NHS
North East Lincolnshire
Clinical Commissioning Group

Annual Report and Accounts

2019-2020

Contents

Performance Report

This section of the Annual Report describes how we carry out our role as a Clinical Commissioning Group (CCG) and what our responsibilities are. It also tells the story of the previous 12 months between 1 April 2019 and 31 March 2020, including our achievements and challenges, and sets out some of the risks that could hinder us achieving our plans for the coming year.

Welcome from our Chair and Clinical Chief Officer

We are NHS North East Lincolnshire Clinical Commissioning Group (CCG), an organisation led by family doctors and other clinicians. We work closely with North East Lincolnshire Council under an arrangement we call the Union to make the most of the total money that is available to us to plan health and care services that make a positive difference to the lives of people in Grimsby, Cleethorpes, Immingham and the rural areas of the borough.

This report sets out what we have done in the past 12 months to help us achieve our ambitions to improve the advice and care services that support our local communities to enjoy a good quality of life, recover from ill health as near home as possible, make healthier choices about their lives and stay active, engaged and independent for as long as they can. Much of this work is about how we can support local people to do more for themselves and for each other as communities.

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

All of this is underpinned by the NEL Commitment to involving local people in our plans and supporting our communities to play the most active role possible in the way we make decisions. The CCG received its second Green Star (the highest rating possible) this year for how it meets its duty to involve the public in health and care issues and this is something we remain very proud of.

This is the CCG's sixth year and achievements in the local health and care system include:

- Support for people to manage their long term conditions and general health through the successful rollout of Thrive NEL, our social prescribing service, access to a health apps library, access to online GP consultations, free access to the MyCOPD app for patients and a new micro website to support better heart health

- Support for Mental Health with a successful bid to fund more mental health and emotional wellbeing support for young people in educational settings, the roll out of suicide prevention training for the general public, the launch of an adult autism service and a website offering mental health support for new parents. Local Mental Health provider Navigo has also extended the opening times of its successful drop-in crisis café in Grimsby.

- Five Primary Care Networks (PCNs) have been established in North East Lincolnshire, after a year of successful collaboration they are now planning to consolidate into three. Other innovation within primary care includes improved sharing of patient records, the roll out of new bowel cancer testing and events to help empower patients with breathing difficulties to take better control of their health ahead of the winter flu season.

- The new Adult Strategy has been launched alongside an action plan setting out our ambition to help our adult population live the best lives they can. The latest Extra Care Housing Development, on the Nunsthorpe Estate in Grimsby, is nearing completion which will give residents access to enhanced levels of care while still maintaining their

independence and their own front door. Work has been underway to improve the expertise of staff working with people who have been or may need to be deprived of their liberty under the Mental Capacity Act and work is ongoing to improve rehabilitation and reablement services to help people regain as much of their independence as possible following stays in hospital.

You can read much more about the examples above later in the service redesign section of the report.

While we have had another successful year and have once again been rated "Good" by NHS England we know there are, areas where our local health and care system needs to make improvements in both the short and long terms and we must drive these positive changes forward.

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

This first section gives a general overview but if you want to know more about how the CCG is governed, how we spend the money allocated to us and how we perform against the targets set nationally then these details can be found in the full report and accounts.

In the last month covered by this report, the country was gripped by the COVID 19 Pandemic and along with its partners and health and care providers, the CCG moved swiftly and decisively in response. The outcome for the area is yet unknown, but it is clear 2020/21 will be a very challenging year for us all. The next annual report will give a full account of the impact of the COVID 19 Pandemic on health and care services across North East Lincolnshire and how we responded.

On behalf of the CCG Governing Body and the Union Board, we are delighted to present our Annual Report and Accounts for 2019/2020. Once again would like to place on record our sincere thanks to our entire team, including clinicians, support staff, managers, community members and our partners in the local health and care system and beyond for their continued support over the past 12 months.

Dr Peter Melton - Clinical Chief Officer

Rob Walsh - Chief Executive

Mark Webb - CCG Chair

Overview

NHS organisations like the CCG have a duty to keep the public up to date with their plans and progress by publishing an annual report and accounts at the end of each financial year. We try to keep this as interesting and relevant as possible but there are sections in the report that are quite technical.

If you do not wish to read the full report, the Overview section is a good introduction as it describes how we carry out our job as a commissioning organisation and sets out our responsibilities. It also tells the story of the last 12 months between 1 April 2019 and 31 March 2020, including our achievements and challenges, and highlights some of the risks that could make it more difficult to achieve our plans for the coming year.

Much more detailed information about the way the CCG has performed, how we make our decisions, how we involve our local communities and groups, and our structure and staffing is available to delve into in the body of the annual report. The annual accounts for the year 2019-20 are set out at the end.

We want to be as environmentally responsible an organisation as possible, so we do not routinely print lengthy documents. You can still obtain a printed copy of the Annual Report and Accounts if you ask us for one.

We have tried to make this report as accessible as possible so people with disabilities should not have difficulty reading this document. However, the information contained in the report can also be made available in other languages and different formats such as audio, large print and Braille.

For more information or to ask for a copy of the report in a different format, please contact us at the address at the end of this section.

Who we are and what we do

CCGs are made up of GPs, other people who are employed in health or care and members of the public who do not work for the NHS. Together they look at what the local population needs and plan and buy those services. Our CCG is led by GPs representing 26 practices who provide health services to families living in Grimsby, Cleethorpes, Immingham and rural North East Lincolnshire, supported by a team of non-clinical staff who carry out the day-to-day running of the organisation. We are accountable to our members, patients and our local communities and are overseen by NHS England and NHS Improvement, a single organisation that supports the NHS and helps us to improve care for patients.

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

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

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

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

The CCG has delegated responsibility for commissioning primary care services.

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

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

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

In 2019/20, the CCG was allocated £280.8million by NHS England. This includes £26.8 million to support delegated Primary Care and £3.8million to pay for the management and operation of the organisation which leaves a total of £250.2million to pay for health services.

The income to fund Adult Social Care is set by North East Lincolnshire Council as part of its annual resource and priorities process, and in 2019/20 the CCG received £45.7million.

How to get in touch with us

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

You can contact the CCG in the following ways:

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

By phone: Switchboard 0300 3000 400

By email: nelccg.askus@nhs.net

Visit our website for more information about the CCG

Follow us on Twitter

Follow us on Facebook

We are also active on Instagram, look for nhs_nelccg

What we want to achieve and how we manage risks

Our plan for the coming year is based on what local people need and reflects the work set out in both the Union strategic plan and our Five Year Strategic Plan. What we do in North East Lincolnshire also has to take into account national ideas to improve the way the NHS works that were published in a document called the NHS Long Term Plan.

We work closely with the Council to ensure that our first priority is North East Lincolnshire as a Borough and a Place and moving from plans into real projects that will help us address the issues facing our local communities and ensure we maintain financial balance.

We also need to work with organisations across a larger area than North East Lincolnshire to tackle the big issues that cause problems for people living here. Working with different health, care and voluntary organisations will help us see where we can be more efficient and spend our limited financial resources to the best advantage, as well as making sure our population gets the best possible clinical care. We call this region Humber, Coast and Vale because of the geographical area it covers. The Humber Coast and Vale Sustainability and Transformation Partnership is made up of six NHS CCGs and six local authority boundaries representing our communities here in North East and North Lincolnshire alongside Hull, East Riding, York and Scarborough and Ryedale. Working together like this will let us share resources in areas where we are currently stretched, providing a better service to patients. Support services such as finance can be shared to make things more efficient and save money. You can find out more by visiting the Humber Coast and Vale website.

Most of the things we do, however, will aim to deliver the best care we can locally, shaped around what the people in our area really need.

Managing risks

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

Going concern basis

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

In addition:

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

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

Performance Analysis

Performance summary

CCG Assurance Framework

Clinical commissioning groups (CCGs) were established on 1 April 2013 and are clinically led organisations. NHS England has a statutory duty (under the Health and Social Care Act 2012) to conduct an annual assessment of every CCG.

The NHS Oversight Framework for 2019/20 has replaced the CCG Improvement and Assessment Framework (IAF) and the provider Single Oversight Framework and will inform assessment of CCGs in 2019/20. It is intended as a focal point for joint work, support and dialogue between NHS England, NHS Improvement, CCGs, providers and sustainability and transformation partnerships and integrated care systems.

The NHS Oversight Framework is supported by technical annexes for CCGs and providers. The CCG technical annex is made up of a set of 60 indicators and explains the rationale and detail of each of these indicators that will be used for the annual assessment of CCGs. The CCG Metrics Technical Annex can be viewed through this web-link.

During 2019/20 NHS England has continued to oversee the performance and development of the CCG through its continuous assurance process in quarterly and year-end, face-to-face meetings. North East Lincolnshire CCG's performance is published on NHS England and updated regularly.

The latest year-end assessment available at the time of this report is 2018/19 and North East Lincolnshire CCG was rated as 'Good'. The 2019/20 year-end assessment will be available at NHS England.

Performance Analysis

How we measure performance

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

NHS constitution rights and pledges and NHS oversight framework

We monitor our performance against the NHS constitution measures and the NHS Oversight framework on an ongoing basis, and we meet with NHS England to formally take stock of our performance against these measures. The outcomes from these meetings are formally reported to our Governing Body.

Financial performance

Our finance team monitors our financial performance on an ongoing basis. Our financial performance is reported to the Delivery and Assurance Committee and our Governing Body.

Provider performance including NHS Constitution standards

We measure the performance of our providers using contractually agreed schedules of key performance indicators and quality indicators. Where performance is below the required standard for measures, the provider is asked for an explanation including actions and timeframes to bring the performance or quality of care back up to the required standard. Performance is reported and monitored by the Delivery and Assurance Committee and our Governing Body via the 'Integrated Assurance Report'.

Better Care Fund (BCF)

The Better Care Fund (BCF) is intended to transform local health and social care services so that they work together to provide improved and joined up care and support. It is a government initiative, bringing existing resources from the NHS and local authorities into a single pooled budget. Performance against the pooled budget is monitored with local authority colleagues, through a sub-committee of the Health and Wellbeing Board. The CCG's is required to complete a quarterly return to show our progress on the BCF.

Adult Social Care Outcomes Framework (ASCOF)

We monitor our performance against the Adult Social Care Outcomes Framework measures on an ongoing basis. Performance is reported and monitored by the Delivery and Assurance Committee and our Governing Body via the 'Integrated Assurance Report'.

Progress on NHS constitution targets

Measure	End of 2017-18 (Mar18)	Latest Period	2019/20				Direction of travel (since Mar-18)	Forecast Position	National Threshold
			Denominator	YTD Perf.	YTD Target	YTD Status			
Total time in A&E: four hours or less - Trust	79.50%	Jan-20	127,217	78.03%	86.22%		Similar	Not Met	95%
ARP Category 1 Mean Response Time – Calls from people with life-threatening illnesses or injuries - EMAS	00:09:45	Dec-19	N/A	00:07:38	00:07:20		Better	Not Met	00:07:00
ARP Category 1 90th centile response time – Calls from people with life-threatening illnesses or injuries - EMAS	00:17:31	Dec-19	N/A	00:13:43	00:15:00		Better	Fully Met	00:15:00
ARP Category 2 Mean Response Time – Emergency calls - EMAS	00:45:05	Dec-19	N/A	00:31:16	00:27:00		Better	Not Met	00:18:00
ARP Category 2 90th centile response time – Emergency Calls - EMAS	01:40:18	Dec-19	N/A	01:05:01	00:50:00		Better	Not Met	00:40:00
ARP Category 3 90th centile response time – Urgent Calls - EMAS	04:15:55	Dec-19	N/A	03:39:38	02:15:00		Better	Not Met	02:00:00
ARP Category 4 90th centile response time – Less Urgent Calls - EMAS	03:12:13	Dec-19	N/A	03:16:11	03:00:00		Similar	Fully Met	03:00:00
Percentage of Patients waiting <6 weeks for a diagnostic test - CCG	92.15%	Dec-19	5,440	83.40%	92.05%		Worse	Almost Met	99%
RTT - Incomplete Patients: % Seen Within 18 Weeks - CCG	71.50%	Dec-19	11,334	79.23%	83.00%		Better	Almost Met	92%
Cancers: two week wait - CCG	96.40%	Dec-19	4,197	97.05%	93%		Similar	Fully Met	93%
Cancers: two week wait (all breast symptoms excluding suspected cancer) - CCG	97.83%	Dec-19	576	96.53%	93%		Similar	Fully Met	93%
Cancer 31 Days Diagnosis to Treatment (First definitive treatment) - CCG	96.20%	Dec-19	715	93.01%	96%		Similar	Almost Met	96%
Cancer 31 Days Diagnosis to Treatment (Subsequent surgery treatment) - CCG	100.00%	Dec-19	104	90.38%	94%		Worse	Almost Met	94%
Cancer 31 Days Diagnosis to Treatment (Subsequent drug treatment) - CCG	95.45%	Dec-19	190	100%	98%		Similar	Fully Met	98%
Cancer 31 Days Diagnosis to Treatment (Subsequent radiotherapy treatment) - CCG	100.00%	Dec-19	219	100.00%	94%		Similar	Fully Met	94%
Cancer 62 Days Referral to Treatment (GP Referral) - CCG	71.80%	Dec-19	347	65.71%	69%		Worse	Not Met	85%
Cancer 62 Days Referral to Treatment (Screening Referral) - CCG	100.00%	Dec-19	21	61.90%	90%		Worse	Not Met	90%
Cancer 62 Days Referral to Treatment (Consultant Upgrade) - CCG	60.00%	Dec-19	20	75.00%	90%		Better	Not Met	N/A
Cancelled Operations offered binding date within 28 days - Trust	11.67%	Q3 2019/20	452	1.99%	11.01%		Better	Fully Met	N/A
Numbers of unjustified mixed sex accommodation breaches - CCG	51	Dec-19	N/A	0	0		Better	Fully Met	0
Proportion on CPA discharged from inpatient care who are followed up within 7 days - CCG	100%	Q3 2019/20	108	99.07%	95%		Similar	Fully Met	95%
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period - CCG	91.7%	Nov-19	1175	84.7%	75.0%		Worse	Fully Met	75%
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period - CCG	95.8%	Nov-19	1175	98.7%	95.0%		Similar	Fully Met	95%
Psychosis treated with a NICE approved care package within two weeks of referral - CCG	100.0%	Nov-19	49	87.8%	56.0%		Worse	Fully Met	56%

Development and performance in-year

Reflecting on our performance for 2019/20, while there are some targets which the CCG has not met, such as the 'total time in Accident & Emergency: four hours or less' standard, the '18-week Referral to Treatment' standard and the ambulance targets, which are especially challenging given the rural nature of much of the CCG's area, the CCG continues to perform well.

Some of the key challenges for the CCG have included:

A&E waiting times have been particularly challenging for North East Lincolnshire in 2019/20. The CCG continues to work with its partners as part of the A&E Delivery Board to improve the A&E position. This work included a whole system summit led by NHSE where the A&E Delivery Board reviewed all transformation initiatives and selected 6 priorities to be the focus of the next 6 months covering the winter period. The impact of progress with these priorities has been modelled as an improvement in bed occupancy to the required planning levels and to maintain the locally agreed trajectory for 4 hr wait performance. January 2020 performance was 73.1% against our local trajectory of 83.1% (national standard 95%)

Referral to Treatment waiting times have continued to be a challenge in 2019/20. Actions being taken to address this performance include sourcing alternative provision for certain specialties, promotion of advice and guidance with practices and Outpatient Transformation focusing on the 3 priority specialties to improve response times. January 2020 Incomplete Pathway overall performance was 78.1% against our local trajectory of 82.98% (national standard 92%)

A number of the cancer treatment waiting times measures are currently below their national thresholds with the 62-day (GP referral) measure proving particularly challenging again in the past year. The CCG is actively engaged with the Cancer Alliance to seek solutions and working collaboratively, we aim to improve timely access to services. Funding has been ring-fenced for our Cancer Alliance to develop Regional Diagnostic Centres and a proposal has been completed to implement this initiative.

Some of the key successes for the CCG in 2019/20 have included:

a) A number of targets relating to cancer treatment waiting times continue to be achieved or are close to target
b) Good progress has been made on the mental health targets with IAPT Roll-Out, IAPT waiting times and First Episode Psychosis treatment with NICE recommended package of care within two weeks of referral all above their respective national standards
c) Dementia is a key priority for North East Lincolnshire. Diagnosis is a key part of the work on dementia with the CCG continuing to perform well on estimated diagnosis rates and above the national standard of 66.7%

Financial information

The financial performance in this year has built on the excellent performance of previous years, despite continued pressures on health and social care funding.

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

Statutory Duties

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

Operational Duties

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

Statutory Financial Duty

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

- **Revenue resource use does not exceed the amount specified in Directions (Reported Surplus equals £8.147m)**
  This duty requires the CCG to achieve an in-year surplus equivalent to no less than 1% of its health allocation. The CCG's total health allocation for 2019/2020 was £288.993m, which includes £8.147m (2.82%) of the CCG's accumulated surplus.

  There were a number of significant pressures in year, despite this, as shown in the Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2020, this duty was met precisely.

- **Revenue administration resource use does not exceed the amount specified in Directions**
  This duty requires the CCG not to spend in excess of its Running Cost Allocation. This allocation for 2019/20 was £3.803m with the CCG spending £3.341m on running costs.

- **Capital resource use does not exceed the amount specified in Directions**
  The CCG received no NHS capital resource in 2019/20.

Administrative Financial Duties

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

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

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

- **Better Payment Practice Code**
  The Better Payment Practice Code states that 95% of invoices should be paid within 30 days of receipt of goods or a valid invoice (whichever is later). Performance is measured in terms of both numbers of invoices and value of invoices. For 2019/2020 the CCG, on average, paid 97.74% of invoices by number and 99.23% of invoices by value in compliance with the code.

Conclusion

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

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

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

Sustainable development

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

Accommodation and travel changes in year

The CCG consolidated on its move into the Municipal offices in year, saving on running costs and impact of the CCG HQ building in terms of revenue and environmental costs.

The CCG has worked with Agile Technology over a number of years. Moving to the Local authority IT Shared service the CCG has been able to share the benefits of the development of the MS Team platform, using audio and video conferencing to reduce the face-to-face travel requirements for its staff. As this develops this will have a significant benefit in reducing home to work and business travel. The CCG operates “Hot Desks” in the new arrangements with the Local Authority so operates a completely flexible workspace policy. The CCG operated at a staff to desk ratio of about 60% after the move and in year brought in the Community Health Care Team, which reduced this to a 50% ratio. This means more staff are encouraged to work at home or in flexible spaces reducing the environmental impact. Additionally, the Municipal Offices have shower and changing facilities and secure cycle storage meaning staff can utilise this facility to avoid further car use and contribute to a healthier workplace.

Total Business mileage for 2019/20 is 56,883 adjusting for 23,299 miles for staff shared with other CCGs. This total compared to 2018/19 is 64,016 adjusting for 12,196 miles for staff shared with other CCGs.

Facilities Management

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

Procurement

As part of the procurement process, the CCG considers social and environmental factors alongside financial factors in making decisions on the purchase of goods and the commissioning of services. Purchasing decisions where practicable consider whole life cost and the associated risks. The sustainability/environmental procurement principle is to deliver sustainable social and environmental activities both within our organisation but also in the services we commission. The CCG also consider the implications of the Social Value Act 2012 and generally as we, commission services rather than products providers necessarily have to recruit and source ancillary services locally, sustaining investment in the local economy.

All procurements have a schedule where we require bidders to answer questions on environmental controls. We ask:

- Does your firm have an Environmental, “Green”, or Environmental Management Policy?
- Please indicate what systems your company operates (together with supporting details) to ensure proper control of processes and procedures that may have an impact on the environment
- Has your firm been prosecuted, or been issued with an Improvement Notice or Enforcement Notice or Order, by any enforcement body responsible for protecting the environment (including a Planning Trust in respect of breach of Planning Control)?
- How does your firm monitor its environmental performance?
- Please provide evidence of the progress you have achieved in following your Environmental Strategy
- Is your organisation certified to ISO14001 or are you working towards this?
- Please supply details of any Environmental Management System and Registration Body you may be working towards

The responses to these questions form part of the overall evaluation of bidders within the procurement process.

Sustainability

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

All meeting papers are on shared drives eliminating the need for paper agendas and speeding up the recording and information dissemination process via email.

Paper and card are recycled separately, and general waste is placed in a separate bin. There are appropriate bins inside and outside the building.

The CCG has continued to work with Residential Care Homes to look at and understand the level of pharmaceutical waste and overstocking from requests to GPs. The changes to prescription ordering

will have a significant impact on waste and cost as the patient has to explicitly request items they need rather than as now where a whole list of repeat items could be ordered by the pharmacy, whether the patient needs them or not. This is a national programme but will have a significant impact on waste and efficiency.

The NHS Standard contract for 2019-20, set out a number of sustainable improvements we required from all our contracted providers. The Providers must maintain a sustainable development management plan, approved by its Governing Body. Within that plan, the Provider must demonstrate how it will make progress on social, economic and environmental aspects of sustainable development for the benefit of public health, including in its performance on climate change adaptation and mitigation, air pollution, minimising wastes and minimising use of plastics, and must provide an annual summary of that progress to the CCG. We monitor this as part of the overall contract management process.

Statutory duties

Engaging People and Communities

Talking, Listening and Working Together

In last year's Annual Report, we outlined our intention develop a joint engagement strategy with our Union partner the local authority setting out how – working for 'Place' - people in North East Lincolnshire have meaningful opportunities to contribute to the planning and design of local services and solutions

Initially the scope of the project was to develop a public and stakeholder engagement strategy for the CCG and council, setting out how the Union will meet its statutory duties around consultation and engagement. However, over the course of the year this developed into something more wide reaching with the co-production of the North East Lincolnshire Commitment with members of the community and the local voluntary, community and social enterprise sector (VCSE) we created the North East Lincolnshire Commitment.

The project has been led by a steering group of council and CCG staff, community members and representatives from VCSE sector organisations, with the CCG Community Forum and Accord Steering Group providing advice and constructive challenge over the course of this project.

We carried out engagement in markets, shopping centres, community centres, libraries, colleges and GP practices. We visited community and special interest groups, and engaged with staff, local providers and elected members. Publications included a newsletter and leaflet, audio information and an online and hard copy survey.

People told us:

- Feeding back and sharing with people the outcomes from engagement were important and this wasn't happening every time
- Listen to communities and provide engagement opportunities that work for them
- People are put off from engaging if they perceive that decisions have already been made so they won't be listened to
- The most positive experiences of engagement have been when communities have worked alongside organisations as equal partners to co-produce plans and solutions
- The ways in which people can influence plans and services is confusing and people are fed up with being asked the same things again and again

We held number of co-production workshops with representatives from the VCSE sector. Key messages from workshops with VCSE representatives in addition to those above were:

- Openness and transparency
- Commitment to listen and act on what people have to say
- Ongoing conversations - taking time to build relationships
- Be accountable

Together we designed a simple statement of principles setting out for how people and communities will be involved in the future so that we make every conversation count in North East Lincolnshire.

This North East Lincolnshire Commitment and Community Engagement Strategy 'Talking, Listening and Working Together' was ratified by the Union Board in November 2019 and launched in February at the first of what we intend will be a number of collaborative working events with the VCSE.

Accord

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

People with an interest in health and social care who are registered with a GP in North East Lincolnshire can join and currently there are 2,600 registered members. Our 'Suits You' menu enables members to tell us what topics they are interested in and how they want to be involved which can range from receiving and reviewing information at home, participating in on-line surveys, attending meetings and focus groups, up to formal appointment as a member of the Community Forum - part of the CCG's governance structure.

Accord has its own dedicated website and members receive regular e-bulletins providing links to local, regional and national health and care engagement opportunities and updates about the outcomes of previous engagement activity.

Members also receive a quarterly Accord newsletter, which is available online, hard copy and audio in partnership with local charity Soundscene.

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

- The North East Lincolnshire Commitment and Community Engagement Strategy
- North East Lincolnshire Adult Strategy
- Changes to the CCG's access to infertility treatment policy
- 'People Panel' involvement in procurements such as Support at Home and …
- Humber Acute Services Review workshops to look at hospital maternity and paediatric care.
- Humber Coast and Vale STP workshops to inform the partnerships response to the NHS Long Term Plan
- Humber, Coast and Vale Cancer Alliance Community Network to transform cancer services
- Local authority consultations such as Housing Assistance and Disabled Adaptations Policy and Social Care Charging Policy
- Bowel and bladder services for children and young people in NEL

The CCG publishes information about how patient and public involvement has influenced our decision making on our website, links to these reports are sent to accord members and stakeholders via the e-bulletin. In response to feedback from young people, we have added Instagram to our social media engagement offer.

This year we have strengthened our links with local colleges attending information fairs and themed events such as LGBT History Week, Equality and Diversity, and Mental Health Awareness Week.

We have also strengthened links with LGBT groups, disability peer- support groups and Carers group. Following engagement with Carers the CCG and the council now include unpaid carers as a protected characteristic as part of our equality's analysis.

To support our work in the community to reach diverse, potentially excluded and disadvantaged groups we have developed a comprehensive equality monitoring report and 2-year action plan.

The Accord steering group provides a link between the wider membership bases of Accord. The role of the steering group is to make sure Accord counts and the CCG values and makes appropriate use of the scheme.

Steering Group achievements over the year included:

- Engaged with job seekers at a DWP Health & Wellbeing Discovery Day' in Immingham to promote Accord
- Supporting the 'Talking, Listening and Working Together' engagement at community venues and meetings across North East Lincolnshire
- Reviewing Accord communications to ensure they are 'reader friendly'

- Planning, hosting and evaluating CCG public and stakeholder engagement events

The Steering group has a lead role in determining the content and format of our twice-yearly public meetings – The Way Forward in March and Getting Better Together Accord annual meeting in September. The steering group prepares an evaluation report and recommendations, which brought about a change of approach to the September meeting this year.

In 2020/21, the group will continue their work to "make sure Accord counts" and explore ways to reach communities who do not routinely engage with Accord.

Public Engagement Events

The CCG held two public and stakeholder engagement events over the course of the year both were jointly hosted with Northern Lincolnshire and Goole NHS Foundation Trust. The purpose of these events is to share information about our priorities and progress and find out participant's views to inform service plans. To cater for people unable to attend a daytime meeting we also hold a 'bite-size' twilight meetings the following week at a community venue.

This year our September event included a Market Place where participants could speak directly to a wide range of health, care and wellbeing commissioners and providers. We wanted to improve the offer for people at the event by providing a mix of presentations, smaller focussed workshops and informal discussions in the marketplace.

This year we used handheld interactive 'voting' handsets to gather views about the Engagement strategy and commissioning plans and priorities to inform the 5-year plan (Place plan).

The outcomes and feedback from these sessions are sent to all participants and published on the CCG website.

Community Equality Impact Assessment Panel

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

During our engagement outreach work in the community this year, we have been seeking to recruit new members to this panel to broaden the community perspective.

Looking forward

The challenge now is for the Union to consistently deliver the Commitment in everything we do by Talking, Listening and Working Together for North East Lincolnshire. A Steering group has been formally established to drive delivery of the strategy, key priorities for 2020/21 will be:

- Community outreach to promote the strategy and continue the ongoing conversation with communities about what is important to them

- Development of a local engagement good practice tool kit and training and development opportunities

- Encouraging provides and partners to adopt the NEL Commitment

- Implement the recommendations from the Equality Impact Assessment

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

Our CCG is a forerunner when it comes to real public involvement. Not only does it have a public membership, accord but also has a recognised group of individuals who form a Community Forum. The Community Forum plays an integral role in the governance of the CCG. The Community Forum also has a key role in the planning, development and delivery of CCG services. Benefits of this level of involvement and engagement are key to the future progression of CCG initiatives not just over the coming year but into the future as well. The Community Forum representatives have specific responsibility for an area of work and meet regularly with clinicians and administrators to discuss and often plan that area of work. The lay challenge is vital as the CCG merges many functions with the local Council under the direction of a Union Board involving both the CCG and North East Lincolnshire Council.

Accord (our community membership) has developed in the last 5 years to become a part of the CCG operation that is managed by representatives from its number and supported by CCG staff. The Accord Steering Group (ASG) has and will be instrumental in the recruitment of, and training of, other Ambassadors to communicate with and engage with the local community and other community groups. The ASG members are highly motivated in ensuring the membership can be used by the CCG and Union Board to help seek public views on delivery of health services in our area. Over the last few months, there has been a keen focus to reinvigorate the membership and involve the public in decisions involving the wider health community. Accord has approximately 2500 members and the ASG is planning to try to increase not just involvement but also quality involvement over the next twelve months.

Accord has held four well attended public events to promote health initiatives over the last twelve months and issues a quarterly newsletter to its members.

The Community Forum has been operating for a number of years and is constituted of community leads who are appointed to a specific community lead role with a service area, committee or working group, working as equal partners with service and clinical leads from the CCG. This is key to the planning and development of services and the link for the lay member to the Forum and then Accord is crucial. The Community Forum has provided more of a challenge to the CCG in service planning and management in the last two years, giving clear directions of what it expects from those making presentation of CCG activity. It is recognised that the Forum will play a more active part as pressures increase to ensure both quality and value for money in service provision. With reviews of hospital services imminent, the Forum has a key role to play.

Aside from the Accord membership and Community Forum, the CCG supports a Committee of PPG (Patient Participation Group) Chairs. Whilst not a decision-making group, it provides a conduit for information to be fed back to PPGs at surgery level. The group has struggled with membership and although supported by some practices there is much room for improvement in attendance. With the development of Primary Care Networks (PCNs), it is hoped there may be a move towards 'super' PPGs to cover whole PCN areas, whilst still providing a support at local practice level with localised PPGs.

Many practices have pharmacists, physiotherapists and highly skilled nurses who can provide advice and treatments without a need to see a GP. The development of 'care navigators has been introduced across the CCG and patients are being made aware that navigators can offer them a choice to see an alternative health professional, but it is also important that patients understand that navigators are not offering clinical advice. In all this communication plays a vital role. With a move towards wider support within PCN areas, it is hoped that the patient voice will be heard.

GP practices still choose to operate their services in different ways, and this suggests good practice is not always shared, especially with the issue of appointment systems. It results in many missed appointments at considerable cost to the NHS. It is to be hoped that PCNs will bring more consistency of approach. The Chairs group will continue to encourage good practice to help reduce the waste that exists in the NHS. Social prescribing has been well supported this year in order to attempt to reduce the costs of medications to the CCG.

As Lay Member, I am a member of the CCG Clinical Governance Committee, to provide lay challenge and review of quality initiatives and monitoring of clinical services provided by and for the CCG. Patient safety has to be at the heart of work within the NHS and work within this Committee is crucial in ensuring there is public scrutiny as well as clinical.

I also serve as vice chair on the Primary Care Commissioning Group alongside the CCG lay Chair and serve as an attendee at the afore-mentioned Accord Steering Group.

In the last six months, I have been invited to join the Union Board and sit alongside the CCG Chair, the CCG Chief Operating Officer and a GP representative. Together we meet with four nominated Councillors including the Leader of the Council, the Deputy Leader, and two other Portfolio holders. This means that my voice and challenge can be heard at the highest level locally.

As PPI Lay Member, I believe the CCG discharges its duty for public involvement very effectively. Engaging with the public is a difficult task at the best of times. Unfortunately, public involvement is strongest when a service is being taken away or changed in what is perceived to be a negative fashion. This engagement will be a key challenge in 2020/21, as key services must be reviewed from both a financial and safety viewpoint.

North East Lincolnshire CCG has involvement of over 2500 of the local population who have committed to be involved and engaged in determining the way health services should be delivered. The Accord membership continues to develop and is fronted by its own members who enthusiastically embrace the challenge of involving others. The Community Forum will increasingly provide an opportunity for service changes to be challenged at all stages by lay members.

Reducing Health Inequalities

As a commissioner of health and social care services, North East Lincolnshire CCG works with other health and social care providers and contractors to ensure that valuing diversity and promoting fair access to services are core elements of care and that full consideration is given to all equality issues when planning or redesigning services and when assessing the health needs of our local population. This has been our approach since our inception and continues to be embedded in our practice.

In relation to health inequalities, the need to reduce the gaps experienced by vulnerable groups continues to be embedded in our service design and equality impact assessment process and we have paid particular attention to those people affected by deprivation in our Borough, as we know this is where the greatest inequality occurs. The two key indicators in relation to access to services and outcomes experienced by patients are what drives our activity in relation to promoting equality and ensuring equitable treatment for all.

This is informed by reference to our local Joint Strategic Needs Assessment and its associated local analysis documents provided by our business intelligence function in conjunction with Public health colleagues – all of which helps to inform and target our efforts in relation to vulnerable groups. For example, we know that older people are a particularly vulnerable group in our areas of high deprivation and the work we have done in relation to targeted support to care homes was supported by our analysis of protected groups. This initiative is already showing improvements for the patient cohort in relation to their health outcomes, with fewer hospital admissions and fewer falls leading to

fractured necks of femur. It is also supported by our close integration work with the local authority around social care which we commission under a Section 75 agreement.

The effectiveness of our systems in relation to reducing health inequalities is monitored and evidenced through a number of mechanisms:

- Periodic reviews of available population health data
- A programme of active engagement with local groups with protected characteristics in order to gather marginalised views and experiences of local services and use this information in our service improvement processes
- Our on-going review of actions identified for services in their equality impact assessments – we check back with services that risks have been mitigated and outcomes are being achieved
- Our service design process includes targeting geographical communities and communities of interest where health inequalities are experienced and putting in place measures and outcomes to tackle those inequalities.
- Our senior leaders review equalities data periodically and receive reports on performance in relation to engagement with and performance of services related to protected groups

All of these mechanisms enable the CCG to contribute towards the prevention agenda by tackling the inequalities experienced by these groups

The CCG also monitors the demographic makeup of its workforce on a quarterly basis and produces an annual Workforce Race Equality Standard (WRES) report which is signed off by the relevant subgroup of the Governing Body and published as required each year

The Equality and Diversity group within the CCG addresses issues that arise from the quarterly workforce report or the WRES report and practice is modified accordingly – for example adjusting our recruitment practice to reach out to BME groups proactively.

This forms part of our compliance with the EDS2 framework.

Improve Quality

Jan Haxby, Director of Quality and Nursing leads the NELCCG Quality Team. The main role of the quality team is to support the commissioning of good quality NHS health and social care services in North East Lincolnshire. The delivery of the Team's role helps to identify specific areas, which require focused quality improvement, this is how we identify and inform our priorities for delivery.

During 2019/2020, our team's priorities were to-

- Improve system safety and the safety culture in North East Lincolnshire
  - By working with Primary Care to drive improvement in CQC safety assessed ratings.
  - Minimise harm by improving our position in respect of pressure ulcers, Never Events, learning from unexpected mortality and healthcare associated infections.
  - Develop the system wide arrangements for safeguarding children and adults
- Understand the pressures in respect of the nursing workforce and strengthening the voice of nurses across the system

- Support the development of a quality framework for the emerging Integrated Care Partnership (ICP)

Our achievements under these priorities this year include-

- An established and embedded process for offering CCG pre-regulator inspection support to our GP practices

- Close focused working with GP practices who have required support and guidance to build a portfolio of evidence of compliance with quality standards

- We are approaching the close of this financial year and whilst our position with heath care associated infections is not as yet where we want to be we have seen improvements in practice implemented across our health and social care system and a positive position maintained in the number of patients affected by c.difficle infections

- We continue to learn from unexpected mortality through established multidisciplinary review meetings and we have established thematic areas which have emerged from the learning which will require our focus to facilitate improvement

- We have worked closely with partners to develop the Integrated Care System (ICS) safeguarding arrangements

- We have strengthened our local arrangements for looked after children and successfully recruited to a specialist nurse post within the multiagency safeguarding hub (MASH)

- The team have implemented the new Child Death Review Processes

- Our local system bid to secure finance to support the facilitation of learning from learning disability deaths under the LeDeR programme has been agreed

- We have successfully implemented a learning into action group for learning we glean from LeDeR, enabling us to roll out and implement best practice across the locality

- We have submitted a bid for £10k in partnership with our Humber Coast and Vale colleagues to hold two identical conference events with view to supporting the continuous professional development of our specialist and named nurses

This year, as well as the “business as usual”, we will be focusing on the following priorities: -

- Safeguarding – we will support the development of a robust and effective children’s safeguarding board. We are prioritising look after children’s heath assessments, working with partners to ensure they are completed in a timely manner. We will establish safeguarding leadership in the developing primary care networks. We will develop a proportionate mechanism for attaining commissioning safeguarding assurance in our smaller providers of health and social care. We will review the effectiveness of our newly established child death review arrangements. We will improve health representation at strategic safeguarding meetings

- Unexpected Mortality – we will build on last year’s priority regarding learning from unexpected death by designing and implementing an action plan to address local improvements and thematic learning from case note reviews. Themed work includes End of Life care, support provided to Care Homes, development of primary care networks and strengthening the working between staff both in and out of hospital

- Safe System – the National Patient Safety Strategy includes specific agendas, which we will need to prioritise for local leadership and implementation, including our management

of incidents and serious incidents and continued agenda around infection prevention and control. In addition to this we will be focusing on implementing local hospital avoidance services, preventing admission and supporting earlier discharge as research has shown that people get better quicker in their own homes

Our business as usual requires us to work closely with our providers and seek routine assurances regarding the quality of health and social care services and the outcomes for service users. Where we have concerns the Quality Team would work at an enhanced level with the provider to support them to address any gaps in quality. The CCG has regular systems and processes in place to capture information, data and concerns and to analyse this into intelligence we can use to inform our approaches and responses.

Principals of remedy – handling of complaints (2020)

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

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

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

Through a unique agreement under Section 75 of the National Health Service Act 2006, North East Lincolnshire CCG delegates responsibility for children's health service commissioning to North East Lincolnshire Council, and in turn, the Council delegates commissioning for adult social care to the CCG – both with the intention of facilitating a more integrated service response with better outcomes for the people of North East Lincolnshire. During the past year, the CCG received 76 complaints, 39 of which were about NHS care and 37 of which were about adult social care. Of the complaints closed during 2019/20 4 were upheld, 10 were partially upheld, 22 were not upheld and 11 were withdrawn.

Ombudsman investigations

No complaints were investigated by the Parliamentary and Health Services Ombudsman. The Local Government and Social Care Ombudsman carried out 2 investigations and did not uphold either of them and as a consequence made no recommendations.

The CCG's Chief Operating Officer and Director of Quality and Nursing personally sign off all complaint responses and details of any remedies or service improvements are included within the response. These are followed up with the provider(s) through an action plan to ensure all actions have been undertaken. A further check is also undertaken during site visits to providers, when we

include seeking assurances regarding actions the provider has said they will do in response to a complaint or incident, to ensure the loop has been closed and learning has been embedded.

Learning from PALS, Complaints, incidents and serious incidents is shared through a regular Bulletin to providers and we meet regularly with stakeholders like the Care Quality Commission and Healthwatch to share information and intelligence.

An appointed lay person from the local community works closely with the Customer Care Team seeking the views of those who have used the complaints process so their feedback can help refine and improve the CCG's complaints handling.

A joint annual report on health and social care complaints is received by the CCG's Governing Body at a meeting held in public, and by North East Lincolnshire Council Cabinet (consisting of elected members) for scrutiny.

Health and Wellbeing Strategy

The CCG and the LA have a joint statutory duty to produce a Joint Strategic Needs Assessment (JSNA) around the current and future health needs of our population, and to apply this in producing a Health and Wellbeing Strategy. These duties are discharged through our Health and Wellbeing Board whose functions are set out in the Health and Social Care Act 2012. The Board also has further duties around oversight of commissioning plans and the Better Care Fund. North East Lincolnshire Council's Portfolio Holder, for Health and Wellbeing, chairs the Health and Wellbeing Board and is a member of the Union Board. There have been some significant developments this year in how these duties and functions are delivered.

Firstly, there is a new approach to how the Health and Wellbeing Board operates building on our existing Place Board and recognising the overlap in membership across both Boards. The new arrangements see the Health and Wellbeing Board effectively embedded in the Place Board. In practice, this means the Health and Wellbeing Board still meets as a distinct entity, at its usual frequency and fulfils its statutory requirement.

The CCG continues to be a statutory member on the Health and Wellbeing Board and is represented on the Place Board.

The Place Board brings together key leaders from across the system to drive forward our 'stronger economy and stronger communities' ambitions for North East Lincolnshire. Our strategic outcomes framework, NELIVES, set out below, describes our areas of focus to deliver those ambitions:

- Learning and Growing: All people in NEL fulfil their potential through skills and learning
- Investment in our Future: All people in NEL benefits from sustainable communities
- Vitality and Health: All people in NEL enjoy good health and wellbeing
- Economy and Strength: All people in NEL enjoy and benefit from a strong economy
- Safe and Secure: All people in NEL feel safe and are safe

A system of key partnership groups is taking forward these outcomes respectively. The Union Board between the CCG and NEL Council is the key partnership that drives forward the health and wellbeing outcome set out below:

> We want people to be informed, capable of living independent lives, self-supporting and resilient in maintaining/improving their own health. By feeling valued throughout their lives feel, people will be in control of their own wellbeing, have opportunities to be fulfilled and are able to actively engage in life in an environment that promotes health and protects people from avoidable harm.

Access will be made available to safe quality services that prevent ill health, support, maintain and restore people back to optimal health or support them with dignity at end of life as close to home as safety allows Services that are part of an affordable innovative and quality health and social care system, which directs resources according to need.

The Health and Wellbeing Board retains oversight and accountability for progress against that outcome, including ensuring, and facilitating where necessary, the respective contributions from across the place-based system. These new arrangements, then, enable a wider focus and contributions to delivery of the health and wellbeing outcome, and increase our capability to address health inequalities

Secondly, a new North East Lincolnshire Strategic Plan for Wellbeing has been developed, consulted upon and finalised. The CCG has contributed to the development of this plan, which has been agreed by the Health and Wellbeing Board. This Plan sets out a range of values and principles and a framework to shape our system-wide approach to the delivery of the health and wellbeing outcome. It also sets out the key priorities for each of the outcomes above, identified by our key partnership groups and informed by our JSNA (known as the State of the Borough Report locally).

Set out below are some examples of how the CCG is contributing to the delivery of the NEL Strategic Plan for Wellbeing, the overarching health outcome and health inequalities:

- Implementation of some key improvements in enabling people to maintain employment or return to work sooner when being affected by mental health difficulties. Employment being one of the biggest factors in supporting people to maintain good mental health.

- New **Autism** Peer Champions have been recruited and trained, promoting the autism agenda and supporting people to support themselves

- NEL CCG has rolled out **Faecal Immunochemical Test (FIT) Testing in Primary Care** for the group of patients without rectal bleeding who are classed as “low risk, but not no risk” of having colorectal cancer in August 2019.

- The CCG has number of free licences of the **My COPD app** available for patients and has been working with both patients and staff to raise awareness of the app and make available. MyCOPD is an NHS approved app to support patients with COPD (Chronic Obstructive Pulmonary Disease) to manage their condition. It has a full education section including videos, a pulmonary rehab programme and advice on how to keep well. We now have over 200 apps issued to patients and are seeking feedback on how this has helped them to manage their condition.

- Together NHS England (NHSE) and the Department for Education (DfE) have established **Mental Health Support Teams**, which aim to provide early intervention on mental health and emotional wellbeing issues, such as anxiety, as well as helping staff within a school or college setting to provide a ‘whole school approach’ to mental health and wellbeing

Commissioning activity

In addition to commissioning health and social care services, the CCG also commissions a range of support services from external organisations. Further information can be found in the Annual Governance Statement.

The CCG, in its strategic role as the commissioner at the centre of the local health and social care economy, has two functions:

- To commission and procure a range of health and social care services on behalf of local people
- To empower individuals to procure services directly which meet their needs

North East Lincolnshire is unique as it has responsibility for commissioning both health and adult social care services on behalf of its registered population through a formal partnership agreement with the Council who have the statutory responsibility to ensure that adult social care is available to meet individuals' needs. North East Lincolnshire Council has delegated its responsibility to the CCG so that health and care can be brought together with the aim of improving the services that individuals receive on a day-to-day basis.

Through this arrangement the CCG has been able to align fee rates and quality requirements for people in long term care, irrespective of whether payment is from health or social care funds, brought services together that people might need to access in a crisis and has been able to come up with innovative solutions to help people better manage their health care needs.

Examples of the services and organisations that the CCG commissions include:

- The majority of hospital services that an individual will access. Its main provider of hospital services is Northern Lincolnshire and Goole Foundation Trust (NLaG), but it also commissions services from Hull and East Yorkshire Hospitals, Sheffield Teaching Hospitals Foundation Trust and others.
- Community health and social care services, such as community nursing, meals on wheels, and learning disability services, from Care Plus Group.
- Adult Mental health services from NAVIGO. Children's mental health services are commissioned on the CCG's behalf by North East Lincolnshire Council from Lincolnshire Partnership Trust.
- Residential and Nursing home care for those with eligible needs.
- Primary care services from 28 local GP practices.
- Home based / domiciliary care, to help people with eligible needs with the tasks associated with daily living
- Social Prescribing services and community based preventative services from the local voluntary and community sector.

In addition to commissioning health and social care services the CCG also commissions a range of support services from external organisations. Further information can be found in the Annual Governance Statement

During 2019/20, the CCG has been working to deliver a number of service developments (both new services and service improvements); some of the service developments started in 2019/20 will not be fully implemented until 2020/21.

Some examples of work commissioned in year include:

- Rolling out the previously piloted approach to commissioning and providing domiciliary care (Homecare) across the Borough to improve the quality and efficiency of local services

- Continued to work with our local care home sector to improve the way that health services provide care to individuals in the homes and support the care homes to provide improved care to their residents, with the aim of improving the overall health of the individuals and therefore to reduce the need for non-elective hospital admissions.

- Continued to develop and expand a Social Prescribing Service – "Thrive NEL" which went live in August 2018. Thrive NEL provides an alternative approach to supporting people to manage long term conditions through the promotion of self-care and self-management, healthy lifestyle choices, and therefore reducing dependency on statutory services

All these pieces of work will continue to be developed during 2020/21 and will contribute towards keeping people well for longer, whatever their circumstances.

The A-Z of service redesign 2019-20

Adult Mental Health

Achievements in 2019-20

This year has been a transitional year as we move from the '5 Year Forward View' to the 'NHS Long Term Plan' national framework. NELCCG has ensured delivery of the 5-year forward view priorities including:

- Increasing the scope of Improving Access to Psychological Therapies (IAPT)
  - Increasing number of people seen in Primary Care settings
  - Broadening the range of long-term conditions to help more people with physical conditions
  - Training more therapists

- Early Intervention in Psychosis
  - Increasing the skill mix in the team to enable a full suite of NICE compliant therapies faster, usually enabling 100% of cases to receive treatment within 2 weeks of referral, and often sooner

Improving Access to Care in a Crisis

- The new Access Team is supporting adults and older people who present through A&E and Diana Princess of Wales Hospital wards to gain the appropriate mental health support faster and in a more targeted way – so people don't need to 'go round the houses' to get the care they need. The team is now in place between the hours of 8am to 8pm – with the intention in 2020-21 to increase this to 24/7.
- The new SafePlace opened in autumn – a crisis café in the Grimsby Town centre, enabling advice and support for people who are having difficulty coping with events in their lives.
- The walk-in Mental Health crisis service operating at Harrison House has been recognised at national level and is used in guidance as an example of new models of care that have a significant positive impact on wider systems, but most importantly the experience of the person in crisis.

- Employment is one of the biggest factors in supporting people to maintain good mental health. This year has seen the implementation of some key improvements in enabling people to maintain employment or return to work sooner when being affected by mental health difficulties
  - Individual Placement Support (IPS) is a structured way of supporting people with long term or severe mental health issues to gain support and maintain employment. This year, through Navigo, North East Lincolnshire was the first CCG in the Humber Coast & Vale STP to implement IPS. Through the STP partnership, we are working with other CCGs to share our learning in doing this.
  - Mental Health Support for people who are unemployed or job seeking is now offered in the Jobcentre premises on a regular basis.
  - The Wellbeing service offers wellbeing advice including positive mental health and healthier living guidance, also is regularly working in the Jobcentre

- Dementia
  - We have worked hard to make sure that fewer people with complex dementia and behaviours that challenge, or people with acute mental ill health, are placed outside of NEL. In 2019/20, we opened a new Complex Dementia Unit, now called the Janine Smith Suite, which has seen the return on four people previously placed out of area, and the prevention of 6 people being placed out of area.

- Learning Disability & Autism
  - The Adult Autism service opened last year has grown from strength to strength – now operating several clubs and autism cafés.
  - The Autism Partnership Board now comprise of 50% people with Autism, building and ensuring co-production in service design into the future.
  - Service users were the main recruitment force in selecting new staff in LD & Autism services through new processes developed and implemented this year
  - New Autism Peer Champions have been recruited and trained, promoting the autism agenda and supporting people to support themselves
  - NEL has achieved 100% timely Care and Treatment Reviews for people with complex LD and Mental Health needs or who are at risk of admission to LD hospitals
  - The STOMP/STAMP campaign has been re-invigorated and supported across many services in NEL.
  - The Learning Disabilities Mortality Review (LeDeR), working in partnership with North Lincolnshire and on a Humber footprint, has developed and analysed its learning to identify trending pathways or conditions that may benefit from support to better care for people with LD. This was shared through a Service User led event supported by Inclusion North at Memorial Hall in Cleethorpes, which saw the sharing of good practice from across the patch.

Think LD! Campaign – a co-produced campaign to prompt services to make reasonable adjustment to enable people with LD and/or Autism to access mainstream services has been developed and rolled out locally.

Adult Services Review

In 2018/19, we commissioned a review of adult services, which aimed to gain a shared view on the problems and areas of opportunities in supporting adults to live independently in the borough. The review looked at our services from a user perspective and highlighted that there was more work to do to ensure that users have a truly integrated and seamless experience. We needed to improve how agencies worked together to ensure that services are better designed and easier to access when people need them. This includes reducing the amount of duplication within our health and care system, being clear about what services are available and how they interact and having systems,

which support the sharing of information about, service users so they only have to tell their story once.

We have used the findings from the adult review to form a new strategy for adult services. This has enabled us to start work on some key issues.

During 2019/20, we started and made progress on the following pieces of work:

a) Review of rehabilitation and re-ablement service support to reduce the cost of short stay residential placements, reduce the likelihood of short stay placements becoming long stay, and improve individuals' mobility, independence and reduction in dependency on home care services.

   This is a long-term piece of work, which is now underway. The review of the housing assistance policy has been concluded and will enable more flexible use of disabled facilities grant to meet needs, reducing care and support requirements.

b) Work collaboratively with children's services pre-transition to improve the value from learning/physical disability placements and consider alternative packages of care.

   A preparation for adulthood working group has been established to examine joint areas of focus and improvement. Joint working is planned with regard to social work practice improvements, sharing of learning between adults and children's practitioners, earlier identification of complex cases and consideration of new care market opportunities. A process of review has commenced for social care, health and Continuing Health Care funded placements.

c) Incentivise collaborative working within the ICP through the application of an efficiency target – this has been completed.

d) Via Union, arrangements agree NHS contribution to adult social care services.

   A business case has been developed to understand how improving performance at the interfaces between health and care can improve outcomes and value for money. In particular, a targeted piece of work has been started to improve our performance in relation to hospital discharged.

Our work programme for 2020/2021

a) Rehabilitation and re-ablement review
   The purpose of the review, which was started during 2019-20, is to ensure we have a flexible and responsive health and care system. The aim will be to ensure that the system operates offer efficient and effective re-ablement, reducing reliance on long-term care packages and formal services. This will offer greater independence for service users as well as providing savings to the adult social care budget. During the next year the rehabilitation and re-ablement review will progress to its service re-design phase and propose new models and options for commissioners.

b) Getting better value from care
   This work commenced in 2019 and will review outcomes and value for money through a systematic review of care packages. Following completion of this initial phase of work, lessons learned from the process, including new service models will be taken forward where possible. A second phase of work will then commence looking at lower value care packages. Taken together with the rehabilitation and re-ablement review this should see a significant increase in value for money and enable us to meet some of the demand pressures within adult social care.

c) Preparation for adulthood
We want to work more effectively with children's services to offer a more holistic approach to families that need more support to remain together, safe and within their own communities. This work is challenging our children's and adults' services to work more holistically together to prevent future needs for care and support and build resilience within families, and especially for those people who may have experienced early childhood trauma. This work also needs to ensure that the cost impacts of children transitioning to adult services are mitigated at an earlier stage through stronger and more robust casework and commissioning. We are collaborating with other councils in the region on the development of practice in this area.

d) Supported living review
Some of our supported living placements will be part of the review of the getting better value from care approach; we want this more detailed review to fundamentally challenge the mix and quality of provision and to ensure that where possible we plan for a more diverse service offer that is more resilient to changing needs within the population. This work commenced during autumn 2019/20, will identify opportunities for improved efficiency, effectiveness, and reduced cost to the adult social care budget.

e) Social work practice development
Adult social work practice is fragmented across a range of agencies, which is leading to inconsistent practice. Please see the section of the annual report providing further detail on this.

f) Residential care quality improvements
Following the fair cost of care exercise, we need to work with residential care providers to ensure sustainable high quality care is delivered in the borough. We will develop a more systematic approach to assuring quality and ensuring that the care offer within and around care homes reduces the rate of accident and emergency attendances and acute hospital admissions. This may offer a saving to health care services and will improve service users' wellbeing but will not deliver a cashable saving to adult social care.

g) Implementation of new support at home model
Following the pilot phases of the new "teams not times" model, we will commence a full borough wide roll out of a new support at home service under a new contract. The aim of the service is to ensure that care and support can be delivered flexibly to meet users' needs and outcomes, that support at homes services is an integral part of the health system, and that it plays a more effective role in the hospital discharge process. The model will also ensure that people can be linked to activities and support within their own communities. The re-modelled service will provide better quality, sustainable support to people living within the community and should delay the need for long-term care but will not deliver a cashable saving to the adult social care budget. There is scope to reduce costs to the health system through avoidable admissions to the acute hospital and by delivering an efficient discharge to home following hospital episodes.

h) Extra care housing programme delivery
Our site at Winchester Avenue, providing 60 units of extra care housing will be completed in summer 2020, which will see people being supported to live independently for longer and reduce the need for residential care. Options to mitigate further delays to the delivery of the Davenport Drive site (90 units) pending the identification of an alternative, suitable playing pitch strategy, will be pursued. This will include exploration of new sites and bringing forward the final scheme required to complete the planned programme.

i) Managing demand – information, advice and guidance
As part of our efforts to improve access to information and sources of self-help, to prevent the need for care and support, we will implement a new system to enable the development of a single point of information. Working with the voluntary and community sector, we will improve the way in which people can access to information about alternative sources of support within their communities. We will also explore the opportunity to develop community led local advice and support hubs.

j) Implementation of the liberty protection safeguards (formerly DOL and DOLS)
We will work towards the implementation of the replacement legislation and guidance for DOL and DOLS. This will include ensuring the appropriate workforce capacity is in place as well as relevant systems, processes, guidance and training. To contain the cost of social care delivery within the budget envelope, it will not be possible to clear the backlog of applications. However, we will continue to prioritise processing based on an assessment of risk.

Day opportunities and specialist community transport review

A review will be commissioned to look at how we make best use of resources to enable people to access support to meet their social needs as an alternative to day-centre based activity. Linked to this we will examine how our specialist community transport can be re-configured to offer a more flexible and responsive service for people with complex needs.

Bowel Screening – Faecal Immunochemical Test (FIT) Testing in Primary Care

In line with national guidance, NEL CCG rolled out FIT for the group of patients without rectal bleeding who are classed as “low risk, but not no risk” of having colorectal cancer in August 2019.

This is one of many programmes of work aimed at increasing the proportion of cancers diagnosed at an early stage, and at reducing the numbers of people presenting with cancers in emergency settings.

- What is FIT?

  The Quantitative Faecal Immunochemical Test is a test to detect hidden or ‘occult’ blood in stool samples. Unlike older tests, FIT uses antibodies that specifically recognise human haemoglobin and so there is no need for patients to undergo dietary restriction prior to using the test. As it is antibody based, FIT is a more sensitive and specific test than the guaiac test and reduces the chances of false positives.

Continuing Health Care (CHC)

The CCG provides a dedicated team to deliver the requirements of NHS Continuing Healthcare. In December 2019, the team of nurses and administrators moved from St Andrew’s Hospice to the Municipal offices as part of the plan to co-locate all CCG Staff. The CCG has embarked on a development plan to ensure that the team is able to deliver this NHS function going forwards. This has involved working with the NHS England Service improvement lead to benchmark the team’s capacity. At the same time, the CCG also commissioned an independent expert to review the work of the team against the national CHC maturity audit. These tools will help the CCG to establish an action plan to ensure capacity, sustainability and collaborative working going forwards.

Deprivation of Liberty Safeguards (DoLS)

In North East Lincolnshire, the CCG and council have a shared aspiration to develop legally literate staff able to champion a rights-based approach to delivering health and care. This includes ensuring that staff recognise, across a range of care settings, when rights under the European Convention on

Human Rights must be considered. This will mean identifying and responding lawfully to deprivations of liberty, as required by Article 5 of the Convention.

Over the preceding year, additional funds have been utilised to ensure that individuals deprived of their liberty are targeted for consideration by highly trained, specialist staff where this is likely to add the most value for the individual. Processes have been reshaped to ensure effective targeting of resources, to maximise the number of individuals benefiting from such expert consideration. Reshaping of processes also complements local work to prepare for the Liberty Protection Safeguards (LPS): an amendment to the Mental Capacity Act 2005 (MCA), which will be implemented in October 2020, and will change the way in which deprivations of liberty are made lawful.

Preparation for LPS is being led locally by a multi-disciplinary, cross-sector partnership, and is focused on ensuring that all relevant staff have a sound MCA and human rights practice base on which to build the knowledge required by LPS. Local involvement in creation of the national Code of Practice and regulations, which will accompany LPS, offers the opportunity for local expertise to inform, and be informed by, this significant and exciting change to practice and legislation.

Long Term Care

"Long term care" refers to the commissioning of residential and nursing homes. Presently there are 44 providers commissioned to deliver a range of residential services across North East Lincolnshire. In 2019, providers adopted a new contract and specification with elements of the previous optional quality award scheme becoming a requirement. The previous quality scheme consisted of three levels, bronze, silver and gold. All requirements of the bronze and silver levels were incorporated into the contract. Following a fair cost of care exercise the CCG will work with residential care providers to ensure sustainable high-quality care is delivered in the borough. The CCG will develop a revised approach to assuring quality and ensuring that the care offer within and around care homes reduces the rate of unnecessary accident and emergency attendances and subsequent admissions. This may offer a saving to health care services and will improve service users' wellbeing. The CCG is actively reviewing the compliance with the new contract and will progress work on key priority areas for quality improvements in residential care settings.

Managing Long Term Conditions (My COPD app)

MyCOPD is an NHS approved app to support patients with COPD to manage their condition. It has a full education section including videos, a pulmonary rehab programme and advice on how to keep well. We have a number of free licences available for patients and have been working with both patients and staff to raise awareness of the app and make available. The app is issued through a range of support services including GP practice, the hospital respiratory team, community service and Social Prescribing. We now have over 200 apps issued to patients and are seeking feedback on how this has helped them to manage their condition.

Mental Health Support Teams

In December 2017, the Government published a Green Paper for transforming children and young people's mental health, which detailed proposals for expanding access to mental health care for children and young people.

Together NHS England (NHSE) and the Department for Education (DfE) have established Mental Health Support Teams, which aim to provide early intervention on mental health and emotional wellbeing issues, such as anxiety, as well as helping staff within a school or college setting to provide a 'whole school approach' to mental health and wellbeing.

North East Lincolnshire have been successful in the second wave of the trailblazer funding for two Mental Health Support Teams. The Mental Health Support Teams will provide early intervention and prevention support all year round whilst reducing the need for escalation. The team will also focus on key transition points for young people, which can cause increased presentations, such as transitioning from primary to secondary school.

We co-developed a selection criterion with the educational settings to identify which type of settings should be invited to express an interest in the trailblazer. Therefore, we have signed up 36 educational settings to be part of the trailblazer, in line with the guidance that each team can support up to 8,000 pupils aged between 5 -18 years. These educational settings are made up of a variety of:

- Primary Schools
- Secondary Schools
- Pupil Referral Units
- Alternative Provision
- Further Education Settings

As part of the trailblazer bid, we will also support all children and young people across the whole of the borough who are:

- Children Looked After
- Elected Home Educated
- Young Carers
- Excluded Pupils/At Risk of Exclusion

There will be a team of 16 staff members supporting the delivery of this project, which will provide the following support to children, young people, their families and education professionals:

- 1:1 Support (e.g. anxiety, self-harm)
- Group Work (e.g. low mood, social problems)
- Parent and Child Workshops
- Staff Training
- Peer Support/Mentoring

Key Achievements to Date:

- Successful in securing funding for two Mental Health Support Teams
- Signed up 36 educational settings to the trailblazer and have confirmed their commitments to the project aims and outcomes
- Undertook a procurement to award the tender to the successful Provider – Compass

- Held a 'Meet and Greet' with educational professionals and key partners to meet Compass and learn more about the offer - the event was attended by over 70 professionals

- Currently recruited 8 Education Mental Health Practitioners who are attending Sheffield University to learn how to support young people – further recruitment being undertaken for other roles

- Developing working relationships with key professionals (e.g. Inclusion Lead)

We are currently looking at options to extend the support available via the Mental Health Support Teams across the whole of North East Lincolnshire through future waves of funding via NHS England and Department for Education.

Primary Care Networks

Primary Care Networks (PCNs) are groups of practices (30-50,000 population) working with other providers (e.g. Community Nursing and Mental Health teams) to best care for patients. These were formally established in July 2019 and in NEL, we currently have five PCNs (although three of these have applied to become one, so this will make a total of three from April 2020). As well as working with other providers, there are 10 new roles, which are funded as part of the PCNs to best support the needs of patients. Good progress has been made with arrangements in place to start working in multi-disciplinary teams in the coming months. There are three national service specifications that have been recently published that the PCNs will be delivering over the next year and we are working with the PCNs to support this.

Primary Care Services

Care Navigation

Refresher training has been offered for clerical staff to gain an understanding of how to guide patients and carers by identifying and enabling access to the most appropriate systems and support available to them within health and social care and beyond, rather than a traditional GP Practice appointment, where appropriate.

Correspondence Management Training

Refresher training has been offered for administrators and team leaders to gain an overview understanding of the clinical read coding and medical terminology needed to contribute to the safe, practical application of dealing with incoming correspondence, within agreed protocols and overall GP oversight.

Digital Enabled Care

The NHS Long Term Plan has a strong emphasis on technology with digitally enabled care becoming mainstream across the NHS. The new five-year GP contract framework expands further on this and includes a significant focus on technology. We have been working closely with GPs and practices to look at better use of technology across North East Lincolnshire and continue to work closely to meet the aims of the Long-Term Plan and five-year GP contract framework.

Below is a summary of some of the programmes that we are supporting practices with: -

- GP Online presence

  Practices are encouraged by the Long-Term Plan and new GP contract to improve their online presence. This includes patients being able to access digital records, order repeat prescriptions and book appointments online.

In order to better meet the accessibility requirements of our patients, as of April 2020, practices are now able to supplement face-to-face consultations with both video and electronic consultations over the internet.

- NHS 111 direct booking

  In North East Lincolnshire, a significant number of practices have piloted NHS111 direct booking and the feedback from those practices has been positive, with efficient communication allowing the 111 service to fill GP appointments slots when appropriate to do so.

  This is now being rolled out to all practices and forms part of the new GP contract where practices will make one appointment per 3,000 patients available each day for NHS111 to clinically triage and book patients in.

- NHS App

  The NHS App is available to download from Apple App and Google Play stores. Patients are able to use the app to check their symptoms using NHS111 online and the health A-Z, featured on the NHS website. Throughout 2019/20, we worked together with our GP Practices to ensure they all have the technical capabilities to offer full functionality of the app to their patient population. This includes using the app to book and manage appointments, order repeat prescriptions; securely view GP medical records register as an organ donor and choose whether their data can be used for research.

  In addition, the NHS App acts as a single identity tool for future health and care apps, therefore future proofing digital solutions and making the patient experience significantly smoother.

- MJOG

  MJOG is a two-way safe and secure patient messaging service that allows GP practices to send messages to their patients either over a text message or through a dedicated phone app, which the patient is then able to respond to in a few simple clicks. This will help to improve efficiencies in practices by reducing 'did not attend' (DNA) appointments. To help increase GP Practice uptake of MJOG we purchased a three-year package 'free' for all our GP community that includes an offer to adopt the then licence for any practice already using the system.

- HumberHealthApps.co.uk

  The CCG recognises that some patients want to have the empowerment to better support their own care through the use of digital tools, and to support them the CCG has launched Humberhealthapps.co.uk an online tool to support patients find the app for them.

  Collated by a group of health, usability and data security experts, Humberhealthapps.co.uk provides a rated library of the top health apps to provide an extra level of assurance to our patients that apps are safe and effective.

- Yorkshire and Humber shared care record

  The Yorkshire and Humber Shared Care Record project, funded through the Local Health Care Record Exemplar (LHCRE), enables the sharing of records across health and social care, reducing risks by decreasing the amount of duplication.

The project offers a single source of information across all care settings, without replacing any systems. From within an individual's record, a professional will be able to open a portal showing the appropriate records from other professionals. Our local hospital trusts are signed up for the next phase of integration and work is underway for the inclusion of end of life, community and social care data sets.

- Engage Consult

  Engage Consult is an online consultation system that makes it possible for patients to submit their symptoms online and receive a response from their practice, which could be advice, signposting or booked in for an appointment. This can help to treat patients without the need for them to attend the practice.

- Supporting GPs with better technology

  All the new digital tools being provided require the appropriate supporting technology in place to support the clinicians to provide the right service, in the right place and at the right time. To support this there is currently a large programme of work underway to deliver superfast secure NHS broadband to every practice across the Humber.

  In light of COVID-19 we have also introduced new tools for allowing GPs and their supporting staff to work in a truly agile manner, allowing them to continue to provide clinical services during a difficult time.

GP International Recruitment

The CCG is continuing to work with the Humber, Coast & Vale STP to recruit international GPs, with a focus on recruiting GPs from Spain. Taster weekends have been hosted to enable interested international GPs to visit the area and spend time in local GP Practices. It is hoped that once their training is complete, they will choose to relocate to North East Lincolnshire. However, there remain a number of challenges, including feedback from candidates that they would prefer to live and work in a city. The CCG continues to promote the local area, which benefits from easily accessible transport links to cities in the Yorkshire and Humber region, and beyond.

Rehabilitation and re-ablement

In July 2019, the NELCCG embarked on a re-ablement review - 'promoting independence, preventing dependence'. The work commenced with a workshop attended by professionals and community representatives. It was agreed the review would be executed using an agile methodology (a flexible approach that focuses on discovering user experience/user feedback prior to making decisions/ changes). The discovery phase occurred between September and December 2019. Over 40 professionals and several users were interviewed, in order to capture their experience. Fifty case studies were collected, and national and regional best practice also directly informed the review.

Feedback has shown that there are several key areas for improvements in re-ablement provision and practice, i.e. across health, social care and community services. An issues paper has been drafted to inform future commissioner decision making, as well as a summary document detailing the areas of good practice that need to be further rolled out across the system. Moving into 2020/ 2021, the intelligence gained from the review will be used to design and implement a re-ablement improvement plan for the system as a whole.

Areas for focus include:

- supporting clients and informal carers to maintain their independence at home

- ensuring support at home (domiciliary care) is designed and skilled to assist with self-care
- ensuring care homes provide environments and opportunities for residents to maintain skills of daily living where possible
- Improving the discharge journey for clients leaving hospital
- Improving the range and availability of therapy based re-ablement provision
- Working to align community services to the emerging Primary Care Networks to ensure clients receive support to meet their needs

It was a challenge to scope the system, due to the sheer number of re-ablement services and the resource required in staff time. Moving forward, there are likely to be challenges of resource to implement the "re-ablement vision for NEL", as well as potential resistance while embedding a change in culture and practice.

Social work practice

North East Lincolnshire's current model

As far as the law allows, the council's adult social care functions are delegated to the CCG. Acting as the Council's agent, the CCG contracts with three organisations – NAViGO, Care Plus Group (CPG) and focus independent adult social work (focus) – to provide the functions and give assurance to the Council on delivery. Both NAViGO and CPG deliver services in addition to adult social care functions provided on behalf of the Council. Focus is a specialist social work practice (SWP).

Local delivery of social work functions can be summarised as follows:

- NAViGO provides assessment, care planning/review, case management and micro commissioning (where social workers plan and put in place the support required for users) for those under 65 with a mental health condition. It also provides Approved Professionals under the Mental Health Act 1983 (AMHPs)
- CPG provides day care (for older adults and those with learning disabilities), transport, enhanced employment opportunities, and emergency/out of hours duty services (comprising shorter term assessment and micro-commissioning
- focus provides the remainder of social work assessments, care planning/review and longer-term case management functions. It approves the appointment of adult mental health practitioners (AMHPs)

These three agencies (focus, Care Plus Group and NAViGO) contribute to specialist functions under the Mental Capacity Act 2005.

This model is leading to inconsistent practice. From a user perspective, these inconsistencies can give rise to inequitable treatment and inconsistencies in care planning and consequently delivery. It also leads to a proliferation of assessments and duplication of processes.

From the adult services review, duplication and overlap between services was identified, leading to inefficiency.

Moving forward through 2020

As the council and CCG have now joined forces formally in the formation of the "Union" and with the increasing pressure on resources, it seems timely to review the arrangements for the delivery of adult social work.

The development of the Union forms part of a period of substantial change and re-alignment of relationships, organisations, strategic and micro-commissioning functions.

We will consider a business case for change in the way in which social work practice is delivered to make best use of our resources. We also need to consider the best way to deliver workforce capacity to support the new liberty protection safeguards process. This proposal should in the longer term strengthen decision making and casework to ensure better management of resources.

Special Educational Needs and Disabilities (SEND) Therapies

Ofsted and the Care Quality Commission (CQC) undertook a joint local area SEND inspection in North East Lincolnshire in July 2018. The inspection team identified areas of strength with examples of good practice and highlighted three areas of weakness that required further improvement. In response, it is recognised that some of the local services do not meet the standards and expectations that our children, young people and their families deserve. In North East Lincolnshire (NEL), there is a joint commitment to deliver improvements across education, health and social care services. The 'Written Statement of Action' (WSOA) sets out actions that address areas of weakness. One of the areas identified was for children and young people (CYP) therapy services.

It was felt that access to therapy services, such as occupational therapy and speech and language therapy, was limited by the capacity of these services to meet CYP's needs. This was because they felt that these crucially important services were not planned or commissioned in a joined-up way. Access to occupational therapy in NEL was additionally limited by long-standing vacancies in this service. Inspectors were concerned that the local area's decision to withdraw speech and language therapy from the youth offending service has led to some CYP, often with unidentified speech and language needs, being unable to access therapy support.

The work to date has seen the joining of key stakeholders to review contractual arrangements, which has been challenging due to the longstanding block contract arrangement in place, which incorporates a range of different adult and children's services. Regular performance monitoring/management is now in place and has been further developed to be a joined-up health and locality authority approach. A comprehensive reporting template that provides data for all three commissioned services is being developed.

A project group has been established to review, map current service provision, undertake national, regional and local data analysis, identify capacity and gaps that exist and explore options for future delivery of services. During the time of this work it has been recognised that speech and language therapy services is particularly complex due to the numerous services in place and it has since been identified that a 'NEL place based' CYP therapy service framework needs to be designed/ established. Supported by the Joint Strategic Needs Assessment and joint strategies, this is recognised as a significant time and resource intensive piece of work, which will take longer than the timescales originally identified. The work will require working closely with all stakeholders such as schools, service users and youth offending services. However, ultimately the aim is to establish services that have been planned and commissioned in a joined up way and where CYP and their families have appropriate, timely and equitable access to therapy services to meet their needs and that they report that they have access to therapy support where and when they need it. It has been recognised that this is what is required to achieve a long-term sustainable service.

There is a recognition of the impact and risks of small teams in each therapy area and that recruitment and retention of therapy staff is a national as well as a local issue. Stakeholders are working together to develop interim solutions whilst the longer-term work continues. Work also continues to enhance existing ways of working between professionals/teams to streamline approaches, processes and develop existing skill sets.

Support at home

Previously known as domiciliary care or care at home, those in receipt of the service chose to rename this provision as "support at home". Re-procurement for this service began in 2019 with a new specification moving away from a traditional time and task model to a more flexible outcomes-based approach. Following good feedback from the initial pilot of this new "teams not times" model, the CCG will commence a full borough wide roll out of the support at home service under the new contract in 2020. The aim of the service is to ensure that care and support will be delivered flexibly to meet users' needs and outcomes, that the service is an integral part of the health system, and that it plays a more effective role in the hospital discharge process. The service will also ensure that people can access activities and support within their own communities. The re-modelled service will provide better quality, sustainable support to people living within the community and should delay the need for long term care but will not deliver a cashable saving to the adult social care budget. There is scope to reduce costs to the health system through avoidable admissions to the acute hospital and by delivering an efficient discharge to home following hospital episodes.

Supporting children and young people with additional needs:

The Access Pathway launched in April 2018 is a multi-agency pathway which merges medical and social models to support children and young people with complex needs across speech, language and communication, difficulties with social interaction, learning difficulties, social, emotional and mental health difficulties, sensory difficulties and neurodevelopmental difficulties; offering support for a number of different needs through a single plan of recommendations.

The joint area Special Educational Needs and Disabilities (SEND) inspection (carried out 5 months after the pathways implementation) highlighted the need for a review of the pathway, as there was still confusion and little coherence about the approach. The inspection highlighted: '<u>While there is a shared belief in the potential of the single access pathway to facilitate better and more timely assessment and improved access to services, the implementation of these new arrangements lacks coherence. Indeed, this fundamentally important element of the local area's arrangements for identifying, assessing and meeting the needs of children and young people who have SEN and/or disabilities is currently in disarray</u>*'.*

This was then translated into a number of actions within the Council and the CCG's response to the inspection (known as the Written Statement of Action) which are:

11. To have an Access Pathway in place which facilitates decision making to ensure improved and timely identification for children and young people who have SEND with additional needs around communication and interaction, cognition and learning and SEMH	11.1	Commence a combined review of the access pathway by both NELC/CCG, parents/carers and voluntary sector including focus on co-production
	11.2	Comprehensive and rolling training and development programme for all practitioners and parents/carers of children and young people who have SEND with additional needs around communication and interaction, cognition and learning and SEMH

11. To have an Access Pathway in place which facilitates decision making to ensure improved and timely identification for children and young people who have SEND with additional needs around communication and interaction, cognition and learning and SEMH	11.1	Commence a combined review of the access pathway by both NELC/CCG, parents/carers and voluntary sector including focus on co-production
	11.3	Develop mechanisms for improving and capturing parent/carer experience of the access pathway

Since October 2018 the commissioner, members of the access pathway panel, Healthwatch and a commissioned consultancy (Impower) have been involved in undertaking reviews of the process alongside the wider children's workforce, children, young people, parents and carers.

Parents and professionals (both clinical and non-clinical) have been listened to, there has been a review of the challenges in the existing model, and best practice from other areas have been draw upon together with a review of national guidance (e.g. National Institute for Health and Care Excellence (NICE)) to co-produce an approach to better meet needs.

Wider System challenge

Through redesigning the new model with professionals and parents it has been recognised that many of the issues raised by parents are symptoms of the challenges within the wider Special Educational Needs (SEN) system in North East Lincolnshire (e.g. workforce with the right skills to support, improved local offer of support) and therefore the new approach needed to be a whole system approach rather than a pathway in isolation. As such, the implementation is not limited to the pathway itself but includes reconfiguring services/systems, workforce development and commissioning specialist support.

There is a strong commitment from both professionals and parents to 'get it right' and parents/carers have articulated that the current pathway roll out was too rushed. They have said that this review process should not be rushed through and time needs to be taken to get it right and co-produce. This was also a key finding from the SEND Inspection.

Therefore, we have proposed a pilot period of the new approach to further co-produce the new model and get it right which will conclude during 2020/21.

What does the new model look like?

Through the workshops, parents and professionals (including clinical professionals) decided on three key agreements to underpin the new approach:

- Based on the multi-agency 'team around the child' approach to support children and young people with additional needs. Children with additional needs require more input than solely the medical view and the process should meet national guidelines and best practice which state that a multi-agency approach is required.

- Ensure all types of support are coordinated to support all children and their different levels of need to best meet the needs of each individual child or young person.

- Consider all types of neurodevelopment and SEN needs; it is not just about supporting those with Autistic Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD).

Parents identified the following principles as very important to them in the workshops. These principles reflect the concerns raised and recommendations made in the Healthwatch report.

1. Information about available support to help children, young people and families is easy to find and navigate
2. Collaborative working between the Council and professionals – identifying clear roles and responsibilities
3. Positive and supportive attitudes from professionals
4. Child and family voice are at the centre of the process
5. A single point of access for children, young people and families that need support, advice, assessment
6. Transparency about how, why, and when decisions are made
7. A simple process and user-friendly referral form
8. Clear and joined up communication
9. A clear timeline – which everyone involved keeps to
10. A point of contact for queries and to help navigate the process

With the ten guiding principles in mind we have co-designed an integrated additional needs support approach.

Additional Needs NEW Approach – summary:

- Step 1: Self- Referral OR Professional Referral (anyone) electronic/ paper based (while you're waiting information sheet)
- Step 2: Discussion with key worker (Signposting to support)
- Step 3: Our Support Plan (OSP) Discussion (parent/carer attendance and NOT a panel)
- Step 4: Agreed OSP (what, when and by who?) PLAN, DO, REVIEW
- Step 5: All referrals and OSP discussed with Multi-Agency Specialist Team
- Step 6: OSP updated with recommendations from Multi-Agency Specialist Team (MAST) chaired by paediatrician
- Step 7: MAST review (observations, assessments, diagnostic tools) chaired by paediatrician with a minimum core team of Speech and Language and a Clinical Psychologist (NICE compliant)

Our 2019/20 objectives

The Corporate Business Plan is split into 3 main themes:

1 Strategic Developments
2 System Resource
3 Overarching Health and Care Priorities

The Corporate Business Plan comprises more than 93 projects and initiatives, each of which has milestones and key performance indicators used to measure progress and achievements. The areas of work described below are headline achievements for the organisation, which reflect a cumulative achievement of these projects and initiatives.

To support the transformation of out of hospital, care the following priorities for action in 2019/20 were identified and a targeted progress was made against each of them:

Objective	Work Areas
Strategic developments	Primary care – new models of care
System resource	Digital support for domiciliary care providers Primary care workforce
Overarching health and care priorities	Social Prescribing Care at home Support to care homes Care home trusted assessor Roll out of FIT across NEL for primary care PHE Improving access to LD, MH and autism services Urgent and emergency care transformation Planned care transformation Maternity system transformation Integrated cardiology

Access to Information (FOI)

During the period from 1 April 2019 to 31 March 2020, the CCG processed the following requests for information under the Freedom of Information Act 2000 (FOIA):

Freedom of Information Requests	2019/2020
Number of FOI requests processed	263
Percentage of requests responded to within 20 working days	100%
Average time take to respond to an FOI request	17 days

The CCG provided the full information requested in 85 cases. The CCG did not provide the information requested in 65 cases because an exemption was applied either to part of, or to the whole request. The exemptions applied were; information was accessible by other means; the cost

of providing the information exceeded the limits set by the FOIA, disclosure of information would be likely to prejudice the commercial interests of any person or the information requested related to personal data or third parties.

The CCG did not provide information in 113 cases where the CCG did not hold the information and, where possible, the applicant was redirected to another organisation for the information.

The CCG received one request for an internal review of an FOI response provided during the year.

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

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

Dr Peter Melton
Accountable Officer
24 June 2020

Accountability Report

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

Corporate Governance Report

Members report

We are a clinically led organisation, which brings together **26** local GP practices and other health professionals to plan and design services to meet local patients' needs.

Our member practices are:

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

Governing Body member profiles

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

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

Current composition of the Governing Body

Clinical members

Dr Peter Melton	Accountable Officer (GP Clinical Chief Officer)
Dr Sudhakar Allamsetty	Chair Council of Members, Vice Chair of Governing Body
Dr Ekta Elston	Medical director, Vice Chair Council of Members,
Dr Jeeten Raghwani	GP representative
Dr Renju Mathews	GP representative
Dr Chris Hayes	Secondary care doctor

Lay members

Mark Webb	Governing Body Chair
Philip Bond	Patient and Public involvement
Tim Render	Governance and audit

Officer Representatives

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

Standing attendees

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

Resignations were received from the following Governing Body members during 2018/2019:

Dr Arun Nayyar	GP representative from April 2013 to March 2019
Dr Rakesh Pathak	GP representative from April 2013 to March 2019

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

Our committees

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

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

Full details of committees, functions, membership and attendance for 2019-20 can be found in the Annual Governance Statement

Register of interests

The CCG have arrangements in place to ensure that conflicts of interest are appropriately managed with transparency and proportionality. We maintain a register of interest and our Standard of Business Conduct and Managing Conflicts of Interest Policy provides guidance and outlines the process in place for maintaining a register of interests. The CCG's Integrated Governance and Audit Committee approve the register.

Governing Body Members, Committee members, employees and member practices are asked to complete a declaration of interest form to identify any potential conflicts of interest. The CCG ensures that declarations of interests are made, confirmed and updated annually.

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

The management of conflicts of interest is embedded into the governance arrangements of the CCG. Where a declaration is made, this is recorded clearly alongside how the conflict was managed.

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

The CCG's registers of interest can be viewed on the CCG website

Modern Slavery Act

NHS North East Lincolnshire CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2020 is published on our website

Personal data related incidents

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

The CCG has not reported any personal data related incidents to the Information Commissioners Office during 2019/20.

Emergency Preparedness

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

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

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

The CCG, although not a “Category 1” responder, has a key role in linking into NHS England in the event of a major incident and in a proportionate coordination role with local providers in the management of incidents depending on their nature.

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

The CCG is active in the LHRP forum and the EPRR assurance process and in October 2019 completed the annual mandatory self-assessment against the EPPR requirements recording a “substantial” compliance level with the requirements. The CCG reported that it was fully compliant with 42 out of 43 of the core standards, which is an increase on the compliant standards in the 2018/19 return.

The CCG, in becoming part of the “Union” with North East Lincolnshire Council, has strengthened its emergency planning links with the Humber Emergency Planning Service (the organisation commissioned to provide Emergency Planning for four Humber Local Authorities). The CCG’s incident control centre is now co-located with NELC’s, and the local authority and CCG ran a live play exercise in July 2019 on arrivals of undocumented migrants to North East Lincolnshire ports.

CCG staff and other members of the North East Lincolnshire Emergency Planning and Response Group (EPARG) have participated in and/or conducted a wide range of tabletop exercises covering a diverse range of risks such as cyber-attacks, COMAH incidents, migrant arrivals in North East Lincolnshire ports and EU Exit. CCG loggists undertook refresher training and senior leaders undertook Strategic Emergency Management training.

The EPARG forum continues to develop with a regular calendar of the considerations of risks, available plans and business continuity. Most of the this year’s considerations were centred around EU Exit as a risk, immediately followed by the management and strategic decision making surrounding the emergence of Covid-19 (Coronavirus). The latter continues to be managed at operational, tactical and strategic level by the CCG, health and social care providers and local authority colleagues.

Health and Safety

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

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

Health and safety is a part of the mandatory e-learning schedule that needs to be undertaken by all staff and data screen assessment (DSE) is part of this training schedule. 81.72% of our staff has completed health and safety training and 94.62% of our staff has completed DSE training

For the period April 2019 to March 2020 there were six incidents reported under the category of Health and Safety none of which were RIDDOR reportable.

Statement of Disclosure to Auditors

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

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

Dr Peter Melton
Accountable Officer
24 June 2020

The Statement of Accountable Officer's Responsibilities

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

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

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

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

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

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

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

I also confirm that:

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

Dr Peter Melton
Accountable Officer
24 June 2020

Annual Governance Statement

Introduction and context

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

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

As at 1 April 2019 the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the Nation Health Service 2006 (as amended).

A Strategic Commissioning Board (SCB) across the four Humber CCGs is to be established in 20/21. It will be responsible for strategic commissioning for the Humber, and it will accelerate delivery of the Long-Term Plan (LTP) and Integrated Care System (ICS) ambitions for Humber, Coast and Vale. It will operate initially in shadow form, whilst work is undertaken to enable formal delegation of functions from the four Humber CCGs Governing Bodies.

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

The CCG has established a Constitution, which together sets out how the organisation will ensure that it is well governed and accountable to both its member GP practices and its local population. The constitution sets out our arrangements for discharging the CCG's statutory responsibilities for commissioning care on behalf of our population. It sets out our governing principles, associated Standing Orders, Prime Financial Policies and Scheme of Delegation, rules and procedures that ensure probity and accountability in the day to day running of our CCG, clarifying how decisions are made in an open and transparent way and in the interests of patients and the public; all of which have been approved by the CCG's membership and certified as compliant with the requirements of NHS England.

The Scheme of Delegation sets out those decisions that are reserved to the membership, its Governing Body, its committees, individual officers and other employees.

The geographical area covered by NHS North East Lincolnshire Clinical Commissioning Group is equal to the area covered by North East Lincolnshire Council. All practices who provide primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract in our area are eligible for membership of our CCG.

As a clinically lead organisation, 26 practices collectively form the members of NHS North East Lincolnshire Clinical Commissioning Group. These are listed in the members report.

Our constitution is a living document, during 2019/20, the CCG has amended its constitution in-line with NHS England New Model Constitution this is currently awaiting formal approval and the expectation is to be a live document by April 2020.

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

Our Governing Body heads our governance structure; it has established several formal committees to which it has delegated responsibilities. During 2019/20, a review of the governance structure for each committee took place to ensure each committee had the appropriate membership to support the Governing Body to deliver all its functions and duties. We have also incorporated templates for governance documents to be used across the governance structure. All committees have at least one Governing Body member as part of their membership and minutes of all committees are shared with all Governing Body members.

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

The Membership, Attendance and Activity Summary

The 2019-20 membership, attendance and activity summary of the Council of Members, Governing Body and the Governing Body committees are given below.

Council of Members

The CCG is a membership organisation comprising all of the GP member practices across North East Lincolnshire. The Council of Members consists of one representative from each practice, to ensure that the CCG includes all GP practices in the area. In addition, there is representation of Adult Social Care (ASC) via the Executive Director (CCG Chief Operating Officer) with responsibility for ASC strategic commissioning and the ASC advisor to the Governing Body are both members of the Council of Members.

The Council of Members (CoM) is the arena in which all member practices come together to:

- Consider and advise on the service commissioning agenda for health and social care
- Ensure that the continued development of the CCG is aligned to the principles and aspirations of the constituent practices
- Shape the organisation's strategic direction and key objectives

- Approve service strategies and significant service change proposals

The CoM held four formal meetings through 2019 and was quorate for each of them.

The CCG recognises that there are continued issues in relation to attendance of all member practices. Discussions took place at the November 2019 meeting and members approved the proposal in the January 2020 meeting that CoM to be incorporated into the existing Protected Time for Learning (PTL) meetings 4 times per year with the option to virtual vote where decisions need to be made outside the existing timetable. This would therefore reduce the amount of meetings practice members are required to attend.

Over the past year, CoM has approved a number of service strategies, service change proposals prior to ratification by the Union Board or relevant committee, agreed changes to the CCG's constitution and received updates regarding service changes. These include:

- Agreement to the CCG's commissioning intentions (direction of travel for service strategy)
- Input into the evaluation of the following service (re)design proposals (please note this list is not exhaustive):
  - Access pathway
  - 3-year pilot for diabetes patients

Members' attendance

Members	Attendance (maximum of 4 meetings)
Beacon Medical Primary Care Centre	4
Birkwood Medical Centre	4
Blundell Park Surgery	0
Chantry Health Group	0
Clee Medical Centre	1
Core Care Family Practice	4
Dr Chalmers & Dr Meier	0
Dr A Kumar	1
Dr A Sinha	4
Dr O Z Qureshi Surgery	0
Dr P Suresh-Babu	0
Dr R Mathews	1

Members	Attendance (maximum of 4 meetings)
Greenlands & New Waltham Surgery	2
Fieldhouse Medical Group	2
Healing Health Centre	0
Humberview Surgery	1
Littlefield Surgery	4
Open Door	0
Pelham Medical Group	1
Quayside Medical Centre	0
Raj Medical Centre	0
Roxton at Weelsby View	3
Scartho Medical Centre	3
The Lynton Practice	0
The Roxton Practice (Immingham)	3
Woodford Medical Centre	0
Executive Director with responsibility for ASC strategic commissioning	3
ASC advisor	3

Governing Body

The Governing Body's main function is ensuring that the group has appropriate arrangements in place to exercise its statutory functions effectively, efficiently and economically and in accordance with the group's principles of good governance. This group makes the final strategic decisions for the organisation.

The mission of NHS North East Lincolnshire Clinical Commissioning Group is delivering to the people of North East Lincolnshire the best possible independent healthy living through joined up solutions.

The Governing Body promotes good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

The Governing Body has responsibility for: -

- ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the group's principles of good governance;

- establishing a remuneration committee to determine the remuneration, fees and other allowances payable to employees or other persons providing services to the group and the allowances payable under any pension scheme it may establish;

- establishing an Audit committee, that will be called the Integrated Governance & Audit Committee, to ensure sound integrated governance and financial management arrangements are in place, and that those arrangements support the efficient, effective and economic delivery of the CCG's functions;

- those matters specified elsewhere in our constitution and in the scheme of reservation and delegation.

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

- Finance Report
- Quality Report
- Commissioning, Contracting and Integrated Assurance Report

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

- Corporate Business Plan
- Long Term Plan
- North Lincolnshire System Plan 2019/20
- Workforce Update
- CCG Assurance Report
- Social Prescribing Update
- Terms of Reference review
- Board Assurance Framework
- Integrated Governance & Audit Annual report
- Community Forum Assurance Report
- Information Governance Framework Strategy
- Child Death Review process
- 2020/21 Budgets / Medium Term Financial Plan
- Emergency Preparedness, Resilience and Response Report
- CQC Report

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

The Governing Body met formally four times in public during 2019/20 and attendance records demonstrate that every meeting was quorate.

The Governing Body discharged its duties in full in 2019/20.

Members' attendance

Members	Attendance (maximum of 4 meetings)
Mark Webb (Chair)	4
Dr Peter Melton	3
Dr Ekta Elston	2
Dr Sudhakar Allamsetty (joined 1 April 2019)	3
Dr Renju Mathews (joined 1 April 2019)	2
Dr Jeeten Raghwani (joined 13 September 2019)	2
Dr Chris Hayes (joined 1 September 2019)	1
Philip Bond	4
Tim Render	3
Rob Walsh	4
Helen Kenyon	3
Laura Whitton	4
Jan Haxby	3
Steve Pintus	1
Joe Warner	4
Anne Hames – standing attendee (joined 3 July 2019)	2
Joanne Hewson – standing attendee	0

Union Board

During 2019/20, the Union Board agreed the following strategic priority areas to inform the Union business plan:

- Primary Care Networks
- Adult Services
- Special Educational Needs and Disabilities (SEND)
- Humber Acute Services Review
- Union Operating Model

The final Union Business Plan is due to be considered for sign off by the Board at its meeting in March 2020.

The Union Board considered the planning approach and timescale for the completion of the Union Health and Care Strategic Plan. The Strategic Plan is due to be signed off by the Board at its meeting in March 2020.

It also reviewed and approved the revised strategic outcome statement and priority areas under the Health and Wellbeing outcome, as requested by the Place Board.

The Union Board approved the following documents during the year:

- Adult Strategy 2019-2022
- Child Death Review Plan
- Joint Engagement Strategy

It also monitored progress with the following:

- Humber Acute Services Review.
- Adult Services Review.
- The development of Primary Care Networks
- Financial performance through quarterly updates
- Adult Social Care performance
- Special Education Needs and Disabilities

In addition, it was consulted on the Better Care Fund Plan for 2019-20 prior to approval by the Place Board.

Procurement matters agreed by the Union Board included the Health Check Service, provision of Mental Health Support Teams and the Oral Health Promotion Service.

The Board received and noted the Adult Social Care Local Account and the Adult Social Services and Health Annual Complaints report.

The Union Board welcomes public engagement and there is the opportunity for the public to ask questions at each meeting. This has been taken up on a couple of occasions during the past year.

Members	Attendance (maximum of 3 meetings)
Mark Webb	3
Dr Peter Melton	2
Philip Bond (joined 1 July 2019)	3
Dr Ekta Elston (left 9 September 2019)	1
Dr Sudhakar Allamsetty (joined 10 September 2019)	2
Councillor Philip Jackson (joined 21 May 2019)	2
Councillor Margaret Cracknell (joined 21 May 2019)	3

Members	Attendance (maximum of 3 meetings)
Councillor John Fenty (joined 21 May 2019)	2
Councillor Ian Lindley (joined 21 May 2019)	3

Community Forum

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

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

Three roles were appointed to this year and we are currently recruiting to a new role as Primary Care Community Lead. New Community Leads receive a comprehensive induction and support. Community members all completed their mandatory online training.

The Community Forum met every month in 2019/20. Meetings are well attended, and each meeting was quorate. A representative from the CCG Leadership team attends each meeting as does the CCG Engagement Lead and CCG administrative support.

The Forum refreshed its Terms of Reference this year, setting out new arrangements whereby the Chair of the Forum provides a direct link into the Governing Body and the Council of Members attending meeting as a non-voting member. The Governing Body receives minutes from Community Forum meetings.

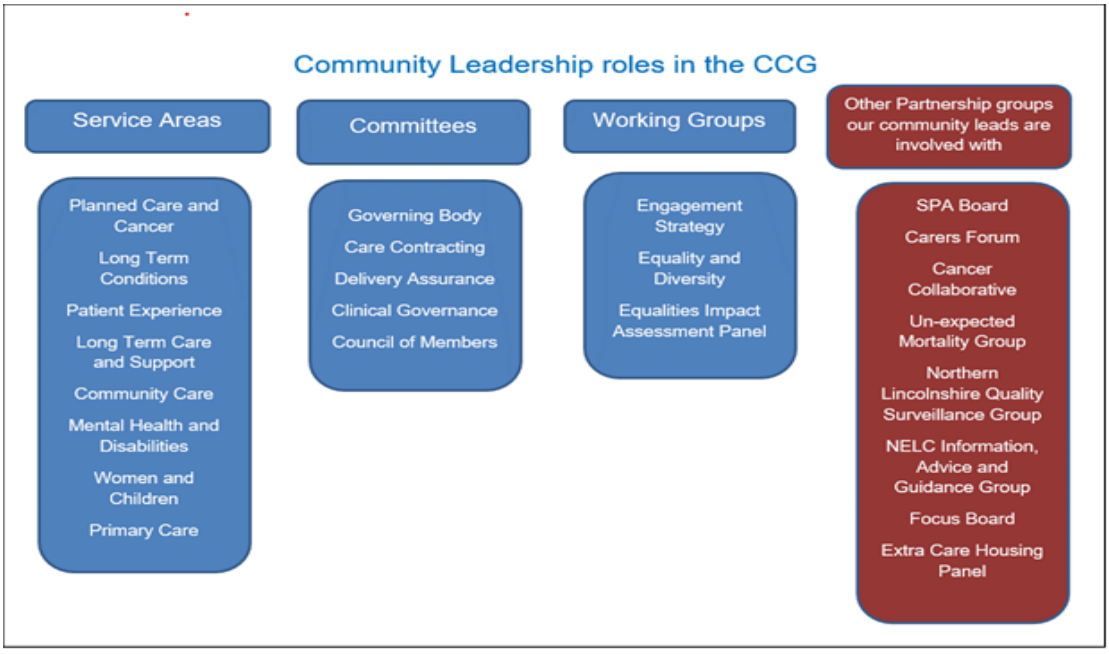
Collectively the forum highlights for 2019/20 include:

- Considered and commented on key CCG commissioning plans and policies including application of the NHS Long Term Plan locally,
- Received information and commented upon CCG corporate plan, commissioning intentions, finance, quality and performance
- Received information and commented upon development of the Union and closer working with the local authority with the joint Chief Executive.
- Received information and commented upon presentations by guest speakers including Telecare, Independent Living through Aids and Adaptations, Cancer Screening initiatives, Hospital discharge process and the Adult Services review
- Received quarterly CCG Engagement activity reports to monitor CCG performance against the Engagement strategy
- Considered, commented and advised on CCG and Humber Coast and Vale engagement and communications plans

- Provided a community perspective and challenge to communications around changes to repeat prescription for some patients

Individually through participation in service triangles, committees and working groups, members' highlights include:

- Procurement panel members for Support of Home and Perinatal Mental health research
- Steering group to develop a joint public engagement strategy for the Union
- Participation in multi-agency initiatives such as the Preventative Services Board, SPA Board, Extra Care Housing Scheme panel, Mortality Group, Care Plus Collaboratives; Children's access pathway development group and the Mental Health Needs Assessment Steering Group
- Equality Impact Assessment panel review of CCG policies and plans including the Joint Engagement Strategy,
- North East Lincolnshire representation on the Humber Acute Services Review Citizens Panel
- Reviewing and commenting on CCG and Humber Coast and Vale Sustainable Transformation Partnership (HCVSTP) engagement materials including surveys, poster campaigns and leaflet



So What?

Each year Community Forum members come together for our 'So What?' workshop where we evaluate our work with the CCG over the past year and how we have carried out our role(s) both as individual leads and collectively as a Forum.

We reflect on the most important activities members have been involved with over the past year in relation to their community leadership role, and consider the achievements of the Community Forum

and the difference this has made to health and social care commissioning by asking ourselves the question 'So What'?

Specifically we look for evidence of how the Forum has:

- challenged and held commissioners to account around involving local people in their decision making
- ensured proposals/decisions have had appropriate community involvement
- listened to, discussed and agreed new proposals/changes that are required; challenging decisions, where appropriate
- Supported the CCG's arrangements to meet the Public Sector Equality Duty in considering the needs of groups who share a protected characteristic when planning and buying services

Then we discuss our focus and priorities for the year ahead. The outcomes from the workshop are then received at the following Community Forum monthly meeting and shared with the CCG Chair and leadership team.

This year we took our assurance role a step further by providing the Governing Body with a formal 'So What?' report which was presented by the Chair of the Forum at the Governing Body meeting in September.

Looking Forward

We identified in our So What? Report last year that we needed to be better cited on the Public Sector Equality Duty to ensure that the needs of groups who share a protected characteristic, are considered in discussions around the planning, buying and delivery of services. Forum members attended a half day workshop to support this and we now ask all speakers who present at our meetings to include equality and diversity implications.

Our focus for 2020/21 will be to continue to provide a community perspective across the service areas, committees and working groups we participate in by linking with and listening to patients, carers and service users through our local community networks. Specifically by:

- Embedding the Community Forum as part of the Governance (and Union) arrangements
- Ensuring that timely engagement with the Forum is built into transformational plans consistently
- Continued involvement in health and care activity on a wider footprint such as the Humber Acute Services Review and Humber Coast and Vale Care Partnership

Members' attendance

Members	Attendance (maximum of 12 meetings)
Anne Hames (Chair)	12
Albert Bennett	12
Philip Bond (left July 2019)	2

Members	Attendance (maximum of 12 meetings)
Jean Cross (joined May 2019)	9
Eveline Dawson	9
Diane Edmonds	9
Christine Foreman	11
Bernard Henry	12
Marie Linford (joined May 2019)	8
Terry Simco	10
Pam Taylor	11
David Walker	6
Wendy Wood (left April 2019)	0
Sally Czabaniuk	9

Integrated Governance & Audit Committee

The Integrated Governance and Audit Committee is accountable to the CCG's Governing Body.

It is responsible for providing to the Governing Body an independent and objective view of all matters pertaining to that body's functions and responsibilities, notably:

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

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

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

Performance highlights include (Please note: This list is not exhaustive)

- Delivery of the Committees Annual Workplan
- Focus on the following key system changes & the management of risk associated with them:
  - Union (NELC/CCG) Development
  - NEL Integrated Care Partnership Development
  - STP / Place Governance

The IG&A Committee met five times throughout 2019/2020 and attendance records demonstrate that each meeting was quorate.

Members' attendance

Members	Attendance (maximum of 5 meetings)
Tim Render (Chair)	5
Dr Karin Severin	1
Councillor Margaret Cracknell (joined July 2019)	4
Joe Warner	4
Philip Bond (joined September 2019)	2 (out of 3)

Primary Care Commissioning Committee

The CCG has now completed its second year of having delegated responsibility from NHS England and Improvement for the commissioning of general medical services (general practice services) on behalf of the local population.

The Primary Care Commissioning Committee oversees the responsibilities associated with this delegated function, and operates within a terms of reference agreed with NHS England. The membership includes lay representatives, the NEL Council director of health and wellbeing, executive officers of the CCG and local GPs. Other interested parties are also invited to be in attendance at the meetings, without voting rights. These include the local Healthwatch representative, Local Medical Committee representative and NHS England and Improvement. These meetings are also open for members of the public to attend and the meeting dates are published on the CCG's website.

During the course of the last financial year, the Committee has considered and approved a range of primary care projects and contractual decisions. The list below provides examples of some of the work the Committee has undertaken:

- Approval of the Primary Care Strategy and oversight of key delivery actions
- Approval of the establishment of 5 Primary Care Networks (groups of practices working together) across North East Lincolnshire
- Oversight of quality issues, including updates regarding support provided to practices prior to their Care Quality Commission visits and after their visits where additional support is required to help improvement
- Assessment of progress against the 2018/19 Quality Scheme
- Approval of a PCN Supplementary Scheme for Medicines Optimisation, to support clinical and cost effective prescribing
- Oversight of results of internal audit into the CCG's delegated commissioning responsibilities (substantial assurance received in 2019/20)
- Oversight of national GP patient survey results and actions being taken to support improvement

- Oversight of the review of updates to service specifications for services that are commissioned from general practices which are over and above their core contract requirements. These are usually aimed at providing treatment in primary and community settings and avoiding the need for hospital attendance

- Approval of practice mergers

During 2019/20 five meetings of the committee were held. These meetings are open for members of the public to observe, and the dates of the meetings are advertised on the CCG's website.

Members' attendance

Members	Attendance (maximum of 5 meetings)
Mark Webb	2
Philip Bond	5
Laura Whitton	5
Dr Ekta Elston/Dr Anupam Sinha	5
Dr Sudhakar Allamsetty/Dr Renju Mathews (joined 10 September 2019)	2
Steve Pintus	4
Councillor Margaret Cracknell (joined 21 May 2019)	2
Jan Haxy/John Berry	5

Remuneration Committee

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

The committee receives regular reports on:

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

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

- Work plan report
- Terms of Reference report
- A report by the new HR providers

In addition to the committees above the Governing Body has a full range of committees to support it in its work and to assist with the discharge of its functions. These are set out below.

Clinical Governance Committee

During 2019/20 four Clinical Governance Meetings took place all of which were quorate.

Delivery Assurance Committee

During 2019/20 six meetings took place all of which were quorate.

Care Contracting Committee

Twelve meetings were held in 2019/2020, 11 of these meetings were quorate and one was not.

UK code of corporate governance

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

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

Discharge of the CCG's statutory functions

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

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

Risk management arrangements and effectiveness

A fundamental element of good governance is ensuring a clear and integrated approach to risk management. The CCG has an agreed Risk Management Framework, which provides assurance to the Integrated Governance & Audit Committee and Governing Body that strategic and operational risks are being managed and where necessary escalated. The framework is designed as a guide to the CCG in its approach to risk management and provides a structural framework with clear definitions and responsibilities. It also identifies how to report risks and how risks are governed within the CCG.

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

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

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

The Governing Body owns and determines the content of the Board Assurance Framework (BAF), identifying the strategic risks to achieving the CCG's commitments and monitoring progress throughout the year. The BAF provides an effective focus on strategic and reputational risks, each risk is regularly reviewed to ensure the controls, assurances remain valid, and any identified gaps are mitigated in a timely manner and clear defined actions.

To support the Governing Body in carrying out its duties effectively, the Integrated Governance and Audit Committee monitors the Board Assurance Framework and the Risk Register at each of its meetings, which ensures robust and adequate progression of the risks are kept live and relevant. The controls, assurances and gaps in controls and assurance are scrutinised along with any actions required to work towards improving the potential risk. This ensures that the process is maintained and act on behalf of the Governing Body to ensure that mitigation plans are in place to manage the risks identified.

During 2019/20, the annual BAF Audit has been completed alongside risk management audit. Although the audits provided the CCG with substantial assurance, the Integrated Governance & Audit Committee agreed that a full review of the risk management/assurance process is to be carried out during 2020/21 to ensure we maintain this level of assurances.

A Governing Body workshop will take place in 2020/21 to review the CCG's risk management arrangements and effectiveness. The Governing Body will be engaged in developing the CCG's risk appetite to enable appropriate decision making, neither exposing the organisation to a great level of risk and agreeing the level of risk that the CCG is prepared to accept, tolerate or be exposed to at any point in time. Specify the target risk score (i.e. the level at which the risk can be tolerated)

Risks are identified from a broad range of sources such as incidents, internal audit, complaints, regulators, committees. Operational risks are recorded on the CCG Corporate Risk Register and risks that may affect the ability of the CCG to meet its strategic commitments are recorded on the Board Assurance Framework. All risks are evaluated using a risk assessment matrix measuring the impact x likelihood, and weighs it using a 5x5 matrix.

Executive and Senior Leadership Team have a specific duty to ensure that appropriate mechanisms are in place within their areas of responsibility for identifying and highlighting new and emerging risks. All risks are allocated a Senior Manager as the risk owner, and an appointed Risk Assignee to ensure appropriate accountability for the management of the risk with support from the governance team.

Initially risks are subject to agreement by senior managers to ensure that the full consequences of the risk have been considered in relation to it actual impact on the CCG and enable effective risk mitigation. The risks are regular reviewed and updated on a regular cycle dependent on the current risk score with the risk assignee and annually with the risk managers. Significant risks are reported to the relevant committees.

Risk Management is embedded within the activities of the CCG through the risk process as follows:-

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

- The CCG has policies in place to encourage employees to highlight risks and report incidents and the Whistleblowing Policy highlights the importance the CCG places upon the open reporting culture. Staff are able to report any concerns through the incident

reporting process via the CCG incident app and each incident is reviewed and investigated by the CCG Quality Team.

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

Capacity to handle risk

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

The CCG fully appreciates its statutory obligations towards risk management and the Governing Body, Senior Managers and staff work together to provide an integrated approach to the management of risk and in developing a culture of reporting risk, understanding and challenging risk and providing opportunities for the analysis of risk and discussions on risk across the whole organisation. We continue to monitor and review our current risks in-line with NHS England's improvement and assurance framework, and promote risk management.

The CCG's Governing Body is responsible for overseeing the risks identified within the organisation and for gaining assurance that the CCG is addressing risks that are considered as strategic and obtaining assurance to satisfy itself that the CCG is fulfilling its organisational responsibilities and public accountability. The Governing Body uses the BAF and exception reports from its committee's as a means to assist achievement of its goals and provides a clear commitment and direction for risk management within the CCG.

The Integrated Governance and Audit Committee has responsibility for ensuring the CCG has an effective risk management system and internal control and monitor the Internal Audit work plan and seek assurance to ensure development of this Annual Governance Statement.

Risk awareness is a key element of the CCG's approach to risk management, ensuring that all staff understand and are able to discharge their roles and responsibilities in relation to risk. Annual risk awareness sessions continue to take place with risk managers and assignees to ensure continued effective risk management and appropriate controls are in place, and mitigating actions are progressed and monitored.

The risk management framework was reviewed and approved by the Integrated Governance & Audit committee in April 2019.

Risk assessment

All risks are assessed in regards to the level of controls and assurances that are in place and are scored on the severity of consequence and likelihood of occurrence. Both assessments are scored on a 5 x 5 matrix and the product of the two gives a risk score that reflects the urgency and degree of action, if any, required for reducing or eliminating the risk.

Risks scored as 15 or above are considered **"**Major**"**. The consequences of the event could have serious impact on the organisation; these risks are reviewed on a monthly basis, considered at each Integrated Governance and Audit Committee, and escalated to the Governing Body if required. Risk scored above 8 but below a 15 are considered as "Manageable" and can realistically be managed within reasonable timeframes through effective risk management monitoring and are reviewed bi-monthly. Risks scored as an 8 or below are considered as "Acceptable" and are reviewed quarterly.

North East Lincolnshire Clinical Commissioning Group compared with neighbouring CCGs will have more operational risks on their risk register due to the partnership working with North East

Lincolnshire Council in relation to the commissioning of Adult Social Care. As at Quarter 4 2019/20, there were **five** Adult Social Care risks on the risk register.

The total risks held on both Board Assurance Framework and the Risk Register at the end of 2019/20 with a residual risk rating being assessed as high level (15+) was 14 opposed to 10 as at 2018/19.

The NHS is currently dealing with the global health emergency created by the Covid-19 pandemic. Due to timings of submission of the annual report and the current escalation of COVID 19. The CCG have identified a new COVID 19 risk, which has been added to the Board Assurance Framework in April 2020. COVID 19 presents a risk to the CCG as an organisation, providers and patients. There are potential staffing shortages due to sickness and carers leave and impact on the CCG finances in order to commission normal and specialist services in order to keep patients safe. The CCG premises is now closed and staff are working from home with continued support. The CCG are working to emerging national guidance and responding to national communications and following requirements and recommendations appropriately. Planning and preparedness-based plans are in place and business continuity plans are being followed.

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

Risk Code	Risk Summary	Current Risk rating	Current Risk Trend Icon	Control	
CCG-BAF.2002	Risks in delivery of key annual performance and quality indicators (Health & Social Care) and standards, including constitutional standards	20		**Assurance on controls**	Regular reporting in to Governing Body, Delivery Assurance Committee, CoM and the operational leadership team. Through reporting to groups above and oversight from Planned Care Board improvement in performance has been noted around RTT particularly in some specialties there has been a focus on (eg Ophthalmology). Additional controls have been developed through joint weekly Planning meetings with NLCCG & NLAG where Trust reporting of activity and KPIs based on more real time data is allowing the system to react more immediately to areas of concern or receive earlier assurances on improvements.
				Positive Assurances	NHSE continue to acknowledge the CCG is taking an active leadership role to address the issues in relation to NLaG. NHSE's overall assessment of the CCG in the improvement and assessment framework was 'Good' for 2018/19 and quarterly meetings throughout 2019/20 have been positive. 2018/19 Year end position of ASC targets was also positive. The CCG received the best available ratings for diabetes services (Outstanding) and Patient & Community Engagement (Green Star). The CCG has also received the highest possible rating (Green Star) for the way it involves the local community in important decision making
				Gaps in controls	None
				Gaps in assurances	We recognise that there is significantly increased oversight and assurance mechanisms in place to oversee NLaG performance however gaps will remain until we start to see improvements feeding through. Some improvements have been noted around waiting times performance in certain specialties but this needs to be delivered consistently and other areas of performance to see improvements to gain greater assurances. In particular there are still concerns with the number of patients waiting for their follow up appointment in Ophthalmology.

Risk Code	Risk Summary	Current Risk rating	Current Risk Trend Icon	Control	Risk Code
CCG-BAF.2003	NLaG Service Sustainability	16		**Assurance on controls**	Chief Executive representation from NL & NEL CCGs and NLaG on the System Improvement Board (SIB)
				Positive Assurances	System Improvement Board whose membership includes NHS England and NHS Improvement. NEL CCG continue to receive positive feedback at its assurance meetings with NHS England There has been a recent NHSI/E meeting at which the NEL/NL system received positive feedback on the progress we have made in terms of joint planning and working together and reduced its assessment of the overall system risk level.
				Gaps in controls	Need assurance of collaborative arrangements with other providers.
				Gaps in assurances	Reporting to Governing Body working to effectively highlight all the collaborative arrangements There is currently no system wide strategic service plan that all organisations have signed up to which is a gap, however there is now a mechanism in place by which such a plan will be produced and this is expected to be complete by the autumn.
CCG-BAF.3005	Financial challenges in partner organisations in the wider system could lead to financial consequences for NEL CCG	15		**Assurance on controls**	Routine financial reports to the Governing Body (CCG, Northern Lincolnshire System & the Union) Delivery Assurance Committee scrutiny of financial plan delivery QiPP monitoring Routine system financial reporting to the wider system via the Contract Transformation Board, and the system Accountable Officers & Union Board Local health community financial monitoring and reporting via weekly System Planning Meeting and STP Finance and Planning
				Positive Assurances	SIB (System Improvement Board) assurance In year Financial Plan reports to IG&A and board Internal audit plan is risk -based Governance arrangements in place re NLAG contract. Governance arrangements in place re the Union
				Gaps in controls	None identified
				Gaps in assurances	Strengthen the assurances from CCC to the Governing Body to include a section on market strategy and management.

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

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
CCG-RR.1008	Unexpected Mortality	16		CCG-RR.1008c Quality Review Meeting	QRM monitors the SHMI data and the work streams of the hospital around mortality. Through this monitoring it puts the challenge back to the NLAG Mortality Improvement Plan.
				CCG-RR.1008e NLaG Mortality Improvement Group	This strategic group is led by the NLaG Medical Director and has a dedicated Consultant Mortality Lead at DPoW. The CCG has representation on this group. The NLaG Mortality Group has oversight of the Trust's strategy and delivery plan and is in place to provide challenge. The 2 groups are working closely together to ensure that lessons are learned from mortality reviews through the Structured Judgement Review system. There has recently been a review by Professor Mohammed as a national expert in this field and an action plan has been implemented. The action plan is being overseen by the Mortality Improvement Group and will also be presented to the CCG Unexpected Mortality Group.

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
				CCG-RR.1008f CCG Unexpected Mortality Group	This is a multi-agency stakeholder group and includes representation from the CCG, Care Plus Group, Healthwatch, NLaG, GPs and Public Health. There are a number of work streams that feed into the CCG unexpected mortality group and they are monitored and challenged by it. The group reports into the CCG clinical governance committee.
CCG-RR.2004	Failure to achieve Accident and Emergency 4 hour targets	20		CCG-RR.2004c A&E Delivery Board	A&E delivery board established as part of a national requirement to ensure system wide ownership and delivery against the A&E target required.
				CCG-RR.2004d A&E delivery board winter plan	The winter plan includes initiatives in and out of hospital to support an agreed A&E 4 hour wait performance trajectory.
CCG-RR.2005	RTT Performance and overdue followups	20		CCG-RR.2005a Performance Reporting	Robust performance reporting is produced for the Service Lead to act upon and is monitored at Delivery Assurance Committee with escalation to CoM and Governing Body.
				CCG-RR.2005b System wide Planned Care Board	A Planned Care Board chaired by the NL CCG Chief Executive has been established to ensure actions are taken to improve performance across NL and NEL which will feed into the NLaG Contract Transformation Board and the System Improvement Board. Senior leadership is present at those meetings with clinically led planning to redesign services for optimum efficiency and effectiveness. Clinical engagement has been secured from both the Trust and the CCG in the service specific transformation Boards. Options put forward for some specialties to manage demand.
				CCG-RR.2005f Commissioning of additional activity from alternative providers	Alternative providers have been commissioned to provide additional capacity to help individuals access care more quickly and reduce the risk of clinical harm.
CCG-RR.2017	Cancer waiting time performance	20		CCG-RR.2005a Performance Reporting	Robust performance reporting is produced for the Service Lead to act upon and is monitored at Delivery Assurance Committee with escalation to CoM and Governing Body.
				CCG-RR.2005b System wide Planned Care Board	A Planned Care Board chaired by the NL CCG Chief Executive has been established to ensure actions are taken to improve performance across NL and NEL which will feed into the NLaG Contract Transformation Board and the System Improvement Board. Senior leadership is present at those meetings with clinically led planning to redesign services for optimum efficiency and effectiveness. Clinical engagement has been secured from both the Trust and the CCG in the service specific transformation Boards. Options put forward for some specialties to manage demand.
CCG-RR.2014	Management of deprivations of liberty safeguards under the Mental Capacity Act 2007			CCG-RR.2014a Well defined and managed MCA process adhering to national best practice	An online process through Systmone has been developed which allows for the systematic processing of applications, recording of decisions and evidence and offers process efficiencies. The framework recommended by ADASS as national practice has been applied.
				CCG-RR.2014b Quality assurance panel	Each case is reviewed by the QA panel to ensure legal compliance, appropriateness and consistent application of the legal tests in each case.
				CCG-RR.2014c Authorised signatories in place	Authorised signatories are trained in the requirements of the law and offer an independent view of each application. There are opportunities to feedback in relation to any issues either via the admin support team at focus or more directly to the MCA/DOLs lead in the CCG.
				CCG-RR.2014d Risk assessed/triaged case load	All cases are risk assessed and prioritised for approval. Work being undertaken with Navigo and Focus to try and prevent inappropriate applications and to prioritise existing ones more effectively

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
				CCG-RR.2014e BIA training and competency framework	High quality BIA training has been procured and the BIA competencies have been defined so that ongoing development of workers can be managed and their competency assessed and assured. This includes arrangements for supervision.
				CCG-RR.2014f MCA training	MCA training is being commissioned following an audit of care providers which revealed a number of gaps in training and concerns about the quality of the training offered. The present provider is working on developing a revised offer that will be developed during 2018/19. Focus have created a training lead post for MCA & Safeguarding and have successfully recruited to this as a job share. The post holders will work with the existing provider to hand over the training package and develop new offers to meet demand. MCA training has been reshaped and a new curriculum and format is now being offered. The feedback has been very positive, unfortunately the demand has now increased as a result and there is now a backlog.
				CCG-RR.2014g BIA forum and ongoing professional development	There is a monthly BIA forum which provides the opportunity to share practice and to learn from case law examples.
				CCG-RR.2014h Light touch approach for low risk cases	We have implemented part of the light tough approach but however this has not alleviated the backlog of cases so the control is still partially effective.
				CCG-RR.2014i Long term care specification and quality framework	The specification and quality approach reflects the need for awareness of, and training in relation to MCA and DOLs issues for key service providers in the borough. The contract and Specification was circulated to all providers before Christmas and we are awaiting their return.
				CCG-RR.2014j Attendance at the regional BIA forum (ADASS)	Regular attendance at the regional forum provides the opportunity to share good practice and keep pace with national developments. The director of adult services in NEL is the ADASS branch regional lead for MCA/DOLs.
				CCG-RR.2014k MCA Strategic Network	The NEL MCA Strategic Forum, has now become a formal subgroup of the Safeguarding Adults Board to ensure spread of strategic development and commitment
				CCG-RR.2014l BIA and MHA capacity	To help manage and maintain the quantity of work BIA Forum continues to support BIA practice. Work being carried out by CCG and Focus have worked up data on the impact of reducing the DoLS backlog to zero within 12 months. Presented to Cabinet Feb 19 with request for further work especially on none standard DoLS. Work is ongoing to review a new option that would focus on certain risk categories. A training programme has been commissioned for BIA training and 10 NEL staff have been put forward. 05/03/2020 Bruce Bradshaw reviewed the risk and advised that: Focus have identified that the present assessment budget has been exhausted and there is potential for an over-spend if work continues in this financial year. Focus have looked at mitigating plans and funding and a paper is being developed for CCC to seek alternative ways to meet the assessment requirement
				CCG-RR.2014m Monitoring of activity at DAC and Safeguarding Board	The risks are monitored as part of the strategic plan and reviewed on a regular basis by the Chair (Jan Haxby NELCCG) and via the Safeguarding Adults Operational Leadership Group. The NEL MCA Strategic Forum has now become a formal subgroup of the Safeguarding Adults Board to ensure spread of strategic development and commitment.
				CCG-RR.2014n Joint working with NELC legal team	Help and support to develop and deliver a process for applications to the court of protection for deprivations in non-standard settings. Providing front end legal advice to practitioners. This is being reviewed by Focus with regards to developing an integrated pathway within SystmOne.

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
CCG-RR.2003	On-going failure to meet Clinical Handover time targets for EMAS patient delivery at DPoW A&E	15	▬	CCG-RR.2003b A&E delivery board	There is an in-hospital initiative for NLaG to work with EMAS to improve handover performance.
				CCG-RR.2003c EMAS Contract Management Meeting	This divisional monthly meeting addresses performance, quality and strategic issues. Commissioners can challenge EMAS and escalate any issues to the lead commissioner (Derby & Derbyshire CCG)
CCG-RR.3013	Failure of the CCG to achieve the planned savings in current year	20	▬	CCG-RR.3013c Internal and external reporting arrangements	Regular reporting and discussion takes place at the following CCG committees: DAC, SLT, OLT, Finance Programme Board, Governing Body. Additionally discussions take place at the following wider community committees: System Planned Care Board; Northern Lincolnshire weekly planning meeting, Northern Lincolnshire monthly QIPP meetings. NHS England returns and monthly reporting to NELC.
				CCG-RR.3013f Service lead reviews	Sign off by service leads around what the scheme is, including supporting evidence of a detailed programme plan. The relevant service lead is supported by a finance representative and a performance representative. High level milestones are reflected in the CCG's corporate plan. Regular monitoring is undertaken between the service lead and finance manager at which any required mitigating actions will be agreed.
CG-RR4007	eMBED Core Contract Delivery	25	▬	CCG-RR.4007a Contract in place	Contract, detailing service spec and SLA in place. Contract was set by NHS E LPF agreement. This contract is therefore not as robust as if the CCG had created the agreement.
				CCG-RR.4007b Transition and Contract Management Arrangements in place	Regular monthly meeting in place with the CCG and eMBED. Attendees are John Mitchell and Eddie McCabe.
				CCG-RR.4007c Programme and Project Plans	Programme controls are in place and used to manage the project and programmes. eMBED able to provide tracking tool. The CCG has taken steps to monitor programme delivery on a monthly basis via the Strategy Group. Running a minimum number of projects.
				CCG-RR.4007d Risk Management in Place	Regular meetings are being held with NHSE to specifically manage the risk with eMBED.
CCG-RR.4023	Liferay System	20	▬	CCG-RR.4023a Fact finding	System experts to examine the system to formally judge the scale of risk and produce an action plan.
				CCG-RR.4023b System update	The software to be updated to a viable security patch (if possible)
				CCG-RR4023c Strategic decision on future system usage	The long term strategic plan on Union document sharing to be decided
				CCG-RR.4023d System implementation	The outcome of the strategic decision on future system usage implemented
CCG-RR.4016	Sustainability Transformation Plan	16	▲	CCG-RR.4016a Executive Group	The CCG's Clinical chief officer and the CEO are members of the Executive group. The group has been established to oversee continued development and delivery of STP and transition into an ICS.
				CCG-RR.4016c Transformation Programme Director	The programme director links into the STP to undertake the at scale work.

Risk Code	Risk Summary	Current Risk Rating	Current Risk Trend	Internal Controls	Description of Control
				CCG-RR.4016d Clinical group	Clinical group established across the STP to support the work of the Exec group and ensure that there is appropriate clinical engagement and sign up to the plans, NEL Chief Clinical Officer is chairing that group
				CCG-RR.4016e STP Joint Commissioning Committee (JCC)	This committee ensures we have a consistent approach to commissioning, planning and delivery for those services that need to be delivered at a scale bigger than the individual "place".
				CCG-RR.4016f Humber Acute Services Review (HASR)	HASR has been established as a work stream and is specifically looking at the work NLaG and Hull need to do together to deliver more specialist services within the patch and value for money.

Other sources of assurance

Internal control framework

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

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

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

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

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

Conflict of interest management

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

Our internal auditors have independently reviewed the organisation's arrangements for managing conflict of interest and an overall opinion of "**substantial assurance**" has been provided. Auditors made two recommendations, at the time of the audit seven individuals had not completed their annual COI training, however the CCG have until 31 January 2020 to comply. A further recommended that the CCG's recruitment process for committee members/Senior staff needs further developments.

The CCG achieved the required levels of training for 2019-20 at 99%, which is above the required target level of 90%. The CCG Accountable Officer and Integrated Governance and Audit Chair (Lay

Member for Governance and Finance) approved the quarterly and annual self-certification returns for 2019/20 as accurate and confirm the CCG's compliance with national requirements.

The CCG is required to publish any breaches in relation to the CCG's Conflicts of Interest Policy.

You can find the CCG's breaches register here.

Data quality

The CCG recognise that good quality data is essential for the effective commissioning of services and underpins the delivery of high quality care.

All of the organisation's main providers are required under their contract to have good quality data that is compliant with national standards. Monitoring data quality is achieved through formal contract monitoring arrangements. Where required local standards are agreed and reviewed on an annual basis.

The Delivery Assurance Committee has delegated responsibility for overseeing the maintenance of a satisfactory level of data quality available to the CCG via the integrated assurance reports and that the CCG maintains a process of continuous data quality improvement.

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

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

Information governance

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

The audit of the Data Security and Protection Toolkit (DSPT) provided an opinion of **"good"** assurance demonstrating a high level of compliance in relation to the evidence to support the CCG's submission of its DSPT self-assessment.

The CCG place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The CCG has a suite of approved Information Governance policies which outline mechanisms in place to ensure that risks to confidentiality and data security are effectively managed and controlled.

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

To comply with the General Data Protection Regulation (GDPR), the CCG's records of processing of personal data must be regularly updated and a documented legal basis for processing must be

kept. The CCG has undertaken reviews of the CCG information asset register which helps fulfil this and monitored every six months. The Information Asset Owners (IAOs) are responsible for managing information risks to the assets within their control. We have also carried out numerous Data Protection Impact Assessments (DPIA's) across all relevant areas and these are publishes on the CCG website.

We have ensured all staff undertake the annual information governance training (Data Security Awareness) and continued to maintain a 100% compliance rate. In additional to the mandatory training the SIRO, Caldicott Guardian and Information Asset Owner completed specialist training. To ensure the CCG work towards cyber security essentials we took advantage of the Cyber Security Training offered by NHS Digital, this was delivered to our Board Members, Caldicott Guardian and Data Protection Officer and an e-learning module provided for our Information Asset Owners. We continue to provide staff with a series of briefings and information governance handbook is available to all staff to ensure they remain aware of their information governance roles and responsibilities in relation to confidentiality, data protection and information security.

There are processes in place for incident reporting and investigation of incidents. Staff are required to report information governance risks and incidents through the centralised incident reporting process. Minor IG incidents are managed through the low level incident process and have been IG assessed as low risk incidents. There have been no serious incident during this period that require reporting to the Information Commissioners Office.

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

Business critical models

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

The Governing Body approved and signed of the register in February 2020.

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

Third party assurances

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

The CCG contracted with a number of external organisations for the provision of support services.

This specifically includes:

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

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

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

- External assurance e.g. Service Auditor reports.
- Work undertaken by AuditOne and the internal auditors of North East Lincolnshire Council.
- Internal work undertaken by the CCG.
- KIER/EMBED Business Assurance.
- Routine monitoring of the contracts we have in place throughout the year.

NHS Shared Business Services Limited Service Auditor Report for the ledger and financial systems has been qualified as the service auditor was unable to test controls for February and March due to COVID 19. Capita Service Auditor Report in respect of processing PMS payments on Exeter has been delayed because of COVID 19, this was qualified in previous years. The CCG however has got local controls in place to mitigate these.

I have been advised that adequate assurances have been provided for 2019/20 for the other services bought by the CCG.

Control issues

Reflecting on our performance for 2019/20 our system has performed well against a number of challenging targets. Our Month 9 Governance Statement highlighted a number of areas of concern in relation to performance issues experienced, increased oversight assurance mechanisms are in place to oversee the performance, and gaps will remain until improvements start to recover. Although concerns have been highlighted, we do not consider any a serious lapse in internal control.

Areas identified in the month 9 governance statement are shown below-

A&E waiting times - December 2019 performance for the trust was 66.67% against the local agreed trajectory target of 87.45%.

The A&E Delivery Boards key considerations in terms of A&E performance are;

- Activity compared to last year being above plan, with pressure from neighbouring systems a continuing theme impacting across various parts of the system
- Flow (waits to be seen and waiting for beds)
- A&E specific operational issues with notable regular incidence of very low performance from midnight to 8am impacting on whole days performance
- The A&E Delivery Board's transformation plan including measures pre-hospital (IUC), in hospital and for discharge and onward care that will have a key role in contributing to improvement in A&E performance.

In September 2019, a whole system summit led by NHSE was held and the A&E Delivery Board reviewed all transformation initiatives and selected six priorities to be the focus of the next 6 months covering the winter period. The impact of progress with these priorities has been modelled as an improvement in bed occupancy to the required planning levels and to maintain the locally agreed trajectory for 4 hr wait performance.
In anticipation of increasing pressure into the winter period an extraordinary meeting of the A&EDB was been called for mid-December to consider co-ordinated system wide actions to improve resilience.

Diagnosis to Treatment/Referral to Treatment - have continued to be a challenge in 2019/20. Actions are being taken to address this performance include sourcing alternative provision specialties, promotion of advice and guidance with practices and Outpatient Transformation focusing on the 3 priority specialties to improve response times.
.
Percentage of Patients waiting <6 weeks for a diagnostic test – Overall performance for incomplete pathways has improved, now standing at 89.1%. NLaG Performance for the month, which accounts for the majority of activity, is up from 84.5% to 88% for the month.

Mitigating Actions: NL&G implementing diagnostics action plan. This is discussed at the weekly Planning Meeting. Additional off site provision (local) for MRI being explored.

Number waiting on an incomplete pathway over 52 weeks - There are currently six patients overall waiting over 52wks for treatment, half or whom relate to Gastroenterology.

Mitigating actions: Continued close monitoring of 52 week and 40 week patients

Gastro Action Plan implemented including

- Advice and Guidance compliance monitored
- Virtual clinics continuing
- Review of long waiting / high cancelling patients and patients either assessed clinically and discharged or appointed as appropriate.

Proportion of children & young people <18 receiving treatment by NHS funded community services - Data flow is still be addressed nationally with Kooth. It is envisaged we will not meet target, as data has not flowed from the beginning of the year from Kooth. However, as noted in the last report local mapping suggests we would meet the target if Kooth data was included.

Children & young people with Eating Disorders ED (routine cases & urgent cases) waiting times – Eating Disorders cases continue to be very low in North East Lincolnshire. Currently working with adult services to agree a shared care arrangement for Eating Disorders to improve patient care and experience.

Personal Health Budgets (PHB) Rate per 100,000 population -The CHC team are being reviewed in terms of capacity using the NHSE SIP Workforce tool and by utilising the 18-Point SIP Maturity Audit it is expected these two tools will report for the end of January 2020 and the team structure

and priority will be developed in light of the findings. There has also been a noticeable drop in the number of checklist being received especially from focus. The present data does not include Sec117 or Wheelchair PHB, which came into effect on the 2nd December 2019. Work is underway to review processes and reporting.

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

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

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

The CCG recognises the need to achieve cost reductions through the delivery of savings from the Quality, Innovation, Productivity and Prevention (QIPP) programme. This work is overseen by Finance and scrutinised in more detail by the Delivery Assurance Committee where open challenge takes place. This provides assurance to the CCG's Governing Body in terms of in-year progress, advising on any significant risks that may affect the organisation in delivery of its QIPP programme.

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

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

The CCG has a procurement policy in place which sets out the organisation's approach for establishing contracts that provide value for money in line with the principles of good procurement practice. Providers of services undergo a rigorous procurement exercise before contracts are awarded and all providers must be registered with the Care Quality Commission.

A list of all those providers with which the CCG currently has a contract can be viewed by accessing the Contracts Register and a Primary Care Contract Value List is also provided to accompany the database and this details the values for enhanced and other GP Commissioned Services

The NHS Oversight Framework has superseded the Improvement and Assessment Framework for 2019/20. The Quality of Leadership measure (165a) has remained, the latest data available is for Q2 2019/20 which the CCG is rated as **Green'**. This remained the same through 2018-19 with our Annual 2018/19 assessment as **Green'.** The year-end results for 2019-20 will be available at NHS England.

Delegation of functions

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

- The Chief Finance Officer
- Senior Management Team

- Clinical Leads

Since 2007, North East Lincolnshire Council and the North East Lincolnshire Clinical Commissioning Group have been working very closely together to deliver health services in North East Lincolnshire. As this relationship has developed, both organisations looked forward to the next stage to consider how they could be better equipped to deal with the on-going challenges faced by local government and the NHS.

Since 2007, North East Lincolnshire Council and the North East Lincolnshire Clinical Commissioning Group have been working very closely together to deliver health services in North East Lincolnshire. In 2018/19, a 'committee in common' known as the Union Board was established to integrate both organisations, as far as practicable and appropriate, in order to maximise use of our combined resources and focus. The focus being, to improve the health, care and wellbeing of the local population of North East Lincolnshire. A Section 75 Agreement is in place that underpins this arrangement and allows the local authority and CCG to jointly commission social care and public health services.

Highlights of the committee's work can be found here.

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

Counter fraud arrangements

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

There is an approved and proportionate risk based counter fraud work plan in place which is monitored at Integrated Governance and Audit Committee meetings, in accordance with Standards for NHS Commissioners. On 29 May 2020, the LCFS submitted, on the CCG's behalf, an agreed annual self-review tool (SRT) to the NHSCFA which provided an overview of the CCG's counter fraud activity, progress against NHSCFA requirements and assists the CFO and audit committee in monitoring and overseeing counter fraud work. The completed SRT was reviewed by the audit committee chair and authorised by the chief finance officer prior to submission. The CCG's overall rating for 2019/20 was assessed as amber. Should a NHSCFA quality inspection be undertaken then any recommendations would be acted upon – to date the CCG has not been subject to an NHSCFA quality inspection.

The AuditOne counter fraud team has undertaken a programme of publicity to raise awareness of counter fraud matters to CCG staff which includes posters, leaflets, newsletters, cartoon videos and payslip messages all of which is aimed at raising awareness of the team and channels for reporting concerns.

Head of internal audit opinion

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

From my review of your systems of internal control, I am providing an opinion of substantial assurance that the system of internal control has been designed to meet the organisation's objectives, and that controls are generally being consistently applied.

During the year internal audit issued the following audit reports

AuditOne

Audit Report	Scope	Level of Assurance
Safeguarding	The arrangements in place to ensure that the CCG effectively discharges its safeguarding duties and responsibilities	Reasonable
Conflicts of Interest	Management of conflicts of interest, based on the requirements set out by NHS England	Substantial
Risk Management Arrangements	Effectiveness of the risk management arrangements in place	Substantial
Procurement – Primary Care Commissioning	CCG's compliance with NHS England's requirements for Primary Care Commissioning.	Substantial
Financial Management	Financial management and control within the CCG	Substantial
Assurance Framework	Board Assurance Framework design and application	Substantial
DSP Toolkit	Compliance with the DSP Toolkit	Good
Procurement	Procurement of goods and services (health and non-healthcare). relating to tendering, contract management and requisitioning	Good

NEL Council

Audit Report	Scope	Level of Assurance
Adult Social Care Income and Expenditure (18/19 plan)	The CCG's arrangements for managing adult social care income and expenditure, specifically progress of Top Up Actions.	Limited
Adult Social Care Income and Expenditure	The CCG's arrangements for managing adult social care income and expenditure, specifically progress of Direct Payment Actions.	Satisfactory
Deprivation of Liberty (Draft Report)	Provide assurance on readiness for the LPS arrangements	Satisfactory
Supported Living/Housing Related Support	Determine the contracted arrangements for supported living	Substantial
Adult Service Review (Carried forward)	Support and ad hoc work derived from Adults services review	
Social Work Practice (In progress)	Provide assurance on consistent social work practice being developed	No significant issues to report work carried into 20/21 planned work in these areas
Partnership Governance (carried forward)	Provide assurance on the partnership arrangements in place that extend beyond the s75 framework	

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

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

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

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

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

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

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

The integrated governance and audit annual report, was presented to the Governing Body on 13 February 2020, detailing the outcomes of the review of the effectiveness of the committee. The report assured the members of the effective governance arrangements of the organisation, and specifically that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principals of good governance.

Conclusion

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

Dr Peter Melton
Accountable Officer
24 June 2020

Remuneration and Staff Report

Remuneration Report

Remuneration committee members

The Remuneration Committee is a formal committee of the Governing Body whose members were appointed by the Governing Body. In 2019/20 members and attendees were:

Members	Attendance (maximum of 2 meetings)
Mark Webb (Chair)	2
Tim Render	2
Dr Sudhakar Allamsetty (joined 1 August 2019)	2
Dr Jeeten Raghwani (joined 12 September 2019)	1
Cllr Peter Wheatley (left 1 June 2019)	0

The Remuneration Committee met twice during the financial year to address agenda requirements, at all times the process followed good principles of governance with special reference to conflicts of interest and the requirements of the terms of reference. The meetings were quorate.

Senior managers' contracts and payments

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

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

Salaries and allowances (subject to audit)

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

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

**The all related pension benefit for Dr Allamsetty is high as he was new in post April 2019 and his previous officer post was for one year in 2011

2019-20 Name	Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) All pension related benefits (bands of £2,500) £000	(f) Total (a to e) (bands of £5,000) £000
Dr P Melton	Clinical Chief Officer	85-90				0-2.5	85-90
Rob Walsh*	Chief Executive –NELCCG/NELC	30-35					30-35
Mark Webb	Chair	20-25					20-25
Helen Kenyon	Chief Operating Officer	100-105				15-17.5	115-120
Jan Haxby	Director of Quality & Nursing	85-90				10-12.5	95-100
Laura Whitton	Chief Finance Officer	95-100				20-22.5	120-125
Philip Bond	Lay Member Community Engagement	5-10					5-10
Dr Renju Mathews	GP Representative (started April 2019)	5-10					5-10
Dr Jeeten Raghwani	GP Representative (started October 2019)	5-10					5-10

2019-20 Name	Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) All pension related benefits (bands of £2,500) £000	(f) Total (a to e) (bands of £5,000) £000
Tim Render	Lay Member Audit & Governance	10-15					10-15
Dr Sudhakar Allamsetty **	Vice CCG Chair/Chair of Council of Members (started April 2019)	10-15				30-32.5	45-50
Dr Chris Hayes	Secondary Care Doctor (started September 2019)	5-10					5-10
Joe Warner	Governing Body Social Care Representative	0-5					0-5
Stephen Pintus	Director of Public Health	0-5					0-5
Dr Ekta Elston	Vice Chair Council of Members/Medical Director	45-50				2.5-5	45-50

2018-19 Name	Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) All pension related benefits (bands of £2,500) £000	(f) Total (a to e) (bands of £5,000) £000
Dr P Melton	Clinical Chief Officer	85-90				0-2.5	85-90
Rob Walsh	Chief Executive –NELCCG/NELC	30-35					30-35
Mark Webb	Chair	20-25					20-25
Helen Kenyon	Chief Operating Officer	100-105				32.5-35	130-135
Jan Haxby	Director of Quality & Nursing	85-90				30-32.5	115-120
Laura Whitton	Chief Finance Officer	95-100				62.5-65	160-165
Philip Bond	Lay Member Community Engagement	5-10					5-10
Dr Arun Nayyar	GP Representative	15-20				0-2.5	15-20
Dr Rakesh Pathak	GP Representative	5-10				0-2.5	10-15
Tim Render	Lay Member Audit & Governance	10-15					10-15
Dr Thomas Maliyil	Vice CCG Chair/Chair of Council of Members	15-20				0-2.5	15-20
Dr D James	Secondary Care Doctor	0-5					0-5
Joe Warner	Governing Body Social Care Representative	0-5					0-5
Stephen Pintus	Director of Public Health	0-5					0-5
Dr Ekta Elston	Vice Chair Council of Members/Medical Director	40-45				0-2.5	40-45

2018-19 Name	Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) All pension related benefits (bands of £2,500) £000	(f) Total (a to e) (bands of £5,000) £000
Cllr P Wheatley	Portfolio Holder Regeneration NELC (left post November 2018)	5-10					5-10
Cllr J Hyldon-King	Portfolio Holder Health Wellbeing and Adult Social Care NELC (left post November 2018)	5-10				5.0-7.5	10-15
Cllr M Patrick	Portfolio Holder for Finance & Resource NELC (left post January 2019)	5-10				0-2.5	5-10

Pension benefits (subject to audit)

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

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

Name and Title	(a) Real increase in pension at age 60 (bands of £2,500)	(b) Real increase in pension lump sum at aged 60 (bands of £2,500)	(c) Total accrued pension at age 60 at 31 March 2020 (bands of £5,000)	(d) Lump sum at age 60 related to accrued pension at 31 March 2020 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2019	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2020	(h) Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Jan Haxby Director of Quality and Nursing	0.0-2.5	0.0-2.5	35-40	95-100	751	20	801	
Helen Kenyon Chief Operating Officer	0.0-2.5	0.0-2.5	40-45	95-100	696	19	745	
Dr Peter Melton Clinical Chief Officer	0.0-2.5	0.0-2.5	05-10	25-30	218	0	232	
Laura Whitton Chief Finance Officer	2.5-5.0	0.0-2.5	30-35	85-90	666	26	721	
Dr Sudhakar Allamsetty Vice CCG Chair/Chair of Council of Members	0.0-2.5	2.5-5.0	00-05	10-15	37	24	71	
Dr Ekta Elston Vice Chair Council of Members/Medical Director	0.0-2.5	0-2.5	5-10	10-15	82	0	91	

Cash equivalent transfer values

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

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

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

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

Real increase in CETV

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

Compensation on early retirement or for loss of office

Nil return for 2019/2020 – refer to **Note 4** of the annual accounts.

Payments to past members

Nil return for 2019/2020 – refer to **Note 4** of the annual accounts.

Exit packages and severance payments

Further details in relation to Exit Packages can be found in **Note 4** in the annual accounts.

Pay multiples (subject to audit)

Year	**2019/20**	**2019/18**
Band of highest paid director's total remuneration (£'000)	120-125	120-125
Median total	30,511	29,226
Ratio	4.0	4.2

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

The banded remuneration of the highest paid director in NEL CCG in the financial year 2019/2020 was £120,000 - £125,000). (2081/2019 £120,000 - £125,000). This was 4.0 times (2018/2019 4.2

times) the median remuneration of the workforce, which was £30,511 (2018/2019 £29,226).

In 2019/2020, no employees (2018/2019, no employees) received remuneration in excess of the highest-paid director as per the remuneration table. Remuneration ranged from £8,040 to £102,308 (2018-19 £7,960 to £101,255).

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

Off-payroll engagements

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

Off-payroll engagements as of 31st March 2020, for more than £245 per day and that last longer than 6 months are as follows:

Table one: Off-payroll engagements longer than six months

Number of existing engagements as of 31 March 2020	38
Of which, the number that have existed:	
For less than 1 year at the time of reporting	12
For between 1 and 2 years at the time of reporting	8
For between 2 and 3 years at the time of reporting	5
For between 3 and 4 years at the time of reporting	4
For 4 or more years at the time of reporting	9

Where the reformed public sector rules apply, entities must complete Table 2 for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than 6 months:

Table 2: New off-payroll engagements

Number of new engagements, or those that reached 6 months in duration, between 1 April 2019 and 31 March 2020	12
of which	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	12
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	26
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll engagements / senior official engagements

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed 'board members and/or senior officers with significant financial responsibility', during the financial year. This figure should include both on-payroll and off-payroll engagements	21

Staff Report

a) Staff Composition

The CCG has a staffing establishment of 86.9 whole time equivalents in its headquarters function, and also has a formal arrangements in place to buy in a range of support services from a number of different providers at a cost of £1.65 Million in 2019/20.

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

Gender	Total (Female)	Total (Male)
Band 8a	2	1
Band 8b	7	3
Band 8c	2	1
Band 8d	1	1
Band 9	0	0
VSM	4	0
Governing Body	1	9
Any other spot salary	2	2
All other employees (including apprentice if applicable)	59	13

b) Employee Benefits and Staff Numbers

2019-20120	ADMIN Permanent employees £'000	Other £'000	Total £'000	PROGRAMME Permanent employees £'000	Other £'000	Total £'000	TOTAL Permanent employees £'000	Other £'000	Total £'000
Employee benefits salaries and wages	2,923	135	**3,058**	553	0	**553**	3,476	135	**3,611**
Social security costs	311	15	**326**	55	0	**55**	366	15	**381**
Employer contributions to the NHS pension scheme	583	18	**601**	132	0	**132**	715	18	**733**
Other pension costs	0	0	**0**	0	0	**0**	0	0	**0**
Apprenticeship levy	3	0	**3**	0	0	**0**	3	0	**3**
Other post-employment benefits	0	0	**0**	0	0	**0**	0	0	**0**
Other employment benefits	0	0	**0**	0	0	**0**	0	0	**0**
Termination benefits	0	0	**0**	0	0	**0**	0	0	**0**
Gross employee benefits expenditure	**3,820**	**168**	**3,988**	**740**	0	**740**	**4,560**	**168**	**4,728**
Less recoveries in respect of employee benefits (note 4.1.2)	(8)	0	**(8)**	(35)	0	**0**	(43)	0	**(43)**
Total – net admin employee benefits including capitalised costs	**3,812**	**168**	**3,980**	**705**	0	**705**	**4,517**	**168**	**4,685**
Less: employee costs capitalised	0	0	**0**	0	0	**0**	0	0	**0**
Net employee benefits excluding capitalised costs	**3,812**	**168**	**3,980**	**705**	0	**705**	**4,517**	**168**	**4,685**

2018-2019	ADMIN Permanent employees £'000	Other £'000	Total £'000	PROGRAMME Permanent employees £'000	Other £'000	Total £'000	TOTAL Permanent employees £'000	Other £'000	Total £'000
Employee benefits salaries and wages	2,760	224	**2,984**	443	16	**459**	3,202	240	**3,443**
Social security costs	287	15	**303**	44	0	**44**	331	15	**347**
Employer contributions to the NHS pension scheme	386	18	**403**	74	0	**74**	460	18	**478**
Other pension costs	0	0	**0**	0	0	**0**	0	0	**0**
Apprenticeship levy	2	0	**2**	0	0	**0**	2	0	**2**
Other post-employment benefits	0	0	**0**	0	0	**0**	0	0	**0**
Other employment benefits	0	0	**0**	0	0	**0**	0	0	**0**
Termination benefits	0	0	**0**	0	0	**0**	0	0	**0**
Gross employee benefits expenditure	**3,435**	**257**	**3,692**	**561**	**16**	**577**	**3,996**	**273**	**4,269**
Less recoveries in respect of employee benefits (note 4.1.2)	(54)	0	**(54)**	(29)	0	**(29)**	(83)	0	**(83)**
Total – net admin employee benefits including capitalised costs	**3,381**	**257**	**3,638**	**532**	**16**	**548**	**3,913**	**273**	**4,186**
Less: employee costs capitalised	0	0	**0**	0	0	**0**	0	0	**0**
Net employee benefits excluding capitalised costs	**3,381**	**257**	**3,638**	**532**	**16**	**548**	**3,913**	**273**	**4,186**

c) Sickness absence

The CCG sickness absence data can found here

All sickness absence at the CCG is managed in line with the Attendance Management policy; this policy enables managers to address sickness absence issues, both short and long-term, in a fair, consistent and equitable manner. It is recognised however that all cases must be dealt with on an individual basis because of differing circumstances. Managers and staff have access to the Occupational Health Service and Counselling services as appropriate.

d) Expenditure on consultancy
Further details in relation to expenditure on consultancy can be found in **note 5** in the annual accounts.

Other employee matters

The CCG is a great place to work

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

The CCG holds all-staff events on a quarterly basis. At these events staff recognition awards are presented to recognise hard work and commitment in the preceding quarter. Additionally, CCG staff are included in Leading Lights, an annual staff recognition event across the Union and other partner organisations.

The CCG also recognises long service upon retirement and in 2019/2020 one long service award was made.

Workplace health, safety and wellbeing and staff recognition

Staff wellbeing is a high priority. NELC have recently recruited a Wellbeing Advisor and Wellbeing Officer to work across the Union, providing confidential support to employees and to co-ordinate and promote a range of wellbeing activities.

Further investment has been made in Mental Health First Aid with additional staff undertaking the accredited training to provide support across the Union.

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

Further details regarding Health, Safety and Wellbeing can be found here.

Policies that support equal treatment in employment and occupation

As an employer the CCG recognises and values people as individuals and accommodates differences wherever possible by making adjustments to working arrangements or practices. Equal opportunities is key across the organisation and Equality Impact Assessments are conducted for all policies.

A new approach to policy development has been agreed, working jointly across the Union wherever reasonably practicable. As policies are reviewed, new versions will be underpinned by the EACH model - treating employees as adults, thinking about them as consumers and understanding them as human beings.

Staff Consultation

A joint Union Stakeholder group has been set up to ensure employee engagement into policy development. Representatives from the CCG’s employee advisory group are included in the Union Stakeholder group and the advisory group will continue to be used to engage the wider teams.

Fortnightly update sessions are held by FutureGov, who have been commissioned to work on developing the future operating model of the North East Lincolnshire Union.

Talent management and development

Staff in the CCG are able to access NELC’s Talent and Leadership Academy, an in-house leadership programme currently in its third year of operation.

A Learning Agreement has been signed with Unite and UNISON, allowing staff access to a range of courses through their online learning platforms.

Staff are able to access NELC's coaching programme, providing access to a trained pool of coaches to support with individual development or to train to become a coach themselves.

Trade Union Facility Time Section

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

Parliamentary Accountability and Audit Report

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

Contingent liabilities	Note 31
Losses and special payments	Note 43
Gifts	Not applicable
Fees and charges	Note 5

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

Dr Peter Melton
Accountable Officer
24 June 2020

Annual Accounts

Foreword to the accounts

NHS NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

These accounts for the year ended 31 March 2020 have been prepared by NHS North East Lincolnshire Clinical Commissioning Group under section 232 (schedule 15.3(1) of the National Health Service Act 2006 in the form which the Secretary of State has, within the approval of the Treasury, directed.

Dr Peter Melton
Accountable Officer
Authorised for Issue

24 June 2020

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

Report on the financial statements

Opinion on the financial statements

We have audited the financial statements of NHS North East Lincolnshire Clinical Commissioning Group ('the CCG') for the year ended 31 March 2020, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by HM Treasury's Financial Reporting Manual 2019/20 as contained in the Department of Health and Social Care Group Accounting Manual 2019/20, and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to Clinical Commissioning Groups in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2020 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20; and
- have been properly prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the CCG's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on regularity

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Responsibilities of the Accountable Officer for the financial statements

As explained more fully in the Statement of Accountable Officer's Responsibilities the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

The Accountable Officer is required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the CCG is informed of the intention for dissolution without transfer of services or function to another entity. The Accountable Officer is responsible for assessing each year whether or not it is appropriate for the CCG to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Health and Social Care Act 2012; and

- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

The CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We have nothing to report in this respect.

Responsibilities of the Accountable Officer

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of

Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Use of the audit report

This report is made solely to the members of the Governing Body of NHS North East Lincolnshire CCG, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Certificate

We certify that we have completed the audit of NHS North East Lincolnshire CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Mark Kirkham, Partner

For and on behalf of Mazars LLP

Mazars LLP
5th Floor
3 Wellington Place
Leeds
LS1 4AP

25 June 2020

Statement of Comprehensive Net Expenditure for the year ended 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Income from sale of goods and services	2	(55,271)	(52,924)
Other operating income	2	(104)	(914)
Total operating income		**(55,375)**	**(53,838)**
Staff costs	4	4,728	4,269
Purchase of goods and services	5	331,292	314,802
Provision expense	5	(128)	(685)
Other Operating Expenditure	5	329	122
Total operating expenditure		**336,221**	**318,508**
Net Operating Expenditure		**280,846**	**264,670**
Other Comprehensive Expenditure			
Remeasurement of the defined pension liability / asset		(1,866)	871
Sub total		**(1,866)**	**871**
Comprehensive Expenditure for the year		**278,980**	**265,541**

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

The notes on pages 102 to 122 form part of this statement

Statement of Financial Position as at 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Trade and other receivables	17	7,363	6,606
Cash and cash equivalents	20	41	186
Total current assets		**7,404**	6,792
Total assets		**7,404**	6,792
Current liabilities			
Trade and other payables	23	(14,658)	(16,537)
Provisions	30	(271)	(765)
Total current liabilities		**(14,929)**	(17,302)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(7,525)**	(10,510)
Non-current liabilities			
Trade and other payables	23	(788)	(2,823)
Total non-current liabilities		**(788)**	(2,823)
Assets less Liabilities		**(8,313)**	(13,333)
Financed by Taxpayers' Equity			
General fund		(4,617)	(7,771)
Other reserves		(3,696)	(5,562)
Total taxpayers' equity:		**(8,313)**	(13,333)

The notes on pages 102 to 122 form part of this statement

The financial statements on pages 100 to 101 were approved by the Governing Body on 24 June 2020 and signed on its behalf by:

Dr Peter Melton
Accountable Officer
24th June 2020

Statement of Changes In Taxpayers Equity for the year ended 31 March 2020
31 March 2020

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20				
Balance at 01 April 2019	(7,771)	0	(5,562)	**(13,333)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(7,771)**	**0**	**(5,562)**	**(13,333)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20				
Net operating expenditure for the financial year	(280,846)	0	0	**(280,846)**
Movements in other reserves	0	0	1,866	1,866
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(280,846)**	**0**	**1,866**	**(278,980)**
Net funding	284,000	0	0	**284,000**
Balance at 31 March 2020	**(4,617)**	**0**	**(3,696)**	**(8,313)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(8,373)	0	(4,691)	**(13,064)**
Transfer of assets and liabilities from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(8,373)**	**0**	**(4,691)**	**(13,064)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Net operating costs for the financial year	(264,670)	0	0	(264,670)
Transfers between reserves	0	0	(871)	(871)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(264,670)**	**0**	**(871)**	**(265,541)**
Net funding	265,272	0	0	265,272
Balance at 31 March 2019	**(7,771)**	**0**	**(5,562)**	**(13,333)**

The notes on pages 102 to 122 form part of this statement

Statement of Cash Flows for the year ended 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(281,015)	(264,880)
(Increase)/decrease in trade & other receivables	17	(757)	(2,743)
Increase/(decrease) in trade & other payables	23	(1,879)	3,375
Provisions utilised	30	(366)	(166)
Increase/(decrease) in provisions	30	(128)	(685)
Net Cash Inflow (Outflow) from Operating Activities		**(284,145)**	(265,099)
Cash Flows from Investing Activities			
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(284,145)**	(265,099)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		284,000	265,272
Net Cash Inflow (Outflow) from Financing Activities		**284,000**	265,272
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(145)**	173
Cash & Cash Equivalents at the Beginning of the Financial Year		**186**	13
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**41**	186

The notes on pages 102 to 122 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Clinical Commissioning Groups (CCG) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2019-20 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 **Accounting Convention**

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

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

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Gorup are outside the scope of IFRS 3 BusinessCombinations. Where 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.

1.4 **Pooled Budgets**

The CCG has entered into a pooled budget arrangement under Section 75 of the NHS Act 2006.

The CCG accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.
If the CCG is in a “jointly controlled operation”, the CCG recognises:

• The assets the CCG controls;
• The liabilities the CCG incurs;
• The expenses the CCG incurs; and,
• The CCG’s share of the income from the pooled budget activities.

If the CCG is involved in a “jointly controlled assets” arrangement, in addition to the above, the CCG recognises:
• The CCG’s share of the jointly controlled assets (classified according to the nature of the assets);
• The CCG’s share of any liabilities incurred jointly; and,
• The CCG’s share of the expenses jointly incurred.

1.5 **Operating Segments**

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

1.6 **Revenue**

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

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

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the CCG accesses funds from the Government’s apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.
The CCG's main sources of revenue are:
• S75 Partnership Agreement
• Contribution from clients towards cost of social care

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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

1.7.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the CCG of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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

1.7.3 **Local Government Pensions**

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

1.8 **Other Expenses**

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

1.9 **Grants Payable**

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

1.10 **Property, Plant & Equipment**

1.10.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.10.2 **Measurement**

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

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

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

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

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

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

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

1.10.3 **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.

1.11 **Intangible Assets**

1.11.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the CCG'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 CCG;
- 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.

1.11.2 **Measurement**

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

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

1.11.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the CCG expects to obtain economic benefits or service potential from the asset. This is specific to the CCG 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 CCG 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.

1.12 **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.

1.13 **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.

1.14 **Non-current Assets Held For Sale**

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve. Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.15 **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.

1.15.1 **The CCG 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 CCG'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.

1.15.2 **The CCG as Lessor**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the CCG'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 CCG'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.

1.16 **Private Finance Initiative Transactions**

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- payment for the fair value of services received
- repayment of the finance lease liability, including finance costs, and
- payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.16.1 **Services Received**

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.16.2 **PFI Asset**

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at current value in existing use.

1.16.3 **PFI Liability**

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

1.16.4 **Lifecycle Replacement**

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the CCG's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.16.5 **Assets Contributed by the CCG to the Operator For Use in the Scheme**

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the CCG's Statement of Financial Position.

1.16.6 **Other Assets Contributed by the CCG to the Operator**

Assets contributed (e.g. cash payments, surplus property) by the CCG to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the CCG, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

1.17 **Inventories**

Inventories are valued at the lower of cost and net realisable value.

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 CCG's cash management.

1.19 **Provisions**

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

Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 0.50% (2018-19: positive 0.29%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 0.51% (2018-19: 0.76%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 0.55% (2018-19:1.14%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 1.99% (2018-19: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 1.99% (2018-19: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

1.20 **Clinical Negligence Costs**

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

1.21 **Non-clinical Risk Pooling**

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

1.22 **Carbon Reduction Commitment Scheme**

The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The CCG is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

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 CCG, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

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

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

1.24 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

1.24.1 **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.

1.24.2 **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.

1.24.3 **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.

1.24.4 **Impairment**

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

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

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

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

1.25 **Financial Liabilities**

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

1.25.1 **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.

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

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

1.25.3 **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.

1.26 **Value Added Tax**

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

1.27 **Foreign Currencies**

The CCG'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 CCG's surplus/deficit in the period in which they arise.

1.28 **Third Party Assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the CCG has no beneficial interest in them.

1.29 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the CCG not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

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

1.30.1 **Critical accounting judgements in applying accounting policies**

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

- Bad Debt Provision
- Local Government Pension Scheme as advised by the actuaries Hymans Robertson LLP

1.30.2 **Sources of estimation uncertainty**

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

• Secondary Care Activity; Counting and coding of secondary care is not finalised until after the completion of the audited annual accounts process in June. Assumptions have been made around the liabilities of this for the CCG with a range of secondary care providers based on a number of factors including historical activity performance and known changes in activity, as well as non-PBR tariffed contract arrangements. The actual cost of activity will be different to the carrying amounts held in the Statement of Financial Performance and any variance will need to be managed in the Statement of Comprehensive Net Expenditure in the subsequent year. There is unlikely to be a significant change to the carrying value of assets and liabilities once activity is validated based on previous years out-turn verses actual.

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

• Quality Outcome Framework (QOF) achievement for delegated primary care. An assessment of the achievement of QOF points is made for independent contractors, based on indicators in the QOF framework. Data is extracted from the clinical system after the completion of the annual accounts process and payment is then made on the data outcomes.

1.31 **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.

1.32 **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 2019-20. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2021-22, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – The Standard is effective 1 April 2020 as adapted and interpreted by the FReM, however implementation has been deferred to 1 April 2021 due to Covid-19.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2 Other Operating Revenue

	2019-20 Admin	2019-20 Programme	2019-20 Total	2018-19 Total
	£'000	£'000	£'000	£'000
Income from sale of goods and services (contracts)				
Non-patient care services to other bodies	-	-	**-**	691
Other Contract income *	1,482	53,746	**55,228**	52,150
Recoveries in respect of employee benefits	8	35	**43**	83
Total Income from sale of goods and services	**1,490**	**53,781**	**55,271**	**52,924**
Other operating income				
Charitable and other contributions to revenue expenditure: non-NHS	-	99	**99**	-
Other non contract revenue	-	5	**5**	914
Total Other operating income	**-**	**104**	**104**	**914**
Total Operating Income	**1,490**	**53,885**	**55,375**	**53,838**

** This includes £45.7m in relation to the adult social care partnership agreement and £9.3m in relation to adult social care private client revenue. In 2018/19 these figures were £39.5m and £9.3m respectively. Further analysis can be found at note 35.*

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

	Non-patient care services to other bodies	Recoveries in respect of employee benefits	Partnership Agreement *	Private Client Revenue *	Other Contract income	Total
	£'000		£'000	£'000	£'000	£'000
Source of Revenue						
NHS	-	-	-	-	20	20
Non NHS	-	43	45,678	9,254	276	55,251
Total	**-**	**43**	**45,678**	**9,254**	**296**	**55,271**

	Non-patient care services to other bodies	Recoveries in respect of employee benefits	Partnership Agreement *	Private Client Revenue *	Other Contract income	
	£'000		£'000	£'000	£'000	£'000
Timing of Revenue						
Point in time	-	43	-	-	20	63
Over time	-	-	45,678	9,254	276	55,208
Total	**-**	**43**	**45,678**	**9,254**	**296**	**55,271**

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

3.2 Transaction price to remaining contract performance obligations

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

4. Employee benefits and staff numbers

4.1.1 Employee benefits **Total** **2019-20**

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	3,476	135	3,611
Social security costs	366	15	381
Employer Contributions to NHS Pension scheme	715	18	733
Apprenticeship Levy	3	0	3
Gross employee benefits expenditure	**4,560**	**168**	**4,728**
Less recoveries in respect of employee benefits (note 4.1.2)	**(43)**	**-**	**(43)**
Total - Net admin employee benefits including capitalised costs	**4,517**	**168**	**4,685**
Net employee benefits excluding capitalised costs	**4,517**	**168**	**4,685**

4.1.1 Employee benefits **Total** **2018-19**

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	3,203	240	3,443
Social security costs	331	15	346
Employer Contributions to NHS Pension scheme	460	18	478
Apprenticeship Levy	2	-	2
Gross employee benefits expenditure	**3,996**	**273**	**4,269**
Less recoveries in respect of employee benefits (note 4.1.2)	(83)	-	(83)
Total - Net admin employee benefits including capitalised costs	**3,913**	**273**	**4,186**
Net employee benefits excluding capitalised costs	**3,913**	**273**	**4,186**

The increase in employee benefits was due to Agenda for Change pay award and an increase in NHS employer pension contributions.

4.1.2 Recoveries in respect of employee benefits

	Permanent Employees £'000	Other £'000	2019-20 Total £'000	2018-19 Total £'000
Employee Benefits - Revenue				
Salaries and wages	(36)	-	**(36)**	(71)
Social security costs	(3)	-	**(3)**	(5)
Employer contributions to the NHS Pension Scheme	(4)	-	**(4)**	(7)
Total recoveries in respect of employee benefits	**(43)**	-	**(43)**	(83)

4.2 Average number of people employed

	2019-20			2018-19		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**88**	**2**	**90**	86	4	90
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

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

There were no departures where special payments have been made in 2019/20.

There were no exit packages in 2018/19.

Analysis of Other Agreed Departures

	2019-20 Other agreed departures		2018-19 Other agreed departures	
	Number	£	Number	£
Early retirements in the efficiency of the service contractual costs	1	21,088	-	-
Total	**1**	**21,088**	**-**	**-**

These tables report the number and value of exit packages agreed in the financial year. Exit costs are accounted for in accordance with relevant accounting standards and the expense associated with these departures have been recognised in full in 2019/20.
Where CCG has agreed early retirements, the additional costs are met by CCG and not by the Local Government Pension Scheme and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

4.5 Pension costs

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

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

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

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

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

4.5.3 Local Government Pension Scheme

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

The contributions rate is determined by the Funds Actuary based on triennial actuarial valuations : the last formal valuation was carried out at 31st March 2016. With effect from 1st April 2017, the employers contribution rate reduced to 25.8%, along with a monthly supplementary payment.

The Local Government Scheme is accounted for as a defined benefits scheme :

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

	31 March 2020	***31 March 2019***
	% p.a.	***% p.a.***
Pension Increase rate	***1.9%***	***2.5%***
Salary Increase rate	***2.8%***	***2.7%***
Discount Rate	***2.3%***	***2.4%***

	31st March 2020		31st March 2019	
Mortality Assumptions	***Males Years***	***Females Years***	Males Years	Females Years
Current Pensioners	***20.9***	***23.3***	**21.7**	**24.2**
Future Pensioners**	***21.8***	***24.8***	**23.7**	**26.4**

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

Sensitivity Analysis	**31st March 2020**		31st March 2019	
Change in assumptions at year ended 31 March 2020	**Approximate % increase to Employer liability**	**Approximate monetary amount £'000**	Approximate % increase to Employer liability	Approximate monetary amount £'000
0.5% decrease in Real Discount Rate	**9%**	**2,930**	10%	3,987
0.5% increase in the Salary Increase Rate	**0%**	**34**	0%	58
0.5% increase in the Pension Increase Rate	**9%**	**2,891**	10%	3,900

The change in the net pensions liability is analysed into seven components:

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

The estimated Employers Contributions payable in the year to 31 March 2021 will be approximately £60,000.

The above information relates to the LGPS annualised calculation used for the actuarial pension valuation.

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

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

* Deferred pensioners include undecided leavers & frozen refunds.

The membership numbers do not affect any calculations and are provided purely for information purposes only.

5. Operating expenses

	2019-20 Admin £'000	2019-20 Programme £'000	2019-20 Total £'000	2018-19 Total £'000
Purchase of goods and services				
Services from other CCGs and NHS England	48	382	**430**	1,248
Services from foundation trusts	-	121,077	**121,077**	110,734
Services from other NHS trusts	-	16,912	**16,912**	15,906
Purchase of healthcare from non-NHS bodies	-	77,755	**77,755**	74594
Purchase of social care	-	53,085	**53,085**	51,225
Prescribing costs	-	28,064	**28,064**	27,157
GPMS/APMS	-	31,445	**31,445**	30,840
Supplies and services – clinical	-	7	**7**	6
Supplies and services – general	232	219	**451**	488
Consultancy services	28	208	**236**	141
Establishment	188	615	**803**	800
Transport	6	0	**6**	7
Premises	109	34	**143**	243
Audit fees	43	-	**43**	43
Other non statutory audit expenditure				
· Internal audit services	54	-	**54**	59
Other professional fees	13	593	**606**	1,012
Legal fees	10	40	**50**	86
Interest (Local Government Pension Scheme)	-	944	**944**	975
Expected return on Assets (Local Government Pension Scheme)	-	(880)	**(880)**	(920)
Education, training and conferences	36	25	**61**	158
Total Purchase of goods and services	**767**	**330,525**	**331,292**	**314,802**
Provision expense				
Provisions	(30)	(98)	(128)	(685)
Total Provision expense	**(30)**	**(98)**	**(128)**	**(685)**
Other Operating Expenditure				
Chair and Non Executive Members	105	-	105	132
Expected credit loss on receivables	-	223	223	(10)
Other expenditure	1	-	1	-
Total Other Operating Expenditure	**106**	**223**	**329**	**122**
Total operating expenditure	**843**	**330,650**	**331,493**	**314,239**

Included within the CCG's operating expenditure are costs of £1,052k in relation to Covid-19.

Included within other professional fees are non-audit services of £13k in respect of Mental Health Investment Standard assurance that NHSE requires CCGs to obtain from an independent reporting accountant, to demonstrate their investment in mental health expenditure rises at a faster rate than their overall published programme funding.

6.1 Better Payment Practice Code

Measure of compliance	2019-20 Number	2019-20 £'000	2018-19 Number	2018-19 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	39,384	167,355	40,009	159,119
Total Non-NHS Trade Invoices paid within target	38,458	165,614	37,926	156,277
Percentage of Non-NHS Trade invoices paid within target	**97.65%**	**98.96%**	**94.79%**	**98.21%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,090	141,475	2,140	128,496
Total NHS Trade Invoices Paid within target	2,078	140,833	2,135	128,493
Percentage of NHS Trade Invoices paid within target	**99.43%**	**99.55%**	**99.77%**	**100.00%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

The CCG had no late payment of commercial debt for the year ending 31 March 2020 (31 March 2019: £NIL).

7. Income Generation Activities

The CCG does not undertake any income generation activities.

8. Investment revenue
The CCG had no investment revenue as at 31 March 2020 (31 March 2019: £NIL).

9. Other gains and losses
The CCG had no other gains and losses as at 31 March 2020 (31 March 2019: £NIL).

10.1 Finance costs
The CCG had no finance costs as at 31 March 2020 (31 March 2019: £NIL).

10.2 Finance income
The CCG had no finance income as at 31 March 2020 (31 March 2019: £NIL).

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

12. Operating Leases

12.1 As lessee

The CCG had a building lease with NHS Property Services Ltd which ceased on 30 September 2018. The CCG also had a lease for photocopiers and a franking machine which also ceased on 30 September 2018.

12.1.1 Payments recognised as an Expense

	Buildings £'000	Other £'000	2019-20 Total £'000	2018-19 Total £'000
Payments recognised as an expense				
Minimum lease payments	-	-	**-**	**47**
Total	**-**	**-**	**-**	**47**

12.1.2 Future minimum lease payments
The CCG had no future minimum lease payments as at 31 March 2020 (31 March 2019: £NIL).

12.2 As lessor
The CCG is not a lessor.

12.2.1 Rental revenue
The CCG had no rental revenue as at 31 March 2020 (31 March 2019: £NIL).

13. Property, plant and equipment
The CCG had no property, plant & equipment as at 31 March 2020 (31 March 2019 : £NIL).

14. Intangible non-current assets
The CCG had no intangible Assets as at 31 March 2020 (31 March 2019: £NIL).

15. Investment property
The CCG had no investment property as at 31 March 2020 (31 March 2019: £NIL).

16. Inventories
The CCG had no inventories as at 31 March 2020 (31 March 2019: £NIL).

17.1 Trade and other receivables	Current 2019-20 £'000	Non-current 2019-20 £'000	Current 2018-19 £'000	Non-current 2018-19 £'000
NHS receivables: Revenue	153	-	249	-
NHS prepayments	358	-	616	-
NHS accrued income	158	-	48	-
Non-NHS and Other WGA receivables: Revenue	3,145	-	3,494	
Non-NHS and Other WGA prepayments	2,095	-	2,053	-
Non-NHS and Other WGA accrued income	1,256	-	1,232	-
Expected credit loss allowance-receivables	(2,678)	-	(2,636)	-
VAT	87	-	35	-
Other receivables and accruals	2,789	-	1,515	-
Total Trade & other receivables	**7,363**	**-**	**6,606**	**-**
Total current and non current	**7,363**		**6,606**	
Included above:				
Prepaid pensions contributions	-		-	

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

Other receivables is £2,789k in relation to the adult social care partnership agreement (18/19: £1,515k).

17.2 Receivables past their due date but not impaired

	2019-20 DHSC Group Bodies £'000	2019-20 Non DHSC Group Bodies £'000	2018-19 DHSC Group Bodies £'000	2018-19 Non DHSC Group Bodies £'000
By up to three months	(96)	(226)	(92)	(493)
By three to six months	(9)	(159)	(11)	(105)
By more than six months	-	(224)	-	(114)
Total	**(105)**	**(609)**	**(103)**	**(712)**

17.3 Loss allowance on asset classes	2019-20 Trade and other receivables - Non DHSC Group Bodies £'000	2019-20 Other financial assets £'000	2019-20 Total £'000	2018-19 Non DHSC Group Bodies £'000
Balance at 01 April 2019 *(no movement on allowance for credit losses)*	(2,636)	-	(2,636)	(3,056)
Amounts written off	179	-	**179**	410
Financial assets that have been derecognised	556	-	**556**	580
Changes due to modifications that did not result in derecognition	-	-	**-**	-
Other changes	(777)	-	**(777)**	(570)
Total	**(2,678)**	**-**	**(2,678)**	**(2,636)**

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

	2019-20 Lifetime expected credit loss rate %	2019-20 Gross carrying amount £'000	2019-20 Lifetime expected credit loss £'000	2018-19 Lifetime expected credit loss £'000
Receivables are provided against at the following rates:				
NHS debt & Adult Social Care -0 - 6 Months	-	1,687	709	687
7 - 9 Months	25	121	40	78
10 -12 Months	50	183	104	58
1 - 2 years	75	342	277	235
Over 2 years	100	1,577	1,548	1,578
Total expected credit loss	**250**	**3,910**	**2,678**	2,636

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

£709k comprises of house sale income and other debt which has been individually assessed and provided for.

18. Other financial assets
The CCG had no other financial assets as at 31 March 2020 (31 March 2019: £NIL).

19. Other current assets
The CCG had no other current assets as at 31 March 2020 (31 March 2019: £NIL).

20. Cash and cash equivalents

	2019-20 £'000	2018-19 £'000
Balance at 01 April 2019	186	13
Net change in year	(145)	173
Balance at 31 March 2020	**41**	**186**
Made up of:		
Cash with the Government Banking Service	41	186
Cash and cash equivalents as in statement of financial position	**41**	**186**
Balance at 31 March 2020	**41**	**186**
Patients' money held by the clinical commissioning group, not included above	-	-

21. Non-current assets held for sale
The CCG had no non-current assets held for sale as at 31 March 2020 (31 March 2019: £NIL).

22. Analysis of impairments and reversals
The CCG had no impairments or reversals recognised in expenditure during 2019-20 (2018-19: £NIL).

23. Trade and other payables	**Current 2019-20 £'000**	**Non-current 2019-20 £'000**	Current 2018-19 £'000	Non-current 2018-19 £'000
NHS payables: Revenue	405	-	633	-
NHS accruals	1,132	-	2,437	-
Non-NHS and Other WGA payables: Revenue	243	-	437	-
Non-NHS and Other WGA accruals	12,321	-	12,390	-
Non-NHS and Other WGA deferred income	38	-	28	-
Social security costs	54	-	56	-
Tax	46	-	45	-
Other payables and accruals	419	788	511	2,823
Total Trade & Other Payables	**14,658**	**788**	**16,537**	**2,823**
Total current and non-current	**15,446**		**19,360**	

Other payables include £238k outstanding pension contributions at 31 March 2020 (31 March 2019: £294k).

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

24. Other financial liabilities
The CCG had no other financial liabilities as at 31 March 2020 (31 March 2019: £NIL).

25. Other liabilities
The CCG had no other liabilities as at 31 March 2020 (31 March 2019: £NIL).

26. Borrowings
The CCG had no borrowings as at 31 March 2020 (31 March 2019: £NIL).

27. Private finance initiative, LIFT and other service concession arrangements
The CCG had no private finance initiative, LIFT or other service concession arrangements that were excluded from the Statement of Financial Position as at 31 March 2020 (31 March 2019: None).

28. Finance lease obligations
The CCG had no finance lease obligations as at 31 March 2020 (31 March 2019: None).

29. Finance lease receivables
The CCG had no finance lease receivables as at 31 March 2020 (31 March 2019: None).

30. Provisions

	Current 2019-20 £'000	Non-current 2019-20 £'000	Current 2018-19 £'000	Non-current 2018-19 £'000
Legal claims	50	-	-	-
Continuing care	97	-	320	-
Other	124	-	445	-
Total	**271**	**-**	**765**	**-**
Total current and non-current	**271**		**765**	

	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2019	**-**	**320**	**445**	**765**
Arising during the year	50	-	28	**78**
Utilised during the year	-	(57)	(309)	**(366)**
Reversed unused	-	(166)	(40)	**(206)**
Balance at 31 March 2020	**50**	**97**	**124**	**271**
Expected timing of cash flows:				
Within one year	50	97	124	**271**
Balance at 31 March 2020	**50**	**97**	**124**	**271**

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

31. Contingent Liabilities

Support services potential VAT liability as at 31st March 2020 £703k. HMRC are reviewing Lead Provider Framework arrangements (Kier Business Services Ltd fall within this for the CCG) and the VAT status. The CCG has reclaimed VAT in line with the relevant VAT category, however should HMRC find this to be wrong, the VAT re-claimed would need to be re-paid.

32. Commitments

32.1 Capital commitments
The CCG had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2020 (31 March 2019: £NIL).

32.2 Other financial commitments

The CCG had no non-cancellable contracts (which were not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2020 (31 March 2019: £434k).

33. Financial instruments

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

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

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

33.1.1 Currency risk

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

33.1.2 Interest rate risk

The CCG 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. Financial instruments cont'd

33.1.3 Credit risk

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

33.1.4 Liquidity risk

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

33.1.5 Financial Instruments

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

33.2 Financial assets

	Financial Assets measured at amortised cost 2019-20 £'000	**Financial Assets measured at amortised cost 2018-19 £'000**
Trade and other receivables with NHSE bodies	173	208
Trade and other receivables with other DHSC group bodies	4,325	3,915
Trade and other receivables with external bodies	213	901
Other financial assets	2,789	1,515
Cash and cash equivalents	41	186
Total at 31 March 2020	**7,541**	**6,725**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2019-20 £'000	**Financial Liabilities measured at amortised cost 2018-19 £'000**
Trade and other payables with NHSE bodies	191	**204**
Trade and other payables with other DHSC group bodies	7,407	**8,920**
Trade and other payables with external bodies	6,504	**6,773**
Other financial liabilities	419	**511**
Total at 31 March 2020	**14,521**	**16,408**

34. Operating segments

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

2018-19	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Health	269,539	(4,869)	**264,670**	3,243	(13,110)	**(9,867)**
Adult Social Care	54,771	(54,771)	**-**	3,549	(7,015)	**(3,466)**
Total	**324,310**	**(59,640)**	**264,670**	**6,792**	**(20,125)**	**(13,333)**

35 Joint arrangements - interests in joint operations

35.1 Interests in joint operations

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

The tables below provides a summary of the income and expenditure in the financial year.

Adult Social Care Partnership Agreement

	2019-20 £'000	2018-19 £'000
NELC Allocation	**45,678**	39,495
Other Contributions*	**13,775**	15,276
Total Social Care Expenditure	**(59,453)**	(54,771)
Total	**-**	-

*Other Contributions, includes £4.2m funding from the Health Better Care Fund Allocation. This is an internal recharge between the Health & Adult Social Care Operating Segments and as such is not reflected as Income & Expenditure on the SOCNE.

Better Care Fund	2019-20 £'000	2018-19 £'000
Underspend b/f	**1,882**	**859**
In Year Allocations:		
BCF - Health	12,033	11,573
BCF - Local Authority	3,139	2,960
IBCF - Local Authority	7,042	5,622
Winter Pressures - Local Authority	780	779
Sub Total	**24,876**	**21,793**
In Year Spend :		
IBCF spend	(7,042)	(5,438)
Winter Pressures Expenditure	(780)	(779)
BCF - Health & Adult Social Care	(12,033)	(11,573)
BCF - Disabled Facilities Grant	(2,025)	(2,121)
Sub Total	**(21,880)**	**(19,911)**
Total	**2,996**	**1,882**

35.2 Interests in entities not accounted for under IFRS 10 or IFRS 11
The CCG has no interests in entities not accounted for under IFRS10 or IFRS 11.

36. NHS Lift investments
The CCG had no NHS LIFT investments as at 31 March 2020 (31 March 2019: £NIL).

37. Related party transactions

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

- **NHS England (including commissioning support units);**
- **NHS Foundation Trusts**

Northern Lincolnshire & Goole Hospitals NHS Foundation Trust
Sheffield Teaching Hospital Foundation Trust

- **NHS Trusts;**

East Midlands Ambulance Service NHS Trust
Hull University Teaching Hospital NHS Trust

- **NHS Business Services Authority.**

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

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

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

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Christopher Hayes				
Governing Body Member Secondary Care Doctor				
Consultant Cardiologist at York Hospital NHS Trust	162	-	11	-
Dr Ekta Elston				
Medical Director/Governing Body/Council of Members Vice Chair				
Partner GP at The Roxton Practice, Immingham	4,835	-	190	103
Partner GP at The Roxton at Weelsby View, Grimsby	329	-	1	-
Health Education England – GP Training Programme Director for Northern Lincolnshire	-	36	-	20
Roxton Practice and The Roxton at Weelsby View are members of 360 Care Limited	501	-	30	-
Roxton Practice and Roxton at Weelsby View are members of Meridian Primary Care Network (PCN). PCN funding goes to a lead practice and for Meridian this is The Roxton Practice, Immingham	622	-	9	-
Roxton Practice and The Roxton at Weelsby View are members Meridian Health Group Federation. Payments are made to Meridian Health Group Ltd	238	-	-	-
Dr Jeeten Raghwani				
Governing Body GP Representative				
GP Principal Greenland's Surgery, Stirling Medical Centre & Greenland's New Waltham	387	-	2	-
Greenland's Surgery is a member of 360 Care Limited	501	-	30	-
Greenland's Surgery is a member of Pegasus at Panacea PCN. PCN funding goes to a lead practice and for Pegasus at Panacea this is Clee Medical Centre	525	-	4	-
Greenland's surgery is a member of the Meridian Health Group Federation. Payments are made to Meridian Health Group Ltd.	238	-	-	-
Dr Peter Melton				
Accountable Officer/GP Clinical Chief Officer				
GP Principal - Roxton at Weelsby View, Grimsby	329	-	1	-
GP Principal - The Roxton Practice, Immingham	4,835	-	190	103
Roxton practice is a member of 360 Care Limited & wife is employed by 360 Care Limited	501	-	30	-
Roxton Practice and Roxton at Weelsby View are members of Meridian PCN. PCN funding goes to a lead practice and for Meridian this is The Roxton Practice, Immingham	622	-	9	-
Roxton Practice and Roxton at Weelsby View are members of the Meridian Health Group Federation. Payments are made to Meridian Health Group Ltd.	238	-	-	-
Dr Sudhakar Allamsetty				
Chair of Council of Members/Vice Chair Governing Body				
GP Partner at Scartho Medical Centre	2,042	-	90	111
Scartho Medical Centre is member of Panacea Federation	326	-	-	-
Scartho Medical Centre are a member of Meridian Health Group Federation. Payments are made to Meridian Health Group Ltd	238	-	-	-
Scartho Medical Centre is member of Phoenix at Panacea PCN. PCN funding goes to a lead practice and for Phoenix at Panacea this is Clee Medical Centre	502	-	4	-
Helen Kenyon				
Chief Operating Officer				
Friend is a director of an independent consultancy company, SJW Solutions in Partnership.	113	-	-	-
Jan Haxby				
Director of Quality/Registered Strategic Nurse				
Daughter works as a newly qualified nurse in DPoW Hospital medical unit in NLaG	119,493	76	463	22

37. Related party transactions *(continued)*

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Joe Warner				
Social Care Representative				
Chief Executive - Focus Adult Social Care Social Enterprise	6,361	-	61	-
Mark Webb				
Governing Body chair (Lay Member)				
Trustee on the board for Centre 4 a community services centre, who provides meeting and office space for NHS providers and CCG	5	-	-	4
Phillip Bond				
Patient & Public Involvement (Lay Member)				
Cousin is employed in a senior position at NLaG	119,493	76	463	22
Registered carer under the Carers Support Service which receives some funding from NELCCG	407	-	-	-
Rob Walsh				
Chief Executive NELCCG/NELC				
Chief Executive - North East Lincolnshire Council	3,829	11,450	187	2,879
Governor, Grimsby Institute of Further and Higher Education	1	-	-	-
Stephen Pintus				
Director of Public Health NELC				
Director of Public Health – North East Lincolnshire Council	3,829	11,450	187	2,879
Tim Render				
Governance & Audit (Lay Member)				
Independent Chair Audit & Governance Committee for North East Lincolnshire Council	3,829	11,450	187	2,879
Dr Renju Mathews				
Governing Body GP Representative				
Director – Rutreb Limited	9	-	2	-
Dr Mathews' Practice is a member of 360 Care Ltd	501	-	30	-
GP – Dr Mathews Practice, Cromwell Road, Grimsby	559	-	33	32
Practice is a member of the Panacea Collaborative	326	-	-	-
Dr Matthew's practice is member of Pegasus at Panacea PCN. PCN funding goes to a lead practice and for Pegasus at Panacea this is Clee Medical Centre	525	-	4	-
The CCG is a clinically-led organisation representing 26 member practices. The funding paid to member practices has been listed below.				
Beacon Medical Primary Care Centre	1,638	-	75	44
Beacon Medical Primary Care Centre is member of Concorde PCN. PCN funding goes to a lead practice and for Concorde this is Beacon Medical Primary Care Centre	488	-	28	-
Birkwood Medical Centre	1,624	-	188	95
Blundell Park Surgery	337	-	8	-
Chantry Health Group	911	-	2	32
Clee Medical Centre	1,901	-	83	44
Clee Medical Centre is member of Pegasus at Panacea PCN. PCN funding goes to a lead practice and for Pegasus at Panacea this is Clee Medical Centre	525	-	4	-
Core Care Family Practice	405	-	-	-
Dr Chalmers & Meier	1,039	-	25	124
Dr A Kumar	527	-	1	-
Dr A Sinha	696	-	42	37
Dr O Z Qureshi Surgery	515	-	1	-
Dr P Suresh-Babu	268	-	21	-
Dr R Matthews	559	-	1	32
Greenland's & New Waltham Surgery	387	-	2	-
Fieldhouse Medical Group	2,225	-	6	-
Healing Health Centre	316	-	1	-
Humberview Surgery	302	-	8	14
Humberview Surgery is member of Freshney Pelham PCN. PCN funding goes to a lead practice and for Freshney Pelham this is Humberview Surgery	644	-	13	-
Littlefield Surgery	864	-	1	37
Open Door	477	-	10	-
Pelham Medical Group	1,192	-	65	32
Quayside Medical Centre	317	-	11	-
Raj Medical Centre	705	-	51	-
Roxton at Weelsby View	329	-	1	-
Scartho Medical Centre	2,042	-	90	111
Scartho Medical Centre is member of Phoenix at Panacea PCN. PCN funding goes to a lead practice and for Phoenix at Panacea this is Clee Medical Centre	502	-	4	-
The Lynton Practice	592	-	1	-
The Roxton Practice (Immingham)	4,835	-	190	103
The Roxton Practice is a members of Meridian PCN. PCN funding goes to a lead practice and for Meridian this is The Roxton Practice, Immingham	622	-	9	-
Woodford Medical Centre	1,312	-	10	-

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

39. Third party assets
The CCG held no third party assets as at 31 March 2020 (31 March 2019: None).

40. Financial performance targets

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

	2019-20 Target	**2019-20 Performance**	2018-19 Target	2018-19 Performance
Expenditure not to exceed income	282,495	282,495	269,539	269,539
Capital resource use does not exceed the amount specified in Directions	24	-	-	-
Revenue resource use does not exceed the amount specified in Directions	280,846	280,846	264,670	264,670
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	3,803	3,341	3,661	3,438

It should be noted that the table above only relates to NHS funding. The CCG also receives £45.7m from North East Lincolnshire Council. This is a pooled budget arrangement under Section 75 of the National Health Service Act 2006, see note 35.

In 2019/20, the CCG received revenue resource of £288,993k from NHS England, including £8,147k relating to cumulative surplus. In the table above the revenue resource does not include this element of cumulative surplus.

41. Analysis of charitable reserves
The CCG held no charitable reserves as at 31 March 2020 (31 March 2019: None).

42. FRS Accounting Information - Pensions

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

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

The actuaries report states that the market value of the assets of the Pension fund as at 31 March 2020 was £32.3 million (31 March 2019 was £36.8 million).

Assets	**Value at 31-March-2020 £000**	**Value at 31-March-2019 £000**
Equity Securities	2,970	3,047
Debt Securities	4,328	5,394
Private Equity	1,647	1,869
Real Estate	3,917	4,345
Investment Funds & Unit Trusts	18,507	20,716
Cash & Cash Equivalents	934	1,456
Total	**32,303**	**36,827**

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

Fair Value	**31-March-2020 £000**	**31-March-2019 £000**
Fair Value of Employer Assets	32,303	36,827
Present Value of Funded Obligations	(33,091)	(39,650)
Net Asset/(Liability)	**(788)**	**(2,823)**

Recognition in the profit or loss	**31-March-2020 £000**	**31-March-2019 £000**
Current service cost	101	64
Interest Cost	944	975
Expected Return on Employer Assets	(880)	(920)
Past Service Cost / (Gain)	0	0
Losses / (Gains) on Curtailments and Settlements	0	0
Total	**165**	**119**

Reconciliation of defined benefit obligation	**31-March-2020 £000**	**31-March-2019 £000**
Opening Defined Benefit Obligation	39,650	36,463
Current Service Cost	101	64
Interest Cost	944	975
Contribution by Members	11	11
Actuarial Losses/(Gains)	(866)	(765)
Past Service Costs / (Gains)	0	0
Losses / (Gains) on Curtailments	0	0
Estimated Benefits Paid	(6,749)	2,902
Closing Defined Benefit Obligation	**33,091**	**39,650**

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

Reconciliation of fair value of employer assets	31-March-2020	31-March-2019
	£000	£000
Opening Fair Value of Employer Assets	36,827	34,300
Expected Return on Assets	880	920
Contributions by Members	11	11
Contributions by the Employer	355	330
Actuarial Gains/(Losses)	(4,904)	2,031
Estimated Benefits Paid	(866)	(765)
Total actuarial gain (loss)	**32,303**	**36,827**

Amounts for the current and previous accounting periods	31-March-2020	31-March-2019
	£000	£000
Fair Value of Employer Assets	32,303	36,827
Present Value of Defined Benefit Obligation	(33,091)	(39,650)
Surplus / (deficit)	(788)	(2,823)
Experience Gains/(Losses) on Assets	(4,904)	2,031
Experience Gains/(Losses) on Liabilities	6,749	(2,902)

Cumulative Statement of Recognised Gains / Losses	31-March-2020	31-March-2019
	£000	£000
Actuarial Gains and Losses	(4,904)	2,031
Effect of Surplus Recovery Through Reduced Contributions	6,749	(2,902)
Actuarial Gains / (Losses) recognised in STRGL	1,845	(871)
Cumulative Actuarial Gains and Losses	(1,579)	(3,424)

43. Losses & Special Payments

In 2019/20 there was 2 loss of minor equipment at a value of £710. In 2018/19 there was 1 loss of minor equipment at a value of £150.

The CCG had no special payment cases during 2019/20 (2018/19: None)

44. Cash Flow Workings

	£'000
Net operating costs for the financial year (per SOCNE)	(280,846)
Pension charge	(169)
Net operating costs for the financial year per cash flow	**(281,015)**

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