers help us to share news, health advice and to signpost to local services. Twitter is a very effective way for healthcare organisations and workers to interact, communicate and educate. As a CCG we encourage conversations and feedback with our partners, patients and other stakeholders to improve the ongoing development of our services. Between 1 April 2021 and 31 March 2022, we shared 2,320 tweets, our tweets were seen 938,406 times and received 8,253 engagements (including 3,777 retweets, 3,471 likes, 539 replies/responses and 1,970 mentions.

CCG website www.lincolnshireccg.nhs.uk

Alongside Twitter and Facebook, one of the key communication tools, which is often a first port of call for the public is the CCG website. We want to ensure that people can easily access information about the CCG and the services available to them. Between 1 April 2021 and 31 March 2022 we had 181,128 users/visitors (82.9% new and 17.1% returning visitors) and 427,091 page views. Our visitors came to us from a variety of routes, 71.71% from organic search, 14.78% direct, 7.14% from our social channels, 6.19% referrals from other sites and 0.18% from email. our top page was about the vaccination programme in Lincolnshire with 123,865 page views.

Equality and Diversity

During 2021 the CCG continued to make good progress in Equality, Inclusion and Human Rights (EIHR), despite the added pressures of the ongoing pandemic. Keeping a balance between responding to the needs of our workforce and diverse communities, in relation to the pandemic, and sustaining ongoing compliance in line with EIHR legislation and standards, continued to be a challenge but one that was successfully met. EIHR work achieved during 2021 as part of the Implementation of the equality objectives and Action Plan 2021-23 included:

Lincolnshire CCG Equality Strategy 2021-23: This strategy, approved in July 2021, ensures that EIHR is central to Lincolnshire CCG's work. The strategy sets out the CCG's intentions around EIHR for 2021-23 to ensure the best possible outcomes for the workforce, the local communities and especially those seldom heard groups who experience health inequalities.

Equality Impact Assessment (EIA): Over the last year staff have continued to undertake EIAs to give due regard to equalities when assessing the impact of an activity, policy, or project. EIAs enable staff to ensure that the services provided to the workforce, providers, and the diverse communities are free from discrimination and are accessible to all. EIA training was also organised to support those staff working in COVID-19 cells, to ensure that they were fully equipped in giving due regard to equalities in COVID -19 related decision making with two sessions organised and delivered in 2021. Further EIA training will be delivered during 2022 – 23 to ensure ongoing support is provided. Furthermore, discussions with providers have been underway to develop a systemwide EIA tool, for all partners to adopt and implement in 2022.

Workforce Race Equality Standard (WRES): A WRES data set was submitted to NHSE/I WRES team before the end of August 2021 deadline. The WRES, report (redacted for publication) was completed, approved, and published on the CCG website in October 2021. Work on the WRES action plan 2020 was reviewed and updated for 2021/22 – the plan is linked to the CCG's equality objective focusing on 'enhancing workforce data and providing staff support'. There is still more work to be done to improve the collation of workforce data to identify underrepresentation amongst different protected characteristics and develop initiatives to overcome gaps in HR practices. One of the ways this is being tackled is through systemwide working – CCG is part of the Systemwide Belonging Committee and the Ethnic Minority and Allies Network. Both groups support systemwide partners to work towards creating fairer and more inclusive HR practices and professional development opportunities for their staff and potential employees from diverse communities. towards creating fairer and more inclusive HR practices and professional development opportunities for their staff and potential employees from diverse communities. This links up to the work that is being undertaken to create a systemwide Belonging strategy.

Training Needs Analysis: The CCG equality forum developed a training needs assessment form, which was circulated to CCG staff in September/ October 21 and aimed to:

- Identify what level of training the CCG offers to the workforce in relation to Equality, Inclusion and Human Rights
- Find out how many staff have undertaken EIHR training and in which aspects
- Assess staff knowledge and awareness of EIHR issues.

This work has been undertaken in line with equality action plan objective 3, Action 3.4 'Assess current Equality training provision and staff professional development and introduce packages to enhance their knowledge and awareness'. The survey results were analysed in December and outcomes, with staff recommendations for further training were shared with senior managers, together with an extended EIHR training proposal for 2022-23. Work will be undertaken to deliver the additional training during April 2022-March 2023 for CCG/ICB staff.

COVID-19 disparities work: The CCG EIHR strategy and action plan states a specific objective and actions to address ethnic minority disparities disparities in relation to COVID-19 and to 'Implement actions within NHS Lincolnshire CCG to assess the disproportionate impact of COVID-19 on ethnic minority staff and communities in line with the associated health inequalities issues raised in the PHE disparities report.' Excellent work was done by the CCG staff and local providers including PCN's, local authorities, district councils, neighbourhood leads, and involvement champions to help ease/eradicate negative impacts on different communities to address barriers and tackle disparities: -

- CCG and other system leaders endorsed the formation of a systemwide system-wide Ethnic Minorities Staff and Allies Forum. This was set up as a renewed and explicit focus within the system to eliminate the inequalities many ethnic minority staff continue to face in the workplace and the adverse impact this has on their sense of being valued, of belonging, wellbeing and career progression, compared to their white counterparts. These inequalities have been amplified in the wake of the COVID-19 pandemic and the Ethnic Minorities Group network works to reset, restore, and repurpose the race equality agenda in the system.
- Collated local information and data to assess disparities that were apparent in Lincolnshire populations
- Collected equality information relating to staff so that EIA/risk assessments could be undertaken to support to support ethnic minority/at risk staff in the frontline
- Targeted comms and engagement exercises as wide as possible to ensure the messages are getting out to different communities in different languages and formats
- Worked with our providers to ensure they were communicating all information in accessible formats in line with the Accessible Information Standard.
- Produced Equality Guidance on COVID-19 as a support tool to help CCG to respond to diverse needs and requirements of different staff and communities
- Promoted the importance of vaccination uptake by targeting difficult to reach groups, especially those who had vaccine hesitancy, via the inclusion and health inequalities vaccination team.

Lincolnshire CCG Equality Forum: Continues to act as a mechanism for staff to discuss ongoing EIHR work priorities, implement key actions, monitor and review action plan objectives and publish outcomes in line with the Equality Act 2010, Public Sector Equality – PSED (2011) duty. Over the last year the Forum has had a more strategic focus where governance links to other CCG committees have been established to enable feedback and endorsement of key EIHR priorities and initiatives. Further to this, membership of the Forum was extended in mid-2021 to local health providers to enable a system-wide approach for sharing information, raising concerns around current issues, and planning collaborative EIHR initiatives.

Equality, Inclusion and Human Rights information is available on the CCG equality webpage: https://lincolnshireccg.nhs.uk/about-us/our-commitment-to-equality-inclusion-and-human-rights/

Compliments, Concerns and Complaints

Valuing Patient Experience

NHS Lincolnshire CCG (CCG) values the opportunity to hear what people think about the services we commission, and we use feedback to support decisions about services. We analyse complaints and monitor the themes and trends to promote learning. This information is reviewed in conjunction with other quality metrics to drive quality improvement and is used to further support the schedule of quality assurance visits, which improves patient experience and patient outcomes.

Breakdown of Formal Complaints 2021/22	
Quarter 1	28
Quarter 2	40
Quarter 3	32
Quarter 4	16
Totals	116

During 2021/22 we received 269 informal concerns and 116 formal complaints, both directly from patients or their family, the public, and from Members of Parliament on behalf of their constituents.

The CCG's views compliments, concerns, and complaints as a valuable source of information and we use this as part of our ongoing monitoring for services we commission.

We ensure that we acknowledge all feedback received, making sure that any concern or complaint response is dealt with compassionately, effectively and in a timely manner.

To prevent informal concerns escalating to formal complaints, we endeavour to resolve concerns by either providing the information needed or signposting the complainant to the appropriate department or organisation to enable direct contact and response.

Our responses to concerns and complaints are administered in line with the Local Authority Social Services and National Health Service (England) Regulations 2009.

By the end of the reporting period 1 April 2021 to 31 March 2022, of these 116 formal complaints, 11 were upheld, 38 were partially upheld, 43 were not upheld, 16 were closed as not pursued, which leaves a total of eight being carried forward.

Principles for Remedy

The CCG continues to use the Principles for Remedy for NHS Complaints, as set out by the Parliamentary and Health Service Ombudsman (https://www.ombudsman.org.uk/about-us/our-principles/principles-remedy).

This identifies good practice with regards to providing remedies for patients wishing to make a complaint and these are supported by the CCG:

1. **Getting it right**
2. **Being customer focused**
3. **Being open and accountable**
4. **Acting fairly and proportionately**
5. **Putting things right**
6. **Seeking continuous improvement**

The CCG has adopted all six principles of remedy in the development of our complaints handling procedure and they form a core part of the CCG's Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments.

The Policy clearly sets out the organisation's process for handling complaints in order for the CCG to meet statutory requirements and how the CCG takes responsibility, acknowledges failures, provides an apology, and uses the learning from any complaint investigation to improve their services.

Freedom of information

The Freedom of Information Act 2000 (FOI) gives people a general right to access information held by or on behalf of public authorities. It is intended to promote a culture of openness and accountability among public sector bodies and to facilitate a better public understanding of how they carry out their duties, why they make the decisions they do and how they spend public money.

Exemptions deal with instances where a public authority may withhold information under the FOI Act or Environmental Information Regulations. Exemptions mainly apply where releasing the information would not be in the public interest, for example, where it would affect law enforcement or harm commercial interests.

Requests are handled in accordance with the terms of the FOI Act and in line with best practice guidelines from the Information Commissioner's Office and the Ministry of Justice. In line with the requirements of the FOI Act, the CCG has a comprehensive Publication Scheme to make information about the CCG readily available to the public without the need for specific written requests.

However, during 2021/22 the CCG processed approximately 184 requests covering the following work streams: Finance, Procurement and Contracting, Medicines Management, Governance, Strategy, Continuing Health Care and Treatments/Clinical Procedures.

John Turner
CCG Accountable Officer

23 June 2022

The Accountability Report

Corporate Governance Report

Members' Report

The Members' Report has been prepared by the Board of the CCG.

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

The CCG Board consists of the CCG Chair, the Accountable Officer, Director of Finance and Contracting, Director of Nursing and Quality, Secondary Care Doctor, seven Non-Executive Directors, four Locality Clinical Leads, senior managerial support and representatives from Public Health, Healthwatch and Health and Wellbeing Board.

Mr Sean Lyons was the CCG Chair up until 31st December 2021. Dr Gerry McSorley, Non-Executive Director was confirmed as the Acting CCG Chair from the 1st January 2022. Mr John Turner has been the Chief Executive (Accountable Officer) for the financial year 2021/22.

The composition of the Board and the Audit and Risk Committee through the year and up to the signing of the Annual Report and Accounts (including advisory and Lay Members) is outlined in this section. Details of members of other committees and sub-committees are set out in the Annual Governance Statement (AGS).

Biographies for each of the Board members are available on the CCG website.

Member practices

The CCG has 84 practices (as at 31st March 2022) which are listed on the website: www.lincolnshireccg.nhs.uk and detailed below:

Practice	Practice Number	Address
ABBEY MEDICAL PRACTICE	C83051	95 Monks Road, Lincoln, LN2 5HR
ABBEYVIEW SURGERY	C83617	Crowland Health Centre, Thorney Rd, Crowland, Peterborough, PE6 0AL
BEACON MEDICAL PRACTICE	C83019	Churchill Avenue, Skegness, PE25 2RN
BEECHFIELD MEDICAL CENTRE	C83003	Beechfield Gardens, Spalding, PE11 1UN
BILLINGHAY MEDICAL PRACTICE	C83030	39 High St, Billinghay, Lincoln, LN4 4AU
BINBROOK SURGERY	C83643	Back Lane, Binbrook, LN8 6ED
BIRCHWOOD MEDICAL PRACTICE	C83082	Jasmin Road, Lincoln, LN6 0QQ
BOULTHAM PARK MEDICAL PRACTICE	C83014	Boutham Park Road, Lincoln, LN6 7SS
BOURNE GALLETLY PRACTICE TEAM	C83054	40 North Rd, Bourne, PE10 9BT
BRANSTON & HEIGHINGTON FAMILY PRACTICE	C83029	Station Road, Branston, Lincoln, LN4 1LH
BRANT ROAD & SPRINGCLIFFE SURGERY	C83078	291 Brant Road, Lincoln, LN5 9AB
BRAYFORD MEDICAL PRACTICE	C83626	Newland Health Centre, 34 Newland, Lincoln, LN1 1XP
CAISTOR HEALTH CENTRE	C83613	Dale View, Caistor, LN7 6NX
CASKGATE STREET SURGERY	C83044	3 Caskgate Street, Gainsborough, DN21 2DJ
CAYTHORPE & ANCASTER MEDICAL PRACTICE	C83020	12 Ermine St, Ancaster, Grantham, NG32 3PP

Practice	Practice Number	Address
CHURCH WALK SURGERY	C83062	Drury Street, Metheringham, Lincoln, LN4 3EZ
CLEVELAND SURGERY	C83018	Vanessa Drive, Gainsborough, DN21 2UQ
CLIFF HOUSE MEDICAL PRACTICE	C83073	82 Burton Road, Lincoln, LN1 3LJ
COLSTERWORTH SURGERY	C83053	Back Ln, Colsterworth, Grantham, NG33 5NJ
EAST LINDSEY MEDICAL GROUP	C83056	153 Newmarket, Louth, LN11 9EH
GLEBE PARK SURGERY	C83079	17 Montaigne Crescent, Lincoln, LN2 4QN
GOSBERTON MEDICAL CENTRE	C83036	Low Gate, Gosberton, Spalding, PE11 4NL
GREYFRIARS SURGERY	C83059	South Square, Boston, PE21 6JU
HAWTHORN MEDICAL PRACTICE	C83045	Hawthorn Road, Skegness, PE25 3TD
HEREWARD MEDICAL CENTRE	C83035	Exeter St, Bourne, PE10 9XR
HIBALDSTOW MEDICAL PRACTICE	C83033	11 Church Street, Hibaldstow, Brigg, DN20 9ED
HOLBEACH MEDICAL CENTRE	C83028	Park Road, Holbeach, PE12 7EE
HORNCASTLE MEDICAL GROUP	C83027	Spilsby Road, Horncastle, LN9 6AL
JAMES STREET FAMILY PRACTICE	C83085	49 James Street, Louth, LN11 0JN
KIRTON MEDICAL CENTRE	C83057	Boston Road, Kirton, PE20 1DS
LAKESIDE HEALTHCARE STAMFORD	C83007	Wharf Rd, Stamford, PE9 2DH
LINDUM MEDICAL PRACTICE	C83009	1 Cabourne Court, Cabourne Avenue, Lincoln, LN2 2JP
LIQUORPOND SURGERY	C83004	10 Liquorpond Street, Boston, PE21 8UE
LITTLEBURY MEDICAL CENTRE	C83065	Fishpond Ln, Holbeach, Spalding, PE12 7DE
LONG BENNINGTON MEDICAL CENTRE	C83067	The Medical Centre, 10 Valley Lane, Long Bennington, NG23 5FR
LONG SUTTON MEDICAL CENTRE	C83063	Trafalgar Square, Long Sutton, Spalding, PE12 9HB
MARISCO MEDICAL PRACTICE	C83064	Stanley Road, Mablethorpe, LN12 1DP
MARKET CROSS SURGERY	C83649	Bourne Rd, Corby Glen, NG33 4BB
MARKET RASEN SURGERY	C83043	Mill Road, Market Rasen, LN8 3BP
MARSH MEDICAL PRACTICE	C83042	Keeling Street, North Somercotes, LN11 7QU
MERTON LODGE SURGERY	C83032	33 West Street, Alford, LN13 9HT
MILLVIEW MEDICAL CENTRE	C83011	1 Sleaford Rd, Heckington, Sleaford, NG34 9QP
MINSTER MEDICAL PRACTICE	C83072	2 Cabourne Court, Cabourne Avenue, Lincoln, LN2 2JP
MOULTON MEDICAL CENTRE	C83039	High St, Moulton, Spalding, PE12 6QB
MUNRO MEDICAL CENTRE	C83022	West Elloe Ave, Spalding, PE11 2BY
NAVENBY CLIFF VILLAGES SURGERY	C83002	Grantham Road, Navenby, LN5 0JJ
NETTLEHAM MEDICAL PRACTICE	C83031	14 Lodge Lane, Nettleham, Lincoln, LN2 2RS
NEWARK ROAD SURGERY	C83071	501a Newark Road, Lincoln, LN6 8RT
NORTH THORESBY SURGERY	C83061	Highfield Road, North Thoresby, DN36 5RT
OLD LEAKE MEDICAL CENTRE	C83049	Church End, Old Leake, Boston, PE22 9LE
PARKSIDE MEDICAL CENTRE	C83010	Tawney Street, Boston, PE21 6PF
RICHMOND MEDICAL CENTRE	C83025	Moor Lane, North Hykeham, LN6 9AY
RUSKINGTON SURGERY	C83013	6 Brookside Cl, Ruskington, Sleaford, NG34 9GQ

Practice	Practice Number	Address
SLEAFORD MEDICAL GROUP	C83023	47 Boston Rd, Sleaford, NG34 7HD
SPILSBY SURGERY	C83005	Bull Yard, Simpson Street, Spilsby, PE23 5LG
ST. JOHNS MEDICAL CENTRE	C83048	62 London Rd, Grantham, NG31 6HR
ST. PETERS HILL SURGERY	C83040	15 St Peter's Hill, Grantham, NG31 6QA
STACKYARD AND WOOLSTHORPE SURGERY	C83653	1 The Stackyard, Croxton Kerrial, Grantham, NG32 1QS
STICKNEY SURGERY	C83055	Main Road, Stickney, PE22 8AA
SUTTERTON SURGERY	C83614	Spalding Rd, Sutterton, Boston, PE20 2ET
SWINESHEAD SURGERY	C83015	Fairfax House, Packhorse Lane, Swineshead, PE20 3JE
SWINGBRIDGE SURGERY	C83008	Swingbridge Rd, Grantham, NG31 7XT
TASBURGH LODGE SURGERY	C83634	30 Victoria Avenue, Woodhall Spa, LN10 6SQ
THE BASSINGHAM SURGERY	C83611	20 Torgate Lane, Bassingham, Lincoln, LN5 9HF
THE DEEPINGS PRACTICE	C83026	Godsey Ln, Market Deeping, Peterborough, PE6 8DD
THE GLEBE PRACTICE	C83038	85 Sykes Lane, Saxilby, Lincoln, LN1 2NU
THE GLENSIDE COUNTRY PRACTICE	C83024	St Johns Close, Grantham, NG33 4LY
THE HARROWBY LANE SURGERY	C83080	Harrowby Ln, Grantham, NG31 9NS
THE HEATH SURGERY	C83046	London Road, Bracebridge Heath, Lincoln, LN4 2LA
THE INGHAM SURGERY	C83052	Lincoln Road, Ingham, Lincoln, LN1 2XF
THE JOHNSON GP CENTRE, SPALDING	C83631	Spalding Rd, Pinchbeck, Spalding, PE11 3DT
THE NEW CONINGSBY SURGERY	C83083	20 Silver Street, Coningsby, LN4 4SG
THE NEW SPRINGWELLS PRACTICE	Y01652	Spring Wells, Billingborough, Sleaford, NG34 0QQ
THE SIDINGS MEDICAL PRACTICE	C83060	Sleaford Road, Boston, PE21 8EG
THE WELBY PRACTICE	C82076	3 Swinehill, Harlaxton, Grantham, NG32 1HT
THE WOODLAND MEDICAL PRACTICE	C83041	Jasmin Road, Birchwood, Lincoln, LN6 0QQ
THE WRAGBY SURGERY	C83650	Old Grammar School Way, Wragby, Market Rasen LN8 5DA
TRENT VALLEY SURGERY	C83641	85 Sykes Lane, Saxilby, Lincoln, LN1 2NU
UNIVERSITY HEALTH CENTRE	C83656	ULHS Ltd, 3 Campus Way, Lincoln, LN6 7GA
VINE STREET SURGERY	C83075	Vine St, Grantham, NG31 6RQ
WASHINGBOROUGH SURGERY	C83058	School Lane, Washingborough, LN4 1BN
WELTON FAMILY HEALTH CENTRE	C83037	4 Cliff Road, Welton, Lincoln, LN2 3JH
WILLINGHAM-BY-STOW SURGERY	C83074	High Street, Willingham by Stow, Gainsborough, DN21 5JZ
WOODHALL SPA NEW SURGERY	C83635	The Broadway, Woodhall Spa, LN10 6ST

Board Members

Name	Role
Mr Sean Lyons	CCG Chair (up to 31st December 2021)
Dr Majid Akram	GP and Clinical Lead, South Locality
Dr Dave Baker	GP and Clinical Lead, South West Locality
Dr David Boldy	Secondary Care Doctor
Mrs Fenella Chambers	Non-Executive Director and Chair of the Remuneration Committee
Mr Jim Connolly	Non-Executive Director, Patient and Public Involvement and Chair of the Quality and Patient Experience Committee (up to 31st October 2021)
Mr Martin Fahy	Director of Nursing and Quality
Mr Graham Felston	Non-Executive Director (from 1st July 2021)
Mr Matt Gaunt	Director of Finance and Contracting
Dr James Howarth	GP and Clinical Lead, East Locality
Mrs Janet Inman	Non-Executive Director
Ms Sue Liburd	Non-Executive Director
Mr Murray Macdonald	Non-Executive Director, Chair of the Finance and Performance Committee (up to 30th June 2021)
Dr Gerry McSorley	Non-Executive Director, Chair of the Primary Care Commissioning Committee, CCG Vice Chair (up to 31st December 2021) and Acting CCG Chair from 1st January 2022
Mr Pete Moore	Non-Executive Director, Chair of the Audit and Risk Committee and Conflicts of Interest Guardian
Dr John Parkin	GP and Clinical Lead, West Locality
Mr John Turner	Accountable Officer

Regular Board Attendees

Name	Role
Mr Pete Burnett	System Strategy and Planning Director
Mrs Sarah Fletcher	Chief Executive, Healthwatch
Mrs Sarah-Jane Mills	Chief Operating Officer, West Locality
Mrs Clair Raybould	Director of Operations and South West Locality Lead
Mr Andy Rix	Chief Operating Officer, South Locality
Mrs Sandra Williamson	Chief Operating Officer, East Locality
Professor Derek Ward	Director of Public Health
Councillor Sue Woolley	Chair of the Health and Wellbeing Board

Committees

To discharge its duties effectively, the Board has a number of formally constituted committees with delegated responsibilities as set out in the CCG Constitution and Scheme of Reservation and Delegation:

- Audit and Risk Committee
- Remuneration Committee
- Primary Care Commissioning Committee
- Finance and Performance Committee
- Quality and Patient Experience Committee
- Members' Forum
- Four Locality Committees

The Audit and Risk Committee

The membership of the Audit and Risk Committee during 2021/22 comprised:

Name	Role
Mr Pete Moore	Non-Executive Director - Governance and Chair of the Audit Committee
Ms Sue Liburd	Non-Executive Director
Mrs Fenella Chambers	Non-Executive Director

The following people are also in attendance:

Mr Matt Gaunt, Director of Finance and Contracting

Mrs Julie Ellis-Fenwick, CCG Corporate Secretary/ Manager
Internal Audit representatives, PwC

External Audit representatives, Ernst and Young

Local Counter Fraud Specialist, PwC

Other Board Committees

For details on our Remuneration Committee please refer to the Remuneration Report section. All other Committees of the Board and Locality Committees are referred to in the Annual Governance Statement.

Register of Interests

The CCG is responsible for the stewardship of significant public resources when making decisions about the commissioning of health and social care services and must demonstrate probity and transparency in the decision making process. This includes the management of conflicts of interest as part of its day-to-day activities.

In line with NHS England statutory guidance for CCGs on managing conflicts of interest (as published in 2017) the CCG has established a Standards of Business Conduct and Conflicts of Interest Policy. This policy sets out clear procedures to deal with situations where an officer/ member has a conflict of interest.

Declared interests or interests of conflict are recorded in the CCG Registers of Interests and are available on the CCG website: www.lincolnshireccg.nhs.uk

One of the requirements of the statutory guidance is for the CCG to identify a Conflicts of Interest Guardian. The Non-Executive for Governance has taken up this role.

Personal data related incidents

There have been no serious incidents in 2021/22 relating to loss of personal data. Further details of the CCG's Information Governance arrangements can be found within the Annual Governance Statement.

Statement of disclosure to Auditors

So far as the Board Members are aware there is no relevant audit information of which the CCGs auditors are unaware, and that each Member has taken all the steps that they ought to have taken as a Member in order to make themselves aware of any relevant audit information and to establish that the CCG auditor is aware of that information.

Modern Slavery Act

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

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Mr John Turner to be the Accountable Officer of NHS 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 CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the CCG'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 CCG to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the CCG and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual issued by the Department of Health 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.

To the best of my knowledge and belief, and subject to the disclosures set out below in respect of the Section 30 letter issued by the CCG's auditors, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Disclosures:

For the 2021/22 financial year the CCG incurred an actual financial deficit of £2,421k against the amount allotted to it for 2021/22 by NHS England.

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.

John Turner
Accountable Officer

23 June 2022

Annual Governance Statement 2021/22

Introduction and context

Lincolnshire Clinical Commissioning Group is a body corporate established by NHS England on 1 April 2020 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, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 31st March 2022 the CCG was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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.

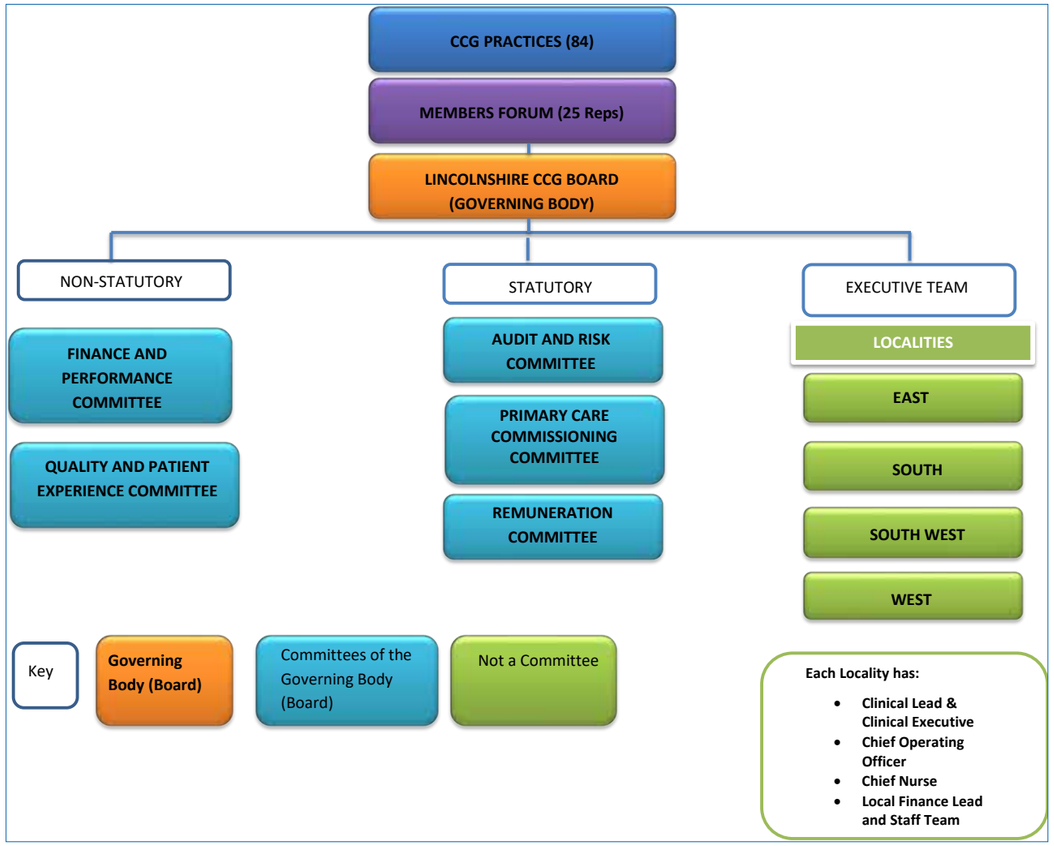
Governance arrangements and Effectiveness

The main function of the Governing Body (referred to as 'the Board') is to ensure that the CCG 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 governance framework of the Clinical Commissioning Group is detailed in the CCG's Constitution and Corporate Governance Handbook. The Constitution and Corporate Governance Handbook set out the details of practices with membership of the CCG, together with arrangements around joining or leaving the CCG and how disputes between member practices should be handled.

The Constitution also reflects the mission, values, function and duties of the CCG and refers to the key governance documents that the CCG has produced – Standing Orders, Delegated Financial Authority Limits, Scheme of Reservation and Delegation, Corporate Governance Handbook and Financial Procedural Limits.

The key Committees of the CCG and their responsibilities, as operated by the CCG at 31 March 2022, are summarised in the diagram below.



The CCG's Committee structure supports the CCG's governance processes and ensures that there is effective monitoring and accountability arrangements for the systems of internal control. The Terms of Reference for these Committees have been reviewed during the year to ensure robust governance and assurance.

In light of the COVID-19 pandemic all meetings of the Members' Forum, Board, and Committee meetings held in 2021/22 have taken place on a virtual basis through Microsoft Teams.

Members' Forum – Elected Chair, Dr Elton Pardoe

The Membership of the CCG meets as a Members' Forum, at which GP and member practices hold the Board of the CCG to account. The Members' Forum consists of 25 members who represent the views of the CCG's 84 practices and include individuals from each of the four Localities – East, West, South and South West.

The Committee met two times in 2021/22 and has had 82% attendance from member practices.

The Members' Forum provides a forum for practice representatives to:

- Set strategic priorities and direction
- Approve strategic and operational plans
- Approve CCG constitutional arrangements
- Ensure CCG clinical governance
- Make decisions and exercise powers reserved to the members, as listed in the Scheme of Reservation and Delegation
- Challenge and hold to account the Board for the discharge of the functions and responsibilities delegated to it.

In 2021/22 the Members' Forum has considered the following:

- Current service pressures and performance
- Clinical Interface – primary and secondary care
- Response to the COVID-19 Pandemic and Vaccine Programme
- Update on System Priorities 2020/21
- CCG Integrated Performance Report
- Changes required to the CCG Constitution
- Members' Forum Annual Report 2020/21
- Update on the White Paper, ICS Development and Guidance
- Launch of the public consultation relating to four of Lincolnshire's NHS services
- Finance Report
- Podiatry Service

Board – Chair, Mr Sean Lyons (up to the 31st December 2021) – Dr Gerry McSorley, Acting CCG Chair from 1st January 2022

The CCG Board usually holds meetings on a monthly basis, with a minimum of eight meetings held per year (as per the CCG Constitution). During 2021/22 the Board has met 11 times and the public meetings have been held as 'Live Events' through Microsoft Teams. The Board has had an overall average attendance of 81% from Board Members. All meetings in 2021/22 were quorate.

The Board is Chaired by a non-clinician Chair who was appointed following a recruitment process which took place in early 2020. Following Mr Lyons departure at the end of December 2021 the CCG Deputy Chair agreed to take on the role of Acting CCG Chair from 1st January 2022 through to the 31st March 2022 (as per arrangement defined in the CCG Constitution). This was subsequently extended due to the delayed timeframe for establishment of the Integrated Care Board which will not take place until the 1st July 2022.

The Board exists to:

- Ensure good governance.
- Monitor quality, safety, risk and progress.
- Ensure safeguarding compliance.
- Manage conflict of interest issues according to guidance and
- Monitor statutory duties.

The Board usually receives monthly updates on quality, finance, risk and performance.

The Board has performed effectively throughout 2021/22 in ensuring good governance around the CCG's decision making processes and in setting up a robust Committee structure to manage areas of risk and priority for the CCG. The Board reviews its effectiveness after each meeting as part of an on-going process.

The membership of the Board is detailed under the Corporate Governance Report on page 53.

Board Performance and Development

Oaks Consultancy were appointed in May 2020 to help the CCG Board develop a meaningful identity and purpose within the Lincolnshire NHS system. This work was completed in April 2021.

As a result of this work the Board agreed a new strapline **'Improving Lincolnshire's Health and** Wellbeing' and a Purpose Statement **'Delivering high quality, people-centred healthcare that tackles health inequalities across Lincolnshire communities through a collaborative, insight-led approach'.**

The Purpose Statement is underpinned by six theme objectives with executive leadership identified for each one with supporting actions. These actions have been progressed in 2021/22 and regular updates provided through the CCG Executive Team meetings, Board Development Sessions and regularly weekly Non-Executive Director briefings.

The Board agreed in April 2021 that two specific Board Development Sessions would be undertaken on the following subjects:

- Influencing, from a CCG perspective, how the Lincolnshire ICS develops and
- Identifying the key areas of focus for the CCG in the second half of 2021/22 to ensure that the CCG both meets its responsibilities as a statutory body up to 31st March 2022 whilst also supports and manages the successful transition of CCG responsibilities and staff into the statutory ICS body.

The Board Development Session on the Lincolnshire Integrated Care System (philosophy and development approach) was undertaken in June 2021.

The Board held further Development Sessions in 2021/22 and considered the following topics:

- Health Inequalities in the Vaccination Programme
- System Financial Position
- Elective Recovery
- Acute Services Review – Pre-Consultation Business Case
- Update on the White Paper and Integrated Care System (ICS), including the Health and Social Care Bill
- Public consultation relating to four of Lincolnshire's NHS Services
- Information Technology, Information Governance and Cyber Security
- Update on Oaks Development Work
- Board and Committee meetings – frequency going forward and the move to an ICS

During 2021/22 two of the CCG Non-Executive Directors – namely Mr Murray Macdonald and Mr Jim Connolly left in June and October 2021 respectively to take up roles with one of the provider organisations in Lincolnshire. Mr Graham Felston replaced Mr Macdonald and commenced with the CCG on the 1st July 2021. Mr Jim Connolly was not replaced.

As a result the Non-Executive Director roles on each of the CCG Committees, support to the four Localities and the CCG's main provider Trusts were re-visited and amended as per the table below.

NED Roles						
Committee/Localities/Trusts	**GF**	**GM**	**SL**	**JI**	**FC**	**PM**
Board Meetings	x	x	x	x	x	x
Board Development Sessions	x	x	x	x	x	x
NED Meetings	x	x	x	x	x	x
Audit & Risk			x		x	x(Chair)
Finance & Performance	x(Chair)			x		
Quality & Public & Patient Experience		x		x	x (Chair)	
Primary Care Commissioning	x	x(Chair)	x			x
Remuneration	x	x	x	x	x(Chair)	x
ULHT					x	
LPFT				x		
LCHS						x
Localities		South	West		East	South West
CCG/LMC Meeting		x				
Ethnic Minorities			x			
Audit Chairs/Directors of Finance and Board Secretaries Meeting						x
System Finance NEDs and Directors of Finance	x					
No of Roles	**4**	**5**	**5**	**4**	**5**	**6**

Board Committees

In order to discharge its duties effectively, the Board has a number of formally constituted Committees as set out in the CCG Constitution and Corporate Governance Handbook, which includes the Scheme of Reservation and Delegation.

The CCG's Board has three statutory committees. They ensure the CCG is compliant with statutory responsibilities and functions.

- Audit and Risk Committee
- Remuneration Committee
- Primary Care Commissioning Committee

The CCG has established two non-statutory Committees:

- Quality and Patient Experience Committee
- Finance and Performance Committee

Audit and Risk Committee – Chair, Mr Pete Moore

The Audit and Risk Committee meets at least four times a year and is chaired by the Non-Executive Director with lead responsibility for governance. The Committee has met six times in 2021/22 and has had an overall average attendance of 93% from Non-Executive Directors. All meetings were quorate.

The Audit and Risk Committee's role is to:

- Give assurance on governance, risk management and internal controls.
- Ensure adherence to prime financial policies.
- Ensure financial governance and ensure stewardship of the financial allocation and compliance with financial regulations.

The Audit and Risk Committee has been attended by, and updates have been received from, the CCG's Internal and External auditors as well as its Counter Fraud Service at each meeting. It also considers the Board Assurance Framework and CCG Strategic Risks.

During 2021/22 the Audit and Risk Committee has reviewed its Terms of Reference, completed a self-assessment and produced its own Committee Annual Report which was presented to the Board.

Remuneration Committee – Chair, Mrs Fenella Chambers

The Remuneration Committee meets as required throughout the year and is chaired by one of the CCG Non-Executive Directors. The Remuneration Committee met on three occasions during 2021/22 and had 93% attendance from Non-Executive Directors. The Committee's role is to determine remuneration and conditions of service for the senior team.

During 2021/22 the Remuneration Committee has reviewed its Terms of Reference and also completed a Self-Assessment.

Further information on the membership and attendance by the Non-Executive Directors of the Remuneration Committee is detailed on page 72.

Primary Care Commissioning Committee – Chair, Dr Gerry McSorley

The Primary Care Commissioning Committee (PCCC) is Chaired by one of the CCG Non-Executive Directors (who is not the Chair of the Audit and Risk Committee). The Committee met seven times in public in the year and has had 100% attendance from Non-Executive Directors. All meetings were quorate.

The Committee was established to provide assurance to the CCG over the management of primary care contracts, and provide a decision making body, managing conflict of interest issues.

During the year the Committee has considered:

Public meetings

- Quality
- Operating Plan
- Primary care access
- GP expansion fund
- LMC Update
- Healthwatch update
- COVID-19
- Finance
- Risks
- Due Diligence process for PCN's
- Configuration and merger of PCN's
- Data review
- Dentistry update
- H2 planning
- Practice specific: list closures and boundary changes
- Committee Self-Assessment Return

Private meetings

- Individual Practice specific issues: Lakeside, Beacon, Glebe Practice, Church Walk, Cliff House, Branston, Deepings, University
- Sidings Procurement
- Pharmacy rebate schemes
- Incorporation Framework
- Sleaford Cavell Update
- Winter Access Fund

The Committee has also held a number of Private Meetings and Development Sessions throughout the year which considered the following:

- Resilience in primary care
- Estates
- Review of previous outputs and discussions
- PCN Maturity
- Tricordant session
- PCNA/PCN Development

During 2021/22 the Primary Care Commissioning Committee has reviewed its Terms of Reference and also completed a Self-Assessment.

Quality and Patient Experience Committee – Chair, Mr Jim Connolly (up until 30th October 2021). Chair, Dr Gerry McSorley (from 1st November 2021 to 31st December 2021), Chair, Mrs Fenella Chambers (from 1st January 2022 to 31st March 2022)

The Quality and Patient Experience Committee (QPEC) was chaired by the Non-Executive with responsibility for Patient and Public Involvement up until 30th October 2021. From the 1st November 2021 one of the other CCG Non-Executive Directors took on the role. The Committee has met six times in 2021/22 and has had 75% attendance from Non-Executive Directors. All meetings were quorate.

The Quality and Patient Experience Committee conducts its role in a number of ways including scrutinising the clinical effectiveness of commissioned health care providers both in and out of the county. This work involves crosschecking multiple sources of information that the CCG receives, such as complaints data, patient experience feedback, performance data, incidents, infection rates and staffing levels.

The Committee can make recommendations and oversee corrective actions and provides assurance to the CCG Board that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the CCG does.

During the year the Committee has considered:

- Integrated Performance report
- Personal health budgets
- Risks
- Healthwatch
- COVID-19
- Research
- Equality & Diversity
- IFR update
- Complaints
- Transforming Care
- Safeguarding
- ASR – QIA and EIA
- PwC Internal Audit reports – Complaints and Health Protection
- Deaths in 30 days of Discharge
- LeDeR
- SHMI Update
- TASL Update
- LD and SMI Health Checks
- Medical Examiner
- Cancer update
- NUH Maternity Services review
- Policy ratification
- POD update
- Committee Self-Assessment Return

During 2021/22 the Quality and Experience Committee has reviewed its Terms of Reference and also completed a Self-Assessment.

Looking forward the CCG will be further improving the methodology for assuring quality as part of the Lincolnshire Integrated Care System (ICS).

Finance and Performance Committee – Chair, Mr Murray Macdonald (up until 30th June 2021) Mr Graham Felston from 1st July 2021)

The Finance and Performance Committee is Chaired by one of the CCG Non-Executive Directors. The Committee met seven times during the year and has had 67% attendance from Non-Executive Directors. All meetings were quorate.

The Committee was established to provide assurance to the Board that the financial strategy, financial policies and Cost Improvement Plans effectively support the organisational strategy.

During the year the Committee has considered:

- Financial Management Report – Month 12
- M1 Budget and Opening Allocations for April 2021 to September 2021
- System Financial Planning Process 2021/22
- Feedback from System Planning Meeting 30.03.21
- 2021/22 Summary CCG Financial Plan and Budgets (months 1 – 6)
- Mental Health Financial Plan Submission 21/22
- National Planning Update
- System Planning Trajectory
- Financial Governance Framework
- Financial Management Report (Month 3)
- Committee Self-Assessment
- H2 (Half-Two) Planning
- Mental Health Financial Position, Investment and Waste Reduction
- Month 5 Management Reports (CCG Finance Report and System Finance Report)
- SBS ISFE Metrics
- Annual Review of Terms of Reference
- 22/23 Draft Financial Planning Approach
- System Risk and Gain Share Approach
- Financial Management Report – Month 8 – CCG Report
- System Risk
- Financial Management Report (month 10) – CCG and System Report
- System Risk – LD High-Cost Packages Trajectory
- Consideration of Draft Financial Plan
- Financial Management Report (month 11) – CCG and System Report

During 2021/22 the Finance and Performance Committee has reviewed its own role, Programme of Work, Terms of Reference and also completed a Self-Assessment.

All of the Committees produce a report for the Board following their meetings which details items of particular note, areas of risk and points of escalation for consideration.

Four Clinical Locality Committees

The CCG also has four Clinical Locality Committees whose key purpose is to provide the CCG Executive and the Board, with advice in order that it is informed by the CCG members within the locality. This recognises the importance of local knowledge and its application in allowing the CCG to discharge its functions successfully. The Locality Committees also provide a conduit for the Board to communicate effectively with practice representatives and the membership of the CCG.

The Committee is jointly accountable to the Member practices within the locality and the CCG Executive.

The Locality Committees set their own Terms of Reference which include membership and frequency of meetings.

Four of the Board Non-Executive Directors have been assigned to each of the four Localities and on occasion attend their meetings.

Items of particular note, escalation or risk from the Localities are escalated through to the CCG Executive Team.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

For the financial year ended 31 March 2022 and up to the date of signing this statement, the CCG has applied the principles of the UK Code of Corporate Governance as considered relevant to the CCG including drawing on other best practice available.

The Annual Governance Statement is intended to demonstrate how the CCG has regard to the principles set out in the Code considered appropriate for CCGs for the financial year ended the 31st March 2022.

Discharge of Statutory Functions

In light of recommendations of the 1983 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 Officer. Officers have confirmed that their structures provide the necessary capability and capacity to undertake all of the Clinical Commissioning Group's statutory duties.

Risk assessment, management arrangements and effectiveness

The Board Assurance Framework (BAF) provides assurance that the CCG's strategic objectives are being effectively delivered and identified risks are being managed in line with agreed risk appetite.

As referred to previously under the section on Board Development and Performance in February 2021 the CCG agreed six 'themed' objectives through to March 2022. These objectives are mapped to four principal risk themes as illustrated below:

Category	Objective	Executive Lead	Mapping to risk theme
Quality	Commission high-quality, safe and effective services to drive continuous improvement in patient outcomes.	M Fahy	2, 3, 4
People Centred	Promote service improvement by working with the population to design services which help people to achieve their goals and lead healthy, independent lives.	C Raybould	1, 4
Health Inequalities	Tackle health inequalities and wider causes of ill health through an embedded, integrated system approach tailored to meeting varying needs within Lincolnshire.	S Williamson	1, 2, 3, 4
Communities	Proactively commission a model of high-quality, integrated care at a local level that delivers improvement in health outcomes.	SJ Mills	1, 2, 3, 4
Collaboration	Foster establish and enhance collaborative ways of working throughout a partnership network that delivers measurable improvement in health outcomes.	A Rix	1, 2, 3
Insight led	Develop a systemwide understanding of need to drive good decisions based on evidence and learning from previous or existing work.	M Gaunt	1, 4

The CCG identified four strategic risk themes which have the potential to prevent the CCG from achieving its stated objectives. Each strategic risk has an identified Executive Risk Owner, who is responsible to overseeing the implementation of identified mitigating actions and for ensuring that their respective BAF template is regularly reviewed and updated. These are as follows:

	Strategic Risk Themes	Owner
1	Systems Leadership/ Reputation	Accountable Officer
2	Quality, safe and effective services	Director of Quality and Nursing
3	Financial sustainability	Director of Finance and Contracting
4	Service transformation	Director of Operations

The six themes have been unpinned by five operational objectives in 2021/22:

COVID Vaccinations

Deliver the COVID Vaccination Programme for the Lincolnshire population in line with national requirements and processes

Recovery & Restoration

Ensure and support delivery for the Lincolnshire population and NHS workforce of national operational planning requirements relating to:

- Workforce
- Services (notably Planned Care, Cancer and Primary Care)
- And meet the CCG financial targets agreed with NHS EI

Integrated Care System

- Deliver all of the key requirements of the CCG (including those relating to the safe transition of CCG staff and responsibilities) in relation to the development and establishment of the statutory Lincolnshire Integrated Care System.
- Progress the sign off of the ASR PCBC, and (subject to Regional and National approval) the subsequent Public Consultation exercise and make a decision on service change informed by this exercise.

CCG Staff

The health and wellbeing needs of CCG staff are identified and supported, and all staff are enabled to continue to personally develop and deliver high quality work.

CCG Principles

- Deliver the action schedule agreed from the Board Development work.
- Seek to embed the commissioning principles in the development of the Lincolnshire ICS.

Risk Management Group and Risk Management Strategy and Framework

At the request of the CCG Executives, Mr Martin Fahy, Director of Nursing set up a working group to reinstate the previous CCG's Risk Management Group. The first meeting took place on 29 April 2021 and the first objective of the Group was to revise the Terms of Reference and the Risk Strategy and Management Framework to align to the single CCG. During the review it was agreed that there would be an extra step in the governance process, which means that the oversight Committee for the group is now the Senior Managers Operational Delivery Group (SMODG) with an overarching oversight by Audit & Risk Committee.

The Terms of Reference (TOR) and Risk Management Strategy and Framework were presented to the Senior Managers Operational Delivery Group (SMODG) on the 23rd September 2021 (TOR) and 25th November 2021 (Risk strategy) and approved.

CCG Risk Register

It had been agreed at a Joint CCG Risk Management Group, prior to COVID-19, to use the format of the Risk Register which had previously been used by South and South West Lincolnshire CCG. There were 71 legacy risks, dating from 2015, from Lincs East and West CCG's which were still held on Datix. Mrs Clair Raybould, Director of Operations agreed at the January 2022 meeting to review the risks and archive where necessary.

Senior Risk Lead	Risk Area of Lead Responsibility
Director of Quality & Nursing and/or Associate Directors of Nursing	• Quality • Safeguarding (adults and children) • Clinical Safety Risks • Infection Control • Continuing Healthcare • Health & Safety • Comms and Engagement • Specialist Education Needs (SEND) • Patient & Public Involvement • Equality & Diversity
Director of Finance & Contracting and/or Chief Finance Officers	• Insight Led • Information Governance • Finance • Commissioning Support Services • Key Performance Indicators • Political, Strategic, Reputational and legal risks (DOF and DON) • BAF delivery
Director of Operations and/or Locality Chief Operating Officers	• Primary Care and Communities • People Centred • Health Inequalities • Collaborative (public & partners) • Contract Negotiation & Management (including procurement of clinical services and commissioning) • Hosted Mental Health & LD Commissioning
System Strategy & Planning Director	• Integrated Care System • Acute Services Review
Board Secretary	• Business Continuity • Governance
Countering Fraud & Bribery Champion	• Countering Fraud and Bribery

Following review, it was agreed to archive 62 of these risks as it was felt that they had now been superseded or were no longer relevant and to receive further review of the nine risks which were not archived.

The CCG has three red risks as at June 2022 which are detailed in the table opposite along with the associated mitigating actions.

The CCG risk scoring matrix is detailed below:

01-03	Very low risk
04-06	Low risk
08-12	Medium risk
15-25	High risk

NHS England (NHSE) has confirmed that there are no identified risks to compliance with the CCG licence.

Reference	PRINCIPAL RISK	MITIGATIONS (*Mitigations are measures to limit harm if, despite controls, a risk materialises*)	ACTION PLAN	LIKELIHOOD May 2022	IMPACT May 2022	CURRENT SCORE May 22
1	Non-delivery of performance and quality standards for cancer leading to actual or potential patient harm.	1. Monitor capacity and highlight early any concerns through SRO/CCG Exec. Lead commissioner to go to neighbouring/border providers 2. Harm Reviews undertaken on long waits	1. Where concerns around achievement are noted, all providers are required to develop and implement a recovery action plan - ? 2. Further action plans agreed with NHSE and NHSI in place, some progress made, however, still fragile in areas such as 2ww due to staffing shortages 3. Continued scrutiny and monitoring of actions to determine impact and alternative actions to be developed where appropriate 4. Individual patient tracking mechanisms for those patients failing to achieve against mandated timeframes 5. Options continue to be developed to move Prostate Cancer Follow Up's out of secondary care (decision due at future Lincolnshire Joint Commissioning Board).	4	4	16
2	Failure to deliver safe and effective services in the Emergency departments that Lincolnshire residents would attend resulting in non delivery of constitutional A&E targets, timely ambulance handovers and long trolley waits and these may result in patient harm	Previous escalation to NHSE and intensified monitoring and recovery planning. During pandemic daily operational system calls. Monthly UEC Delivery Board to ensure relevant actions for all partners progressed.	1. CQC unannounced visit - previously completed 2. Risk Summit - NHSE/I - previously completed	5	4	20
3	Therer is a risk that financial deterioration within the Integrated Care System becomes so severe that they require reductions in the scope and quality of services rather than investment and development in the healthcare of the Lincolnshire population	* The CCG has done work to understand the impact of inequalities on healthcare and has sought external support to improve its own approach to population health management * The CCG is reviewing the framework and governance structures for it's savings programmes, making sure that they meet best practice standards *External factors cannot be controlled, but the CCG is ready to identify any impacts on staff, goods or services, discuss these with NHSEI and key partners, and take mitigating action as required.	1. Development of effective efficiency savings 2. Maintain staff resilience using workforce strategy 3. Establishment of robust governance framework for Lincolnshire as part of the new ICB	4	4	16

CCG Transition Plan & Due Diligence Checklist and ICB Readiness to Operate Statement

To enable the CCG to transition to an ICB from 1st July 2022 two interrelated programmes with Senior Responsible Officers (SRO) were put in place in 2021/22 as follows:

- CCG Transition Programme (Director of Finance); and
- ICB Establishment Programme (System Strategy and Planning Director).

As part of these programmes an ICB Transition Programme Board was established to provide oversight and assurance of the arrangements for transitioning the CCG functions, assets and liabilities to the new Lincolnshire ICB ensuring the that the ICB is "safe and legal" to operate from 1 April 2022.

Following the issue of the 2022/23 planning guidance the establishment date for Lincolnshire Integrated Care Board (ICB), and the transfer of all the functions, assets and liabilities of the current Lincolnshire Clinical Commissioning Group (CCG) has been revised from 1st April 2022 to 1st July 2022.

The Programme Board reports directly to the CCG/ICB Executive (via joint Senior Responsible Officers) on progress and escalates relevant issues. An assurance report has also been regularly presented to the Audit and Risk Committee during 2021/22 to provide the information and assurance about how this change in timescales is being handled and the progress with the overall transition programme.

Specifically, the paper includes the following:

- Progress with preparation for the transition including key risks and issues
- Progress with the transition due diligence checklist
- Progress with the Readiness to Operate Statement (ROS)

Due Diligence Checklist	**Red** - high risk	**Amber** - medium risk
1. Core Due Diligence Checklist	0	3
2.1 HR Due Diligence Checklist	0	0
3.1 Financial - Governance	0	0
3.2 Financial - Accts & Audit	0	1
3.3 Financial - Ledger Require	0	0
3.4 Financial - Banking	0	0
3.5 Financial - Contracts	0	0
3.6 Financial - Assets	0	0
3.7 Financial - Liabilities	0	0
4.0 IT Assets, IT and Records	0	0
5.0 DPST Checklist	0	1
6.0 ODS Reconfig Checklist		
7.0 Quality DD Checklist	0	2
Total	0	7

Transition Programme Progress

Whilst the revised programme provided an additional three months to prepare for the transition from CCG to ICB. It was agreed at the January 2021 ICB Programme Transition Board, that wherever possible the existing programme would be maintained, but recognising that both legal (e.g. staff transfer) and external factors (e.g. issue of NHSEI guidance) would necessitate a number of changes to the original plan.

The ICB Transition Programme Board has met monthly since inception, and has in place a Risk, Action and Issue log (RAI) for progressing issues arising from the meeting. The most significant programme risk was assessed to be the reliance on external factors and the fact that some national/regional timescales are still evolving. The Programme Board assessed this risk as unlikely to prevent a "Safe and Legal" transfer, but it was highly likely/certainty that the timescales for some key activities is likely to be compressed toward the second half of June 2022.

In 2021 NHSE issued a Due Diligence Checklist to support the planning and execution of transition from CCG to ICB, and further versions have been regularly published during 2021/22.

NHSEI asked for the Due Diligence checklist to be submitted for review on 20 May 2022. In preparation for this, each workstream lead undertook a detailed review of progress with the transition Programme Director, which was also reviewed by the Senior Responsible Officer. The table opposite demonstrates that there were seven amber risks outstanding on the 20th May 2022.

The Due Diligence Checklist is an iterative process, and the next phase focused on identifying information sources and populating the Due Diligence Checklist with evidence to support the transition process.

Readiness to Operate Statement (ROS)

The ROS is a formal document that will require sign off by the CCG Accountable Officer ahead of transition from CCG to ICB. The date for this to happen shifted from mid-March to the 10th June 2022.

As such the revised programme worked to a revised ROS submission in June 2022, which was completed, and the final version formed the basis for Accountable Officer sign off on the 10th June 2022.

Commissioning Support Unit

The CCG purchases the majority of its commissioning support services from Arden & GEM CSU. This includes the following:

- Provider Management
- Business Intelligence
- Human Resources
- Information Governance
- Equality and Diversity
- Health and Safety
- Business Continuity
- Freedom of Information

Joint Commissioning

The Health and Social Care White paper (2021) *Integration and Innovation: working together to improve health and social care for all* asks that 'every part of the NHS, public health and social care system should continue to seek out ways to connect, communicate and collaborate so that the health and care needs of people are met'. This builds on an increasingly stronger national policy narrative in recent years, not least the Better Care

Fund (BCF) and its predecessor the Integration and Transformation Fund (ITF). The direction of travel is therefore clear and to ensure we continue to build upon a history of collaboration in Lincolnshire it was agreed that a new group be formed to take forward joint strategic commissioning so that health and care resources are best deployed to pursue that objective.

The Joint Commissioning Oversight Group was established in 2021 and is a strategic forum comprising of representatives from the CCG and Lincolnshire County Council, with representatives of other partners and stakeholders invited to join as required.

Capacity to Handle Risk

The Accountable Officer has overall responsibility for the management of risk by the CCG. All employees have a responsibility to identify and manage risk appropriate to their own role in the organisation.

The role of each senior officer is to ensure that appropriate arrangements are in place for the identification and elimination or reduction of risk to an acceptable level. Officers must also ensure compliance with policies, procedures and statutory requirements.

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 CCG demonstrates internal control by a variety of mechanisms. The CCG Committee structure as described earlier in the report ensures that a systematic and controlled process is in place to review and approve relevant policy documentation and ensure robust governance is in place. The Audit and Risk Committee has specific responsibility for reviewing, managing and reporting risk to the Board. There are financial controls in place to comply with good practice and these are audited by internal and external auditors each year.

The internal audit programme is extensive and covers key areas of the CCG business to review the CCG's compliance with policies and procedures and to recommend strengthening where appropriate.

Annual audit of conflicts 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.

The CCG's internal auditors have carried out a Conflicts of Interest audit during 2021/22 with the following low risk rating actions during 2021/22 as identified on the table below. These actions have already been addressed as at March 2022.

Recommended Actions	Response
1. CoI Declarations – Operating Effectiveness The CCG will: • Remind Executive and Non-Executives and other senior employees of the importance of providing a complete record of all interests held. This will then enable the CCG to assess which interests give rise to a potential conflict and require disclosure/mitigation. • Update the declaration of interest register for the additional interests identified above	Response: • Those colleagues that had not included full detail were requested to complete a new form and the importance of completing forms raised at Execs and NED's meetings. • The COI Register is live and regularly updated.
2. CoI Training The CCG will: • Remind employees where the CCG's Conflicts of Interest and Fraud, Bribery and Corruption policies are located; and • Undertake refresher training with colleagues to remind them of the rules and regulations regarding gifts and hospitality.	Response: • Briefing update on all aspects of conflicts of interest including fraud, bribery, corruption, gits and hospitality shared with staff in late 2021. Location of policies also detailed in Team Talk News, all available on both the CCG website and intranet. • Training exercise/quiz developed by PwC and shared with staff for completion.

Data Quality

The data used by the Membership and Board is based on the NHS national data sets. All data is checked for accuracy and is automated to avoid errors and inconsistency. To ensure consistency procedures are documented and regularly reviewed.

There has been no data quality issues reported during 2021/22.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, personal identifiable information, and special category data. This framework is supported by NHS Digital's Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals, that personal information is safeguarded securely and used properly in line with National Data Guardian requirements.

For this financial year, the CCG has demonstrated it is meeting these requirements by submitting its DSPT return with a score of "Standards Met". This was secured by completing 89 of 89 mandatory evidence items and completing 33 of 38 assertions, 5 assertions contained non- mandatory items which were not required to be completed as detailed within the DSPT return.

We place high importance on ensuring there are robust information governance, data security and protection systems and processes in place to help protect patient and corporate information. We have ensured all staff complete annual data security and awareness training and have implemented a suite of policies to ensure staff members are aware of their information governance/data security and protection roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. The CCG has not had any personal data related incidents in year that have met the criteria for external reporting to the information commissioner's office. We have developed data privacy impact assessments (DPIAs) and management procedures to embed an information risk culture throughout the organisation against identified risks.

The CCG purchases its Information Governance services and its Data Protection Officer service from Arden & GEM Commissioning Support Unit.

Business Critical Models

The CCG does not use any business critical models at this time and will continue to review any models that it uses in the future to ensure quality assurance of such models.

Third party assurances

Arden & GEM Commissioning Support Services

Arden & GEM Commissioning Support Services provide Finance and Payroll services to a number of CCGs. For Lincolnshire CCG Arden & GEM only provided Payroll services for the majority of 2021/22. The CCG received a Type II Service Auditor Report in respect of these services which assessed the effectiveness of the control environment design which covers the period 1st April 2021 to 31st March 2022.

The report advised that key controls in relation to Payroll were suitably designed and operating effectively throughout the period 1st April 2021 to 31st March 2022 with no exceptions noted in relation to payroll services with one exception noted.

NHS Digital

NHS England has shared a Type II ISAE 3000 Service Auditor Report in relation to NHS Digital's Description of its Control System for General Practitioners Payment Services for the period 1st April 2021 to 31st March 2022.

The report confirms the description fairly presents the GP Payments system for processing customers' throughout the period. The controls related to the control objectives stated in the accompanying description were suitably designed and operated effectively throughout the period with the exception of two controls in relation to:

- appropriate segregation of duties between the development and the production environments of the GP Data Collection (GPDC) application.

- appropriate timely removal of leavers from GPDC.

These two controls did not operate effectively during the period 1 April 2021 to 31 March 2022. As a result, controls were not operating effectively to achieve both of these controls and therefore the Auditor issued a qualified opinion.

Capita Business

Capita Business Services Limited provides Primary Care Support Services to NHS England and CCGs across the country. NHS England has shared a Type II ISAE3402 Service Auditor Report in respect of these services for the period 1st April 2021 to 31st March 2022.

The auditors noted exceptions on 6 out of 17 control objectives. Therefore the Auditor issued a qualified opinion.

NHS Shared Business Services

NHS Shared Business Services provides Employment Services to a number of organisations across the country. The CCG received a Type II ISAE3402 Service Auditor Report in respect of these services which assessed the effectiveness of the control environment design which covers the period 1st April 2021 to 31st March 2022.The report advised that 10 out of 14 key controls were suitably designed and operating effectively throughout the period 1st April 2021 to 31st March 2022. An unqualified opinion was issued in respect of 10 of the 14 control objectives. A qualified opinion was issued in relation to four control objectives.

NHS Business Services Authority

NHS Business Services Authority is an Arm's Length Body of the Department of Health and Social Care which provides a Prescription Payments process to CCGs across the country. The CCG received a Type II ISE3402 Service Auditor Report in respect of these services which assessed the effectiveness of the control environment design which covers the period 1st April 2021 to 31st March 2022. The report identified that one control was not suitably designed and in place to provide appropriate periodic review of user access, and in a number of instances, the controls related to timely removal of leavers' access to applications and the network did not operate effectively. As a result, controls were not suitably designed and did not operate effectively during the period 1 April 2021 to 31 March 2022. The Auditor issued a qualified opinion.

NHS Business Services Authority – Electronic Staff Record

NHS Electronic Staff Record is part of the NHS Business Services Authority which provides a single payroll and Human Resources (HR) Management system to NHS organisations across the country.

The CCG received a Type II ISAE3000 Service Auditor Report in respect of these services which assessed the effectiveness of the control environment design which covers the period 1st April 2021 to 31st March 2022. The report covers the effectiveness of the Information Technology (IT) general controls in place which facilitate the stability and reliability of the service. These controls are predominantly designed and operated by IBM.

The report issued confirmed that the controls necessary to ensure that access to the development and production areas of the NHS hub was controlled and appropriately restricted, were not in place from 1 April 2021 to 6 June 2021 but were implemented on 7 June 2021. As a result, there were insufficient logical access controls in place to appropriately restrict access to the development and production area of the NHS hub for part of the reporting period and therefore controls were not suitably designed to achieve Control Objective 2 "Controls provide reasonable assurance that security configurations are created, implemented and maintained to prevent inappropriate access" during the period 1 April 2021 to 6 June 2021.

Commissioning Support Units

Calculating Quality Reporting Service (CQRS)

From 31st October 2020, responsibility for the CQRS system delivery transferred to a collaboration of Commissioning Support Units. For the financial year 2021/22 the ISAE 3402 reports were provided by Deloitte. A Type I report was provided for the period 1 April 2021 to 30 September 2021 and a Type II report was provided for 1 October 2021 to 31 March 2022.

The Type 2 report provided a qualified opinion as one minor exception was noted. The data used by the CQRS system is provided by the GP Extraction Service and for 1 April to 31 May 2021 data from NHAIS was also used. This service is provided by NHS Digital and is covered by an ISAE3400 report from PWC. The PWC report provided a qualified opinion as two minor exceptions were noted.

Control Issues

The CCG has implemented governance, risk management and internal control processes and subjected these to both internal scrutiny (through the various Committees of the Board as well as a comprehensive internal audit programme). There were no control issues identified within the Month 9 Governance Statement return but since then one gap in control has been identified within the CCG's financial statutory duties with an actual outturn deficit of £2.4m. The planned deficit was £5.1m deficit so whilst breaching statutory duties the year end position is better than planned.

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

For 2021/22 the Government agreed an overall financial settlement for the NHS for the first half of the year (H1) which was based on H2 (second half of the year) 2020/21 funding envelopes and included a continuation of the system top-up and COVID-19 fixed allocation arrangements. Funding arrangements for the H2 period of 2021/22 were broadly consistent with a continuation of the H1 financial framework with adjustments for inflation, efficiency requirements and policy priorities.

The CCG developed fully triangulated financial plans separately for the H1 and H2 period of 2021/22. System financial plans for H1 were submitted in their final form during June 2021 and for H2 were submitted in mid-November 2021. November 2021. The Lincolnshire system submitted balanced financial plans for both of the two periods. These plans formed the basis on which the CCG's budgets were determined for 2021/22.

Reporting to the CCG Board during 2021/22 has been in line with the different financial regime.

Internal audit has reviewed the systems and processes in place during the year and published reports detailing the required actions within specific areas to ensure economy, efficiency and effectiveness of the use of resources is maintained. Recommendations are managed by the Chief Finance Officer and progress against the identified actions is reported quarterly to the Audit and Risk Committee.

Delegation of functions

The CCG received delegated authority for Primary Care Commissioning budgets when it was established on 1 April 2020.

These consisted of GP contract budgets, and related areas of expenditure. To assure itself of the effective use of resources for delegated budgets the CCG accesses monthly payment information, which is reviewed and challenged for understanding and further information if required. A financial report is taken monthly to the Primary Care Commissioning Committee of the CCG which allows review and challenge by Non-Executive Directors.

There is a risk register covering primary care risks and emerging risks. This is reviewed by the Primary Care Commissioning Committee at each meeting.

Escalation reports from the Primary Care Commissioning Committee are reviewed at the Board, and the delegated budgets form part of the overall financial report of the CCG.

Internal audit have undertaken a review of delegated Primary Care Commissioning in 2021/22 and have concluded that the area is low risk with three specific areas highlighted:

- Investment and Impact Fund Payment Calculations Oversight
- Transaction Reconciliations
- Finance Report – regular reporting to the Committee.

Counter fraud arrangements

The CCG is compliant with the NHS Counter Fraud Authority Standards for Commissioners: Fraud, Bribery and Corruption.

The CCG contracts with PwC for an accredited Counter Fraud Specialist (CFS) service to undertake counter fraud work. The CFS works with the CCG to conduct a self-assessment of the position against the Standards for Commissioners which is approved by the Audit and Risk Committee and submitted to NHS Counter Fraud Authority on an annual basis.

The executive lead role for Anti-Fraud and Anti-Bribery and Corruption sits with the Director of Finance (as a member of the CCG Board). The CFS attends the regular meetings of the Audit and Risk Committee, providing formal updates against an agreed annual programme of activities.

There were five new cases of fraud reporting 2021/22, four of which were closed as of 31st March 2022.

Head of Internal Audit Opinion

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

"Our opinion is as follows:

Generally satisfactory with some improvements required.

Governance, risk management and control in relation to CCG critical areas is generally satisfactory. However, there are some areas of weakness in the framework of governance, risk management and control which potentially put the achievement of objectives at risk.

Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control.

In summary, our opinion is based on the following:

- Medium risk rated weaknesses identified in individual assignments that are not significant in aggregate to the system of internal control.
- High risk rated weaknesses identified in individual assignments that are isolated to specific systems or processes; and
- None of the individual assignment reports have an overall classification of critical risk."

The Audit and Risk Committee approved the Internal Audit plan that had been developed in conjunction with the Senior Leadership Team.

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

	OVERALL
Mental Health, Learning Disability and Autism Spectrum Disorder (MH, LD and ASD) Review	High
Conflict of Interest	Low
Urgent & Emergency Care	Medium
Safeguarding	Low
Financial Controls	Medium
Primary Care Commissioning	Low
Complaints	Medium

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, 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 assurance framework provides me with evidence that the effectiveness of controls that manage risks to the Clinical Commissioning Group achieving its principal objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- Board
- Audit and Risk Committee
- Primary Care Commissioning Committee
- Finance and Performance Committee and
- Quality and Patient Experience Committee

A plan to address weaknesses and ensure continuous improvement of the system is in place.

Conclusion

My review confirms that NHS Lincolnshire CCG has a generally sound system of internal control which supports the achievement of our policies, aims and objectives but that there has been one gap in internal control identified in relation to delivery of our statutory financial duties, with a £2.4m deficit at year end. The planned deficit was a £5.1m deficit so whilst breaching statutory duties, in conclusion the year end position is better than planned.

John Turner
Accountable Officer

23 June 2022

Remuneration and Staff Report

Remuneration Report

As required by the Companies Act 2006 the CCG has prepared a Remuneration Report containing information about director's remuneration. This report is in respect of the senior managers of the CCG. Some of the information in the report is part of the annual audit of the accounts, and this is indicated when it applies in the title of each section.

The definition of "senior managers" is: 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Clinical Commissioning Group. This means those who influence the decisions of the CCG as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory and Lay Members.'

The tables on subsequent pages of this report summarise the remuneration (excluding National Insurance contributions) and pension status of the CCG's Board members members and other senior managers for the year ended 31 March 2022 (with prior year comparators for the year ending 31 March 2021).

The CCG's Remuneration Committee, which is a Committee of the Board sets the principles of the pay and rewards strategy for the CCG to ensure that it is both equitable and fair. The Committee approves the overall approach and methodology for determining pay and conditions of staff subject to local terms. It also ensures that the CCG's most senior managers are appropriately and fairly rewarded for their contributions, conforming to the CCGs' probity and financial integrity as part of the corporate governance arrangements.

There were three meetings of the Remuneration Committee held in 2021/22 and further information on attendance is included in the Annual Governance Statement.

The membership of the Remuneration Committee throughout the financial year was as follows:

Mrs Fenella Chambers	Non-Executive Director and Chair of the Committee
Mr Jim Connolly	Non-Executive Director (up to 31st October 2021)
Mr Graham Felston	Non-Executive Director (from 1st July 2021)
Mrs Janet Inman	Non-Executive Director
Ms Sue Liburd	Non-Executive Director
Mr Sean Lyons	CCG Chair (up to 31st December 2021)
Dr Gerry McSorley	Non-Executive Director
Mr Murray Macdonald	Non-Executive Director (up to 30th June 2021)

Policy on the Remuneration of Senior Managers

The Remuneration Committee is responsible for determining the remuneration of all individuals who are non-employees and engaged under Contracts for Services. Remuneration for these positions is informed by local and national pay benchmarking. Their remuneration is reviewed periodically to ensure that it keeps pace with increasing demands on the time of the individuals in those positions. In order to avoid any conflict of interest in respect of Non-Executive Directors who constitute the majority of the membership of the Remuneration Committee, their own remuneration is set directly by the Board. The Non-Executive Directors who are conflicted are not part of the decision-making.

The notice period for executive directors is six months and the arrangements for compensation payments for early termination of contract will comply with NHS regulations. The remuneration for executive directors does not include any performance related bonuses and none of the executives receives personal pension contributions other than their entitlement under the NHS Pension Scheme.

Remuneration of Very Senior Managers

Employment terms for a Very Senior Manager (VSM) or member of the CCG's Executive Team are determined separately and where appropriate the principles of Agenda for Change are applied to these employees to ensure equity across the CCG. There is no national body to determine remuneration for VSM employees; therefore a robust process is in place within the CCG. The Remuneration Committee sets and approves the remuneration for all VSM employees. The Remuneration Committee comprises Non-Executive Directors from the Board and their decisions are informed by independent, local and national benchmarking to ensure the best use of public funds and to help with recruitment and retention. Their decisions also take into consideration annual VSM pay review guidance from NHSEI and annual Agenda for Change pay circulars to ensure parity where appropriate. All VSM salaries are reviewed by the Remuneration Committee and a recommendation is presented to to the Board for their approval. The Chief Executive is remunerated in line with this guidance.

Salaries and Allowances (Audited)

Salaries and allowances for the senior managers of the CCG for the last two years are shown in Tables 1a and 1b below. The notes describe principles which apply to both years.

Salaries and Allowances Notes

1. Total remuneration includes salary and non-consolidated performance-related pay as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.
2. None of the CCG's senior employees are entitled to performance related bonuses.
3. There were no service contracts with senior managers during the financial year.
4. There were no payments or awards made to past senior managers, payments made for loss of office during the financial year or payments to anyone who was not a senior manager but has previously been a senior manager at any time.
5. All pension related benefits show the increase in 'lifetime' pension which have arisen in each year. The sum reported reflects the amount by which the annual pension received on retirement age has increased in the year multiplied by 20 (the average number of years a pension is paid to members of the NHS pension scheme following retirement). 'All pension related benefits' exclude employee contributions as directed in the Finance Act 2004.
6. Where a salary amount sits exactly on a pay boundary then the salary is reported at the lower band. For example, if an employee had a salary of £50,000, they would be shown in the salary band (£'000) 45-50.
7. Where an employee has been in post for part of the year, their pay and pension amount are time apportioned to reflect their time in post with the CCG. Any start and end dates are shown in the notes.
8. The calculation of pension related benefits includes allowance for employee contributions. It should be noted that on some occasions a small proportion of the employee contributions relates to a previous financial year.

Table 1a: Salaries and Allowances for the year ending 31 March 2021

Name and title		2020-21					
		Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Dr Majid Akram, Locality Clinical Lead		50 - 55	0	0	0	22.5 - 25	70 - 75
Dr David Baker, Locality Clinical Lead		45 - 50	0	0	0	0	45 - 50
Mrs Elizabeth Ball, Director of Nursing and Quality		40 - 45	0	0	0	0	40 - 45
Dr David Boldy, Secondary Care Doctor		15 - 20	0	0	0	0	15 - 20
Mr Pete Burnett, System Strategy and Planning Director		55 - 60	0	0	0	0	55 - 60
Ms Fenella Chambers, Non-Executive Director		10 - 15	0	0	0	0	10 - 15
Mr Jim Connolly, Non-Executive Director		10 - 15	0	0	0	0	10 - 15
Dr Andrew Doddrell, Locality Clinical Lead		50 - 55	0	0	0	0	50 - 55
Mr Martin Fahy, Director of Nursing and Quality	*	90 - 95	0	0	0	87.5 - 90	180 - 185
Mr Matt Gaunt, Director of Finance and Contracting	*	135 - 140	0	0	0	80 - 82.5	215 - 220
Dr James Howarth, Locality Clinical Lead		0 - 5	0	0	0	0	0 - 5
Ms Janet Inman, Non-Executive Director		10 - 15	0	0	0	0	10 - 15
Ms Sue Liburd, Non-Executive Director		10 - 15	0	0	0	0	10 - 15
Mr Sean Lyons, Chair		50 - 55	0	0	0	0	50 - 55
Mr Murray Macdonald, Non-Executive Director		10 - 15	0	0	0	0	10 - 15
Mr Gerry McSorley, Non-Executive Director		10 - 15	0	0	0	0	10 - 15
Ms Sarah-Jane Mills, Chief Operating Officer - West	*	100 - 105	0	0	0	12.5 - 15	115 - 120
Mr Pete Moore, Non-Executive Director		10 - 15	0	0	0	0	10 - 15
Dr John Parkin, Locality Clinical Lead		40 - 45	0	0	0	0	40 - 45
Ms Clair Raybould, Director of Operations	*	110 - 115	800	0	0	47.5 - 50	160 - 165
Mr Andy Rix, Chief Operating Officer - South	*	95 - 100	0	0	0	72.5 - 75	170 - 175
Mr John Turner, Chief Executive	*	150 - 155	0	0	0	0	150 - 155
Mrs Sandra Williamson, Chief Operating Officer - East	**	100 - 105	4,500	0	0	15 - 17.5	120 - 125

Notes to Table 1a

Mr Pete Burnett, System Strategy and Planning Director was in post on secondment from the NHS Trust Development Authority (NHS TDA) for the full year receiving a total banded salary in the range 85-90 (000). The NHS TDA agreed to fund some of the costs as part of the secondment agreement, so only costs to the value of 55-60 (000) were borne by the CCG.

All postholders reported above were in post for the full year with exception to the following:
- Mr Martin Fahy, Director of Nursing and Quality – in post from 15 June 2020
- Dr Andrew Doddrell, Locality Clinical Lead – in post to 31 December 2020 (replaced by Dr James Howarth)
- Dr James Howarth, Locality Clinical Lead - in post from 1 February 2021
- Mrs Elizabeth Ball, Director of Nursing and Quality - in post to 21 August 2020 (replaced by Mr Martin Fahy)

Note that the salary disclosed in the published audited annual report and accounts in 2020/21 included an error. The salary range for Mrs Sandra Williamson was shown as 100,000 - 105,000. However, this figure included expense payments in error. Corrected figures are shown in Table 1a above.

Note also that the salary disclosures for 2020/21 published in the annual report last year included estimates of 14,000 for back pay for 7 of the managers. The actual back pay for the senior managers was 18,869, and these values have been removed from payments in 2021/22 to calculate the salaries shown in Table 1b below.
The original back pay estimates for 2020/21 have been left in Table 1a so that there is consistency with the disclosures in the annual report from last year for all those marked *. In all these cases, there would be no change to their pay band by moving from back pay estimates to actual back pay.

For Mrs Sandra Williamson (marked **), the actual back pay is included rather than the estimate. This has been done so that all relevant costs are included across Tables 1a and 1b, given the change in reported expenses in 2021/22 (see Table 1b). The inclusion of actual back pay corrects an error which understated the salary for 2020/21. A separate error from last year meant that expenses were mistakenly included in the salary disclosures for Mrs Sandra Williamson, overstating salary. These two adjustments (inclusion of expenses in salary totals, and back pay estimate being too low) offset one another and so the pay band for 2020/21 previously disclosed was correct and remains unchanged in Table 1a above.

Table 1b: Salaries and Allowances for the year ending 31 March 2022

Name and title	2021-22						2020-21
	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Corrections to prior year expense payments (taxable) to nearest £100
	£000	£	£000	£000	£000	£000	£
Dr Majid Akram, Locality Clinical Lead	50 - 55	0	0	0	15 - 17.5	65 - 70	
Dr David Baker, Locality Clinical Lead	40 - 45	0	0	0	0	40 - 45	
Dr David Boldy, Secondary Care Doctor	15 - 20	0	0	0	0	15 - 20	
Mr Pete Burnett, System Strategy and Planning Director	100 - 105	0	0	0	40 - 42.5	145 - 150	
Ms Fenella Chambers, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	
Mr Jim Connolly, Non-Executive Director	5 - 10	0	0	0	0	5 - 10	
Mr Graham Felston, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	
Mr Martin Fahy, Director of Nursing and Quality	115 - 120	0	0	0	87.5 - 90	205 - 210	
Mr Matt Gaunt, Director of Finance and Contracting	135 - 140	0	0	0	35 - 37.5	170 - 175	
Dr James Howarth, Locality Clinical Lead	45 - 50	0	0	0	0	45 - 50	
Ms Janet Inman, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	
Ms Sue Liburd, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	
Mr Sean Lyons, Chair	30 - 35	0	0	0	0	30 - 35	
Mr Murray Macdonald, Non-Executive Director	0 - 5	0	0	0	0	0 - 5	
Mr Gerry McSorley, Non-Executive Director	5 - 10	0	0	0	0	5 - 10	
Mr Gerry McSorley, Interim Chair	10 - 15	0	0	0	0	10 - 15	
Ms Sarah-Jane Mills, Chief Operating Officer - West	100 - 105	0	0	0	87.5 - 90	190 - 195	
Mr Pete Moore, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	
Dr John Parkin, Locality Clinical Lead	40 - 45	0	0	0	0	40 - 45	
Ms Clair Raybould, Director of Operations	110 - 115	0	0	0	30 - 32.5	140 - 145	
Mr Andy Rix, Chief Operating Officer - South	100 - 105	0	0	0	80 - 82.5	180 - 185	
Mr John Turner, Chief Executive	155 - 160	0	0	0	182.5 - 185	340 - 345	
Mrs Sandra Williamson, Chief Operating Officer - East	100 - 105	0	0	0	105 - 107.5	210 - 215	-4,500

Notes to Table 1b

All postholders reported above were in post for the whole of 2021/22 with exception to the following:

- Mr Sean Lyons, Chair - left 31 December 2021 (replaced by Mr Gerry McSorley);

- Mr Gerry McSorley was Non-Executive Director until 31 December 2021 when he became Acting Chair;

- Mr Murray MacDonald, Non-Executive Director - left 30 June 2021 (replaced by Mr Graham Felston);

- Mr Graham Felston, Non-Executive Director – in post from 1 July 2021;

- Mr Jim Connolly, Non-Executive Director – left 31 October 2021.

Note that expense payments made automatically to Mrs Sandra Williamson during 2020/21 were repaid during 2021/22. This was due to an unexpected change in working practices because of the pandemic.

Non-cash remuneration: benefits in kind

Employees can receive non-cash benefits which must be reported to HMRC each year on a P11D form. These include discounted services or goods, vouchers (including childcare vouchers), living accommodation, travel allowances, company cars, vans, bikes or other vehicles available for private use, low cost loans, private insurance, professional fees and subscriptions.

None of the senior managers received benefits in kind during 2021-22. In the previous year, Ms Clair Raybould had a lease car for which the net costs which were paid were £800 (to the nearest £100).

Pensions benefits (Audited)

Most of the senior managers do not have pensionable pay, either because (for the medical staff) they are part of a GP pension scheme or because (for for Non-Executive Directors) their engagement does not qualify as pensionable pay. Figures for the remaining staff for the last two years are shown in Tables 2a and 2b below. The notes describe principles which apply to both years.

Pension Benefit Notes

1. The below information is based on data provided by the NHS Pensions Agency.
2. The employer's contribution rate to pension benefits has been 20.68% of pensionable pay in 2020/21 and 2021/22.
3. Pension figures included in the table below are for senior managers that have pensions paid directly by the CCG and include all of their NHS service, not just pension payments that related to the year in question.
4. Where an employee has been in post for part of the year their pension amount is time apportioned to reflect their time in post.
5. Staff are able to make additional voluntary contributions alongside their regular contributions.
6. Mr John Turner, Chief Executive, opted out of the NHS Pension Scheme prior to 1 April 2020. In line with national guidance, no pension disclosures are provided for individuals who did not contribute to the NHS Pension Scheme in the year. Mr Turner re-joined the pension scheme on 1 April 2021 and left again on 31 December 2021, so pension and CETV figures are shown as at 31 December 2021 in Table 2b below.
7. The calculation of the real increase in Cash Equivalent Transfer Value includes allowance for employee contributions. It should be noted that on some occasions a small proportion of the employee contributions relates to a previous financial year.
8. The benefits and corresponding Cash Equivalent Transfer Value disclosed in Tables 2a and 2b below do not allow for any potential adjustment in relation to the McCloud judgement.

Table 2a: Pension Benefits for the year ending 31 March 2021

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr Majid Akram, Locality Clinical Lead	0 - 2.5	0 - 2.5	10 - 15	20 - 25	164	14	140	0
Mrs Elizabeth Ball, Director of Nursing and Quality	0	0	40 - 45	130 - 135	0	0	983	0
Mr Martin Fahy, Director of Nursing and Quality	2.5 - 5	7.5 - 10	55 - 60	140 - 145	1,080	86	939	0
Mr Matt Gaunt, Director of Finance and Contracting	2.5 - 5	0	25 - 30	0	397	61	310	0
Ms Sarah-Jane Mills, Chief Operating Officer - South West	0 - 2.5	0	40 - 45	100 - 105	904	21	855	0
Ms Clair Raybould, Director of Operations	2.5 - 5	2.5 - 5	25 - 30	45 - 50	438	36	381	0
Mr Andy Rix, Chief Operating Officer - South	2.5 - 5	10 - 12.5	45 - 50	145 - 150	1,178	104	1,043	0
Mr John Turner, Chief Executive	0	0	0	0	0	0	0	0
Mrs Sandra Williamson, Chief Operating Officer - East	0 - 2.5	0	30 - 35	70 - 75	586	15	549	0

Note that the real increases in Cash Equivalent Transfer Value for the year ending 31 March 2021 in Table 2a have been amended to allow for employee pension contributions and so do not match the 2020/21 published annual report and accounts. The corrected values vary by person but are around 22% lower in total.

It should also be noted that the 2020/21 Remuneration Report did not include the Chief Executive within the disclosure of 'Table 2: Pension Benefits for the year ending 31 March 2021' because the information cannot be provided by the NHS Pensions Agency for members who are no longer paying contributions. Consequently, the external auditor issued a qualification on the 2020/21 Remuneration Report on this matter. The Department of Health and Social Care Group Accounting Manual for 2021/22 has been updated to confirm that where a senior manager has opted out of the pension arrangements for the whole of the year, no pension figures should be reported. This updated guidance applies to 2021/22 and 2020/21 comparative guidance and has been used in the preparation of current year and prior year disclosures to resolve the prior year qualification.

Table 2b: Pension Benefits for the year ending 31 March 2022

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2022	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr Majid Akram, Locality Clinical Lead	0 - 2.5	0 - 2.5	10 - 15	25 - 30	182	9	164	0
Mr Pete Burnett, System Strategy and Planning Director	2.5 - 5	0	35 - 40	0	398	23	359	0
Mr Martin Fahy, Director of Nursing and Quality	2.5 - 5	7.5 - 10	60 - 65	150 - 155	1,194	91	1,080	0
Mr Matt Gaunt, Director of Finance and Contracting	2.5 - 5	0	25 - 30	0	448	30	397	0
Ms Sarah-Jane Mills, Chief Operating Officer - West	2.5 - 5	7.5 - 10	45 - 50	105 - 110	1,020	97	904	0
Ms Clair Raybould, Director of Operations	0 - 2.5	0 - 2.5	25 - 30	45 - 50	478	22	438	0
Mr Andy Rix, Chief Operating Officer - South	2.5 - 5	7.5 - 10	50 - 55	155 - 160	1,304	105	1,178	0
Mr John Turner, Chief Executive	7.5 - 10	17.5 - 20	55 - 60	150 - 155	1,255	189	1,044	0
Mrs Sandra Williamson, Chief Operating Officer - East	5 - 7.5	5 - 7.5	40 - 45	75 - 80	686	82	586	0

The following definitions are provided for the pension tables above.

Cash Equivalent Transfer Values

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

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

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

Real Increase in CETV

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

Compensation on early retirement or for loss of office

There have been no compensation payments for early retirement or for loss of office in 2021/22 (and there were none in 2020/21).

Payments to past directors

There have been no payments to past directors.

Fair pay disclosures (Audited)

Percentage change in remuneration of highest paid director

Entities are required to disclose pay ratio information and detail concerning percentage change in remuneration concerning the highest paid director.

There are no material transactions other than salaries and allowances.

Percentage changes from 2020-21 to 2021-22	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	4.1%	n/a
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	-8.0%	n/a

The reduction to average staff pay reflects the increase in bank and interim staff to support the vaccination programme. The salary increase for the highest paid director relates to the transition to an Integrated Care Board; salaries for directors of the ICB have been set in advance in accordance with prevailing policies and guidance.

Pay ratio information

As at 31 March 2022, remuneration ranged from £2,500 to £172,500 (2020/21: £2,500 to £152,500) using midpoints of the bands based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

It should be noted that the annual equivalent remuneration of the highest-paid director as at 31 March 2022 was higher than the total received for the year (reported in Table 1b).

Remuneration of Lincolnshire CCG staff shown in the table below:

Pay ratio analysis for all staff (in £5,000 pay bands)	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
As at 31 March 2021	20 - 25	30 - 35	45 - 50
As at 31 March 2022	15 - 20	25 - 30	45 - 50

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director against the 25th percentile, median and 75th percentile of remuneration of the CCG's workforce. (Salary is the only component, so no further breakdown is presented.) The banded remuneration of the highest paid member of the Board in the Clinical Commissioning Group in the financial year 2021-22 was annualised full time equivalent remuneration of £170-£175,000 (2020/21: £150-£155,000) based upon gross earnings in March 2022. The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
2020-21	7.24	4.86	3.33
2021-22	10.66	6.21	3.76

In 2021/22 no employees received remuneration in excess of the highest-paid Director/Member (and nor did they in 2020/21).

The midpoint of the banded remuneration for the highest paid member of the Governing Body was 6.21 times the median remuneration of the workforce (2020/21: 4.86), which was £25-£30,000 (2020/21: £30-£35,000). The ratio has increased because the salary for the highest paid member has increased, whilst an increased use of interim staff for the vaccination programme has reduced the median salary. The use of interim staff for the vaccination programme has also increased the ratios for the 25th and 75th percentiles over the last year.

Description	2021/22	2020/21
Band of highest paid directors' total remuneration (£'000)	170 - 175	150 - 155
Band of median (£'000)	25 - 30	30 - 35
Ratio of median to banded midpoint of highest paid director	6.21	4.86

Note that the median pay ratio for 2020-21 has been corrected from 4.87 in the previous year's published annual report to the value shown above of 4.86. The change reflects the inclusion of temporary staff in line with Department of Health guidance and a change in methodology required this year.

Exit Packages for the year ending 31 March 2022 (Audited)

There were no exit packages agreed during 2021/22 (and there were none in 2020/21).

Table 1: Exit Packages for the year ending 31 March 2022

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£'s	Number	£'s	Number	£'s	Number	£'s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
More than £200,000	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0

Table 2: Exit Packages for the year ending 31 March 2021

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£'s	Number	£'s	Number	£'s	Number	£'s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
More than £200,000	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0

Reporting of redundancy and other departure costs is in accordance with the provisions of the Agenda for Change redundancy policy. Exit costs in this note are accounted for in full in the year of departure. Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Other Departures

There have been no other departures during 2021/22 (and there were none in 2020/21).

Table 1: Other Agreed Departures for the year ending 31 March 2022

	Agreements	Total Value of Agreements
	Number	£'s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
Total	0	0

Table 2: Other Agreed Departures for the year ending 31 March 2021

	Agreements	Total Value of Agreements
	Number	£'s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
Total	0	0

As a single exit packages can be made up of several components (each of which will be counted separately in this Note) the total number above will not necessarily match the total numbers in Note 4.4 Exit Packages which will be the number of individuals.

* Any non-contractual payments in lieu of notice are disclosed under "non-contractual payments requiring HMT approval" below.

**Includes any non-contractual severance payment made following judicial mediation, and 0 relating to non-contractual payments in lieu of notice.

There were no non-contractual payments (£0) made to individuals where the payment value was more than 12 months' of their annual salary.

Off Payroll Engagements

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

For all highly paid off-payroll engagements as of 31 March 2022, greater than £245 per day:

	Number
Number of existing engagements as of 31 March 2022	4
Of which, the number that have existed:	
For less than one year at the time of reporting	4
For between one and two years at the time of reporting	0
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	0

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

Table 2: New Off Payroll engagements

For all off-payroll appointments engaged at any point between 1 April 2021 and 31 March 2022, greater than £245 per day:

	Number
The number of off-payroll workers engaged between April 2021 and March 2022	11
Of Which:	
The number not subject to off-payroll legislation	0
The number subject to off-payroll legislation and determined as in-scope of IR35	3
The number subject to off-payroll legislation and determined as out-of-scope of IR35	8
The number of engagements reassessed for compliance or assurance purposes during the year	0
of which the number of engagements that saw a change to IR35 status following review.	0

Note: A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

The CCG confirms that all existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 3: Off Payroll board members/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022.

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year.	22

Expenditure on Consultancy is £597,127 in 2021/22 (£96,835 in 2020/21).

Staff Report

2021/22 has been another unprecedented year and again the response from all our teams has simply being staggering with everyone playing their part to ensure that the vaccination roll out was delivered on time as part of a co-ordinated approach across the Lincolnshire Healthcare system.

This required the recruitment of new temporary staff, including those returning to practice and volunteers, all who stepped up to deliver a diverse vaccination programme, keeping the community we serve safe.

For this reason, we are immensely proud of our staff who have contributed brilliantly to any role that they have been asked to undertake across the wider system as well as those staff who have continued to deliver business as usual services.

Staff Engagement - In 2021/22 the CCG participated in the NHS National Staff Survey. The survey is undertaken every year seek the views of staff and ultimately improve their experience of working within the NHS. The survey was sent out to 386 staff with a completion rate of 72%. The results of the survey were generally positive with 72% of staff stating that they were positive about their job and 67% stating that the CCG acted fairly with respect to career progression. Although the number of staff stating that they had an appraisal (67%) was less than that of similiar sized organisations (84%) this was an increase on the number of staff previously stating that they had received an appraisal (50.5%).

75% of staff indicated that they were happy with flexible working patterns. Although again this is below the average for similar size organisations (81%), this is something that the CCG is addressing as it moves towards a more flexible working model that will benefit the majority of staff.

The CCG will work with its established Staff Engagement Group to put together an action plan to make necessary improvements in scores. This in turn will feed into the broader actions set out in the NHS People Plan in particular locally agreed actions across the Lincolnshire System.

Our Staff Engagement Group continue to play an integral part in helping to shape our organisation and as we move forward into the ICB. In 2021/22 the staff engagement team led or fed back on a number of initiatives including new ways of working, wellbeing, and employee induction.

Although we were unable to meet in person, two virtual staff events have provided the opportunity to focus on and bring alive the Integrated Care System. This has enabled staff to engage with the Executive Team in participating in the transitioning of the CCG into the Integrated Care Board.

We will continue to engage and consult with our staff as we move closer to the provisional transition date of 1 July 2022.

The CCG Chief Executive, supported by Executive Director colleagues, has continued to hold regular staff briefings on a Monday morning throughout the whole of 2021/22. These include a summary of the national picture on COVID, local updates on vaccinations, development of the Integrated Care System (ICS), operational pressures across the system and key information for staff (such as return to the office, accommodation, staff wellbeing as examples).

Staff health and wellbeing has been critical throughout this year and we have continued to survey our staff to find out what is important to them and build on the Lincolnshire and CCG offers.

The CCG Executive announced in late January 2022, following discussion and agreement by the Staff Engagement Group (SEG) that all staff had been allocated a 'wellbeing day' to be taken by the end of March 2022.

The NHS People Plan - the CCG continues to work with system partners with respect to the five pillars of the NHS People Plan which have been agreed across the Linolnshire System . We will continue to collaborate in this work taking account of the needs of the organisation to help deliver its strategic responsibilities across the Lincolnshire Healthcare System.

Staff Turnover – Turnover rate for the CCG staff in 2021/22 was FTE (12 months) 15.42%. The CCG monitors it staff turnover through its monthly workforce reporting process. Additionally, all staff leaving the CCG are entitled to complete an exit interview survey. The results of these surveys are analysed at regular intervals and any specific trends or concerns will be reviewed by the CCGs senior management team who will ensure that any recommendations are implemented across the organisation.

Trade Union Facility time NHS LCCG does not have any designated trade union representatives and is reporting a nil return under the Trade Union (Facility time Publication's requirements) regulations 2017.

Whistleblowing - The CCG is committed to conducting its business with honesty and integrity, through continuing to maintain and develop a culture of openness and accountability in a supportive environment, in which staff can raise any issues or concerns in accordance with the provisions of its Freedom to Speak up and Raising Concerns Policy (previously referred to as Whistleblowing).

In the financial year 2021/2022 there were no concerns raised that required investigation under this policy.

Finally, as we move into a new year and look forward we want to say thank you to all our teams. We couldn't have done it without you!

Staff Composition

We monitor a number of human resource indicators, including staff sickness rates, vacancy rates and staff turnover. This allows us to explore further management of such issues and to gain assurance around the proactive support offered to staff regarding their health and wellbeing.

We are pleased to report that although we have had some monthly peaks in absence our cumulative absence total for the year as at 31 March 2022 remains at 4.28%. This is remarkable achievement given that our staff have delivered against the significant challenges presented by COVID-19.

Of course the welfare of our staff is of paramount importance to us and when staff are absent, they will be supported by our Occupational Health Service and our Employee Assistance Programme in addition to locally and nationally agreed support packages for NHS staff which have been adapted to support staff during the Pandemic and which are in line with the broader objectives of the NHS People Plan around the wellbeing of staff.

Sickness Absence Data	
	2021/22
Total days lost	3320
Total staff years	351
Average working days lost	9.4

Staff Composition			
Payscale	Gender	Permanent/ Fixed term staff (WTE)	Bank staff (head-count)
Band2	Female	1.80	0
	Male	2.00	0
Band 3	Female	20.77	0
	Male	8.00	0
Band 4	Female	62.15	89
	Male	11.88	22
Band 5	Female	27.80	68
	Male	5.92	5
Band 6	Female	40.67	13
	Male	13.00	0
Band 7	Female	46.09	1
	Male	13.40	0
Band 8a	Female	26.88	2
	Male	15.00	0
Band 8b	Female	23.51	1
	Male	5.40	0
Band 8c	Female	14.36	1
	Male	4.00	0
Band 8d	Female	4.00	0
	Male	4.80	0
Band 9	Female	2.00	0
	Male	2.00	0
Board Members	Female	0.00	0
	Male	3.00	0
GP's/Clinical Advisors	Female	1.20	2
	Male	1.84	1
VSM	Female	3.00	0
	Male	1.00	0
TUPE Staff	Female	11.43	0
	Male	5.00	0

Sickness Absence Data

Month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Monthly Sickness	3.46%	3.24%	3.14%	3.03%	3.11%	3.58%	4.71%	5.13%	4.40%	6.03%	4.45%	4.94%
Cumulative Sickness	3.46%	3.34%	3.27%	3.21%	3.19%	3.26%	3.48%	3.70%	3.79%	4.04%	4.07%	4.28%
Total	£36,295	£35,261	£34,795	£37,498	£30,485	£44,538	£61,025	£62,535	£50,790	£74,907	£65,005	£61,453

	Female		Male		Total	
	Headcount	% of workforce	Headcount	% of workforce	Headcount	% of workforce
Board Members	0	0.00%	3	0.69%	3	0.69%
Senior Managers (Band 8c and above)	24	5.50%	12	2.75%	36	8.26%
Other members of staff	307	70.41%	90	20.64%	397	91.06%
Total	331	75.92%	105	24.08%	436	100.00%

Staff Policies

During the year we began a process of reviewing our core HR policies. This was to ensure that all policies from the former constituent CCGs were aligned to ensure that both staff and managers had access to consistent information.

Our staff intranet is regularly updated and includes a dedicated HR page which provides support and guidance for all our staff. As a result of the pandemic we have expanded our wellbeing offer to staff to make sure that they are fully supported in both their physical and mental health health. We regularly review this offer with our partner organisations to make sure our support is aligned with the wider Lincolnshire System. We continue to support disabled people and we are a Disability Confident Employer. We are committed to:

- inclusive and accessible recruitment
- communicating vacancies
- offering an interview to disabled people
- providing reasonable adjustments
- supporting existing employees

We have established processes where our staff can meet with their line manager regularly to have a one-to-one discussions. Additionally, we have in place an annual appraisal where more in depth discussions can take place to enable managers and employees to discuss performance wellbeing and career development.

Our equality information available on our website. This information is part our public commitment to meeting the equality duties placed upon us by legislation and we pledge to update this regularly. For further specific information on equalities and diversity please see Pages 50 and 51 of this annual report.

Employee Benefits and Staff Numbers (Audited)

	31-Mar-22								
	ADMIN			PROGRAMME			TOTAL		
	Perm	Other		Perm	Other		Perm	Other	
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	5,496	165	5,660	9,584	1,729	11,313	15,080	1,894	16,974
Social security costs	603	-	603	990	-	990	1,592	-	1,592
Employer contributions to the NHS Pension Scheme	1,558	-	1,558	1,086	-	1,086	2,644	-	2,644
Other pension costs	-	-	-	-	-	-	-	-	-
Apprenticeship Levy	64	-	64	-	-	-	64	-	64
Other post-employment benefits	-	-	-	-	-	-	-	-	-
Other employment benefits	-	-	-	-	-	-	-	-	-
Termination benefits	-	-	-	-	-	-	-	-	-
Gross Employee Benefits Expenditure	**7,721**	**165**	**7,885**	**11,659**	**1,729**	**13,388**	**19,380**	**1,894**	**21,274**
Less: Recoveries in respect of employee benefits (note 4.1.2)	(107)	-	(107)	(48)	-	(48)	(154)	-	(154)
Net employee benefits expenditure including capitalised costs	**7,614**	**165**	**7,779**	**11,611**	**1,729**	**13,341**	**19,225**	**1,894**	**21,119**
Less: Employee costs capitalised	-	-	-	-	-	-	-	-	-
Net employee benefits expenditure excluding capitalised costs	**7,614**	**165**	**7,779**	**11,611**	**1,729**	**13,341**	**19,225**	**1,894**	**21,119**

Parliamentary Accountability and Audit report

The CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report from page 86 onwards. An audit certificate and report is also included in this Annual Report.

Financial Statements

Entity name:	NHS Lincolnshire CCG
This year	2021-22
Last year	2020-21
This year ended	31-March-2022
Last year ended	31-March-2021
This year commencing:	01-April-2021
Last year commencing:	01-April-2020

NHS Lincolnshire CCG - Annual Accounts 2021-22

Foreword to the Accounts

2021-22 was the second year of NHS Lincolnshire Clinical Commissioning Group following the creation of the organisation in April 2020 from the 4 former Lincolnshire CCGs. The CCG had a historic deficit of £22,607,000 brought forward from the former Lincolnshire CCGs. In 2020-21, it achieved a £23,415 surplus against an allocation of £1,344,832,630.

In 2021-22, the CCG received allocations to the value of £1,516,316,197. As set out in these accounts, the CCG incurred net operating expenditure of £1,518,737,194 during 2021-22 leading to a deficit in the year of £2,420,997 (as demonstrated in Note 40 to the accounts).

It was anticipated that this would be a difficult financial year - the plan for the year was a deficit of £5,119,000. Compared to the deficit plan, the CCG has produced a favourable variance of £2,698,003 for 2021-22.

The CCG has continued to host the Lincolnshire vaccination programme. All the associated expenditure has been refunded to the CCG by NHS England & Improvement. The CCG has used a large number of agency and interim staff in order to deliver this service, which can be seen in some of the notes to the accounts and the analysis of staff costs.

As at 31 March 2022 the CCG had net liabilities of £67,149,101 (£69,075,780 as at 31 March 2021). The reduction in liabilities comes from an increase to Receivables as at March 2022, reflecting adjustments to be transacted with non NHS providers for the work done in the year.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. As set out in Note 38 – Events after the end of the reporting period, on 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, CCGs will be abolished and the functions, assets and liabilities of NHS Lincolnshire CCG will transfer to NHS Lincolnshire Integrated Care Board from the 1 July 2022. As such these Financial Statements have been prepared on a going concern basis.

These accounts have been prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021-22 the Clinical Commissioning Group and are now subject to audit.

Mr John Turner
Accountable Officer
23 June 2022

NHS Lincolnshire CCG - Annual Accounts 2021-22

CONTENTS **Note**

The Primary Statements:

Notes to the Accounts

NHS Lincolnshire CCG - Annual Accounts 2021-22

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

	Note	2021-22 £'000	2020-21 £'000
Income from sale of goods and services	2	(2,028)	(1,917)
Other operating income	2	-	-
Total operating income		**(2,028)**	**(1,917)**
Staff costs	4	21,274	16,277
Purchase of goods and services	5	1,496,709	1,329,054
Provision expense	5	2,873	621
Other Operating Expenditure	5	(91)	774
Total operating expenditure		**1,520,765**	**1,346,726**
Net Operating Expenditure		**1,518,737**	**1,344,809**
Finance income		-	-
Finance expense		-	-
Net expenditure for the Year		**1,518,737**	**1,344,809**
Net (Gain)/Loss on Transfer by Absorption		-	68,039
Total Net Expenditure for the Financial Year		**1,518,737**	**1,412,848**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Actuarial (gain)/loss in pension schemes		-	(3)
Sub total		**-**	**(3)**
Comprehensive Expenditure for the year		**1,518,737**	**1,412,845**

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Total non-current assets		-	-
Current assets:			
Trade and other receivables	17	11,442	8,157
Cash and cash equivalents	20	5	18
Total current assets		**11,447**	8,175
Non-current assets held for sale	21	-	-
Total current assets		**11,447**	8,175
Total assets		**11,447**	8,175
Current liabilities			
Trade and other payables	23	(74,855)	(76,364)
Provisions	30	(3,701)	(802)
Total current liabilities		**(78,556)**	(77,166)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(67,109)**	(68,991)
Non-current liabilities			
Provisions	30	(40)	(85)
Total non-current liabilities		**(40)**	(85)
Assets less Liabilities		**(67,149)**	(69,076)
Financed by Taxpayers' Equity			
General fund		(67,149)	(69,076)
Total taxpayers' equity:		**(67,149)**	(69,076)

The notes on pages 93 to 118 form part of this statement.

The financial statements on pages 89 to 92 were approved by the Board on 15 June 2022 and signed on its behalf by:

Accountable Officer
Mr John Turner

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

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(69,076)	**(69,076)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	**(69,076)**	**(69,076)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22		
Net operating expenditure for the financial year	(1,518,737)	**(1,518,737)**
Movements in other reserves	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(1,518,737)**	**(1,518,737)**
Net funding	1,520,664	**1,520,664**
Balance at 31 March 2022	**(67,149)**	**(67,149)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21		
Balance at 01 April 2020	0	**0**
Transfer of assets and liabilities from closed NHS bodies	(68,039)	**(68,039)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	**(68,039)**	**(68,039)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21		
Net operating costs for the financial year	(1,344,809)	(1,344,809)
Movements in other reserves	3	3
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(1,344,807)**	**(1,344,807)**
Net funding	1,343,769	1,343,769
Balance at 31 March 2021	**(69,076)**	**(69,076)**

The notes on pages 93 to 118 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(1,518,737)	(1,344,809)
Depreciation and amortisation	5	0	0
Non-cash movements arising on application of new accounting standards		0	0
Movement due to transfer by Modified Absorption		0	0
Interest paid		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in trade & other receivables	17	(3,285)	6,964
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(1,509)	(6,738)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	(18)	(25)
Increase/(decrease) in provisions	30	2,873	621
Net Cash Inflow (Outflow) from Operating Activities		**(1,520,677)**	(1,343,987)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Non-cash movements arising on application of new accounting standards		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(1,520,677)**	(1,343,987)
Cash Flows from Financing Activities			
Net funding received		1,520,664	1,343,769
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**1,520,664**	1,343,769
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(13)**	(218)
Cash & Cash Equivalents at the Beginning of the Financial Year		**18**	236
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**5**	18

The notes on pages 93 to 118 form part of this statement.

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

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

As set out in Note 38 – Events after the end of the reporting period, on 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, CCGs will be abolished and the functions, assets and liabilities of NHS Lincolnshire CCG will transfer to NHS Lincolnshire Integrated Care Board from the 1 July 2022.

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

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. It remains the case that the Government has issued a mandate to NHS England and NHS Improvement for the continued provision of services in England in 2022/23 and CCG published allocations can be found on the NHS England website for 2022/23 and 2023/24. The commissioning of health services (continuation of service) will continue after 1 July 2022 but will be through the Lincolnshire Integrated Care Board, rather than NHS Lincolnshire CCG.

Mergers or a change to the NHS Structure, such as the transfer of CCG functions to the ICB, is not considered to impact on going concern. Our considerations cover the period 12 months beyond the date of authorisation of issue of these financial statements. Taking into account the information summarised above, the Board have a reasonable expectation that the CCG (and the successor commissioning organisation) will have adequate resources to continue in operational existence for the foreseeable future.

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 fundtions 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.

Notes to the financial statements

1.4 **Joint arrangements**

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

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

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

1.5 **Pooled Budgets**

The Clinical Commissioning Group has entered into a pooled budget arrangement with Lincolnshire County Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Learning Disabilities, Child and Adolescent Mental Health, Community Equipment and Proactive Care in the Community. Note 35 to the accounts provides details of the income and expenditure.

1.6 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group. NHS Lincolnshire Clinical Commissioning Group considers it has only one operating segment, that is commissioning of healthcare services.

1.7 **Revenue**

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

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

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

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

1.8 **Employee Benefits**

1.8.1 **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.

Notes to the financial statements

1.8.2 **Retirement Benefit Costs**

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

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

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

1.9 **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.

1.10 **Grants Payable**

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

1.11 **Property, Plant & Equipment**

1.11.1 **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 clinical commissioning group;
· It is expected to be used for more than one financial year;
· The cost of the item can be measured reliably; and,
· The item has a cost of at least £5,000; or,
· Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
· Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Notes to the financial statements

1.11.2 **Measurement**

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

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

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

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

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

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

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

1.11.3 **Subsequent Expenditure**

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

1.12 **Intangible Assets**

1.12.1 **Recognition**

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

· When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
· Where the cost of the asset can be measured reliably; and,
· Where the cost is at least £5,000.

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

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

Notes to the financial statements

1.12.2 **Measurement**

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

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

1.12.3 **Depreciation, Amortisation & Impairments**

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

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

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

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

1.13 **Donated Assets**

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

1.14 **Government grant funded assets**

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

Notes to the financial statements

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

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

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

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

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

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

1.16 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.17.1 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.17.2 **The Clinical Commissioning Group as Lessor**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.18 **Cash & Cash Equivalents**

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

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

Notes to the financial statements

1.19 **Provisions**

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

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

1.20 **Clinical Negligence Costs**

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

1.21 **Non-clinical Risk Pooling**

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

1.22 **Carbon Reduction Commitment Scheme**

The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Clinical Commissioning Group does not meet the qualification criteria for this scheme.

Notes to the financial statements

1.23 **Contingent liabilities and contingent assets**

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

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

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

1.24 **Financial Assets**

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

Financial assets are classified into the following categories:
- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

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

1.25.1 **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.

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

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

1.25.3 **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.

1.25.4 **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 clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

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

Notes to the financial statements

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 clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

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

1.26 **Financial Liabilities**

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

1.27.1 **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.

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

1.27.3 **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.

1.28 **Value Added Tax**

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

1.29 **Foreign Currencies**

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

1.30 **Third Party Assets**

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

1.31 **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 clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

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

1.32.1 **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 Clinical Commissioning Group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

• It is appropriate to prepare the accounts on a 'going concern' basis;

• Continuing healthcare claims (CHC) prior to 31 March 2013 and which relate to the population of the Clinical Commissioning Group are not directly recognised in the accounts, rather, they are managed via a national risk pool. There is no contribution to the risk pool by Clinical Commissioning Groups in 2021-22. Payments for claims from NHS Lincolnshire Clinical Commissioning Group residents are made by the Clinical Commissioning Group but are recharged to the central NHS England risk pool;

• That all contract, and other, arrangements are correctly assessed for risk to exposure to additional expenditure that may require provision in accordance with the relevant International Accounting Standard (IAS 37);

• That all arrangements containing leases have been correctly identified in accordance with the relevant interpretation issued by the International Financial Reporting Interpretations Committee (IFRIC 4);

• The Clinical Commissioning Group hosts some staff and service costs for the Lincolnshire Sustainability and Transformation Partnership. Costs are shared across provider and commissioner partners on an equal basis and reported using net accounting; and

• The Better Care Fund reporting has been agreed with Lincolnshire County Council. This is shown on a net accounting basis in the accounts. Note 35 Pooled Budgets provides further detail.

1.32.2 **Sources of estimation uncertainty**

In the application of the Clinical Commissioning Group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily available from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions used are continually reviewed. Revisions to accounting estimates are recognised in the period from which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The most significant area of estimation uncertainty relates to the estimation of accruals for healthcare in the latter months of the year for which actual data was not received prior to the closure of the accounts. The material accruals relate to the provision of healthcare by the private sector mainly relating to the provision of Continuing Healthcare and Mental Health complex case provision where the BroadCare system is used to inform forecasts for contracts at individual patient level. In addition the estimation of accruals for Primary Care Prescribing relies on the forecasting methodology of the Business Services Authority (BSA).

Provisions have been made for the Clinical Commissioning Group's liability for Continuing Healthcare for nursing care provided after 1 April 2013. Claims have been made by the public where they have borne the nursing costs but believe that there was a health need which should have been met by the Clinical Commissioning Group. Each case has its own set of circumstances and appeals can be made against the initial ruling.

1.33 **Gifts**

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

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

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

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

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

On transition to IFRS 16 on 1 April 2022, the clinical commissioning group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the clinical commissioning group's incremental borrowing rate. The clinical commissioning group's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

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

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the clinical commissioning group does not expect this standard to have a material impact on non-current assets, liabilities and depreciation.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted. The application of IFRS 17 would not have a material impact on the accounts for 2020-21, were they applied in that year.

2 Other Operating Revenue

	2021-22 Total £'000	2020-21 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**(1)**	-
Prescription fees and charges	**1,516**	1,554
Other Contract income	**359**	321
Recoveries in respect of employee benefits	**154**	42
Total Income from sale of goods and services	**2,028**	**1,917**
Other operating income		
Other non contract revenue	**-**	-
Total Other operating income	**-**	**-**
Total Operating Income	**2,028**	**1,917**

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

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Source of Revenue				
NHS	-	-	-	154
Non NHS	(1)	1,516	359	-
Total	**(1)**	**1,516**	**359**	**154**

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Timing of Revenue				
Point in time	(1)	-	359	154
Over time	-	1,516	-	-
Total	**(1)**	**1,516**	**359**	**154**

Clinical Commissioning Group revenue is entirely from the supply of services. NHS Lincolnshire Clinical Commissioning Group receives no revenue from the sale of goods.

The contract income that has been recognised was not included within the opening balances of contract liabilities and contract income has not been recognised in the reporting period from performance obligations satisfied in a previous reporting period.

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 Permanent Employees £'000	Other £'000	2021-22 Total £'000
Employee Benefits			
Salaries and wages	**15,080**	**1,894**	**16,974**
Social security costs	**1,592**	**-**	**1,592**
Employer Contributions to NHS Pension scheme	**2,644**	**-**	**2,644**
Other pension costs	**-**	**-**	**-**
Apprenticeship Levy	**64**	**-**	**64**
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	19,380	1,894	21,274
Less recoveries in respect of employee benefits (note 4.1.2)	**(154)**	**-**	**(154)**
Total - Net admin employee benefits including capitalised costs	19,226	1,894	21,120
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	19,226	1,894	21,120

4.1.1 Employee benefits

	Total Permanent Employees £'000	Other £'000	2020-21 Total £'000
Employee Benefits			
Salaries and wages	12,434	435	12,869
Social security costs	1,272	-	1,272
Employer Contributions to NHS Pension scheme	2,087	-	2,087
Other pension costs	-	-	-
Apprenticeship Levy	50	-	50
Termination benefits	-	-	-
Gross employee benefits expenditure	15,843	435	16,278
Less recoveries in respect of employee benefits (note 4.1.2)	(43)	-	(43)
Total - Net admin employee benefits including capitalised costs	15,800	435	16,235
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	15,800	435	16,235

4.1.2 Recoveries in respect of employee benefits

	Permanent Employees £'000	Other £'000	2021-22 Total £'000	2020-21 Total £'000
Employee Benefits - Revenue				
Salaries and wages	**(122)**	**-**	**(122)**	(34)
Social security costs	**(15)**	**-**	**(15)**	(4)
Employer contributions to the NHS Pension Scheme	**(17)**	**-**	**(17)**	(5)
Other pension costs	**-**	**-**	**-**	-
Termination benefits	**-**	**-**	**-**	-
Total recoveries in respect of employee benefits	(154)	-	(154)	(43)

4.2 Average number of people employed

	2021-22 Permanently employed Number	Other Number	Total Number	2020-21 Permanently employed Number	Other Number	Total Number
Total	**241.96**	**124.52**	**366.48**	196.95	61.69	258.64
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	-	-	-

4.3 Exit packages agreed in the financial year

NHS Lincolnshire CCG agreed no exit packages, that being compulsory redundancies and other, or non-compulsory, departures for the financial year ending 31 March 2022 (financial year ending 31 March 2021 nil).

4.5 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:

4.5.1 Accounting valuation

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

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

4.5.2 Full actuarial (funding) valuation

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

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

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

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

5. Operating expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	8,554	5,814
Services from foundation trusts	258,428	240,349
Services from other NHS trusts	687,225	568,615
Services from Other WGA bodies	25	24
Purchase of healthcare from non-NHS bodies	224,331	199,374
Purchase of social care	-	-
General Dental services and personal dental services	-	-
Prescribing costs	149,676	150,689
General Ophthalmic services	91	80
GPMS/APMS and PCTMS	149,832	142,981
Supplies and services – clinical	313	21
Supplies and services – general	1,956	2,556
Consultancy services	597	97
Establishment	1,578	6,553
Transport	8,316	7,649
Premises	3,823	2,837
Audit fees	267	216
Other non statutory audit expenditure		
· Internal audit services	146	146
· Other services	39	19
Other professional fees	809	405
Legal fees	99	454
Education, training and conferences	604	173
Non cash apprenticeship training grants	-	-
Total Purchase of goods and services	**1,496,709**	**1,329,053**
Provision expense		
Provisions	2,873	621
Total Provision expense	**2,873**	**621**
Other Operating Expenditure		
Chair and Non Executive Members	159	320
Clinical negligence	11	14
Expected credit loss on receivables	(263)	434
Other expenditure	2	7
Total Other Operating Expenditure	**(91)**	**775**
Total operating expenditure	**1,499,491**	**1,330,449**

Audit fees stated are inclusive of non-recoverable VAT. External audit services are provided by Ernst & Young LLP, the value of their standard fees exclusive of VAT is £180,000. There are additional fees relating to the 2021-22 audit of £42,500 (exclusive of VAT). Internal audit services are provided by PricewaterhouseCoopers LLP, fees for 2021-22 were £145,960.

Within the total operating expenditure of £1,499,491,233 there are costs relating to COVID-19 activities of £19,292,519. Of this, specific allocations were received from NHS England & Improvement for the Vaccination Programme (£12,075,000) and for the Hospital Discharge Programme (£3,627,000), with the remainder funded from the CCG's main allocation.

The Clinical Commissioning Group contracts with its auditors provides for a limitation of the auditor's liability of £2,000,000.

6.1 Better Payment Practice Code

Measure of compliance	2021-22 Number	2021-22 £'000	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	50,112	464,415	43,594	446,249
Total Non-NHS Trade Invoices paid within target	49,567	459,726	42,770	440,726
Percentage of Non-NHS Trade invoices paid within target	**98.91%**	**98.99%**	**98.11%**	**98.76%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	979	967,014	3,052	847,955
Total NHS Trade Invoices Paid within target	944	966,769	2,978	845,774
Percentage of NHS Trade Invoices paid within target	**96.42%**	**99.97%**	**97.58%**	**99.74%**

The NHS aims to pay at least 95% of all NHS and non-NHS invoices within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The performance for both 2021-22 and 2020-21 demonstrates this was achieved.

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

There were no payments made under the Late Payment of Commercial Debts (Interest) Act 1998 in either 2021-22 or 2020-21.

7. Income Generation Activities

The CCG did not undertake any income generation activities in either 2020-21 or 2021-22.

8. Investment revenue

The CCG received no investment revenue during either 2020-21 or 2021-22.

9. Other gains and losses

There were no other gains and losses during either 2020-21 or 2021-22.

10.1 Finance costs

The CCG did not incur any finance costs during either 2020-21 or 2021-22.

10.2 Finance income

The CCG did not receive any finance income during either 2020-21 or 2021-22.

11. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. 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.

	2021-22 £'000	2020-21 £'000
Transfer of cash and cash equivalents	-	236
Transfer of receivables	-	15,121
Transfer of payables	-	(83,102)
Transfer of provisions	-	(290)
Net loss on transfers by absorption	**-**	**(68,035)**

NHS Lincolnshire East CCG, NHS Lincolnshire West CCG, NHS South Lincolnshire CCG and NHS South West Lincolnshire CCG merged on the 1st April 2020 to establish NHS Lincolnshire CCG. Therefore, the figures disclosed relate to adjusting for inter-trading balances between the four Clinical Commissioning Groups in 2020-21 only.

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense

	2021-22			2020-21		
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense						
Minimum lease payments	1,383	7	**1,390**	1,793	16	**1,809**
Contingent rents	-	-	**-**	-	-	**-**
Sub-lease payments	-	-	**-**	-	-	**-**
Total	**1,383**	**7**	**1,390**	**1,793**	**16**	**1,809**

12.1.2 Future minimum lease payments

	2021-22			2020-21		
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payable:						
No later than one year	1,383	5	**1,388**	1,318	10	**1,328**
Between one and five years	300	-	**300**	-	4	**4**
After five years	100	-	**100**	-	-	**-**
Total	**1,783**	**5**	**1,788**	**1,318**	**14**	**1,332**

12.2 As lessor

NHS Lincolnshire Clinical Commissioning Group is not a party to any leasing arrangements where it acts in the capacity of a lessor nor receive any associated revenue for the financial year ending 31 March 2022 (financial year ending 2021 nil).

13 Property, plant and equipment

The CCG did not hold any property, plant and equipment during either 2020-21 or 2021-22.

14 Intangible non-current assets

The CCG did not hold any intangible non-current assets during either 2020-21 or 2021-22.

15 Investment property

The CCG did not hold any investment property during either 2020-21 or 2021-22.

16 Inventories

The CCG had no inventories as at 31 March 2022 (nil as at 31 March 2021).

17.1 Trade and other receivables

	Current 2021-22 £'000	Non-Current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS receivables: Revenue	284	-	943	-
NHS prepayments	56	-	235	-
NHS accrued income	3,254	-	3,299	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	517	-	1,111	-
Non-NHS and Other WGA prepayments	1,750	-	1,627	-
Non-NHS and Other WGA accrued income	5,106	-	835	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	(185)	-	(635)	-
VAT	645	-	736	-
Other receivables and accruals	15	-	6	-
Total Trade & other receivables	**11,442**	**-**	**8,157**	**-**
Total current and non current	**11,442**		**8,157**	

17.2 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000
By up to three months	50	349	18	566
By three to six months	-	6	50	0
By more than six months	175	6	520	379
Total	**225**	**361**	**588**	**945**

17.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2021	(635)	-	**(635)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	(3)	-	**(3)**
Lifetime expected credit losses on trade and other receivables-Stage 3	163	-	**163**
Amounts written off	13	-	**13**
Changes due to modifications that did not result in derecognition	89	-	**89**
Other changes	188	-	**188**
Allowance for credit losses at 31 March 2022	**(185)**	**-**	**(185)**

18 Other financial assets

The CCG has no other financial assets in either 2020-21 or 2021-22.

19 Other current assets

The CCG has no other current assets in either 2020-21 or 2021-22.

20 Cash and cash equivalents

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	18	236
Net change in year	(13)	(218)
Balance at 31 March 2022	**5**	**18**
Made up of:		
Cash with the Government Banking Service	5	18
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**5**	**18**
Bank overdraft: Government Banking Service	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2022	**5**	**18**

There is no patients' money held by the clinical commissioning group in either 2020-21 or 2021-22.

21 Non-current assets held for sale

The CCG has no non-current assets held for sale to disclose in either 2020-21 or 2021-22.

22 Analysis of impairments and reversals

The CCG has no impairments and reversals to disclose in either 2020-21 or 2021-22.

23 Trade and other payables	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	2,802	-	1,708	-
NHS accruals	4,031	-	2,473	-
NHS deferred income	-	-	-	-
Non-NHS and Other WGA payables: Revenue	7,811	-	5,954	-
Non-NHS and Other WGA accruals	37,293	-	44,493	-
Non-NHS and Other WGA deferred income	32	-	-	-
Social security costs	239	-	194	-
VAT	-	-	-	-
Tax	200	-	177	-
Payments received on account	-	-	-	-
Other payables and accruals	22,447	-	21,365	-
Total Trade & Other Payables	**74,855**	**-**	**76,364**	**-**
Total current and non-current	**74,855**		**76,364**	

Included above are liabilities of £0, for people, due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2021; nil).

Other payables include £883,611 outstanding pension contributions at 31 March 2022 (31 March 2021, £732,930). This includes amounts related to GP pensions (£602,783) and outstanding contributions to the NHS Pension Scheme (£278,515) and NEST scheme contributions (£2,313). The in-year movement is attributable to the timing of the payments only.

24 Other financial liabilities

The CCG had no other financial liabilities during 2020-21 or 2021-22.

25 Other liabilities

The CCG had no other liabilities during 2020-21 or 2021-22.

26 Borrowings

The CCG had no borrowings in either 2020-21 or 2021-22.

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

The CCG had no private finance initiative, LIFT and other service concession arrangements during 2020-21 or 2021-22.

28. Finance lease obligations

The CCG had no finance lease obligations during either 2020-21 or 2021-22.

29. Finance lease receivables

The CCG had no finance lease receivables during either 2020-21 or 2021-22.

30 Provisions

	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Redundancy	118	-	-	-
Continuing care	3,201	11	782	56
Other	382	29	20	29
Total	**3,701**	**40**	**802**	**85**
Total current and non-current	**3,741**		**887**	

	Redundancy £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2021	**-**	**838**	**49**	**887**
Arising during the year	424	2,859	364	**3,647**
Utilised during the year	-	(16)	(2)	**(18)**
Reversed unused	(306)	(468)	-	**(774)**
Unwinding of discount	-	-	-	**-**
Change in discount rate	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	**-**
Balance at 31 March 2022	**118**	**3,212**	**411**	**3,741**
Expected timing of cash flows:				
Within one year	118	3,201	382	**3,701**
Between one and five years	-	11	29	**40**
After five years	-	-	-	**-**
Balance at 31 March 2022	**118**	**3,212**	**411**	**3,741**

Continuing Care

The Clinical Commissioning Group is responsible for liabilities, legal and financial elements relating to NHS Continuing Healthcare claims connecting to periods of care since the establishment of the former Lincolnshire Clinical Commissioning Groups (1 April 2013). The total value of NHS Continuing Healthcare provision at 31 March 2022 is based on live claim cases (including appeals) and has been evaluated based on historical experience of claim success rates and average rates within the CCG since its establishment and is £45,832 (2020-21, £225,121).

Under the accounts direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before the establishment of the Clinical Commissioning Group (CCG). The CCG is responsible for liabilities, legal and financial, relating to NHS Continuing Healthcare claims relating to periods of care since the establishment of the former Lincolnshire CCGs.

A provision has been included for Learning Disabilities Responsible Commissioner due to the unexpected and backdated costs. This assessment is based on historical experience and an average cost of a patient has been used to identify a provision value. It is estimated that £1,325,334 will be paid in less than a year. The £195,376 that was provided for in 2020-21 was reverse unused for that particular provider.

The Clinical Commissioning Group included a provision for Funded Nursing Care Continuing Healthcare as an estimate of likely costs of outcomes of Decision Support Tools. The historic success rate for each type of CHC care has been used alongside average costs of that care to identify a provision value.

A further provision of £1,381,302 has arisen in respect of historical VAT charges (2019 to 2021) relating to a key care provider that based on risk of these charges being settled has been provided for. The CCG has sought legal advice in respect of this matter.

Other

A provision has been included within Other for staff excess travel arrangements that were agreed within two of the former legacy Lincolnshire Clinical Commissioning Groups. This relates to the change of base for CCG employees. This is a four year agreement; 2021-22 is Year Three.

31 Contingencies

	2021-22 £'000	2020-21 £'000
31.1 Contingent liabilities		
Continuing Healthcare	289	400
Net value of contingent liabilities	**289**	**400**

The Clinical Commissioning Group is responsible for liabilities, legal and financial, relating to NHS Continuing Healthcare (CHC) claims for periods of care since the establishment of the Clinical Commissioning Group (including the former Lincolnshire CCGs). The Clinical Commissioning Group has provided for the anticipated costs of continuing care claims (see Note 30 Provisions above) where it is probable that it will incur costs. Note 31 Contingencies discloses the difference between the estimated value of claims and the recorded provisions as £289,091 as at 31 March 2022 (£400,216 at 31 March 2021).

31.2 Contingent assets

The CCG had no contingent assets as at 31 March 2022 (31 March 2021 nil).

32 Commitments

The CCG had no commitment balances during either 2020-21 or 2021-22.

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 and therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

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

33.1.3 Credit risk

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

33.1.4 Liquidity risk

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

33.1.5 Financial Instruments

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

33 Financial instruments cont'd

33.2 Financial assets

	Financial Assets measured at amortised cost 2021-22 £'000	Financial Assets measured at amortised cost 2020-21 £'000
Trade and other receivables with NHSE bodies	1,417	4,013
Trade and other receivables with other DHSC group bodies	7,227	1,064
Trade and other receivables with external bodies	532	1,116
Cash and cash equivalents	5	18
Total at 31 March 2022	**9,181**	**6,211**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	Financial Liabilities measured at amortised cost 2020-21 £'000
Trade and other payables with NHSE bodies	1,107	1,725
Trade and other payables with other DHSC group bodies	5,705	26,815
Trade and other payables with external bodies	67,571	47,453
Total at 31 March 2022	**74,383**	**75,993**

34. Operating segments

NHS Lincolnshire Clinical Commissioning Group considers it has only one operating segment: commissioning of healthcare services.

35 Joint arrangements - interests in joint operations

Information is disclosed in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

35.1 Interests in joint operations

The 2021-22 pooled budgets are for Learning Disabilities, Adolescent Mental Health Services, Proactive Care and Integrated Community Equipment Services (ICES). These budgets are predominantly hosted and managed on a day to day basis by Lincolnshire County Council, in instances where this is not the case the CCG jointly host and manage. As a commissioner of healthcare services, the CCG makes a contribution to the pool which is then used to purchase healthcare services. The CCG accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement in line with the 2021-22 Group Accounting Manual and as defined in IFRS 11.

The pooled budget represents contributions to the areas of identified spend; it is quite likely that the respective organisations have spend relating to the schemes contained within over and above these contributions.

All cash is transacted by all parties in the month concerned. There are no outstanding cash balances or liabilities at each period end for all organisations concerned.

Lincolnshire County Council is responsible for the production of memorandum accounts for the pooled budget. These will not be produced until after the publication of the CCG's accounts.

The Clinical Commissioning Group's share of the income and expenditure as handled by the pooled budgets in the financial year were:

	2021-22			2020-21		
	NHS Lincolnshire Clinical Commissioning Group	**Lincolnshire County Council**	**Total Pooled Budget**	NHS Lincolnshire Clinical Commissioning Group	Lincolnshire County Council	Total Pooled Budget
	2021-22 £'000	**2021-22 £'000**	**2021-22 £'000**	2020-21 £'000	2020-21 £'000	2020-21 £'000
Income						
Section 75 - Proactive Care	-	(12,478)	(12,478)	-	(11,613)	(11,613)
Section 75 - Integrated Community Equipment Services	-	(3,815)	(3,815)	-	(3,413)	(3,413)
Section 75 - Learning Disabilities	-	(26,682)	(26,682)	-	(24,233)	(24,233)
Section 75 - Child and Adolescent Mental Health	-	(10,843)	(10,843)	-	(7,936)	(7,936)
	-	**(53,818)**	**(53,818)**	-	(47,195)	(47,195)
Expenditure						
Section 75 - Proactive Care	26,491	63,576	90,067	25,202	62,581	87,783
Section 75 - Integrated Community Equipment Services	3,815	7,185	11,000	3,413	6,290	9,703
Section 75 - Learning Disabilities	26,682	87,926	114,608	24,233	85,199	109,432
Section 75 - Child and Adolescent Mental Health	10,843	11,568	22,411	7,936	8,661	16,597
	67,831	**170,255**	**238,086**	60,784	162,731	223,515
Assets	-	-	-	-	-	-
Liabilities	-	-	-	-	-	-
Net Total	**67,831**	**116,437**	**184,268**	60,784	115,535	176,320

36 NHS Lift investments

The CCG had no Lift investments during either 2020-21 or 2021-22.

37 Related party transactions

During the year none of the Governing Body Members or parties related to them have undertaken any material transactions with NHS Lincolnshire Clinical Commissioning Group, other than those set out below (transactions identified were not with the member but between the Clinical Commissioning Group and the related party).

Details of related party transactions for 2021-22 with individuals are as follows:

Board Member	**Related Party Name**	**Payments to Related Party**	**Receipts from Related Party**	**Amounts owed to Related Party**	**Amounts due from Related Party**
		£'000	**£'000**	**£'000**	**£'000**
Dr James Howarth	Spilsby Surgery	2,228	2	-	2
Dr Majid Akram	The Deepings Practice	2,099	-	-	-
Dr David Baker	Vine Street Surgery	1,292	-	-	-
		5,619	**2**	-	**2**

Details of related party transactions for 2020-21 with individuals are as follows:

Board Member	**Related Party Name**	**Payments to Related Party**	**Receipts from Related Party**	**Amounts owed to Related Party**	**Amounts due from Related Party**
		£'000	**£'000**	**£'000**	**£'000**
Dr Andrew Doddrell	Greyfriars Surgery	1,611	-	17	-
Dr James Howarth	Spilsby Surgery	349	-	-	-
Dr Majid Akram	The Deepings Practice	2,029	-	-	-
Dr David Baker	Vine Street Surgery	1,141	-	2	-
		5,130	**-**	**19**	**-**

The Department of Health & Social Care is regarded as a related party. During the year the CCG had a significant number of material transactions with entities for which the Department of Health is regarded as the parent. For example:

- NHS England
- NHS Foundation Trusts
- NHS Trusts
- NHS Arden and Greater East Midlands Commissioning Support Unit

Details of such organisations with whom the CCG had contracts for the financial year ended 31 March 2022 with are as follows:

	Payments to Related Party	**Receipts from Related Party**	**Amounts owed to Related Party**	**Amounts due from Related Party**
	£'000	**£'000**	**£'000**	**£'000**
Cambridge University Hospitals NHS Foundation Trust	4,360	-	-	-
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	1,735	-	-	-
Hull and East Yorkshire Hospitals NHS Foundation Trust	3,239	-	-	-
Norfolk And Norwich University Hospitals NHS Foundation Trust	1,009	-	-	-
North West Anglia NHS Foundation Trust	73,728	17	-	17
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	51,219	-	-	-
Nottingham University Hospitals NHS Trust	20,844	1	0	14
Royal Papworth Hospital NHS Foundation Trust	1,739	-	-	-
Sheffield Teaching Hospitals NHS Foundation Trust	2,360	-	-	-
Sherwood Forest Hospitals NHS Foundation Trust	5,647	-	-	-
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	12,601	-	-	-
United Lincolnshire Hospitals NHS Foundation Trust	531,146	308	587	606
University Hospitals of Derby & Burton NHS Foundation Trust	2,675	-	-	-
University Hospitals of Leicester NHS Foundation Trust	5,639	-	-	-
Lincolnshire Community Health Services NHS Trust	99,711	129	642	148
Lincolnshire Partnership NHS Trust	99,101	81	458	-
NHS England	101	6,326	-	5,533
NHS Arden & Greater East Midlands CSU	8,265	-	370	-
	925,119	**6,862**	**2,057**	**6,318**

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies, namely Lincolnshire County Council.

NHS Derby and Derbyshire Clinical Commissioning Group also has material transactions with all the GP Practices within its locality and membership.

The Clinical Commissioning Group has not made any provision for doubtful debts for any of the above related parties.

37 Related party transactions (continued)

Details of such organisations with whom the CCG had contracts for the financial year ended 31 March 2021 with are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Cambridge University Hospitals NHS Foundation Trust	4,338	-	-	-
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	1,722	-	-	-
Hull and East Yorkshire Hospitals NHS Foundation Trust	3,145	-	-	-
Norfolk And Norwich University Hospitals NHS Foundation Trust	990	-	-	-
North West Anglia NHS Foundation Trust	72,460	-	-	-
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	50,294	-	(18)	-
Nottingham University Hospitals NHS Trust	20,430	-	-	1
Royal Papworth Hospital NHS Foundation Trust	1,673	-	-	-
Sheffield Teaching Hospitals NHS Foundation Trust	2,314	-	-	-
Sherwood Forest Hospitals NHS Foundation Trust	5,523	-	-	-
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	12,347	-	-	-
United Lincolnshire Hospitals NHS Foundation Trust	409,354	15	10	-
University Hospitals of Derby & Burton NHS Foundation Trust	2,471	-	-	-
University Hospitals of Leicester NHS Foundation Trust	5,802	235	-	-
Lincolnshire Community Health Services NHS Trust	92,014	9	63	-
Lincolnshire Partnership NHS Trust	84,633	-	-	-
NHS England	507	5,670	55	307
NHS Arden & Greater East Midlands CSU	6,086	-	929	-
Total at 31 March 2021	**776,103**	**5,929**	**1,039**	**308**

38 Events after the end of the reporting period

On 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, Clinical Commissioning Groups will be abolished and the functions, assets and liabilities of NHS Lincolnshire CCG will transfer to NHS Lincolnshire Integrated Care Board from the 1 July 2022. This constitutes a non-adjusting event after the reporting period. This does not impact the basis of preparation of these financial statements.

39 Third party assets

The CCG did not hold any third party assets during either 2020-21 or 2021-22.

40 Financial performance targets

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

	2021-22 Target £'000	**2021-22 Performance £'000**	2020-21 Target £'000	2020-21 Performance £'000
Expenditure not to exceed income	1,518,344	1,520,765	1,346,750	1,346,726
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	1,516,316	1,518,737	1,344,833	1,344,809
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	15,295	14,606	15,122	14,038

41 Analysis of charitable reserves

The CCG did not hold any charitable reserves during either 2020-21 or 2021-22.

42 Losses and special payments

42.1 Losses

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

	Total Number of Cases 2021-22 Number	**Total Value of Cases 2021-22 £'000**	Total Number of Cases 2020-21 Number	Total Value of Cases 2020-21 £'000
Administrative write-offs	7	13	-	-
Fruitless payments	-	-	1	2
Total	**7**	**13**	**1**	**2**

42.2 Special payments

	Total Number of Cases 2021-22 Number	**Total Value of Cases 2021-22 £'000**	Total Number of Cases 2020-21 Number	Total Value of Cases 2020-21 £'000
Extra Contractual Payments	1	1	-	-
Ex Gratia Payments	1	1	-	-
Total	**2**	**2**	**-**	**-**

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

Opinion

We have audited the financial statements of NHS Lincolnshire Clinical Commissioning Group ("the CCG") for the year ended 31 March 2022 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 42, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the 2021/22 HM Treasury's Financial Reporting Manual (the 2021/22 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2021/22 and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England).

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Lincolnshire Clinical Commissioning Group as at 31 March 2022 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021 to 2022; and
- have been properly prepared in accordance with the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements 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 the Comptroller and Auditor General's AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of Matter – Transition to an Integrated Care Board

We draw attention to Note 38 - Events after the end of the reporting period, which describes the NHS Lincolnshire Clinical Commissioning Group's transition into the NHS Lincolnshire Integrated Care Board from the 1 July 2022. Our opinion is not modified in respect of this matter.

Conclusions relating to going concern

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

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's, or the successor body's, ability to continue as a going concern for a period of 12 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. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the CCG's ability to continue as a going concern.

Other information

The other information comprises the information included in the Annual Report and Accounts 2021/22, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the Annual Report and Accounts 2021/22.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

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 course of 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 themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on the Remuneration and Staff Report

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued in the Department of Health and Social Care Group Accounting Manual 2021/22; or
- we issue a report in the public interest under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we make a written recommendation to the CCG under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have nothing to report in these respects.

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014

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

At 31 March 2022, NHS Lincolnshire CCG has reported a deficit of £2,421,000 against its Revenue allocation for the financial year.

Under section 223I(3) of the National Health Service Act 2006, a clinical commissioning group must ensure that its revenue resource use in a financial year does not exceed the amount specified by direction of the NHS Commissioning Board.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities in respect of the Accounts, set out on page 58, 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.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or has no realistic alternative but to do so.

As explained in the Annual Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibility 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant are the Health and Social Care Act 2012 and other legislation governing NHS CCGs, as well as relevant employment laws of the United Kingdom. In addition, the CCG has to comply with laws and regulations in the areas of anti-bribery and corruption and data protection.

- We understood how NHS Lincolnshire Clinical Commissioning Group is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, the head of internal audit and those charged with governance, and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. This includes appropriate oversight of those charged with governance, a culture of honesty and ethical behaviour and placing an emphasis on fraud prevention, to reduce opportunities for fraud to take place, and fraud deterrence, which could persuade individuals not to commit fraud because of the likelihood of detection and punishment.

- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy, testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the CCG is engaging in any transactions outside the usual course of business.

- Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures involved enquiry of management, and those charged with governance, reading and reviewing relevant meeting minutes of those charged with governance and the Governing Body and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations.

- We addressed our fraud risk related to the overstatement/ understatement of expenditure accruals and prepayments by undertaking testing to gain assurance over the completeness, existence and valuation of a sample of manual accruals raised outside the purchase order system and prepayments. We checked that criteria for recognition had been met and the estimate of the value was supportable with reference to underlying evidence. We also performed sample testing of expenditure cut-off and unrecorded liabilities to ensure that transactions had been recorded in the correct financial year.

- We addressed our fraud risks related to management override through implementation of a journal entry testing strategy, assessing accounting estimates for evidence of management bias and evaluating the business rationale for significant unusual transactions. This included testing postings in the general ledger that fell outside of the standard transaction process flow.

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2020, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in December 2021 as to whether the CCG had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 (as amended) to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 (as amended) requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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.

Report on Other Legal and Regulatory Requirements

Regularity opinion

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (as amended) (the "Code of Audit Practice").

We are required to obtain evidence sufficient to give an opinion on whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Qualified opinion in 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, except for the incurrence of expenditure in excess of the specified revenue resource limit as set out in Note 40 to the financial statements.

The CCG has reported a deficit of £2.421 million for the 2021/22 financial year.

We referred this matter to the Secretary of State on 23 June 2022 under section 30 of the Local Audit and Accountability Act 2014.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have issued our Auditor's Annual Report for the year ended 31 March 2022. We have completed our work on the value for money arrangements and will report the outcome of our work in our commentary on those arrangements within the Auditor's Annual Report.

Until we have completed these procedures, we are unable to certify that we have completed the audit of the accounts in accordance with the requirements of the Local Audit and Accountability Act 2014 (as amended) and the Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the members of the Governing Body of NHS Lincolnshire Clinical Commissioning Group in accordance with Part 5 of the Local Audit and Accountability Act 2014 (as amended) and for no other purpose. 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 members as a body, for our audit work, for this report, or for the opinions we have formed.

Hayley Clark (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Birmingham

23 June 2022

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