NHS
Lincolnshire
Clinical Commissioning Group

NHS Lincolnshire CCG

Annual Report

2022/23

1 April 2022 - 30 June 2022

Contents

Statement by the Acting CCG Chair and Accountable Officer (Chief Executive)

Welcome to the final Annual Report 2022/23 for NHS Lincolnshire Clinical Commissioning Group which covers the period 1 April 2022 to 30 June 2022. The Annual Report of Lincolnshire CCG has been prepared in accordance with the National Health Service Act 2006 (as amended) Directions by NHS England, in respect of Clinical Commissioning Groups' Annual Report.

The last 18 months in the NHS has been an extraordinary and extremely challenging time for the whole of the country, and the population of Lincolnshire. There have been significant difficulties across the health and social care system and the impact on patients, the CCG and its staff, partners and NHS workforce colleagues has been profound.

At its final meeting on 29 June 2022, the CCG Board reflected on the exceptional work staff undertook on behalf of Lincolnshire since the CCG's formation on 1 April 2020, in which we can all take immense pride. Our staff have together faced the unprecedented challenge and impact of the pandemic, with all of its profound effects on our population, patients, partners, NHS workforce colleagues, and the entirety of the NHS itself; and will continue to address the consequences and service recovery demands in the coming years.

Staff responded superbly and consistently went the 'extra mile', adapted rapidly to changing circumstances and demands, and served Lincolnshire exceptionally well. In meeting these challenges CCG staff worked closely with all of the CCG's partners across Lincolnshire and together made great progress in system and partnership working, in improving care for patients, in how health inequalities are tackled, in improving health outcomes and to social justice. Their hard work, commitment and dedication are hugely important and valued and we would like to express our genuine thanks and appreciation.

We would also like to say a big thank you to our partners who the CCG worked with very closely across the health and care system in Lincolnshire, be that our GPs, our NHS Trust colleagues, and those in local government and in the care and third sector.

There was a huge team effort in terms of getting us through the COVID-19 pandemic and out the other side.

There has been a number of key highlights over the last 18 months of the CCG, but one of the most significant has been the vaccination programme. We are immensely proud of the vaccination programme in Lincolnshire which is still ongoing at the time of writing. This was not just an NHS vaccination programme; it was a whole healthcare system programme. Right from its instigation the vaccination programme was up there amongst the leading systems in the whole of the country and Lincolnshire was one of the first systems to establish hospital hubs for vaccinations, along with mass vaccination sites. We would like to express our heartfelt appreciation to everyone involved in its delivery to date and those of you who continued to support the rollout of the booster and flu campaign the following Autumn.

Alongside dealing with the response to the pandemic and delivery of the vaccination programme, we have all been working really hard across the health and care system to fully restore NHS services and again, we would like to pay tribute to everybody across primary care, mental health, our community services as well as hospital services in terms of their input and contribution to that. We have made excellent progress, particularly in areas such as operations and elective care, cancer, mental health, learning disabilities, autism, children and young people and primary care. We have also made good progress in the reduction of 104-week waits.

One area of particular note is the conclusion of the Acute Services Review (ASR). This related to the review of four of NHS Lincolnshire's services which included a very detailed and comprehensive public consultation and in turn a range of engagement exercises with the public. The outcome of the consultation and all associated feedback was presented to the CCG Board at its meeting held on 25 May 2022 and the four service change proposals were approved. There is further information on this later in the report under the section on key achievements.

Other areas of ongoing good progress made include our mental health transformation, which has been recognised nationally. We have a very significant programme of work taking place and which is being led by the Chief Executive, Lincolnshire Partnership NHS Foundation Trust (LPFT) but working very closely with colleagues across the broader health and care system. We have seen the ongoing good development of primary care. We have 15 Primary Care Networks (PCNs) across Lincolnshire that are now well established and are undertaking some fantastic work and played a lead role in the delivery of the vaccination programme.

We have also been recognised, both nationally and regionally, as undertaking some important and excellent work in terms of tackling health inequalities and this remains one of the most significant challenges that we face going forward. We have also made good progress in ensuring that safeguarding continues to work really well with the CCG Safeguarding Team dovetailing with the teams within Lincolnshire County Council.

However, we know there is much more to do, and our financial position remains challenging and also NHS workforce, with a number of vacancies in key clinical substantive roles, but there is a great deal of really good work taking place to address both of those challenges.

In terms of final comments on the last 18 months, in July 2022 Her Majesty the Queen awarded the George Cross, to the four National Health Services of the UK, in recognition of over 74 years of service including the exceptional efforts of NHS staff across the country during the COVID-19 pandemic. It was absolutely wonderful to be part of that.

From 1 July 2022, there will be significant changes to the NHS structure following the implementation of the Health and Care Act 2022 which completed the parliamentary process and received Royal Assent on 28 April. This confirms the establishment of statutory Integrated Care Systems (ICSs) on 1 July 2022.

The Health and Care Bill requires ICS to have two statutory functions:

- Integrated Care Board (ICB) bringing the NHS together locally to improve population health and care. In addition, the functions currently performed by Clinical Commissioning Groups will be conferred onto ICBs.
- Integrated Care Partnership (ICP): a joint committee of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly created by the County Council and Integrated Care Board with specific statutory responsibility for preparing an Integrated Care Strategy for the ICS footprint.

ICSs 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.

In establishing the Integrated Care Boards on 1 July, Clinical Commissioning Groups will be subsumed into the ICB and will be statutorily dissolved at midnight on 30 June 2022.

We would like to express our thanks to those CCG Board Members who will not be going forward with the ICB, namely Mrs Fenella Chambers, Ms Sue Liburd, Mrs Janet Inman and Mr Graham Felston. Their support and guidance under the CCG umbrella and as part of the transition process for the ICB have been invaluable.

As we step into the ICB arrangements, we do so with ambition, a positive mindset to meet the challenges ahead, and a determination to use the opportunities of the Integrated Care System to best effect for our patients and communities.

The CCG leaves the ICB with a strong and impressive legacy to build on, and an excellent staff team.

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
Accountable Office
(Chief Executive)

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 807,813 registered patients across 83 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 1 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 GPs), 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 Quarter One 2022/23 was £378m 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 1 April 2021, Lincolnshire became a Designate ICS. As a key partner in the developing Integrated Care System (ICS) we work closely with local hospital and community 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, which 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 below.

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 prevent 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 provides the CCG with regular feedback from patients on their experiences of accessing NHS services and assists 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:

Homepage - Healthwatch

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 Accountable Officer 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 is informed about local health services and involved in any key decisions we make about the services we commission.

Primary Care Networks

Primary Care Networks (PCNs) are groups of GP practices working together with other local organisations, such as community, mental health, social care, pharmacy, hospital and voluntary services. They will support the needs of a population that has grown, is living longer, and may need to access local health services more often.

Our GP practices have been working together for a number of years, through federations, networks, clusters and partnerships. The NHS Long Term Plan and the new five-year framework for the GP contract, published in January 2019, make this more formal without creating new statutory bodies.

In practice PCNs will build on the work already undertaken and the current services offered by your GP practice. It will mean greater provision of proactive, personalised and coordinated care, as well as more integration between health and social care. This will provide clear benefits for patients and GPs.

PCNs are based on GP-registered lists and typically serve communities of 30,000 to 50,000. There are some smaller and some larger than this. They are designed to still provide the personalised care valued by patients but be big enough to have impact and economies of scale through closer working.

All GP practices across the country have been encouraged to be part of a local PCN, with the aim that PCNs cover the whole country. In Lincolnshire, we have 100% coverage via 14 PCNs.

Further details can be found here:

https://lincolnshire.icb.nhs.uk/about-us/our-gp-members/primary-care-networks/

Our vision and priorities

Our vision and priorities shape who we are and how we work, and help us to make the right decisions on 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 during the first three months of 2022/23, and it is anticipated will become a key building block of our Integrated Care System (ICS).

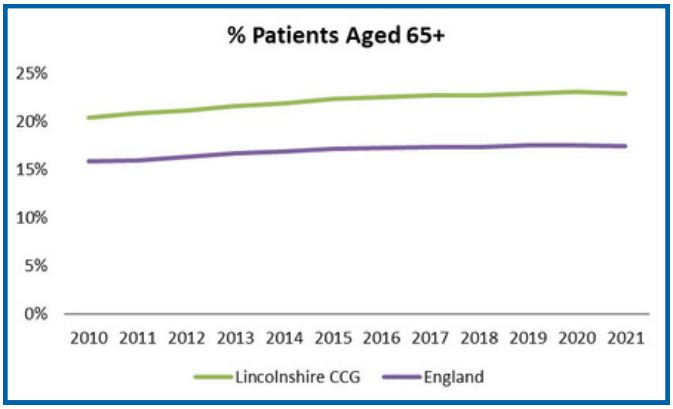
Social, community and human rights issues

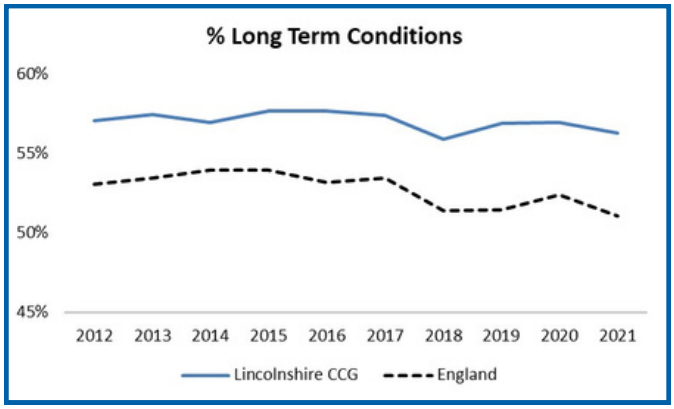
The CCG places a high priority on ensuring that it discharges its obligations as a good corporate citizen and takes into account its responsibilities towards serving and meeting the needs of local people, including safeguarding their human rights.

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 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 the 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 NHS England are not trading bodies.

However, the CCG will cease to be in existence after the 30th June 2022 as all CCGs in the country will be abolished. The CCG will be replaced by NHS Lincolnshire Integrated Care Board with effect from 1 July 2022.

Performance Summary - Chief Executive

2021/22 was clearly 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 coordinated emergency response, and some non-essential services were temporarily suspended due to the immediate pressures. Much of this has impacted 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'. These demands continued through the period of April-June 2022.

As we begin to manage living with COVID, however, we are beginning to be able to see significant strides in our recovery plan as a result of protecting elective capacity in COVID-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 number 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, the 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 as part of the National COVID Restore Agenda, which moves away from a focus on constitutional standards to the expectation of 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	2021/22 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 Governing Body (GB) and Quality Patient Experience Committee (QPEC) 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 undertaken to improve performance.

COVID-19 Recovery

Following the urgent response to the COVID-19 response 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.

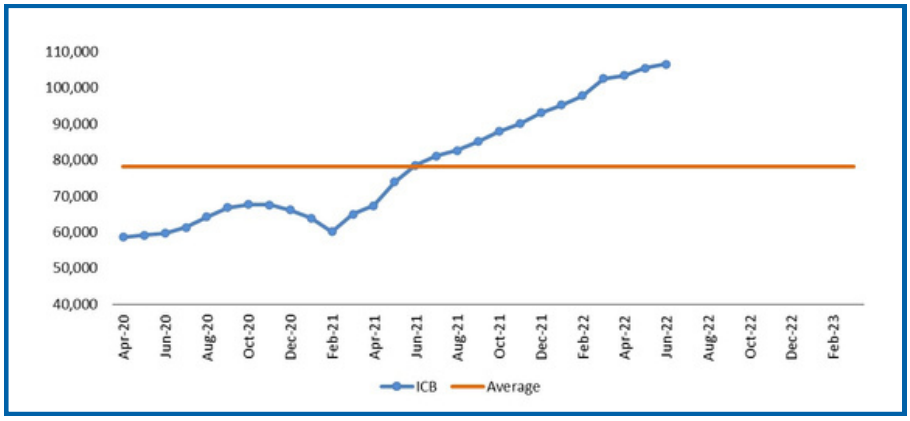
Planned Care

Lincolnshire CCG works with a wide range of providers to improve the time patients wait for treatments. The COVID-19 pandemic 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 Quarter One 2022, the performance focus remained to slow the increase of the elective waiting list size, along with reducing the number of patients having to wait 104 weeks (two years) for treatment to zero by July 2022.

As expected, the total waiting list size for Lincolnshire patients at all hospitals has continued to increase and the reported figure for July 2022 was 106,567.

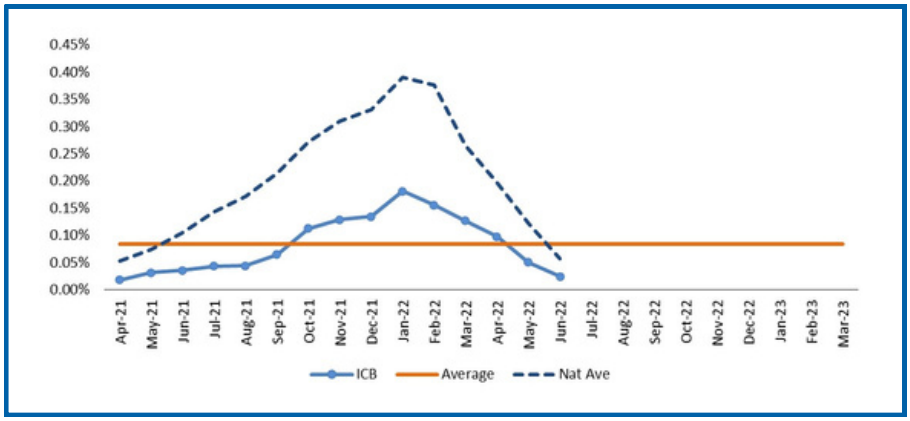
However, the total elective activity is above plan and there are signs that this is beginning to stabilise as illustrated in the run chart below.

Total waiting list



We have continued to strengthen our oversight of patients waiting over 104 weeks with our main acute providers, and as a result of this work the percentage of our waiting list has remained significantly under the national average (0.02 per cent compared to 0.06 per cent and the number of patients waiting over 104 weeks has reduced from a peak of 172 to 26.

Percentage of patients waiting over 104 weeks



The Elective Activity Coordination Hub (EACH) has expanded to support the further transfer of clinically suitable patients on current waiting lists to alternative providers where waiting times are shorter as well as linking in with out-of-county providers to offer support for Lincolnshire patients to 'wait well'.

Emphasis is now being placed on reducing the number of patients waiting over 78 weeks by the end of March 2023.

This includes a process of validation to ensure patients are being offered the most appropriate appointment for their needs and increasing capacity within

Providers where possible. Emphasis also continues to be placed on increasing both Advice and Guidance (A&G) 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 continues to be engaged in the Midlands Elective Delivery Programme both sharing, and learning from, best practice for certain clinical specialities to ensure we maximise opportunities to deliver the best clinical outcomes and experience for patients.

The re-procured community Optometrist Triage Assessment and Treatment Service has led 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.

A new Community Diagnostic Centre (CDC) on Grantham's Gonerby Road commenced seeing patients in the last week of April and was formally opened by a local councillor and ULHT's Director of Nursing on 6th May.

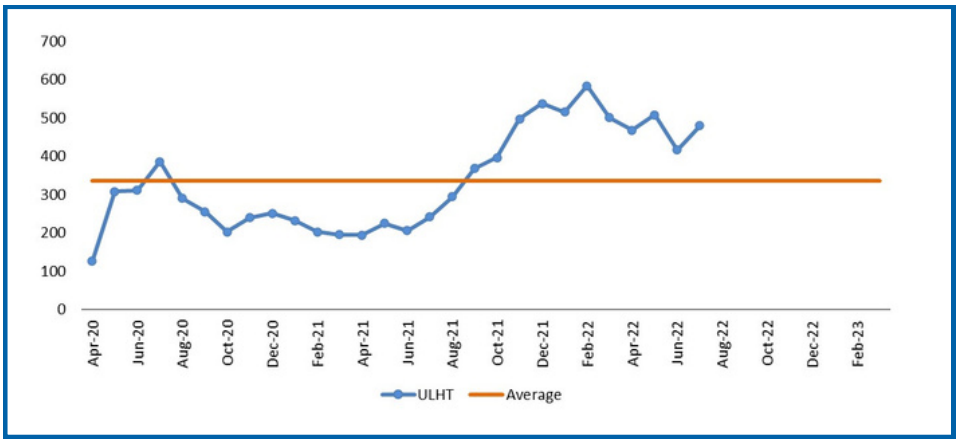
Services include ultrasound, echo and plain X-ray. Up to the end of Quarter One, we delivered 2,657 NOUS, 443 ECHO and 4,872 plain film activity through the CDC project. Unfortunately, the fire at Lincoln County at the end of March affected diagnostic capacity, particularly in MRI, CT and DEXA, however, initial recovery of waiting times was achieved quickly with support from neighbouring providers and mobile units.

The Lincolnshire system 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. 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. 85 per cent of GP Practices have requested the equipment, training sessions on how to use the new scopes are being delivered throughout September and October. ULHT has since seen A&G requests increase from 50 requests per month to over 370 requests as of August 2022. The service provided a consistent average response rate of 97 per cent within 48 hours since the implementation of the enhanced A&G service, which is an increase on the previous average of 72 per cent. Dermatology A&G requests now equate to over 25 per cent of routine dermatology referrals.

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. Nationally the focus remains on reducing the backlog of patients waiting 62 and 104 days for treatment. In June 2022, 416 patients were waiting more than 62 days for treatment, a reduction from the peak of 538 in December.

Patients waiting more than 62 days for treatment (LCCG)



Improvement work within the cancer pathway has been slow to progress over the last year of the CCG due to the sheer size of the backlog following COVID-19 coupled with staffing shortages in a number of key areas due to sickness and difficulty recruiting. However, the backlog position improved from December 2021. There has also been an improvement in the new 28-day Faster Diagnosis Standard, helping ensure patients are diagnosed or have cancer ruled out within 28 days of being referred urgently by their GP for suspected cancer. Colorectal cancer pathways currently account for 62 per cent of the backlog, with an intense recovery programme in place to recover the colorectal backlog working in collaboration across the healthcare system, locally, regionally and nationally.

Cancer two-week wait (2WW) referrals increased by 26 per cent compared to pre-COVID levels. Working collaboratively across the system we developed alternative pathways to reduce the number of patients accessing specialist care utilising a 2WW pathway - a great example of this is the Mastalgia pathway, which ensures patients presenting with breast pain alone are seen locally in a community setting by a specialist instead of having to go through the 2WW suspected cancer pathway, reducing anxiety and improving the patient experience.

In the early part of the year, we saw the rollout of the NHS Galleri trial in Lincolnshire. In a first of its kind, the trial assesses how well the test works in the NHS and whether the technology can be used as a tool to screen people with no cancer symptoms. The trial aims to recruit 140,000 participants nationally, with over 4,000 in Lincolnshire. The outcome of the trial will be shared in due course, with Phases 2 & 3 of the trial to be rolled out in 2023 & 2024 respectively.

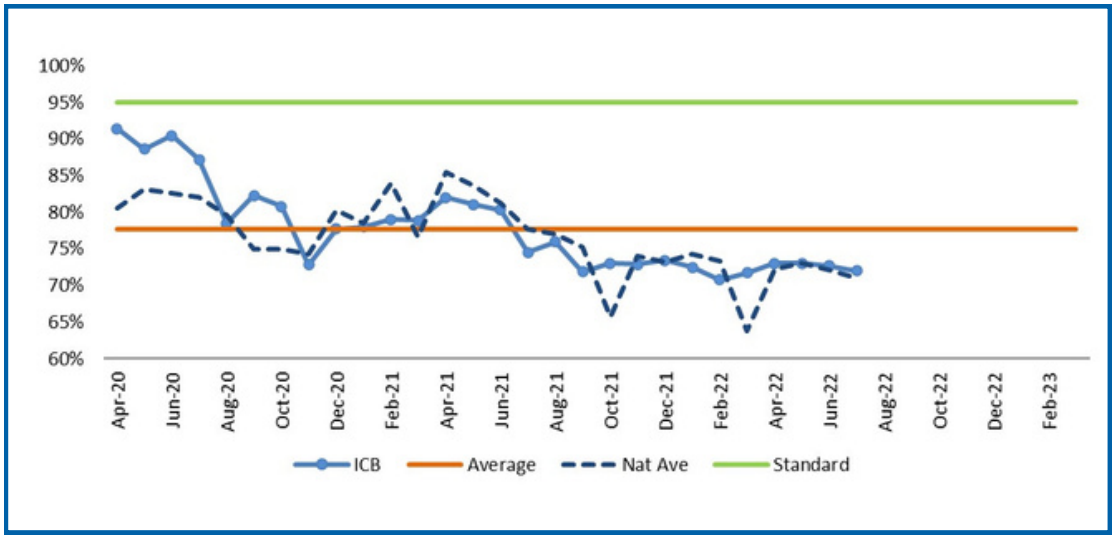
The Living with Cancer (LWC) programme was also severely impacted by the COVID pandemic, however, remaining staff in ULHT continued to support people LWC by completing Holistic Needs Assessments, and support from the Macmillan Information Centres and other support mechanisms were moved online. Restore and Recovery plans were developed in May 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 resulted in the capacity to deliver a re-planned programme, focusing on the implementation of the NHS personalised care model, addressing health inequalities, using existing assets, workforce development and digitalisation.

Urgent Care

The core standard for urgent & emergency care (UEC) is that all patients should be seen and discharged from A&E within four hours. However, there continue to be challenges with the delivery of urgent care targets, and in particular the delivery of the four-hour accident and emergency (A&E) target.

However, as shown in the run chart below, these challenges experienced have been shared nationally; many areas continue to see rising attendance and an impact on their performance levels as well. For the constitutional 4-hour A&E target, Lincolnshire performance consistently remained close to the national performance.

A&E admission, transfer, discharge within 4 hours



The Lincolnshire system continued to experience significant pressure within urgent care throughout 2022/23, with levels of escalation throughout the summer period being equal to those typically seen in winter. There has been an ongoing deterioration in the number of patients waiting more than 12 hours in the emergency department and the number of ambulance handover delays outside Lincolnshire A&E departments remains high.

The pressure on services spanning the entire UEC pathways was felt within all partner organisations. This presented the system with a greater challenge than seen in previous years.

The UEC programme focuses on discharge and flow, attendance and admission avoidance and management of the risk within the pathways due to the level of pressure.

The 100-day discharge challenge programme of work reached the 100-day review mark, and the Lincolnshire system was keen to ensure that all aspects were delivered, not just priority areas. Integrated Discharge Hubs have been established on the two main acute sites, bringing together the partners involved in supported discharge to ensure timely discharge for pathways 1, 2 and 3. The acute improvement work within ULHT is focused on the simple/Pathway 0 discharges.

The 2-hour Urgent Community Response service is now fully established and in conjunction with wider out-of-hospital services, such as the evolving Virtual Ward model of care, is supporting the Lincolnshire population to be cared for at home wherever safe and appropriate to do so.

This helps to reduce the risk to patients around hospital-acquired infections and deconditioning that are a consequence of hospital admissions for the frail population

The level of capacity and scope of the virtual wards will continue to increase and expand throughout the second half of the year. The Mental Health Urgent Assessment Centre is fully operational providing an alternative to emergency departments (ED) for those patients requiring mental health support without a physical health need. This service is well utilised by police and ambulance staff and has a good working relationship with Emergency Departments.

The System convened a clinical summit to bring together clinicians and professionals from across the system to ensure that there was a sound understanding of where the risks lie, and a robust plan to address these.

The outputs of this event informed the final development of the winter plan with strong strategic leadership and oversight. A number of specific winter schemes were also put in place to provide additional capacity, efficiencies in service response and robust oversight of the operational position.

Moving into the second half of the year, a Lincolnshire system strategy for Urgent and Emergency Care is to be developed, linking to the national strategy review, the winter assurance framework, learning from ongoing transformation and the output of the clinical summit.

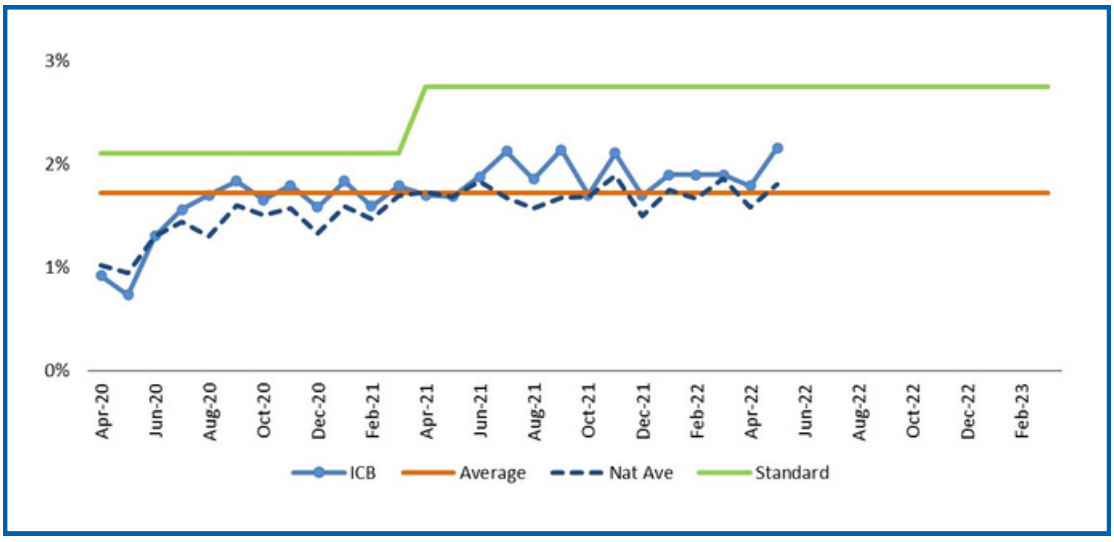
Mental Health

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 acute services so more people can access them. The Lincolnshire IAPT service aimed to achieve a 25 per cent target access rate by April 2022. The target achieved was slightly below at 20.7 per cent but above the national average.

The service has had a high number of trainees which impacted on capacity but this will in time improve overall capacity.



A number of trainees qualified in March and September 2022 which helped improve delivery into 2022/23, and a further 18 trainees commenced in October 2022.

Trainees currently work to 60 per cent capacity whilst studying but upon qualification, this increases to 100 per cent, with the courses lasting for a year. The Recovery rate was maintained above the 50 per cent national target.

A new online system was also been implemented to support self-referral by patients via the service website. And increase in expected access rates resulted in a paper submitted to the LPFT Sustainability Committee, which highlighted this and delivery challenges for the future.

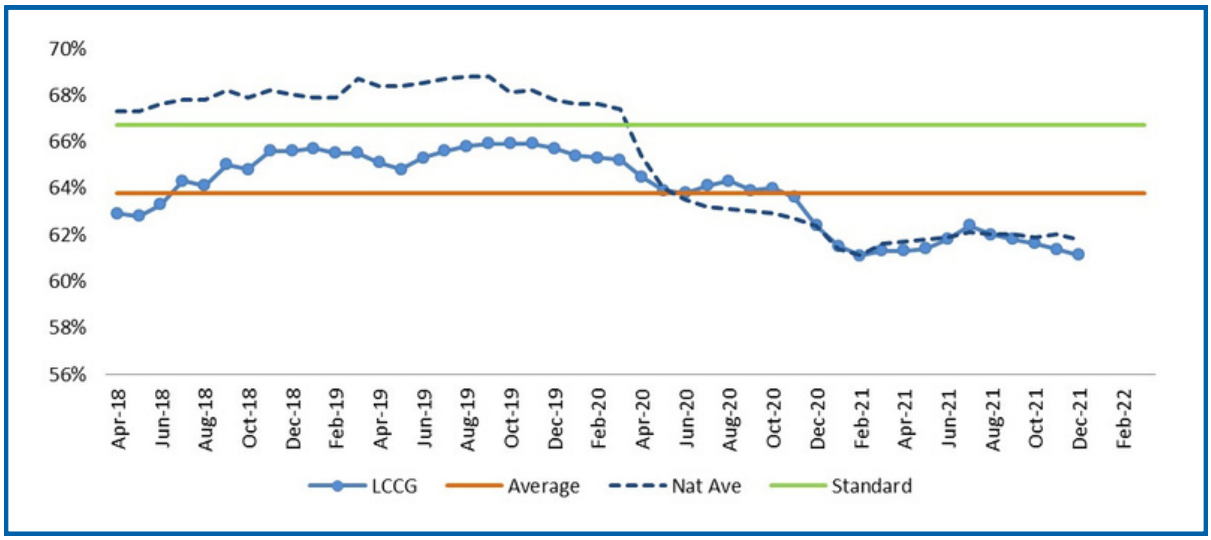
Dementia Diagnosis Rate

As mentioned earlier in this report people registered to GP practices in Lincolnshire ICB have a higher than average incidence of long standing health conditions, including dementia.

Early diagnosis of dementia ensures that people can be signposted to the services available to help them manage their conditions, and effective management of these conditions can improve the patient's quality of life and reduce the number of acute hospital stays required.

The dementia diagnosis standard is now calculated by how many patients are diagnosed with dementia against an estimated prevalence based on the population, with the standard being that two thirds (66.7 per cent) ofthe estimated prevalence shouldbe diagnosed as having dementia.

At the end of June 2022, 61.2 per cent of Lincolnshire patients had a diagnosis below the 66.7 per cent standard. This had declined from the previous year due to the impact of the pandemic, however, has followed the national trend. This was perhaps due to less people coming forward to see their GP with a memory concern, primary care resources being redirected to the COVID-19 vaccination programme and waits for diagnosis in secondary care (impacted by the pandemic).



As we moved into 2022/23 and the ICB, a new GP clinical lead was appointed to work with primary care to undertake education and support embedding of the Lincolnshire dementia pathway and referral form, designed to improve performance in this area.

Work also commenced with LPFT to improve waiting times for diagnosis.

Learning Disability Annual Health Checks

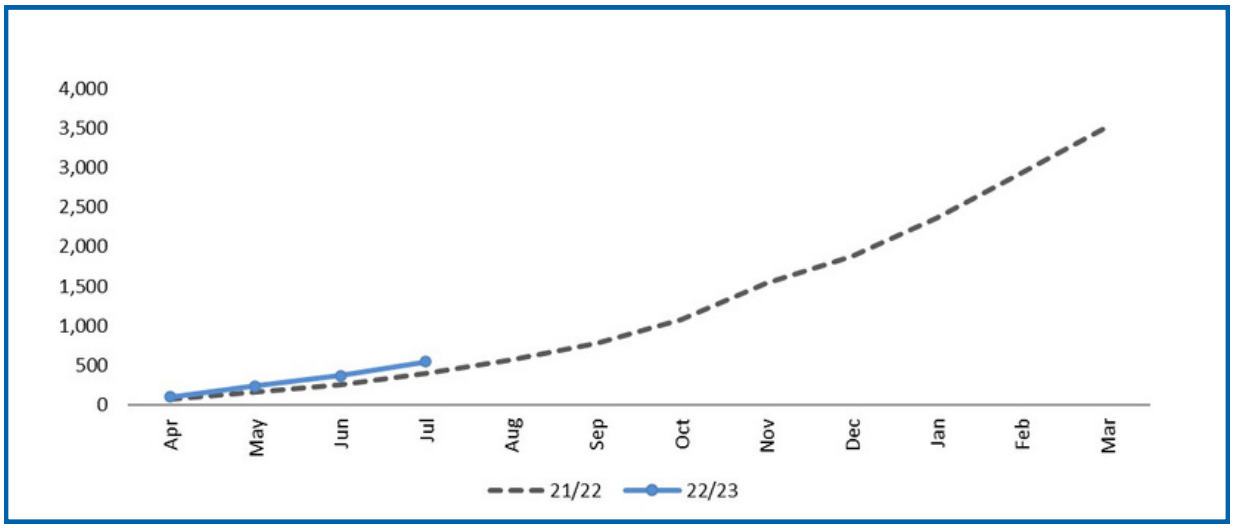
Annual Health Checks support people with a Learning Disability stay well by helping to find health problems earlier and giving time to agree on the right care.

The CCG worked closely with primary care and system partners to refocus efforts on improving access to Annual Health Checks for people with a Learning Disability, which commenced in 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.

As a result, an additional 1,638 annual health checks were delivered in 2021/22 when compared to 2019/20, meaning

the CCG achieved 79.3 per cent against the national target of 80 per cent of people registered with their practice as having a Learning Disability receiving a Health Check.

This success continued into 2022/23 where at the end of June 2022, 371 health checks had been completed compared to 254 in June 2021.



Key Achievements in 2022 / 2023 (months 1 - 3)

Integrated Care System

Following the publication of the government's Health and Care Bill in 2021, the Lincolnshire NHS System has been preparing for the transition to the new NHS architecture.

On the 28 April 2022 the Health and Care Bill received Royal Assent and the Health and Care Act 2022 (the Act) was passed into law. Clinical Commissioning Groups were dissolved and replaced with an integrated Care Board (ICB) on 1 July 2022.

Lincolnshire CCG prepared for the transition to the Lincolnshire Integrated Care Board to ensure it had the capacity to discharge the statutory functions conferred on it.

The process to appoint the statutory roles to the NHS Lincolnshire ICB was completed in June 2022 with Sir Andrew Cash appointed as ICB Interim Chair and Mr John Turner, ICB Chief Executive.

Up until 1 July the CCG continued to develop the ICB Constitution, policies and governance arrangements in conjunction NHS Partners and the Local Authority.

Review of four NHS services in Lincolnshire

On 29 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 30 September to 23 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 30 September 2021.

It ran for 12 weeks until 23 December 2021 and was widely promoted via stakeholder organisations, leaflet deliveries to 370,000 households across Lincolnshire, posters and leaflets in GP practices and public locations, online and traditional media coverage and advertisements, and to United Lincolnshire Hospitals NHS Trust (ULHT) and Lincolnshire Community Health Services NHS Trust (LCHS) service users, among others.

Throughout the consultation, the CCG, supported by partner organisations, undertook 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 advertised locally, online and across social media at a variety of locations and times.

During the consultation period, stakeholders were invited to provide feedback through:

- A consultation questionnaire for all residents, stakeholders and organisations; the questionnaire was available online (hosted by ORS) and paper questionnaires were widely circulated and available on request. An easy-read version and translated documents were also available.

- Engagement activities undertaken by NHS Lincolnshire CCG including:
    - Written or email submissions from residents, stakeholders and organisations.
    - Petitions (organised by two local campaign groups and submitted to ORS).

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 detailed service.

The final report was received by the CCG in March 2022. 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 finalised.

The Decision-Making Business Case (DMBC) was presented to the CCG Board at its meeting held on 25 May and the four services change proposals approved.

- Consolidate planned orthopaedic surgery at Grantham and District Hospital, to establish a ‘centre of excellence’ in Lincolnshire.
- Establish a dedicated day-case centre at County Hospital Louth for planned orthopaedic surgery.
- Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre (UTC).
- Develop integrated community/acute medical beds at Grantham and District Hospital, in place of the current acute medical beds.
- Consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service.

Community Diagnostic Centre (CDC)

Lincolnshire's first Community Diagnostic Centre was formally opened on Friday 6 May 2022. The facility, which is located just north of Grantham town centre, will be known as the Gonerby Road Community Diagnostic Centre and is part of a first wave of 40 Community Diagnostic Centres (CDCs) set to open across England.

Improving diagnostic capacity is recognised as a priority in the NHS Long-Term Plan, and the new Community Diagnostic Centres will play a crucial role in the delivery of diagnostic services, which will support the delivery of treatments for cancer, cardiovascular disease, and stroke.

Thousands of patients locally and from across the county will benefit from what the new Gonerby Road Community Diagnostic Centre has to offer, including x-ray and general ultrasound.

The site of the new Gonerby Road Community Diagnostic Centre had previously been used during the height of the COVID pandemic to deliver outpatient services away from an acute hospital setting. In its new guise as a CDC, it began delivering diagnostic services on Monday 25 April.

Adult Hearing Loss service

The Adult Hearing Loss service in Lincolnshire has been expanded to cover patients registered at GP practices in and around Lincoln. Originally launched in 2017, the Adult Hearing Loss service has been running successfully in the east, south and south west of the county, providing a vital service for people aged 50 and over whose hearing problems are assessed as non-complex.

Expanding the service not only allowed the CCG to equalise access to the service for all patients in Lincolnshire, it also allowed care to be moved closer to home. In addition, an at-home service was put in place across Lincolnshire for those patients who are unable to travel and/or have mobility issues, so they can access the Adult Hearing Loss service in their own homes. The Adult Hearing Loss service also offers patients a 24/7 telephone helpline, extended hours access – including, in some cases, seven-day access – and shorter waiting times, as well as easy access to repairs and replacement batteries, including a postal service if required.

Summer Planning

During the summer months there is an influx of visitors to Lincolnshire, particularly to the east coast with many thousands of visits made each year. This influx invariably places added pressure on our Urgent and Emergency Care services so this year the CCG devised a postcard and poster to be distributed to caravan parks, holiday camps and healthcare settings called 'Be Prepared – your guide to Health Services While Away from Home'. It gave advice on how to self-care, accessing GP services while away as well as highlighting the services offered by NHS 111. Lincolnshire's largest visited attraction on the east coast is Butlins at Skegness and 45,000 postcards were distributed for them to give to visitors In addition, the CCG supported this with social media activity both locally and in areas where we know that visitors come to the east coast from.

Financial Performance

The CCG was required to prepare accounts for the period 1 April 2022 to 30 June 2022 due to new legislation which meant that Clinical Commissioning Groups transitioned to a new statutory body called an Integrated Care Board (ICB). The 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 Group's annual accounts. The accounts have been prepared on a 'going concern' basis to show the long-term commitment to healthcare services despite the transition to ICBs. The 'going concern' basis is described in note 1.1 to the accounts.

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 were set a Revenue Resource Limit (RRL) by NHS England that represents the maximum that can be spent in the reporting period. This was used to inform the financial plan for the year. The CCG agreed a plan with NHS England to break even against its RRL for the period April to June. The actual outcome was in line with this plan, being a £1k surplus as at 30 June 2022. This position was largely a result of changes to the phasing of allocations to match expenditure by NHS England. A more representative view of expenditure against the RRL will be seen when performance for the whole of 2022/23 is completed (three months from the CCG and nine months from the ICB). However, it should be noted that expenditure for the first three months of the year will have been lower than the rest of the year due to delays in new investments and from one-off benefits where expenditure estimates from the previous year were not as high as expected.

The CCG was the only part of the Lincolnshire healthcare system to produce formal accounts for April to June 2022. In general, the wider Lincolnshire NHS system (including the CCG and NHS providers) was managing expenditure within financial plans during this period, but the financial outlook for 2022/23 is challenging, and a recovery support programme will be needed for the Lincolnshire system. The combined CCG / ICB financial plan for 2022/23 is a £3.25m deficit as part of a breakeven position for the Lincolnshire healthcare system. This plan includes significant financial risks which will need to be managed and mitigated.

Summary Headline Financial Information

NHS Lincolnshire CCG's delivery of its financial targets for the period to 30 June 2022 (and annual comparators) as follows:

	2020/21 £ 000	2021/22 £ 000	2022/23 Q1 £ 000
Revenue resource limit	1,344,833	1,516,316	376,014
Net operating expenditure	1,344,809	1,518,737	376,013
Surplus / (deficit)	24	(2,421)	1

The CCG managed its administration functions within the allocated Running Costs Allowance of £3.505 million (being one quarter of the initial Running Costs Allowance for 2022/23).

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

The CCG was 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 per cent 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 per cent of non-NHS invoices paid within 30 days.

Full details are given in Note 6 of the accounts.

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

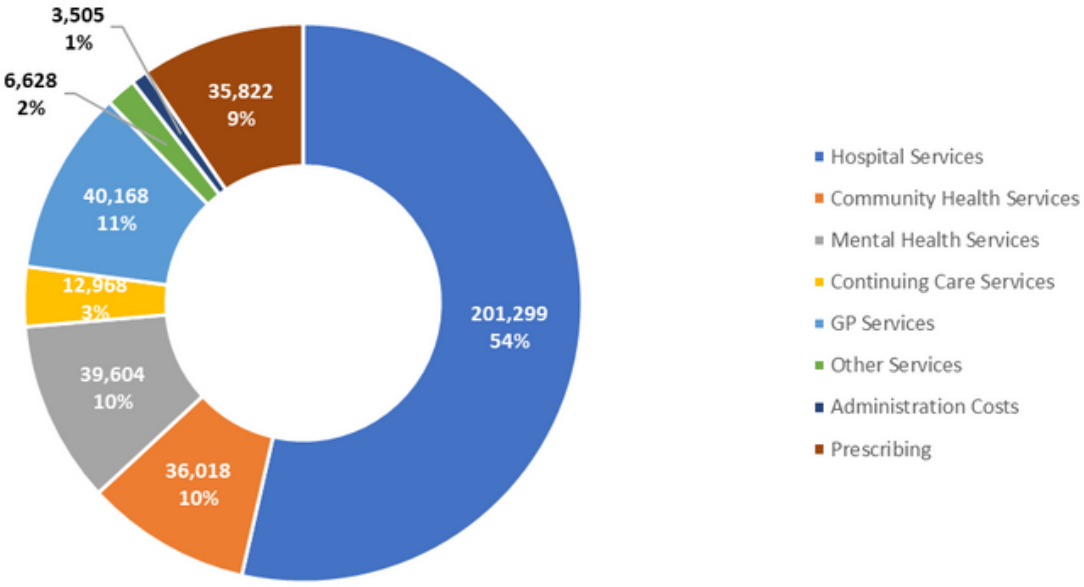
- Programme – this is expenditure on the purchase of healthcare. In the period April to June, the CCG spent £372.5 million on programme expenditure, in line with its allocation, representing 99.07% of its total resources utilised on programme expenditure.
- Administration – costs that are not for the purchase of healthcare but relate to the direct running costs of the CCG. The CCG spent 0.93% of its total resources on administration expenditure.

The changes in Programme and Administration expenditure from 2021/22 to 30 June 2022 are shown in the table below.

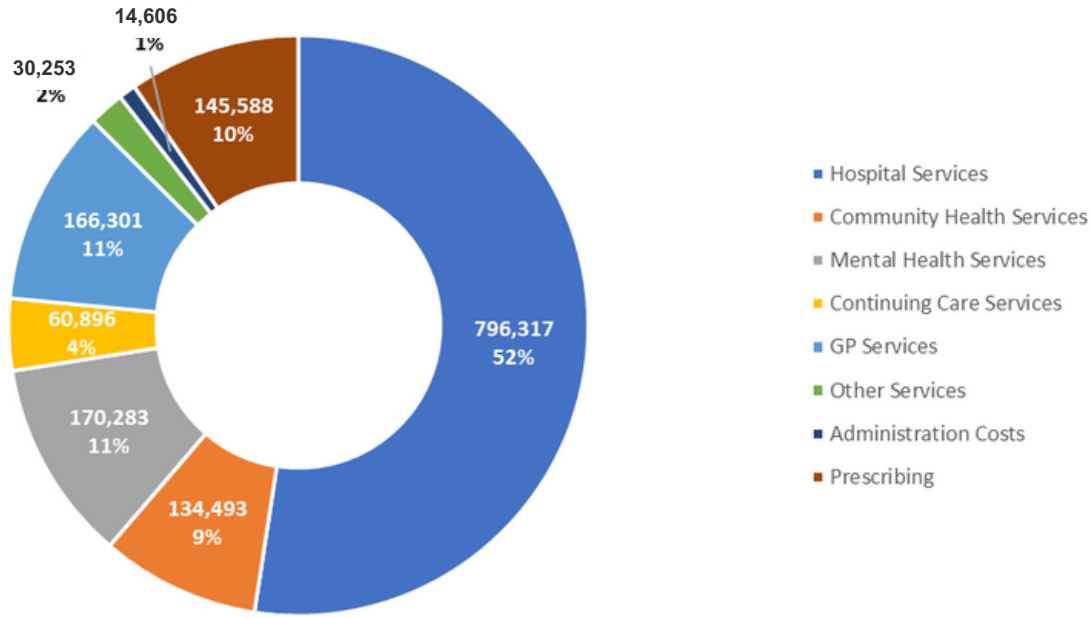
Expenditure type	2021/22 £'000	Q1 2022/23 £'000	Pro rata 2022/23 estimate £'000	Value change £'000	Percengage change	Explanation
	a	b	c = b x 4	d = c - a	e = d / a	
Programme	1,504,131	372,508	1,490,032	(14,099)	(0.9%)	Reduced spend due to one-off prior year benefits and delays in new investments.
Administration Costs	14,606	3,505	14,021	(585)	(4.0%)	Delays filling vacancies for new ICB staff structure.
Total	1,518,737	376,013	1,504,053	(14,684)	(1.0%)	

Analysis of the CCG's expenditure in 2021/22 and a similar analysis for April to June 2022 can be seen in the charts on the following page.

2022/23 Analysis of Net Expenditure
For the period 1 April 2022 to 30 June 2022
£000's



2021/22 Analysis of Net Expenditure
For the period 1 April 2021 to 31 March 2022
£000's



There 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.

	30-Jun-22 £'000	31-Mar-22 £'000	Explanation of movements
Total assets	12,492	11,447	Increase in amounts due to the CCG relating to lower performance in non NHS elective contracts.
Total liabilities	(68,921)	(78,596)	Reduction in liabilities due to higher level of settled amounts prior to the cessation of the CCG.
Total equity	(56,429)	(67,149)	

Improving Health, Reducing Health Inequalities and Prevention

This section explains how the CCG from 1 April 2022 to 30 June 2022 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, (Lincolnshire CCG and Local Authority) and communities work together with other partners to improve the health and wellbeing of our 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 a 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 - 2024, which sets out the plans across four core ambitions, including prevention. Lincolnshire's 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 population, as well as 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.
- People having to travel further to access services and many communities have limited or no mobile phone and broadband coverage.

- With people having to travel further to access services and many communities have limited or no mobile phone and broadband coverage.

The information on the next page 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.

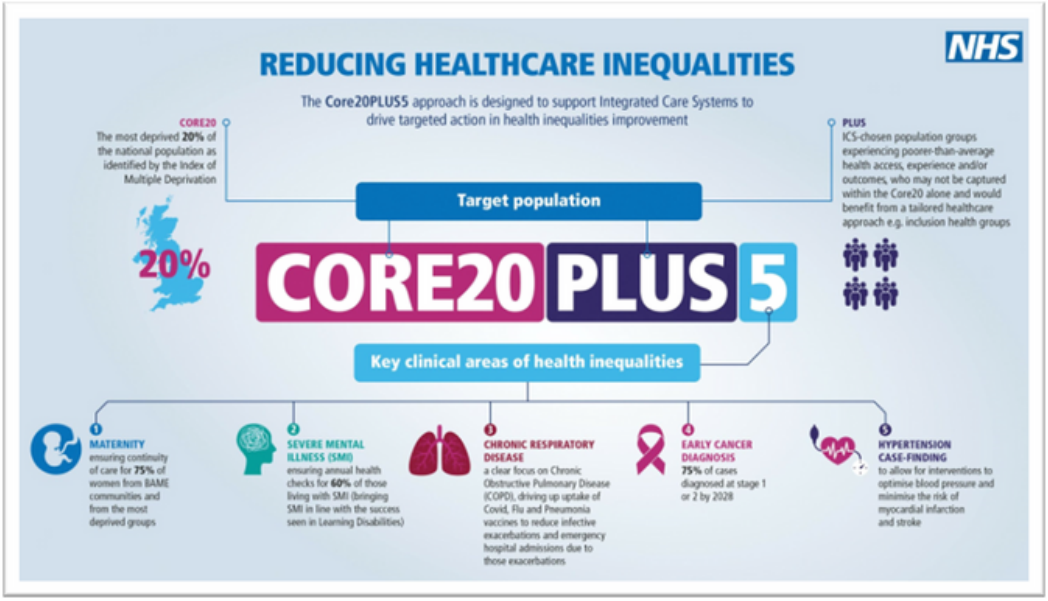
Impact of COVID-19

As per the previous year, over the last three months of the CCG, the COVID-19 pandemic 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 was around service provision and supporting patients and staff to maintain their health and wellbeing during the pandemic. We 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 outlined the approach to support the reduction of health inequalities at both national and system level – **see the infographic on page 30.**

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 Core 20Plus population are:

- The 20 per cent most deprived communities as identified by the Index of Multiple Deprivation (IMD) – 120,000 patients, 15 per cent of Lincolnshire's population.
- Plus - BAME communities (101,000 patients, 13 per cent of Lincolnshire), with the largest BAME group being “any other white background” (8.2 per cent) - 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 CORE20 alone and would benefit from a tailored health care approach – key groups identified for Lincolnshire include travellers, homeless, rural and coastal communities, farming and military families.

The effectiveness of our response depends on a whole-of-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 Lincolnshire’s NHS 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.

During April to June 2022, the Health Inequalities Programme has had an immediate focus on implementation of the framework Core20PLUS5 and a wider role to shape and strengthen our 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 identified a named Executive Board Member responsible for tackling inequalities, as well as CCG Board Non-Executive lead. Each PCN (Primary Care Network) identified a Health Inequalities lead and through the PCN Alliance a nominated PCN system lead for Health Inequalities.

Working relationships between the CCG and Lincolnshire County Council were 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 roles is 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 is a member 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 our 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 population 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 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.

Example of Mental Health Transformation Programme that supports 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, 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 VCSE 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 citizens experiencing poor mental health and other associated health problems.

Through local discussions it has been identified that a large challenge with supporting the communities is being able to connect with them, and 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.

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

The Core20PLUS5 identifies a key clinical service priority around the 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 Lincolnshire Wolds team has commenced booking women onto the Continuity of Carer pathway and next steps will be to establish teams in Boston (English for speakers of other languages (ESOL) patients, predominantly expected to Eastern European – Lithuanian). We will also be establishing our Skegness Team in 2022/23 – 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 service and procurement exercises undergo a process of EIA. As part of the planning process for 2022/23, the use of the Health Equity Assessment Template (HEAT) was rolled out and will be embedded within ICS project management and governance arrangements going forward.

The Clinical Policy Sub-group (a sub-committee of the QPEC) reviews all clinical policy decisions including service specifications and consider 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 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 CCGs had a legal duty to respond to inequalities in the health of their respective 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 within 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 an update. By working with Public Health and through active engagement at the Health and Wellbeing Board, we have confirmed the CCG's contribution to the delivery of the joint health and wellbeing strategies.

As may be expected, the focus of 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

Example of COVID Vaccination Programme which supports Health Inequalities

Significant work has been undertaken 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 programme work has included tailored approaches to support uptake amongst specific health inclusion groups, for example Homeless, travellers community and population groups where analysis shows uptake is lower than average. (ethnicity/ deprivation).

We have developed a Health Inclusion Strategy for COVID-19 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 our 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 continuing to adopt culturally competent approaches to increasing vaccination uptake in groups that have a lower-than-overall average uptake as of March 2022.

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 2022, support was provided to Ukrainian 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 their 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 was delayed in light of the required response to deal with the COVID-19 pandemic.

Environmental Matters

Greener NHS and Green Plan

A Draft System Green Plan was agreed with system leaders. This will be refreshed in 2023 to be presented to the ICB for sign-off. Discussions also took place regarding the future governance arrangements for the green agenda within the new system architecture and there has been engagement with the Primary Care Alliance, to link PCNs and primary care into this work.

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.

The CCG through the Programme Director for Strategic Estates, Partnerships and Planning has been working with District Councils and the county regarding opportunities for integrated estates/capital projects. This has included work in Boston and South Holland to support their Levelling Up two bids.

The Programme Director sits on the three Towns Fund Boards and the Greater Lincolnshire One Public Estate Board and has been working with the Local Enterprise Partnership to build on the relationships as the ICB/ICS develops.

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

CCG - Sustainability

The CCG is aware of its responsibilities as a socially 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 below for the period 1 April 2022 to 30 June 2022 is detailed below:

	Bridge House	COC
	£	£
Utilities - Gas	N/A	4,790
Utilities - Electricity	1,385	7,914
Water	375	707
Total spend	1,760	13,411

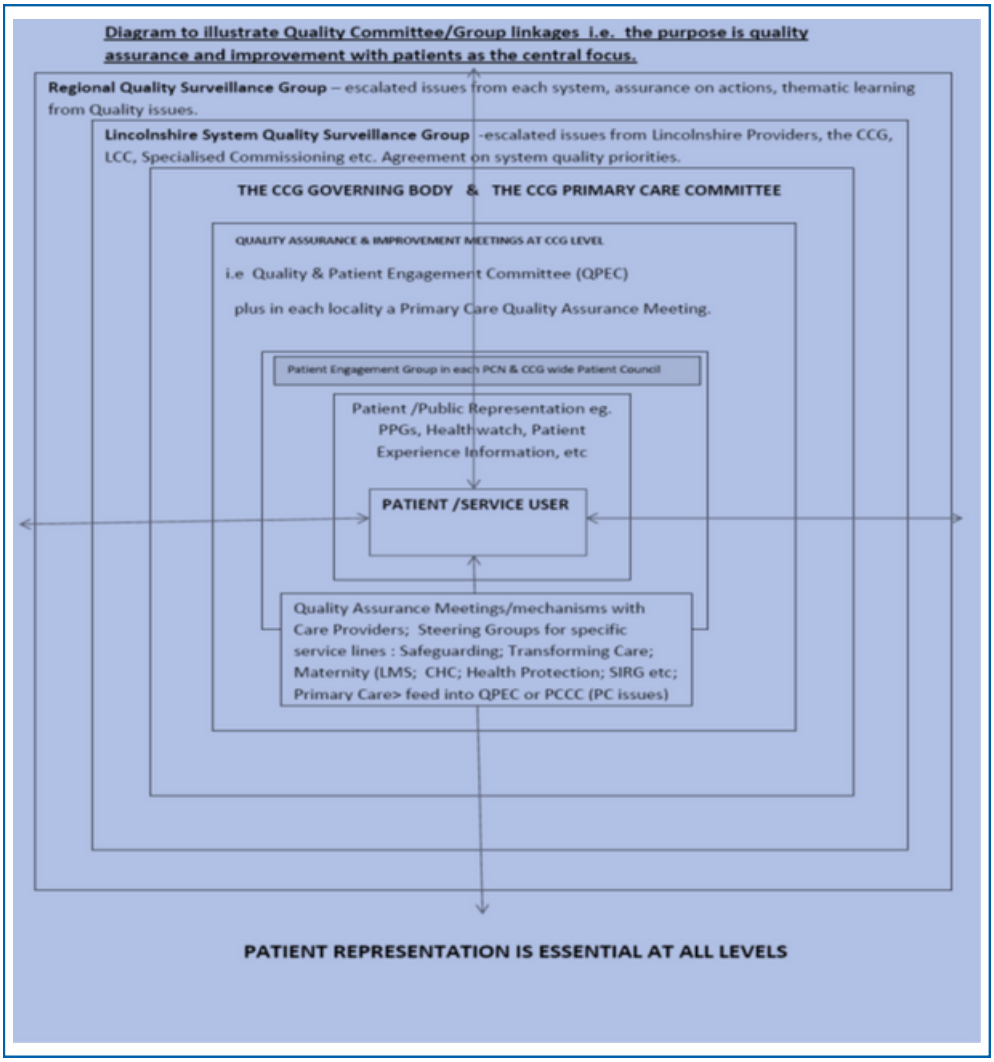
Improvements in Quality

Quality Governance

For Quarter One 2022/23, the remaining quarter of the CCG prior to transition to the Lincolnshire ICB, 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. By Quarter One most staff redeployed from the quality team due to the COVID-19 response had returned to the team, albeit some were still assisting within the COVID-19 Vaccination Programme, and there were also significant vacancies in the team due to staff leaving for career progression. The CCG continued in this period to adapt and enhance processes to monitor and support improvement in care quality in readiness for transition to the ICB.

Established incident reporting and quality surveillance mechanisms, including regular dialogue with provider Quality Leads, CCG Clinical Leads, general practice leaders, and CCG teams and also through quality contracting/governance meetings with and within our main providers enabled 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), as a Committee to the CCG Governing Body, received assurance that CCG Officers were appropriately discharging their duties to ensure the quality of all commissioned services for the people of Lincolnshire. The CCG QPEC met bi-monthly in 2022 to seek this assurance, escalating any priority issues for action by the Governing Body. The last meeting of the CCG QPEC was in June 2022 where quality issues, both legacy and current for handover to the new ICB were considered and agreed. The System Quality Group also continued to meet bi-monthly in 2022, last meeting under the auspices of the CCG in May 2022, 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, which will be maintained in the new ICB, is to ensure that quality improvement support is given from relevant system partners as needed and also for assurance to all the organisation Quality Leads represented, and 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 quarterly in 2022 and will continue for the Integrated Care System (ICS). The Committee, chaired by the Bishop of Grantham, has continued to consider and make recommendations on any system-wide ethical issues/ dilemmas, for example, advising on the ethical acceptability of new locally adopted Infection Prevention and Control Guidance for the system in June 2022.



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 and what patient surveys and concerns told us, including via Healthwatch, and also what the CCG, observed through quality reviews and quality visits.

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 Quarter One 2022/23

Health Protection

Infection Prevention and Control with safe environments of care for patients and staff continued as a vital focus in Quarter One 2022/23 due to the continued prevalence of COVID-19 and also higher potential public susceptibility to other infections and viruses due to previous lockdowns and social restrictions. The CCG assisted with this through the work of our Health Protection Team.
The CCG 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 from April to June 2022 the work of this team has continued to be of paramount importance.

In Quarter One 2022/23 the CCG Health Protection Team, which itself was now fully established after a period of vacancies and expansion of the team, was able to re-establish further assurance reporting and support visit processes with our providers, which had been suspended necessarily during the height of the COVID-19 pandemic. Each Trust receives at least a quarterly visit from the team, and all other providers, at least annually. The outcomes of Quarter-One visits were positive with generally good compliance to IPC standards. Where issues were identified, the team have worked with the relevant provider to advise and support mitigating actions.
The team have supported the system to keep the local guidance on living with COVID-19 up-to-date and relevant.

The team also put together the local guidance for the management of suspected and confirmed cases of Monkeypox along with input from system partners.

The CCG Health Protection team regularly attend briefings and webinars to ensure that the Lincolnshire processes are clear and in line with national guidance. The Lincolnshire pathways were highlighted by NHSE as being a good example and shared with the region.

The team have attended a number of conferences and other forms of training relevant to health protection, to ensure that the staff are qualified and competent to provide up-to-date advice and guidance to system partners. The team also attended the Lincolnshire Show in Quarter One with LCC Health Protection colleagues, using this as an additional way to provide proactive health protection advice to the attending public. The team continue to support the Influenza and COVID-19 vaccination campaigns e.g. 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 was a significant Avian Influenza outbreak in Lincolnshire, spanning several months from December 2021 and affecting a number of farms.

The CCG Health Protection Team continued to support the response to this in Quarter One.

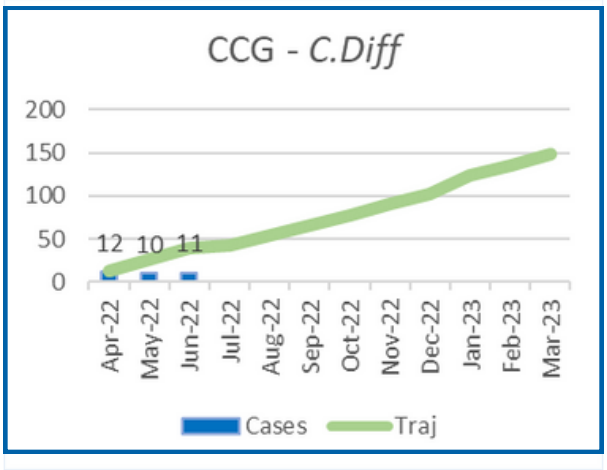
CCG attributed Healthcare-Associated Infections

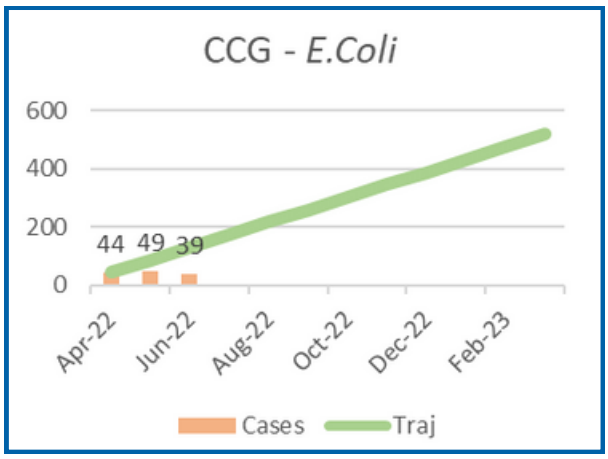
The system was under trajectory for C.difficile and one case over for E.Coli. in Quarter One 2022/23. E.Coli rates will continue to be regularly monitored going forward.

Due to the COVID-19 pandemic, there has not been the usual oversight of Gram Negative Blood Stream Infections (GNBSI) and, therefore, the reduction plans have not been scrutinised. There is a sub-group of the System IPC Group which will be addressing this over the course of 2022/23.

There is a zero tolerance approach to MRSA and cases are reviewed to identify and share lessons learnt.

Organism	**Quarter 1 totals**			
	Cases/Trajectory	**Cases/Trajectory**	**Cases/Trajectory**	**Cases/Trajectory**
	LCCG	**ULHT**	**NWAFT**	**NLAG**
C.Diff	**33/39**	**13/15**	**13/30**	**8/6**
E.Coli	**132/131**	**14/27**	**6/20**	**7/18**
P. aeruginosa	**17/18**	**1/4**	**4/6**	**2/2**
Klebsiella spp.	**47/39**	**9/10**	**4/9**	**4/7**
MRSA	**4**	**0**	**1**	**0**
MSSA	**45**	**7**	**2**	**6**





Pathway Pressures/ Capacity Constraints

Increased pressure on Urgent and Emergency Care Services continued in Quarter One 2022/23, with activity levels across services remaining high. This, together with significant staffing constraints across most services due to illness, COVID-19 isolation requirements or vacancies, contributed to significant periods of time where there were long ambulance handover delays at our Emergency Departments, long delays for ambulances to attend patients in the community, delays for transfers out of our Emergency Departments and delayed hospital discharges.

Both delays in care and delays with discharge can potentially cause harm to patients, so all very long waits and delays have continued to be subject to harm reviews to help ensure that, although patient experience may have been compromised through preventative action by the staff involved with a patient's care, there has been no or at most minimal impact on patient safety. The Lincolnshire Community Health Service Executive Team 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 continued with a significant contribution to this work through their involvement in the related programmes of work e.g. Discharge & Flow; Palliative & End of Life Care improvement work, UEC Board & operational delivery and Care Closer to Home.

Activity levels have also remained high for our mental health services, mental health illness and issues exacerbated by the pandemic and economic downturn.

Successful international recruitment has addressed some of the workforce gaps experienced by Lincolnshire Partnership Foundation Trust (LPFT), but some wards and services continued to have notable workforce constraints necessitating some service restrictions and different ways of working.

Despite this the LPFT continued important quality improvement work, 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. Work to improve the offer and uptake of Learning Disability Health Assessments via general practice has continued and the successful approach used for this work is now being referenced to guide work to improve Significant Mental Illness Annual Review uptake for patients. Additionally the CCG continued to effectively lead the Learning Disability Mortality Review programme, to ensure there is identification of any shortcomings in care provided to patients with a Learning Disability and improvement actions progressed when indicated. The latter summarised within an Annual Report received into the CCG in Quarter One 2022/23.

To support the Health and Wellbeing of Health and Care staff, which is extremely important during these pressured times, and as we come through the pandemic, LPFT previously led a piece of work to establish an extensive Health and Wellbeing support resource and network for staff. This remains in place and is continuously promoted to staff across the system through team meetings, one-to-one meetings with managers and staff newsletters.

Waiting list backlogs resultant from COVID-19 lockdowns and suspension of services is another area of recovery focus maintained during Quarter One 2022/23. CCG staff worked with United Lincolnshire Hospitals NHS Trust (ULHT) and others to ensure elective and cancer service delivery was effective and available as possible, given the limitations resulting from the pandemic and UEC service pressures. 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 necessitated this to be a continued area of focus for improvement by the CCG.

The success of the COVID-19 vaccination has been positive for care homes with residents much less affected by the virus 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-19 illness, plus recruitment and retention issues. Domiciliary care has equally been adversely affected and this has created significant difficulties at times sourcing home care for patients needing this on discharge from hospitals.

The CCG 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 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.

Patient Safety

In Quarter One 2022/23 there was 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.

A monthly meeting chaired by the CCG and with the main Lincolnshire Trusts in attendance considered serious incidents that have occurred within the system.

This meeting allows for collaborative review, discussion and assurance of serious incident investigations and it has provided a positive forum to share learning across different healthcare organisations. Within the forum. discussions regarding care pathways have taken place, including sharing of good practice, and of assessment and investigation tools for example.

Through this forum development work occurred in Quarter One to support future implementation of the new Patient Safety Incident Response Framework (PSIRF). Incidents and incident themes were shared by the CCG Quality Leads into specific system Programme Boards, to support learning and improvement within specific patient care pathways e.g. urgent and emergency care, safe patient discharge, end of life care and maternity.

During Quarter One 2022/23, collaborative working with the COVID-19 vaccination programme Team has continued in relation to incident management and broader quality initiatives.

Work on improving the quality of Recommended Summary Plans for Emergency Care and Treatment (ReSPECT) continued in Q1 following the appointment the previous year by the CCG of a clinical project manager within the Palliative and End of Life team to drive this area of work forward. 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. The project manager has particularly been supporting Care Homes in 2022, to improve the quality of these plans for their residents. 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 usually 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. Also undertaking 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.

Maternity

The Lincolnshire Local Maternity and Neonatal Services Network (LMNS) continues to work very proactively with ULHT and other system partners to drive improvements in maternity and neonatal care. The CCG and a LMNS representative also attended the ULHT monthly Maternity and Neonatal Oversight Meeting to receive assurance on the quality of Maternity Services, this includes consideration of progress with an overarching improvement plan which encompasses all previously identified areas for improvement. Good progress with this plan and Ockenden Review required improvement actions has continued to be demonstrated.

ULHT were subject to a review visit by the Regional NHSE Maternity Team and partners in June 2022, post publication of the second Ockenden report into service failings in Maternity Care at Shrewsbury & Telford NHS Trust (SaTH).

All maternity services serving Lincolnshire Families had previously positively responded to the Ockenden Review (Part 1) giving assurance that the issues that occurred at SaTH were mitigated. The outcome of the review visit was in accord with this providing assurance against the seven immediate and essential actions from the first Ockenden report.

The inspection report following the visit referenced the outstanding senior leadership team within ULHT, and the presence of clear executive and NED visibility across maternity services at ULHT. They found many examples of Quality Improvement projects in place within maternity.

The visiting team commented on the strong governance methodology being visible across the division, with good connections with the corporate team, particularly in incident management and robust assurance processes.

Staff were able to articulate a positive culture in which they felt confident to challenge decision making and escalating any concerns across both sites. The Maternity Voice Partnership Chair was recognised for driving an innovative pilot work programme aimed at supporting military families.

Safeguarding

Lincolnshire CCG has a wide range of statutory duties in relation to safeguarding its population. The expert CCG Safeguarding Team provides advice on various safeguarding issues and also directly manages complex safeguarding cases.

The team provides training, support and guidance to other professionals, either with specific safeguarding responsibilities or support with individual and organisational safeguarding issues.

The team also 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 CCG Associate Director of Nursing and Quality or Designated Doctor attend Lincolnshire Safeguarding Children Partnership (LSCP) and Lincolnshire Safeguarding Adult Board (LSAB) executive meetings. There is also representation from the safeguarding team at the Lincolnshire Safeguarding Adult Partnership Board and the Domestic Abuse Partnership Strategic group, to ensure that any safeguarding issues are identified, addressed and mitigated.

The LCCG safeguarding team are actively involved in all sub-groups of the Boards, including statutory safeguarding reviews, Child Safeguarding Practice Review (CSPR), Serious Adult Reviews (SAR) and Domestic Homicide Reviews (DHR)). The CCG team also supports the development of the safeguarding board priorities and local and national policy.

At the end of Quarter One the Boards had nine ongoing Domestic Homicides Reviews, with no Serious Adult Reviews (SAR) at that stage, although scoping for two potential SARs was underway, plus scoping for one combined Child Safeguarding Practice Review and DHR Safeguarding Adults. Mental Capacity / Court of Protection -The draft MCA Code of Practice was published on 17 March 2022, the consultation period concluded on 14 July 2022. A response was made by the CCG/ICB using the local implementation group, as well as appropriate staff.

The government will now take into account the comments made to determine the final code content and review the timeline for new Liberty Protection Safeguards (LPS) to be implemented. The latter will replace the current Deprivation of Liberty Safeguarding processes.

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 and to ensure positive safeguarding outcomes for individuals who have contact with their services.

The Designate Nurse and Doctor for the CCG maintain regular contact, with provider and Local Authority safeguarding lead practitioners, to provide both peer support and to identify any safeguarding themes or trends that are emerging.

Safeguarding Level 3 Training for Children and for Adults to general practice and CCG staff has been maintained through on-line training. The feedback from participants in the training as always remains very positive. General Practitioner Safeguarding Forums have also continued virtually. The team have also continued to support general practice regarding domestic abuse and their engagement with the multi-agency risk assessment conference (MARAC) process.

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) outlined that CCGs must:

- Work with the local authorities to contribute to the online Local Offer of services available.
- 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.
- Support the Extended Powers of the Tribunal process.

The DCO team have also delivered on a number of high-impact projects including the development of:

- SEND Education Programme for Clinicians, developed in conjunction with Liaise (Independent Advice Support Service to Lincolnshire SEND), which will be delivered several times throughout 22/23. This Programme covers: SEND law and guidance; SEN funding; The graduated approach; Support services; Reviews of SEN support; When might a child/young person require an EHC Needs assessment; & ·the Involvement of Health Services.
- An online e-learning resource for professionals who work with CYP with SEND called a 'Rough Guide To Not Putting Your Foot In It' funded by NHSE and developed in collaboration with Lincolnshire Young Voices and the Local Authority is complete and set to launch in July 2022.
- The online Sensory Processing Disorder Education and Training Programme to support CYP with sensory processing difficulties is now live and very well subscribed. A further four workshops have been added for 2022 due to demand.
- Special Schools Health Strategy development for the establishment of an integrated school system where children and young people with SEND get the right health, care and education, in the right place, at the right time, as close as possible to where they live; where provision is without boundaries: where children feel they belong, are respected, hopeful and optimistic about their future. All Lincolnshire Special Schools, with the exception of Special Education Mental Health Provision, to become Locality All Need Schools, with investment in Special Schools to ensure they have the premises and resources to meet All Needs.
- There is an £86m Capital programme to include specialist clinical and therapeutic spaces to support a collaborative health offer – visiting professionals, medical room, physiotherapy room, and group rooms for therapy interventions.

General Practice

The Quality of general practice provision continued to be assured through the work of CCG Locality Primary Care Quality Assurance Groups and constituent CCG locality-linked staff. Any areas of concern are then escalated to the Primary Care Quality Oversight Group and ultimately to the Primary Care Commissioning Committee.

In 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 into Quarter One 2022/23 – normal workload, plus backlog after 'lockdowns', positive COVID cases and long COVID; patients needing ongoing care as they await elective procedures; and because of the additional workload associated with delivery of the COVID-19 vaccination programme.

General practice has continued to ensure safe service access in Q1 22/23 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. COVID-19 prevalence in the community has continued to present significant workforce pressures with staff illness or staff isolating. In Quarter One some practices remained affected by staff absences either due to COVID-19 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 continued 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 and consultations being undertaken routinely now by general practice when it is appropriate to do so.

Lakeside Medical Practice in Stamford has been particularly supported by the CCG and Local Medical Committee to make improvements after a CQC overall inadequate rating post-inspection in June 2021. The practice received a further CQC inspection in early March 2022 and the inspection visit report was published on 1 June 2022 with an overall requires improvement rating. The practice is to remain in Special Measures with the CQC for a further six months to ensure any further improvements are progressed and improvement work embedded.

CCG senior representatives continue to meet regularly with the practice team to receive assurance on continued actions to address concerns and to support. The LMC are also supporting the practice.

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 and increase primary care nurse training and opportunities continues in conjunction with The University of Lincoln and the Lincolnshire Training Hub.

Children and Young People

Transformation work continued with system partners in areas such as mental health services for children and new mental health support teams in the community for lower acuity mental health issues, child diabetes, asthma, and epilepsy, with greater focus being given to the transition from children to adult services. As lead the CCG has worked with partners to continue to deliver the COVID-19 vaccination programme for school-aged children in line with recommendations from the Joint Committee on Vaccination and Immunisation (JCVI).

Continuing Healthcare

The CCG Continuing Healthcare (CHC) service has continued to maintain good performance on eligibility decisions being made within 28 days. There is also robust performance on Discharge to Assess for patients requiring CHC on hospital discharge, with the team joining daily discharge calls to ensure any CHC service blocks are addressed for patients.

There have been workforce challenges in the team due to illness and vacancies which have caused a backlog with annual reviews.

To address this, additional agency staffing cover has been secured and an external provider utilised to address priority reviews and ensure an acceptable trajectory for clearance of any outstanding reviews and workload management.

The CHC team has continued work to improve access to personal health budgets for all our patients. The clinical team have concentrated on ensuring packages of care are personalised for our patients, and that they are fully involved in decisions made about them

A Personal Health Budget (PHB) workshop involving clinicians from across the health and care system was held in June 2022 and used to inform the CCG/ICB Personal Health Budget future strategy and priority areas to explore for initiation of PHBs over the next year. The CCG continued to achieve NHS targets set for numbers of PHBs in place.

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 it can involve its 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 in our values which 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.
- Our Voluntary Engagement Team and Stakeholder Board allow open discussion of our plans, and challenges 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.
- We meet fortnightly with our engagement colleagues from across the NHS system to share expertise and knowledge and enable a visible, joined-up approach to our engagement activities.
- A Communications and Engagement Network has also been established, meeting bi-monthly with colleagues from organisations across Lincolnshire such as Local Authorities, NHS Provider organisations including East Midlands Ambulance Service and key local voluntary and community groups. Its purpose is to collaborate and coordinate activities across Lincolnshire to enhance our collective interface with the public and communities.

Seeing the impact of participation

Throughout the final months as a CCG, we have continued to involve our patients, the public and stakeholders. Some examples of our engagement activities include:

- Engagement to shape the principles of Community Diagnostic Centres and inform the development of our second CDC site as well as preparing for a co-production group to 'walk through' the pathway and patient experiences.
- Engagement and patient experience on the new Hip and Knee pathway in the Musculoskeletal service. We are also developing an approach to co-produce the new pathways and communications requirements
- Supported the Ockenden Review Engagement to help improve and shape the future of maternity services by asking service users, families and carers to share their views and experiences.
- The Maternity Voices Partnership has also been gathering experiences of maternity care during the COVID-19 pandemic.
- Engagement on prevention of, and education for, the diabetes service.
- We have held conversations with various co-production groups and our Involvement Champions on our early thinking about what the best health and care for Lincolnshire looks like and how we can describe this new relationship and the roles we each have to play in this. We are doing this as part of Better Lives Lincolnshire, which is a shared partnership across the health, care and independent sector and voluntary, community and social enterprises (VCSE) in the county.
- We have held Listening Clinics in some of our GP Practices as well as undertaken engagement and consultations on various changes to Primary Care including extended access at PCN level.
- Engagement with GP Practices is ongoing to support practices to refresh and set up Patient Participation Groups.
- Continued to develop and increase our stakeholder database contacts and strengthened our groups and meetings such as County Wide PPG Meeting, Involvement Champions, Citizen's Panel and other community groups and networks.
- Continued to grow our social media presence as well as getting out and about in our local communities through a series of events and roadshows which has also significantly increased the number of people signed up to receive our Engagement Bulletin.
- Engagement to shape the development of the Lincolnshire GP Practice websites to ensure they meet the needs of patients, this included engagement with people with sensory loss, people who didn't have English as a first language people with dyslexia, carers and people with long-term conditions.
- Engagement on the Lincolnshire wheelchair and equipment services review and re-procurement. In March, alongside Lincolnshire County Council (LCC), the CCG undertook an engagement exercise to involve patients in the development of the service specification for the re-procurement of these services. We were particularly interested in hearing about how the service was being provided and how it could be improved as we move forward.

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 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 uptake of vaccinations, visiting local people in community venues. We continue to produce promotional material in a range of different languages and used methods including billboards, targeted fliers to households and businesses, videos and social media and work alongside key community leaders to share the messages.

We have also provided training to vaccination and Age UK staff to support engagement and promote walk-in vaccination sessions to help provide more local services to patients.

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 topics 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 regard to ongoing programmes of work such as personalisation.

How we enable and support those who want to get involved

The CCG has a number of ways to support involvement including Patient Participation Group representatives joining our County Wide PPG Meeting, people registering their interest in becoming one of our Involvement Champions or joining our Citizen's Panel etc. All of these opportunities are promoted on our social media and website as well as circulated in our Engagement Bulletin, sent fortnightly to our stakeholder and patient group database.

Social Media

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 encourages conversation and feedback to improve the ongoing development of our services.

Unlike other methods of promotion, social media encourages two-way communication 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 Coronavirus 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 as a system 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, people 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 30 June 2022, we had 2,995 followers of our page, which opened in 2020. Between 1 April 2022 and 30 June 2022, we shared 200 posts, with a total reach of 166,056 and received over 604 post likes and reactions, 608 shares, 184 post comments and 843 link clicks.

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. As of 30 June 2022, we had 1,931 followers of our account, which opened in 2020. Between 1 April 2022 and 30 June 2022, we shared 568 tweets, our tweets were seen 152,979 times and received 2,854 engagements (including 681 retweets and 535 likes).

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 2022 and 30 June 2022, we had 46,092 users/visitors (80.9 per cent new and 19.1 per cent returning visitors) and 126,593 page views. Our visitors came to us from a variety of routes, 50.78 per cent from organic search, 15.23 per cent direct, 14 per cent paid search, 11.19 per cent from our social channels, 8 per cent referrals from other sites, 0.77 per cent from other channels and 0.02 per cent from email.

Our top page was our vaccination programme landing page with 25,235 page views.

Equality and Diversity

Equality Inclusion and Human Rights (EIHR) training programme

Approval was given in May 2022 to deliver the Equality, Diversion and Inclusion (ED)I training programme proposed for April 2022 to March 23 that was developed as an outcome of the training needs analysis work that was undertaken. The following training for staff was agreed as part of this:

- Equality Impact Assessment training (EIA): Covering policy and service reviews/changes both clinical and non-clinical.
- General EIHR training: Covering moral, legal and business case elements and focusing on all protected characteristics and different socially excluded groups.
- Tackling bias and discrimination: Focusing on recruitment and selection, professional development, workplace activities and the delivery of services.
- Raising awareness of different protected characteristics and intersectionality: Individual sessions focusing on different protected characteristic and/or those facing health inequalities as well as refugees, asylum seekers, gypsies and travellers.

Work began in May to organise three EIA sessions for ICB staff (to take place in July, September and November). As part of this, during May to June, the EIA guidance and template were reviewed and updated, and an EIA checklist of the process was developed, with the intention of staff receiving the full EIA pack as part of their training.

A good response was received from participants, the majority stating that they found the training very helpful in understanding the different steps of the EIA process and more confident in undertaking EIAs.

Cultural intelligence training

The wider Lincolnshire system has been supporting the implementation of Cultural Intelligence (CQ®) within Lincolnshire with a variety of targeted sessions having taken place. This is delivered by accredited facilitators within the system and funded by the Lincolnshire People Board. A session took place at the end of June 2022, and two senior leaders from the CCG/ICB were offered places to attend.

Cultural Intelligence (CQ®) is a globally recognised way of assessing and improving effectiveness in culturally diverse situations. Cultural Intelligence (CQ®) goes beyond existing approaches of cultural sensitivity, unconscious bias, and cultural awareness and sets out the skills, abilities, and capabilities that individuals and organisations need to successfully and respectfully work with difference and diversity to become skilled intentional inclusive leaders. Leaders who attended felt the course was interesting, informative and at times challenging.

EIHR end-of-year equality report

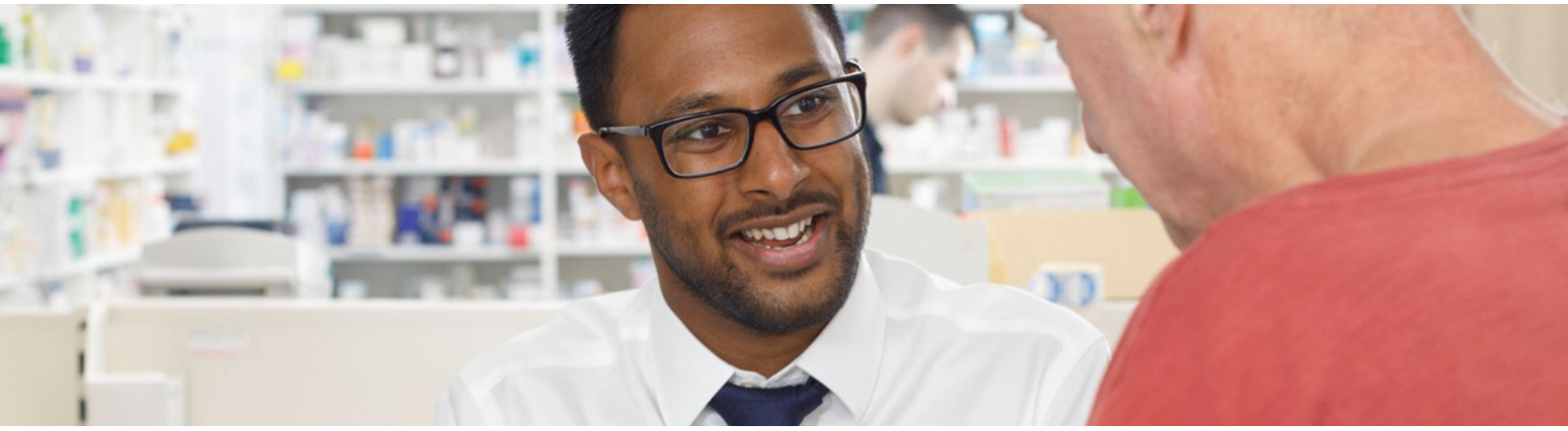
Equality summary report of outcomes for 2021-22 of the Equality Action Plan 2020-23 and priorities for 2022-23 were agreed by Executive Meeting in May 2022.

The report covers the key areas of EIHR work achieved for NHS Lincolnshire CCG from April 2021 to March 2022 as part of the Implementation of the equality strategy objectives and actions of the Action Plan 2020-23. Work outcomes in the report have been aligned with each equality objective. The report was published on the new website in April to enable the CCG/ICB to continue to achieve compliance with the Equality Act 2010, (PSED 2011).

System-wide BAME and Allies Forum

Work took place during April to June to ensure that the BAME and Allies Forum continued as a group to support Black, Asian and Minority Ethnic staff, following the resignation of the Chair and Vice Chair, both of whom had been in these positions since the inception of the Forum two years previously.

Triggered by the Black Lives movement, Lincolnshire CCG and other system leaders endorsed the setting up of the systemwide BAME and Allies Forum as part of a renewed and explicit focus within the system to eliminate inequalities that BAME staff face in the workplace compared to their white counterparts. Discussions have begun around revisiting the aims and objectives and the TOR, having a new Chair and Vice Chair and setting clear objectives and governance processes for the next three years. Meetings have also taken place with system-wide staff responsible for the system Belonging Strategy and People Plan to enable links to be formed with the Forum and to support work around the system-wide belonging strategy priority pillars.



Compliments, Concerns and Complaints

Valuing Patient Experience

NHS Lincolnshire CCG (LCCG) 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.

From April 2022 to June 2022, we received 70 informal concerns and 19 formal complaints, both directly from patients or their families, the public, and from Members of Parliament on behalf of their constituents.

The CCG 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 from 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.

Breakdown of Formal Complaints – April to June 2022	
April 2022	5
May 2022	10
June 2022	4
Total	19

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 2022 to 30 June 2022, of these 19 formal complaints, two were upheld, 11 were partially upheld, four were not upheld and one was closed as not pursued, which leaves a total of one 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

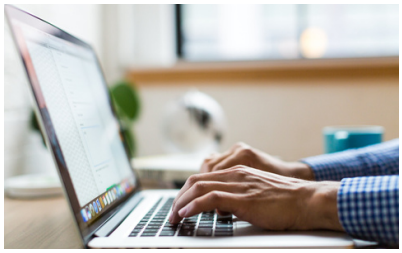
(https://www.ombudsman.org.uk/about-us/our-principles/principles-remedy)

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

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

LCCG 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 LCCG 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 Quarter One of 2022/23, the CCG processed approximately 53 requests covering the following work streams: Finance, Procurement and Commissioning, Medicines Management, Statistical information, Primary Care, Continuing Health Care and Organisational Structure.

Mr John Turner
Accountable Officer (Chief Executive)
July 2023

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.

Dr Gerry McSorley, Non-Executive Director was the Acting CCG Chair for Quarter One of 2022/23. Mr John Turner was the Chief Executive (Accountable Officer) for Quarter One of 2022/23.
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).

Member Practices

The CCG has 83 member practices as of 30th June 2022 as 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	Boultham 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
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
HEART OF LINCOLN MEDICAL GROUP		60 Portland Street, Lincoln, LN5 7LB
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
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
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
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
Dr Gerry McSorley	Acting CCG Chair
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 Martin Fahy	Director of Nursing and Quality
Mr Graham Felston	Non-Executive Director
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 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
Mr Pete Moore	Non-Executive Director - Governance and Chair of the Audit Committee (not available during the period April to June 2022)

Regular Board Members

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 following people are also in attendance:

- Mr Matt Gaunt, Director of Finance and Contracting
- Mrs Julie Ellis-Fenwick, CCG Corporate Board Secretary
- Internal Audit representatives, PwC
- External Audit representatives, KPMG and Ernst and Young (as of
- Local Counter Fraud Specialist

Audit and Risk Committee

The membership of the Audit and Risk Committee during 2022/23 (months 1-3) comprised:

Name	Role
Mr Graham Felston	Non-Executive Director – Acting Chair of the Audit and Risk Committee
Mr Pete Moore	Non-Executive Director (on long term sick leave during April 2022 to June 2022)
Ms Sue Liburd	Non-Executive Director
Mrs Fenella Chambers	Non-Executive Director

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's 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.

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 Quarter One of 2022/23 relating to loss of personal data. Further details of the ICB's Information Governance arrangements can be found within the Annual Governance Statement.

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 are 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, 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.

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 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.

Mr John Turner
Accountable Officer (Chief Executive)
July 2023

Annual Governance Statement 2022/23 (1 April 2022 to 30 June 2023)

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 to arrange 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.

Between 1 April 2022 and 30 June 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

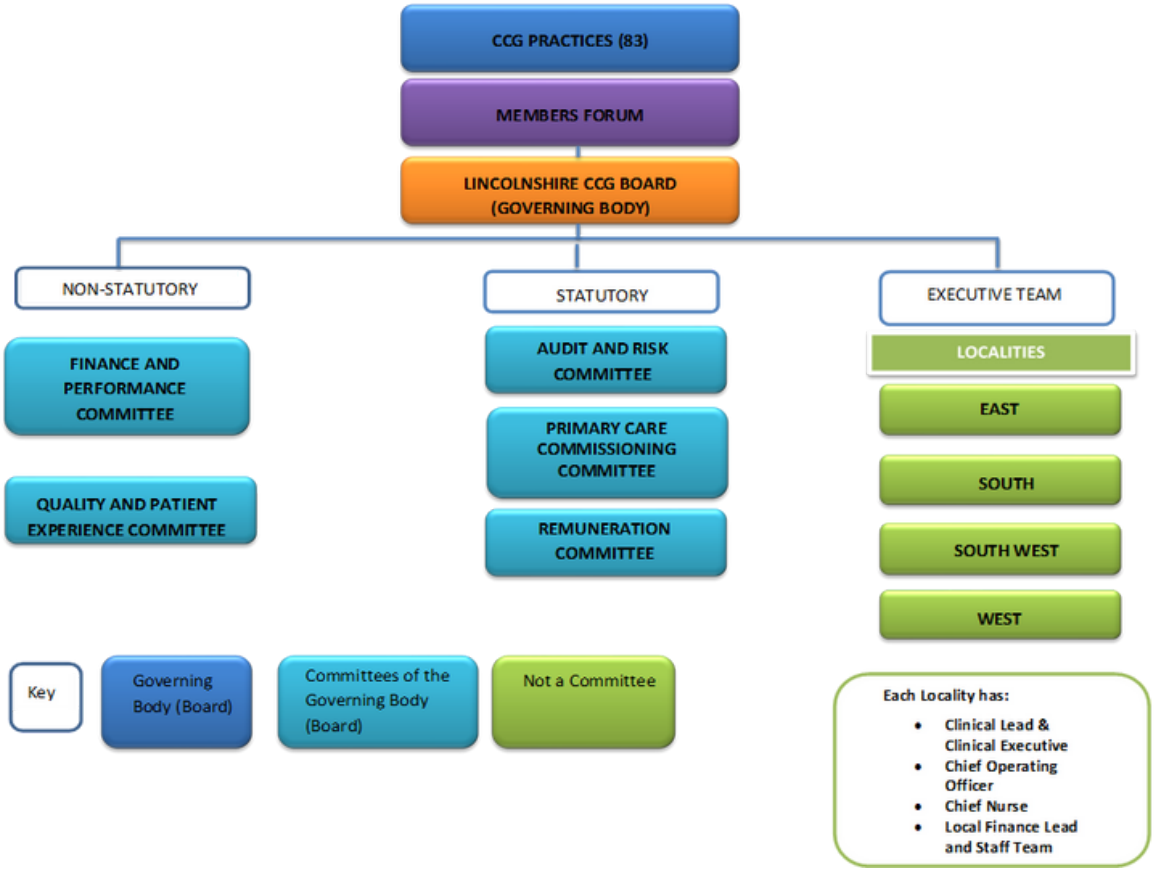
The main function of the Governing Body (referred to as 'the Board') is to ensure that the CCG has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant 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 are summarised in the diagram shown on the next page.



The CCG's Committee structure supports the CCG's governance processes and ensures that there are 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 the first three months of 2022/23 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 83 practices and include individuals from each of the four Localities – East, West, South and South West.

The Committee met once in 2022/23 and has had 45 per cent 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.

At the May 2022 meeting the Members' Forum considered the following:

- Review and update of NHS service challenges and next steps.
- Update and discussion regarding the establishment of the statutory Integrated Care System (ICS) in Lincolnshire from 1 July 2022.

Board – Dr Gerry McSorley, Acting CCG Chair from 1 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 2022/23 the Board has met three times and the public meetings have been held as 'Live Events' through Microsoft Teams. The Board had 85 per cent attendance from all Members. All meetings in 2022/23 were quorate.

The Board is Chaired by a non-clinician Chair who agreed to take on the role following the departure of the previous CCG Chair, namely Mr Sean Lyons at the end of December 2021 (as per the arrangements defined in the CCG Constitution).

The Board exists to:

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

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

The Board has performed effectively throughout the first three months of 2022/23 in ensuring good governance around the CCG's decision making processes and in continuing with the robust Committee structure which was established to manage areas of risk and priority for the CCG.

The membership of the Board is detailed under the Corporate Governance Report on page 56.

Board Performance and Development

The CCG Board is committed to reviewing and ensuring that it is as effective as it can be. In light of the transition from the CCG to the ICB on the 1 July 2022, the Board did not hold any development sessions, but weekly briefings continued to take place on a Wednesday morning with the CCG Non-Executive Directors. Regular meetings were also held, usually on a weekly basis, with the CCG Executive Team which involved senior Directors on the Board and also the four Locality Clinical Leads.

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 (Mr Graham Felston, Non-Executive Director and Deputy Chair of the Audit and Risk Committee Chaired the meetings from 1 April 2022 to 30 June 2022)

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 membership of the Audit and Risk Committee is detailed on page 57.

The Committee has met two times in the first three months of 2022/23 and has had 93 per cent attendance 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 2022/23 the Audit and Risk Committee completed a Committee Handover report which was produced as part of the close-down process of the CCG and also to provide information to the new incoming ICB Board Members, specifically the Non-Executive Directors.

The handover report included details on the following:

- Summary of key issues/areas of focus during 2021/22.
- Position of those key issues/areas of focus as of 30 June 2022.
- Any key considerations, risks, challenges etc for the ICB Board and its Committees to be aware of.

The Audit and Risk Committee also produced its Annual Report for 2021/22 and a Self-Assessment.

All three documents as detailed above were presented to the CCG Board at its final meeting held on 29 June 2022.

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 once during 2022/23. The Committee's role is to determine remuneration and conditions of service for the senior team.

Further information on the membership and attendance by the Non-Executive Directors of the Remuneration Committee is detailed on page 76.

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 has met two times in public in the first three months of 2022/23 and has had 71 per cent attendance from the 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 2022/23 the Primary Care Commissioning Committee completed a Committee Handover report which was produced as part of the close-down process of the CCG and also to provide information to the new incoming ICB Board Members, specifically the Non-Executive Directors. This included a Self-Assessment.

Quality and Patient Experience Committee – Chair, Dr Gerry McSorley

The Quality and Patient Experience Committee (QPEC) was chaired by the Non-Executive with responsibility for Patient and Public Involvement.

The Committee has met two times in the first three months of 2022/23 and has had 85 per cent 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 2022/23 the Quality and Patient Experience Committee completed a Committee Handover report which was produced as part of the close-down process of the CCG and also to provide information to the new incoming ICB Board Members, specifically the Non-Executive Directors.

Finance and Performance Committee – Chair, Mr Graham Felston

The Finance and Performance Committee is Chaired by one of the CCG Non-Executive Directors. The Committee met three times during the first three months of 2022/23 and has had 67 per cent 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 2022/23 the Finance and Performance Committee completed a Committee Handover report which was produced as part of the close-down process of the CCG and also to provide information to the new incoming ICB Board Members, specifically the Non-Executive Directors. This included 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 are 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.

However, we believe that good governance is important and therefore 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 as of 30 June 2022.

Discharge of Statutory Functions

NHS Lincolnshire 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 legislation 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 the 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 CCG recognises that the principles of governance must be supported by an effective risk management system which is embedded throughout the organisation and is integral to its business processes and procedures. The principles of risk management apply to all staff and in all areas of the CCG regardless of the type of risk.

The CCG Board is ultimately responsible for ensuring that an effective risk-aware culture is in place and that risk is effectively managed, recorded, reported and mitigated. The process of risk escalation through the committees and Board is an essential mechanism to ensuring that senior managers and executives as well as Board members are aware of current and emerging risks and that prompt action is taken to mitigate them.

In February 2021 the CCG agreed six 'themed' objectives through to March 2022, which were subsequently rolled forward to the end of June 2022 in light of the delay in the establishment of ICBs from 1st April 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 for 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
Systems Leadership/ Reputation	Accountable Officer
Quality, safe and effective services	Director of Quality and Nursing
Financial sustainability	Director of Finance and Contracting
Service transformation	Director of Operations

The six themes have been underpinned by four operational objectives in the first three months of 2022/23 as follows:

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 England.

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

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

Senior Risk Lead	Risk Area of Lead Responsibility
Director 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 Deputy Director of Finance	• Insight Led • Information Governance • Finance • Commissioning Support Services • Key Performance Indicators • Political, Strategic, Reputational and legal risks (DOF and DON) • BAF delivery
Director for System Delivery and/or Deputy Director for System Delivery	• 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
Director for System Strategy and Planning	• Integrated Care System • Acute Services Review
ICB Board Secretary	• Business Continuity • Governance
Countering Fraud & Bribery Champion	• Countering Fraud and Bribery

Risk Management Group and Risk Management Strategy and Framework

The CCG has a Risk Management Group which has responsibility for undertaking a co-ordinated review of risk and ensuring that the CCG takes a consistent approach to risk assessment and risk measurement.

Oversight for the Risk Management Group is through the Senior Managers Operational Delivery Group (SMODG) with an overarching oversight by the Audit and Risk Committee.

The core membership and responsibilities of the Risk Management Group are as detailed in the table above.

The Risk Management Group met on one occasion during the period 1 April 2022 to 30 June 2022 which took place on the 24th May 2022

The Group considered the latest version of the CCG Corporate Risk Register and specifically those risks rated as red. The Group also considered the details of two new financial risks which had been submitted for consideration. It was agreed to add those to the Corporate Risk Register.

In 2021 the CCG updated its Risk Management Strategy and Framework which details the governance structure and the process for managing risk. Everyone within the CCG has responsibility for identifying and responding to risk. In addition, there are senior managers who have specific lead responsibility for routinely managing key areas of risk.

Responsibilities have been attributed to the CCGs' Committees and Board.

CCG Risk Register

The Corporate Risk Register contains operational risks related to the delivery of operational objectives and priorities of the CCG. As of 30 June 2022, the CCG had three red risks which are detailed in the table below.

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

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.

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

The Health and Care Act 2022 completed the parliamentary process and received Royal Assent on 28 April. This confirms the establishment of statutory Integrated Care Systems (ICSs) on 1 July. The Health and Care Bill requires ICS to have two statutory functions:

- Integrated Care Board (ICB): bringing the NHS together locally to improve population health and care. In addition, the functions currently performed by Clinical Commissioning Groups will be conferred onto ICBs.
- Integrated Care Partnership (ICP): a joint committee of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly created by the County Council and Integrated Care Board with specific statutory responsibility for preparing an Integrated Care Strategy for the ICS footprint.

In establishing the Integrated Care Boards on 1 July, CCGs will be subsumed into the ICB and will be statutorily dissolved at midnight on 30 June 2022.

To ensure the smooth transition to the ICB and effective closure of the CCG, staff within the CCG have been working to deliver the requirements outlined by NHS England and Improvement guidance. The guidance focused on the due diligence requirements to ensure the effective closure of the CCG and the readiness to operate requirements to ensure the legal establishment of the ICB.

CCG Due Diligence

NHSEI published 'ICS implementation guidance: Due diligence, transfer of people and property from CCGs to ICBs and CCG close down' in August 2021.

This document outlines the due diligence process required for the safe transfer of people (staff) and property (in its widest sense) from clinical commissioning groups (CCGs) to integrated care boards (ICBs) and the legal processes used for transfer, establishment and close down.

To ensure the due diligence process was delivered effectively an ICB Transition Programme Board was established in December 2021 which was chaired by the rector of Finance and Contracting, with senior representation for each workstream (Finance, HR, Governance, Quality, IT & IG). The Programme Board has met monthly and regularly reported progress to the Audit and Risk Committee.

The System Strategy and Planning Director are members of the Programme Board to ensure alignment with the process for developing the Readiness to Operate.

Each workstream lead developed, and has been implementing, a transition plan for their areas of responsibility. The Programme Board has monitored overall progress and dealt with risks and issues as they have arisen.

The National Due Diligence checklist has been a key part of the planning and implementation process for the Programme Board. This is a live document and is held in a shared document repository currently maintained by the CCG Company Secretary, along with supporting evidence. Internal Audit has also provided independent assurance on the transition process to the Audit Committee.

This has included attendance at all Programme Boards and Finance Workstream project meetings, review of workstream plans, and governance arrangements.

Internal audit performed three specific reviews on the completeness and accuracy of higher-risk Due Diligence information – Contract Register, Staff Transfer Information and Quality Governance Metrics. These audits have found the relevant Due Diligence information to reconcile to the source information, but at the same time identified a small number of areas where processes could be improved going forward.

The formal audit report findings will be handed over to the ICB Audit Committee for any follow-up and a handover report has been produced.

To complete the process John Turner as Chief Executive of the CCG had to provide in writing assurance that NHS Lincolnshire CCG followed a robust due diligence process to prepare for closedown and for the safe transfer of staff and property (in its widest sense) to NHS Lincolnshire Integrated Care Board on 1 July 2022.

Readiness to Operate Statement

NHSEI published 'ICS implementation guidance: ICB Readiness to Operate Statement (ROS) and Checklist' in August 2021. The ROS checklist provides a high-level summary of the legal and operationally critical elements that need to be in place for the establishment of ICBs.

The checklist reflects core elements of the ICB functions, governance and leadership arrangements described in the ICS Design Framework. It includes the due diligence activities needed to prepare for the people, property (in its widest sense) and liabilities of CCGs to be transferred to ICBs.

The ROS Checklist has been submitted in line with NHSEI requirements and supporting evidence was provided at each submission to underpin the assessment. The final submission was made on 10 June 2022 along with the signed ROS statement.

All but one of the criteria in the checklist was identified as being completed. The exception was the Partner Member appointments to the ICB Board which was still being concluded (as at the end of June 2022). The national NHSE Team approved the final submission as at the end of 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 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 carried out a Conflicts of Interest (CoI) audit during 2021/22 with some low-risk rating actions identified. These actions have been addressed as of 30th June 2022.

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 the quality assurance of such models.

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 have been no data quality issues reported during 2022/23 (months 1-3).

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 individuals, that personal information is safeguarded securely and used properly in line with National Data Guardian requirements.

In 2022 the CCG demonstrated it was 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. No update to this was required for the period 1 April 2022 to 30 June 2022.

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 the year that have met the criteria for external reporting to the Information Commissioner's Office.

We have developed data protection 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.

The CCG relies on CSU governance and assurance for the probity and stewardship of services provided.

The CCG keeps all contracts under review in order to ensure efficiency and value for money.

The CCG also receives Service Auditor Reports which provide assurance about the operation of their internal controls and which are detailed later in the Annual Governance Statement along with other sources of assurance, such as from Internal Audit.

Third-party assurances:

Capita Business

Capita Business Services Limited provides Primary Care Support Services to NHS England and CCGs across the country. Capita shared an ISAE3402 Assurance Letter of Comfort in respect of Primary Care Support Services covering the period 1 April 2022 to 30 June 2022. This period included the Transformation of some areas of the PCSE services, which required updates to a number of the standard operating procedures and controls tested in the 2021/22 service auditor report provided by Mazars.

For 2021/22, the auditors noted exceptions on 8 out of 17 control objectives. The report provided a Qualified Opinion that the exceptions were minor. NHS England continues to work with Capita to assure the control measures in place are applied consistently by the operational teams and to address the improvement actions identified.

NHS Shared Business Services Authority

NHS Shared Business Services Authority shared a Service Auditor report bridging letter as an assurance of the control environments for the following services, for the period 1 April to 30 June 2022:

- Dental Payments
- Prescription Payments
- Electronic Staff Record (ESR)
- Human Resources (HR) Shared Services

The letter included an update on the actions taken to address exceptions identified in the service auditor reports for the year ended 31 March 2022.

NHS Shared Business Services

NHS Shared Business Services shared a Service Auditor report bridging letter for the period 1 April to 30 June 2022.

The letter advised for the period of 1 April 2022 through to 30 June 2022, to their knowledge, there have been no changes to the internal controls for Finance and Accounting or Procurement (NHS SBS), which were described in the ISAE3402 2021/22 Reports, that could materially or adversely affect such internal controls subsequent to the date of the ISAE3402 2021/22 Reports that have not been previously disclosed within the ISAE3402 2021/22 Reports. With regards to ISAE3402 2021/22, all exceptions have been addressed.

Control Issues

The CCG has implemented governance, risk management and internal control processes and subjected them to scrutiny through the various Committees of the Board. There were no control issues identified within the return covering the period 1 April 2022 to 30 June 2022.

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

The CCG Board has overarching responsibility for ensuring there are appropriate arrangements in place to exercise CCG functions effectively, and economically. The CCG sets a Financial Plan at the beginning of the year which is as agreed by the CCG Board.

The Plan is monitored on a monthly basis and reported to the Board.

The CCG also uses non-financial measures to manage its day-to-day business and to give a comprehensive and balanced view of performance. The Governing Body reviews the performance report on a monthly basis.

In April 2022 the CCG was required to submit a draft financial plan covering the time period 1 April 2022 to 31 March 2023 in line with national requirements. This covered the Quarter One period for the CCG (1 April 2022 to 30 June 2022 and nine months of the ICB (1st July 2022 to 30th March 2023).

The CCG Board reviewed the draft Financial Plan at its meeting held on the 25 May 2022 (following a detailed review by the Finance and Performance Committee) and noted the contents along with the proposed budget for Quarter One 2022/23.

An update on the financial position was provided to the CCG Board at its final meeting held on 29 June 2022.

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.

Counter fraud arrangements

The CCG is compliant with the NHS Counter Fraud Authority Standards for Commissioners: Fraud, Bribery and Corruption. The submission of the Counter Fraud Functional Standard Return (CFFSR) on the NHS Counter Fraud Authority (NHS CFA) portal was completed on 8 June 2022. The CCG's overall rating is Green.

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 three new referrals of fraud reported during Quarter One 2022/23 which were all subsequently closed.

Head of Internal Audit Opinion

Following the 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 Quarter One 2022/23, Internal Audit issued the following audit reports:

	OVERALL
Corporate Governance	Low
Risk	Low

The Audit and Risk Committee acknowledges the risks identified in the reports presented. Any actions associated with the two areas identified will be handed over to the ICB Audit and Risk Committee to monitor as appropriate.

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.

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

Improvement and strengthening of financial controls were undertaken following a review in the early part of the year.

During the first three months of 2022/23, the CCG has developed and strengthened its governance arrangements.

The CCG will continue to use the Board Assurance Framework to assure the Board and others that the CCG's key controls to manage strategic risks are assessed and continuously improved.

Mr John Turner
Accountable Officer (Chief Executive)
July 2023

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 and other senior managers for the period ended 30 June 2022. Prior year comparators are provided for April 2021 to March 2022.

The CCG's Remuneration Committee, which is a Committee of the Governing Body, 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 CCG's probity and financial integrity as part of the corporate governance arrangements.

Remuneration Committee

The membership of the Remuneration Committee throughout the period April to June 2022 was as follows:

Mrs Fenella Chambers	Non-Executive Director and Chair of the Remuneration Committee
Mr Graham Felston	Non-Executive Director
Mrs Janet Inman	Non-Executive Director
Ms Sue Liburd	Non-Executive Director
Dr Gerry McSorley	Acting Chair of the CCG

There was one meeting of the Remuneration Committee held in the period April to June 2022 and further information on attendance is included in the Annual Governance Statement.

Arden & GEM are contracted by the CCG to provide professional Human Resource advice to the CCG. Although Arden & GEM were paid for the advice as part of their overall contract, no fee or other payment was made to any individual employed by Arden & GEM CSU.

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. To avoid any conflict of interest in

respect of Lay Members who constitute the majority of the membership of the Remuneration Committee, their own remuneration is set directly by the Governing Body. The Lay Members 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 receive 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 Lay Members from the Governing Body 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 NHS England 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 Governing Body for their approval.

Salaries and Allowances [Audited]

Salaries and allowances for the senior managers of the CCG for April 2022 to June 2022 are shown in Table 1b below, with the full year of 2021/22 in Table 1a for comparison purposes. The notes describe principles which apply to both periods. Pension-related benefits shown in Table 1b are pro rata apportionments of the full year April 2022 to March 2023 data in line with NHS Business Services Authority guidance. This was necessary as pensions data can only be provided on an annual basis.

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 periods shown 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 the 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 period April 2021 to 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 1a

Note that figures in Table 1a are full-year figures for April 2021 to March 2022 and so are likely to be approximately 4 times higher when compared to the first quarter of 2022/23 in Table 1b.

The following comments for Table 1a relate to the full year 2021/22:

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

- Mr Sean Lyons, Chair who left on 31 December 2021 (replaced by Mr Gerry McSorley)
- Mr Gerry McSorley was Non-Executive Director until 31 December 2021 when he became interim Chair
- Mr Murray MacDonald, Non-Executive Director who left on 30 June 2021 (replaced by Mr Graham Felston)
- Mr Graham Felston, Non-Executive Director was in post from 1 July 2021
- Mr Jim Connolly, Non-Executive Director who left on 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 due to the pandemic.

Table 1b: Salaries and Allowances for the period April – June 2022

Name and title	2022-23					
	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	10 - 15	0	0	0	0	10 - 15
Dr David Baker, Locality Clinical Lead	10 - 15	0	0	0	0	10 - 15
Dr David Boldy, Secondary Care Doctor	0 - 5	0	0	0	0	0 - 5
Mr Pete Burnett, System Strategy and Planning Director	25 - 30	0	0	0	5 - 7.5	30 - 35
Ms Fenella Chambers, Non-Executive Director	0 - 5	0	0	0	0	0 - 5
Mr Graham Felston, Non-Executive Director	0 - 5	0	0	0	0	0 - 5
Mr Martin Fahy, Director of Nursing and Quality	25 - 30	0	0	0	27.5 - 30	55 - 60
Mr Matt Gaunt, Director of Finance and Contracting	30 - 35	0	0	0	20 - 22.5	50 - 55
Dr James Howarth, Locality Clinical Lead	Consent to disclose withheld.					
Ms Janet Inman, Non-Executive Director	0 - 5	0	0	0	0	0 - 5
Ms Sue Liburd, Non-Executive Director	0 - 5	0	0	0	0	0 - 5
Mr Gerry McSorley, Interim Chair	10 - 15	0	0	0	0	10 - 15
Ms Sarah-Jane Mills, Chief Operating Officer - West	25 - 30	0	0	0	7.5 - 10	30 - 35
Mr Pete Moore, Non-Executive Director	0 - 5	0	0	0	0	0 - 5
Dr John Parkin, Locality Clinical Lead	10 - 15	0	0	0	0	10 - 15
Ms Clair Raybould, Director of Operations	25 - 30	0	0	0	7.5 - 10	35 - 40
Mr Andy Rix, Chief Operating Officer - South	25 - 30	0	0	0	17.5 - 20	45 - 50
Mr John Turner, Chief Executive	40 - 45	0	0	0	0	40 - 45
Mrs Sandra Williamson, Chief Operating Officer - East	25 - 30	0	0	0	7.5 - 10	30 - 35

Notes to Table 1b
Pension-related benefits shown in Table 1b are pro rata apportionments of the full year April 2022 to March 2023 in line with NHS Business Services Authority guidance. This was necessary as pensions data can only be provided on an annual basis.

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 the period April to June 2022, and none did in the whole of the previous year 2021-22.

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 non-executive directors) their engagement does not qualify as pensionable pay. Figures for the full year for 2021/22 are shown in Table 2a but figures for April to June 2022 (Table 2b) are pro rata apportionments of the full year April 2022 to March 2023 in line with NHS Business Services Authority guidance. This was necessary as pensions data is only provided on an annual basis.
The notes describe principles which apply to both periods.

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 2021/22 and 2022/23.
3. Pension figures included in the table below are for senior managers that have pensions paid directly by the CCG and include all 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 can 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, re-joined the pension scheme on 1 April 2021 and left again on 31 December 2021, so pension and CETV figures are shown as of 31 December 2021 in Table 2a 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 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 2021	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	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	164	9	182	0
Mr Pete Burnett, System Strategy and Planning Director	2.5 - 5	0	35 - 40	0	359	23	398	0
Mr Martin Fahy, Director of Nursing and Quality	2.5 - 5	7.5 - 10	60 - 65	150 - 155	1,080	91	1,194	0
Mr Matt Gaunt, Director of Finance and Contracting	2.5 - 5	0	25 - 30	0	397	30	448	0
Ms Sarah-Jane Mills, Chief Operating Officer - West	2.5 - 5	7.5 - 10	45 - 50	105 - 110	904	97	1,020	0
Ms Clair Raybould, Director of Operations	0 - 2.5	0 - 2.5	25 - 30	45 - 50	438	22	478	0
Mr Andy Rix, Chief Operating Officer - South	2.5 - 5	7.5 - 10	50 - 55	155 - 160	1,178	105	1,304	0
Mr John Turner, Chief Executive	7.5 - 10	17.5 - 20	55 - 60	150 - 155	1,044	189	1,255	0
Mrs Sandra Williamson, Chief Operating Officer - East	5 - 7.5	5 - 7.5	40 - 45	75 - 80	586	82	686	0

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 April to June 2022.

Table 2b: Pension Benefits for the period April - June 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 30 June 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 30 June 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 30 June 2022	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr Majid Akram, Locality Clinical Lead	0	0	10 - 15	20 - 25	182	0	178	0
Mr Pete Burnett, System Strategy and Planning Director	0 - 2.5	0	35 - 40	0	398	4	409	0
Mr Martin Fahy, Director of Nursing and Quality	0 - 2.5	2.5 - 5	60 - 65	155 - 160	1,194	30	1,238	0
Mr Matt Gaunt, Director of Finance and Contracting	0 - 2.5	0	30 - 35	0	448	17	474	0
Ms Sarah-Jane Mills, Chief Operating Officer - West	0 - 2.5	0 - 2.5	50 - 55	105 - 110	1,020	11	1,043	0
Mrs Clair Raybould, Director for System Delivery	0 - 2.5	0 - 2.5	30 - 35	45 - 50	478	7	492	0
Mr Andy Rix, Chief Operating Officer - South	0 - 2.5	0 - 2.5	55 - 60	155 - 160	1,304	0	32	0
Mrs Sandra Williamson, Chief Operating Officer - East	0 - 2.5	0 - 2.5	40 - 45	80 - 85	686	8	703	0

Table 2 covers the period April to June 2022. Data provided by the NHS Pensions Agency for the full year 2022/23 has been pro-rated to give the figures shown.

As described above, pension information as at 30 June 2022 was estimated from full-year data for the period April 2022 to March 2023 as the NHS Pensions Agency are only able to provide data for the full financial year. This was done by:

- Starting with the opening figures as at 1 April 2022.
- Uplifting the opening figures in line with the HM Treasury price increase tables (taking 25% of the annual uplift to estimate the increase from April to June).
- Adding an estimate of the real increase in pensions from April to June by apportioning the annual increase across the year.

Also, note the following:

- Mr John Turner chose not to be covered by the pension arrangements during the reporting period.
- Mr Andy Rix exceeded the normal pension age for the pension scheme known as the Existing Scheme during 2022/23. This means that year-end figures for the Cash Equivalent Transfer Value (CETV) were declared as nil in accordance with the prevailing NHS guidance. Hence, nil value is shown in Table 2b for the Existing Scheme, but the apportionment methodology could be applied to the 2015 Scheme and the outcome of £32k for the CETV has been included.

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.

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that were extant at 31 March 2023.HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023 to 2024 CETV figures.

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 April to June 2022 (and there were none in 2021/22).

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 for the highest paid director. Prior-year comparators are also required and are presented in the second table. There are no material transactions other than salaries and allowances.

The change from 2021-22 to 2022-23

Percentage changes from 2021-22 to 2022-23	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	11.4%	n/a
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	2.7%	n/a

The small increase in average staff pay reflects a reduction in the use of 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.

The change from 2020-21 to 2021-22

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; there was a part-year effect in 2021-22 before the full year effect the following year.

Pay ratio information

As at 30 June 2022, remuneration ranged from £2,500 to £172,500 (2021/22: £2,500 to £172,500) 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.

Remuneration of Lincolnshire CCG staff is 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 2022	15 - 20	25 - 30	45 - 50
As at 30 June 2022	20 - 25	30 - 35	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 Governing Body in the CCG in the period April to June 2022 was annualised full time equivalent remuneration of £170-£175,000 (2021/22: £170-£175,000) based upon gross earnings in June 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
2021-22	10.66	6.21	3.76
2022-23	8.48	5.52	3.76

In 2022/23 no employees received remuneration greater than the highest-paid director (and nor did they in 2021/22).

The midpoint of the banded remuneration for the highest paid member of the Governing Body was 5.52 times the median remuneration of the workforce (2021/22: 6.21), which was £30-£35,000 (2021/22: £25-£30,000). The ratio has reduced because a lower use of interim staff for the vaccination programme has increased the median salary. Similarly, the use of interim staff for the vaccination programme has also increased the value of the 25th percentile, hence reducing the ratio with the highest paid member of the Governing Body over the reporting period.

Description	2022/23	2021/22
Band of highest paid directors' total remuneration (£'000)	170 - 175	170 - 175
Band of median (£'000)	30 - 35	25 - 30
Ratio of median to banded midpoint of highest paid director	5.52	6.21

Exit Packages for the period April to June 2022 [Audited]

There were no exit packages agreed in the period April to June 2022 (and there were none in 2021/22).

Table 1: Exit Packages for the period April to June 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 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

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 period. 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 in the period April to June 2022 (and there were none in 2021/22).

Table 1: Other Agreed Departures for the period April to June 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 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

As a single exit package 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.

Staff Report

Quarter 1 in 2022/23 saw extensive preparations by the CCG for the transfer of staff to the newly established Integrated Care Board from 1 July 2022. The CCG planned a number of events (both virtual and in person) that staff could attend to find out more about the upcoming transfer to the new organisation.

Preparations were also in place to ensure that there would be a seamless transfer of services to the new organisation and staff were kept informed of changes taking place through the CCGs weekly briefing Team Talk Live and its weekly newsletter Team Talk News.

Staff Engagement

Throughout Quarter One the Staff Engagement Team met and continued their excellent work on a number of staff engagement activities including the NHS Lincolnshire “Tree for Me” recognition scheme, shaping our return to the office post-COVID, and preparing our teams for the transfer to the ICB which is due to take place on 1 July 2022. We place on record our thanks to all members of Staff Engagement Group (SEG) throughout this busy first quarter of the year.

Staff Health & Wellbeing

We had a continued focus on health and wellbeing for our staff and we continued to support them through our retained Occupational Health Services, our Employee Assistance Programme and a number of bespoke initiatives promoted by our teams including Men’s Health Week, Diabetes Awareness and Healthy Eating Week.

Staff Turnover

Turnover rate for the CCG staff in Quarter One was 23.14 per cent in April, 23.75% in May and 23.60 per cent in June 2022.

The CCG monitors its 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 CCG's senior management team who will ensure that any recommendations are implemented accordingly.

Trade Union Facility time

The CCG 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 Quarter 1 of 2022/23, there were no concerns raised that required investigation under this policy.

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 in Quarter 1 our absence was 4.52 per cent. Although slightly higher than our year-end figure of 4.28 per cent this is still commendable given that our staff have been continuing to work in challenging conditions brought about by the pandemic.

Details on our Off Payroll Engagements, Staff Composition and Sickness Absence can be found on the next two pages.

Off Payroll Engagements

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

For all highly paid off-payroll engagements as of 30 June 2022, greater than £245 per day:

	Number
Number of existing engagements as of 30 June 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 2022 and 30 June 2022, greater than £245 per day:

	Number
The number of off-payroll workers engaged between April 2022 and June 2022	4
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	1
The number subject to off-payroll legislation and determined as out-of-scope of IR35	3
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 2022 and 30 June 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.	19

Staff composition table

Payscale	Gender	Permanent/Fixed Term staff (WTE)	Bank Staff (headcount)
Band 2	Female	4.70	1.00
	Male	4.00	0.00
Band 3	Female	20.37	0.00
	Male	8.00	0.00
Band 4	Female	58.11	57.00
	Male	11.24	17.00
Band 5	Female	30.97	67.00
	Male	10.04	6.00
Band 6	Female	42.61	23.00
	Male	14.00	1.00
Band 7	Female	45.79	3.00
	Male	10.00	0.00
Band 8a	Female	34.92	7.00
	Male	16.00	1.00
Band 8b	Female	22.51	3.00
	Male	5.00	0.00
Band 8c	Female	12.00	3.00
	Male	3.00	0.00
Band 8d	Female	3.00	0.00
	Male	3.50	0.00
Band 9	Female	3.00	2.00
	Male	2.00	2.00
Board Members	Female	0.00	0.00
	Male	3.00	0.00
GP's/Clinical Advisors	Female	0.40	0.00
	Male	2.33	0.00
VSM	Female	3.00	0.00
	Male	1.00	0.00

	Female		Male		Total	
	Headcount	% of workforce	Headcount	% of workforce	Headcount	% of workforce
Board Members	0	0.00%	3	0.71%	3	0.71%
Senior Managers (Band 8c and above)	21	4.94%	10	2.35%	31	7.29%
Other members of staff	301	70.82%	90	21.18%	391	92.00%
Total	322	75.76%	103	24.24%	425	100.00%

Sickness Absence Tables

Sickness Absence Data	
	Apr-Jun 2022
Total days lost	609
Total staff years	78
Average working days lost	7.8

Month	Apr-22	May-22	Jun-22
Monthly Sickness	4.52%	4.09%	4.96%
Cumulative Sickness	4.52%	4.30%	4.52%
Cost	£57,561	£48,098	£58,483

Staff Policies

Our existing policies were previously aligned with the four constituent CCGs to ensure our managers had access to consistent information. Our staff intranet is regularly updated and in Quarter One we continued to highlight our wellbeing offers to staff to support them in both their physical and mental health. We continue to 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 discussion. 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 is available on our website. This information is part of our public commitment to meeting the equality duties placed upon us by legislation and we pledge to update this regularly

Further specific information is included in the section on equality and diversity.

Expenditure on consultancy is £3,103 in April to June 2022 (£597,127 in 2021/22).

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.

John Turner
Accountable Officer (Chief Executive)
July 2023

Entity name:	NHS Lincolnshire CCG
This year	For the three months 1 April 2022 to 30 June 2022
Last year	2021-22
This year ended	30 June 2022
Last year ended	31 March 2022
This year commencing:	1 April 2022
Last year commencing:	1 April 2021

Contents

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

	Note	For the three months 1 April 2022 to 30 June 2022 £'000	2021-22 £'000
Income from sale of goods and services	2	(754)	(2,028)
Other operating income	2	(429)	-
Total operating income		**(1,183)**	(2,028)
Staff costs	4	5,182	21,274
Purchase of goods and services	5	371,548	1,496,709
Depreciation and impairment charges	5	17	-
Provision expense	5	274	2,873
Other Operating Expenditure	5	172	(91)
Total operating expenditure		**377,193**	1,520,765
Net Operating Expenditure		**376,010**	1,518,737
Finance income		-	-
Finance expense		4	-
Net expenditure for the Year		**376,014**	1,518,737
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**376,014**	1,518,737
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of right-of-use assets		-	-
Net (gain)/loss on assets held for sale		-	
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Reclassification adjustment on disposal of available for sale financial assets		-	-
Comprehensive Expenditure for the year		**376,014**	1,518,737

Notes 1 to 40 form part of this statement.

Statement of Financial Position as at 30th June 2022

	Note	30th June 2022 £'000	2021-22 £'000
Non-current assets:			
Right-of-use assets	12	401	-
Total non-current assets		401	-
Current assets:			
Trade and other receivables	16	12,090	11,442
Cash and cash equivalents	19	1	5
Total current assets		**12,091**	11,447
Total current assets		**12,091**	11,447
Total assets		**12,492**	11,447
Current liabilities			
Trade and other payables	22	(64,648)	(74,855)
Lease liabilities	12	(60)	-
Provisions	28	(3,830)	(3,701)
Total current liabilities		**(68,539)**	(78,555)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(56,047)**	(67,108)
Lease liabilities	12	(343)	-
Provisions	28	(39)	(40)
Total non-current liabilities		**(383)**	(40)
Assets less Liabilities		**(56,429)**	(67,148)
Financed by Taxpayers' Equity			
General fund		(56,429)	(67,149)
Total taxpayers' equity:		**(56,429)**	(67,148)

Notes 1 to 40 form part of this statement.

The financial statements on pages 92 to 95 were approved by the Board on 19 July 2023 and signed on its behalf by:

John Turner
Accountable Officer (Chief Executive)
July 2023

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

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for For the three months 1 April 2022 to 30 June 2022		
Balance at 01 April 2022	(67,149)	(67,149)
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(67,149)**	(67,149)
Changes in NHS Clinical Commissioning Group taxpayers' equity For the three months 1 April 2022 to 30 June 2022		
Net operating expenditure for the financial year	(376,013)	(376,013)
Total revaluations against revaluation reserve	-	-
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Period	**(376,013)**	(376,013)
Net funding	386,734	386,734
Balance at 30th June 2022	**(56,429)**	(56,429)

	General fund £'000	Total reserves £'000
Balance at 01 April 2021	(69,076)	(69,076)
Transfer of assets and liabilities from closed NHS bodies	-	-
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(69,076)**	(69,076)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22		
Net operating costs for the financial year	(1,518,737)	(1,518,737)
Total revaluations against revaluation reserve	-	-
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)

Statement of Cash Flows for the period ended 30 June 2022

Statement of Cash Flows for the period ended 30th June 2022

	Note	For the three months 1 April 2022 to 30 June 2022 £'000	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(376,014)	(1,518,737)
Depreciation and amortisation	5	17	-
Interest paid		4	-
(Increase)/decrease in trade & other receivables	16	(648)	(3,285)
Increase/(decrease) in trade & other payables	22	(10,206)	(1,509)
Provisions utilised	28	(146)	(18)
Increase/(decrease) in provisions	28	274	2,873
Net Cash Inflow (Outflow) from Operating Activities		**(386,719)**	(1,520,677)
Cash Flows from Investing Activities			
Net Cash Inflow (Outflow) from Investing Activities		**-**	-
Net Cash Inflow (Outflow) before Financing		**(386,719)**	(1,520,677)
Cash Flows from Financing Activities			
Net Funding Received		386,734	1,520,664
Repayment of lease liabilities	12	(19)	-
Net Cash Inflow (Outflow) from Financing Activities		**386,715**	1,520,664
Net Increase (Decrease) in Cash & Cash Equivalents	19	**(4)**	(13)
Cash & Cash Equivalents at the Beginning of the Financial Year		**5**	18
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**1**	5

Notes 1 to 40 form part of this statement.

Notes to the financial statements

Note 1 Acounting Policies

1 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 were abolished and the functions, assets and liabilities of NHS Lincolnshire CCG were transfered 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.

Due to rounding of transactions, in some places, there may be minor rounding differences in relation to casting/cross-casting in these accounts

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
Note 1 Accounting Policies

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 asincome inaccordance withIAS 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
Note 1 Accounting Policies

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,
- 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
Note 1 Accounting Policies

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 Recognition**

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
Note 1 Accounting Policies

1.12.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.12.3 **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 anyresidual value, over their estimated useful lives, ina mannerthat reflectsthe 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
Note 1 Accounting Policies

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.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale.

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
Note 1 Accounting Policies

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 medium-term rate of 0.70% (2021-22: 0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 0.95% (2021-22 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 0.66% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

HM Treasury have issued a nominal discount rate for the 2022 calendar year in December 2021 as shown above, as part of its annual release of discount rates. A discount rate for the 2023 calendar year will be issued in December 2022.

When someor all of theeconomic benefits requiredtosettle aprovision are expectedtobe recovered froma 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
Note 1 Accounting Policies

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 cashflow and business model characteristics of the financial assets, asset 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
Note 1 Accounting Policies

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.

Notes to the financial statements
Note 1 Accounting Policies

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 the 3 months to 30 June 2022. 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 interpretationissued by the International Financial Reporting Interpretations Committee (IFRIC 4);
- The Clinical Commissioning Group hosts some staff and service costs for the Lincolnshire Sustainability andTransformation 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).

Notes to the financial statements
Note 1 Accounting Policies

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.

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

	For the three months 1 April 2022 to 30 June 2022 Total £'000	2021-22 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	-	(1)
Prescription fees and charges	400	1,516
Other Contract income	308	359
Recoveries in respect of employee benefits	46	154
Total Income from sale of goods and services	754	2,028
Other operating income		
Other non contract revenue	429	-
Total Other operating income	429	-
Total Operating Income	1,183	2,028

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

	Prescription fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Source of Revenue			
NHS	-	-	46
Non NHS	400	308	-

	Prescription fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Timing of Revenue			
Point in time	-	-	-
Over time	400	308	46
Total	400	308	46

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

	For the three months 1 April 2022 to 30 June 2022		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	3,889	104	3,993
Social security costs	456	-	456
Employer Contributions to NHS Pension scheme	716	-	716
Apprenticeship Levy	17	-	17
Gross employee benefits expenditure	5,077	104	5,182
Less recoveries in respect of employee benefits (note 4.1.2)	(46)	-	(46)
Total - Net admin employee benefits including capitalised costs	5,031	104	5,136
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	5,031	104	5,136

4.1.1 Employee benefits	2021-22		
	Permanent Employees £'000	Other £'000	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
Apprenticeship Levy	64	-	64
Gross employee benefits expenditure	19,380	1,894	21,274
Less recoveries in respect of employee benefits (note 4.1.2)	(154)	-	(154)
Net employee benefits excluding capitalised costs	19,225	1,894	21,119

4.1.2 Recoveries in respect of employee benefits

	For the three months 1 April 2022 to 30 June 2022			2021-22
	Permanent Employees £'000	Other £'000	Total £'000	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(37)	-	(37)	(122)
Social security costs	(5)	-	(5)	(15)
Employer contributions to the NHS Pension Scheme	(5)	-	(5)	(17)
Total recoveries in respect of employee benefits	(46)	-	(46)	(154)

4.2 Average number of people employed

	For the three months 1 April 2022 to 30 June 2022			2021-22
	Permanently employed Number	Other Number	Total Number	Total Number
Total	282	110	392	366
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 period ending 30 June 2022 (financial year ending 31 March 2022 nil).

4.4 Pension costs

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

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

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

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

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

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

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

5. Operating expenses

	For the three months 1 April 2022 to 30 June 2022 Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	1,908	8,554
Services from foundation trusts	67,257	258,428
Services from other NHS trusts	173,331	687,226
Services from Other WGA bodies	36	25
Purchase of healthcare from non-NHS bodies	52,211	224,331
Prescribing costs	36,766	149,676
General Ophthalmic services	19	91
GPMS/APMS and PCTMS	36,141	149,832
Supplies and services – clinical	56	313
Supplies and services – general	113	1,956
Consultancy services	3	597
Establishment	603	1,578
Transport	2,093	8,316
Premises	782	3,823
Audit fees	25	267
Internal audit services	26	146
Other services	50	39
Other professional fees	67	809
Legal fees	12	99
Education, training and conferences	47	604
Funding to group bodies	0	0
Non cash apprenticeship training grants	0	0
Total Purchase of goods and services	**371,548**	1,496,709
Depreciation and impairment charges		
Depreciation	17	0
Total Depreciation and impairment charges	**17**	0
Provision expense		
Change in discount rate	0	0
Provisions	274	2,873
Total Provision expense	**274**	2,873
Other Operating Expenditure		
Chair and Non Executive Members	56	159
Grants to Other bodies	0	0
Clinical negligence	2	11
Research and development (excluding staff costs)	0	0
Expected credit loss on receivables	2	(263)
Expected credit loss on other financial assets (stage 1 and 2 only)	0	0
Inventories written down	0	0
Inventories consumed	0	0
Other expenditure	113	2
Total Other Operating Expenditure	**172**	(91)
Total operating expenditure	**372,011**	1,499,491

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 for the period ended 30 June 2022 is £198,000 + VAT. £54,000 (inclusive of VAT) has been recognised in CCG accounts as shown under 'Audit fees' above.

In addition to the £54,000 recognised in these financial statements, there is an accrual reversal relating to the 2021-22 audit of £29,200 (inclusive of VAT) that was not agreed until November 2022. As such, the 2021/22 overruns totalling £35,642 (inclusive of VAT) have been recognised in the ICB financial statements.

The CCG's contract with its auditors provides for a limitation of the auditor's liability of £2,000,000.

Internal audit services are provided by PricewaterhouseCoopers LLP, fees for the 3 months reported were £26,000.

Within the total operating expenditure of £372,010,681 there are costs relating to COVID-19 activities of £2,546,517 which are fully reimbursed by NHS England & Improvement.

6.1 Better Payment Practice Code

Measure of compliance	For the three months 1 April 2022 to 30 June 2022 Number	For the three months 1 April 2022 to 30 June 2022 £'000	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	12,468	112,066	50,112	464,415
Total Non-NHS Trade Invoices paid within target	12,366	109,629	49,567	459,726
Percentage of Non-NHS Trade invoices paid within target	**99.18%**	**97.83%**	98.91%	98.99%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	330	243,257	979	967,014
Total NHS Trade Invoices Paid within target	324	243,234	944	966,769
Percentage of NHS Trade Invoices paid within target	**98.18%**	**99.99%**	96.42%	99.97%

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 the 3 months to 30 June 2022.

7. Income Generation Activities

The CCG did not undertake any income generation activities in either 2021-22 or the 3 months to 30 June 2022.

8. Investment revenue

The CCG received no investment revenue during either 2021-22 or the 3 months to 30 June 2022.

9. Other gains and losses

There were no other gains and losses during either 2021-22 or the 3 months to 30 June 2022.

10.1 Finance costs

	For the three months 1 April 2022 to 30 June 2022 £'000	2021-22 £'000
Interest		
Interest on lease liabilities	4	-
Total interest	4	-
Total finance costs	4	-

10.2 Finance income

The CCG did not receive any finance income during either 2021-22 or the 3 months to 30 June 2022.

11. Net gain/(loss) on transfer by absorption

The CCG did not receive any finance income during either 2021-22 or the 3 months to 30 June 2022.

12 Leases

12.1 Right-of-use assets

For the three months 1 April 2022 to 30 June 2022	Buildings excluding dwellings £'000	Total £'000
IFRS 16 Transition Adjustment	418	418
Cost/Valuation at 30th June 2022	**418**	**418**
Depreciation 01 April 2022	-	-
Charged during the year	17	17
Depreciation at 30th June 2022	**17**	**17**
Net Book Value at 30th June 2022	**401**	**401**

Revaluation Reserve Balance for right-of-use assets

	Buildings £'000	Total £'000
Balance at 01 April 2022	-	-
Revaluation gains	-	-
Impairments	-	-
Release to general fund	-	-
Other movements	-	-
Balance at 30th June 2022	**-**	**-**

12 Leases cont'd

12.2 Lease liabilities

	For the three months 1 April 2022 to 30 June 2022 £'000
Lease liabilities at 01 April 2022	-
IFRS 16 Transition Adjustment	418
Interest expense relating to lease liabilities	4
Repayment of lease liabilities (including interest)	(19)
Lease liabilities at 30th June 2022	**403**

12.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	For the three months 1 April 2022 to 30 June 2022 £'000
Within one year	(75)
Between one and five years	(300)
After five years	(81)
Balance at 30th June 2022	**(456)**
Effect of discounting	53
Included in:	
Current lease liabilities	(60)
Non-current lease liabilities	(343)
Balance at 30th June 2022	**(403)**

12.4 Amounts recognised in Statement of Comprehensive Net Expenditure

For the three months 1 April 2022 to 30 June 2022	For the three months 1 April 2022 to 30 June 2022 £'000
Depreciation expense on right-of-use assets	17
Interest expense on lease liabilities	4
Expense relating to short-term leases	69

12.5 Amounts recognised in Statement of Cash Flows

	For the three months 1 April 2022 to 30 June 2022 £'000
Total cash outflow on leases under IFRS 16	(19)

13 Intangible non-current assets

The CCG did not hold any intangible non-current assets during either 2021-22 or the 3 months to 30 June 2022.

14 Investment property

The CCG did not hold any investment property during either 2021-22 or the 3 months to 30 June 2022.

15 Inventories

The CCG had no inventories as at 30 June 2022 (nil as at 31 March 2022).

16.1 Trade and other receivables	**Current**	**Non-current**	Current	Non-current
	For the three months 1 April 2022 to 30 June 2022	**For the three months 1 April 2022 to 30 June 2022**	2021-22	2021-22
	£'000	**£'000**	£'000	£'000
NHS receivables: Revenue	2,898	-	284	-
NHS prepayments	1,123	-	56	-
NHS accrued income	85	-	3,254	-
Non-NHS and Other WGA receivables: Revenue	782	-	517	-
Non-NHS and Other WGA prepayments	2,775	-	1,750	-
Non-NHS and Other WGA accrued income	4,297	-	5,106	-
Expected credit loss allowance-receivables	(186)	-	(185)	-
VAT	314	-	645	-
Other receivables and accruals	4	-	15	-
Total Trade & other receivables	**12,090**	**-**	11,442	-
Total current and non current	**12,090**		11,442	
Included above:				
Prepaid pensions contributions	-		-	

16.2 Receivables past their due date but not impaired

	For the three months 1 April 2022 to 30 June 2022	**For the three months 1 April 2022 to 30 June 2022**	2021-22	2021-22
	DHSC Group Bodies	**Non DHSC Group Bodies**	DHSC Group Bodies	Non DHSC Group Bodies
	£'000	**£'000**	£'000	£'000
By up to three months	348	68	50	348
By three to six months	14	14	-	6
By more than six months	175	15	175	6
Total	**536**	**98**	225	361

16.3 Loss allowance on asset classes	**For the three months 1 April 2022 to 30 June 2022**	**For the three months 1 April 2022 to 30 June 2022**	**Total**
	Trade and other receivables - Non DHSC Group Bodies	**Other financial assets**	
	£'000	**£'000**	**£'000**
Balance at 01 April 2022	(185)	-	**(185)**
Lifetime expected credit losses on trade and other receivables-Stage 2	(2)	-	**(2)**
Lifetime expected credit losses on trade and other receivables-Stage 3	-	-	**-**
Amounts written off	-	-	**-**
Other changes	-	-	**-**
Allowance for credit losses at 30 June 2022	**(186)**	**-**	**(186)**

17 Other financial assets

The CCG has no other financial assets in either 2021-22 or the 3 months to 30 June 2022.

18 Other current assets

The CCG has no other current assets in either 2021-22 or the 3 months to 30 June 2022.

19 Cash and cash equivalents

	For the three months 1 April 2022 to 30 June 2022	2021-22
	£'000	£'000
Balance at 01 April 2022	5	18
Net change in year	(3)	(14)
Balance at 30th June 2022	**1**	5
Made up of:		
Cash with the Government Banking Service	1	5
Cash and cash equivalents as in statement of financial position	**1**	5
Total bank overdrafts	**-**	-
Balance at 30th June 2022	**1**	5

There is no patients' money held by the clinical commissioning group in either 2021-22 or the 3 months to 30 June 2022.

20 Non-current assets held for sale

The CCG has no non-current assets held for sale to disclose in either 2021-22 or the 3 months to 30 June 2022.

21 Analysis of impairments and reversals

The CCG has no impairments and reversals to disclose in either 2021-22 or the 3 months to 30 June 2022.

22 Trade and other payables	**Current For the three months 1 April 2022 to 30 June 2022 £'000**	**Non-current For the three months 1 April 2022 to 30 June 2022 £'000**	Current 2021-22 £'000	Non-current 2021-22 £'000
NHS payables: Revenue	170	-	2,802	-
NHS accruals	8,962	-	4,031	-
Non-NHS and Other WGA payables: Revenue	4,495	-	7,811	-
Non-NHS and Other WGA accruals	33,567	-	37,293	-
Non-NHS and Other WGA deferred income	53	-	32	-
Social security costs	263	-	239	-
Tax	197	-	200	-
Other payables and accruals	16,942	-	22,447	-
Total Trade & Other Payables	**64,648**	**-**	74,854	-
Total current and non-current	**64,648**		74,854	

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 2022; nil).

Other payables include £868,465 outstanding pension contributions at 30 June 2022 (31 March 2022, £883,611). This includes amounts related to GP pensions (£584,511) and outstanding contributions to the NHS Pension Scheme (£281,906) and NEST scheme contributions (£2,048). The in-year movement is attributable to the timing of the payments only.

23 Other financial liabilities

The CCG had no other financial liabilities during the 3 months to 30 June 2022 or 2021-22.

24 Other liabilities

The CCG had no other liabilities during the 3 months to 30 June 2022 or 2021-22.

25. Borrowings

The CCG had no borrowings in either 2021-22 or the 3 months to 30 June 2022.

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

The CCG had no private finance initiative, LIFT and other service concession arrangements during 2021-22 or the 3 months to 30 June 2022.

27. Finance lease receivables

The CCG had no finance lease receivables during either 2021-22 or the 3 months to 30 June 2022.

28. Provisions

	Current	**Non-current**	Current	Non-current
	For the three months 1 April 2022 to 30 June 2022	**For the three months 1 April 2022 to 30 June 2022**	2021-22	2021-22
	£'000	**£'000**	£'000	£'000
Redundancy	118	-	118	-
Continuing care	3,430	10	3,201	11
Other	283	29	382	29
Total	**3,830**	**39**	3,701	40
Total current and non-current	**3,870**		3,742	

	Redundancy £'000	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2022	**118**	**3,212**	**411**	**3,742**
Arising during the year	-	671	-	**671**
Utilised during the year	-	(145)	(1)	**(146)**
Reversed unused	-	(298)	(99)	**(397)**
Unwinding of discount	-	-	-	
Balance at 30th June 2022	**118**	**3,440**	**312**	**3,870**
Expected timing of cash flows:				
Within one year	118	3,430	283	**3,830**
Between one and five	-	10	29	**39**
years After five years	-	-	-	**-**
Balance at 30th June	**118**	**3,440**	**312**	**3,870**

2022 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 30 June 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 (2021-22, £45,832).

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 exists in respect of Learning Disabilities Responsible Commissioner due to 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 £1,557,207 will be paid in less than a year (2021-22, £1,325,334).

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 is being held 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; 2022- 23 is Year Four.

29. Contingencies

	For the three months 1 April 2022 to 30 June 2022 £'000	2021-22 £'000
Contingent liabilities		
Continuing Healthcare	221	289
Net value of contingent liabilities	**221**	289

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 £221,344 as at 30 June 2022 (£289,091 at 31 March 2022).

Contingent assets

The CCG had no contingent assets as at 30 June 2022 (31 March 2022 nil).

30. Commitments

The CCG had no commitment balances during either 2021-22 or the 3 months to 30 June 2022.

31. Financial instruments

31.1 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

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.

31.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the

31.1.2 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.

31.1.4 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.

31.1.5 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.

31 Financial instruments cont'd

31.2 Financial assets

	Financial Assets measured at amortised cost 30th June 2022 £'000	Financial Assets measured at amortised cost 2021-22 £'000
Trade and other receivables with NHSE bodies	736	1,417
Trade and other receivables with other DHSC group bodies	6,473	7,227
Trade and other receivables with external bodies	855	532
Cash and cash equivalents	1	5
Total at 30th June 2022	**8,066**	9,180

31.3 Financial liabilities

	Financial Liabilities measured at amortised cost 30th June 2022 £'000	Financial Liabilities measured at amortised cost 2021-22 £'000
Trade and other payables with NHSE bodies	502	1,107
Trade and other payables with other DHSC group bodies	8,742	5,705
Trade and other payables with external bodies	55,295	67,571
Total at 30th June 2022	**64,539**	74,383

32. Operating segments

NHS Lincolnshire Clinical Commissioning Group considers it has only one operating segment: commissioning of healthcare services

33 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.

33.1 Interests in joint operations

The pooled budgets for the 3 months to 30 June 2022 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 2022-23 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

The Clinical Commissioning Group's share of the income and expenditure as handled by the pooled budgets in the financial year were:

	NHS Lincolnshire Clinical Commissioning Group	Lincolnshire County Council	Total Pooled Budget
	For the three months 1 April 2022 to 30 June 2022 £'000	For the three months 1 April 2022 to 30 June 2022 £'000	For the three months 1 April 2022 to 30 June 2022 £'000
Income			
Section 75 - Proactive Care	-	(3,709)	(3,709)
Section 75 - Integrated Community Equipment Services	-	(925)	(925)
Section 75 - Learning Disabilities	-	(6,676)	(6,676)
Section 75 - Child and Adolescent Mental Health	-	(2,772)	(2,772)
	-	(14,082)	(14,082)
Expenditure			
Section 75 - Proactive Care	7,452	15,894	23,346
Section 75 - Integrated Community Equipment Services	925	1,796	2,721
Section 75 - Learning Disabilities	6,676	21,981	28,657
Section 75 - Child and Adolescent Mental Health	2,772	2,892	5,664
	17,825	42,563	60,388
Assets	-	-	-
Liabilities	-	-	-
Net Total	17,825	28,481	46,306

34 NHS Lift investments

The CCG had no Lift investments during either 2021-22 or the 3 months to 30 June 2022.

35 Related party transactions

During the period to 30 June 2022 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 the 3 months to 30 June 2022 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
Dr James Howarth	Spilsby Surgery	566	-	-	-
Dr Majid Akram	The Deepings Practice	539	-	-	-
Dr David Baker	Vine Street Surgery	327	-	-	-
		1,432	-	-	-

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

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 period ended 30 June 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	1,087	-	-	-
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	432	-	-	-
Hull and East Yorkshire Hospitals NHS Foundation Trust	789	-	-	-
Norfolk And Norwich University Hospitals NHS Foundation Trust	252	-	-	-
North West Anglia NHS Foundation Trust	18,290	-	-	-
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	12,787	-	-	-
Nottingham University Hospitals NHS Trust	5,195	-	-	-
Royal Papworth Hospital NHS Foundation Trust	433	-	-	-
Sheffield Teaching Hospitals NHS Foundation Trust	588	-	-	-
Sherwood Forest Hospitals NHS Foundation Trust	1,407	-	-	-
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	3,143	-	-	-
United Lincolnshire Hospitals NHS Foundation Trust	130,033	2,037	-	2,171
University Hospitals of Derby & Burton NHS Foundation Trust	667	-	-	-
University Hospitals of Leicester NHS Foundation Trust	1,404	-	-	-
Lincolnshire Community Health Services NHS Trust	27,589	-	-	-
Lincolnshire Partnership NHS Trust	25,995	-	-	-
NHS England	27	1,708	-	2,616
NHS Arden & Greater East Midlands CSU	1,849	-	-	-
	231,968	3,745	-	4,787

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.

36 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 were abolished and the functions, assets and liabilities of NHS Lincolnshire CCG were transfered 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 as the services of the clinical commissioning group(s) continue to be provided using the same assets by another public sector entity.

37 Third party assets

The CCG did not hold any third party assets during either 2021-22 or the 3 months to 30 June 2022.

38 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:

	Target	Performance		Target	Performance	
	For the three months 1 April 2022 to 30 June 2022	For the three months 1 April 2022 to 30 June 2022	Duty Achieved?	2021-22	2021-22	Duty Achieved?
	£'000	£'000		£'000	£'000	
Expenditure not to exceed income	377,197	377,197	Yes	1,518,344	1,520,765	No
Capital resource use does not exceed the amount specified in Directions	-	-	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	376,014	376,013	Yes	1,516,316	1,518,737	No
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	3,505	3,505	Yes	15,295	14,606	Yes

39 Analysis of charitable reserves

The CCG did not hold any charitable reserves during either 2021-22 or the 3 months to 30 June 2022.

40 Losses and special payments

40.1 Losses

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

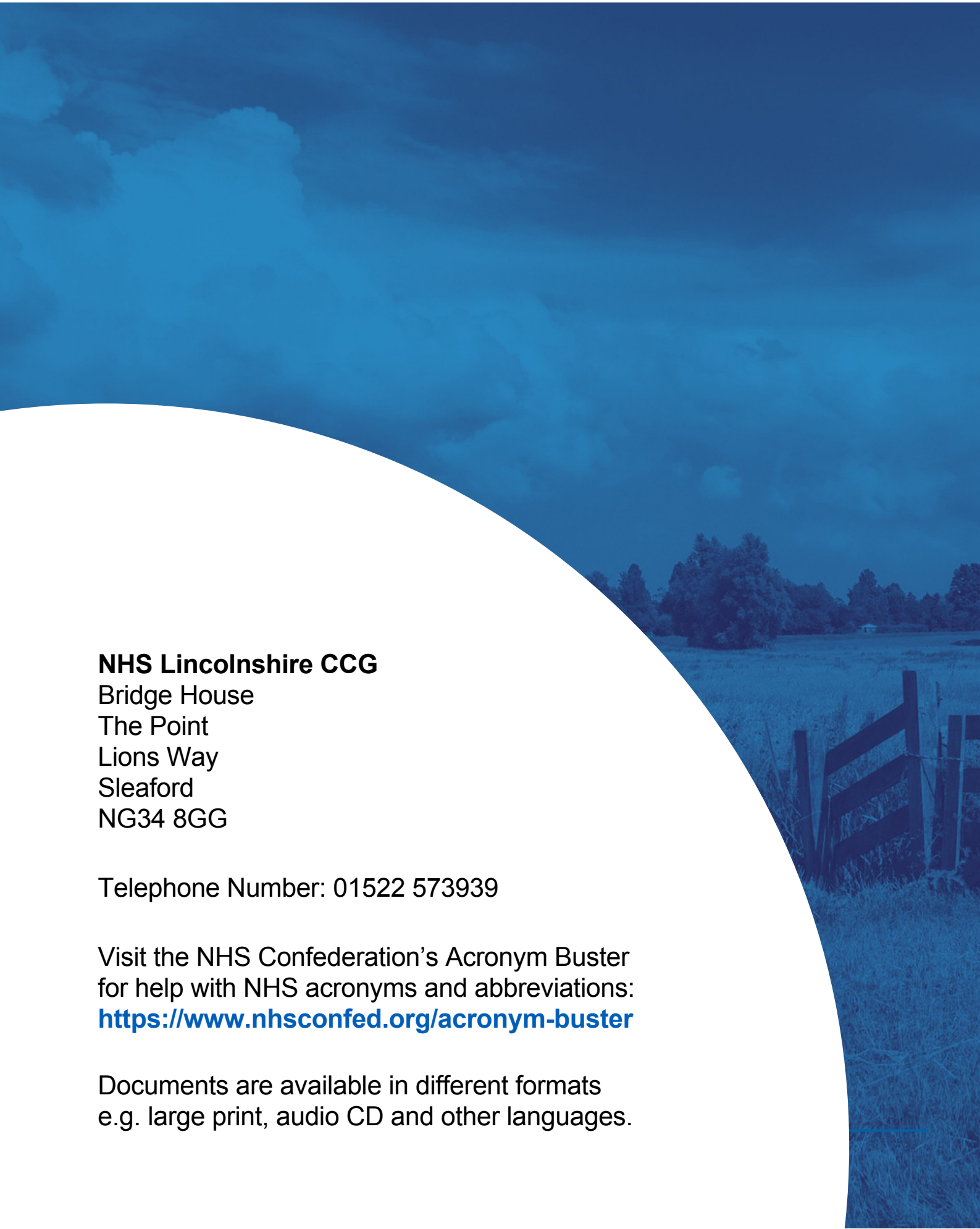
	Total Number of Cases For the three months 1 April 2022 to 30 June 2022	Total Value of Cases For the three months 1 April 2022 to 30 June 2022	Total Number of Cases 2021-22	Total Value of Cases 2021-22
Administrative write-offs	-	-	7	13
Total	**-**	**-**	**7**	**13**

40.2 Special payments

	Total Number of Cases For the three months 1 April 2022 to 30 June 2022 Number	Total Value of Cases For the three months 1 April 2022 to 30 June 2022 £'000	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £'000
Extra Contractual Payments	1	109	1	1
Ex Gratia Payments	-	-	1	1
Total	**1**	**109**	**2**	**2**

41 Impact of IFRS 16	Total £'000
Operating lease commitments under IAS 17 at 31 March 2022	**(1,788)**
Prior Period adjustment made to Operating Lease Commitments at 31 March 2022	-
Adjusted Operating Lease under IAS17 Total at 31 March 2022	(1,788)
Incremental Borrowing Rate	0.0095%
Operating lease commitments under IAS17 discounted using incremental borrowing rate	(1,771)
Add: Leases without full documentation previously excluded from operating lease disclosure	-
Add: Differences in the assesment of the lease term used for future minimum payments at 31 March 2022.	-
Add: Correction of immaterial prior period error in IAS 17 disclosure	-
Less: Short term leases (including those with <12 months at application date)	-
Less: Low value leases	-
Less: Irrecoverable VAT previously included in IAS 17 commitments	-
Less: Variable payments not included in the valuation of the lease liabilities	-
Less: Differences in the assesment of the lease term used for future minimum payments at 31 March 2022.	**1,353**
Less: Correction of immaterial prior period error in IAS 17 disclosure	-
Add/Less: Other	-
Lease liability at 1 April 2022	(418)
Right-of-use asset at 1 April 2022	418
Lease liability at 1 April 2022	**(418)**
Impact on taxpayer's equity on initial application	-

NHS
Lincolnshire
Clinical Commissioning Group



NHS Lincolnshire CCG
Bridge House
The Point
Lions Way
Sleaford
NG34 8GG

Telephone Number: 01522 573939

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