North Cumbria
Clinical Commissioning Group

Annual Report and Annual Accounts 2021/22

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INTRODUCTION

This year has continued to challenge health and care services with the unprecedented demand created by the Covid-19 pandemic.

We are proud to have supported one of the largest vaccination rollouts in modern history and throughout 2021-2022, we have continued to see incredible work from our primary care teams, community pharmacies, hospital Trusts and a veritable army of volunteers and support from our other partners to ensure that communities in north Cumbria are protected. Teams adapted and mobilised quickly with a unique flexibility and resilience under extreme pressures; to deliver exactly what was asked of them. We are deeply proud of our record in north Cumbria and once again thank communities for their patience, understanding and support through what have been incredibly challenging times.

Despite significant pressures – local NHS teams have continued to work throughout the pandemic with regular 'day to day' appointments, adapting services where necessary to ensure that medical care continued for all our communities, with the most vulnerable patients prioritised. As we all get used to living with Covid-19, it has also proved particularly challenging for our CCG Staff whom, over recent months and like all organisations, have experienced the impact on staff absences from positive Covid tests. Teams have worked tirelessness to provide patients with the best service possible with the resources available and we are very thankful to communities and patients for their compassion, understanding and patience.

During the pandemic we have seen the advancement of technology really come to the forefront with new ways of working for both front line and back office staff. Although remote technology and video appointments have been around for some time, there continues to be some focused work in north Cumbria to increase these opportunities, thus reducing travel for patients and clinicians in our large rural areas. We appreciate that every patient and situation is different – with some understandably still preferring face to face contact – but the availability of these other options is still an achievement not to be overlooked and opens up lots of potential for the future.

System working has again played an absolute crucial role in how we deliver care to communities and this will continue to be the case as we work through the recovery phase. Much of our work has focused on the enormous task of supporting the system to treat those who have seen their operations delayed, and ensuring that those may have been put their health concerns on hold, can access the help they need. The health of our communities is massively improved when we adopt a partnership approach and ensure that the patient is at the heart of everything we do. We are very aware that this includes not just the physical health of our communities but also mental health. The events we have all lived through over the last year will have certainly raised anxiety and uncertainty among many, and we must ensure that this is an integral part of our system approach.

General Practice also continues to develop how they work, with more varied teams looking after communities, for example, if it is more appropriate, you may see a practice nurse or a social prescriber to provide treatment, guidance or advice. Integrated Care Communities and our Primary Care Networks will continue to develop ensuring our collaborative approach in bringing together primary care, community care, adult social care and our vibrant third sector organisations.

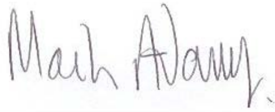
As we look ahead, we reflect too upon the final chapter of NHS Clinical Commissioning Groups as we move towards the implementation of the North East and North Cumbria Integrated Care Board. Although things will change in the commissioning structures behind the scenes, please be assured that keeping patients safe and working for the best health outcomes for our population in north Cumbria, will continue to be our top priority. We know that new structures can be confusing and often challenging to understand, but the key thing to take away is that the local relationships that have been built in our communities will continue on the journey of engagement, tackling inequalities and ensuring the best patient care. Change can bring new opportunities especially for collaboration and potentially innovative new ways of working to deliver better outcomes and improvements. As we emphasised last year, throughout this period of change we will remain a strong voice for our community.

Finally a huge heartfelt thank you to all the colleagues, communities and organisations who have been a part of the CCG's journey over the last 9 years. Especially for all those involved in our co-production work and those who offered feedback, enthusiasm and provided inventive solutions. There have been difficult moments and challenges but also innovative solutions, new ways of working, important relationships and valuable discussions that will continue as north Cumbria moves into the new world of Integrated Care Boards.

Jon Rush
Chair

Mark Adams
Accountable Officer

PERFORMANCE REPORT



Mark Adams
Accountable Officer
17 June 2022

Overview

NHS North Cumbria Clinical Commissioning Group (CCG) has a registered population of **329,110 (at 1 February 2022)**.

The CCG is characterised by a higher than average proportion of the population living in rural communities. Population density is therefore very low. Our west coast communities are geographically relatively isolated, and there are significant pockets of economic deprivation especially in the urban areas. These issues present major challenges for our health services in terms of delivery and recruitment/retention of staff.

The CCG has a total of 35 member Practices (as of April 2022), serving populations between just 908, to over 36,979 registered patients.

Out of hours primary care is provided by Cumbria Health on Call (CHoC).

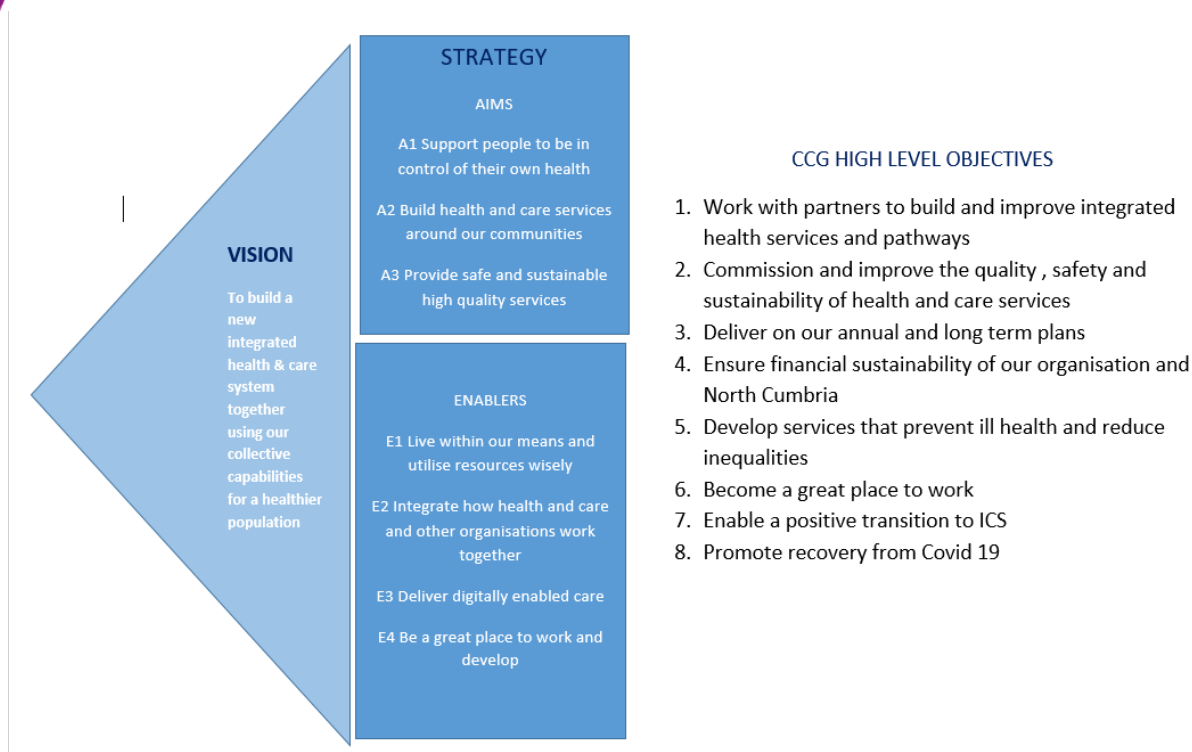
North Cumbria is served by three main NHS Trusts:

- **North Cumbria Integrated Care NHS Foundation Trust (NCIC)** is responsible for providing healthcare services in North Cumbria.
- **Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)** provides mental health services in North Cumbria
- **North West Ambulance Service NHS Trust (NWAS)** delivers Paramedic Emergency Services, Patient Transport Services and NHS 111.

For the North Cumbria population there are significant patient flows to a number of Trusts in the North East, particularly Newcastle Hospitals NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust, Gateshead Health NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust.

What we want to achieve and the risks that could affect it

The CCG's vision and purpose are shown below and continue to reflect the continuing significant change and challenge the CCG faces in line with other CCGs and NHS bodies.



During 2021 and 2022 our NHS North Cumbria CCG has supported our health and care partners on our collective priorities:

- **Health Inequalities and Population Health**
- **Developing our workforce**
- **Recovery from Covid**
- **Finance**
- **Patient flow**
- **Continuing development of our Integrated Care Communities**

There are a number of inherent risks identified to delivery of these priorities that have a significant impact, notably:

The impact of COVID, both on the population health but also the impact on capacity, productivity and associated patient flow through our services. This has had a direct impact on both unscheduled and planned care in all sectors, including acute hospital care, mental health services, emergency ambulances and all aspects of out of hospital care.

As previously noted the staffing challenge is also a significant problem for all providers, both directly within the NHS and particularly in the care sector. There are risks in terms of key clinical staff in all NHS sectors but also particular pockets in the care sector where a combination of rurality and wider economic factors (e.g. employment levels) create a particular challenge. Nevertheless, the CCG has worked with NHS and local authority partners to provide further stability in the care market over winter to improve staff retention and also look at other opportunities to minimise the impact on the ability of the system to discharge patients from secondary care.

The underlying financial challenge for both the CCG and wider NHS system in North Cumbria is very significant, although to some extent the short-term risk has been mitigated by the NHS COVID financial regime in place since 2019/20. However, this issue and consequential service impact has been recognised by the system, with collective endeavours being applied to develop a financial recovery process while acknowledging the short-term operational risk presented by COVID. It is important to recognise a key driver of the risk is the challenge of providing accessible and safe services across a geographically remote area, both within North Cumbria itself (e.g. two acute hospital sites for a population of 329,110) and the ability to mitigate risk given the distance from "nearest neighbour" services.

More detail on the CCG's approach to assessing and managing risk is covered on pages 83 to 86 of this report.

Values and Behaviours

As part of our organisation's commitment to continuous improvement we have agreed values and behaviours across the organisations covering how we act towards each other, our colleagues and the wider community. The values continue to be embedded as part of our organisational behaviours.

The CCG worked with our provider colleagues to develop the values so they reflect the ambition and behaviours across all NHS organisations in North Cumbria. These updated values were initially rolled out in 2019 and are shared with North Cumbria Integrated Care NHS Foundation Trust.

Kindness -
Kindness and compassion cost nothing, yet accomplish a great deal.
Respect -
We're respectful to everyone and are open, honest and fair.
Ambition -
We set goals to achieve the best for our patients, teams, organisation and partners.
Collaboration -
We're stronger and better working together with and for our patients.

The end of CCGs and the path to an ICB (Integrated Care Board)

All CCGs will be changing from 1 July 2022. The CCGs in our areas will become the North East and North Cumbria Integrated Care Board (NENC ICB).

From a patient perspective you will still continue to have the same NHS services. The new organisation will take on the roles of the current CCGs and these changes are all part of the behind the scenes organisation in the region's focus on improving patient care across the North East and North Cumbria area ensuring:

- Secure, effective structures that ensure accountability, oversight and stewardship of resources.
- High quality planning arrangements to address population health needs, reduce health inequalities and improve care.
- Ensure the continuity of effective place-based working between the NHS, local authorities and partners.

As part of these changes the following **key terminology** should be a useful guide in these new structures and help to understand the new emerging organisational NHS commissioning landscape.

- **Integrated Care System (ICS)** – the geographical area – in our case the North East and North Cumbria - in which health and care organisations (including third sector, public health and community groups) work together through the following bodies

- **Integrated Care Board (ICB)** – the statutory NHS organisation that replaces the 8 CCGs currently in the North East and North Cumbria area. They will take on the CCG's previous responsibilities to plan and deliver healthcare across the 13 upper tier local authorities (our 'places') in the ICS area. The ICB will delegate many of its functions to this 'place' level.

- **Integrated Care Partnership (ICP)** – a joint committee of the ICB and the 13 local authorities responsible for developing an Integrated Care Strategy built up from the needs assessments from each of our 13 places that the ICB and the local authorities must 'have regard to' in planning and delivering services.

  There will be four 'sub regional ICPs' underneath this larger board. In North Cumbria this will be the North Cumbria Health and Care Partnership which you may be familiar with and is detailed in the next section.

  Health and Wellbeing Board (HWBBs) – a statutory sub-committee of each local authority responsible for developing a Joint Strategic Needs Assessment (JSNA) for their local area, and a Joint Health Wellbeing Strategy. The ICB and its place-based teams will work with HWBBs as CCGs currently do.

More on the North East and North Cumbria Integrated Care System (NENC ICS) can be found at: https://www.NortheastandNorthcumbriaics.nhs.uk. We work collaboratively across the region to ensure the best outcomes for our patients and tackle some of our shared challenges together. ICSs are systems in which NHS commissioners and providers, working closely with GP networks,

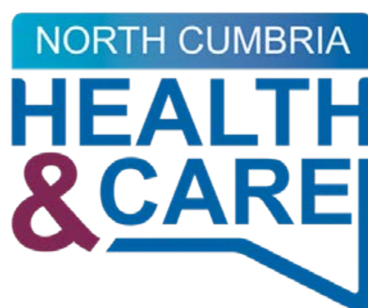
local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they use their collective resources to improve quality of care and health outcomes.

The new ICB organisation will continue to put the voices of people and communities at the centre of decision making and governance. This will also be the case at every level of the ICS.

The CCG’s co-production work and approach will continue in the ICB, starting engagement early when plans are developing, ensuring feedback to people and communities about how their engagement has influenced activities and decisions.

We will also continue to build on our understanding of communities in North Cumbria including their needs, experience and aspirations. Our local relationships with key partners will also continue to build on the work that the CCG has supported, ensuring clarity to accessible public information about our vision, plans and progress to continue building understanding and trust.

Our North Cumbria Health and Care Partnership



The North Cumbria Health and Care Strategy, published in 2020, continues to guide the collaborative approach taken by our health and care partners.

The North Cumbria Integrated Care Partnership Leadership Board has continued to meet and develop more strategic links into our wider community, involving new partners including our universities, the county's Local Economic Partnership (LEP) and Active Cumbria. It is made up of health and care commissioners and providers which include NHS North Cumbria Clinical Commissioning Group, North Cumbria Integrated Care NHS Foundation Trust, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, NHS England, NHS Improvement, North West Ambulance Service and Primary Care, working in partnership with Cumbria County Council, third sector organisations and our community.

More information can be found here: https://Northcumbriaccg.nhs.uk/about-us/North-cumbria-health-and-care-partnership/North-cumbria-integrated-care-partnership-leaders-board

These priorities are closely connected with the **North Cumbria Health and Care Strategy:**

3 Strategic Aims: We will

1) *improve the health and care outcomes of our local communities and support people of all ages to be in control of their own health*

2) *build health and care services around our local communities*

3) *provide safe and sustainable high quality services.*

To help us achieve this we will focus on key areas – **our strategic enablers: we will**

A) *be a great place to work and develop*

B) *integrate how health and care and other organisations work together*

C) *live within our means and spend resources wisely*

D) *deliver digitally enabled care*

Performance Analysis

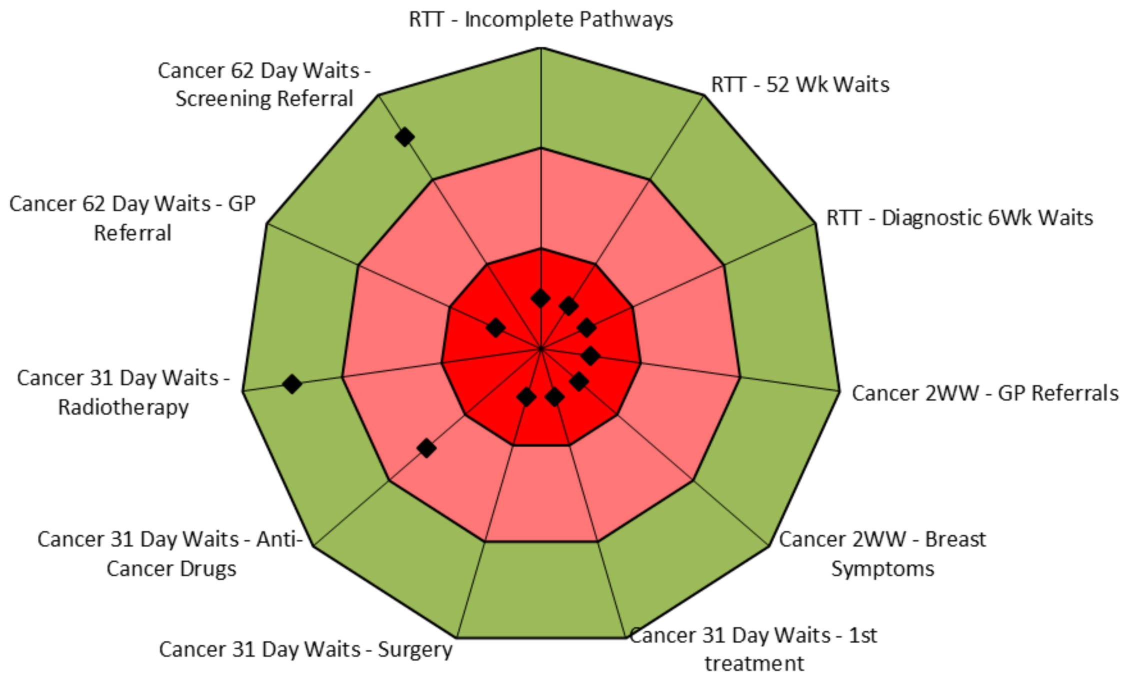
Measuring our performance against national and local priorities helps ensure our services are being delivered to a high quality standard and provide value for money. NHS North Cumbria CCG works within the wider health and care system to oversee and monitor the performance of its local healthcare providers to ensure that:

- Local people receive good quality care. There are processes in place to measure quality of care under three domains: Patient Safety (including infection prevention and control and clinical incident reporting), Patient Experience and Clinical Effectiveness (including how providers of care ensure they are providing the most clinically effective care).
- Patient rights under the NHS constitution are being promoted. These include: waiting times for A&E, cancer treatment, elective surgery and ambulance calls; mixed-sex accommodation breaches and the mental health care programme approach.

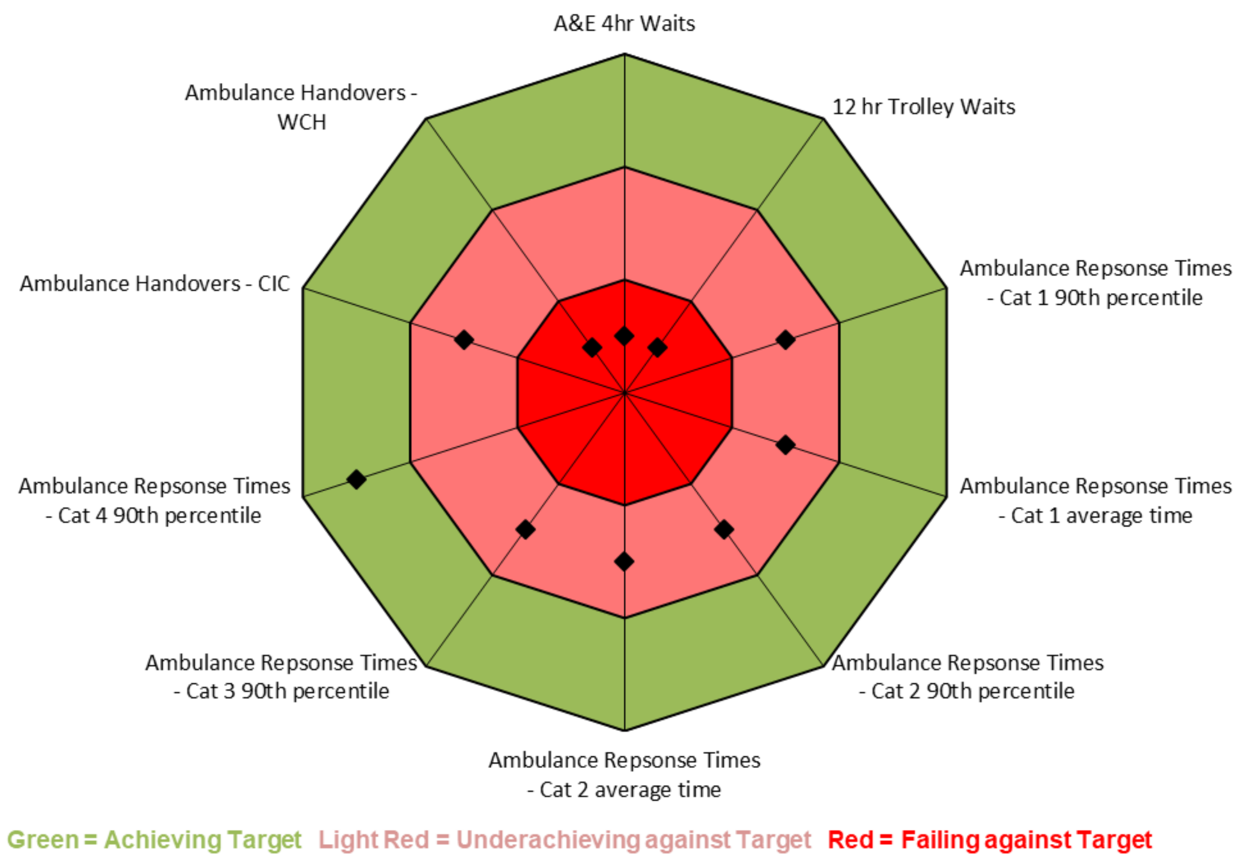
As services have sought to recover during the later stages of the Covid-19 Pandemic, North Cumbria has continued to see challenges in many areas. Notable successes have been the reductions in those waiting over 2 years for elective procedures and an overall improvement in waiting times for diagnostic services, though further progress is needed.

Performance Measures
One of the primary aims of the NHS Constitution, and the associated service standards, is to set out clearly what patients, the public and staff can expect from the NHS. The CCG aims to ensure compliance with the constitution and its standards in the services it commissions from providers such as hospitals, community services and ambulance services.

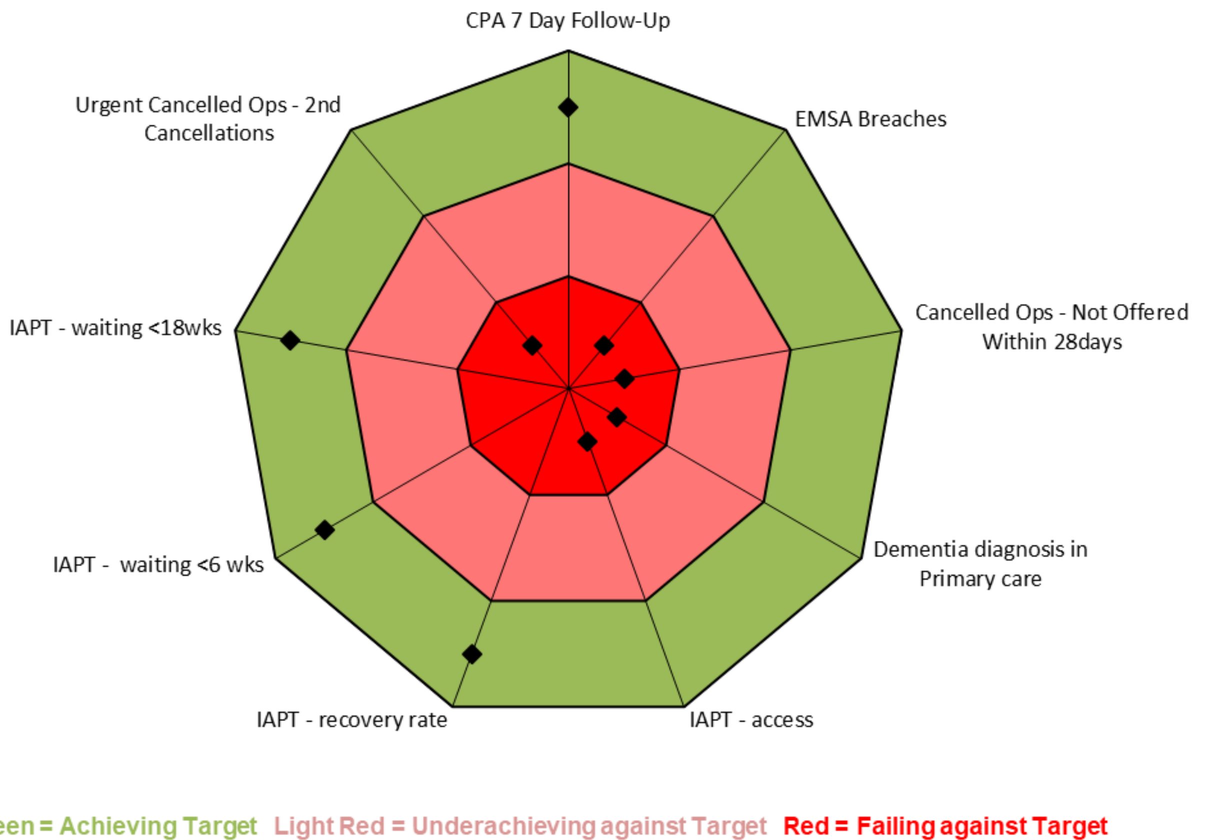
At the end of March 2022 the CCG had achieved the standards in six of the key national measures. Many of the pressures which were experienced across the NHS nationally as a result of the Covid-19 Pandemics have impacted in North Cumbria, with specific challenges for patient access times for cancer and routine elective care. In a number of instances, the CCG and its care providers have been unable to fully deliver the constitutional standards but are working hard to secure improvements. Where necessary, specific recovery plans have been agreed with providers.



Acronyms: RTT – Referral to Treatment, 2WW – two week wait, 52 Wk – 52 week wait, 6Wk – six week wait



Acronyms: A&E – Accident and Emergency, CIC - Cumberland Infirmary Carlisle, WCH West Cumberland Hospital



Acronyms: CPA – Care Programme Approach, EMSA – Eliminating Mixed Sex Accommodation, IAPT - Improving Access to Psychological Therapies

Key areas for improvement and what the CCG is doing about them:

Cancer – the pandemic placed significant pressure on cancer services at North Cumbria Integrated Care NHS Foundation Trust (NCIC). Staff sickness, radiology challenges and a significant increase in referrals all had an impact on the Trust's ability to diagnose and treat patients within the standards. None of the waiting time targets was achieved, with the 62-day standard continuing to be very challenging. However, the Trust has made improvements in a number of areas including using innovative tests like colon capsule endoscopy and Cytosponge, introducing Teledermatology and opening a modular endoscopy unit. Looking forward, NCIC has developed a Cancer Delivery Plan with a focus on tackling the backlog, improving pathways and streamlining steps to reduce how long North Cumbria patients have to wait for diagnosis and treatment.

Urgent and Emergency Care - both Emergency Departments have faced ongoing pressures from increased attendances, high admission rates and the impact of Covid absences on staffing levels. As

a result, performance against the A&E four hour waiting time target has remained consistently below standard. A further issue at both sites is persistently high numbers of medically optimised patients awaiting discharge. This has created challenges for patient flow through the hospitals, leading in turn to significantly high numbers of 12-hour trolley waits. The CCG has made assurance visits to both Emergency Departments and is working with the Trust and wider partners to make continual improvements to discharge arrangements and community provision.

There has been significant challenges to ambulance response times throughout the pandemic but North West Ambulance Service's performance in North Cumbria continues to be notably better than other areas of the North West. Work continues at both hospital sites to improve ambulance handovers.

Elective Care Waiting Times - the pandemic placed significant strain on the delivery of elective services leading to longer waits for many patients and an increasing waiting list. NCIC has a plan in place to tackle the backlog of elective care and return to delivering constitutional standards in full over the medium term. The Trust has successfully removed waits in excess of 104 weeks and is focussed on reducing 78 week waits to zero in the coming year. The Trust's theatre improvement plan is a key priority and work is underway on a plan to transform and improve outpatient services.

Diagnostic Waiting Times – the position deteriorated significantly during the Covid peaks as activity reduced and social distancing requirements led to ongoing capacity issues. Performance against the 6 week waiting time standard is improving and the total waiting list has reduced considerably following around 18 months at roughly double the pre-Covid volume. Additional capacity is in place in cardiology and echocardiography and FIT testing of colonoscopy patients has started. £5.7 million awarded to NCIC as part of the community diagnostic centre bid will be used to bolster capacity.

Improved Access to Psychological Services (IAPT) – performance against the access standard has been below target throughout the year reflecting the impact of the pandemic. The recovery rate however has been close to or above target and waiting times for the service have been consistently better than the minimum standard.

Dementia Diagnosis is an area where the CCG has been working hard to improve its standard. An improvement action plan is in place, a Health Pathway for the assessment and management of cognitive impairment has been developed, and recruitment is underway for Memory Link Workers. Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust (CNTW) have improved the referral triage process to reduce time from referral to diagnosis and have been developing rapid diagnosis clinics.

Cancelled Operations under the 28 day rule are those cancelled by the hospital at the last minute for non-clinical reasons and where the patient has not been offered another binding date within 28 days. These have been notably high at NCIC throughout the pandemic reflecting the pressures on staffing and bed capacity.

Eliminating Mixed Sex Accommodation – reporting was paused for most of the year but the most recent position shows a relatively high number of breaches. Most of these are at NCIC and reflect the ongoing pressures on capacity within the Trust.

Sustainable development

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services.

Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. Meeting the diverse needs of people in existing and future communities, promoting personal wellbeing, social cohesion and inclusion, and creating equal opportunity is all at the heart of both our engagement and co-production work.

During this year our commitment in North Cumbria has continued to develop. Our carbon footprint continued to be reduced considerably with CCG staff working predominately from home, meaning less traffic on roads and also reduced printing. This also extends to miles travelled to meetings, with the majority taking place 'online' using virtual tools. These virtual technologies were initially used out of business necessity, linked to the Covid-19 pandemic, but it has also created new ways of working providing structures, ideas and has expanded the CCG's options to support our sustainable development with a hybrid approach to work currently taking place.

The offices at our 'Parkhouse' location in Carlisle are more economic and environmentally sustainable than our previous offices and should again help to continue to lower our carbon footprint with reduced energy costs.

By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources.

We acknowledge this responsibility to our patients, local communities and the environment as we continue to work at minimising our footprint with our staff newsletters also running articles that provide ideas to encourage people to 'go green'.

Local developments

In this section of the Annual Report we describe some of the service developments that have taken place in North Cumbria during April 2021-March 2022.

Commissioning

Weight Management Service

2021/22 has seen the successful development and implementation of a Tier 3 Weight Management Service for the population of North Cumbria. The service has been commissioned in pilot phase from North Cumbria Integrated Care NHS Foundation Trust (NCIC) during the last quarter of the year and will be opened up fully to GP referrals from 1 April 2022. This is a full multi-disciplinary team, patient focused service for individuals who meet the relevant criteria for access to the service. It has been a gap in local service provision for a number of years and will mean that patients who would benefit from this intensive weight management programme will no longer have to travel to providers out of county.

Ageing Well

There has been significant work undertaken under the umbrella of Ageing Well. The priority focus for 2021/22 was the development and implementation of Urgent Community Response. Urgent Community Response Teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours, between 8-8pm every day. In North Cumbria, planning for this project began in June 2021, with the first ICC areas going live in October 2021, with full coverage across North Cumbria in March 2022.

The service is available for all statutory partners to refer patients into and plans are in place for patients to be able to self-refer into the service via 111 in 2022/23. In North Cumbria we are already achieving the national target of 70% of referrals receiving a service within 2 hours. This initiative has been an excellent example of integrated working between local providers, out of hours providers, the Local Authority, CCG and Primary Care colleagues.

Also under the Ageing Well banner, work has been undertaken to enhance healthcare in care-homes. A care-home digital pack has been purchased for care homes to enable care home staff to make digital referrals to Out of Hours Services and Community Teams and additional Speech & Language Therapy staff are being recruited to increase the therapy support to care homes.

Community Urgent Eye Care Service

2021/22 has also seen the successful implementation of a Covid (now called Community) Urgent Eye Care Service which has been commissioned to allow local optometry practices to see urgent eye

care conditions either remotely or in person referred to them by GP practices, hospital eye service, 111 and self-referrals. This service ensures that patients are directed to the most appropriate setting for any appropriate urgent eye conditions and has the added benefit of freeing up capacity in GP surgeries and hospital eye services for other patients who require these services. Patient and GP feedback has been extremely positive.

Voluntary Sector

North Cumbria health and care system have developed a close working relationship with third sector partners during the last 18 months to two years, and in particular over the 2021/22 winter period, providing financial support to the charitable and community sector to help people regain and maintain their independence at home and in the community once they are discharged from hospital.

The CCG funded Cumbria Voluntary Services (CVS) to provide a Health & Welfare Telephone Support Service which would assess patients referred to them at discharge and ensure that the correct voluntary sector support was provided to meet their needs. CVS now incorporates a Third Sector Referral Coordination service to support the increase in activity into voluntary sector support at discharge.

During the winter of 2021/22 the increasing challenges experienced in enabling patients to be discharged led to a further exploration of what additional support the voluntary sector might be able to offer to enable patients to be discharged home from hospital. Cumbria Community Foundation received a grant from the CCG from which to allocate funds in response to proposals from voluntary sector organisations.

As a result, the following initiatives commenced:

- Age UK provided a flexible service to prepare a patients home for their return. Support included, for example, one off tasks such as reconnecting utilities, one off initial light housework, moving furniture, prescription collection or equipment prescriptions. In the west this also included delivery of meals from Wiltshire Farm foods for those that had difficulty catering for themselves initially
- In the Carlisle area, Meals on Wheels provided a service of 3 hot meals and a tea-time sandwich per week for 4 weeks after discharge to patients that needed this support
- The British Red Cross provided an equipment provision service
- Working in partnership, Citizens Advice Allerdale, Copeland and Carlisle & Eden provided advice and support with benefits applications, housing issues and other similar challenges
- Eden Carers, Carlisle Carers and West Cumbria Carers worked in partnership to assess and administer £500 carers grants and provide support to those families. This was to enable carers to put in place initial arrangements needed to take the patient home safely.

This support has been really valuable providing support to vulnerable people to meet a range of needs. The CCG aims to continue to support the voluntary sector with grant funding in 2022/23 to enable this work to continue and develop and to focus not just on patient discharge but also to explore how voluntary sector support might prevent admissions happening.

Learning disabilities and/or autism

The Enhanced Community Model (ECM) is now active and links to the Dynamic Support Register (DSR) - a register which highlights an individual with a learning disability or disabilities and/or autism who is at risk of hospital admission. This is updated weekly with actions to prevent admission and enables enhanced community support to those in crisis, thus preventing unnecessary admissions and supporting with timely discharges. Additionally we have recruited four independent clinical reviewers for Care (Education) and Treatment (CETR) reviews.

'Experts by Experience' are now supporting with regular oversight visits for those in in-patient facilities to ensure that they are receiving high-quality and safe care that is appropriate to their needs and aspirations, and that discharge planning commences from the point of admission. Despite the pandemic our host commissioner visits have continued appropriately, regularly and in a COVID-secure manner: we review the care and treatment of all patients who have been admitted and provide feedback to other commissioners who may have patients in North Cumbria.

Other proactive work includes: quarterly reporting of DSR/CETR processes to inform commissioning/planning including identifying service issues and gaps; commissioning post-diagnostic-support via third-sector partners to relieve pressures on autism waiting lists; developing and facilitating a 6-week course for individuals and their families/supporters to help understand their autism; and the continuation of weekly 'lunch clubs' for people with autism to establish peer-support networks to assist in reducing isolation and loneliness.

Community Mental Health Transformation

Community mental health services play a crucial role in delivering mental health care for adults and older adults with severe mental health needs as close to home as possible. As part of the commitment to the NHS long term plan, the CCG was awarded £4.6million, over the next 3 years to invest in community mental health services for service users who have severe mental illness (SMI).

In 2021/22 the CCG launched this program of work and has worked alongside the Third Sector in order to fund a volunteer and work placement scheme especially for people with SMI, as we know that this can be an important step to recovery, improving self-esteem, confidence and reducing psychological distress.

We have also partnered with Cumbria Community Foundation to offer grants to the Third Sector in order to help deliver some of the transformation objectives such as working with service users from disadvantaged backgrounds in order to support them to engage with statutory and community services, as well as support physical health needs of people with SMI.

The CCG is currently working on expanding the eating disorders pathway, specifically focusing on early intervention. We are introducing a physical health team who will work with GP's to perform physical health checks with people who have SMI as we know the physical health of people with SMI is poorer and many of these service users are dealing with multiple co-existing conditions. We are investing in a mental health rehabilitation hub and bespoke model to provide SMI service users

who have co-existing substance abuse issues with support and recovery services within their communities.

We are also delivering bespoke training for staff who work in social prescribing and connecting roles.

Mental health Support Teams in Schools (MHSTs)

The CCG has continued to make progress with the development of the Mental Health Support Teams (MHSTs) that are working with designated schools in Carlisle and Allerdale.

The practitioners working in the Carlisle team have completed their training year, passing their qualification with distinction and are now working full time in schools meeting the needs of children and young people and helping to establish the team.

The Allerdale team practitioners have all started their formal training and the team is getting to know their schools and communities.

Recruitment has been challenging. However both teams are now fully recruited.

The next significant challenge is resolving the decision on where the third team will be working. To assist in this process an Engagement Officer has been appointed by the provider, Barnardo's, to ensure that the voices of children, young people and their families are heard throughout the decision making process.

Primary Care

Vaccination programme

Covid-19 continued to be the biggest challenge our NHS has faced in 2021/22. The role of the Primary Care team has been to continue to support our providers and ensure that our communities were able to receive services, support and information throughout 2021-2022.

Our focus on dealing with the pandemic in 2021/22 was the continued support to deliver two main priorities. Firstly, to coordinate and support how Health and Care services continued to deliver services and secondly, to promote and support the delivery of the effective flu vaccine and Covid-19 vaccine programmes in order to protect our communities.

Through the continued support from Primary Care Networks, General Practices, Community Pharmacies, NCIC, CNTW, Local Authorities and the incredible support from the Third Sector, by the end of March 2022 there had been over 263,000 first vaccinations administered (85% of those eligible), 252,000 seconds (80% of those eligible) and 208,000 Boosters (85% of those eligible), bringing a total of 723,000.

The flu vaccination campaign achieved a final uptake of 169,000 (72.5% of those eligible) which was the best performance from any CCG within the Northern and Yorkshire Region.

Development of PCN structures

The 8 Primary Care Networks (PCNs) continued to develop throughout the year with the Clinical Directors, Operational Leads and Practice Managers all working closely with the CCG's Primary Care Team to deliver services as the Covid pandemic and vaccination programme continued to dominate. General practice responded to help to protect patients so 'Covid Pathways' continued within PCNs, along with the use of PPE and increased offer of telephone appointments and video consultations to support patients remotely.

Recruitment to key roles within PCNs including GPs and nursing roles continued to be a significant challenge. The CCG supported PCNs to introduce new roles via the Additional Roles Reimbursement Scheme (ARRS). This included the development of associated service specifications, ARRS induction programmes and introducing peer support networks. The aim of the scheme is to build and utilise the additional roles to help the workforce shortage in general practice including, First Contact Practitioners (Physiotherapists), Clinical Pharmacists, Social Prescribing Link Workers, Physician Associates, Community Paramedics, Care Coordinators, Health and Wellbeing Coaches, Mental Health Practitioners and other Allied Health Professionals.

Dr Niall McGreevy stood down as the Chair of The General Practice Provider Collaborative (GPPC) and Dr. Robert Westgate from Carlisle Healthcare took over this position.

Integrated Care Communities

The Integrated Care Communities (ICCs) worked hard to prevent people being admitted to hospital as well as offering support to enable patients to be discharged as early as possible. The Covid pandemic caused major difficulties with ongoing infections and staff absences. The North Cumbria System Executive commissioned a paper to consider the Value for Money offered by ICCs and this was presented and discussed in the Autumn with all recommendations being agreed. These included appointing a Senior Responsible Officer to take forward a 'diagnostic and review' of the ICCs and renewing the business case, including the vision, objectives, measures and involvement of all stakeholders.

Supporting primary care element of new pathways

The CCG introduced a number of new clinical pathways in 2021/22 including Long COVID, a Covid Medicine Delivery Unit, Blood Pressure at home monitoring and Oximetry at home monitoring. These new services supported patients in their own homes and those patients who are vulnerable to infection.

A Winter Access Fund (WAF) was delivered across all PCNs and practices, bringing new funding to the area, overseen by the CCG's Primary Care Team.

Digital

In year, there were a number of 'behind the scenes' key structural projects being implemented. These included the active mail directory migration, moving mail from servers in Morecambe Bay to North Cumbria, converting e-mail addresses to nhs.net, the setting up of a virtual desktop infrastructure to support remote working for clinicians, setting up a remote and locum hub for GPs and other clinical roles to ensure that all possible clinical capacity is utilised within the CCG area.

Professional Development

A GP and GP Nurse Fellowship programme was established and a Practice Nurse Leadership structure was agreed, with posts to be recruited to.

An Intermediary Group was created to address clinical issues arising through organisational interfaces e.g. primary and secondary care, ensuring that people are treated and supported at the right time and in the most appropriate settings.

Improve Quality

The CCG Nursing & Quality Team has maintained a focus on Quality and Safety in the services provided to the population served during 2021/22. The Covid-19 pandemic made this another challenging year with a continued need to be innovative, creative and flexible in the way that the CCG has fulfilled its responsibilities for quality assurance of the services. The most significant impact of the Covid-19 pandemic this last year has been on staff sickness across the whole health and social care economy and this has had direct consequences on the fragility and sustainability of services, independent agencies and individual packages of care.

The demand on health and social care services has remained high and with additional winter pressures has resulted in large number of medically optimised patients in hospital for long periods, significant waits for discharge from mental health and learning disability beds and long waits in Accident and Emergency Departments. The CCG has worked closely in partnership with statutory and Third Sector agencies as well as in its assurance role to support improvements in these areas.

The CCG Outcomes & Quality Assurance Committee (OQAC) continued throughout the year. This group reports to the CCG Governing Body on quality matters in the services the CCG commissions. This Committee, chaired by a Governing Body Lay Member (Quality & Performance), has provided appropriate challenge to ensure the most robust approaches to improving quality were being considered and implemented, and gave collective oversight of the progress towards safer patient care. The group has a focus on 'making a difference' and on what is being achieved in improving quality.

The OQAC had these general functions:

- To facilitate joint working within and across the system to address specific quality issues affecting service delivery
- To provide a mechanism for facilitating direct assurance of the quality in the health care system across North Cumbria
- To monitor and be assured around both Adult and Children Safeguarding across the system
- To share good progress and practice and build upon positive improvements in quality of care

The OQAC included in its oversight assurance reports on quality of care to the Governing Body updates from the Ambulance Service, the Drug and Alcohol service provider, Cumbria Health on Call (CHOC) the Out of Hours GP service and the Hospice services in addition to our larger Foundation Trusts. We have also worked closely in partnership with North East CCG colleagues in the quality oversight of CNTW across North East and North Cumbria.

CCG Nursing and Quality leads through formal quality review meetings, NCIC Quality Board and regular assurance meetings have had oversight of progress against CQC actions plans

NHS Continuing Health Care

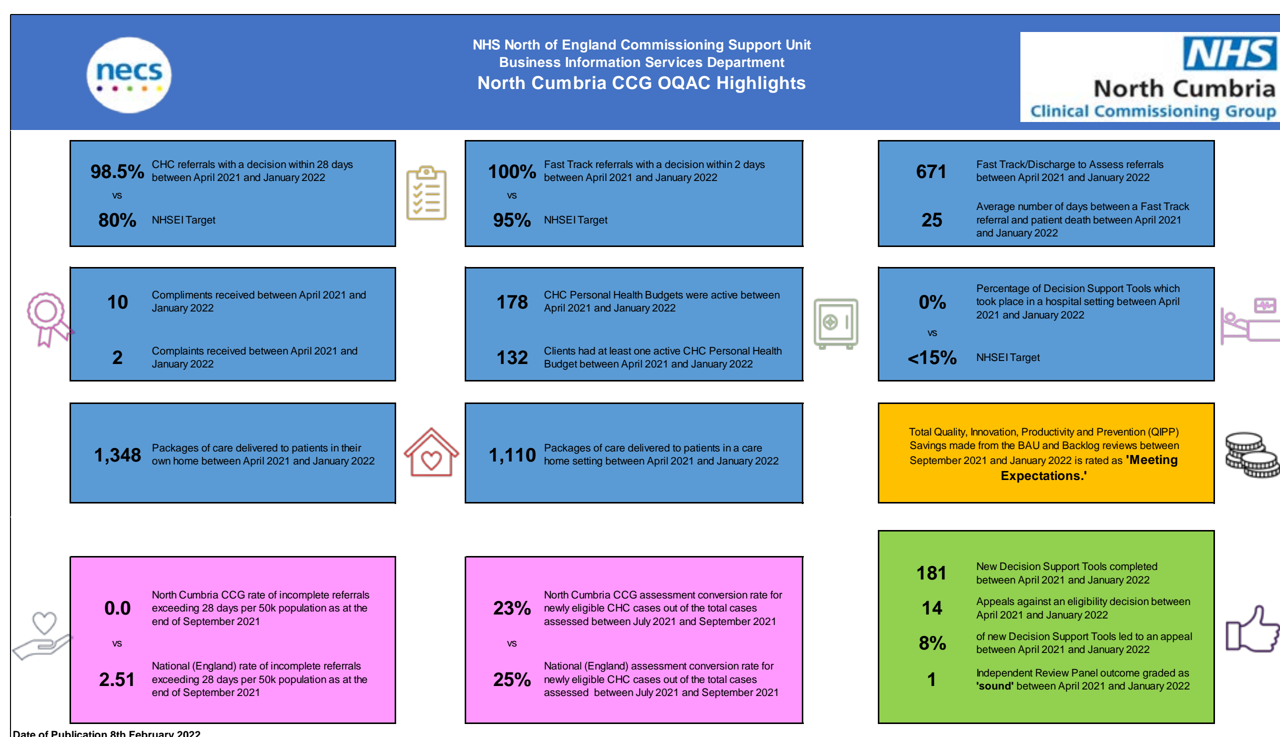
NHS Continuing Healthcare (CHC) is a package of ongoing care that is arranged and funded solely by the National Health Service (NHS) where the individual has been assessed and found to have a

'primary health need'. Such care is provided to an individual aged 18 or over, to meet health and associated social care needs that have arisen as a result of disability, accident or illness.

Continuing Health Care processes have continued despite the pressures from new waves of Covid-19. The team has continued to work with hospital staff to support the work on hospital discharges and to work with local providers who have also suffered major workforce pressures as a result of the pandemic.

The CHC team has successfully managed to address the back log of work as a consequence of CHC work being paused including reviews that had been deferred, to ensure that individuals were safely placed in the appropriate place. The team has continued to assess people for continuing health care following their discharge from hospital within the 4 week period described in national guidance (D2A).

During the second Covid-19 wave the CHC team has continued to directly support the acute hospitals to find appropriate placements for individuals. There has also been a continued strong focus of work to support individual packages of care and to prevent the need for hospital admission, with many people receiving extra care to enable them to be able to stay at home wherever possible.



End of Life Care

The Nursing & Quality Team has continued to refocus our ambitions for Palliative & End of Life Care (PEOLC) including stakeholder engagement and hosting a number of workshops in which our Vision and Values for End of Life Care have been defined and agreed. Close links have also been established with the ICS and national PEOLC clinical networks. Work is now progressing in the following areas to inform a revised co-produced 5 PEOLC year strategy:

- Mapping of provision to identify emerging themes to inform the proposed strategy.

- Refresh of a PEOLC Partnership Group with appropriate senior stakeholder and patient/family representation.
- Ongoing review of the priorities and agreeing action plans going forward.

LeDeR (Learning from lives and deaths reviews of people with a learning disability or Autism)

LeDeR work has been focused on implementing the new national policy and extending the reviews to include people with Autism.

A new governance process is in place to ensure all partner agencies share learning across the health and care system.

Responding to themes that have emerged from reviews the Action from Learning group has progressed training and development initiatives, improvements to the Hospital Passport and improving the Health Action Plans as part of the Annual Health Check.

The team has again co-produced the LeDeR Annual report with our local 'Confirm & Challenge group' and have benefited from working closely with people with lived experience and their families to improve the reviews and learn from the findings. This excellent piece of co-production work has been shared at the CCG Governing Body and Adult Safeguarding Board

Themes and Trends from the LeDeR Reviews– Positive Practice

Care Providers Educational Webinars

The CCG has collaborated with Cumbria County Council to develop and roll out educational webinars for North Cumbria Care Providers.

A series of ongoing fortnightly 1 hour educational webinars commenced in June 2021. The aim of the rolling programme is to engage with Care Providers and deliver a variety of clinical and technical information to enable the empowerment of staff to deliver high quality care.

Topics have included Wellbeing, End of Life Care, Covid-19 booster & Flu vaccination uptake, Mental Capacity and Deprivation of Liberty, Oral Health and Leadership among many others.

Independent Care Sector (Nursing & Residential Homes and Domiciliary Care) contract compliance 2021/22

The CCG commissions Continuing Healthcare for adults from local Independent Nursing & Residential Homes and Domiciliary Care. The CCG has a NHS Standard Contract with every Care Provider it commissions care from.

The Nursing & Quality Team (N&Q) liaise closely with the Contracts Team to monitor and gain assurance against the contracts standards. A Care Provider Dashboard has been developed to collate and provide regular oversight of all providers. The N&Q Team offer support as required where areas of improvements are required including signposting to training, educational webinars or individual assistance as required. There has been a programme of Commissioning Assurance Visits to review and validate quality and safety of care within the independent sector. Visits have been undertaken to domiciliary commissioned services against the Care Quality Commission Fundamental Standards. The main challenges highlighted by the Domiciliary Providers during these reviews were the recruitment and retention of care staff into their services. During the pandemic many staff left the care sector to work in the retail and hospitality sector for more competitive wages and better working conditions. The Domiciliary Providers have highlighted their sustainability challenges in this economic climate.

Registered Care Sector – Enhanced Health in Care Homes

Through the year the Nursing & Quality Team worked with the primary care teams to support the work of the Ageing Well Programme, which is in place to increase the NHS support to the Independent Sector Nursing & Residential Care Homes.

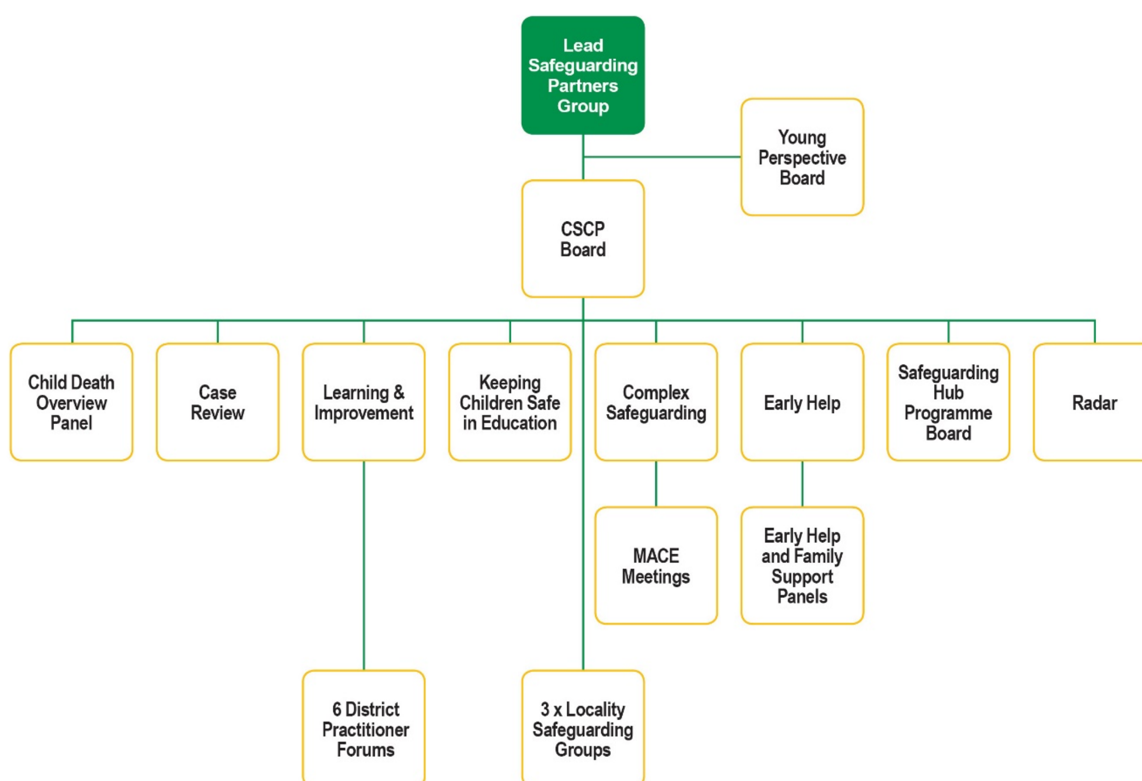
Key service improvements:

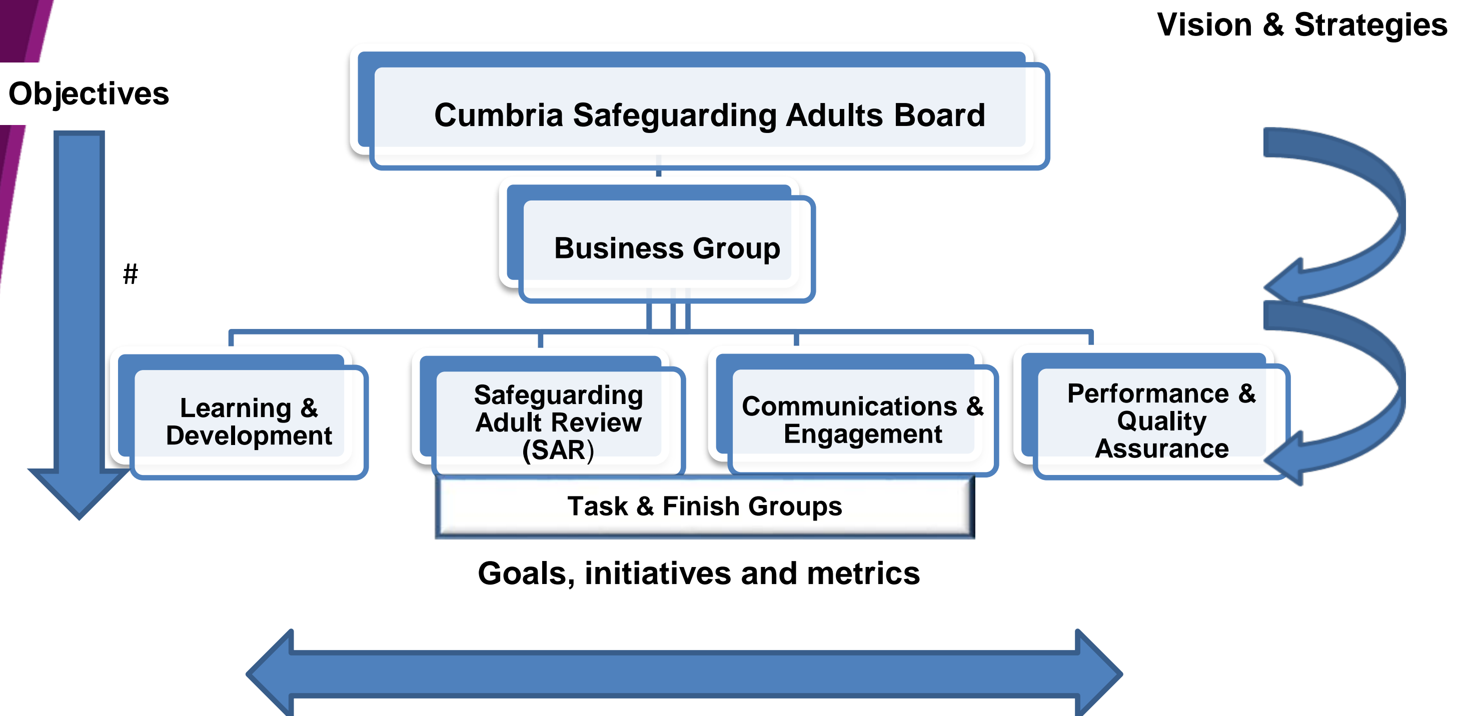
- CCG Infection Prevention Nurse supported primary care in delivering the Covid-19 immunisation and booster programmes for the care homes.
- Provision of specialist respiratory support, and providing equipment for the homes managing residents with Covid-19.
- Supported the ‘flow’ of patients from the acute hospitals by providing guidance on safe discharge, and helping to remove obstacles and blockages to reduce delays.
- The CCG made an arrangement with the mental health care provider to give psychological support to care home staff who had been affected by the difficulties experienced in caring for older people through the pandemic.

During the year the registered care sector, including domiciliary care, had significant difficulties during the Omicron wave of the pandemic, with a large number of homes in 'outbreak' with significant numbers of staff absent because of the virus and consequently closed to admissions. Pressure in these services had an impact on acute and community care, and the 'flow' through the hospitals, with people being unable to be discharged. This pressure was particularly marked in A&E departments with patients not being able to be admitted promptly. In common with the national picture, whilst the elective recovery programme has commenced there remains a large number of people waiting for elective (non-emergency) care. The CCG has announced its intention to undertake an assurance review into the management of waiting lists in NCIC.

Safeguarding

The CCG has effective arrangements in place to ensure the statutory requirements in respect of governance and accountability are in place. The Integrated safeguarding team work collaboratively in partnership with the following two Boards/ Partnerships;





Partnership arrangements extend to the Safer Cumbria Board, the Cumbria PREVENT Board and the Cumbria Corporate Parenting Board. The collective memberships of the aforementioned Boards ensure that all statutory elements of the safeguarding portfolio are covered. Local Authority and Police are also statutory partners and local NHS Provider organisations are central to these arrangements. The wider partners include Fire Service, Probation and voluntary partners.

The CCG Safeguarding team continue to provide leadership and share expertise to effectively respond to early warning signs and manage any risks as a system. Identifying early learning is central to what we do, utilising support systems developed to cascade and ultimately embed that learning into services that we commission.

As the CCG moves from pandemic response through to recovery it has been vital to maintain the locality based safeguarding work groups. This has included work testing out what the impact of neglect has had on families and our communities. Domestic Abuse has emerged as a recurring feature during the pandemic and this is reflected in prevalence of Home Office Domestic Homicides. There were fifteen open cases across Cumbria, eleven of which were within North Cumbria at 31 March 2022.

Other statutory reviews include Safeguarding Adult reviews, Child Safeguarding practice reviews and Child Death Overview systems for which the CCG provides expertise and leadership.

The associated working frameworks of the five Boards collectively tackle the NHS Safeguarding Portfolio. Specific sub groups focus upon areas such as Domestic Abuse, exploitation and missing children, Modern Slavery, harmful practices such as Female Genital Mutilation (FGM), so called honour based violence, Forced Marriage, Counter Terrorism and Self Neglect as examples.

The CCG Safeguarding Designated Professionals collectively lead and participate in all aspects of the Boards work. They also work closely internally with the Communications team and Primary Care team. Some aspects of the portfolio involve joint work such as assurance in partnership with the wider CCG Quality team in terms of emerging concerns within Care Homes and complex cases across all ages.

The CCG has effective arrangements to receive assurance from commissioned services and this has been enhanced this during 2021/22 with face to face visits to service areas which have proven helpful and will be built upon during the next year.

The Designate professionals are well positioned to adapt to the new Integrated Care Board arrangements. Currently the CCG has agreed to act as one of three Professionals representing our NENC ICB with both the Looked After Children and Safeguarding regional groups. In addition to these arrangements the team attend the ICB Safeguarding network and National Safeguarding networks.

The reach of the safeguarding team has been extended during 2021/22 to strengthen relationships and support across the CCG into Provider Organisations and Primary Care. The provision of supervision has been refreshed and professional advice and support continued.
Training provision has been revisited with an extensive consistent offer to Primary Care and internally to CCG staff. This will be further strengthened during 2022 / 2023.

Special Educational Needs & Disabilities (SEND) Improvement Programme CCG Annual Report – 2021/22

The SEND Improvement programme has continued through 2021/22. As Covid-19 restrictions have eased access to CYP in schools and settings has gradually improved although this has fluctuated more with the impact of Omicron. Technology has certainly helped the partners in the programme to stay connected and plan for the expected Local Area SEND re-visit following the OFSTED/CQC inspection in March 2019. Preparations for anticipated re-visit included thoroughly updating the self-evaluation (SEF) and highlighted 3 areas which would benefit from an Accelerated Progress Plan (APP)

1. Educational Healthcare Plan (EHCP) quality & data
2. Transition to Adulthood (particularly health and social care)
3. Autism Assessment pathway

These Accelerated Progress Plans commenced in Sept 2021 and are monitored monthly.

The Designated Clinical Officer (DCO) leadership role has continued to support in a number of areas including

- Support to the provider trusts to implement a quality assurance process before submitting health advice to the local authority for an Education Health and Care Plan.
- Bi-monthly meetings with the Deputy Designated Nurse for Safeguarding and Children Looked After Designated Nurse (local provider) to highlight and discuss vulnerable young people who have SEND and are Children Looked After
- Work with Primary Care Teams in both North and South Cumbria to improve the number of eligible children and young people who are flagged on their GP system for an Annual Health Check
- Produced guidance in conjunction with Lead GPs in both North and South Cumbria and the Local Authority Inclusion Team (Cumbria County Council) about the use of 'sick-notes/fit-notes' for children and young people (e.g. unfit to attend school full-time but able to attend part-time/ not fit to attend school today).
- Work closely with the Special Educational Needs and Disabilities Information, Advice and Support Service (SENDIAS) to unblock health issues and signpost where needed in the work that SENDIAS do with families.

Education Health and Care Plan numbers this year:

	Allerdale & Copeland	Carlisle & Eden	Furness & South Lakes	Grand Total
EHCP Assessments completed April 21 - Mar 22	**208**	**208**	**215**	**631**
Final EHCPs issued April 21 - Mar 22	**222**	**186**	**220**	**628**
Total EHCPs to end March	**1571**	**1671**	**1130**	**4372**

Complaints

The CCG aims to improve the health and well-being of all people in North Cumbria by ensuring that our patients receive the highest standards of healthcare possible. When mistakes happen we ensure that lessons are learned to help avoid a similar incident occurring again. We welcome feedback, both positive and negative, about NHS services commissioned or provided by those organisations as well as about the CCG itself. The North of England Commissioning Support Unit (NECS) supports the CCG with the management of complaints.

The team handled a total of 718 cases during the reporting period across all North East and North Cumbria CCGs; 14 of these related to NHS North Cumbria CCG compared to 11 in the previous year. 6 of the NHS North Cumbria CCG cases were handled under the NHS complaints procedure and all were acknowledged by the NECS Complaints Team within the target timescale of 3 working days. The theme of complaints/concerns for NHS North Cumbria CCG was Continuing Healthcare decisions and processes (7). These included complaints/concerns regarding eligibility decisions (3), case management (1), process delay (1), payment dispute (1) and access to assessment (1).

Three formal complaints relating to the CCG were closed during the year; two were not upheld and one was partially upheld. No specific service improvements were made as a result of the investigation. No North Cumbria CCG complaints were investigated during the year by the Parliamentary and Health Services Ombudsman (PHSO).

34 further complaints/concerns were received from or on behalf of North Cumbria residents which related to other organisations such as NHS trusts, GP practices, NHS England. These were passed to the relevant organisations for investigation and response.

13 compliments from or on behalf of North Cumbria residents were received, all related to the Continuing Healthcare Team.

Maternity

The CCG has worked closely with NCIC in support of its maternity improvement programme. There has been regular reporting of the Trusts response to the initial Ockenden Reports including the essential and immediate actions. The Trust has been actively engaged in the delivery of the Local Maternity Neonatal System (LMNS) and in working to achieve the Maternity Transformation deliverables. Assurance and improvement in maternity care in North Cumbria has been affected by the pandemic period and subsequent staffing shortages.

Maternity Voices Partnership

Work continues from both the West and Carlisle Partnership groups to support the continued improvement of maternity services locally.

The Carlisle & Eden MVP covers Cumberland Infirmary and Penrith Birth Centre, while the West Cumbria MVP covers West Cumberland Hospital and both groups are chaired by Sandra Guise. Sandra has chaired both groups since their inception, she was also the Service User Voice representative on the West North East Cumbria Local Maternity System (WNEC LMS) up until July 2021.

Both MVPs work tirelessly to continually improve the quality of maternity care, and as a part of that:

- Have a focus on closing inequality gaps
- Listen to and seek out the voices of women, families, and carers using maternity service, even when that voice is so quiet that it is hard to hear
- Enabling people from our diverse communities to have a voice

The MVPs have worked extremely hard to adapt to COVID-19 and soon moved to using Microsoft team to facilitate meetings. Interestingly, the number of service users attending the MVP meetings and topic based workshops has grown throughout the pandemic. Women have reported that virtual meetings are much more accessible than having to drive long distances with a young baby, however, they also recognise the value of coming together face to face too.

Examples of recent MVP work include:

- excellent multi-disciplinary workshops on birth choices and postnatal care which have been facilitated by local women and student midwives and organising a range of surveys e.g. the impact of COVID-19 and the uptake of COVID-19 vaccination in pregnancy; and
- a focused workshop to review the 6 week postnatal check process was successful and well attended providing useful feedback from mothers and highlighting some themes for improvement.

Co-production

The CCG have made involvement of service users a priority and attempt to engage with our local population in a variety of ways: Including

- Working closely with local advocacy group to support feedback from vulnerable groups
- Made improvements to learning disability hospital passport – co-produced with users and professionals
- Worked with local Confirm & Challenge group to co-produce LeDeR Annual Report and various service improvements
- Worked with Maternity Voices Partnership to listen to the voices of parents and improve maternity services
- Engaged with parents to improve SEND services

Addressing Inequalities & Initiatives with Hard to Reach Groups

- The CCG work with Lakes College, University of Cumbria to support students to receive their Covid vaccination

- Reasonable adjustments to patients with a learning disability to undergo procedures and treatments using desensitisation techniques

- Worked with Multicultural Cumbria & Furness Multicultural to produce resources in different languages, these were shared where specific communities congregate (i.e. in Polish specific shop)

- CCG supported work for clients in a local bail hostel and homeless shelter to received their Covid vaccination

- Work to enable a Covid specific vaccination centre to attend Appleby Horse Fare for Roma, Gypsy and Traveller Communities

Infection Prevention & Control/Healthcare Associated Infections (HCAIs)

Healthcare-associated Infections (HCAI) remain a priority for the CCG and its partners as they are a major cause of avoidable patient harm in the UK. With this in mind, the CCG has developed 'The Infection Prevention 3 year strategy'.

This strategy takes into account the learning from the Covid-19 pandemic and forms an action plan to reduce HCAI. Priority for Year 1 was given to the Independent Care Sector and Primary Care based on needs identified throughout the pandemic. Training for both the Independent Care Sector and Primary Care has been carried out and a standard approach to Infection Prevention and Control and Leadership has been agreed by the GP Executive group across North Cumbria CCG's footprint. Infection control champions for each practice have been trained and have access to standard policies and audits. The implementation of this strategy is monitored via The North Cumbria system HCAI group and the outputs from the HCAI group along with its associated sub-groups (The CDI Group and the UTI Collaborative) are fed into the regional HCAI/AMR Board.

The Covid-19 pandemic has continued to create extra challenges to patient safety throughout this year both within the community and hospitals. The CCG worked collaboratively with its partners to reduce the spread and potential harm caused by Covid-19 by continuing to provide support around implementing the national and local guidance. Covid-19 related deaths both in community and hospital settings have significantly reduced this year compared with the previous waves, thus highlighting the importance of the successful Covid-19 vaccination programme.

HCAI Performance Trajectories

NCCCG is monitored against the following HCAIs national performance trajectories set by NHS England (See table 1):

- Clostridium Difficile Infection (CDI)
- Methicillin-resistant Staphylococcus Aureus (MRSA)
- Escherichia Coli (E.coli) Blood Stream Infection (BSI)

Table 1 NCCCG's HCAI Performance Trajectory over the last 3 years

Year Trajectory V Actual	2019-20 Trajectory	2019 -20 Actual	2020 -21 Trajectory	2020- 21 Actual	2021 -22 Trajectory	2021 - 2022 Actual published (Feb 22)
Number of CDI cases	99	106	83	118	98	95
Number MRSA BSI cases	0	4	0	1	0	0
Number of E.coli BSI Cases	221	327	185	285	302	299

MRSA

The trajectory for MRSA Blood Stream Infections (BSI) in England is zero as it is deemed no Healthcare-acquired MRSA is acceptable due to the potential harm it may cause. To date, this year there have been zero community-acquired MRSA Blood Stream Infections assigned to NCCCG for the local population.

CDI

CDI cases are once again heading above their trajectory. This increase in CDI both within in the community and hospital environment is an area of concern. It is therefore important that the local health and care system has work in partnership to understand the causes of these infections, identify themes and share learning in order to help improve patient safety. In 2021/2022 the focus has moved to a system-wide approach for the delivery of the improvement plan to reduce the number of cases assigned. The deliverer of the CDI improvement plan is monitored via the system CDI Group.

E.coli BSI

There has been an increase of local E.coli BSI cases over the last 3 years mirroring the national picture - the reasons for these increases are currently unknown. However, the most common source of infection is the urogenital tract and therefore targeting urinary tract infections (UTIs) could have a significant impact in reducing the number of E-coli healthcare associated infections. With this in mind, the local UTI Collaborative is delivering the UTI improvement plan across the health and care system with an aim to reduce overall infections. This group recognises the need to continue to share learning in order to reduce the number of avoidable E-coli BSI cases.

Patient Safety Strategy

The NHS Patient Strategy 2020/21 (2019) objective is to help NHS organisations improve patient safety. The CCG continues to progress work in support of core components of this strategy including:

- The implementation of the 'Patient Safety Incident Response Framework' in order to encourage system learning from incidents: The CCG and NCIC have reviewed the implementation of this framework together and are now awaiting further guidance from NHS England to take this forward locally.
- The implementation of the 'Framework for involving patients in their own safety'; the Patient Safety Lead is a member of a national task group that is reviewing how to involve patients in their own safety. The CCG is developing a plan, based on national strategies, with its partners to encourage patients to be become more involved in their own safety journey both in the community and hospital. Patient Stories have also been undertaken in order to learn from experience and thus improve safety.
- The recruitment of Patient Safety Partners: A local project group is currently being established to take this recruitment plan forward.
- The development of the role of Patient Safety Specialists: The CCG named Patient Specialist has actively engaged in the local, regional and national patient safety agenda and is currently evaluating local improvement priorities with their partners.

- The Patient Safety Syllabus training will be completed by all NHS staff. All CCG staff have completed the Patient Safety Syllabus level 1 training and are awaiting national direction on the next steps.

Reducing health inequality

In this section of the Annual Report we summarise some of the work the CCG has undertaken with partners to reduce health inequalities.

Patient Participation Groups (PPGs)

PPGs involve patients working in partnership with practice staff and GPs who meet at regular intervals to discuss a variety of issues effecting patients and the Practice. Unfortunately the Covid pandemic made meeting difficult and a lot of PPGs haven't met during the last 12 months. Some practices are taking this time to review their PPG and look at future development options.

Equality

NHS North Cumbria Clinical Commissioning Group is committed to ensuring an equitable, responsive and appropriate service to all communities in North Cumbria, encouraging and supporting the appropriate use of services and promotion of health and wellbeing and creating a culture where all staff feel valued and where people want to come and work in an inclusive and supportive working environment that encourages development and retention of staff.

In response to Covid-19, NHS England set out an additional 8 urgent actions for local systems to tackle health inequalities, these are:

1. Protect the most vulnerable from Covid-19.
2. Restore NHS services inclusively.
3. Develop digitally enabled care pathways in ways which increase inclusion.
4. Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes.
5. Particularly support those who suffer mental ill health.
6. Strengthen leadership and accountability.
7. Ensure datasets are complete and timely.
8. Collaborate locally in planning and delivering action to address health inequalities.

The Public Sector Equality Duty was temporarily suspended due to Covid. That has now ended and organisations were expected to publish an Equality Report by March 31st 2022.

Covid-19 Response

A group specifically looking at inequalities in relation to Covid-19 vaccinations continued to review vaccination data to identify and target specific groups who were not accessing a Covid-19 vaccination.

Addressing Inequalities – Examples of Good Practice

Vaccine Bus

While there was a range of opportunities for people across North Cumbria to access the Covid vaccine, we know some communities had a lower take up of the vaccine. Working with St John's Ambulance team and the Green Tree pharmacy in Kirkby Stephen and St Paul's Pharmacy in Carlisle we have offered vaccine bus pop-ups at

- Appleby Horse Fair
- Carlisle College
- University of Cumbria, Fusehill Street Campus
- Lakes College, Workington
- Nestle factory (opened to staff and sixth formers at Caldew and the village of Dalston)
- Carlisle United home match

While take up wasn't enormous, the opportunity to have conversations - asking questions about issues which they may be worried about - was highly valuable.

Other Vaccine Initiatives

- Clinics out of hours – weekends and evenings.
- Using the county's local networks to reach agricultural networks, tourism workers, and diverse communities.
- Information focusing on 'we know life is busy but if you haven't booked do it now' shared through the National Farmers Union in the Northwest newsletter and Facebook The Cumbrian Farmer Network.

Information in Alternative Languages and Formats

Making sure information about the Covid-19 vaccine is available in alternative languages and formats has been a priority. Working with other NHS organisations and local authorities across Cumbria we agreed to house the information on our website where it was easily accessible, prioritising the most requested languages in the NHS, and the most common languages accessed by schools.

We also identified local community champions and amplified their messages about vaccine confidence and connected with Multicultural Cumbria and other organisations in Cumbria who are working with communities where English isn't their first language. We are building stronger relationships but have much more to do.

Accessible Information Standard (AIS)

From 1 August 2016 all publicly funded health and social care organisations are legally required to adhere to the standard requirements. This means that all NHS and Social Care Organisations should ask people with disabilities or sensory impairment about their communications and support needs.

We use ReachDeck (a successor to Browsealoud) on our website, offer alternative formats if requested and have vastly increased the amount of information available in alternative languages and continue to provide easyreasd versions where we should. The national Silktide accessibility index places NHS North Cumbria CCG at 6th in the national CCG listings rating us as 'great – 89'.

ASK RECORD FLAG SHARE ACT

Workforce Equality Standards
In accordance with NHS England's requirements, the CCG completed the Workforce Race Equality Standard (WRES) for 2021, providing both data and narrative around race equality issues within the workforce.

Equality Impact Assessment (EIA)
The purpose of an EIA is to ensure that our services, policies and practices do not directly or indirectly, intentionally or unintentionally, discriminate against the users of our services or our staff.

Undertaking an ***Equality Impact Assessment (EIA)*** enables us to consider the impact of each current and proposed service, policy, procedure or function, not only with regard to ethnicity, disability, age and gender, but also in relation to religion and belief, sexual orientation, and human rights. It is designed to ensure that 'due regard' is given to equality in relation to our service users and the manner in which we recruit, train and develop our staff.

Engaging people and communities

The CCG is committed to involving our community in shaping, developing and improving services. We encourage people to work with us and share ideas.

Information detailing all the ways people can get involved can be found on our website here: www.Northcumbriaccg.nhs.uk/get-involved It also describes what we have achieved, how to ask questions, provide feedback and make suggestions.

Many ways for you to get involved

We want the people that use and work in our services to be the ones helping to shape them for the future.

We encourage our community to:
• Provide feedback on your experience of health services

- Receive information and take part in completing surveys and questionnaires
- Join your GP practice Patient Participation Group (PPG)
- Attend public meetings and take part in consultations
- Join forums and workshops looking and contributing to shaping service development
- Join our co-production projects
- Become a member of our local Foundation Trusts.

Covid-19 vaccine programme

The Covid-19 vaccine rollout programme has had real impact across North Cumbria with high rates of take up from the start. A huge part of the success of our Carlisle roll-out was the impact of the St Paul's vaccination centre and the inclusive approach taken by the lead pharmacists on site.

The open access and high visibility of St Paul's meant it was often a focus for media attention and at key stages (as cohorts opened up, as there were calls to get the booster etc…) the team opened their doors to the media. This meant it built confidence within our community – they could see the vaccine being administered, see the queues and see the call to action – understanding you may have to wait, but we will get to you. They saw the hard work of the volunteers from the church and St Johns Ambulance supporting the rollout, and they saw the individual approach taken to those who may have struggled to access the jab.

The team have also supported our vaccination outreach programme focusing on hard to reach groups, working with St John Ambulance, and has included:

- Brunton Park, the home of Carlisle United on match day
- Carlisle College / University of Cumbria
- Factory visits including Nestle and Cavaghan and Gray
- Appleby Horse Fair – traveller community (with Kirkby Stephen pharmacy)
- Hostel accommodation

2021/22 Engagement case study:

LINK (Barnardo's Young People Social Prescribing Service)

The Primary Care Network teams in 3 of our rural Primary Care Networks (PCNs) – Keswick & Solway, Brampton & Longtown and Eden - identified a growing need to support children and young people struggling with a range of issues related to emotional wellbeing. These included social and rural isolation, deprivation, issues around gender identity and sexuality and mental health issues such as low mood and anxiety.

Led by GP Dr Richard Massey, the 3 PCNs partnered with Barnardo's to engage a group of children and young people and co-design the service. This collaborative group then included children and young people in the interview process for the LINK workers.

The LINK service offers a 'non-medical' solution that provides a holistic approach to managing some of the issues young people face today – many of which have been heightened by the challenges faced as a result of the Covid-19 pandemic. Worries and anxiety about isolation, identity, school, exams, and parents and carers working on the frontline have all increased over the last couple of years.

The service for 5-19 year olds was co-designed with local children of primary and secondary school ages who were involved with recruitment, branding and advising on service aims and delivery. LINK practitioners were brought on board to the service in March 2020, the day of the first lockdown.

The LINK team has been dynamic in shaping and delivering a brand new service alongside the young people it supports. The scope of the work that LINK is undertaking is shifting and adapting to meet the needs of the people it serves. Examples of this include well-being drop ins within school communities, the development of an LGBTQ+ co-production group for young people and the volunteer programme that is currently seeing all LINK volunteers actively working directly with young people supporting them.

Colleagues across the 3 PCNs value the service which is easing their workload, but more importantly is ensuring children and young people can be supported through an effective and trusted service.

This team has recently been named The Best Children & Young People's Social Prescribing Project in the UK at the recent Social Prescribing Network Awards 2022, which involves sharing learning through national forums and NHSEI. The local team is working with Barnardo's at a national level so learning from the Cumbria LINK scheme can help shape other projects across the country.

Communications and Engagement

The CCG's communication and engagement activities have continued to have a key focus on:

- Keeping people informed
- Keeping people involved
- Keeping people safe

This is in both relation to the Covid-19 pandemic but also with other services, resources and information. This year has seen us continue to update and focus on the rollout of the vaccination programme, as well as promoting key health messages, managing service expectation and providing timely updates on local and national developments.

Keeping People Informed

The CCG deals with various enquiries from the community and in terms of some of our statutory requirements between **1 April 2021 and 31 March 2022** the CCG has dealt with:

- **215 FOI requests**
- **77 MP enquiries**

Anonymised copies of FOI responses are available to the public through a Disclosure Log on the CCG website.

Social media has continued to be a key communication channel to highlight important information to the people of North Cumbria and media enquiries were also responded to accordingly with the number of our followers continuing to increase.

Engagement has remained a priority during the last challenging 12 months and the CCG continued to use virtual platforms where required.

- Connecting people with the vaccine roll-out in their own community has continued to be one of our most important pieces of work throughout 2021 – 2022 largely through primary care and increasingly through our community pharmacy colleagues.

- The CCG has worked with Multicultural Cumbria to highlight important Covid information to diverse communities and different languages. Multicultural Cumbria is an organisation working with minority communities to share their culture and connect with their neighbours and their community.

- The CCG has continued to support and play a vital role in the West Cumbria Community Forum and the East Cumbria Community Forum which has been meeting jointly on Zoom.

- Members of our Working Together Group have been provided with updates and smaller focused co-production sessions took place around primary care developments helping us

develop our ‘Why is primary care working differently’ posters shared in practices and on social media

- Virtual sessions have also continued to be held with our Patient Participation Group (PPG) Leads around changes to General Practice during the Covid-19 pandemic.

- Our Copeland Community Stroke Prevention Project has continued to work throughout the pandemic with its own Facebook page sharing stroke prevention advice and health improvement tips. It also went ‘old tech’ with banners and leaflets being provided in supermarkets.

- Over the last 12 months the CCG has supported the SEND Special Educational Needs and Disability improvement programme supporting a co-production approach

- Our close work with Healthwatch Cumbria and Cumbria Voluntary Service continued to share vital information through their networks and respond to issues being raised has never been more important.

Find out more about our Communications and Engagement at: www.Northcumbriaccg.nhs.uk/you

Health and wellbeing strategy

The Health and Wellbeing Board exists to provide a mechanism for partners to work better together so that everyone in Cumbria is able to benefit from improvements in health and wellbeing. The Board is formally a committee of Cumbria County Council, and is chaired by the Leader of the Council. The Chairs of NHS North Cumbria CCG and NHS Morecambe Bay CCG are the joint Vice Chairs of the Board.

During 2021/22 the Board has inevitably focused significantly on the supporting the response to the Covid-19 pandemic in Cumbria, and in beginning the collective work for the longer term recovery phase. This has included regular, full update discussions from the Director of Public Health and the two CCG's across all of the issues associated with the pandemic. As a consequence of the pandemic, the Board reviewed and revised its key objectives to incorporate not just improving health and reducing inequalities, but also specifically the additional challenges from Covid-19.

In addition to supporting the challenges from Covid-19, the Board has continued to focus on other important areas, for example:

- Improving services for children, young people and their families relating to SEND (Special Education Needs and Disabilities) with regular reports on progress against the areas identified for improvement following inspection
- Improving integration, for example through the Better Care Fund and Improved Better Care Fund
- Improving population health approaches and ensuring that health inequalities are addressed as part of the recovery and restart programmes. The Health and Wellbeing Board has established a working group to review its priorities and actions through the prism of inequality. The Health and Wellbeing Board has also worked with the Health Equity Commission chaired by Professor Sir Michael Marmot and the findings are intended to inform the work of the Board going forward.
- Improving the longer term sustainability and quality of health and care services, for example the residential and nursing home sector.

Financial review

As with previous years, 2021-22 continued to be challenging as a result of continued pressures on both health and social care funding along with the operational impact of Covid-19. From a financial planning perspective for 2021-22 North Cumbria CCG's plans were prepared in conjunction with the wider North East and North Cumbria Integrated Care System (ICS). The level of financial challenge was recognised with the CCG agreeing a planned deficit with NHS England for 2021-22 although this was off-set by compensating planned surpluses across the ICS. This position recognised that within the NHS financial regime established as part of addressing the Covid pandemic in 2020-21 and 2021-22, a significant majority of the CCG's costs were effectively fixed for the year as a direct consequence of these arrangements.

The CCG has a range of statutory and operational duties and the CCG's performance against these are shown in the table below:

Financial Duties

- Revenue resource use does not exceed the amount specified in Directions - **Not achieved** (Deficit £14.7m)
- 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 year-end cash within 1.25% of monthly drawdown – **Achieved**
- Meet the "Better Payment Practice Code" (95%) – **Achieved**

Statutory Financial Duties

There are the following statutory (legal) financial duties for CCGs, as follows:

a) **Revenue resource use does not exceed the allocation (Break-even duty)**
This duty requires the CCG to report a surplus position (i.e. to spend less than the allocated funding). The CCG achieved an in-year financial deficit of £14.7m which is slightly greater than the originally planned £13.99m deficit, and was agreed by NHSE and off-set by increased surpluses across the ICS. This change was as a consequence of addressing a number of historical, non-recurring issues prior to the formation the North East & North Cumbria ICB planned for July 2022.

b) **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 allowance. This allocation for 2021-22 was £6.2m, with the CCG spending £5.9m on running costs; the balance was invested in patient care.

c) **Capital resource use does not exceed the amount specified in Directions**

The CCG received no capital resource in 2021-22.

Administrative Financial Duties

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

d) Manage cash within 1.25% of monthly drawdown

The CCG is required to have a cash balance at the end of the year no greater than 1.25% of the March cash drawdown. The CCG met this requirement.

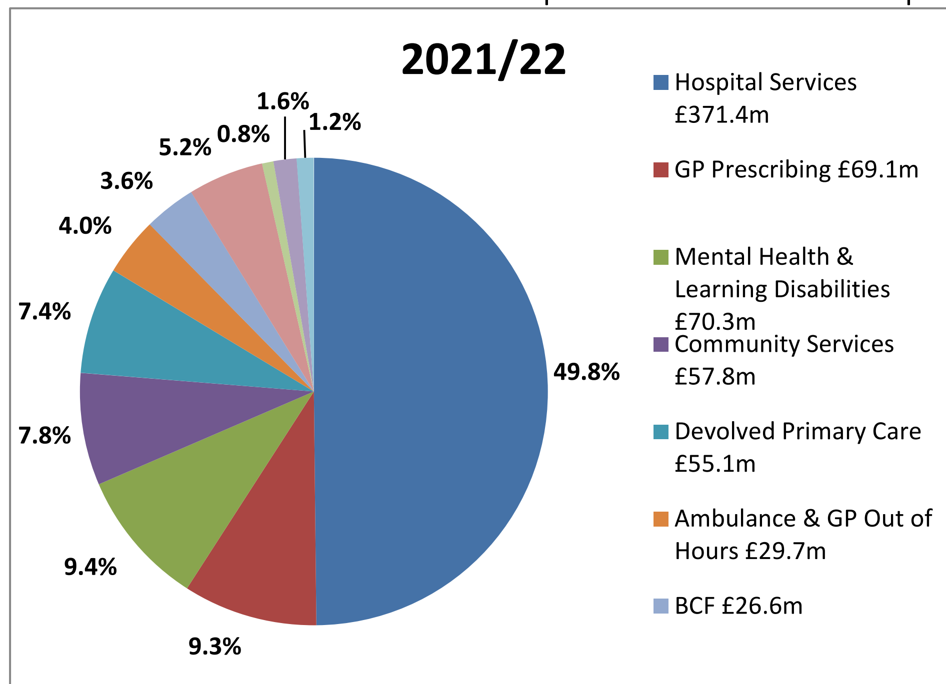
e) Better Payment Practice Code (BPPC)

The BPPC 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 2021/22 the CCG, on average, paid over 99% of invoices by both number and value in compliance with the code.

How was the money spent in 2021-22?

The CCG works hard to ensure that the revenue allocation it receives is spent wisely, and that it supports the aim of commissioning high quality healthcare whilst ensuring effectiveness and value for money.

The chart below shows how the CCG's expenditure of £745.4m was spent:



The accounts have been prepared under a Direction issued by NHS England under the National Health Service Act 2006 (as amended).

A full breakdown of our annual accounts is included as **Part3**.

Statement of Going Concern

The CCG's accounts have been prepared on the going concern basis.

Public Sector bodies are assumed to be a going concern where the continuation of the provision of services in the future is anticipated. The CCG has been formally notified of its financial allocations for 2022-23 which shows an increase in funding year on year. An NHS body will only have concerns about its going concern status if there is the prospect of services ceasing altogether in the future by itself or another public sector entity. The CCG has not been dissolved and its services continue to be provided up to 30 June 2022. The Health and Care Bill was introduced into the House of Commons on 6 July 2021 and received Royal Assent on 28 April 2022. The Bill allows for the establishment of Integrated Care Boards (ICB) across England form 1 July 2022 and all clinical commissioning groups (CCGs) will be abolished on 30 June 2022. The ICBs will take on all the CCG functions, assets and liabilities.

Conclusion

The CCG has experienced a very challenging financial year and continues to work closely with partners in the North Cumbria and across the wider North East and North Cumbria system to deliver a financially sustainable health and social care system for the area.

ACCOUNTABILITY REPORT

Mark Adams
Accountable Officer
17 June 2022

Corporate Governance Report

Directors' and Members' Report

The Directors and Members' Report has been provided by the Governing Body and provides an overview of GP practices which are members of the CCG, the composition of the Governing Body, the Director Team, GP Leadership and Lay Representatives. It includes a biography of members of the Governing Body, Directors and Lead GP's working with the CCG and other key points of interest. It also details who the Primary Care Networks (PCN) Clinical Directors were for 2021/22.

Each individual, who is a member of the Governing Body at the time this Report is approved, confirms so far as the member is aware that there is no relevant audit information of which the CCG's external auditor is 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.

The Annual Report and Accounts as a whole is fair, balanced and understandable and I take personal responsibility [for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable] to ensure that those requirements are met.

The table below provides details of the Chair and Accountable Officers during 2021/22 and up to the signing of the Annual Report & Accounts.

Name	Designate	Commencement date
Jon Rush	Lay Chair	1 April 2017
Mark Adams	Accountable Officer	1 April 2020

Member profiles

Our Member Practices

NHS North Cumbria CCG is a clinically-led organisation which brings together 35 local GP Practices and other health professionals to plan and design services to meet local patients' needs. Our member practices are:

Practice Name	Practice Code	Address
Alston Medical Practice	A82004	The Surgery Cottage Hospital Alston Cumbria CA9 3QX
Appleby Medical Practice	A82006	The Riverside Building Chapel Street Appleby Cumbria CA16 6QR
Aspatria Medical Group	A82055	Aspatria Medical Group West Street Aspatria Cumbria CA7 3HH
Birbeck Medical Group	A82035	Penrith Health Centre Bridge Lane Penrith Cumbria CA11 8HW
Brampton Medical Practice	A82012	4 Market Place Brampton Cumbria CA8 1NL
Caldbeck Surgery	A82014	Friar Row Caldbeck Wigton Cumbria CA7 8DS
Carlisle Healthcare	A82016	Carlisle Healthcare Spencer House St Paul's Square Carlisle CA1 1DG

Practice Name	Practice Code	Address
Castlegate & Derwent Surgery	A82021	Cockermouth Community Hospital & Health Centre Isel Road Cockermouth Cumbria CA13 9HT
Castlehead Medical Centre	A82028	Ambleside Road Keswick Cumbria CA12 4DB
Court Thorn Surgery	A82631	Low Hesket Carlisle Cumbria CA4 0HP
Dalston Medical Group	A82022	Townhead Road Dalston Cumbria CA5 7PZ
Distington Surgery	A82023	Hinnings Road Distington Cumbria CA14 5UR
Eden Medical Group	A82020	Port Road Carlisle Cumbria CA2 7AJ
Fellview Healthcare Ltd	A82044	Cleator Moor Health Centre Birks Road Cleator Moor CA25 5HP
Fusehill Medical Practice	A82019	Fusehill Medical Centre Fusehill Street Carlisle Cumbria CA1 2HE
Glenridding Health Centre	A82620	Greenside Road Glenridding Cumbria CA11 0PD
James Street Group Practice	A82047	James Street Workington Cumbria CA14 2DL

Practice Name	Practice Code	Address
Kirkoswald Surgery	A82617	Ravenghyll Kirkoswald Cumbria CA10 1DQ
Longtown Medical Practice	A82646	Longtown Medical Centre Moor Road Longtown Cumbria CA6 5XA
Lowther Medical Centre	A82041	1 Castle Meadows Whitehaven Cumbria CA28 7RG
Mansion House Surgery	A82075	19/20 Irish Street Whitehaven Cumbria CA28 7BU
Maryport Group Practice	A82032	Alneburgh House Ewanrigg Road Maryport Cumbria CA15 8EL
Queen Street Medical Practice	A82058	Richard Benedict House 149 Queen Street Whitehaven Cumbria CA28 7BA
Seascale Health Centre	A82024	Gosforth Road Seascale Cumbria CA20 1PN
Shap Medical Practice	A82031	Shap Health Centre Peggy Nut Croft Shap Cumbria CA10 3LW
Silloth Group Medical Practice	A82037	Lawn Terrace Silloth-on-Solway Cumbria CA7 4AH

Practice Name	Practice Code	Address
Spencer Street Surgery	A82018	10 Spencer Street Carlisle Cumbria CA1 1BP
Temple Sowerby Medical Practice	A82038	Linden Park Temple Sowerby Cumbria CA10 1RW
The Croft Surgery	A82029	Kirkbride Cumbria CA7 5JH
The Lakes Medical Practice	A82036	Penrith Health Centre Bridge Lane Penrith Cumbria CA11 8HW
Upper Eden Medical Practice	A82013	The Health Centre Silver Street Kirkby Stephen Cumbria CA17 4RB
Warwick Road Surgery	A82015	65 Warwick Road Carlisle Cumbria CA1 1EB
Warwick Square Group Practice	A82654	Warwick Square Carlisle Cumbria CA1 1LB
Westcroft House	A82064	66 Main Street Egremont Cumbria CA22 2DB
Wigton Group Medical Practice	A82045	Southend Wigton Cumbria CA7 9QD

There have been no changes in the number of practices in 2021/22.

Governing Body, GP Leads, Clinical Leaders and Lay Representative profiles

The Governing Body is responsible for ensuring that the CCG has appropriate arrangements in place to exercise its functions efficiently and economically and in accordance with the principles of good governance. It is made up of a membership that includes doctors and healthcare professionals, clinical and lay members.

Full details of the CCG's committee structures, roles and responsibilities and an overview of the year's work coverage can be found in the Annual Governance Statement contained in this document.

The CCG's Register of Interests for 2021/22 can be viewed in full on the CCG's website.

Governing Body Members

During 2021/22 there has not been a review of the Membership of the Governing Body. This decision was taken in light of the Government White Paper to transfer CCGs responsibilities to an Integrated Care System (ICS). Therefore, it is envisaged that the CCG will cease to exist from 30 June 2022, subject to the relevant legislation being passed.

Name & Biography	Position	Governing Body and Wider System Committees
Mark Adams – is also the Chief Officer of NHS Newcastle Gateshead, North Tyneside and Northumberland Clinical Commissioning Groups. He is also a lead for the North of Tyne and Gateshead ICP.	Accountable Officer	Executive Committee North Cumbria Integrated Care Partnership (ICP) Leaders Board ICP Executive Group Northern CCG Joint Committee
Dr Amanda Boardman - supports GPs to enable effective safeguarding and provides clinical leadership in developing children's services.	GP Lead for Safeguarding, Maternity, Children, Mental Health and Learning Disability	Executive Committee
Dr Gareth Coakley – is a GP at Longtown Medical Centre and was appointed to the role November 2018.	Chief Clinical Information Officer	Executive Committee

Name & Biography	Position	Governing Body and Wider System Committees
Carole Green - has almost 30 years of health management experience, working at senior levels both in the UK and internationally in health and social care, plus experience in the private sector.	Lay Member for Quality and Performance	Audit Committee Auditor Panel Finance & Performance Committee Outcomes & Quality Assurance Committee (Chair) Primary Care Commissioning Committee Remuneration Committee
Dr Helen Horton – is partner of Distington Surgery and was appointed to her role at the CCG in September 2015.	GP Lead for Commissioning	Executive Committee
Dr Deb Lee - is a former paediatrician who worked at the West Cumberland Hospital and following retirement has continued to be North Cumbria's designated doctor for reviewing child death. In addition she has been part of the North Cumbria Health & Care Working Together Group.	Secondary Care Doctor	Finance & Performance Committee Outcomes & Quality Assurance Committee Remuneration Committee
Denise Leslie – is a former teacher and has been involved in community healthcare delivery in Greater Manchester for the last 10 years.	Lay Member for Patient and Public Engagement	Audit Committee Auditor Panel Finance & Performance Committee Outcomes & Quality Assurance Committee Primary Care Commissioning Committee Remuneration Committee
Louise Mason Lodge – is a registered nurse and has worked in a variety of clinical, partnership and leadership roles.	Director of Nursing & Quality and Registered Nurse on the Governing Body	Outcomes & Quality Assurance Committee Executive Committee ICP Executive Group
Dr Colin Patterson – was previously a GP at the Carlisle Healthcare and has a special interest in	Clinical Lead/Acting Medical Director & Deputy Chair	Executive Committee Primary Care Commissioning Committee – Non Voting Member ICP Executive Group

Name & Biography	Position	Governing Body and Wider System Committees
cancer services and primary care.		
Peter Rooney – is responsible for ensuring the effective functioning of the CCG and has a focus on internal/external relationships and performance.	Chief Operating Officer	Executive Committee Finance & Performance Committee ICP Executive Group ICP Leaders Board
Jon Rush - was a Chief Superintendent with Greater Manchester Police and had spent 24 years working for Cumbria Constabulary. Initially the Lay Member for Patient Engagement and became the Lay Chair on 1 April 2017.	Lay Chair	Full Council of Members (Non- voting Chair) Finance & Performance Committee (Chair) Primary Care Commissioning Committee (Chair) Northern Joint CCG Committee (Chair) ICP Leaders Board (Chair)
Ed Tallis - has been involved with the NHS for over 30 years. All of his roles have had patient care at the forefront and his role as Director of Primary Care brings all of this experience and knowledge together, to support the CCG in achieving its goals.	Director of Primary Care	Primary Care Commissioning Committee Executive Committee ICP Executive Group
Charles Welbourn - was previously Deputy Director of Finance in the former NHS Primary Care Trust before securing his post upon the commencement of the CCG in 2013.	Chief Finance Officer	Executive Committee Finance & Performance Committee Primary Care Commissioning Committee ICP Executive Group
John Whitehouse – is a qualified public finance accountant. In a career spanning 36 years he	Lay Member Finance and Governance &	Audit Committee (Chair) Auditor Panel (Chair) Finance & Performance Committee Remuneration Committee (Chair) ICP Leaders Board

Name & Biography	Position	Governing Body and Wider System Committees
has worked in local government, the private sector and the NHS.	Conflict of Interest Guardian	

Lead GPs

All the CCG's Lead GPs are Members of our Governing Body and their details are provided in the Governing Body Membership table above.

Integrated Care Communities (ICCs) GP Leads – Primary Care Network Clinical Directors

In 2019 Primary Care Networks (PCNs) were established to work together to focus on local patient care. This expanded on the work that the CCG's had been doing with its ICC GP Leads and this work has been ongoing throughout 2021/22. The PCN Clinical Directors for 2021/22 were as follows:

Name	PCN
Mark Alban	Carlisle Rural
Alex Docton	Carlisle Network
Alan Edwards	Carlisle Healthcare
Robert Westgate	Carlisle Healthcare
Cherryl Timothy-Antoine	Workington
Celia Heasman	Copeland
Eve Miles	Copeland
Richard Massey	Keswick & Solway
Simon Desert	Cockermouth & Maryport
Matt Dombrowsky (until 31 March 2022)	Cockermouth & Maryport
Mark Kinghan (from 1 April 2022)	Cockermouth & Maryport
Helen Jervis	Eden
Shonagh Speed-Andrews	Eden

Clinical Leaders

Name & Biography	Position	Governing Body Committees
Dr Nicola Cleghorn - is an experienced Community Paediatrician with special interest in Safeguarding Children and Young People in Forensic Paediatrics.	Designated Doctor for Safeguarding Children	None

Helena Gregory – supporting primary care clinicians with quality, safety and cost- effectiveness of prescribing.	Medicines Lead	None

Senior Management Arrangements

Mark Adams, Louise Mason Lodge, Peter Rooney, Ed Tallis and Charles Welbourn are also part of the Senior Management Team and their details are provided in the Governing Body Membership table above.

Name & Biography	Position	Governing Body Committees
Anita Barker - Anita has a General Practice background before moving into a commissioning role. Anita currently leads the wider commissioning team as well as working on a number of county wide and regional work-streams.	Deputy Director of Commissioning	None
Suzanne Hamilton – an experienced Organisational Development leader and coach who manages the Cumbria Learning and Improvement	Head of Improvement and Development	None

Register of Interests

The CCG annually updates its Decision Makers Register of Interests in line with the latest statutory guidance from NHS England and can be viewed at https://northcumbriaccg.nhs.uk/about-us/declarations-interest . The Lay Member for Finance & Governance and Audit Committee Chair, John Whitehouse, is the CCG's Conflicts of Interest Guardian.

Additional Disclosures

Personal data related incidents

The Information Governance (IG) Team has not recorded any IG incidents between 1 April 2021 and 31 March 2022.

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.

Modern Slavery Act

The Modern Slavery Act 2015 has introduced changes in UK law focused on increasing transparency in supply chains, to ensure our supply chains are free from modern slavery (that is, slavery, servitude, forced and compulsory labour and human trafficking). As both a local leader in commissioning health care services for the population of North Cumbria and as an employer the CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking and has produced a statement in respect of its commitment to, and efforts in, preventing slavery and human trafficking practices in the supply chain and employment practices.

The statement was reviewed and the Governing Body approved it on 17 March 2022 and the revised version can be found on the CCG's website.

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). Mark Adams was appointed as the Interim Accountable Officer on 1 April 2020 after the retirement of his predecessor. After a formal appointment process NHS England confirmed his permanent appointment as Accountable Officer on 1 June 2020.

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

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

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

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and Social Care 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 Group Accounting Manual issued by the Department of Health and Social Care have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

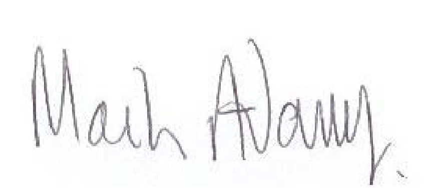
To the best of my knowledge and belief, and subject to the disclosures set out below, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Disclosures:

- The CCG has not met its statutory requirement '223H(1) Expenditure not to exceed income' for 2021/22. A formal notification of this position will be made by the CCG's external auditors, Grant Thornton UK LLP, to the NHS Commissioning Board (NHS England) in June 2022. A referral to the Secretary of State under Section 30a of the Local Audit and Accountability Act 2014 will also be made at the same time (and will be detailed in note 2 of the Annual Accounts).

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the Clinical Commissioning Group'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 Clinical Commissioning Group's auditors are aware of that information.



Mark Adams
Accountable Officer
17 June 2022

Governance Statement

Introduction and context

CCG's became corporate bodies established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended). NHS North Cumbria CCG came into being on the 1 April 2017 following a boundary change which saw the southern part of the previous NHS Cumbria CCG, join with NHS North Lancashire CCG, to create NHS Morecambe Bay CCG. NHS North Cumbria CCG covers the areas of Allerdale, Eden, Carlisle and most of Copeland.

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

As of 1 April 2021, the CCG was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

The Clinical Commissioning Group has not met the statutory requirement '223H(1) Expenditure not to exceed income' as the actual 2021-22 expenditure performance is £14.696m over the income received. A formal notification of this position will be made by the CCG's external auditors, Grant Thornton UK LLP, to the NHS Commissioning Board (NHS England) in May 2022. A referral to the Secretary of State under Section 30a of the Local Audit and Accountability Act 2014 will also be made at the same time. This breach of financial duties is detailed in note 2 to the accounts which shows the CCG has reported a deficit of £14.696m in 2021-22 against a planned deficit of £13.992m.

Scope of responsibility

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

I am responsible for ensuring that the CCG 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 CCG as set out in this governance statement.

Governance arrangements and effectiveness

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

Compliance with UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, the CCG considers that compliance is good practice and strives through its leadership and governance arrangements to ensure it meets the main principles of the Code.

This has been demonstrated by:

- Leadership – the CCG has worked across the system to ensure that effective leadership was in place during 2021/22 especially in light of the continuing Covid-19 pandemic. Working closely with the CCG's partnership organisations across North Cumbria and the North East to further develop an Integrated Care System (ICS) and, in the North Cumbria Integrated Care Partnership (ICP). The CCG's Accountable Officer attends the ICS Management Group and the Health Strategy Group in the North East. The CCG's Chair and Chief Operating Officer attend the Cumbria Health & Wellbeing Board and the CCG's Chair, Accountable Officer, Chief Operating Officer and Lay Member for Finance & Governance are also members on the North Cumbria ICP Leaders Board.

- Effectiveness – During 2021/22 the CCG has continued to review its effectiveness and to support the development of both the ICS and ICP. Working with its partners across the health system it reviews the requirements across the ICP and where possible, provides resources to support improvements or to cover for staff vacancies. There has also been pooled resources during the peak of the pandemic to ensure that support was continued to be provided across the ICS to ensure hospital flows and discharges were managed.

- Accountability – The Governing Body receives regular updates and assurance from its committees to enable it to have an understandable assessment of the CCG's position and prospects. This has included monthly updates on the pandemic and the impact on services across the ICS. Alongside of this, the CCG's risk assurance framework has been fully reviewed and updated to provide the Governing Body with a clear understanding of its main risks to achieving its strategic objectives. There has also been a significant amount of work undertaken across both the ICS and ICP in response to the COVID-19 pandemic, which escalated in March 2020 and continued throughout both the 2020/21 and 2021/22 financial years.

- Remuneration - The CCG works within the Agenda for Change framework for the remuneration of its employees. For Very Senior Officers (VSM's) the Remuneration Committee ensures it has a formal and transparent process for determining the

remuneration packages of these officers. This includes evaluating the requirements of the post and undertaking comparisons with like for like organisations to ensure that the CCG retains professional, high quality officers.

- Relations with Stakeholders – Throughout 2021/22 the CCG has continued to work closely with its stakeholders while ensuring we have followed Covid-safe guidance and safety measures. It has been important to keep community leaders and networks informed during the pandemic and to ensure stakeholders have access to trusted and timely information. This has been mainly through remote technology such as Zoom and Teams.

Through the narrative within this Annual Governance Statement, the Annual Report and Accounts, the CCG has described how it has fulfilled the main principles of the Code specifically in relation to leadership, effectiveness, accountability, remuneration and its relationship with stakeholders. For the financial year ending 31 March 2022, and up to the date of signing this statement, the CCG has applied the principles of the Code that are directly relevant, and via this Annual Governance Statement, Annual Report and Accounts, demonstrated how it has discharged its responsibilities.

The CCG's Constitution

The CCG has a Constitution which has been agreed by its Member Practices. It sets out the arrangements it has in place to enable the CCG to undertake its responsibilities for commissioning care for the people for whom it is responsible.

It describes the governing principles, rules and procedures that ensure probity and accountability in the day to day running of the CCG to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to its goals.

In accordance with section 14L (2) (b) of the 2006 Act (as amended), section 4.4.3 of the CCG's Constitution reflects that, throughout each year, the Governing Body has had an ongoing role in reviewing the CCG's governance arrangements to ensure that the CCG continues to reflect the principles of good governance. These include:

- The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
- The Good Governance Standard for Public Service
- The standards of behaviour published by the Committee on Standards in Public Life (1995) known as the 'Nolan Principles';
- The Seven Key principles of the NHS Constitution;
- The Equality Act 2010
- The Bribery Act 2010
- NHS Counter Fraud Authority Requirements

The CCG's Constitution is a living document and has been reviewed regularly throughout 2020/21 and 2021/22, especially in light of the pandemic. Emergency measures were approved by the Governing Body in April 2020 and remained in place until 31 March 2022. These are referenced below:

National guidance/Constitution, Standing Orders and Scheme of Delegation

Due to the pandemic and in line with the NHS England/Improvement (NHSE/I) guidance (C0113) around reducing the burden and releasing capacity dated 28 March 2020, the CCG initially stood down some of its scheduled committees and "business as usual" arrangements. It also reviewed its Governance Arrangements at its Governing Body meeting on 16 April 2020 and approved a number of changes to its Scheme of Delegation to enable quick and effective decision making whilst dealing with a pandemic. These included:

- Using the provision in 6.2 of the CCG's Standing Orders for Emergency Powers and Urgent Decisions. Any decisions taken under these rules would be ratified by the Governing Body at its next meeting.
- The Chief Operating Officer was designated the Accountable Emergency Officer and, if necessary, was authorised to take any urgent response/decision if the emergency arrangements specified above could not be enacted. Again any decisions taken under this rule would be ratified by the Governing Body at its next meeting.
- The Governing Body would continue to meet bi-monthly but all other meetings would either be stood down or held by exception.
- With the COVID-19 situation, changes were made to the CCG's scheme of Delegation which included an increase in authorisation level for a number of individuals to deal with packages of care, receipting invoices etc.

The full details of this report can be found on the CCG's website along with the minutes outlining the approval given. The CCG's Standing Orders were also updated with the changes and have been published on the CCG's website.

The above changes have been reviewed by the Governing Body on a regular basis throughout 2021/22 and remained in place until 31 March 2022. It was also agreed that in light of the CCG ceasing to exist from 30 June 2022, (subject to the final legislation being approved), there would not be a review of the CCG's Constitution in 2021/2022.

Members Information

The Membership information is updated regularly. The CCG currently has 35 Member Practices and the details have been included in the Corporate Governance Report above.

Committee Changes

There has been no changes to any of the CCG's Committees in 2021/22. This was due to the fact that it was envisaged that the CCG would cease to exist from 31 March 2022. However, in December 2021, this was pushed back to 30 June 2022 as the approval of the final legislation had been delayed.

It should also be noted that a number of committees were stood down throughout 2020/21 and 2021/22 during peaks in the pandemic to release capacity.

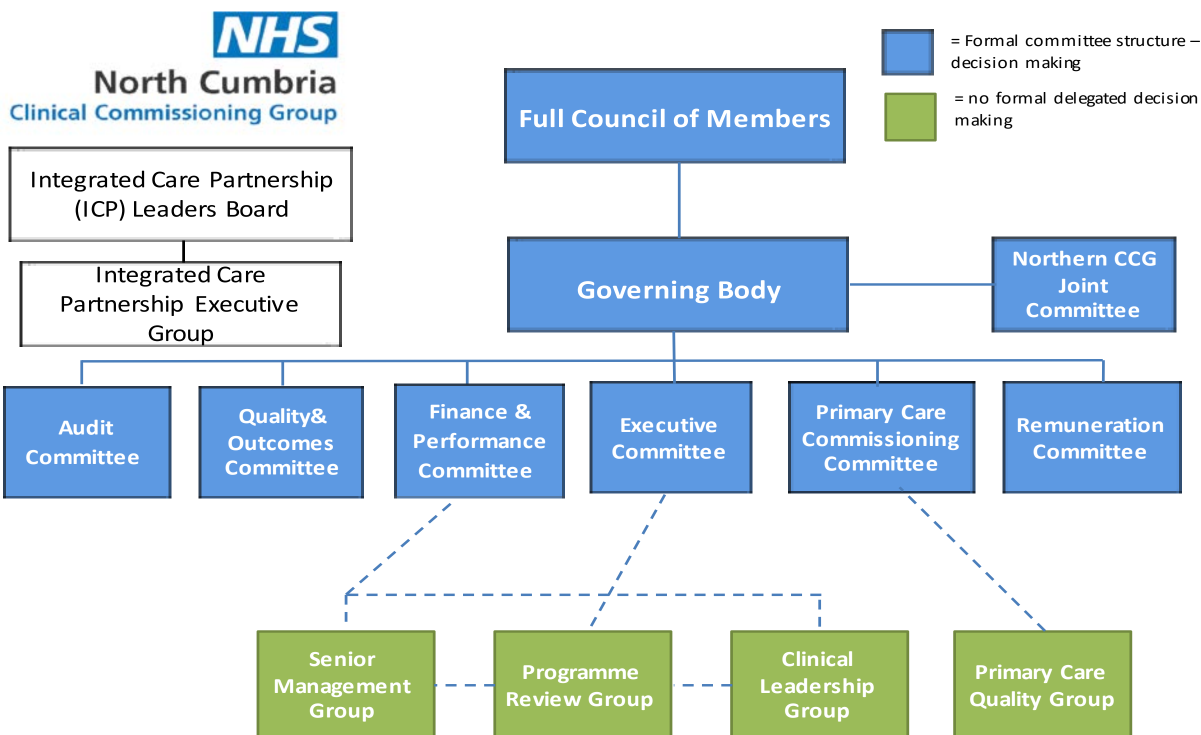
The CCG has also been heavily involved, via various work streams, to support the development of the Integrated Care Board Constitution and its committees along with ensuring that due diligence is managed effectively for the close down of the CCG.

Full Council of Members, Governing Body and the Committee Governance Structure

The CCGs governance meeting structure is headed by the Full Council of Members and it has reserved a small number of functions to itself (these are outlined in Section J, 1.1. to 1.5 of the CCG's Scheme of Delegation which can be found in its Standing Orders on the CCG's website). The Governing Body has accountability to undertake the roles and responsibilities as delegated through the Constitution approved by the Member Practices which constitute the CCG.

The NHS Constitution requires NHS organisations to involve the public when considering how it provides services. Healthwatch Cumbria facilitates a local forum where Clinicians and Directors from partners in the North Cumbria Integrated Care Partnership (ICP) meet regularly with members of the public and third sector groups. These are then actively involved in working on initiatives that are supported by the Action for Health network run by the local CVS. The CCG has also continued with its work on co-production, working with its communities to help shape service changes in North Cumbria. This has included establishing a network within which information can be shared, feedback can be sought and new ideas can be developed together. This has strengthened valuable links with the CCG's communities, and despite the pandemic it has been able to keep community leaders and networks informed and to ensure stakeholders have access to trusted and timely information.

The committee structure that has been established to support the Governing Body in fulfilling its functions is detailed in below:



The Membership, Attendance and Activity Summary

Full Council of Members
Role and Performance Highlights 2021/22

The Full Council of Members is an arena in which all member practices have the opportunity to come together to:

- 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
- approve the CCG's Constitution
- ensure that the Governing Body has published its Annual Reports and Accounts

The Full Council met twice in 2021/22. The CCG has, through its Primary Care Team, worked in conjunction with the Clinical Director Teams in the Primary Care Networks to ensure that our Member Practices have been included in the development work to continue to support the system through this pandemic and been updated on the White Paper proposals for the creation of the North East and North Cumbria Integrated Care System and the closedown of the CCG.

Performance/highlights include:

- Journey from Clinical Commissioning Group to Integrated Care Board
- Primary Care Networks / General Practice Provider Collaborative updates

Membership Practice	Name of Representative & Role	Attendance *(2 meetings held)*
Alston Medical Practice	No representatives attended	0
Appleby Medical Practice	Dr Shonagh Speed-Andrews - GP	1
Aspatria Medical Group	Dr Julie Saxton – GP Dr Shihani Elayakumar - GP	2 1
Birbeck Medical Group	Amanda Riley - PM	2
Brampton Medical Practice	No representatives attended	0
Caldbeck Surgery	Dr. Richard Massey – GP	2
Carlisle Healthcare	No representatives attended	0
Castlegate & Derwent Surgery	No representatives attended	0
Castlehead Medical Centre	No representatives attended	0
Court Thorn Surgery	No representatives attended	0
Dalston Medical Group	No representatives attended	0

Membership Practice	Name of Representative & Role	Attendance *(2 meetings held)*
Distington Surgery	Dr. Helen Horton – GP Dr. Heather Naylor - GP	2 1
Eden Medical Group	No representatives attended	0
Fellview Healthcare Ltd	No representatives attended	0
Fusehill Medical Practice	No representatives attended	0
Glenridding Health Centre	No representatives attended	0
James Street Group Practice	Dr Cheryl Timothy-Antoine - GP	1
Kirkoswald Surgery	No representatives attended	0
Longtown Medical Practice	Dr Gareth Coakley - GP	1
Lowther Medical Centre	No representatives attended	0
Mansion House Surgery	No representatives attended	0
Maryport Group Practice	Dr Dan Berkeley - GP	1
Queen Street Medical Practice	No representatives attended	0
Seascale Health Centre	No representatives attended	0
Shap Medical Practice	Dr Hannah Judson - GP	1
Silloth Group Medical Practice	No representatives attended	0
Spencer Street Surgery	Julie Swan - PM	2
Temple Sowerby Medical Practice	Paula Breen - PM Anna Sives - PM	1 1

Membership Practice	Name of Representative & Role	Attendance *(2 meetings held)*
The Croft Surgery	No representatives attended	0
The Lakes Medical Practice	Samantha Gargett - PM	1
Upper Eden Medical Practice	No representatives attended	0
Warwick Road Surgery	No representatives attended	0
Warwick Square Group Practice	No representatives attended	0
Westcroft House	No representatives attended	0
Wigton Group Medical Practice	No representatives attended	0
Attendees		
North Cumbria Primary Care Alliance	Professor John Howarth - Chief Executive Officer Medical Director Karen Morrell - Managing Director Joanne Percival	2 1 1
Governing Body Members	Mark Adams – Accountable Officer Amanda Boardman – County Lead GP Children and Safeguarding Carole Green – Lay Member for Quality & Performance Denise Leslie – Lay Member for Public Engagement Louise Mason Lodge – Director of Nursing & Quality Colin Patterson – Interim Medical Director/Clinical Lead/Deputy Chair Jon Rush – Lay Chair (Non-voting Chair) Peter Rooney – Chief Operating Officer Ed Tallis – Director of Primary Care Charles Welbourn – Chief Finance Officer	2 1 2 2 2 2 2 1 2 1
CCG Team	Ann-Marie Grady – Primary Care Development Lead Gemma Bowe – Senior Administrator Primary Care Brenda Thomas – Governing Body Support Officer	2 1 2

*   Please note:

• that where there was more than one representative attending, only one representative counted towards the meeting being quorate
• PM = Practice Manager

Governing Body
Role and Performance Highlights 2021/22

The Membership of the Governing Body is outlined in the Accountability section of this report.

The prime focus of the Governing Body is to ensure that 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 whilst remaining true to its vision and values.

In addition to its core business the Governing Body has effectively overseen the following key areas of work. Please note this list is not exhaustive and business transacted and the decisions taken by the Governing Body in 2021/22 can be found on the CCG's website.

Performance/highlights:-

- The CCG's
    - Assurance Framework
    - Modern Slavery Statement
    - Annual Reports and Annual Accounts (AGM)
- COVID-19 Responses and Updates
- North East & North Cumbria Integrated Care Board (ICB) Plans, Strategies and Workforce
- Annual Reports, including the CCG's Safeguarding and Cumbria Learning and Improvement Collaborative (CLIC)
- Quality Reports
- Performance Reports
- Finance Reports
- North Cumbria Integrated Health Care NHS Foundation Trust (NCIC) Care Quality Commission (CQC) Action Plan
- Learning Disability Mortality Review (LeDeR) Annual Report
- Maternity Services – Ockenden Review and Workforce

The Governing Body has had 8 formal meetings during the said period and attendance records demonstrate that all meetings were quorate.

The Governing Body discharged its duties in full in 2021/22.

Name	Role	**Attendance** *(8 meetings held)*
Mark Adams	Accountable Officer	8
Dr Amanda Boardman	GP Lead for Safeguarding, Maternity, Children, Mental Health and Learning Disability	6
Dr Gareth Coakley	Chief Clinical Information Officer	5
Carole Green	Lay Member for Quality & Performance	7
Dr Helen Horton	GP Lead for Commissioning	4
Deb Lee	Secondary Care Doctor	8
Denise Leslie	Lay Member for Public Engagement	4
Louise Mason Lodge	Director of Nursing & Quality and Registered Nurse on the Governing Body	7
Jon Rush	Lay Chair (Chair)	7
Dr Colin Patterson	Interim Medical Director/Clinical Lead/Deputy Chair	6
Peter Rooney	Chief Operating Officer	8
Ed Tallis	Director of Primary Care	8
Charles Welbourn	Chief Finance Officer	8
John Whitehouse	Lay Member for Finance & Governance	7
Observers at Public Meetings		
David Blacklock	Healthwatch, Cumbria	4

Name	Role	Attendance *(8 meetings held)*
Toni Phillips	Local Medical Council	3

Audit Committee
Role and Performance Highlights 2021/22

The Audit Committee is responsible for the CCG's governance and risk management process controls and internal control arrangements.

The Committee met four times throughout 2021/22 and attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights include: Please note this list is not exhaustive and the minutes of this Committee outlining the business transacted for 2021/22 can be found in the Governing Body papers on the CCG's website.

- Internal Auditors Assurance on planned work programmes which included (please note this is not an exhaustive list):
    - Governance structures and risk management arrangements
    - Conflicts of interest/Openness and honesty/Standards of Business Conduct
    - Data security and protection toolkit
    - Primary medical care commissioning
    - Commissioning, Contract and performance monitoring
    - Key financial controls
    - Continuing Health Care and Funded Nursing Care

- Internal Auditor Assurance on Counter Fraud
- Assurance on year end processes including the production of the Annual Report and Accounts

Members Name	***Role***	***Attendance*** *(4 Meetings held)*
Carole Green	Lay Member for Quality & Performance	4
Denise Leslie	Lay Member for Public Engagement	3

Members Name	*Role*	*Attendance (4 Meetings held)*
John Whitehouse	Lay Member for Finance & Governance (Chair)	4

Auditor panel
Role and Performance Highlights 2021/22

The prime responsibility of the Auditor Panel is to advise the CCG on the selection, appointment and removal of the CCG's external auditors and ensures that the proposed contractual arrangements are appropriate.

The panel has not met during 2021/22.

Members Name	*Role*	*Attendance*
Carole Green	Lay Member for Quality & Performance	No meetings held
Denise Leslie	Lay Member for Public Engagement	
John Whitehouse	Lay Member for Finance & Governance (Chair)	

Executive Committee
Role and Performance Highlights 2021/22

The Committee's key objective is to support the CCG, the Governing Body and the Accountable Officer in the discharge of their functions. It will assist the Governing Body in its duties to promote a comprehensive health service, reduce health inequalities and promote innovation. Its remit includes development and implementation of strategy, monitoring and delivery of statutory duties, operational, financial, contractual and clinical performance. It is responsible for ensuring effective clinical engagement and promoting the involvement of all member practices in the work of the CCG in securing improvements in commissioning of care and services along with the on- going development of primary care through Primary Care Networks and the associated Integrated Care Communities.

This Committee has met 12 times in 2021/2022 and the attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights include: Please note this is not an exhaustive list. The business transacted and decisions taken by this committee can be found on the CCG's website

- Covid-19 updates
- 5 Key System wide priorities, CCG Priorities and OGIMs (Objectives, Goals, Initiative & Measures)
- Quality & Performance Reports
- Finance Reports
- Clinical Priorities
- 2021/22 Planning Submission
- Integrated Care System/Integrated Care Partnership Updates
- Waiting Well
- Strategic Mental Health Memorandum of Understanding
- Primary Care Workforce Strategy
- Governing Body Assurance framework
- Risk Register

Members Name	***Role***	***Attendance*** *(12 Meetings held)*
Mark Adams	Accountable Officer (Chair)	8
Dr Amanda Boardman	GP Lead for Safeguarding, Maternity, Children, Mental Health and Learning Disability	11
Dr Gareth Coakley	Chief Clinical Information Officer	10
Dr Helen Horton	GP Lead for Commissioning	7
Louise Mason Lodge	Director of Nursing & Quality	9
Dr Colin Patterson	Lead GP	7
Peter Rooney	Chief Operating Officer	9
Ed Tallis	Director of Primary Care	11
Charles Welbourn	Chief Finance Officer	11

Finance & Performance Committee
Role and Performance Highlights 2021/22

The core aims and responsibilities of the Finance & Performance Committee is to provide assurance to the Governing Body on the CCG's finances and performance issues. Including:

- providing leadership in making recommendations to the Governing Body for the deployment of resources and budgets
- providing leadership in ensuring that the CCG is fulfilling its responsibilities in improving the performance of the health care system against standards, and in managing its contract activity effectively.

The Committee met 10 times throughout 2021/22 and attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights include: Please note this list is not exhaustive and the minutes of this Committee outlining the business transacted and decisions taken for 2021/22 can be found in the Governing Body papers on the CCG's website.

- Performance Reports
- Finance Reports
- Health & Safety Corporate Assurance Report
- HR update Reports and policy approvals
- Operational & Financial Planning updates
- Equality & Choice Policy
- High Cost Review
- 2021/22 Inflation Uplift to None NHS Organisations
- Data Protection Toolkit
- Risk Management Framework

Members Name	Role	Attendance *(10 Meetings held)*
Carole Green	Lay Member for Quality & Performance	6
Deb Lee	Secondary Care Doctor	7
Denise Leslie	Lay Member for Public Engagement	5
Peter Rooney	Chief Operating Officer	9

Jon Rush	Lay Chair (Chair)	10
Charles Welbourn	Chief Finance Officer	10
John Whitehouse	Lay Member for Finance & Governance	9

Outcome & Quality Assurance Committee Role and Performance Highlights 2021/22

The Outcomes & Quality Assurance Committee examines, in detail, the areas of concerns in the quality of care provided to patients in North Cumbria. It works closely with the Nursing & Quality team to ensure that the assurance provided to the Governing Body is robust and demonstrates that the quality assurance systems and processes are in place.

The Committee met six times throughout 2021/22 and attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights include: Please note this list is not exhaustive and the minutes of this Committee outlining the business transacted and decisions taken for 2021/22 can be found in the Governing Body papers on the CCG's website.

- Scrutinising Quality Report prior to presentation to the Governing Body (including unexplained deaths, pressure ulcers, serious untoward incidents, never events)
- North Cumbria Integrated Care NHS Foundation Trust (NCIC) Care Quality Commission (CQC) Action Plan
- Maternity Services – Ockenden Review and Workforce
- Learning from Lives and Deaths (LeDeR)
- Special Educational Needs & Disability (SEND) Update
- Cancer Services
- Primary Care
- Patient Safety
- North West Ambulance Service
- Care Homes & Hospices
- Continuing Health Care
- Joint Domestic Homicide Review

Members Name	Role	Attendance *(6 Meetings held)*
Amanda Boardman	Nominated Deputy for Medical Director	5
Carole Green	Lay Member for Quality & Performance (Chair)	6
Deb Lee	Secondary Care Doctor	4
Denise Leslie	Lay Member – Public Engagement	3
Louise Mason Lodge	Acting Director of Nursing & Quality, Designated Safeguarding Lead and Registered Nurse on the Governing Body	6
Paula Smith	Patient Safety Lead	3
Nicki Trewhitt	Senior Nurse	6

Primary Care Commissioning Committee Role and Performance Highlights 2021/22

On 1 April 2017 North Cumbria CCG was delegated authority by NHS England to review, plan and procure primary medical care services in North Cumbria. As part of that delegation the Governing Body established a Primary Care Committee which meets in public to manage those functions agreed between NHS England and the CCG, together with certain duties delegated to it by the CCG (as set out in its Scheme of Delegation). The Committee's full Terms of Reference can be found on the CCG website.

The Committee met six times throughout 2021/22 and attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights include: Please note this list is not exhaustive and the minutes of this Committee outlining the business transacted and decisions taken for 2021/22 can be found in the Governing Body papers on the CCG's website at:

- Covid-19 Updates
- Integrated Care Communities (ICC)
- Primary Care Networks
- CCG Gain Share Schemes
- CCG Gain Share General Practice Forward View Proposals
- Quality Improvement Schemes
- Special Allocation Schemes
- Finance Updates

- Primary Care Team Updates
- Contract Baseline Reports
- Primary Care Committee Performance Review

Members Name	Role	Attendance *(6 Meetings held)*
Carole Green	Lay Member for Quality & Performance	6
Denise Leslie	Lay Member for Public Engagement	4
Jon Rush (Chair)	Lay Chair	6
Ed Tallis	Director of Primary Care	6
Charles Welbourn	Chief Finance Officer	6

Remuneration Committee
Role and Performance Highlights 2021/22

The Remuneration Committee is responsible for making recommendations to the Governing Body about appropriate remuneration and terms of service for all posts above the top threshold of the National Agenda for Change (AfC) pay-scale, including off-payroll appointments, including:

- all aspects of salary (including any performance-related elements / bonuses)
- provisions for other benefits e.g. car allowances
- advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

The Remuneration Committee has not met during the 2021/22 financial year. This was due to the fact that the NHS Ministers' recommendation on 2021/22 annual pay increase for very senior managers (VSMs) issued on 8 September 2021 was due to be considered by a Remuneration Committee in Common from across the North East & North Cumbria Integrated Care System. This would have been made up of the Chair of each CCG's Remuneration Committee. However, unfortunately this meeting was not convened. Therefore, North Cumbria CCG's Remuneration Committee met on 19 April 2022 to consider the above and their recommendations were approved at the Part 2 Governing Body meeting on 19 May 2022.

Members Name	Role	Attendance *(Meeting held April 2022)*
Carole Green	Lay Member for Quality & Performance	1
Deb Lee	Secondary Care Doctor	1
Denise Lesley	Lay Member for Public Engagement	1
John Whitehouse	Lay Member for Finance & Governance (Chair)	1
In Attendance		
Kirstin Blundell	HR Business Support, North of England Commissioning Support (NECS)	1
Amber Minton	HR Business Support, North of England Commissioning Support (NECS)	1
Jon Rush	Lay Chair	1

Joint CCG Committee for the North East and North Cumbria

This Northern CCG Joint Committee was established in October 2017. This Committee has continued to meet during 2021/22 and has been guided by the following principles:

- Securing continuous improvement to the quality of commissioned services to improve outcomes for patients with regard to clinical effectiveness, safety and patient experience
- Promoting innovation and seeking out and adopting best practice by supporting research and adopting and diffusing transformative, innovative ideas, products, services and clinical practice within its commissioned services which add value in relation to quality and productivity
- Developing strong working relationships with clear aims and a shared vision putting the needs of the people we serve over and above organisational interests
- Avoiding unnecessary costs through better co-ordinated and proactive services which keep people well enough to need less acute and long term care

Throughout the year the Joint Committee routinely discussed governance proposals to support the shared ambition of the NHS organisations in the North East and the North Cumbria (NENC) to become an Integrated Care System (ICS).

With the anticipated adoption of an Integrated Care Board (ICB) for the NENC in July 2022, the necessity for the Joint Committee will no longer exist.

Membership

During 2021-22 membership of the Joint Committee comprised the following Clinical Commissioning Groups (CCGs):

NHS County Durham CCG
NHS North Cumbria CCG
NHS North Tyneside CCG
NHS Sunderland CCG
NHS Newcastle Gateshead CCG
NHS Northumberland CCG
NHS South Tyneside CCG
NHS Tees Valley CCG

NHS North Yorkshire CCG is an Associate Member and is eligible to attend the Joint Committee as a non-voting member. However, where there is an issue requiring a decision to be made that will affect the NHS North Yorkshire CCG, the Accountable Officer or nominated deputy will have full voting rights in relation to the relevant issue.

Voting membership of the Joint Committee comprises the Chair and Chief Officer from each member CCG (or a nominated deputy) and each CCG is entitled to exercise one vote as required. There are also two (non-voting) lay members of CCGs on the Joint Committee.

The Managing Director of North of England Commissioning Support (NECS), Chair of the Cumbria and North East CCG Chief Finance Officers' Group and Director of Governance and Partnerships North East and North Cumbria Integrated Care System also attend meetings of the Joint Committee in a non-voting capacity.

There were eight meetings of the Joint Committee held in 2021/22. Due to Covid-19, it was not possible to hold meetings of the Committee in public and it met in private virtually. Relevant extracts from these minutes were approved for publication on CCG websites.

The following key areas of the Joint Committee work in 2021/2022 are outlined below:

- Developing an Integrated Care System (ICS) in the North East and North Cumbria
- Research and evidence annual update
- Update on the use of Avastin for the treatment of wet AMD (age-related macular degeneration)
- Academic Health Science Network (AHSN) and its role with the National Lipid Management Pathway including inclisiran
- Northern Joint Committee Annual Report 2020/21
- Northern Treatment Advisory Group (NTAG) Annual Report 2020/21
- Learning Disabilities Treatment and Assessment Review

- North of England Commissioning Support (NECS) customer board reports.
- Gender Dysphoria
- System approach to preparing well for surgery in North East North Cumbria (NENC)
- Acute pressures
- Pre-Term Birth Clinics - commissioning for safety, quality and equity: request to combine Allocations
- Value Based Clinical Commissioning Policy (VBCC) – Confirmed Updates to Regional Policy – April 2022 Refresh
- Individual Funding Request (IFR) Policy / Standard Operating Procedures (SOP) / Terms of Reference (ToR) - Update

North Cumbria Integrated Health and Care Partnership

These arrangements consist of two mutually related groups, namely, the Integrated Care Partnerships (ICP) Leaders Board which is supported by the ICP Executive Group. Both groups consist of all NHS Partners, Cumbria County Council and Third Sector representatives that service the North Cumbria geographical area. The main remit of the arrangements is to co-ordinate the partnership working of the local health and care system; set an agreed strategy that dovetails into the Cumbria Health and Well Being Strategy and supports the Integrated Care System work streams for the North East and North Cumbria; manage and monitor partnership performance.

This year the Leaders Board has concentrated on developing and shaping its approach to the emerging relationship with the Integrated Care System for the North East, whilst the Executive Group has prioritised the operational response to Covid and the delivery of the other 4 key priorities of Patient flow and discharge; Workforce; Population Health and Finance. A review of Integrated Care Communities was also undertaken to revise and develop our approach.

The CCG is represented on the Leaders Board by the Chair, Jon Rush; the Accountable Officer, Mark Adams; the Chief Operating Officer, Peter Rooney and the Lay Member for Finance and Governance, John Whitehouse. Jon Rush is also the Chair of the Board.

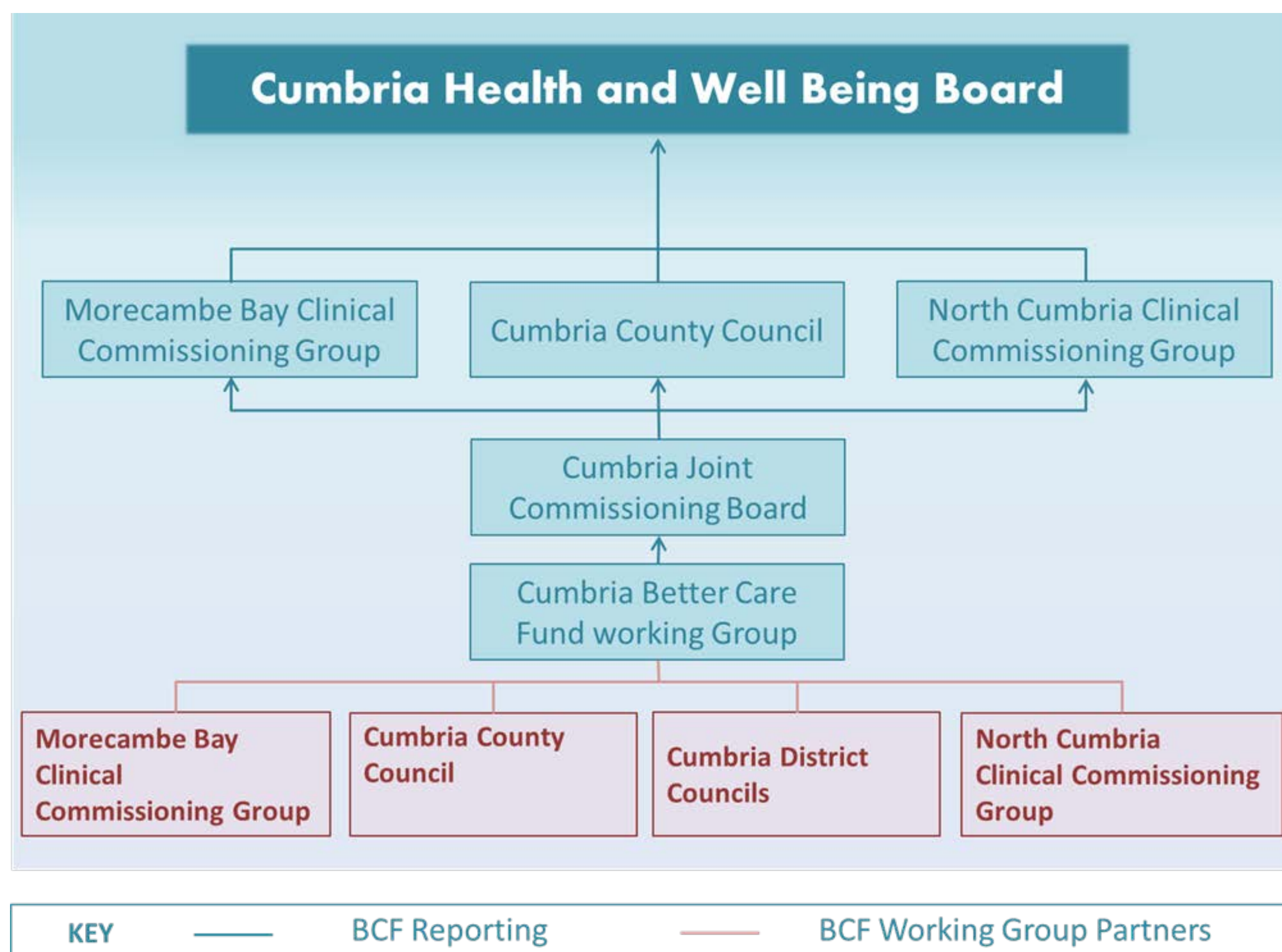
Better Care Fund Governance Arrangements

The Better Care Fund (BCF) is a single pooled budget, managed through a Section 75 Agreement, which began in 2014/15. It was introduced to further encourage joint commissioning of integrated health and social care services and brings together a portion of existing NHS and Local Government resources.

Whilst, at a local level, NHS North Cumbria CCG, NHS Morecambe Bay CCG and Cumbria County Council are the accountable bodies for their respective elements of the BCF, the Cumbria Joint Commissioning Board, established as a working group of the Cumbria Health and Well Being Board, leads the performance management and provides the co-ordination role for the delivery of the Better Care Fund.

The NHS England Policy Framework for the Better Care Fund requires the Health and Wellbeing Board to receive and sign off the final plan and quarterly progress reports to ensure oversight of the strategic direction and delivery of better integrated care. This helps to fulfil their statutory duty to encourage integrated working between commissioners.

In North Cumbria the schemes identified within the BCF plan are all closely aligned to the on-going development of Integrated Care Communities, being a key element of delivering the objectives identified in the North Cumbria strategy launched during 2020/21.



Discharge of Statutory Functions

In accordance with the recommendations of the 1983 Harris Review, the CCG 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 CCG 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. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties. In line with the NHS England/Improvement guidance (C0113) around reducing the burden and releasing capacity dated 28 March 2020 the CCG reviewed its "business as usual" arrangements to release capacity from across the CCG to support the system with the Covid-19 pandemic. This included providing staff to support in other areas such as:

- Testing centre bookings systems
- Discharges from Hospitals
- Care & Residential Homes
- Infection Control
- Supporting the establishment of vaccination Hubs/Centres and the roll out of the vaccination programme

This impacted on the CCG's normal OGIM (Objectives, Goals, Initiatives and Metrics) framework. However, the CCG has now returned to 'business as usual' and the Programme Review Group has resumed and met regularly throughout 2021/22.

Risk management arrangements and effectiveness

The CCG's Risk Management Framework sets out the approach and arrangements for the management of risk. The CCG ensures a common and systematic approach to risk management to ensure it is embedded across all directorates which enables risks to be identified and managed effectively in the most appropriate place. These principles are consistent with those within the NHS England's Risk Management Policy and Process Guide issued in January 2015.

However, the Governing Body in April 2020 agreed a set of interim corporate governance arrangements to deal with the pandemic that resulted in many of the CCG's "business as usual" arrangements being stood down during 2020/21 and 2021/22. This reflected that the changed priorities around the national COVID response introduced significant uncertainties over the scale of risks locally and the options available to manage them, especially as the NHS nationally paused all routine planning work for 2021/22 Operational Plans. The national framework for recovery of 'living with COVID' for NHS services is only just emerging and this will shape the way North Cumbria responds over the next few months. The Risk Register will be updated to reflect these expectations as they become clearer, but the risk register and Governing Body Assurance Framework have both been refreshed in 2021/22.

These arrangements were formally reviewed periodically by the Governing Body during the year and were maintained until March 2022. Hence, the CCG has effectively maintained the previous approach to risk management. Nevertheless, during 2021/22 the CCG commenced a process of working towards "business as usual" and re-introduced a number of processes such as re-establishing operational risk assessments within departments and individual departmental objectives based upon the corporate approach. However, this approach was still very much managed through the key risks of COVID and recovery objectives. The following are therefore noteworthy:

Directors and Senior managers from all CCG directorates participate in the Programme Review Group meeting and decisions taken to address operational risks are formally recorded. The impact of COVID and the recovery is a standing item.

- The Governing Body and supporting Committees have been continually updated on the risks facing the organisation (and wider system) and there was a standing item on the Governing Body agenda (until March 2022) to record any emergency decisions taken outside formal delegations.

- The CCGs Outcomes & Quality Assurance and Finance & Performance Committees have also continued to meet and be provided with regular reports on quality, performance and finance issues 'outside of' COVID-19 during the year.

Capacity to Handle Risk

The CCG's Governing Body has overall responsibility for governance, assurance and management of risk. The Governing Body has a duty to assure itself that the organisation has properly identified the risks that it faces, and that it has processes and controls in place to mitigate those risks and the impact they may have on the organisation and its stakeholders. The tool used by the Governing Body to gain this assurance is the Governing Body Assurance Framework (GBAF).

Despite the overall approach, as a consequence of the pandemic, the CCG's Governing Body undertook a full review of the GBAF during 2021/22, supported by the work of the Executive Committee. In light of the November 2020 NHS England & Improvement (NHSE/I) Board report regarding the development of Integrated Care Systems (and subsequent NHSE/I guidance) about the future direction for CCGs then this approach was focussed upon:

1. Enabling the CCG to demonstrate good governance
2. Providing a framework to ensure the organisation retains focus on the key strategic aims during whatever transition process takes place, remembering the organisational structure is a means to achieving the objectives (enabler)
3. Enabling a good handover process to whatever structure emerges for the future.

This process continued during 2021/22 in light of further guidance issued by NHSE/I and the confirmed target date of 1 July 2022 for the transfer of CCG functions to the new NENC Integrated Care Board. This approach concentrated upon strategic risks, which by definition will be risks to

achieving the CCG's strategic aims, as set out in the North Cumbria Health & Care Strategy 2020-24 previously approved by the CCG Governing Body in January 2020 and noted below:

Strategic Objectives: we will

- improve the health and care outcomes of our local communities and support people of all ages to be in control of their own health.
- build health and care services around our local communities.
- provide safe and sustainable high quality services.

To help us achieve this we will focus on key areas – our strategic enablers: we will

- be a great place to work and develop
- integrate how health and care and other organisations work together
- live within our means and spend resources wisely
- deliver digitally enabled care

Therefore a further stocktake has been undertaken by the Senior Leadership Team and presented to the CCG's Executive Committee comparing the documents below with the North Cumbria Integrated Care Partnership Strategy 2020-2024:

- The last iteration of the GBAF
- The CCGs risk register as refreshed during 2021/22
- Covid recovery work schedule identified by NHSE/I

This process considered the completeness of the list, key changes that have happened since the various documents were produced and also looked to segregate key strategic issues from the more operational "day to day" issues (being managed through the arrangements noted previously). Hence, the refreshed document was considered by the Executive Committee and subsequently approved by the Governing Body in January 2022.

It also noteworthy that the response to Covid is excluded in the final analysis for the reasons noted below. However, as work plans to mitigate the risks to the strategy are developed they will naturally need to reflect the medium and longer-term effects of Covid, and how the country learns to "live with Covid".

- This is a national pandemic that is being managed through a national approach
- The CCG established an Incident Management Team (IMT) that is linked to other statutory functions to manage the CCG's response, which has been "stood up" and "stood down" in response to particular operational circumstances during the year.
- The CCG has a set of systems and processes to address the challenges of Covid and the CCG's response is reported at each Governing Body meeting to provide both assurance and scrutiny of our actions.
- A key risk identified is the achievement of NHS performance standards that will continue to be influenced by the direct and longer term impact of Covid-19.

The process for updating the GBAF was also reviewed by the Audit Committee in February 2022 (including input from Internal Audit).

The GBAF will continue to be kept under review to maintain the approach that has been described above in conjunction with further planning and implementation guidance issued by NHSE/I, including as part of the “due diligence” process for handover to the NENC ICB.

It is also noteworthy that in response to Covid-19, as supported by the Governing Body and noted previously, the CCG suspended many of its “business as usual” processes. This was most acute in the early part of the year where priority was specifically given to supporting the local system operationally as a consequence of the high infection and hospitalisation rates and supporting the rollout of the vaccine. Therefore, as a direct consequence of this approach the CCG has not been maintaining the risk register in the ‘usual way’ although this process re-commenced during the year as previously noted through the working of the Programme Review Group, as approved by the CCG Executive Committee in March 2021.

Risk Assessment

The CCG’s Audit Committee has developed, implemented and monitored a risk management review process. This has resulted in the Finance and Performance Committee and Governing Body being assured that there are robust, sound and safe risk escalation and management processes in place across the organisation.

The CCG internal auditors undertook a risk based audit on Governance Structures for 2021/22 and considered the governance, risk management and control arrangements. The conculsion of the audit resulted in substantial assurance being given.

In addition to managing the COVID response directly (especially coordinating hospital discharge and vaccination) the CCG faces significant risks in terms of providers failing to meet key NHS Constitution targets, adversely impacting on patient care and potentially resulting in additional costs to the CCG. The most material issue relates to the backlog of elective care as a result of non-urgent hospital planned care being suspended for long periods of the 2020/21 financial year.

Similarly, there have also been major challenges in addressing cancer waiting times along with concerns that patients have not been accessing services in a timely manner as a direct consequence of COVID. Each of these areas has been the subject of significant joint working between the CCG and its partners and in particular its main local secondary care provider, North Cumbria Integrated Care NHS Foundation Trust (NCIC) and Cumbria County Council (CCC).

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the CCG 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, 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.

As specified above the CCG's Internal Auditors, Auditone, undertook a risk based audit of the Assurance Framework in March 2022 and found that governance, risk management and control arrangements provided substantial assurance that the risks identified are managed effectively. Compliance with the control framework was found to be taking place.

Annual audit of Conflicts of Interest management

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

The CCG's Internal Auditors, Auditone, undertook the required annual audit on Conflicts of Interest in March/May 2022 and has issued a good assurance level.

Data Quality

The Governing Body relies on the data quality elements in its contracts with providers. This includes both the requirement that providers quality assure their data prior to submission, and the active monitoring and management of the data quality improvement plans are included within the contracts. In addition, the CCG commissions the North of England Commissioning Support (NECS) services to manage all local and national information flows on behalf of the CCG, including quality assurance, analysis and reporting. Therefore, the CCG's contract with NECS outlines our expectations with respect to data quality and reporting.

Information Governance (IG) (including Cyber Incidents and Business Critical Models)

Information Governance is to do with the way the CCG processes and handles information. It covers personal information (relating to patients/service users and employees) and also corporate information (for example financial and accounting records). By embedding Information Governance in the culture of the CCG, we can provide assurance to the public and our regulators that the CCG complies with relevant legislation and central guidance and that information is handled appropriately, lawfully and securely. The Information Governing vision is that we "Enable high quality care by facilitating the ethical, legal, effective & appropriate use of accurate & reliable information that maintains confidentiality, integrity & availability".

The 2020/21 Data Security and Protection Toolkit Report, which was submitted in June 2021, confirmed compliance with 'Standards Met'. Due to the impact Covid-19 has had, the submission of the Data Security and Protection Toolkit report for 2021/22 is not due until June 2022.

The CCG takes its responsibilities for the protection of patient and staff information seriously. Breaches of confidentiality or loss of personal data are reported and investigated through the Trust's Incident Reporting procedure and assurance processes. During the reporting period, the Information Governance Team has not recorded any IG incidents between 1 April 2021 and 31 March 2022.

Third party assurances

As a result of the support service arrangements provided by the North of England Commissioning Support (NECS) under a signed services level agreement, the CCG will receive a number of assurance reports covering from the 1 April 2021 to 31 March 2022.

Control Issues

In seeking to ensure that the CCG has a robust system of internal control that is implemented effectively, the CCG Audit Committee has established a cyclical, risk-based programme of internal audit work. At the time of writing this report no issues of significant risk have arisen from this work. A similar approach has been taken to manage the risk of fraud and/or misuse of resources and again no significant issues have been reported.

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

During 2021/22 the NHS has continued to work through a national "Covid-19" financial regime first introduced during 2020/21, with many of the normal transactional process (e.g. contracts with NHS providers) suspended and nationally mandated payments made. As part of this process the CCG has required all expenditure to be assessed as reasonable and proportionate to secure funds from NHSE where appropriate and meet agreed financial objectives for the year. The CCG has therefore ensured that all expenditure planning has been overseen by the Governing Body with separate plans agreed for the first ("H1") and second ("H2") halves of the year, and has also undertaken work to ensure the CCG has continued to support investment in mental health services in accordance with Long Term Plan objectives. However, owing to Covid-19 many of the CCG's resources have been directed towards supporting the NHS response to the pandemic rather than pursuing productivity improvements particularly during H1. For example the CCG medicines optimisation team has been instrumental in supporting Primary Care Networks in delivery of the vaccination programme.

The CCG has also continued to ensure that any staff vacancies are assessed via the Vacancy Panel which requires the line manager to produce a business case for any post(s) that they may wish to recruit to. In addition any vacancies are being advertised across the North Cumbria system in the first instance to ensure, where possible, that resources come from within the existing system.

As part of the CCG's Organisational Development Programme continuous improvement continues to be embedded into the organisation and training is available from Cumbria Learning and Improvement Collaborative.

An internal audit work plan was agreed by the Audit Committee and Auditone has been systematically undertaking the reviews planned for 2021/22. Reviews undertaken include:

- Governance structures and risk management arrangements
- Conflicts of interest/Openness and honesty/Standards of Business Conduct
- Data security and protection toolkit
- Primary medical care commissioning
- Commissioning, Contract and performance monitoring
- Financial and strategic planning
- Key financial controls
- Continuing Health Care and Funded Nursing Care

The outcomes of these audits are reported through the Head of Internal Audit Opinion.

The Audit Committee is made aware of the findings of each review and the proposed actions made by management to address any areas of concerns raised. Auditone has also implemented an action follow up system which seeks confirmation that the actions programmed as a result of an audit have been completed.

In addition to all of the above the Finance & Performance Committee gives detailed consideration to the CCG's financial and performance issues to provide the Governing Body with assurance that all issues are being appropriately managed and escalated where necessary.

The Governing Body also receives a quality, performance and finance report at each meeting.

Delegation of functions

The CCG currently contracts with a number of external organisations for the provision of back office services and functions. These external services include:

- The provision of Oracle financial system and financial accounting support from NHS Shared Business Services. The use of NHS Shared Business Services is mandated by NHS England for all CCGs.
- The provision of financial accounting services from the North of England Commissioning Support Unit (NECS)
- The provision of payroll services from Northumbria Healthcare NHS Foundation Trust

Assurance on the effectiveness of the controls is received in part from annual service audit reports and internal audit assurance reports from the relevant service providers. The outcomes from these audits are reported to the Audit Committee.

Freedom to Speak Up: Raising Concerns (Whistleblowing)

The CCG is committed to an open and honest culture whereby all staff feel able and are supported to raise concerns at work. In June 2021 we appointed out first standalone Freedom to Speak Up (FTSU) Guardian, Kate Holliday, who is currently supported in her role by the CCG's FTSU, Louise Mason -Lodge, Executive Lead and Denise Leslie, Lay Member for Patient & Public Engagement.

Actions taken following appointment to this role have included:

- Formal training of the guardian with the National Guardian Office, as well as formal training of the FTSU Exec Lead and Lay Member for Public & Patient Engagement,
- Development of a CCG Freedom to Speak Up Vision and Strategy for 2021/22. This was agreed on 16 September 2021 Governing Body and was presented to staff at the September CCG staff briefing.
- Review of and making appropriate changes to current CCG Freedom to Speak Up/ Whistleblowing Policy.
- Development of a raising concern form for CCG staff to complete and submit to a confidential FTSU contact email address.
- Development of a template to support managers in structuring their response to colleagues speaking up through the guardian route.
- Developed an MS Teams background to promote the FTSU role at every Teams meeting.
- Developed a CCG FTSU intranet page and communication resources to raise awareness of the role.
- Presentation by the Guardian (autumn 2021) to all CCG staff outlining the role of the FTSU and raising awareness of the whole FTSU movement across the CCG.
- On a monthly basis the Guardian has linked into wider networks regarding FTSU locally, regionally and nationally.
- The Guardian, CCG FTSU Executive Lead and Lay Member for Patient & Public Engagement meet formally on a monthly basis.

Counter Fraud Arrangements

The CCG's counter fraud activity plays a key part in deterring risks to the organisation's financial viability and probity. An annual counter fraud plan is agreed by the Audit Committee, which focuses on the deterrence, prevention, detection and investigation of fraud.

Through the contract with AuditOne, the CCG has counter fraud arrangements in place that comply with the NHS Counter Fraud Authority Requirements for Fraud, Bribery and Corruption including:

- An accredited counter fraud specialist who is contracted to undertake counter fraud work proportionate to identified risks.
- Well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption.
- A report against each of the NHS Counter Fraud Authority Requirements for Fraud, Bribery and Corruption received by the Audit Committee at least annually.
- Executive support and direction for a proportionate proactive work plan to address identified risks.
- The Chief Finance Officer, as a member of the Governing Body, is proactively and demonstrably responsible for tackling fraud, bribery and corruption.
- Appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations.

The CCG also has a Counter Fraud page on the CCG's website which promotes how to recognise what fraud looks like and how to report it and also has the CCG's relevant policies around this in place.

Head of Internal Audit Opinion

The planned audit work for the financial year 2021/22 for the CCG is at the time of writing being finalised. The Head of Internal Audit Opinion issued has been an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Final Head of Internal Audit Opinion for 2021/22 can be found below:

1. Introduction

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion on the overall adequacy and effectiveness of the organisation's system of internal control.

The purpose of this report is to provide the Audit Committee with the Head of Internal Audit Opinion for the year ended 31 March 2022, which should be used to inform the Annual Governance Statement.

2. Head of Internal Audit Opinion for the year ended 31 March 2022

2.1 Roles and responsibilities

The Accountable Officer is responsible for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

- How the individual responsibilities of the Accountable Officer are discharged in relation to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- The purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and
- The conduct and results of the review of the effectiveness of the system of internal control, including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation’s Assurance Framework should bring together all of the evidence required to support the Annual Governance Statement requirements. In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon, and limited to, the work performed, on the overall adequacy and effectiveness of the organisation’s risk management, control and governance processes (i.e. the organisation’s system of internal control). This is achieved through a risk-based plan of work, approved by Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans, generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Accountable Officer takes into account in making the Annual Governance Statement. The Accountable Officer will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement.

2.2 The Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpins the organisation’s own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist in the completion of the Annual Governance Statement.

My opinion is set out as follows:

2.2.1 Overall opinion;
2.2.2 Basis for the opinion;
2.2.3 Commentary.

2.2.1 Overall Opinion

From my review of your systems of internal control, I am providing substantial assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation’s objectives and that controls are being consistently applied.

2.2.2 Basis of the Opinion

The basis for forming my opinion is as follows:

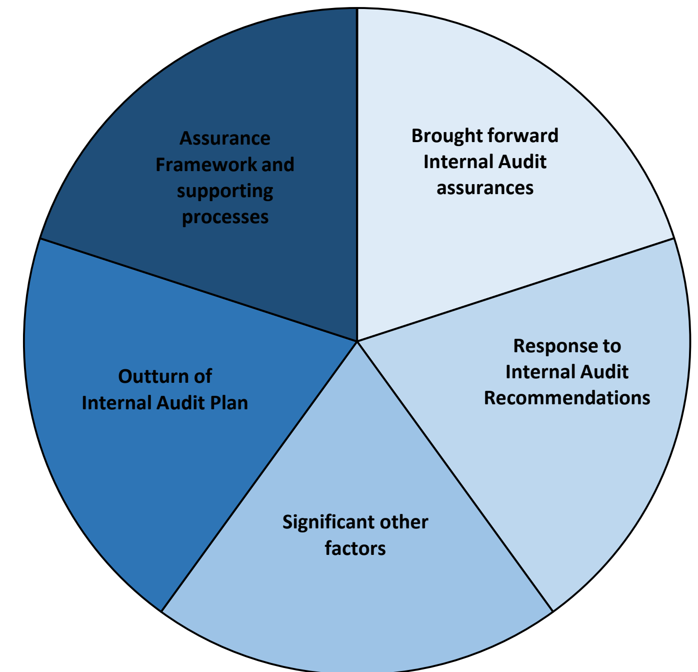
1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes for governance and the management of risk;

2. An assessment of the range of individual opinions arising from audit assignments, contained within risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses;

3. Brought forward Internal Audit assurances;

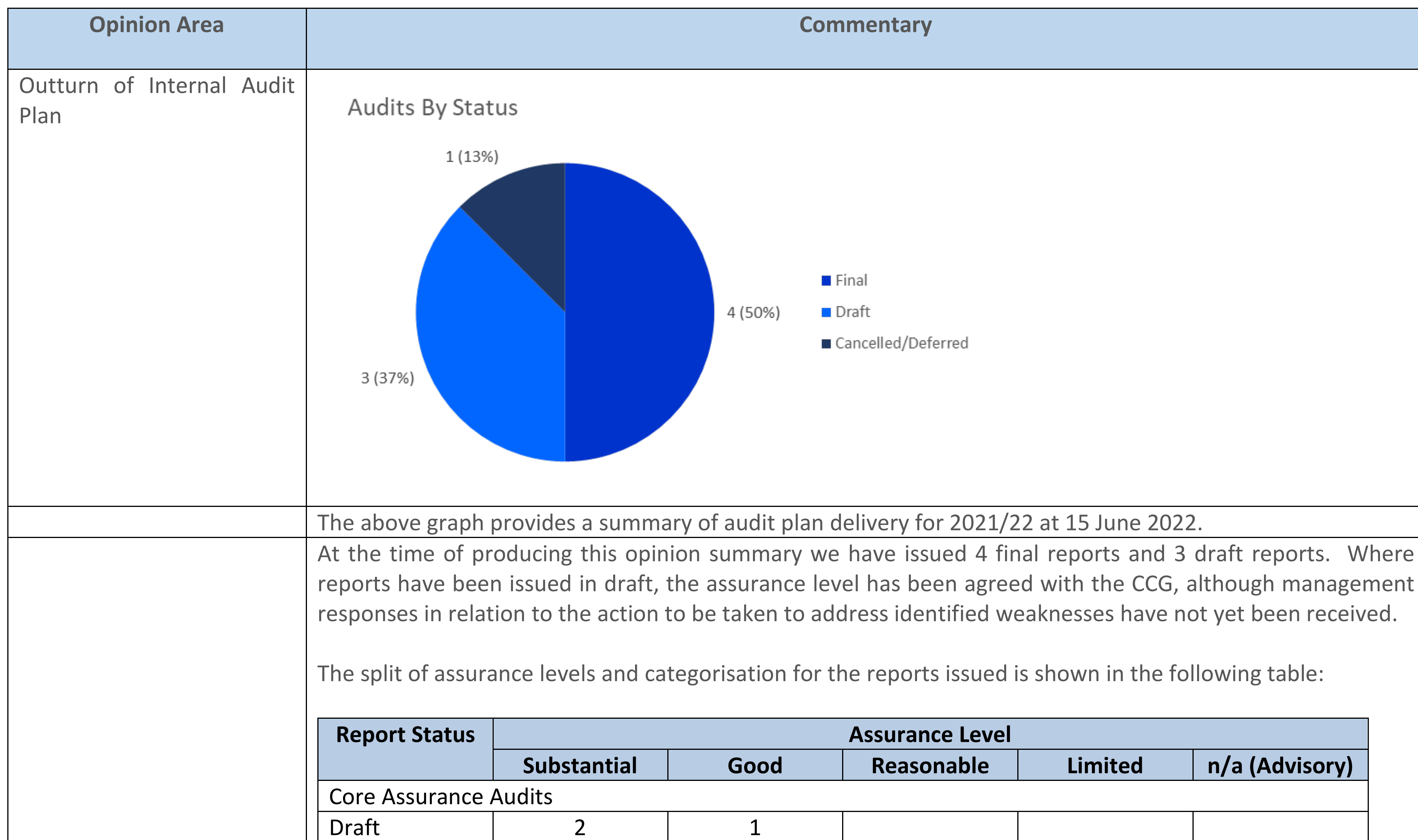
4. An assessment of the organisation's response to Internal Audit recommendations, and

5. Consideration of significant factors outside the work of Internal Audit.



2.2.3 Commentary

Opinion Area	Commentary
Design and operation of the Assurance Framework and supporting processes	The CCG's Risk Management Framework sets out the frequency with which the corporate risk register and assurance framework should be submitted to the Governing Body and its sub-committees. We were advised by the CCG's General Manager that the Framework required update to reflect current practices and that the corporate risk register and assurance framework had not been presented per the frequency set out in the Framework. Our review of Governing Body and sub-committee papers for the year indicated that the assurance framework had been presented to the Governing Body in January 2022, the Audit Committee in February 2022, an update on the assurance framework had been presented to the Executive Team in November 2021 and the corporate risk register had been presented to the Finance and Performance Committee in October 2021 and May 2022. As part of the handover to the new organisation, we have recommended that a final review of the assurance framework and corporate risk register is carried out by the CCG to ensure that they are up to date and reflect the current position; and are presented to the June 2022 Governing Body meeting.



Opinion Area	Commentary
Outturn of Internal Audit Plan	Audits By Status (chart above)
	The above graph provides a summary of audit plan delivery for 2021/22 at 15 June 2022.
	At the time of producing this opinion summary we have issued 4 final reports and 3 draft reports. Where reports have been issued in draft, the assurance level has been agreed with the CCG, although management responses in relation to the action to be taken to address identified weaknesses have not yet been received. The split of assurance levels and categorisation for the reports issued is shown in the following table:

Report Status	Assurance Level				
	Substantial	**Good**	**Reasonable**	**Limited**	**n/a (Advisory)**
Core Assurance Audits					
Draft	2	1			

Opinion Area	Commentary

Final	2	1		1	
Total	**4**	**2**	**0**	**1**	**0**

As can be seen from the table above, reports issued during the year have been issued with assurance level of substantial, good and limited.

The limited assurance report relates to the audit of the Data Security and Protection Toolkit for the year 2020/21 and was undertaken in accordance with NHS Digital's 2020 guidance for internal auditors. We considered whether the organisation meets the requirement of 35 evidence texts across 13 mandatory in-scope assertions and also considered the broader maturity of the CCG's data security and protection control environment. The Toolkit was not subject to review during 2021/22 but we have tracked and reported to Audit Committee the management actions resulting from the 2020/21 assessment. At the time of reporting residual actions are in relation to:

Area	Original action	Target	Latest position
Disaster Recovery Testing	Agreed and DR Testing is planned	Aug 21	DR Test didn't perform as expected. A replacement virtual platform (Nutanix) has been commissioned as it is more efficient and reliable; the existing system is reaching end of life. DR process forms part of the acceptance testing and a full test will be complete once all live systems are configured. This work is expected to be completed by the end of July 22 and a full DR test will be arranged for August/Sept 22. Note that part of the acceptance testing of the new platform was a simulated failover (using dummy virtual machines) so we have

<table>
<tr><th>Opinion Area</th><th>Commentary</th></tr>
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<tr><td></td><td></td><td></td><td>confidence that the process works, just need to test with live systems running on it.</td></tr>
<tr><td>Backup System Testing</td><td>A full test restore will be performed as part of the DR test</td><td>Aug 21</td><td>Normal yearly DR testing will resume once the migration has completed. A backup audit was completed and an action plan is being drawn up.</td></tr>
</table>
For context the CCG critical systems are Email, Active Directory and File Storage. The CCG have recently transitioned to NHSMail so the critical services supplied by NCIC (who provide IT support) are reduced to AD and File Storage. AD is a resilient multi-site service, so only File Storage is contingent on the DR testing.
</td></tr>
<tr><td>Brought forward Internal Audit assurances</td><td>The Head of Internal Audit Opinion given for the year ended 31 March 2021 gave a level of assurance of ‘substantial’. There were no material issues identified to be brought forward for consideration in this opinion statement.</td></tr>
<tr><td>Response to Internal Audit recommendations</td><td>The implementation of internal audit recommendations is a key indicator of the organisation’s engagement with ourselves and the importance it places on the recommendations we have made and have been agreed to be implemented. The Audit Committee receives updates on the progress of agreed actions for all high and medium issues raised, but it does not require updates in relation to low priority issues so these are not subject follow-up by AuditOne.

In the year to 31 March 2022, 13 high or medium recommendations were due to be implemented based on initial or revised target dates, at 15 June 2022, 10 (77%) were closed. The table below provides a breakdown of the position based on the priority level of the recommendations.</td></tr>
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<tr><th>Opinion Area</th><th>Commentary</th></tr>
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<tr><th></th><th>Due in the year to 31 March 2022</th><th>Closed</th><th>Outstanding</th></tr>
<tr><td>High</td><td>4</td><td>2 (50%)</td><td>2(50%)</td></tr>
<tr><td>Medium</td><td>9</td><td>8 (89%)</td><td>1 (11%)</td></tr>
<tr><td>Total</td><td>13</td><td>10 (77%)</td><td>3 (23%)</td></tr>
</table>

During the year all recommendations made in reports have been routinely followed up using our automated software and reported to the Audit Committee at each meeting during 2021/22. As outlined in the section above the remaining high risk actions have renewed target dates and the current risk of business interruption is substantially lessened with the transition of the email platform.
</td></tr>
<tr><td>Significant factors outside the work of internal audit</td><td>While the Head of Internal Audit Opinion provides the CCG with assurances in relation to the areas covered by the internal audit plan, it is only one of the sources of assurance available to the CCG. As the CCG outsources many of its functions, assurances from third parties are equally as important when the CCG draws up its Annual Governance Statement.

The main ones usually received that we have been made aware of are summarised below:

• Payroll services are provided by NHS Payroll Services hosted by Northumbria Healthcare NHS Foundation Trust. The CCG, through its membership of the Payroll Consortium, receives an annual assurance letter setting out the results of the internal audit work carried out during the year.

• The CCG outsources many of its support services to the North of England Commissioning Support Unit (NECS), hosted by NHS England, under a signed service level agreement. Assurance on the operation of</td></tr>
</table>

Opinion Area	Commentary
	certain financial and payroll controls will be provided by NHS England's internal auditors, Deloitte LLP, via an ISAE 3402 Type II report. • Assurance in respect of the operation of the finance and accounting services provided by NHS Shared Business Services (SBS) is provided by the NHS SBS' auditors on an annual basis. • Assurance in respect of the primary care support services provided from Capita Business Services Limited to NHS England and CCGs is provided by Capita's auditors, Mazars, on an annual basis. • Assurance in respect of the operation of the prescription payments process provided by NHS Business Service Authority and Capita is provided by the NHS BSA's auditors, PwC LLP, via an ISAE 3402 Type II report on an annual basis. • Assurance in respect of the operation of the NHS GP Payment Service provided by NHS Digital for is provided by the NHS Digital's auditors, PwC LLP, via an ISAE 3402 Type II report issued on an annual basis. • Your counter fraud specialist is required to submit an annual Counter Fraud Functional Standard Return (CFFSR) (formerly known as the Self Review Tool) to the NHS Counter Fraud Authority (NHSCFA) in relation to the CCG's counter fraud, bribery and corruption arrangements. This provides an overview of the CCG's counter fraud activity, progress against NHSCFA requirements and assists the Chief Finance Officer (CFO) and Audit Committee in monitoring and managing the counter fraud service. The CFFSR for 2021/22 will be reviewed and approved by both the Audit Committee chair and CFO prior to the submission deadline. The CCG's overall rating for 2021/22 will be confirmed following CFFSR approval. The CCG has not been subject to an NHSCFA engagement meeting in 2021/22.

Opinion Area	Commentary
	• The Electronic Staff Record (ESR) service is provided by IBM. An ISAE 3000 Type II report covering the operation of the national system is issued on an annual basis by their external auditors, PwC LLP. It is for the CCG to decide what assurance to take from these reports and whether any of the weaknesses identified should be included within the CCG's Annual Governance Statement. Nevertheless, I can advise the Governing Body that the work on the outsourced payroll functions will have been undertaken in accordance with the Public Sector Internal Audit Standards.

In providing this opinion, it is important to recognise the additional limitations on our work caused by the COVID-19 pandemic. These limitations include access to CCG personnel and the timely supply of information that would be available to us under normal circumstances. However, as your Head of Internal Audit I am satisfied that we have sufficient evidence, to provide the Trust with a robust Head of Internal Audit Opinion.
I would like to take this opportunity to thank the staff at North Cumbria CCG for the co-operation and assistance provided to my team during the year.

Carl Best
Associate Director of Audit, AuditOne
Date: 15 June 2022

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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the CCG 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 improvements in the Audits undertaken on the Risk Assurance Framework, Managing Conflicts of Interest and Governance Structures, comments made by the external auditors in their annual audit letter and other reports which have been provided throughout the year.

The CCG's assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed. The CCG also has strong connections not only in the North Cumbria Health System but across the Integrated Care Systems in the North East and the North West.

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

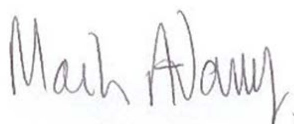
- the Governing Body;
- the Audit committee;
- the Finance & Performance committee;
- the Quality and Outcomes Assurance Committee; and
- Internal audit

The CCG has a programme of continuous improvements and will continue to review how it undertakes its duties to ensure that they are delivered in an effective and efficient way.

As Accountable Officer I work closely with the Chief Finance Officer who is the Senior Information Risk Owner (SIRO) and leads on the CCG Assurance Framework. This framework details the principal risks to the CCG achieving its objectives. During 2021/22 a review of these arrangements have been undertaken and have been set out in the Risk Management Arrangements and Effectiveness of this report.

Conclusion

At the time of writing this report a system of internal control has been maintained throughout the year and up to the date of the submission of this draft annual report and accounts. Based on the work undertaken in 2021/22, and the substantial assurance has been provided by the Head of Internal Audit (although draft at this stage and is subject to further work) that there is a generally sound system of internal control, designed to meet the CCG's objectives, and that the controls are generally being consistently applied. No significant issues have been identified.



Mark Adams, Accountable Officer, 17 June 2022

Remuneration and Staff Report

Remuneration Committee

The Remuneration Committee is a non-executive committee of the Governing Body and was established in accordance with the CCG's Constitution.

The Remuneration Committee is responsible making recommendations to the Governing Body about appropriate remuneration and terms of service for all posts above the top threshold of the National Agenda for Change (AfC) pay-scale, including off-payroll appointments, including:

- all aspects of salary (including any performance-related elements / bonuses);
- provisions for other benefits e.g. car allowances
- advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

The membership consists of:

Members Name	Role
Carole Green	Lay Member for Quality & Performance
Denise Lesley	Lay Member for Public Engagement
John Whitehouse	Lay Member for Finance & Governance (Chair)
Deb Lee	Secondary Care Doctor

The Remuneration Committee has not met during the 2021/22 financial year. This was due to the fact that the NHS Ministers' recommendation on 2021/22 annual pay increase for very senior managers (VSMs) issued on 8 September 2021 was due to be considered by a Remuneration Committee in Common from across the North East & North Cumbria Integrated Care System. This would have been made up of the Chair of each CCG's Remuneration Committee. However, unfortunately this meeting was not convened.

Therefore, North Cumbria CCG's Remuneration Committee met on 19 April 2022 to consider the above and their recommendations were approved at the Part 2 Governing Body meeting on 19 May 2022.

Policy on the remuneration of senior managers

The CCG remains committed to the principles it adopted to ensure that it is in a position to attract and retain high quality senior officers. This includes maintaining salaries at a competitive level, whilst taking into account the previous level of experience of post holders; application of appropriate promotional increases to new appointees and application of relevant percentage increases (as determined at national level), all whilst recognising the restraint on the public purse.

As part of the steps the CCG takes to satisfy itself the remuneration is reasonable, the Remuneration Committee also takes cognisance of the following reference and policy documents:

- NHS Commissioning Board (NHSCB) Clinical Commissioning Groups: Remuneration Guidance for Chief Officers (where the senior manager also undertakes the Accountable Officer role) and Chief Finance Officer
- The Hay Group CCG Remuneration Guidance on GPs Remuneration in CCGs in North West England
- Tenon Technical Employment Status Guidance – tax, national insurance and superannuation implications for GPs involved in Clinical Commissioning Group roles
- Agenda for Change and VSM pay frameworks
- Equal pay for equal work
- The Seven Principles of Public Life, referred to as the Nolan Principles
- Standards of Governing Body Members
- Hutton Fair Pay principles

Remuneration of Very Senior Managers

The CCG has 4 posts which receive remuneration in excess of £150,000 pro-rata per annum; all except 1 are part time.

These posts are all clinical roles (Doctor level) and are broken down as follows:

- Governing Body x 4 posts (1 full time)

Remuneration for these posts was approved by the Remuneration Committee as per the steps outlined above.

Senior Manager Remuneration (including salary and pension entitlements) subject to Audit

Name	Title	Note	2021-22 Salary (bands of £5,000) £000	2021-22 Expense payments (taxable) (Note 9) (rounded to the nearest £100) £	2021-22 All pension-related benefits (Notes 10,11) (bands of £2,500) £000	2021-22 TOTAL (bands of £5,000) £000	2020-21 Salary (bands of £5,000) £000	2020-21 Expense payments (taxable) (Note 9) (rounded to the nearest £100) £	2020-21 All pension-related benefits (Notes 10,11) (bands of £2,500) £000	2020-21 TOTAL (bands of £5,000) £000
Governing Body Members										
Jon Rush	Lay Chair	1	45-50	-	-	45-50	60-65	-	-	60-65
Mark Adams	Accountable Officer	2	40-45	-	-	40-45	40-45	-	-	40-45
Anna Stabler	Director of Quality & Nursing	3					35-40	-	65-67.5	100-105
Louise Mason-Lodge	Acting Director of Quality & Nursing / Designated Nurse- Safeguarding Children and Adults	3	90-95	4,600	-	95-100	90-95	4,600	-	95-100
Dr Deb Lee	Clinical Member: Secondary Care Clinician	4	25-30	-	-	25-30	25-30	-	-	25-30
Carole Green	Lay Member: Quality & Performance	4	10-15	-	-	10-15	10-15	-	-	10-15
John Whitehouse	Lay Member: Finance & Governance	4	10-15	-	-	10-15	10-15	-	-	10-15
Denise Leslie	Lay Member: Patient & Public Engagement	4	10-15	-	-	10-15	10-15	-	-	10-15
Charles Welbourn	Chief Finance Officer		115-120	6,400	32.5-35	155-160	115-120	9,100	27.5-30	150-155
Peter Rooney	Chief Operating Officer		115-120	1,200	32.5-35	150-155	115-120	8,900	30-32.5	155-160
Dr Colin Patterson	Clinical Lead: Primary Care & ICC development / Deputy Chair / Interim Medical Director	5	130-135	-	45-47.5	175-180	140-145	-	35-37.5	175-180
Dr Amanda Boardman	Clinical Lead: Safeguarding, Maternity, Children, Mental Health & Learning Disability		155-160	-	40-42.5	195-200	155-160	-	32.5-35	185-190
Ed Tallis	Director of Primary Care	6	105-110	-	25-27.5	130-135	75-80	-	10-12.5	85-90
Dr Helen Horton	GP Lead: Commissioning & Specialised Commissioning		60-65	-	15-17.5	75-80	60-65	-	10-12.5	70-75
Dr Gareth Coakley	Chief Clinical Information Officer	7	75-80	-	17.5-20	95-100	100-105	-	20-22.5	120-125
Other Senior Managers										
Caroline Rea	Director of Primary Care & ICC Development	6					25-30	-	-	25-30
Stephen Singleton	Clinical Director CLIC	8					25-30	-	-	25-30

Note:

1. Jon Rush's tenure as Chair was due to end on 31 March 2022 but has been extended to 30 June 2022 ; this is the current expected cloesdown date of the CCG but is subject to the passage and approval of the Health and Care Bill which includes the establishment of Integrated Care Boards and means that until 1 July 2022 the current CCG statutory arrangements will remain in place. Jon increased his sessions from 3 to 4 sessions per week effective 1 April 2019 and received £10-15k backdated pay relating to 2019-20 in April 2020.
2. Mark Adams was appointed as Acting Accountable Officer by NHS England effective 1 April 2020 and confirmed as Accountable Officer from 1 June 2020. Mark is employed as Accountable Officer by NHS Newcastle Gateshead CCG and works for NHS North Tyneside CCG, NHS Northumberland CCG and NHS North Cumbria CCG as part of a staff sharing arrangement.The salary disclosed above relates to North Cumbria CCG's share of remuneration of 25%. Pension benefits are reported in full by Newcastle Gateshead CCG.
3. Anna Stabler left the CCG 5 July 2020 having been on secondment to North Cumbria Integrated Care NHS Foundation Trust (NCIC) from 1 January 2020 and did not act as a CCG Governing Body member for the period of the secondment. Louise Mason-Lodge was covering the role as Acting Director of Nursing & Quality from 1 January 2020 until 27 July 2020 when she was appointed substantively to the role.
4. Lay members receive a flat daily rate and thus remuneration received reflects the number of days worked. The Lay members' tenure have been extended to 30 June 2022 ; this is the current expected cloesdown date of the CCG but is subject to the passage and approval of the Health and Care Bill which includes the establishment of Integrated Care Boards and means that until 1 July 2022 the current CCG statutory arrangements will remain in place. Deborah Lee's remuneration includes £10-15k relating to a non-managerial role.
5. Colin Patterson was appointed Deputy Chair 1 April 2020 ; Colin increased his sessions from 8 to 10 sessions per week for the 3 months April to June 2020 to support COVID-19 panademic work, reduced to 9 sessions per week for the 3 months July to September 2020 and then worked 8 sessions per week from October 2020 onwards.
6. Ed Tallis joined the CCG as Director of Primary Care on 8 July 2020 taking over the role from Caroline Rea who retired on 30 June 2020.
7. Gareth Coakley joined the CCG 1 November 2018 working 2 sessions per week to 1 Feb 2020 when his sessions increased to 4 per week; Gareth's sessions were increased from 4 to 8 per week for the 3 months April to June 2020 to support COVID-19 panademic work ; Gareth reduced his sessions from 8 to 6 for the 3 months July to September 2020 and then to 4 sessions from October to 12 November when increased to 6 sessions until 1 December when increased to 7 sessions to 31 March 2021 when he then reduced to 5 sessions per week onwards.
8. Stephen Singleton retired on 30 June 2020.
9. Expense payments relate to taxable benefits of lease cars.
10. All pensions related benefits information is provided by NHS Pensions. The value of pensions benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pensions rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.
11. Stephen Singleton and Caroline Rea (from 1.11.19) were already in receipt of pension. Louise Mason-Lodge is not in the NHS Pension Scheme. As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

Staff sharing arrangements for senior manager remuneration 2021-22

Mark Adams is employed by Newcastle Gateshead CCG and works for North Cumbria CCG, North Tyneside CCG and NHS Northumberland CCG as part of a staff sharing arrangement. No other post-holder is shared under joint management arrangements with any other CCG. The total remuneration earned for all work across the four CCGs is shown below:

Name	Title	2021-22 Salary (bands of £5,000) £000	2021-22 Expense payments (taxable) (Note 9) (rounded to the nearest £100) £	2021-22 TOTAL (bands of £5,000) £000	2020-21 Salary (bands of £5,000) £000	2020-21 Expense payments (taxable) (Note 9) (rounded to the nearest £100) £	2020-21 TOTAL (bands of £5,000) £000
Mark Adams	Accountable Officer	170-175	-	170-175	170-175	-	170-175

No performance pay and bonuses were paid during the year ended 31 March 2022 (2020-21 £nil).

No long term performance pay and bonuses were paid during the year ended 31 March 2022 (2020-21 £nil).

Pension benefits (subject to Audit)

Name		Note	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2021 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2022 £000
Amanda Boardman	Clinical Lead: Children's Commissioning, Mental Health, Learning Disability & Safeguarding		2.5-5	0-2.5	35-40	40-45	543	40	609
Gareth Coakley	Chief Information Officer		0-2.5	0-2.5	15-20	30-35	201	9	223
Helen Horton	Commissioning GP: Specialised Commissioning & Pathway development, Map of Medicine & IFR		0-2.5	0-2.5	15-20	25-30	209	11	230
Colin Patterson	Clinical Lead: Primary Care & ICC development / Deputy Chair		2.5-5	-	20-25	45-50	408	31	459
Peter Rooney	Chief Operating Officer		0-2.5	0-2.5	35-40	55-60	512	24	555
Ed Tallis	Director of Primary Care		0-2.5	0-2.5	20-25	55-60	461	26	504
Charles Welbourn	Chief Finance Officer		2.5-5	0-2.5	45-50	95-100	904	41	966

Note: Pension related benefits information is provided by NHS Pensions and excludes general practitioner pension contributions.
There were no contributions to stakeholder pensions.
The pension figures shown relate to the benefits that individuals have accrued as a consequence of their total membership of the scheme.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

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. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

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 or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement for loss of office

There were no payments made for compensation on early retirement or loss of office made to senior managers of the CCG in 2021/22.

Payments to past directors

No payments have been made to past members in 2021/22.

Fair pay disclosures (subject to Audit)

Percentage change in remuneration of highest paid director	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	0%	N/A
The average percentage change from the previous financial year in respect of employees of the entity, taken	-7%	N/A

The average remuneration has reduced year-on-year as a result of a reduction in the number of higher paid directors who left during 2020-21 as detailed in the Salaries & Allowances table.

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest paid member of the Governing Body against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the salary component.

The banded remuneration of the highest paid member of the Governing Body of the Clinical Commissioning Group in the financial year 2021-22 was £162.5k (2020-21, £162.5k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Pay ratio information table	25th percentile	Median	75th percentile
2021-22			
Total Remuneration (£)	29,294	41,378	65,707
Salary Component of total remuneration (£	29,294	40,057	65,664
Pay ratio information	5.55	3.93	2.47
2020-21			
Total Remuneration (£)	30,781	40,988	73,516
Salary Component of total remuneration (£	30,781	40,894	73,516
Pay ratio information	5.28	3.96	2.21

In 2021-22 1 employee (2020-21, 1 employee) received remuneration in excess of the highest paid member of the Governing Body. Remuneration packages ranged from £13k to £162k (2020-21 £21k to £180k).

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

Staff Report

Number of Senior Managers

The CCG has a total of:

- Two Directors at Very Senior Managers (VSM) pay
- Two Directors at Agenda for Change band 9 pay
- Four Clinical Leads at Clinical/Medical pay

Staff number and costs

Total CCG Employee benefits (subject to audit)

	2021-22		
Employee Benefits	Permanent Employees	Other	Total
	£'000	£'000	£'000
Salaries and wages	3,556	71	3,627
Social security costs	396	6	402
Employer contributions to the NHS Pension Scheme	653	6	659
Other pension costs	2	-	2
Apprenticeship Levy	4	-	4
Employee benefits expenditure	4,611	83	4,694

	2020-21		
Employee Benefits	Permanent Employees	Other	Total
	£'000	£'000	£'000
Salaries and wages	3,408	86	3,494
Social security costs	378	8	386
Employer contributions to the NHS Pension Scheme	631	6	637
Other pension costs	1	-	1
Apprenticeship Levy	3	-	3
Employee benefits expenditure	4,421	100	4,521

Average number of people employed (subject to audit)	2021-22			2020-21		
	Permanent Number	Other Number	Total Number	Permanent Number	Other Number	Total Number
Medical and dental	3	-	3	3	0	3
Administration and estates	56	1	57	57	1	58
Nursing, midwifery and health visiting staff	4	-	4	1	0	1
Total	63	1	64	61	1	62

Staff composition

The table below provides an analysis of gender distribution for CCG Governing Body members, other senior managers not included in Governing Body and all other employees not included in either of the previous two categories:

	MALE	FEMALE
Governing Body Members	**8**	**6**
All other senior managers, including all managers at grade VSM, not included above	**0**	**0**
All other employees not included in either of the previous 2 categories	**4**	**71**
TOTAL	**12**	**77**

Sickness absence data

All sickness absence at the CCG is managed in line with the sickness absence 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 as appropriate.

FTE Days Lost	Headcount	FTE	Average FTE Days lost / Headcount	Average FTE Days lost / fte
951.96	91	71.44	10.46	13.32

There were no ill-health retirements in 2021/22.

Staff turnover percentages

The annual staff turnover for 2021/22 was 17.34%

Staff policies

The CCG is committed to equality of opportunity for all employees and is committed to employment practices, policies and procedures which ensure that no employee, or potential employee, receives less favourable treatment on the grounds of any protected characteristics.

The promotion of equality, diversity and inclusion will be actively pursued through policies and the CCG will ensure that employees receive fair, equitable and consistent treatment and ensure that employees, and potential employees, are not subject to direct or indirect discrimination. Equality Impact Assessments are also carried out on any developed policies to ensure there is no impact.

The CCG has a suite of policies in place including;

- Sickness Absence
- Management of Organisational Change
- Flexible Working
- Other Leave
- Performance Management
- Disciplinary
- Grievance
- Raising Concerns (Whistleblowing)
- Pay progression

Trade Union (Facility Time Publication Requirements) Regulations 2017
NHS North Cumbria CCG Report for 2021/22

In compliance with the above Regulations the following information is provided:

Relevant union officials

The total number of employees who were relevant union officials during 1 April 2021 to 31 March 2022 is:

Number of employees who were relevant union officials during the relevant period	Full time equivalent number
0	0

Percentage of time spent on facility time

The number of employees who were relevant union officials employed during 1 April 2020 to 31 March 2021 spent their working hours on facility time as follows:

Percentage of time	Number of employees
0%	0
1-50%	0
51-99%	0
100%	0

Percentage of pay bill spent on facility time

The percentage of the total pay bill spent on paying employees who were relevant union officials for facility time during 1 April 2021 to 31 March 2022 is:

Total cost of facility time	Nil
Total pay bill	£4,964,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time/total pay bill)x100	0%

Paid trade union activities

As a percentage of total paid facility time hours, the number of hours that was spent by employees who were relevant union officials during 1 April 2021 to 31 March 2022 on paid trade union activities was:

Time spent on paid trade union activities as a percentage of total paid facility time hours, calculated as: (total hours spent on paid trade union activities by relevant union officials during relevant period / total paid facility time hours)x100	0%

Expenditure on consultancy

There was £127k consultancy expenditure with PA Consulting who worked with the CCG to support financial recovery across North Cumbria in 2021/22.

Losses and special payments

The total number of Clinical Commissioning Group losses and special payments cases, and their total value, was as follows:

Losses

	Total Number of Cases	**Total Value of Cases**	Total Number of Cases	Total Value of Cases
	2021-22	**2021-22**	2020-21	2020-21
	Number	**£'000**	Number	£'000
Administrative write-offs	9	10	-	-
Total	**9**	**10**	-	-

The Clinical Commissioning Group made no special payments in 2021-22 (2021-21: nil).

Off-payroll engagements

For all off-payroll engagements as of 31 March 2022, for more than £245 per day.

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

For all off-payroll engagements as of 31 March 2022, for more than £245 per day:

	Number
Number of existing arrangements as of 31 March 2022	2
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	-

Table 2: Off-payroll workers engaged at any point during the financial year

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

	Number
Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	2
Of which:	
number not subject to off-payroll legislation[1]	1
number subject to off-payroll legislation and determined as in scope of IR35[2]	1
number subject to off-payroll legislation and determined as out of scope of IR35	-
number of engagements reassessed for compliance or assurance purposes during the year	-
Of which : number of engagements that saw a change to IR35 status following the consistency review	-

[1]see table below

[2]The temporary worker in scope of IR35 is paid via the CCG's payroll.

Table 3: Off-payroll engagements / senior official engagements

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

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	1
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 includes both off-payroll and on-payroll engagements	14

Mark Adams joined the CCG on 1 April 2020 and is employed as Accountable Officer by NHS Newcastle Gateshead CCG and also works for NHS North Tyneside CCG, NHS Northumberland CCG and NHS North Cumbria CCG as part of a staff sharing arrangement. The CCG are recharged for his gross costs via invoice.

Exit Packages (subject to Audit)

There were no exit packages in 2021-22.

Parliamentary Accountability and Audit Report

NHS North Cumbria CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes pages 122-134 in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report at page 135.

ANNUAL ACCOUNTS

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

	Note	**2021-22 £'000**	2020-21 £'000
Income from sale of goods and services	3	**(157)**	(148)
Other operating income	3	**(411)**	(868)
Total operating income		**(568)**	(1,016)
Staff costs	4	**4,694**	4,521
Purchase of goods and services	5	**741,143**	666,762
Depreciation charges	5	**-**	3
Other operating expenditure	5	**111**	126
Total operating expenditure		**745,948**	671,412
Comprehensive expenditure for the year		**745,380**	670,396

The notes 2 to 5 on pages 127 to 129 form part of this statement

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Intangible assets	8	**-**	-
Total non-current assets		**-**	-
Current assets:			
Trade and other receivables	9	**2,207**	5,705
Cash	10	**105**	19
Total current assets		**2,312**	5,724
Total assets		**2,312**	5,724
Current liabilities:			
Trade and other payables	11	**(36,298)**	(27,461)
Provisions	12	**-**	(3)
Total current liabilities		**(36,298)**	(27,464)
Assets less liabilities		**(33,986)**	(21,740)
Financed by Taxpayers' Equity			
General fund		**(33,986)**	(21,740)
Total taxpayers' equity:		**(33,986)**	(21,740)

The notes 8 to 12 on pages 130 to 132 form part of this statement

The financial statements on pages 118 to 121 were approved by the Audit Committee, under delegation from the Governing Body, on 17 June 2022 and signed on its behalf by:

Accountable Officer
Mark Adams

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

	2021-22 General fund £'000	2020-21 General fund £'000
Balance at 1 April	**(21,740)**	(8,348)
Changes in taxpayers' equity for the financial year		
Net operating expenditure for the financial year	**(745,380)**	(670,396)
Net recognised expenditure for the financial year	**(745,380)**	(670,396)
Net funding	**733,134**	657,004
Balance at 31 March	**(33,986)**	(21,740)

Statement of Cash Flows for the year ended 31 March 2022

	Note	**2021-22**	2020-21
		£'000	£'000
Cash flows from operating activities:			
Net operating expenditure for the financial year		**(745,380)**	(670,396)
Amortisation	5,8	**-**	3
Decrease in trade & other receivables	9	**3,498**	3,654
Increase in trade & other payables	11	**8,837**	9,740
Provisions utilised	12	**(3)**	-
Net cash outflow from operating activities		**(733,048)**	(656,999)
Net cash outflow before financing		**(733,048)**	(656,999)
Cash flows from financing activities:			
Net funding received		**733,134**	657,003
Net cash inflow from financing activities		**733,134**	657,003
Net increase in cash	10	**86**	5
Cash at the beginning of the financial year		**19**	14
Cash at the end of the financial year		**105**	19

The notes 5 to 12 on pages 129 to 132 form part of this statement

DRAFT NOTES TO THE FINANCIAL STATEMENTS

1. Accounting policies

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

1.1 Going Concern

These accounts have been prepared on a going concern basis despite the issue of a report to the Secretary of State for Health and Social Care under Section 30b of the Local Audit and Accountability Act 2014.

The Health and Care Act 2022 received Royal Assent on 28 April 2022. The Act allows for the establishment of Integrated Care Boards (ICB) across England and abolishes Clinical Commissioning Groups (CCG). ICBs are due to take on the commissioning functions of CCGs from 1 July 2022 and the CCG functions, assets and liabilities are due to transfer to the North East and North Cumbria ICB as at 1 July 2022.

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

Where a Clinical Commissioning Group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the Financial Statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022 on a going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 Movement of Assets within the Department of Health Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care Group Accounting Manual requires the application of absorption 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 Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Joint Arrangements

Arrangements over which the Clinical Commissioning Group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Clinical Commissioning Group is a joint operator it recognises its share of assets, liabilities, income and expenses in its own accounts.

The Clinical Commissioning Group has entered into a pooled budget arrangement with Cumbria County Council and NHS Morecambe Bay Clinical Commissioning Group under Section 75 of the National Health Service Act 2006 (as amended). Under the arrangement, funds are pooled for developing an integrated approach between health and social care. Note 17 provides details of the income and expenditure.

The pooled budget is hosted by Cumbria County Council. The Clinical Commissioning Group 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.

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 Clinical Commissioning Group. The Clinical Commissioning Group considers it has only one segment: commissioning of healthcare services.

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 Clinical Commissioning Group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less.
- The Clinical Commissioning Group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

1. Accounting policies (continued)

1.6 Revenue (continued)

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

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

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

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

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

1.7 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 non-consolidated performance pay earned but not yet paid.

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 covers 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 Clinical Commissioning Group 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 Clinical Commissioning Group commits itself to the retirement, regardless of the method of payment.

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

1.8 Other expenses

Purchases of goods and services and 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 Intangible Non-current Assets

Intangible non-current assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Clinical Commissioning Group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the Clinical Commissioning Group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Intangible non-current assets acquired separately are initially recognised at cost. 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.

Following initial recognition, intangible non-current assets are carried at depreciated historic cost as a proxy for current value in existing use.

1.10 Amortisation & Impairments

Amortisation is charged to write off the costs or valuation of intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Clinical Commissioning Group expects to obtain economic benefits or service potential from the asset. This is specific to the Clinical Commissioning Group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

At each reporting period end, the Clinical Commissioning Group checks whether there is any indication that any of its 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.

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. Accounting policies (continued)

1.11 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.

1.11.1 The Clinical Commissioning Group as lessee
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.

1.12 Cash
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

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

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

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
- A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

1.15 Non-clinical Risk Pooling
The Clinical Commissioning Group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Clinical Commissioning Group pays an annual contribution to 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.

1.16 Contingent liabilities and contingent assets
A contingent liability is:
- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group; or,
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

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

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

1. Accounting policies (continued)

1.17 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.17.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.17.2 Impairment

For all financial assets measured at amortised cost, the Clinical Commissioning Group recognises a loss allowance representing the expected credit losses on the financial asset.

The Clinical Commissioning Group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables 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 Clinical Commissioning Group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the Clinical Commissioning Group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

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

1.18 Financial Liabilities

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

After initial recognition, financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.19 Value Added Tax

Most of the activities of the Clinical Commissioning Group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Foreign Currencies

The Clinical Commissioning Group’s functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Clinical Commissioning Group’s surplus/deficit in the period in which they arise.

1.21 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

In the application of the Clinical Commissioning Group’s accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.21.1 Critical Judgements in Applying Accounting Policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Clinical Commissioning Group’s accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- None.

1. Accounting policies (continued)

1.21 Critical Accounting Judgements and Key Sources of Estimation Uncertainty (continued)

1.21.2 Key Sources of Estimation Uncertainty

There are considered to be no sources of estimation uncertainty that are likely to have a material effect on the amounts recognised in the Clinical Commissioning Group's financial statements.

- Estimates are inherent in a number of operational areas including accruals for prescribing costs, and expenditure dependent on

1.22 Accounting Standards that have been issued but have not yet been adopted

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022-23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- **IFRS 16 Leases** – IFRS 16 Leases has been deferred until 1 April 2022.

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

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

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

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

  The Clinical Commissioning Group has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income as follows:

	£'000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	2,613
Additional lease obligations recognised for existing operating leases	(2,613)
Net impact on net assets on 1 April 2022	-
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	255
Additional finance costs on lease liabilities	24
Lease rentals no longer charged to operating expenditure	(268)
Estimated impact on surplus / deficit in 2022/23	11

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

2. 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:

NHS Act section	Duty	2021-22 Target £'000	2021-22 Performance £'000	2021-22 Duty Achieved	2020-21 Target £'000	2020-21 Performance £'000	2020-21 Duty Achieved
223H (1)	Expenditure not to exceed income	**731,252**	**745,948**	**No**	657,457	671,412	No
223I (2)	Capital resource use does not exceed the amount specified in Directions	**-**	**-**	**Yes**	-	-	Yes
223I (3)	Revenue resource use does not exceed the amount specified in Directions	**730,684**	**745,380**	**No**	656,441	670,396	No
223J (1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	**-**	**-**	**Yes**	-	-	Yes
223J (2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	**-**	**-**	**Yes**	-	-	Yes
223J (3)	Revenue administration resource use does not exceed the amount specified in Directions	**6,295**	**5,944**	**Yes**	6,285	6,037	Yes

Note: for the purposes of 223H(1) expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amount accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

The Clinical Commissioning Group has not met the statutory requirement '223H(1) Expenditure not to exceed income' as the actual 2021-22 expenditure performance is £14.696m over the income received. A formal notification of this position will be made by the CCG's external auditors, Grant Thornton UK LLP, to the NHS Commissioning Board (NHS England) in June 2022. A referral to the Secretary of State under Section 30b of the Local Audit and Accountability Act 2014 will also be made at the same time.

The Clinical Commissioning Group made an in-year overspend (i.e. deficit) of £14.696m against its in-year revenue resource (2020-21: £13.955m in-year deficit), against a planned deficit of £13.992m. The £0.704m variance from the planned deficit represents 0.09% of overall expenditure.

The Clinical Commissioning Group received no capital resource during 2021-22 and incurred no capital expenditure (2020-21: £nil)

3. Other operating revenue

	2021-22 Total £'000	2020-21 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**157**	148
Total Income from sale of goods and services	**157**	148
Other operating income		
Other non contract revenue[1]	**411**	868
Total Other operating income	**411**	868
Total Operating Income	**568**	1,016

Notes:

[1] £106k lower Primary Care Rebate Scheme monies ; 20/21 non-recurrent funding: £202k cancer funding ; £145k training funding.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the Clinical Commissioning Group and credited to the General Fund.

The Clinical Commissioning Group has received no revenue from the sale of goods in 2021-22 nor 2020-21.

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

	2021-22 Education and training £'000	2020-21 Education and training £'000
Source of Revenue		
NHS	-	-
Non NHS	157	148
Total	**157**	148

	Education and training £'000	Education and training £'000
Timing of Revenue		
Point in time	-	-
Over time	157	148
Total	**157**	148

4. Employee benefits and staff numbers

4.1 Employee benefits

	2021-22			2020-21		
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits						
Salaries and wages	**3,556**	**71**	**3,627**	3,408	86	3,494
Social security costs	**395**	**6**	**401**	378	8	386
Employer Contributions to NHS Pension Scheme[1]	**654**	**6**	**660**	631	6	637
Other pension costs[2]	**2**	**-**	**2**	1	-	1
Apprenticeship Levy	**4**	**-**	**4**	3	-	3
Gross employee benefits expenditure	**4,611**	**83**	**4,694**	4,421	100	4,521

Notes:

[1] The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1 April 2019. For 2021-22, NHS Clinical Commissioning Groups continued to pay over contributions at the former rate with the additional amount being paid by NHS England on the Clinical Commissioning Groups' behalf. The full cost of £203,433 (2020-21 £194,485) and related funding has been recognised in these accounts.

[2] Contributions made to NEST workplace pension scheme.

4.2 Average number of people employed

	2021-22			2020-21		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**63**	**1**	**64**	61	1	62

4.3 Exit packages agreed in the financial year

The Clinical Commissioning Group did not agree any exit packages in 2021-22 nor 2020-21.

4.4 Pension costs

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

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

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

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

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

4. Employee benefits and staff numbers (continued)

4.4.2 Full actuarial (funding) valuation (continued)

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

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

5. Operating expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	**3,172**	4,779
Services from NHS Foundation Trusts[1]	**485,119**	413,978
Services from other NHS Trusts	**22,943**	22,122
Purchase of healthcare from non-NHS bodies	**98,859**	97,980
Purchase of social care	**70**	177
Prescribing costs	**58,858**	59,792
GPMS/APMS and PCTMS	**66,552**	61,604
Supplies and services – clinical	**2**	2
Supplies and services – general	**2,149**	2,090
Consultancy services	**127**	-
Establishment	**1,793**	2,255
Transport	**1**	0
Premises	**678**	1,048
Audit fees[2]	**65**	61
Audit related assurance services[3]	**6**	24
Other professional fees[4]	**195**	213
Legal fees	**71**	102
Education, training and conferences	**483**	537
Total Purchase of goods and services	**741,143**	666,762
Depreciation charges:		
Amortisation	**-**	3
Total depreciation charges	**-**	3
Other Operating Expenditure		
Chair and Non Executive Members	**110**	125
Clinical negligence	**1**	1
Total Other Operating Expenditure	**111**	126
Total operating expenditure	**741,254**	666,891

Notes:

1 Due to COVID pandemic NHS England advised of block payment values to main providers: £70.8m greater payments to North Cumbria Integrated Care NHS Foundation Trust.

2 The audit fee is inclusive of VAT (i.e. £53.3k plus VAT). The auditor's liability for external work carried out for the financial year 2021-22 is limited to £2,000,000.

3 Assurance engagement £12k fee for reviewing compliance with Mental Health Investment Standard of 2019-20 ; the assurance review for 2020-21 was cancelled and so the £12k accrual was released but an increased £18k fee has been accrued for the 2021-22 review.

4 Includes internal audit and counter fraud services provided by Audit One at a cost of £36k for 2021-22 (£34k 2020-21).

The NHS has continued in 2021-22 to work in a special COVID financial regime that was initially established during 2020-21 that includes a number of key transactional changes from previous financial years:

- All payments by CCGs to NHS Trusts are on the basis of nationally agreed “block” contracts including support funding in for operational and COVID costs for which the CCG received funding allocations.
- CCGs have received funding allocations to cover reasonable expenditure incurred in addressing the challenge of COVID. Similarly, further allocations were provided to support primary care providers in addressing the challenge of the pandemic.
- NHS continuing health care (CHC) was effectively suspended for patients discharged from hospital from mid-March until 1 September with costs of their on-going care funded from the national hospital discharge programme (HDP). From September 2020 this was limited to cover the first 6 weeks after discharge and then to the first 4 weeks after discharge from July 2021.

6. Better Payment Practice Code

Measure of compliance	2021-22 Number	2021-22 £'000	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	21,753	165,055	22,562	158,548
Total Non-NHS Trade Invoices paid within target	21,548	164,293	22,379	157,813
Percentage of Non-NHS Trade invoices paid within target	**99.06%**	**99.54%**	99.19%	99.54%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	412	514,261	994	437,376
Total NHS Trade Invoices Paid within target	408	514,246	989	437,250
Percentage of NHS Trade Invoices paid within target	**99.03%**	**100.00%**	99.50%	99.97%

The Better Payment Practice Code requires the Clinical Commissioning Group to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Clinical Commissioning Group has achieved the set target to pay 95% of invoices within this requirement.

The volume and value of invoices processed has decreased and increased respectively year-on-year as a result of the COVID pandemic. NHS England and Improvement determined monthly block and top-up payment values for NHS providers ; NHS providers could not raise invoices for activity in either year, in particular with regards to non-contracted activity (NCA) which are high volume but low value transactions. In the early part of 2020-21 NCA invoices relating to the prior year were still received and processed.

7. Operating leases

The Clinical Commissioning Group has arrangements in place with NHS Property Services Ltd and Community Health Partnerships Ltd in respect of the utilisation of various clinical and non-clinical properties. The Clinical Commissioning Group moved premises in the summer 2020 to a shared building with the local authority and NHS provider which has a lower occupancy cost. Although formal signed contracts are not in place for these properties, the transactions involved do convey the right to use property assets and accordingly the payments made in in each year are disclosed as minimum lease payments in note 7.1.

While our arrangements for the utilisation of various clinical and non-clinical properties fall within the definition of operating leases, the rental charge for future years has not yet been agreed and consequently no disclosure of future minimum lease payments for these arrangements is made for buildings in note 7.2.

The Clinical Commissioning Group does not act as lessor.

7.1 Payments recognised as an expense

	2021-22 Buildings £'000	2020-21 Buildings £'000
Payments recognised as an expense		
Minimum lease payments	**287**	313
Total	**287**	313

7.2 Future minimum lease payments

	Buildings £'000	Buildings £'000
Payable:		
Total	**-**	-

8. Intangible non-current assets

	2021-22 Computer Software: Purchased £'000	2020-21 Computer Software: Purchased £'000
Cost at 1 April	**9**	9
Cost at 31 March	**9**	9
Amortisation 1 April	**9**	6
Charged during the year	**-**	3
Amortisation at 31 March	**9**	9
Net Book Value at 31 March 2022	**-**	-

8.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	1	3

9. Trade and other receivables

9.1 Trade and other receivables

	Current 31-March-2022 £'000	Current 31-March-2021 £'000
NHS receivables: Revenue[1]	**1,051**	4,746
NHS prepayments	**-**	20
NHS accrued income	**514**	97
Non-NHS and Other WGA receivables: Revenue	**222**	381
Non-NHS and Other WGA prepayments	**344**	426
Expected credit loss allowance-receivables	**(1)**	(10)
VAT	**75**	43
Other receivables and accruals	**2**	2
Total Trade & other receivables	**2,207**	5,705

Notes:

[1] includes £42k (2020-21: £2,345k) debit balances as at 31 March transferred from Trade payables for presentational purposes, these balances will not be received by the Clinical Commissioning Group but netted off against future invoice payments to those relevant suppliers; £1,134k older debt paid by local NHS Trust.

9.2 Receivables past their due date but not impaired

	31-March-2022 DHSC Group Bodies £'000	31-March-2022 Non DHSC Group Bodies £'000	31-March-2021 DHSC Group Bodies £'000	31-March-2021 Non DHSC Group Bodies £'000
By up to three months	**1,413**	**92**	3,795	175
By three to six months	**99**	**1**	66	37
By more than six months	**159**	**98**	1,178	17
Total	**1,671**	**191**	5,039	229

The Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2022 nor 31 March 2021.

The great majority of trade is with other Department of Health and Social Care (DHSC) group bodies. As NHS England is funded by Government to provide funding to Clinical Commissioning Groups to commission services, no credit scoring of them is considered necessary.

9.3 Loss allowance on asset classes

	2021-22 Trade and other receivables - Non DHSC Group Bodies £'000	2020-21 Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 1 April	**(10)**	(10)
Amounts written off	**9**	-
Balance at 31 March	**(1)**	(10)

9.4 Provision Matrix on lifetime credit loss

	31-March-2022 Lifetime expected credit loss rate %	31-March-2022 Gross Carrying Amount £'000	31-March-2022 Lifetime expected credit loss £'000	31-March-2021 Lifetime expected credit loss £'000
Current	0.5%	**9**	**-**	-
1 - 30 days	1.5%	**8**	**-**	-
31 - 60 days	3.0%	**-**	**-**	-
61 - 90 days	10.0%	**-**	**-**	-
Greater than 90 days	25.0%	**1**	**1**	10
Total expected credit loss		**18**	**1**	10

10. Cash

	2021-22 £'000	2020-21 £'000
Balance at 1 April	**19**	14
Net change in year	**86**	5
Balance at 31 March	**105**	19
Made up of:		
Cash with the Government Banking Service	**105**	19
Cash as in statement of financial position	**105**	19

11. Trade and other payables

	Current 31-March-2022 £'000	Current 31-March-2021 £'000
NHS payables: Revenue	**101**	313
NHS accruals	**19**	-
Non-NHS and Other WGA payables: Revenue	**3,786**	3,897
Non-NHS and Other WGA accruals[1]	**31,266**	22,777
Social security costs	**57**	53
Tax	**56**	55
Other payables and accruals[2]	**1,013**	366
Total Trade & Other Payables	**36,298**	27,461

Notes:

1 Owing to the COVID pandemic and the wider NHS response to it, the timing of transactions has fluctuated considerably during the year and is reflected in the position at year-end. The Clinical Commissioning Group has used all endeavours to pay invoices on time but the pattern and timing of invoices into the Clinical Commissioning Group has varied year-on-year. Accruals impacted by £4m increased continuing healthcare accruals as arrangements have restarted following suspension in 2020-21 and £2m market sustainability accrual with funding having been confirmed in quarter 4.

2 Other payables include £638,511 outstanding pension contributions at 31 March 2022 (£300,820 at 31 March 2021).

12. Provisions

	Current 31-March-2022 £'000	Current 31-March-2021 £'000
Legal claims	**-**	3
Total	**-**	3

	2021-22 Legal Claims £'000	2020-21 Legal Claims £'000
Balance at 1 April	**3**	3
Utilised during the year	**(3)**	-
Balance at 31 March	**-**	3
Expected timing of cash flows:		
Within one year	**-**	3
Balance at 31 March	**-**	3

Legal claims are calculated from the number of claims currently lodged with the NHS Resolution and the probabilities provided by them. The value of provisions carried in the books of NHS Resolution in regard to clinical negligence claims as at 31 March 2022 is £nil (31 March 2021 £nil).

13. Contingencies

The Clinical Commissioning Group had no contingencies as at 31 March 2022 nor at 31 March 2021 which could be quantified.

The following information is supplied relating to areas where it is not possible to give a reliable cost:
Unreported incidents - in common with many other healthcare providers, it is possible that claims and litigation could arise in the future due to incidents that have already occurred. The future expenditure which may arise from such incidents cannot be determined until such time as claims are made.

14. Commitments

The Clinical Commissioning Group had no contracted capital commitments nor non-cancellable contracts (which were not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2022 nor at 31 March 2021.

15. Financial instruments

15.1 Financial risk management

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

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

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

15.1.1 Currency risk

The 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 Clinical Commissioning Group has no overseas operations and therefore has low exposure to currency rate fluctuations.

15.1.2 Interest rate risk

The Clinical Commissioning Group has no borrowings and therefore has low exposure to interest rate fluctuations.

15.1.3 Credit risk

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

15.1.4 Liquidity risk

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

15.2 Financial assets

	Note	**Financial Assets measured at amortised cost 31-March-2022**	Financial Assets measured at amortised cost 31-March-2021
		£'000	£'000
Trade and other receivables with NHSE bodies	9	**1,407**	888
Trade and other receivables with other DHSC group bodies*	9	**162**	3,955
Trade and other receivables with external bodies	9	**220**	383
Cash	10	**105**	19
Total at 31 March		**1,894**	5,245

* includes £43k (2020-21 £2,345k) debit balances as at 31 March transferred from Trade payables for presentational purposes, these balances will not be received by the Clinical Commissioning Group but netted off against future invoice payments to those relevant suppliers.

15.3 Financial liabilities

	Note	**Financial Liabilities measured at amortised cost 31-March-2022**	Financial Liabilities measured at amortised cost 31-March-2021
		£'000	£'000
Trade and other payables with NHSE bodies	11	**46**	147
Trade and other payables with other DHSC group bodies*	11	**648**	561
Trade and other payables with external bodies*	11	**35,491**	26,645
Total at 31 March		**36,185**	27,353

*mapping of GMS/PMS accruals has changed from other DHSC group bodies in 2020-21 (£4,365k) to external bodies in 2021-22 (£5,900k).

16. Operating segments

The Clinical Commissioning Group considers it has only one segment: commissioning of healthcare services.

17. Joint arrangements - interests in joint operations

The Clinical Commissioning Group operates one pooled fund in partnership with Cumbria County Council under section 75 of the Health Act 2006 (as amended). The Better Care Fund is hosted by Cumbria County Council and there has been no change to the operation of the fund. The Clinical Commissioning Group no longer operates a pooled fund for Learning Disability with Cumbria County Council and Morecambe Bay but continues to work closely with Cumbria County Council to commission arrangements for North Cumbria residents with a Learning Disability.

17.1 Interests in joint operations

The Clinical Commissioning Group's shares of the income and expenditure (North Cumbria) handled by the pooled budget were:

Name of arrangement	Parties to the arrangement	Description of principal activities	2021-22 Income	2021-22 Expenditure	2020-21 Income	2020-21 Expenditure
			£'000	£'000	£'000	£'000
Better Care Fund	NHS North Cumbria CCG, NHS Morecambe Bay CCG and Cumbria County Council	To support health and social care services to deliver integrated services	**-**	**26,625**	-	25,354
Learning Disability Specialised Commissioning Pooled Fund	NHS North Cumbria CCG, NHS Morecambe Bay CCG and Cumbria County Council	To commission services to improve the general well-being and life chances of people of all ages with a learning disability	**-**	**-**	-	6,136

18. Related party transactions

Details of related party transactions with individuals are as follows:

During the year none of the Department of Health Ministers, Clinical Commissioning Group Governing Body members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Clinical Commissioning Group, other than the members set out below.

2021-22	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Distington Surgery [Dr H Horton]	**1,501**	-	-	-
Longtown Medical Practice [Dr G Coakley]	**555**	-	-	-

2020-21	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Carlisle Healthcare GP Practice [Dr C Patterson]	**8,460**	-	**3**	-
Distington Surgery [Dr H Horton]	**1,489**	-	-	-
Longtown Medical Practice [Dr G Coakley]	**518**	-	-	-

Transactions are between the Clinical Commissioning Group and the declared organisation, not the individual, and form part of the Clinical

Dr C Patterson is no longer a salaried GP partner at Carlisle Healthcare GP Practice as of April 2020.

The Department of Health and Social Care (DHSC) is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the DHSC is regarded as the parent Department. These entities are:

- Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust
- North Cumbria Integrated Care NHS Foundation Trust
- NHS Business Services Authority (NHS Pension Scheme)
- NHS England (including North of England Commissioning Support Unit)
- North West Ambulance Service NHS Trust
- Northumbria Healthcare NHS Foundation Trust
- The Newcastle Upon Tyne Hospitals NHS Foundation Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- Wrightington, Wigan & Leigh NHS Foundation Trust

In addition, the Clinical Commissioning Group 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 Cumbria County Council and HMRC.

19. Events after the end of the reporting period

The Health and Care Act 2022 received Royal Assent on 28 April 2022. The Bill allows for the establishment of Integrated Care Boards (ICB) across England and abolishes Clinical Commissioning Groups (CCG). ICBs are due to take on the commissioning functions of CCGs from 1 July 2022 and the CCG functions, assets and liabilities are due to transfer to the North East and North Cumbria ICB as at 1 July 2022.

Independent Auditor’s Report to the members of the Governing Body of NHS North Cumbria Clinical Commissioning Group

Independent auditor's report to the members of the Governing Body of NHS North Cumbria Clinical Commissioning Group

Report on the Audit of the Financial Statements
Opinion on financial statements

We have audited the financial statements of NHS North Cumbria Clinical Commissioning Group (the ‘CCG’) for the year ended 31 March 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by 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, as required by the Code of Audit Practice (2020) (“the Code of Audit Practice”) approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the ‘Auditor’s responsibilities for the audit of the financial statements’ section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC’s Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 19 to the financial statements, which indicates that, under the Health and Care Act 2022 the commissioning functions, assets and liabilities of NHS North Cumbria CCG are due to transfer to the North East and North Cumbria Integrated Care Board on 1 July 2022.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the CCG's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the CCG to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Accountable Officer with respect to going concern are described in the 'Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

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

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

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Qualified Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity section of our report, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

The CCG reported expenditure of £745.948 million against income of £731.252 million and a deficit of £14.696 million in its financial statements for the year ending 31 March 2022. The CCG thereby breached two of its duties under the National Health Service Act 2006, as amended by paragraphs 223H and 223I of Section 27 of the Health and Social Care Act 2012, to ensure that annual expenditure does not exceed income and revenue resource use does not exceed the amount specified by direction of NHS England.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; 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 make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 2 June 2022 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to NHS North Cumbria CCG's breach of its revenue resource limit for the year ending 31 March 2022.

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer's Responsibilities (set out on pages 59 to 60), the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, 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.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

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 the 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 the financial statements in accordance with the Code of Audit Practice.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).

- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
    - the identification, evaluation and compliance with laws and regulations;
    - the detection and response to the risks of fraud; and
    - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
    - journal entries that improved the CCG's financial performance for the year; and
    - the reasonableness of the assumptions used in determining accounting estimates for accruals within trade and other payables.
- Our audit procedures involved:
    - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
    - journal entry testing, with a focus on significant journals which impacted on the CCG's financial performance;
    - challenging assumptions and judgements made by management in its significant accounting estimates in respect of accruals; and
    - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, included the breach of the CCG's revenue resource limit, the breach of the CCG's duty to ensure that annual expenditure does not exceed income, the potential for fraud in expenditure recognition, and the significant accounting estimates related to accruals included within trade and other payables.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
    - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
    - knowledge of the health sector and economy in which the CCG operates
    - understanding of the legal and regulatory requirements specific to the CCG including:
        - the provisions of the applicable legislation

- NHS England’s rules and related guidance
- the applicable statutory provisions.

- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The CCG’s operations, including the nature of its operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework**.**

Report on other legal and regulatory requirements – the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

Our work on the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the CCG’s arrangements in our Auditor’s Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor’s report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2022.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, 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 the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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 undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS North Cumbria CCG for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the members of the Governing Body of the 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 CCG and the members of the Governing Body of the CCG as a body, for our audit work, for this report, or for the opinions we have formed.

Signature: ***Joanne Brown***

Joanne Brown, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Glasgow
Date: 21 June 2022

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