NHS Manchester Clinical Commissioning Group (CCG)

Annual Report

2021/22

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This is the 2021/22 Annual Report and Accounts for NHS Manchester Clinical Commissioning Group (MCCG) covering the period from 1 April 2021 to 31 March 2022. MCCG is a clinically-led organisation, with a membership drawn from each of the GP practices in the city of Manchester, responsible for commissioning health services for the people who live in Manchester and those registered with GP practices in the city. In April 2017, we established a formal partnership with Manchester City Council to form Manchester Health and Care Commissioning (MHCC) – a single commissioner of health, public health and adult social care for the city of Manchester. These arrangements changed in April 2021 (which is set out in more detail in the 'Our organisation' section of this report), however the CCG and the Local Authority have continued to work closely to ensure the health needs of the people of Manchester are met.

**It should be noted that throughout the document there are links to the websites of external organisations and information outside Manchester CCG and Manchester Health and Care Commissioning, and as such the CCG and MHCC do not take responsibility for the content in these external links. These are included to provide further background for readers who want to access it. This information should not be interpreted as having been read by our auditors.*

Chair's introduction

Nothing ever stands still in life and our NHS & care system is no exception. As we prepare this, what we expect will be our final annual report; we are simultaneously preparing to close the doors of MHCC *and* transition into the new structures that will take over in Greater Manchester from July 2022. This is a little later than originally planned - it was always ambitious to attempt a restructure of this scale during an international pandemic - but it does, happily, mean that we get to spend just a little bit longer in the company of our highly skilled and much appreciated colleagues.

Since our beginning in April 2017, we have been through a great deal together as a CCG. From supporting the health response to the Manchester Arena Attack, to prioritising the reduction of health inequalities and social injustice across so many of our work programmes, to developing our neighbourhoods to work in broader, more holistic ways, better meeting the needs of our communities. And, in the last few years, alongside maintaining core commissioning of services for patients and meeting our statutory responsibilities, we have led and guided the response to Covid-19 in our city, something that will live with us for the rest of our days.

The difficulties of the pandemic have continued over this last twelve months and we know that many people in our city continue to struggle with the impact of Covid-19. I see this in every GP surgery that I hold in my practice in Wythenshawe. The work that now needs to take place to recover our NHS services will dominate the next decade and we look to the new leadership structures in Manchester and Greater Manchester to guide us through this.

You will read in more detail throughout this report of the work we have done this past year. I hope that our commitment and dedication to patients and citizens shines through. These have been exceptional times and our teams have worked tirelessly in the face of ever changing demand, sacrificing their own personal needs to support delivery of the best care they can.

Despite the seriousness of the times, there is much to be proud of. For my part, I am unendingly proud to have served as Chair of MHCC. Born and bred in Manchester, the first person in my family to go to university, the first, & now only, woman to have been a CCG Chair in Manchester. It has been an honour and a privilege to serve my city, representing my GP colleagues, working with brilliant, dedicated people from MHCC and far beyond. I have made some amazing friendships along the way, and learned so very much that I will take with me into my next adventure, whatever that might be.

And, I sincerely hope that colleagues will carry their own sense of pride and celebration in their work with them, as they transition into new roles and take on new challenges. I know there is and has been great sadness at the thought of us losing those human connections we have come to cherish and rely on over recent years. My hope for everyone is that there will be a new sense of purpose and pride in whatever comes next. There is such talent at MHCC and the new NHS structures need to embrace and harness what each of our colleagues here has to offer because the work for our city does not go away. In fact, as we build back from Covid-19 and focus on recovery, the work we do here will, I sincerely believe, be more important than ever.

So as we step into the future, may I take this opportunity to say to all of you who make MHCC what it is… please know how valued and important your contributions have been and always remember that the work that you have done here has really mattered.

Thank-you from the bottom of my heart,

Dr Ruth Bromley

Chair, Manchester Health and Care Commissioning and Manchester CCG Governing Body

PERFORMANCE REPORT

Introduction

As you may be aware, we will transition over to a wider Greater Manchester Integrated Care System from 1 July 2022, so this will be my last opportunity as Chief Accountable Officer at Manchester Health and Care Commissioning to provide an overview of the last year and describe our performance.

Before I do that, I would like to thank all our staff for their hard work over the past five years. Your dedication to ensuring the people of Manchester receive the best possible care has been remarkable. It is thanks to your contributions that we have made real progress in ensuring that Manchester is a city where everyone can live a healthier life, so thank you to you all.

This year, just like last, much of our work has been centred around supporting our city through the pandemic, so I would also like to say another thank you to the people of Manchester and the health and care staff across the city, who have worked together to combat the threat posed by Covid-19.

Despite this focus, it is still important that people can see how taxpayers' money is being used in the city and the impact it is having on the population's health and the services provided.

Below is a summary of our achievements over the last year, under each of our organisation's strategic aims. In each case the most recent data available is used.

Strategic aim one: Improve the health and wellbeing of people in Manchester

- Continued to work collaboratively with MFT to deliver the surveillance phase of our Lung Health Check programme (Targeted Lung Cancer Screening), identifying patients at increased risk of developing lung cancer and offering regular surveillance through community based ultra-low dose CT scans.
- Created easy read leaflets for people with learning disabilities (LD) with embedded links, such as cancer screening, health promotion, chronic disease, constipation, falls, healthy lifestyle and vaccinations.

- Supported Afghan refugees as part of the Afghan Resettlement Assistance Programme, delivering a population health management approach, reducing health inequalities for one of most vulnerable communities.
- Business Intelligence data and systems have been developed which have allowed an improved understanding of programme outcomes, including the Covid-19 Vaccination Programme and the GM Care Record.
- Successfully developed and implemented Long Covid pathway and services, including receipt of funding to support rehabilitation services for people with Long Covid.
- A Mental Health Support Team setup to support education settings in the city, with specialist mental health support services being offered to children via Manchester Thrive in Education. Provided one to one help to over 460 students in its first year of operation (September 2020 to August 2021).
- Additional Discharge to Assess beds commissioned to support hospital discharge, with home first considered the default discharge pathway.
- Additional funding for Primary Care via the Primary Care Quality Recovery and Resilience Scheme (PQRRS) for 2021/22.

Strategic aim two: Strengthen social determinants of health & promote healthy lifestyles

- Supported the delivery of the Manchester Covid-19 Vaccination Programme, which has delivered over one million vaccinations so far.
- Refreshed the Our Healthier Manchester Locality Plan for 2022, which provides a strategic framework for how Manchester partner organisations support the health and care needs of Manchester residents.
- An increased focus on cancer screening uptake, with screening now included in Primary Care Network (PCN) early cancer diagnosis enhanced service offer. Each PCN now has a Cancer Lead, and Quality Improvement Plans.

Strategic aim three: Ensure services are safe, equitable & of a high standard with less variation

- Established a 24/7 mental health crisis helpline for known and unknown service users and their families, helping to manage service demand.
- In partnership with GMMH, reviewed referral pathways for mental health crisis care with the aim of reducing psychiatric admissions.

- Expanded the Crisis Care Pathway by opening two crisis cafes / listening lounges in the north and the city centre.
- New dermatology service for Manchester patients was launched in 2021.
- The Community Health Protection Team have supported the management of more than 300 Covid -19 outbreaks across Manchester and supported institutions across Manchester in managing over 160 outbreaks of other infections.
- Supported agile working in Primary Care during the Covid-19 pandemic, ensuring all GP practices are able to deliver online support such as digital triage and consultation.
- Supported GP practices to sustain business as usual and maintain access in the face of increasing Covid pressures, including the distribution of 60,000 lateral flow device tests throughout General Practice to ensure staff could continue to test at a time where LFDs were difficult to access.
- Supported patients with access to digital services, including providing devices and training to those who may have experienced digital inclusion issues.
- Following a safe and wellbeing review, established new process to ensure no person with a learning disability and / or autism is in a mental health inpatient facility inappropriately – process has been commended across Greater Manchester as a gold standard and is expected to be rolled out nationally.
- Implementation of Gateway®, a new referral management software which is fully integrated into the GP clinical system, improving the quality of referrals.
- Developed a Patient Initiated Follow Up processes (PIFU) to allow patients to schedule follow-ups at a time which is more convenient to them.
- Delivered a comprehensive anti-racism programme for MHCC staff, including the Executive Team and Senior Managers. This includes fair and inclusive recruitment training for managers, which has increased recruitment of people from communities experiencing racial inequalities, as well as increased the satisfaction of MHCC staff from communities experiencing racial inequalities.

Strategic aim four: Enable people & communities to be active partners in their health & wellbeing

- The MHCC engagement team successfully recruited and supported over 3000 volunteer marshals for the Covid-19 Vaccination Programme.

- Engaged with communities on digital inclusion issues relating to GP access - 13 community organisations now been commissioned to support their communities to increase confidence in accessing health care digitally, including the use of the NHS App.
- Developed plans for the implementation and performance management of community diagnostic centres using an addressing inequalities approach - centres are being rolled out in 2022 within Imaging, Cardiorespiratory, Endoscopy and Phlebotomy services to be provided.

Strategic aim five: Achieve a Sustainable system

- Supported PCNs to recruit over 200 new 'Additional Roles Reimbursement Scheme' (ARRS) roles to support General Practice to deliver additional Pharmacist, Nursing, Mental Health and Social Prescribing roles.
- The estates team successfully applied for circa £5m of NHS England capital grant funding to enable a number of primary care estates schemes to be progressed, including:
    - Construction costs for the GP practice accommodation in the new build Gorton Hub which will enable Gorton Medical Practice to relocate in October 2022. The Gorton Hub is a new learning, health and community hub that will bring together a range of different services under the same roof for the first time in Manchester.
    - Acquisition of the leasehold of ground and first floor accommodation within the newly built Elizabeth Tower in the Great Jackson Street residential city Centre development. This new GP practice accommodation provides 16 clinical rooms which will enable a number of GP practices provide additional primary care services for the growing residential population. The accommodation will be fitted out and be operational in January 2023.
    - Relocation of the Jolly Medical Practice to the refurbished Crumpsall Vale on the North Manchester General site in summer 2022.
- The MHCC Business Intelligence Team have been awarded the 'Excellence in Informatics Level 2 Accreditation', one of only two CCGs to receive the award in the North West.

- The single hospital service in Manchester has now been established, with a business case developed for the regeneration of the North Manchester General Hospital.
- Funding agreed for the redevelopment of the Mental Health inpatient facility at New Park House.
- Addressing inequalities plan developed, with partners working to identify which areas of their work could help reduce health inequalities across the city.
- MHCC Medicines Optimisation Team has started to expand across the city to deliver critical work-streams in PCNs, including structured medication reviews.

Manchester Covid-19 Vaccination Programme

The Manchester Covid-19 Vaccination Programme has been an unprecedented success in terms of the speed of the roll-out and the coverage of our population in response to the pandemic. In the last twelve months over one million vaccinations have been delivered to patients registered in Manchester, through a co-ordinated effort across multiple system partners including Primary Care Networks, Manchester Foundation Trust/Local Care Organisation, Community Pharmacy, the City Council and VCSE (Voluntary Community Social Enterprise) partners.

This collaborative approach has demonstrated the strength and effectiveness of closer partnership and system working across local vaccination venues across Manchester. The vaccination programme has further exposed the health equity challenges within the city and offered significant opportunities to test new approaches to address inequalities. Key highlights include numerous pop-up clinics at mosques, markets, colleges and community centres right across the city, bespoke clinics for at risk children, people with learning disability and severe mental illness, wraparound adult clinics, support to in-school vaccinations, and a highly successful overseas vaccination recording pilot.

Independent evaluation by the University of Manchester found that the targeted vaccination drive which focused on specific wards and ethnic groups (Black African, Black Caribbean, Pakistani, Bangladeshi, Chinese, Gypsy, Roma and Irish Traveller) was effective in narrowing the coverage gap between these groups and the general population. https://www.mhcc.nhs.uk/about-us/our-people/board/meetings/meeting/april-2022.

The sustained focus on addressing inequalities is being taken wider into all future vaccination and immunisation planning and wider population health programmes.

Over the following pages, we detail the context we work within, what we do, and how we do it. We also describe the impact of our work on the city's health and wellbeing and describe where there are still challenges.

If you would like any further information on the work of MHCC, please contact communicationsmanchester@nhs.net.

Ian Williamson

Accountable Officer

16 June 2022

Our organisation

NHS Manchester Clinical Commissioning Group (MCCG)

NHS Manchester CCG (MCCG) was established as a statutory organisation on 1st April 2017, following the merger of its predecessor organisations – North, Central, and South Manchester CCGs. It is accountable as a statutory organisation to NHS England/Improvement. This is the Annual Report of MCCG although the majority of references throughout this Performance Section of the report refer to MHCC. This reflects the way we work and the integrated nature we work with Manchester City Council.

Manchester Health and Care Commissioning (MHCC)

Manchester Health and Care Commissioning, formed on 1 April 2017, is the partnership between Manchester City Council (MCC) and NHS Manchester Clinical Commissioning Group (MCCG) which was established to commission health, public health and adult social care in the city.

On 1 April 2021, new arrangements came into place between MCC and Manchester Foundation Trust (MFT) to support Manchester's Local Care Organisation (MLCO). This included the creation of a new Section 75 (S75) between MCC and MFT which included Adult Social Care services, which previously made part of the S75 between MCCG and MCC. The changes meant that:

- MHCC would no longer have any role, responsibility or accountability with regard to Adult Social Care (which would now be delivered by the MLCO as part of a new S75 agreement between MCC and MFT).
- The Population Health and Wellbeing function would remain part of the MHCC working arrangements through the Director of Population Health and his team. However, the budget would be overseen by MCC.
- The integrated budget arrangements would cease. However, in line with Better Care Fund planning requirements, the CCG and MCC would continue have a Better Care Fund (BCF) and Improved Better Care Fund (IBCF) pooled budget (in accordance with Section 75 of the National Health Service Act 2006).

- Manchester CCG and Manchester City Council would seek a continued and meaningful relationship under the banner of Manchester Health and Care Commissioning.
- In order to maintain continuity, alignment, and the ability to effectively carry out MHCC's functions for 2021/22, the CCG continued to have MCC representation on the MHCC Board and relevant Committees.

MHCC's partnership arrangements are described in a Section 75 agreement (relating to the BCF and IBCF) and decision making is carried out through its and MCCG's governance structures detailed later in this Annual Report.

The MHCC offices are based at Parkway Business Centre, Princess Road, Manchester, M14 7LU.

We hold MHCC Board meetings monthly in Manchester city centre, however some meetings were held virtually during 2021/22 due to the government's COVID-19 pandemic restrictions. The meetings are open to the public and further information is available on the MHCC website at https://www.mhcc.nhs.uk/about-us/board-meetings.

These are followed by Governing Body meetings when matters reserved to the CCG require discussion.

MHCC oversees the commissioning of a range of health and care services, including:

- Urgent and emergency care including A&E, ambulance and out-of-hours services
- Older people's healthcare services
- Planned, non-emergency hospital care
- Rehabilitation services
- Mental health and learning disabilities services
- Healthcare services for children
- Community health services including continuing healthcare
- Maternity services

- Infertility services
- Co-commissioning of primary medical services with NHS England

These services are delivered by a range of providers, including NHS hospitals, community health and social care providers, primary care providers, private and third sector organisations, and the Manchester Local Care Organisation (MLCO), a partnership between health and care providers which was established in April 2018. As a strategic commissioner, MHCC transfers to providers a number of resources and responsibilities, including service design, demand and capacity planning, and the subcontracting of services. This is intended to provide greater opportunities for providers to provide joined up care, transform the health and care system, and take a more proactive approach to improving health outcomes. Under these arrangements MHCC focuses on long term objective setting and system-level transformation programmes.

MHCC operates across five directorates. The Clinical Directorate links closely with primary care, acts as a key interface with providers on clinical matters, and works to ensure patients across the city are given the best and most cost-effective medicines. The Directorate of Corporate Services performed functions associated with operational finance, workforce and OD, IM&T and corporate affairs. The Directorate of Performance, Quality Improvement & Reform for Delivery is primarily concerned with monitoring provider performance and facilitating improvement and reform of services. The Directorate of Population Health, Nursing and Safeguarding focuses on public health, health intelligence, and nursing and safeguarding. The Directorate of Strategy is concerned with the provision of integrated care (including services for children and people with learning disabilities, autism and mental health conditions), as well as business intelligence, strategy, policy and planning.

Our five strategic aims are:

- Improve the health & wellbeing of people in Manchester
- Strengthen social determinants of health & promote healthy lifestyles
- Ensure services are safe, equitable & of a high standard with less variation
- Enable people & communities to be active partners in their health & wellbeing

- Achieve a sustainable system

During 2021/22 many of MHCC's work programmes continued to be affected by the impact of Covid-19, and we focused on developing plans and approaches to recover from the impact of the pandemic. In order to achieve MHCC's strategic aims (as set out above) and to support system recovery, work programmes were concentrated around the following themes:

- Reducing Inequalities – including the development of an addressing inequalities plan to reduce the gap in health and wellbeing outcomes for people across the city; improve children's outcomes in their first 1000 days of life; support people with health conditions to be in work; enable people to be confident in managing their own health and care; enable people in mid to later life to live longer in good health; and to reduce the number of people dying from preventable causes.
- Recovery – including the development of plans within elective care, cancer, outpatients, community care, Mental Health and Learning Disability to support a recovery of services back to pre-pandemic levels and reduce backlogs.
- Supporting the LCO and expanding primary care – including the expansion of primary care through the recruitment of additional staff roles, improving digital access to primary care and having effective community pathways in place to support timely hospital discharge and to avoid unnecessary hospital admissions.
- Covid response – which involved a comprehensive vaccination programme including community engagement to target take up.
- System working and integrated care – which involved effective working across the system including the development of Manchester Partnership Board priorities, the development of a strategic resource allocation model across Manchester
- Manchester strategies, infrastructure and resources – including developing a health infrastructure as a driver for economic regeneration such as the North Manchester General Hospital regeneration and the refreshing of the city strategies such as the Manchester Locality Plan.

Greater Manchester Health and Social Care Partnership

MHCC is a partner in the Greater Manchester Health and Social Care Partnership (GMHSCP).

Over the past five years, Greater Manchester has progressed the delivery of its strategy *Taking Charge Together* as a devolved health and social care system. The integrated health and social care models developed in each of the 10 localities in Greater Manchester are a fundamental part of this.

Of course, the last two years have seen us face an unprecedented challenge in the shape of the Covid-19 pandemic. Partners from across Greater Manchester rallied to the cause and worked more closely together than ever to respond to the pandemic. This was seen in the coordinated work to deliver the vaccination programme across localities; in the way that hospitals collaborated and provided mutual aid to each other; and in the joined-up approach to discharge across health and social care.

However, the pandemic also laid bare the impact of deprivation on health outcomes for our citizens compounded by a multitude of wider inequalities. This is a challenge for the whole of Greater Manchester. It reinforces the ongoing need for a broad public service reform agenda, linked to a commitment to sustainability and the building of a more inclusive economy. Integrated care, delivered across all 10 localities, has a significant role to play throughout this agenda.

The advent of the Integrated Care System provides the opportunity to accelerate the work that has taken place on over the last five years and more in Greater Manchester: towards integrated place-based working that connects all partners who can contribute to health benefit and tackle health inequalities, and to a stronger model of collaboration at the GM level which ensures more consistent and reliable responses to systemic challenges.

Greater Manchester strongly supports the national objectives for Integrated Care Systems and has recognised our enhanced potential for being ambitious in pursuit of them. For example, the depth of connection across public services and with the VCSE; the alignment to the Greater Manchester Strategy; the population health potential as the only Marmot City Region with a Mayoral Combined Authority and

dedicated Population Health Board to coordinate capacity at the GM level; and the existence of Health Innovation Manchester connecting the NHS, academic and GM industry base to support broader social and economic development and develop and spread innovation at pace and scale.

Work continues to establish the statutory Integrated Care System in Greater Manchester by 1st July 2022. Each of the 10 localities are putting plans in place to further develop integrated, place-based models of care and support. How all of this comes together will be described in a new Integrated Care Strategy for Greater Manchester (the successor document to *Taking Charge Together*), which will be published later this year.

The Manchester Population

Manchester has a resident population of 582,900 according to the Manchester City Council Forecasting model. This is significantly higher than the **557,741** Office of National Statistics estimate for mid-2020 which calculates the amount of migration into and out of Manchester and the scale of local housebuilding very differently to the City Council's measure.

In addition to the resident population of Manchester, MHCC is also responsible for commissioning health services for the **697,380** people who were registered with a GP practice in Manchester as of March 2022, although there is clearly a large overlap between this figure and the resident population.

Just under 38% of the population of Manchester is aged under 25 – higher than the average for England as a whole (Source: ONS Mid-Year Estimates)

Manchester is the 6th most deprived local authority in England. Around 43% of areas within the city are classed as being in the most deprived 10% of areas in England (Source: IMD 2019)

The proportion of the population from a non-White British ethnic group is twice the average for English local authorities as a whole. The number of different ethnic groups living in Manchester is higher than any other UK city outside of London (Source: 2011 Census).

In 2021, just over 26% of Manchester residents were estimated to have been born outside of the UK and around 18% were non-UK nationals (Source: ONS Annual Population Survey). It is estimated that there are over 200 languages spoken in the city.

Life expectancy at birth for men in Manchester is the 3rd lowest in England. For women, it is the 5th lowest. A boy born in Manchester can expect to live just over 9 years less than a boy born in the most affluent parts of England. A girl can expect to live around 8 years less.

Over the next 10 years, the resident population of Manchester is projected to increase. Forecasts produced by the City Council suggest that there will be around 646,900 people living in the city by 2028. The City Council's forecasts indicate that the annual population growth rate in Manchester is likely to be greater than that assumed by the ONS in its subnational population projections. We will have a more accurate picture of the current and future size of the local population once data from the 2021 Census is published in the summer of 2022.

The Coronavirus (COVID-19) pandemic has had a significant impact on health outcomes in Manchester and on the levels of health inequality experienced by our communities. This represents a continuation of the trend seen in the period immediately prior to the pandemic, when the data was starting to show a slowing down of the rate of improvement in a range of different health outcomes, including a stagnation in increases in life expectancy. Inequalities in life expectancy between the most and least deprived parts of the city have also been widening.

The pandemic has further accelerated these pre-existing trends and has helped to widen the scale of health inequalities experienced by some communities in the city. The latest data shows that life expectancy at birth for Manchester residents has fallen by 3.0 years for men and 2.0 years for women in 2020 compared with 2019. The falls in life expectancy in Manchester were greater than those seen across England as a whole. In total, there were around 568 more deaths in men and 295 more deaths in women living in Manchester in 2020 compared with 2019.

To stop the pandemic's damage worsening health and inequalities further, MHCC will work with its partners to tackle the poverty and inequity causing poor health and

shorter lives, especially Black lives, and those of Asian and Minority Ethnic groups, disabled and older people, children and young people, women, and those on low incomes.

Professor Sir Michael Marmot, an international expert in tackling health inequalities, produced recommendations for Greater Manchester in his “Build Back Fairer in Greater Manchester” report. He described steps the City Region can take to improve the ‘indicators’ of better living or the ‘causes of the causes’ of health inequalities. In Manchester, given our particular challenges which are often greater than in other boroughs, we are responding to this by developing our own Marmot Health Inequalities Action Plan (more information on this can be found in the ‘Health and Wellbeing Strategy and Reducing Inequalities section of this report) to narrow the unacceptable gap between the healthiest and the least healthy and to continue to improve the life chances and opportunities of our children and young people.

Performance Overview

Performance Summary

The performance and quality of commissioned services is managed by the Performance, Quality Improvement and Reform (PQIR) Team (shared between Manchester Health and Care Commissioning (MHCC) and Trafford CCG). The core function of the PQIR team is to monitor and manage the performance and quality of commissioned providers.

The team produces and operational framework every year which sets out how the team will work and provide assurance to the CCG's Board and Committees.

In simple terms, this involves:

- Having well developed and embedded governance structures, with leadership from Quality and Performance Committees; Boards; Urgent Care Strategic and Operational Delivery Boards;
- Having SMART objectives for providers
- Having robust data about all providers – both quantitative and qualitative. This includes, but is not exclusive to,
    - delivery against agreed performance and quality standards;
    - feedback from incident reporting procedures;
    - patient feedback;
    - findings from walkrounds; and
    - Progress against improvement/recovery plans where applicable.

This forms the basis of assurance reporting and escalation where necessary via the governance structures described above.

The '2021/22 priorities and operational planning guidance' set out the following priorities at the start of the year and was updated in October 2021 (H2) to reconfirm

the objectives set and to reflect the challenges for the remainder of the year due to seasonal pressures exacerbated by the ongoing impact of the COVID-19 pandemic.

- Supporting the health and wellbeing of staff and taking action on recruitment and retention
- Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
- Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
- Working collaboratively across systems to deliver on these priorities

Consequently, the focus in 2021 / 22 has been on recovery and the return to pre-pandemic levels of activity and performance.

Performance Analysis

Ensuring and driving quality, performance and improvement

At every meeting, the Board receives reports on performance against local and national measures and performance of MHCC's main providers:

- Manchester University Hospital NHS Foundation Trust (MFT)
- Manchester Local Care Organisation (TLCO)
- Greater Manchester Mental Health NHS Foundation Trust (GMMH)
- Independent sector providers (including voluntary sector)

- General Practice services.

Measurement of the CCG's effectiveness is underpinned by a range of monitoring frameworks that are directly influenced by the performance of our providers, both acute and community;- constitutional standards, national and local Key Performance Indicators (KPI's) and the System Oversight Framework (SOF).

Constitutional standards

The ability to meet the performance requirements of the constitutional standards has been extremely challenging across all organisations, severely hampered due to the disruption caused by the Covid-19 pandemic, both nationally and locally, and is where our recovery efforts will continue to be focussed moving forward into 2022/23. At CCG level, these include;

- **Accident and Emergency (A+E)**

Performance against the 4 hour standard has been unachievable throughout the year averaging 68% against the target of 95%, with a high of 78.5% and a low of 61%. There have been significant improvements in the number of patients remaining in hospital following a "No Reason to Reside" decision, and this continues to be a focus of initiatives designed to improve the discharge process from hospital. Attendances at A+E have fluctuated significantly across the year, reducing by 29% between the high and low points.

A single Manchester and Trafford Urgent Care 10 Point Action Plan has been produced to focus on recovery and ensure system oversight and governance.

- **Referral to Treatment Times (RTT)**

At various points throughout the year, non-urgent elective operations were stood down allowing hospitals to focus on the COVID response. Consequently, all elements of performance in relation to referral to treatment were negatively affected.

The waiting list size increased by 20% and performance against the 18 weeks 92% standard dropped significantly to 52%. The number of patients waiting more than 52 weeks reached over 7,200 before recovering slightly towards the end of the year but

this was offset by the emergence of over 670 patients waiting more than 104 weeks (2 years).

All secondary care providers have in place recovery plans in line with National Planning Guidance throughout 2022/23. We are fully engaged with the Greater Manchester (GM) Elective Recovery and Reform Programme focussing on;

- Outpatient Reform
- Theatre capacity and demand modelling
- Elective hub modellling
- Clinical Reference Group establishment - Orthopaedics / Ophthalmology / Ear, Nose & Throat / Children's Surgery / Gynaecology / Oral Surgery / Dermatology / General Surgery / Endoscopy Network
- Waiting Well Programme

- **Access to Diagnostic Tests**

The onset of the pandemic meant that the proportion of people waiting more than 6 weeks for a diagnostic test rose from 1.6% in December 2019 to an unprecedented 40% in Jan 2022, with an average of 31% through 2021 / 22.

The focus for improvement is via the development of Community Diagnostics Centres (CDC) which will help to achieve;

- earlier diagnoses for patients through easier, faster, and more direct access to the full range of diagnostic tests needed to understand patients' symptoms including breathlessness, cancer, ophthalmology
- a reduction in hospital visits which will help to reduce the risk of COVID-19 transmission
- a reduction in waits by diverting patients away from hospitals, allowing them to treat urgent patients, while the community diagnostic centres focus on tackling the backlog

- a contribution to the NHS's net zero ambitions by providing multiple tests at one visit, reducing the number of patient journeys and helping to cut carbon emissions and air pollution

CDC's are planned for Clayton Health Centre (North), Brownley Green Health Centre (South) and The Vallance Health Centre (Central) within Manchester

- **Cancer Standards**

During 2021 / 22, 2 out of 9 cancer standards were met. Of particular note is that providers have been unable to consistently deliver the 2 week wait and cancer treatment within the 62 day standards. Manchester's performance is reflective of the national challenges faced by cancer services in terms of increased demand and staffing issues across all providers.

A cancer recovery programme is in place with the aim of returning to 2WW and 62-day performance (for internal MFT patients only) back to pre-COVID levels by March 2022. Patient Tracking List (PTL) size is being monitored but the volume of referrals, diagnostic/treatment capacity and patient fitness/choice are affecting MFT's ability to make significant reductions.

- **Mental Health**

The national access target for 2021 / 22 was to ensure 22% of patients with a common mental health condition receive treatment. As at quarter 3, performance indicated that this target would be reached with a trajectory to year end of 23.3%.

In relation to recovery rates for people with depression and/or anxiety disorders, as at quarter 3, the national standard of 50% had not been met in all months with an average of 44% being reported.

The guidance for 2022/23 reiterates the importance of continued delivery of the Mental Health Long Term Plan. Integrated Care Systems are being asked to continue the expansion and transformation of mental health services. There should be a focus on improving equalities and the mental health Investment Standard remains a mandatory minimum requirement.

National and Local KPI's

Despite the disruption to all areas of service provision, in relation to national and local KPIs, there were some notable areas of achievement in 2021 / 22, namely;

- No Cancer patients waited more the 31 days for drug or radiotherapy treatment
- No Manchester patients acquired MRSA infection
- On track for 80% of people with Learning Disabilities to have received an annual health check by year end, ahead of the national target
- The access rate to the Children and young people's mental health service was projected to be 55% at year end, significantly above the national target of 35%
- All children and young people with eating disorders were seen with 1 week (urgent cases) and 4 weeks (routine cases) against targets of 90% and 95% respectively
- All patients referred for Psychological Therapy services waited no longer than 18 weeks to be seen
- The proportion of women receiving specialist perinatal mental health care was 7%, significantly exceeding the national target of 4.8%
- The diagnosis rate for dementia was 71%, ahead of the national target of 67%
- 67% of people with a first episode of psychosis started treatment with a NICE-recommended package of care within 2 weeks of referral, ahead of the 60% target.

NHS System Oversight Framework (SOF)

NHS England has a legal duty to annually assess the performance of each Clinical Commissioning Group (CCG). The assessment must consider the duties of CCGs to improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties.

From 2015/16 to 2019/20, this was done first under the auspices of the CCG Improvement and Assessment Framework and for 2019/20 the NHS Oversight Framework. This provided an approach whereby CCG performance was assessed in key areas that covered leadership, financial management and performance in priority areas. On the basis of this performance, NHS England provided each CCG with an overall assessment rating using the CQC rating terminology of 'Outstanding', 'Good', 'Requires Improvement' and 'Inadequate'.

For 2020/21, a simplified approach to the annual assessment of CCGs' performance was taken as a result of the differential and continued impact of COVID-19. It provided scope to take account of the different circumstances and challenges CCGs faced in managing recovery across the phases of the NHS response to COVID-19 and focused on CCGs' contributions to local delivery of the overall system recovery plan. A narrative assessment, based on performance, leadership and finance, replaced the ratings system previously used for CCGs.

This approach has been adapted for 2021/22 to provide greater flexibility to reflect both the continued uncertainty faced by the NHS in light of COVID-19 and the increasingly significant differences between the size and nature of CCGs with the delivery of streamlined commissioning arrangements aligned to Integrated Care System (ICS) footprints.

As part of this, a revised set of oversight metrics will be used by NHS England / Improvement and ICSs to flag potential issues and prompt further investigation of support needs with ICSs, place-based systems and/or individual trusts and commissioners.

The revised indicators are a single set of metrics covering ICSs, trusts, clinical commissioning groups (CCGs) and primary care, aligned to five national themes;

- Quality of Care, Access and Outcomes
- Preventing Ill Health and Reducing Inequalities
- People
- Finance and the Use of Resources

- Leadership and Capability

The initial framework consists of 100 indicators, 22 of which are placeholders for future development. 38 of the indicators are currently reported at CCG level

For each indicator, the ranking for Manchester nationally and against its closest peers is provided. The summary points from the most recent update (March 2022) are:

Of the 39 indicators that are reported so far, MHCC has;

- 8 (21%) in the highest performing quartile
- 17 (44%) in the interquartile range
- 14 (35%) in the lowest performing quartile

The national rankings for indicators in the top and bottom quartiles are as follows;

Indicators in the top quartile (8)

Metric	**Rank**
Waiting times for Urgent Referrals to Children and Young People's Eating Disorder services	**1 / 106**
Waiting times for Routine Referrals to Children and Young People Eating Disorder Services	**1 / 106**
Proportion of cancers diagnosed at stages 1 or 2	**2 / 79**
People with severe mental illness receiving a full annual physical health check and follow up interventions	**14 / 106**
Estimated diagnosis rate for people with dementia	**11 / 106**

Children and young people (ages 0-17) mental health services access (number with 1+ contact)	**20 / 106**
IAPT access (total numbers accessing services)	**19 / 106**
Diagnostic activity levels – Endoscopy	**23 / 106**

Indicators in the bottom quartile

Metric	**Rank**
Percentage of people aged 14+ on the GP learning disability register receiving an annual health check	**77 / 105**
Clostridium difficile infections	**80 / 106**
Overall size of the waiting list	**85 / 106**
Proportion of people that survive cancer for at least 1 year after diagnosis	**75 / 97**
Diabetes patients that have achieved all the NICE recommended treatment targets (Adults and children)	**88 / 106**
Patients waiting more than 52 weeks to start consultant-led treatment	**89 / 106**

IAPT recovery rate (%)	**93 / 106**
% Cancer Referrals meeting faster diagnosis standard	**95 / 106**
Rate per 100,000 population of people in adult acute mental health beds with a length of stay ***over 60 days***	**98 / 106**
Population vaccination coverage – MMR for two doses (5 years old) to reach the optimal standard nationally (95%)	**99 / 106**
Personal Health Budgets	**101 / 105**
Percentage of people aged 65 and over who received a flu vaccination	**101 / 106**
Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	**104 / 106**
Rate per 100,000 population of people in adult acute mental health beds with a length of stay ***over 90 days***	**104 / 106**

The current position in relation to the CCG's performance against key indicators can be found on the NHS futures website via the following link: https://future.nhs.uk/connect.ti/OandA/view?objectId=30646928

Improvement in Quality of Services

Quality incorporates patient safety, clinical effectiveness and patient experience and is at the heart of everything we do. We recognise that strong clinical leadership and engagement is critical in improving quality and improving outcomes for patients. We are working with providers and other commissioners collaboratively to achieve the best possible outcomes for patients within the present climate and the financial pressures all sectors of the health system are under.

At every meeting the Board receives updates on key issues in relation to quality. These include results from Care Quality Commission (CQC) Inspections, quality standards, for example nutrition and hydration, medicine management, patient experience and quality issues in hospital, such as patient safety, serious incidents and contractual performance of our providers against key quality measures.

Maintaining Quality throughout the COVID-19 Pandemic

Throughout 21/22 our providers have prioritised work to support the COVID-19 pandemic but continued to keep a grip on quality. We have continued to work alongside our providers to gain assurance and maintain quality.

Some key quality improvements and celebrations of success include:

Urgent Care

Urgent care system redesign

2021/22 has continued to see progress on improving pathways for accessing urgent care. Pre-bookable appointments allow patients to be seen by the most appropriate service. Bookings are now live within Greater Manchester Clinical Assessment Service (GMCAS) and NHS 111 into Emergency Department (ED), Urgent Treatment Centre (UTC) and minor injuries / illnesses. Heralded information is shared on referral which allows clinicians to have patient information further improving patient experience and supports patient flow.

Additionally, all MFT sites now have front door streaming in place for walk-in patients. This ensures that all patients are directed to the most appropriate service

no matter how patients access urgent care. This has helped with triage and to further reduce waiting times.

Greater Manchester Clinical Assessment Service (GMCAS)

The Greater Manchester Clinical Assessment Service (GMCAS) supports lower acuity referrals and helps connect a patient to local services. If a patient has called NHS 111 or 999, and does not need to attend ED straight away, the Clinical Assessment Service (CAS) will call the patient back and complete a more in-depth assessment. This service is staffed by doctors and other health professionals and has access to a wide range of local services to support the patient's needs. The service will offer self-care advice or book the patient into appointments in primary care, community services or other secondary care services where appropriate.

Urgent Treatment Centres (UTCs)

Urgent Treatment Centres (UTCs) are open 12 hours a day, seven days a week, and integrated with local urgent care services. They offer patients who do not need hospital accident and emergency care, treatment by clinicians with access to diagnostic facilities. UTCs are fully operational on acute sites in Manchester and Trafford. There is a formal designation process on the standards that must be met for full UTC status. The Trafford General Hospital and Manchester Royal Infirmary UTCs received designation in December 2021, with the Wythenshawe and North Manchester General Hospital UTCs set to follow in spring 2022.

Improving patient discharge

The Manchester and Trafford urgent care system has continued to work together in collaboration across all health and social care partners to improve hospital discharge. Implementation of discharge to assess has helped to reduce the time people spend in hospital, with assessment for longer-term care and support needs in the community. Additional Discharge to Assess beds have been commissioned to support the model, with home first considered the default discharge pathway. A standard discharge referral form has been adopted and embedded across all Greater Manchester organisations which has improved discharge process. The criteria to reside tool showing patients ready for discharge is fully embedded across

all our acute sites and utilised across operational teams, and supports a safe and timely discharge.

Urgent Care Communications

In order to convey messaging to the public and local communities a widespread communication campaign to promote “NHS111 First”. NHS111 First is the national campaign to encourage people to call 111 before attending A&E where appropriate. The campaign was across a variety of local media channels including radio, outdoor advertising, online through social media and in conjunction with the Manchester Evening News. Continued communication was promoted through system partners including primary and community care. Additionally, further targeted communications were directed to students and local communities.

Elective Care

Referral Optimisation

Implementation of **Gateway**®, a new referral management software which is fully integrated into the GP clinical system, is a more efficient process and improves the quality of referrals. The software demonstrates what can be achieved when technological innovation meets collaboration.

Virtual Triage / Advice & Guidance

Collaborative working with MFT to introduce electronic triage via Referral Assessment Services (RAS) / Virtual Triage to optimise patient pathways within secondary care e.g., directing referrals straight-to-test, upgrade to 2ww, redirect to another clinic, and in order to embed advice and guidance as an option for referrals.

Patient initiated follow up (PIFU)

This project is part of the collaborative Out-patients Recovery Programme led by MFT / MHCC / Trafford CCG. Rather than having a scheduled follow-up some patients are offered the option to initiate their own follow-up as and when it is needed. The decision to move to a PIFU pathway is at the discretion of the treating clinician in collaboration with the patient. Patients receive condition specific

guidance from the treating clinician and information on how to access the PIFU service.

Centralisation of Andrology Service

Following review of the Wythenshawe Hospital Andrology Service (semen analysis testing) the service was centralised to the Department of Reproductive Medicine at Saint Mary's Hospital, MFT from January 2022. Benefits of this change includes wider range of appointment days and times for patients to attend and Primary Care can order and receive results electronically via ICE.

Gynaecology – Education

Two education events held in March 2022 with a focus on:

- How to link to Primary Care (Tier 1) / Community Care (Tier 2) / Secondary Care (Tier 3)
- When to refer to the next tier
- Appropriate use of diagnostics
- Referral guidelines

Manchester Local Care Organisation (MLCO)

During 2021/22, MHCC worked with the MLCO and PQI sector leads continued to attend the bi-monthly Quality and Safety Committee. The Committee receives regular updates from each locality, north, central, and south, as well as specialist and children's services, and Adult Social Care. This committee also receives quality and safety updates for the Trafford Local Care Organisation (TLCO).

Key areas of note from the Q&S Committee include:-

- The development of a comprehensive quality dashboard
- Review of national guidance such as the *NHS England Patient Safety Incident Response Framework*

- Review of the MLCO Annual Complaints report and resulting action plan
- Care Quality Commission (CQC):- changes in strategy and involvement with MLCO services
- Policy and audit updates and visibility of action plans
- New service development updates such as the Manchester Crisis Response services designed to respond to patient referrals within the national 2 hour target

Each meeting starts with a Person Voice story; a case study illustrating how staff within the organisation have listened to patients, their families, and carers, to respond to concerns, and to help drive improvements to service delivery.

The Committee promotes the sharing of best practice within and between services.

Primary Care Quality Assurance and Improvement Framework

Manchester Health and Care Commissioning (MHCC) has delegated responsibility for commissioning Primary Care services from NHS England (Greater Manchester Health and Social Care Partnership, GMHSCP). This includes most aspects of quality and safety, excluding complaints and individual GP performance issues which remain with NHSE.

The Primary Care Quality Assurance and Improvement Framework is a key element of the overarching Performance and Quality Improvement (PQI) team's overarching Framework and describes how MHCC continues to embed robust procedures for understanding and supporting improvements to the performance and quality of the services it commissions, and in turn, improve the health of its population.

The Primary Care Framework links closely to but is not exclusive to where GP practices have failed to achieve a Good or Outstanding rating with the Care Quality Commission (CQC) and require support to help them address areas for improvement. MHCC has a well-established Multi-disciplinary Team (MDT) approach, directing support, advice, and guidance from MHCC subject matter experts as appropriate. These experts include colleagues from the Medicines

Optimisation Team, Safeguarding Leads, Nursing and Patient and Public Engagement, etc. The MDT is co-ordinated and overseen by the PQI team.

Following a consultation during 2020/21, the CQC launched its new strategy from 2021 and strengthened their commitment to deliver their purpose: to ensure health and care services provide people with safe, effective, compassionate, high-quality care and to encourage those services to improve. PQI leads and MDT members have worked closely with CQC inspectors to better understand how the strategy will be implemented locally and to support practices with how best practices can prepare for inspection.

During 2021/22 eighty-two out of eight-four (97%) of Manchester's GP practices have maintained a Good or Outstanding rating with the CQC.

Mental Health

Despite the COVID pandemic, GMMH have delivered on several key performance metrics, including:

- Improved waiting times and increased access to psychological therapy
- Met the two-week target for seeing patients experiencing a first episode of psychosis
- Increased access to specialist perinatal teams
- 86% of people discharged within four hours of attending A and E in mental health crisis
- Gradual drop in the number of out of area placements for adults requiring acute inpatient care
- Eight out of every ten patients discharged from hospital receive a follow up within three days
- Most patients referred for an assessment of possible dementia are diagnosed with 12 weeks of referral

Perfect Week Manchester

Greater Manchester Mental Health Trust ran two ‘Perfect Weeks’ in 2021/22. This is a week-long initiative on achieving the best possible care for patients and identifying the blockages that are preventing people from being discharged, working in partnership with the City Council and MHCC. This partnership approach led to the discharge of 34 patients in Manchester, exceeding their weekly average. A number of the patients are also delayed transfer of care (DTOC) patients with long length of stay in hospital. DTOC patients are those who no longer need to be in hospital, but are awaiting a package of care in the community before they can be discharged.

A summary of the achievements relating to the ‘perfect week’ specifically were as follows:

- 36% increase in discharges during the perfect week events
- A 3.4 day reduction in Length of Stay (LoS) - Jan 2022
- A 52% reduction in DTOC - Jan 2022 (37 avg)
- Monthly A&E Conversion Rates reduced by 2.44% - Jan 2022
- A 41% reduction in Surge Use bed nights - Jan 2022

Learning from Serious Incident Workshop

MHCC/Trafford CCG worked closely with GMMH to hold a Serious Incident Workshop on the August 21. Colleagues from CCGs across the GMMH footprint were also in attendance, from various specialism including medicine management, safeguarding, and commissioning.

The focus of the workshop was on the key themes arising from serious incidents, and the improvement work being carried to ensure that the learning from serious incidents is embedded across the Trust.

There was an overview of the new National Patient Safety Strategy and the work being carried out to implement the Strategy. This was followed by the actions being carried out by the Trust to address the serious incident themes of suicide and self-harm, physical health, falls, medication safety. Key actions include:

- Trust Wide Carers Event Held, with an action plan to improve carer engagement.
- Review of Trust risk assessment tool underway
- Development of 7-minute briefing, following learning events
- Trust clinical risk training to include more emphasis on formulation of risks
- Roll-out of management and supervision tool (MaST) across CMHTs
- Action plan to improve care for people with diabetes
- Continues work on reducing falls - there has been a 21% reduction in falls between June 2019 and June 2021.
- National Early Warning Score (NEWS2) well established in clinical practice.
- Review of medicine management training

GMMH engagement with families and carers.

One of the themes identified in patient safety incidents is staff engagement with carers and families of our service users. To address this a Trust wide learning event was held in March, focussing on carer engagement by GMMH staff. 70 senior staff from across the Trust attended the event. There were interactive presentations from the Head of Patient Safety and the Trust Carer lead in relation to themes and data around carer involvement.

At the end of the event, staff were asked to meet in their own operational divisions and discuss the barriers to carer engagement and how they were going to address this. Each division has developed an action plan to improve carer engagement which will be shared and monitored through the Trust's Post Incident Review Panel.

Manchester Thrive in Education Service

A new service which supports the emotional wellbeing of children and young people in schools across Manchester, has provided one to one help to over 460 students in its first year of operation (September 2020 to August 2021).

The young people's mental health support team, called 'Manchester Thrive in Education' is delivered in collaboration between Manchester Foundation Trust, 42nd Street, Mind, Place 2 Be and One Education, working closely with Manchester City Council. This new service helps children aged 4 to 18 who are experiencing emotional and behavioural difficulties. So far, the service has worked within 48 schools, delivering over 250 mental health workshops to school staff and students. More schools are expected to be supported in the coming months.

Cancer Services

Manchester Lung Health Check Programme & Targeted Lung Cancer Screening

Surveillance scans for patients identified as being at increased risk of lung cancer continued during 2021-22. Since 2019, 4500 have been identified as being at increased risk of lung cancer. Annual low dose CT scanning has identified patients with abnormalities that require urgent investigation or close monitoring. 150 patients have been diagnosed with lung cancer, 80% at stage 1&2, and 85% of patients have had curative treatment. Other long term conditions such as cardiovascular disease and respiratory conditions have also been identified, and patients are now being managed to reduce the risk of serious disease. Lung health checks and targeted lung cancer screening is recommended in the planning guidance and full coverage across Greater Manchester is being planned from 2023 onwards.

Rapid Diagnosis Clinics at MFT

A referral pathway for patients with Non-Site Specific Symptoms has been developed in collaboration with MFT and NCA. Rapid Diagnosis Clinics have been established on 3 MFT hospital sites with additional CT capacity. In addition RDC principles (triage, straight to test, one stop clinics) have been applied to several tumour pathways to reduce delays and support the 28d Faster Diagnosis Standard.

Best Timed Pathways (BTP) at MFT

National best timed pathways for lung, colorectal and prostate cancer have been implemented at MFT. BTP for UGI, H&N and gynaecological cancer are now in development and will be implemented during 2022/23

Faecal Immunochemistry Testing (FIT)

FIT service has been commissioned and made available for GPs to request this test for patients with LGI symptoms. FIT is indicated for 2 groups of patients:

- Patients at low risk of LGI cancer – a negative FIT result can exclude cancer and avert a 2WW referral to secondary care

- Patients at increased risk of LGI cancer – FIT should be requested alongside making the 2WW referral to ensure the result is available to secondary care clinicians as part of the triage process

FIT uptake is monitored on a quarterly basis and compared with LGI 2WW referral rates. PCNs with low FIT uptake are notified by the MHCC cancer team and encouraged to make use of this test.

GM cancer alliance have pledged some additional resource to support laboratories with FIT analyser capacity and improve turnaround times in order to speed up the diagnostic pathway and wait for colonoscopy.

Quality Surveillance Reviews

MHCC cancer team was represented and contributed to the annual QS review process of MFT cancer services.

Primary Care

MHCC cancer team works closely with the primary care team to promote cancer education sessions through Gateway-C resources. In addition various projects are underway such as, development of EMIS searches to identify cancer screening non-responders, reduce the incidence of rejected cervical screening samples, the production of baseline PCN cancer data packs to support the early cancer Diagnosis DES. All PCNs now have a nominated cancer lead – the MHCC cancer team meet regularly with the PCN leads and produce regular communications & updates.

Independent Providers

Over the past two years there has been a focus on improving recording of patient's race and sexual orientation. For the services that are reporting against these KPI's, on average 90% of patients have race recorded and 80% have their sexual orientation recorded.

Sustainable Development

As an NHS organisation and a spender of public funds, MHCC has 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, smart and efficient use of natural resources and building healthy, resilient communities. 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 the rising cost of natural resources. The CCG acknowledges this responsibility to our patients, local communities and the environment by working hard to minimise our environmental footprint.

The Greener NHS website explains in detail how the NHS is becoming greener and that in October 2020, the NHS became the world's first health service to commit to reaching carbon net zero, in response to the profound and growing threat to health posed by climate change. The "Delivering a Net Zero Health Service" report sets out a clear ambition and evidence-based targets.

During 2020, MHCC reduced its office footprint by approximately half, and adopted and implemented a Hybrid Working Policy. Staff now share their working time between office and home working, which has reduced our utility costs, and staff's reduced travel to and from the office contributes to the lowering of emissions. In addition, as the introduction of the GM Integrated Care System approaches, MHCC are working with partners on the development of the GM Integrated Care System Green Plan.

The data below is provided by NHS Property Services (NHSPS) regarding the buildings in use by the CCG in 2021/22, with a comparison of 2020/21 figures.

2021/22 Utilities Report

The following table provides utilities information relating to the CCG's occupied space at our Parkway 3 office building for 2021/22:

Financial Data (Spend):	Units	2021/22
Total Energy Cost (all energy supplies)	£	34,363
Electricity Cost	£	32,592
Gas Cost	£	724
Water Cost	£	1,047
Resource Use:		
Electricity Consumed	kWh	263,879
Gas Consumed	kWh	15,559
Water/Sewerage Consumed	m^3	355

2020/21 Utilities Report

The following tables provide utilities information relating to the CCG's occupied space at our Parkway 3 office building for 2020/21, as well as Parkway 1, which was part occupied by the CCG between April and September 2020.

Parkway 3

Financial Data (Spend):	Units	2020/21
Total Energy Cost (all energy supplies)	£	41,168
Electricity Cost	£	37,257
Gas Cost	£	2,016
Water Cost	£	1,895
Resource Use:		
Electricity Consumed	kWh	243,430
Gas Consumed	kWh	69,881
Water/Sewerage Consumed	m^3	794

Parkway 1

The CCG occupied part of the Parkway 1 building for the first half of 2020/21. Utilities information is provided below for the full year, and an additional column for the approximate usage for the period where the CCG occupied the space in the building (as NHSPS are unable to provide information for only part of the year).

Financial Data (Spend):	Units	2020/21 (Full Year)	Approximation – April to Sep 2020
Total Energy Cost (all energy supplies)	£	41,039	20,519.5
Electricity Cost	£	37,140	18,570
Gas Cost	£	2,010	1,005
Water Cost	£	1,889	944.5
Resource Use:			
Electricity Consumed	kWh	242,666	121,333
Gas Consumed	kWh	69,662	34,813
Water/Sewerage Consumed	m^3	792	296

Total (Parkway 3 and Parkway 1)

The following table provides the total utilities information relating to the CCG's occupied space at our Parkway 3 and Parkway 1 (approximate usage as detailed above) office buildings for 2020/21.

Financial Data (Spend):	Units	2020/21
Total Energy Cost (all energy supplies)	£	61,687.5
Electricity Cost	£	55,827
Gas Cost	£	3,021
Water Cost	£	2,839.5
Resource Use:		
Electricity Consumed	kWh	364,763
Gas Consumed	kWh	104,694
Water/Sewerage Consumed	m^3	1,090

Engaging people and communities

Manchester Health and Care Commissioning is committed to working with local people to improve health and secure high-quality healthcare for the people of Manchester, now and for future generations.

We want everyone to have greater control of their health and wellbeing, and to be supported to live longer, healthier lives with high quality health and care services that are compassionate, inclusive, and constantly improving.

Co-production and public involvement helps us to understand local needs and to prioritise those people who experience the poorest health outcomes, enabling us to improve access and reduce health inequalities. It provides opportunities to see things differently and to be innovative, leading to a better use of our limited resources.

As our ambition is to place patients, the public and our local communities at the heart of everything we do; genuine patient and public participation is essential.

There are several ways in which we have involved and engaged local people and communities, and these include:

- The Patient and Public Advisory Committee – developing volunteers as patient leaders and embedded in the governance of the organisation
- COVID Health Equity Manchester Group and sounding boards – co-designing our response to COVID-19
- Manchester Long COVID Peer Support Group – facilitating and supporting people living with Long COVID to inform and influence development of services
- Volunteer Marshals - who have been supporting the Manchester COVID Vaccination sites throughout 2021 and 2022
- Engagement projects with voluntary, community and social enterprise sector organisations to inform the commissioning of services

- North Manchester General Hospital VCSE Assurance Group – who supported the business case for the development of the hospital site
- Community Explorers - working with voluntary, community and social enterprise organisations
- Social media surveys, polls and focus groups
- Facilitated discussions and presentations at local groups
- Patient and carer stories and case studies

It is our aim to reflect our diverse population and their needs in the way that services are co-designed, monitor and commissioned city-wide and in a place-based way.

We can only do this by working in partnership with patients, carers, the public and a range of stakeholders to ensure we recognise and understand the wider social determinants that impact on health and wellbeing.

Patient and Public Advisory Committee (PPAC)

The Patient and Public Advisory Committee is a formal sub-committee of the Manchester Health and Care Commissioning Board, chaired by our Lay Representative for Patient and Public Involvement. It provides assurance on the patient and public involvement across all aspects of the work of the organisation.

PPAC members are residents and patient leaders who volunteer their time and skills to improve outcomes for people living in Manchester using health and care services.

During the COVID-19 pandemic, PPAC members have continued to meet virtually for both social and formal committee meetings. Throughout the year PPAC members have:

- Used their lived experiences and knowledge to inform the COVID-19 response to the pandemic, covering prevention, testing and vaccine coverage uptake
- Used their skills to develop and inform outcomes for commissioned services

- Provided feedback and shared experiences on the monitoring of commissioned services

- Participated in a range of working groups and committees to ensure the patient and carer voice is embedded into the work of the organisation

Listening to our communities, patients, and the public

Throughout the year we have carried out engagement activity both online and face to face working with voluntary and community sector organisations to have conversations with members of the public and understand what matters to them. This has included targeted engagement to influence and inform the response to increase the vaccine uptake coverage to communities who have been disproportionally impacted by the pandemic.

This information has been used to inform the Manchester response plan to COVID-19 and has established trust and relationships with VCSE organisations and communities across the city. It has also provided us with an understanding of the impact of COVID-19 on the wider determinants of health and wellbeing for employment, housing and poverty and living with long COVID.

An example of this was the Community Champions Programme. This programme of work continues to make a real difference through its initiatives in our South Asian, Black African and Black Caribbean, and Disabled communities who have been and continue to be most at risk from Covid 19.

The Community Champion Covid Chat community continues to grow with a further 51 champions joining the programme meaning a total of 91 Covid chatters are out making a real difference in the communities of Manchester.

All the volunteers are provided with bespoke training which enables them to provide a person-centred conversation about what matters to the individual. By August 2021, a total of 1634 chats had taken place, meaning since July a total of 2421 people have been listened to and sign posted to accurate Covid-19 information and wider support where needed.

The strength-based approach that the Covid chat programme is built upon enabled the service users to feel listened to and respected so that they felt comfortable talking about wider health and social issues during the conversation. Using existing staff and volunteers from the Covid chat programme, the “Covid Chats” were able to be delivered in community languages which improved trust amongst the attendees.

Partnership working with the Voluntary and Community Sector

Throughout 2021/2022, we commissioned the voluntary and community sector as an inclusive way of listening to and acting on lived experiences of people based on their age, disability, gender, race, religion and belief, sexual orientation, pregnancy and maternity, marriage and civil partnership and gender reassignment. Additional engagement has taken place to better understand the needs of communities of interest and identity, such as homelessness, asylum seekers and refugees and looked after children.

Commissioning activity in this way is in recognition of the knowledge and skills voluntary and community sector has and supports our strategic plans in reducing health inequalities.

Examples of reducing health inequalities and improving outcomes have included:

- The development of the COVID Health Equity Manchester programme has continued throughout 2021/2022. The aim is to improve experiences of and outcomes for, communities that suffer disproportionate adverse impacts from COVID-19.

There are four objectives:

1. Development and delivery of culturally competent, targeted public health messaging and engaging and involving groups identified as most at risk.

2. A whole system approach to protecting people in identified at risk groups from contracting the virus.

3. Preventing severe disease and death among people in identified groups who acquire the virus and/or develop symptoms.

4. Addressing the immediate indirect consequences of COVID-19 on the identified groups at highest risk.

The co-design and delivery of culturally competent messaging and face to face engagement has continued working closing with the Population Health Team, Primary Care vaccination sites and health and council neighbourhood teams.

The funded sounding boards are facilitated by voluntary and community organisations to target the following communities: Black African and Black Caribbean, South Asian, Pakistani, Bangladeshi, Disabled People, and Inclusion Health.

Our thanks to the Caribbean and African Health Network, Manchester BME Network, Bollyfit CIC, Ananna, Breakthrough UK and Europia.

- The Proud Trust was grant funded by the Department of Health and Manchester Health and Care Commissioning to deliver a Trans Care Navigator role to support and advise young trans people. Support included helping young trans people to access housing support, how to access NHS care, what was available, supporting young people to understand and cope with changes to their care pathways in light of the Tavistock v Bell court decision, in-depth discussions and practical exercises on body confidence and self-esteem, supporting young people to access adult and child and adolescent mental health services, supporting young people with alcohol abuse and accessing appropriate support, advocating for young people experiencing transphobia within the NHS and experiencing significant physical risk due to denial of care. 68 unique young people were supported during 2021.

- BHA for Equality were commissioned by Manchester Health and Care Commissioning to provide community engagement to support the Latent TB programme, working in partnership with Manchester University Hospitals NHS Foundation Trust. Through clinical and community outreach, 312 people have had face to face conversations about Latent TB providing one to one information and advice from April to December 2021. Over 600

cards and 500 flyers have been distributed to raise awareness of Latent TB and symptoms.

- During 2021 we provided funding to support a targeted grants programme to help with the engagement of Pakistani and Black African and Black Caribbean communities to better understand how people had been affected by COVID-19 and share key messages and awareness resources. 19 voluntary and community organisations received funded, and over 165,110 Black African, Black Caribbean and Pakistani people were engaged, reached, and impacted by activities through the funding.

- Equality and patient experience information is collected through contracts with our providers, both large and small, and they can demonstrate changes to services for people with specific protected characteristics and how they have changed their service delivery, made reasonable adjustments, and changed signage and buildings to support accessibility.

- The Wai Yin Society delivered engagement activity with the Chinese community on awareness of mental health and to better understand the needs of the community. 25 people participated in activities. The COVID-19 pandemic made people feel unsafe and not in control of their lives. The situation had a negative impact to their mental health and well-being. Participants believed that optimism is an important factor to overcome difficult situations. Due to lots of Chinese or BAME group having language barriers, positive thinking training sessions in their language enabled them to gain new skills to overcome difficulties and enhance their life satisfaction.

- Engagement funding was provided to George House Trust to engage with people living with HIV to raise awareness of flu vaccinations. The engagement project had 3 key elements: To develop a HIV communications pack, to deliver universal and targeted messages to key communities within the service user group and target Young people with HIV, Black, Asian and Minority Ethnic people living with HIV and LBGT people (predominantly gay and bisexual men) living with HIV and to deliver targeted telephone engagement with service users. Not everyone who is

registered with their GP disclose their HIV status to their GP and therefore are not routinely notified about access to a flu vaccination. There remains a stigma element to this that needs to be tackled. George House Trust's diverse service users don't all connect via social media, therefore key messages around flu (and COVID) reach some audiences more effectively through one-to-one discussions, group work and online events, particularly when considering more marginalised communities.

- The Long COVID Peer Support Group was founded in 2020 and has continued to meet weekly throughout 2021/2022 for people living with the symptoms following a COVID-19 infection. The Peer Support Group members are reflective of the following protected characteristics - gender (60:40 split women and men), age, disability and ethnicity. Members have used their lived experience to inform and influence of the delivery of the Long COVID service for Manchester and Trafford, development of a patient question in the annual national GP survey, development of an information leaflet to raise awareness of Long COVID.

- Community Engagement funding was provided to the Big Life Group to engage local African and African-Caribbean community about the flu vaccination. From engaging and listening to fifty men and fifty females, from the wards of Hulme and Moss Side, it was understood that individuals were hesitant because they had questions to ask about the flu vaccination and how it would interact with their current medication, as from this study 97 per cent of the participants were living with long-term health conditions. Over three quarters of the participants thought that having the flu vaccine was a good idea, however, the lived experience shared, demonstrated how one incident could influence an individual's attitude and perception towards the flu vaccine and this perception could then be disseminated and magnified in the community. Lack of knowledge, no access to the relevant information and the inability to get an appointment with their GP were identified as the main reasons for individuals not receiving the vaccine and not just because they did not feel like accepting the invitation to be

vaccinated. This work is being repeated in 2022 using the recommendations and learning from 2021.

- The African Caribbean Care Group receives grant funding and with this delivered an advocacy and support service to the Black Caribbean community. During 2021/2022, the service supported community members around the following issues: Immigration, Domestic Abuse, Financial Support, Housing, Benefit advice and support, Mental Health, Complex Families and issues, Food Poverty, supporting people with disabilities around aids and adaptations and Blue Badge applications, hospital discharge and support with social workers and community nursing teams and digital inclusion with helping people to get information where they are required to access it online. This is a targeted approach to supporting the Black Caribbean community from a trusted source ensuring a cultural approach to meeting needs and empowering people.

Community Champions Programme

The Community Champions programme continues to make a real difference through its initiatives in our South Asian, Black African and Black Caribbean, and Disabled communities who have been and continue to be most at risk from Covid 19. The Community Champion Covid Chat community continues to grow with a further 51 champions joining the programme meaning a total of 91 Covid chatters are out making a real difference in the communities of Manchester. All the volunteers are provided with bespoke training which enables them to provide a person-centred conversation about what matters to the individual. By August 2021, a total of 1634 chats had taken place, meaning since July a total of 2421 people have been listened to and sign posted to accurate Covid-19 information and wider support where needed. The strength-based approach that the Covid chat programme is built upon enabled the service users to feel listened to and respected so that they felt comfortable talking about wider health and social issues during the conversation. Using existing staff and volunteers from the Covid chat programme, the “Covid Chats” were able to be delivered in community languages which improved trust amongst the attendees.

Development of grant programmes

Our grant programmes have continued to be co-designed using the skills and knowledge of voluntary and community sector organisations have included patients, public, carers and young people.

Young Manchester was commissioned to develop Thrive grants and collaboration took place with young people and the voluntary sector to inform and shape the process and evaluated the bids that came in.

We also worked with Young Manchester to deliver COVID-19 Recovery Fund. This programme was a collaborative investment between Our Manchester Voluntary and Community Sector Grants Programme, One Manchester and Manchester Health and Care Commissioning. The grants programme was an investment aimed at increasing the resilience of the VCSE sector in Manchester so that it can continue to provide critical services that support Manchester's residents.

Through the Our Manchester VCSE team at Manchester City Council a range of stakeholders were also involved in the delivery and evaluation of the First 1000 days and the Older People's Neighbourhood Support grants.

External experience and research reports

It is important that we also learn from other co-production and engagement work that takes place across the city that informs and influences how services are developed, monitored, and redesigned by Manchester Health and Care Commissioning.

Throughout all this engagement work it has enabled Manchester Health and Care Commissioning to develop relationships and involve, engage, and listen to people with lived experience from diverse communities of interest and identity.

The Health and Wellbeing Strategy and Reducing Health Inequality

Throughout 2021/22 the Manchester Health & Wellbeing Board has continued to provide the governance for the delivery of the Population Health Plan (2018-2027) to tackle Manchester's entrenched health inequalities. MCCG is a statutory member of the Health & Wellbeing Board and discharges its duty, in partnership with other

members of the Board, including MHCC which is represented by the Chair, GP Board members and the Director of Population Health.

During this time, our commissioned services have continued to deliver and respond to increased demand during the pandemic. Activities have focused on:

- Reducing Infant Mortality Strategy
- Adverse Childhood Experiences (ACEs)
- Smoke Free Manchester Tobacco Control Plan
- Healthy Weight Strategy
- Age-Friendly Neighbourhood Working
- Suicide Prevention Strategy
- Winning Hearts and Minds Programme
- Be Well service/Social Prescribing Programme
- 0-19 Healthy Child Programme
- Priorities for Sexual Health
- Priorities for Drugs & Alcohol Services
- GM Drug & Alcohol Harm Reduction Plan
- Homelessness Strategy 2018-2023 and GMCA ‘A Bed Every Night’ Scheme

Additional investment was made available to our provider services for support to recover from Covid-19 (for example, additional investment help with reducing waiting lists / blockages in the Community Falls Service and the Specialist Weight Management Service).

Reducing health inequalities has been a large part of our Covid-19 response. Following the Public Health England report of June 2020 ‘Understanding the impact on communities that experience racial inequality’, MHCC developed a detailed

‘Addressing Inequalities’ programme plan. The NHS Planning guidance for 2021/22, and more recent guidance on the transition to the Integrated Care System (ICS), has further prioritised this work, as has the City’s Covid-19 Recovery Framework for Health and Care. The plan addresses the following:

- Improved demographic data collection
- Community research to inform service delivery
- Improved access, experience & outcomes
- Culturally competent workforce risk assessment
- Culturally competent education & prevention
- Target culturally competent health promotion & disease prevention
- Ensure that recovery plans reduce inequalities caused by wider determinants

MHCC resources have also continued to be re-directed to respond to the pandemic, including delivery of the test and trace and vaccination programmes. In addition, Covid-19 Health Equity Manchester (CHEM) was set up in July 2020 in response to clear evidence about the disproportionate impact of the Covid-19 virus on particular groups already known to experience poorer health and care outcomes before the pandemic. These groups included Black, Asian and Minority Ethnic people, people born outside the UK, disabled people, and those at high occupational risk and / or in poverty. By working to understand the views, needs and barriers to vaccine uptake, CHEM has worked collaboratively with the groups most affected by the pandemic, partly by facilitating Sounding Boards. The Sounding Boards have brought together groups of people that can act as a voice for the communities disproportionately affected by the pandemic to identify and share what the priority issues and concerns are for the communities they represent. Some of the resulting activities/interventions have included developing culturally competent information, and providing targeted funding to engage, support and address community-identified health-related issues.

Alongside this work, the Population Health Plan (2018–2027) is being refreshed and refocused in collaboration with key stakeholders in the city to align with the Build

Back Fairer approach (Marmot et al, 2021). The resulting Marmot Health Inequalities Action Plan provides a structure for greater collaboration between multi-agency and cross sectoral partnerships to mobilise organisations to place health equity at the heart of governance, policy development, resource allocation, workforce planning and commissioning arrangements. The plan will describe how to push forward on the goal of reducing health inequalities in Manchester and to prioritise wellbeing by building on the city's many investments, policies and strategies that are pro-equity in relation to economic inclusion, employment, housing, transport, the environment, education, community support and public health. It seeks to add value and strengthen the interventions already in place that aim to reduce health inequalities and make the most of the wealth of resources within communities by focusing on the six themed areas outlined in the 'Build Back Fairer' report: early years, children and young people; work and skills; income, poverty and debt; housing, transport and the environment; communities and places; and the prevention of ill-health and preventable deaths. In addition to these six themes, stakeholders have included a 7th theme in recognition of Manchester's multicultural demographic: systemic and structural discrimination and racism, as root causes of health inequities.

The Chair of the Health and Wellbeing Board and Leader of the City Council, Cllr Bev Craig has provided the following feedback:

"I can confirm that the CCG, through MHCC, are active members of the Health and Wellbeing Board and have provided strong leadership to both the development and implementation of our local strategy".

Financial Performance Overview

2021-22 saw the CCG return to a more 'business-as-usual' operating model, with the pandemic non-recurrent costs incurred during 2021-22 significantly reduced from the previous financial year. The CCG spent and was funded nationally £23m for the pandemic response in 2020/21, with costs and funding in 2021-22 totalling £8m. The CCG was still impacted by the pandemic in the financial year, with significant staff input leading the vaccination programme.

There were a number of changes in relation to financial management within the NHS, in terms of the way the organisation operates, which have remained in place for 2021-22:

- NHS contracting rounds remained suspended

- Payment systems for NHS Providers remained in place
- One Lead CCG for the system, through which all system funding was transacted
- Financial Sustainability Programmes re-introduced, although minimal requirements in 2021-22
- Independent sector expenditure managed at a system level

Financially in 2021-22, the CCG operated within a system control total covering providers and commissioners within the Greater Manchester system. The CCG acted as the lead CCG transacting funding across the system in line with system agreements for the whole financial year, compared to 2020-21, when the CCG had undertaken this role for six months only. Financial plans were submitted which covered the financial year and included finance, activity and workforce.

In addition, for 2021-22 MHCC's formal governance changed as a result of the change in delegation of Adult Social Care functions from MCC to Manchester Foundation Trust (MFT) as part of Manchester's Local Care Organisation (MLCO). (The delegation had previously been to MHCC) However, there remained in place a Section 75 relating to the Better Care Fund pooled budget and MHCC has:

- Retained the population health and wellbeing and health function;
- Acted as the engine room for Manchester Partnership Board and co-ordinator of the Locality Plan; and
- Connect the strategic/policy agenda between health and the wider City Strategy

Delivery of Financial Duties

The financial duties of a clinical commissioning group (CCG) as set out by NHS England (listed below) have been delivered by NHS Manchester CCG:

- Expenditure not to exceed the revenue resource limit in any one year
- Expenditure not to exceed the capital resource limit in any one year
- To remain within the cash limit in any one year
- To remain within the running costs target of a maximum of £11,880k (including allocations associated with the additional pensions contribution)
- To deliver a break-even financial position in year

The table below demonstrates that NHS Manchester CCG delivered all of its statutory duties in 2021-22.

	Duty	Target (£k)	Actual (£k)	Variance (£k)	Duty Met?
Expenditure not to exceed Revenue Resource Limit**	Statutory	1,916,547	1,916,353	(194)	Y
Expenditure not to exceed income	Statutory	1,932,298	1,932,104	(194)	Y
Expenditure not to exceed Capital Resource Limit	Statutory	n/a	n/a	n/a	
To remain within its Cash Limit	Admin	1,929,340	1,929,340	0	Y
To remain within the running cost target of £22.07 per head	Admin	11,880	11,811	(69)	Y

** This excludes historic surplus

Expenditure not to exceed revenue resource limit

Limits are set by NHS England for clinical commissioning groups, within which they must contain net expenditure for the year. These are termed “resource limits” and there are separate limits issued for revenue and capital.

NHS Manchester CCG’s in year revenue resource limit for 2021-22 was £1,916,547k. Against this, costs amounted to £1,916,353k and therefore the organisation has delivered a minimal surplus in line with national policy.

The CCG did not have a capital resource limit in 2021-22 and no capital expenditure.

To remain within cash limit

All CCGs are set a limit on the amount of cash they can spend in a financial year. The 2021/22 cash limit for the CCG was £1,929,340k and the organisation drew down cash from the government amounting to £1,929,340k. As at 31 March 2022, the CCG utilised 100% of the funding. From the £1,929,340k cash drawn down, £39k, which was within the 1.25% allowable limit.

To remain within the running costs target

The CCG receives an allocation for running costs or administrative expenditure. The target limits the amount the CCG can spend on administrative functions, for instance back-office functions, headquarters, training etc. In addition to this, the CCG

received an additional in year allocation of £1,050k, relating to a 6.3% pension uplift and national funding. The total allocation for NHS Manchester CCG in 2021/22 was £11,880k. During 2021/22 the CCG spent £11,811k on administrative expenditure (this figure is net of income generated), generating a £69k under spend against the target.

In addition, the CCG should comply with the Better Payment Practice Code. The code is summarised as:

Target: to pay all NHS and non-NHS trade creditors within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Compliance: at least 95% of invoices paid (by the bank automated credit system or date and issue of cheque) within 30 days or within agreed contract terms.

During the pandemic NHS organisations were encouraged to make payments within 7 days, or 14 days if there were queries on the invoice, but this change was not reflected in the target.

The following table highlights the performance both in terms of the number and value for non-NHS and NHS invoices.

Measure of compliance	**2021/22**	**2021/22**
	Number	**£000**
Non-NHS Payables		
Total Non-NHS trade invoices paid in the year	23,599	295,308
Total Non-NHS Trade invoices paid within target	22,793	293,887
Percentage of Non-NHS trade invoices paid within target	96.58%	99.52%
NHS Payables		
Total NHS Trade invoices paid in the year	1,108	1,524,512
Total NHS Trade invoices paid within target	1,076	1,524,464
Percentage of NHS trade invoices paid within target	97.11%	100.00%

The above table shows that the performance measure has been met for both NHS and Non-NHS trade invoices.

The financial statements are included in this report at page 131 and include:

- Statement of Comprehensive Net Expenditure for the year ended 31st March 2022
- Statement of Financial Position as at 31st March 2022
- Statement of Changes in Taxpayers' Equity for the year ended 31st March 2022
- Statement of Cash Flows for the year ended 31st March 2022

These accounts have been prepared for NHS Manchester CCG under Section 17 of Schedule 1A of the National Health Service Act 2006 (as amended) in the form which the Secretary of State has, with the approval of the Treasury, directed.

Income

In total the CCG received funding of £1,932,298k in 2021/22. The majority of this funding (£1,916,547k) is received directly from NHS England in the form of allocations. Other income of £15,751k has been received in the year from other organisations.

Expenditure

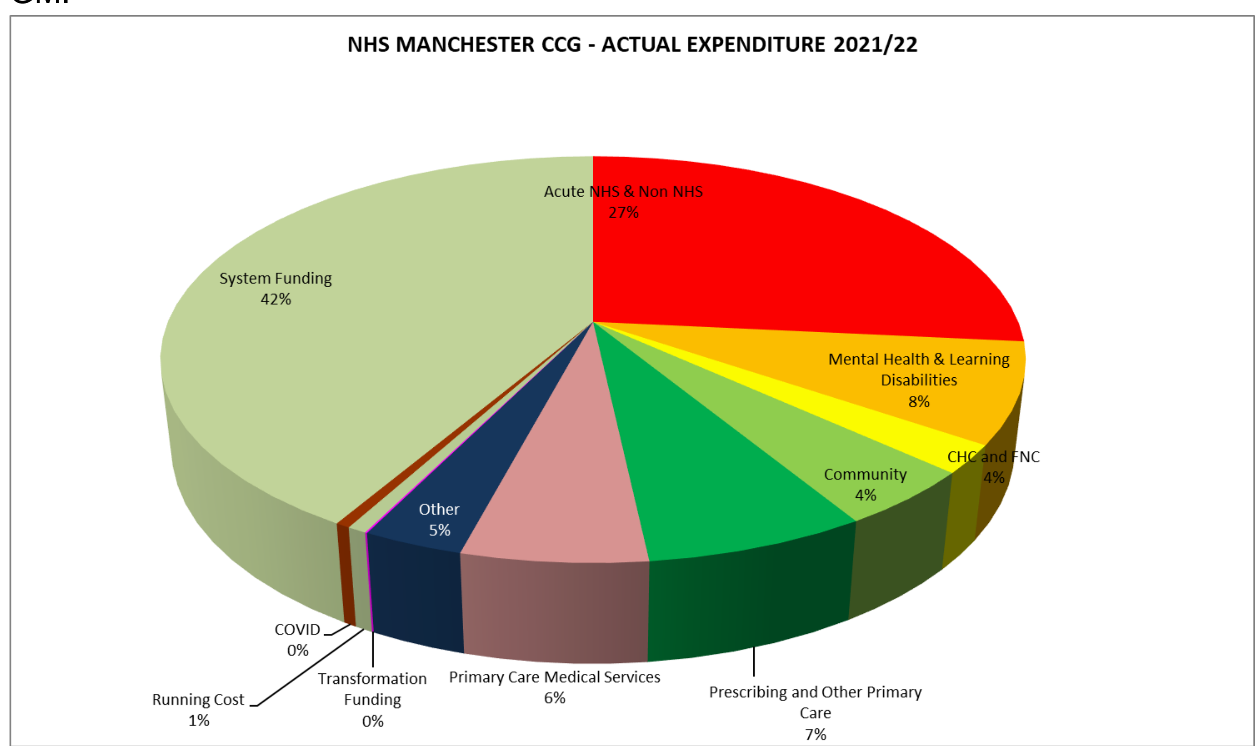
The Statement of Net Comprehensive expenditure included in the Annual Accounts details income and expenditure split by programme and administration costs. The total costs within 2021/22 are £1,932,104k, of which £12,237k (gross costs excluding income) relates to administrative/running costs expenditure and £1,919,867k to healthcare (programme) spend. The numbers quoted are gross expenditure and exclude any income.

The CCG hosts the Greater Manchester Health & Social Care Partnership (Devolution Manchester) team on behalf of the 10 CCGs of Greater Manchester and the Association of Greater Manchester Authorities. Within the financial statements, the expenditure and income associated with this hosted service is shown net in the accounts.

As the system moves towards the ICB and in line with the hosting of the GMH&SCP, the organisation also hosts the ICB Chair designate and two recently appointed non-executive members on behalf of the Greater Manchester ICB, with key appointments in the process of recruitment.

The chart below details a breakdown of expenditure for the CCG in 2021-22, which separates out the costs directly incurred as a consequence of the COVID-19

pandemic and the system funding for which Manchester CCG was the lead CCG for GM.



	% age of Total Spend
Board Heading	
Acute NHS & Non NHS	27%
Mental Health & Learning Disabilities	8%
Continuing Health Care and FNC	2%
Community	5%
Prescribing and Other Primary Care	7%
Primary Care Medical Services	6%
Other	3%
Transformation Funding	0%
Running Cost	1%
COVID	0%
System Funding	42%
Net Expenditure Total	100%

The total spend related to the pandemic and funded nationally by NHSE/I for 2021-22 was £8m, compared to £23m in 2020-21. The main area of spend related to the following schemes:

- Continuation of the Hospital Discharge Programme.

  In 2020/21 the Hospital Discharge Programme was introduced to support the timely and appropriate discharge from hospital inpatient settings for patients who had new or additional care needs. This programme was initially introduced to support the system throughout the Pandemic and the funding continued throughout 2021/22. In 2021/22 the programme was split into two schemes:

  Scheme 3a

  For packages that commenced between 1st April 2021 to 30th June 2021 the national discharge fund provided financial support for up to 6 weeks of the

package start date by covering the full package costs for the first 6 weeks as well as any support costs which enable the timely reablement and assessment of the client.

Scheme 3b

For packages that commenced between 1st July 2021 to 31st March 2022 the national discharge fund covered the full package costs up to 4 weeks of care, as well as any support costs which enable the timely reablement and assessment of the client.

The programme provided support for all patients discharged with new or additional care needs which resulted in the NHS incurring the costs for packages which may not have fallen within the responsibility of the NHS under normal operational circumstances. To reduce the risk of the NHS incurring further costs a risk share was agreed between the CCG and the local authority for any packages that breached the period funded by the Hospital Discharge Programme.

- Vaccination programme costs incurred, although the majority of these were recharged to NHSE.

Investments

MHCC made a limited number of key investments as the health sector recovered from the pandemic in order to improve patient outcomes. The CCG invested in mental health services in line with the requirements of the Mental Health Investment Standard and in line with national guidance on investments during the pandemic. A summary of the key investments or extensions to current investment made are outlined below:

- Community Neuro rehabilitation services
- Cancer Services
- Smoking cessation in pregnancy
- GM Services / Urgent Care
- Transforming Community Services (national funding)
- Lung Health checks (national funding)
- Childrens' Long Term Ventilation Team
- Long COVID Clinics (national funding)
- Primary care estates

- Community Diagnostic Hubs (national funding)
- Discharge to Assess beds in Care Homes (national funded)

Within primary care the key investments included:

- Primary care Quality, Resilience and Recovery system which aimed to support recovery of services, boost workforce resilience and fund time to ensure quality was embedded in the recovery across General Practice.
- Winter resilience funding was used to support practices by funding additional capacity during the winter period (November to March). This was supplemented by additional national winter access funding.
- Funding for COVID-19 response - National COVID Capacity Expansion funding was extended for the period April to September 2021. This funding enabled additional sessional capacity within General Practice. It was also used to support recovery of phlebotomy, support delivery of Home Oximetry monitoring and fund mobile vaccination units.
- Additional Roles - A major part of the PCN DES funding is to fund an expansion of workforce via the Additional Roles Reimbursement Scheme (ARRS). Funding per PCN was based on weighted list size on 1st January 2021. In 2021/22 3 new roles were introduced to the scheme, paramedics, mental health practitioners and advanced practitioners. The scheme was much better utilised compared to the previous financial year with all of the CCG baseline funding being committed and a substantial drawdown of the centrally held funding for ARRS.
- Vaccination Programme – the CCG funded infrastructure to support the delivery of the vaccination programme across multiple fixed and pop up vaccination sites.
- Digital Information Management & Technology Investments
- Discharge to Assess beds in Care Homes

Financial Sustainability Plans

With the reduced impact of the pandemic on health services during 2021-22 compared to the height of the pandemic, the planning guidance asked organisations to start to look at delivery of efficiencies within the financial year. The CCG delivered efficiencies as outlined below:

- prescribing and waste management cost savings were delivered within an operationally challenging environment, due to the redeployment of the medicines optimisation team to the vaccination programme and supporting the Discharge to Assess beds in care home.

- Vacancies within the CCG were reviewed and only appointed into business critical roles
- The CCG rationalised its headquarters estate during 2020-21, with the full year effect of the savings delivered in 2021-22
- Recovery from the pandemic was slowed in the north west, and although plans were set to achieve pre-pandemic activity levels, these were not achieved and delivered a non-recurrent saving in year.

Better Care Fund

NHS England required the CCG to contribute a minimum of £47,265k to the Manchester Better Care Fund in 2021-22, with the CCG contributing £47,265k.

There are two partners within the scope of the Manchester Better Care Fund which is hosted by NHS Manchester CCG and includes:

- Manchester City Council
- NHS Manchester CCG

There is a contract in place between the partners that describes how the Better Care Fund (BCF) operates, including funding, governance, approved schemes and risk management arrangements.

Better Care Fund (BCF) Pooled budgets 2021-22

The BCF pooled budget arrangement was expanded with effect from 2018-2019 to include additional MHCC baseline budgets. Budgets for Manchester CCG are as follows:

2021-22 Manchester BCF	Budget £000s	Actual £000s	Variance £000s
BCF – Minimum Contribution	47,265	47,265	0
BCF – Additional Contribution**	34,650	34,650	0
TOTAL	81,915	81,915	0
**Additional contribution is over and above the minimum contribution required by CCG			

There are no outstanding assets and liabilities as at 31st March 2022 relating to the Better Care Fund.

The table below details the MHCC total pooled budget and actual expenditure for 2021-22 by service description:

Service Description	Budget			Actual		
	CCG	Council	TOTAL	CCG	Council	TOTAL
	£'000	£'000	£'000	£'000	£'000	£'000
Adult Community Services	43,227		43,227	43,227		43,227
Care Act	1,748		1,748	1,748		1,748
Adult Social Care	15,356		15,356	15,356		15,356
Integrated Community Teams	5,903		5,903	5,903		5,903
Intermediate Care	1,894		1,894	1,894		1,894
Reablement	13,788		13,788	13,788		13,788
Sub Total	**81,915**	**-**	**81,915**	**81,915**	**-**	**81,915**
Care Act	- 1,748	1,748	- 0	- 1,748	1,748	- 0
Protection of Social Care	- 15,356	15,356	-	- 15,356	15,356	-
iBCF: Adult Social Care Grant		28,150	28,150		28,150	28,150
iBCF: Improved Better Care Fund		2,666	2,666		2,666	2,666
Disabled Facilities Grant		8,483	8,483		8,483	8,483
TOTAL	**64,811**	**56,402**	**121,213**	**64,811**	**56,402**	**121,213**

Balance Sheet

The Statement of Financial Position (SoFP) shown in the Annual Accounts Appendix at page 132 is the CCG's balance sheet. The CCG was established on 1st April 2017 and inherited no legacy balances or capital assets.

The CCG has no capital assets as all premises are leased through NHS Property Services Ltd and Community Health Partnerships. The CCG did not purchase any assets in the financial year as it only received a revenue allocation.

The CCG's financial health is assured on a monthly basis at the MHCC's Board meeting. The role of detailed scrutiny is delegated to the monthly Finance Committee, which is a formal sub-committee of the MHCC Board, is chaired by the Lay Representative for Finance and has representation from the other Lay Members. It also includes membership from Manchester City Council due to our partnership approach to the health and social care delivery.

Independent assurance is provided to the Governing Body by External Audit as follows:

- An opinion on the accounts.
- Regularity opinion on whether the expenditure has been incurred as intended by Parliament. Failure to meet statutory financial targets automatically results in a qualified regularity assertion.
- The auditor needs to be satisfied that the clinical commissioning group has made "proper arrangements for securing economy, efficiency and effectiveness in its use of resources." This is a change from previous years when the auditors issued a value for money conclusion, this is now a commentary within the Auditor's Annual Report.

Additional independent assurance is also provided to the Governing Body by the CCG's internal auditors and this is covered within the Head of Internal Audit Opinion in the Corporate Governance section.

The external Audit work programme is supported by the Internal Audit work programme, both of which are agreed and monitored by the Audit Committee.

2022-23 Financial Landscape

MHCC wishes to ensure that the integrated approach adopted in 2021-22 to improvement continues and the MHCC functions are safely passed on to the Greater Manchester Integrated Care System and structures, which is the CCG's successor body from the 1 July 2022. The CCG will exist until the 30 June 2022, whereafter all statutory duties and functions will transfer to the Greater Manchester Integrated Care Board.

The ICB system planning guidance was issued in February 2022 and financial plans have been constructed based on ICB principles, with an initial submission in March and a final system submission at the end of April 2022. There has been a significant amount of system level working including the agreement of contract values, investments and the values of QIPP required and agreed across both providers and commissioners. NHSE has reinforced its commitment to the delivery of the Mental Health Investment Standard in 2021/22 and there is a separate planning submission for mental health covering the whole financial year.

ACCOUNTABILITY REPORT

Ian Williamson

Accountable Officer

16 June 2022

Corporate Governance Report

Members Report

Member practices

Ailsa Craig Medical Practice	Lime Square Medical Centre
Al-Shifa Medical Centre	Longsight Medical Practice[3]
Ardwick Medical Practice[1]	Maples Medical Centre
Ashcroft Surgery	Mauldeth Medical Centre
Ashville Surgery	Mount Road Surgery
Barlow Medical Centre	New Bank Health Centre
Beacon Medical Centre	New Islington Medical Centre
Benchill Medical Practice	Newton Heath Health Centre
Bodey Medical Centre	Northenden Group Practice
Borchardt Medical Centre	Northern Moor Medical Practice
Bowland Medical Practice	Park View Medical Centre
Brooklands Medical Practice	Parkside Medical Centre
Charlestown Surgery	Peel Hall Medical Practice
Cheetham Hill Medical Centre	Princess Road Surgery
Chorlton Family Practice[2]	Queens Medical Centre
City Health Centre	R K Medical Practice
Collegiate Medical Centre	Simpson Medical Practice
Conran Medical Practice	Singh Practice
Cornbrook Medical Practice	St Georges Medical Centre
Cornerstone Family Practice	Surrey Lodge Group Practice
Cornishway Group Practice	The Alexandra Practice
Dam Head Medical Centre	The Arch Medical Practice
David Medical Centre	The Avenue Medical Centre
Dickenson Road Medical Centre	The Docs
Didsbury Medical Centre	The Neville Family Medical Centre
Dr Khan's Practice	The Park Medical Centre
Droylsden Rd Family Practice	The Range Medical Centre
Drs Chiu, Koh & Gan	The Robert Darbishire Practice
Drs Hanif and Bannuru	The Whitswood Practice
Drs Ngan & Chan	The Wilbraham Surgery
Eastlands Medical Practice	Tregenna Group Practice
Fallowfield Medical Centre	Urban Village Medical Practice
Fernclough Surgery	Valentine Medical Centre
Five Oaks Family Practice	Victoria Mill Medical Practice
Florence House Medical Practice	Wellfield Medical Centre
Gorton Medical Centre	West Gorton Medical Centre
Hawthorn Medical Centre	West Point Medical Centre
Hazeldene Medical Centre	Whitley Road Medical Centre
Jolly Medical Centre	Willowbank Surgery
Kingsway Medical Practice	Wilmslow Road Medical Centre
Ladybarn Group Practice	Woodlands Medical Practice
Levenshulme Medical Centre	

[1] *Previously named Dr Cunningham & Partners*

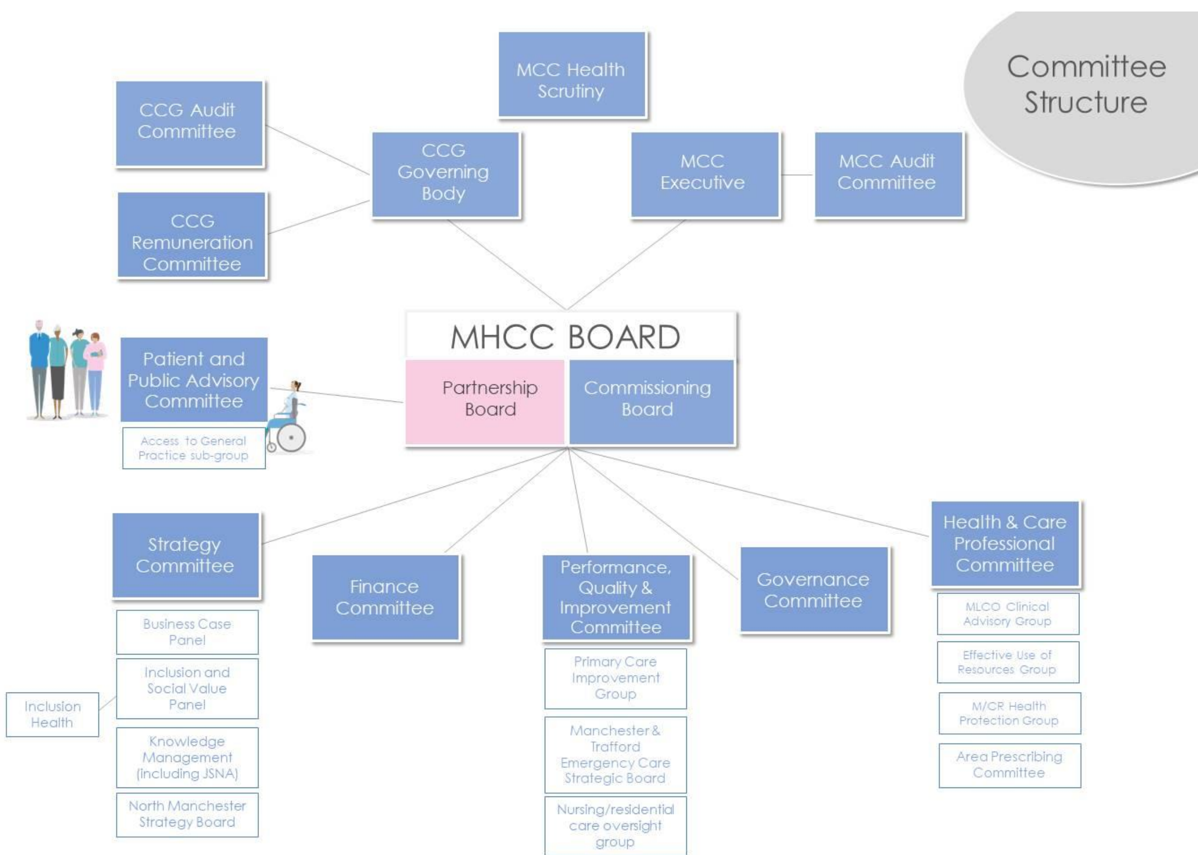
[2] *Corkland Road Medical Practice merged with Chorlton Family Practice during 2021/22*

[3] *Manchester Medical merged with Longstight Medical Practice during 2021/22.*

Composition of Governing Body

To comply with NHS England requirements that functions being carried out jointly with MCC must be managed by a separate committee to those functions being carried out by the CCG alone, we established two Committees, the Commissioning Board and the Partnership Board, which meet at the same time, in the same place and share the same membership. These act together to form the MHCC Board which has a single agenda and set of minutes.

The structure of our Board(s) and Committees is best shown in the diagram below.



The Manchester CCG Governing Body and the Manchester Health and Care Commissioning Board

Dr Ruth Bromley, Chair, MHCC – MCCG Governing Body and MHCC Board Member

Ian Williamson, Chief Accountable Officer, MHCC – MCCG Governing Body and MHCC Board Member

Claire Yarwood, Chief Finance Officer, MHCC – MCCG Governing Body and MHCC Board Member

Dr Denis Colligan, GP Member, MHCC – MCCG Governing Body and MHCC Board Member

Dr Geeta Wadhwa, GP Member, MHCC – MCCG Governing body and MHCC Board Member

Dr Murugesan Raja, GP Member, MHCC – MCCG Governing Body and MHCC Board Member

Grenville Page, Lay Member, Governance, MHCC – MCCG Governing Body and MHCC Board Member (Resigned 31.08.2021)

Chris Jeffries, Lay Member, Finance and Audit, MHCC – MCCG Governing Body and MHCC Board Member

Atiha Chaudry, Lay Member, Patient and Public Involvement (PPI), MHCC – MCCG Governing Body and MHCC Board Member

Dr Peter Williams, Secondary Care Doctor, MHCC – MCCG Governing Body and MHCC Board Member

Christine Pearson, Board Nurse, MHCC – MCCG Governing Body and MHCC Board Member

Joanne Roney, Chief Executive, MCC – MHCC Board Member

Councillor Bev Craig, Executive Councillor, MCC – MHCC Board Member (from 01.04.2021 until 30.04.2021)

Councillor Joanna Midgley, Executive Councillor, MCC – MHCC Board Member (appointed as a Board member on 01.05.2021)

Councillor Garry Bridges, Executive Councillor, MCC – MHCC Board Member

Ed Dyson, Executive Director of Strategy, MHCC – MHCC Board Member

David Regan, Executive Director of Population Health and Wellbeing, MHCC – MHCC Board Member

Dr Manisha Kumar, Medical Director, MHCC – MHCC Board Member

Bernie Enright, Director of Adult Social Services, MCC – MHCC Board Member

Committee(s), including Audit Committee

Audit Committee	Lay Member for Finance and Audit (Chair) – Chris Jeffries Lay Member for Governance (Deputy Chair) – Grenville Page (resigned 31.08.2021) Lay Member for Patient and Public Involvement – Atiha Chaudry Secondary Care Doctor – Dr Peter Williams Board Nurse – Christine Pearson
Performance & Quality Improvement	Secondary Care Doctor – (Chair) - Dr Peter Williams GP Board Member (Co-Deputy chair) – Dr Murugesan Raja Director of Performance & Quality Improvement (Exec Lead) - Michelle Irvine (Resigned 01.10.2021) GP Clinical Lead for Quality and Performance (Co-Deputy Chair) – Dr David Adam-Strump Medical Director - Dr Manisha Kumar Director of Safeguarding – Andrea Patel Deputy Director of Quality and Patient Services Specialist - Kate Provan Deputy Director of Performance - Zoe Mellon Head of Reform for Delivery - Sara Fletcher Deputy Director, Strategy Integrated Care - Fiona Meadowcroft Head of Engagement - Val Bayliss-Brideaux Business Intelligence Lead - Graham Hayler

	Deputy Director and Head of Medicines Optimisation - Kenny Li Head of Commissioning – Primary Care – Caroline Bradley Lay Member for Patient and Public Involvement - Atiha Chaudry PPAC representative - Colin Bayley Lay Member, Board Nurse - Christine Pearson Public Health Specialist (Health Intelligence) – Neil Bendel Clinical Lead for Mental Health P&Q – Michael Capek (member until 31.07.2021) Clinical Lead for Mental Health P&Q – Dr Ruth Thompson (member from 01.09.2021 onwards) Associate Director of Nursing – Carolina Ciliento
Health and Care Professional (HCPC) (our forum for clinical governance and effectiveness)	GP Board Member – North (Chair) Dr Denis Colligan Board Nurse (Deputy Chair) – Christine Pearson Associate Director of Nursing - Carolina Ciliento MHCC Clinical Chair – Dr Ruth Bromley Board Secondary Care Doctor – Dr Peter Williams GP Board Member – Central - Dr Murugesan Raja GP Board Member – South – Dr Geeta Wadhwa Strategic Director Adult Social Care - Bernie Enright Public Health Consultant – Cordelle Mbeledogu LMC Representative – Simon Minkoff Urgent Care Lead – Dr Peter Fink GP Deputy Medical Director – Dr Claire Lake GP Deputy Medical Director – Dr Paul Wright Director for Safeguarding - Andrea Patel Deputy Director - Meds Optimisation - Kenny Li
Governance	Lay Member for Governance (Chair) – Grenville Page (Resigned 31.08.2021) Lay Member for Finance and Audit (member and Deputy Chair until 31.08.2021 and Chair from 01.09.2021 onwards) – Chris Jeffries Secondary Care Doctor (Deputy Chair) – Dr Peter Williams (member from 01.09.2021 onwards)

	Lay Member for Patient and Public Involvement – Atiha Chaudry Director of Corporate Affairs, MHCC – Nick Gomm (Resigned 30.06.2021) Head of Finance, MHCC – Kaye Abbott Head of Corporate Governance, MHCC – Chris Gaffey Head of IT/IG, MHCC – Graham Hayler (member until 06.06.2021) Data Protection Officer (MHCC) – Sharvanah Purves (member from 07.06.2021 onwards)
Finance & Contracting	Lay Member for Finance and Audit (Chair) - Chris Jeffries Lay Member for Governance (Deputy Chair) - Grenville Page (Resigned 31.08.2021) Lay Member for Patient and Public Involvement (Deputy Chair) – Atiha Chaudry (member from 01.09.2021 onwards) Chief Finance Officer – Claire Yarwood Chief Accountable Officer – Ian Williamson Deputy Medical Director – Dr Peter Fink (member until 30.04.2021) Deputy Medical Director – Dr Claire Lake (member from 01.05.2021 onwards) Executive Director of Strategy – Ed Dyson (member from 01.06.2021 onwards) Executive Member for Adult & Social Care - Cllr Bev Craig (member until 30.04.2021) Executive Member of Adult and Social Care – Cllr Joanne Midgley (member from 01.05.2021 onwards) Director of Adult Social Care Commissioning – Bernie Enright (member until 30.04.2021) Interim Deputy City Treasurer - Manchester City Council – Helen Seechurn (member until 30.04.2021) Head of Strategy & Planning – Leigh Latham (member from until 30.04.2021)

	Executive Member for Finance - Cllr Carl Ollerhead (member from until 30.04.2021)
Remuneration	Lay Member for Governance (Chair) – Grenville Page (Resigned 31.08.2021) Lay Member for Audit and Finance – Chris Jeffries (Chair from 01.09.2021 onwards) Lay Member for Patient and Public Involvement – Atiha Chaudry Secondary Care Doctor – Dr Peter Williams Board Nurse – Christine Pearson
Strategy	MHCC Board Executive Member (MCC) (Co-Chair) - Cllr Bev Craig (member until 30.04.2021) MHCC Board Executive Member (MCC) (Co-Chair) - Cllr Joanna Midgley (member from 01.05.2021 onwards) MHCC Board Lay member - Finance (Co-Chair) – Chris Jeffries Executive Director of Strategy (lead officer) – Ed Dyson Lay Member – Patient and public involvement – Atiha Chaudry GP Board Member – Dr Geeta Wadhwa Healthwatch - Vicky Szulist Chief Finance Officer – Claire Yarwood Director of Strategy - Julie Taylor Executive Director of Commissioning / DASS – Bernie Enright (no longer a voting member Head of Reform and Innovation MCC – James Binks Public Health Consultant – Cordelle Mbeledogu Medical Director – Manisha Kumar Director of Corporate Affairs – Nick Gomm (Resigned 01.07.2021)
Patient and Public Advisory Committee (PPAC)	Lay Member for Patient and Public Involvement (Chair) – Atiha Chaudry Patient and Public Advisory Committee volunteer members

Register of Interests

The Register of Interests is available on MHCC's website at https://www.mhcc.nhs.uk/about-us/how-we-manage-conflicts-of-interest/

This was updated in May 2022. The register is refreshed and republished at least annually in line with NHSE requirements, however in reality the register will be published more regularly to reflect changes in interests throughout the year. The register of interests of all staff, Board and Committee Members and practices is updated on a regular basis as interests arise (or cease) and when other opportunities present themselves to update. Information regarding Board Members who have now left the organisation is available on request.

Personal data related incidents

In the year being reported, there were no personal data related incidents within MHCC.

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

Manchester CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2022 is published on our website at https://www.mhcc.nhs.uk/about-us/safeguarding/safeguarding-adults/slavery-and-human-trafficking-statement/.

Statement of Accountable Officer's Responsibilities

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

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 Government Financial Reporting Manual and in particular to:

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

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

I also confirm that, as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and 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.

Ian Williamson
Accountable Officer
16 June 2022

Governance Statement

Introduction and context

Manchester CCG is a body corporate established by NHS England on 1 April 2017 under the National Health Service Act 2006 (as amended).

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

Scope of responsibility

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

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

Governance arrangements and effectiveness

The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively,

efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

Our Constitution states that, in accordance with section 14L(2)(b) of the 2006 Act, the CCG will at all times observe "such generally accepted principles of good governance" in the way it conducts its business. 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 Services
- 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 geographical area covered by NHS Manchester Clinical Commissioning Group is fully coterminous with Manchester City Council. Membership of the CCG is open to all practices that sit within the wards of Ancoats and Beswick , Ardwick, Baguley, Brooklands, Burnage, Charlestown, Cheetham, Chorlton, Chorlton Park, Clayton and Openshaw, Crumpsall, Deansgate, Didsbury East, Didsbury West, Fallowfield, Gorton and Abbey Hey, Harpurhey, Higher Blackley, Hulme, Levenshulme, Longsight, Miles Platting and Newton Heath, Moss Side, Moston, Northenden, Old Moat, Piccadilly, Rusholme, Sharston, Whalley Range, Withington, and Woodhouse Park.

As a clinically led organisation, general practices in the geographical area described above collectively form the membership of NHS Manchester Clinical Commissioning Group. 83 practices made up the membership of the Group at the end of 2020/21, as listed in the Members' report.

The principles underpinning MHCC were agreed prior to April 2017 by the three Manchester Clinical Commissioning Groups (CCGs) and Manchester City Council (MCC), and were re-confirmed in the Partnership Agreement which created MHCC.

On 1 April 2021, new arrangements came into place which changed the MHCC partnership. As detailed within the 'Our Organisation' section of this Annual Report, the pooled budget arrangements between MCCG and MCC were reduced, meaning the partnership would no longer be responsible for the commissioning of Adult Social Care and Public Health services. The Section 75 agreement between MCCG and MCC was amended to reflect these changes, with the agreement as of 1 April 2021 covering the Better Care Fund and Improved Better Care Fund only, as required by legislation.

Although the pooled budgets were reduced, both the CCG and the Local Authority agreed that they would continue to maintain a meaningful relationship under the banner of Manchester Health and Care Commissioning, and confirmed:

- The Population Health and Wellbeing function would remain part of the MHCC working arrangements through the Director of Population Health and his team. However, the budget would be overseen by MCC.
- In order to maintain continuity, alignment, and the ability to effectively carry out MHCC's functions for 2021/22, the CCG welcomed continued MCC representation on the MHCC Board and Strategy Committee.

Following the changes, the MHCC governance structure and MHCC Board and Executive Team membership remained broadly the same (as detailed within the Corporate Governance Report section of this Annual Report, and within the MCCG Constitution).

In terms of the design of MHCC's governance structure, the following principles continue to be applied:

- MHCC should act like, and be treated as, a single organisation.
- Accountability for delivery of all MHCC's functions will rest with the MHCC Chief Accountable Officer, be exercised through the Executive Team and MHCC governance structure, and be informed by public, clinical and professional opinion.
- The MHCC Board will be the primary decision-making body of MHCC and is supported in its work by a range of sub-committees.

- The MHCC Board must be able to make decisions on the commissioning of the widest possible range of services. This scope will be replicated on all the Board's sub-committees (within the scope of their responsibility).

As a result of the change to the MHCC partnership, MHCC's Committee Terms of References were reviewed to ensure the memberships remained aligned to their responsibilities.

In compliance with the regulations which control the establishment of CCGs that do not allow local authority elected members (who are members of the MHCC Board) in decision making positions on a CCG's Governing Body, only those functions, which statute demands are within its control, are reserved to MCCG's Governing Body. These are:

- ensuring 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
- determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act
- approving any decision taken by the Commissioning Board to enter into the Partnership Agreement; and, if it considers it appropriate, initiate and approve the CCG's exit from the Partnership Agreement
- approving any recommendation made by the Commissioning Board to change the CCG's overarching scheme of reservation and delegation
- proposing to the members any amendments to this constitution which will assist in supporting the above

The governance structure was established with the following key features:

- The most minimal (legally possible) reservation of functions to MCCG's Governing Body and MCC's meetings to ensure clarity of decision-making over MHCC in-scope functions. These reservations include the Audit and

Remuneration functions, and a responsibility for an overview of the governance structure;

- The MHCC Board, with appropriate membership from MCC and MCCG, overseeing all commissioning decisions for in-scope services, and providing assurance to MCCG and MCC for all in-scope functions.;
- A range of Board sub-committees, with appropriate membership to support the Board to deliver all its functions and duties;
- Executives, officers and lay representatives who work for MHCC across all in-scope functions, no matter who their employing organisation is.
- In line with statute, the CCG's Governing Body has two Committees – the Audit Committee and the Remuneration Committee (see the Members' Report for the membership of these committees).

The rest of the CCG's functions have been delegated to the MHCC 'Board' for management. To this end, we established two bodies, the Commissioning Board and the Partnership Board, which meet at the same time, in the same place and share the same membership. These act together to form the MHCC Board which has a single agenda and set of minutes. All Governing Body members are members of the MHCC Board.

MHCC's Board has a full range of sub-committees to support it in its work. These are (see the Members' Report for the membership of these committees):

- Finance and Contracting Committee
- Governance Committee
- Health and Care Professional Committee
- Performance, Quality and Improvement Committee
- Strategy Committee
- Patient and Public Advisory Committee

Attendance at Committees and the Board is reported to the Governance Committee twice a year and the key actions taken by Committees are reported to the Board following their respective meetings.

MHCC regularly reviews its governance structures, however there were no significant changes made to the substantive Board and Sub-Committee structures during 2021/22 beyond the annual reviews and refresh of sub-committee Terms of Reference and their memberships.

UK Corporate Governance Code

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

However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the clinical commissioning group, namely:

- Leadership
- Effectiveness
- Accountability
- Remuneration
- Relationships with stakeholders

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the 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 clinical commissioning group's statutory duties.

Risk management arrangements and effectiveness

Manchester Health and Care Commissioning's Risk Management Framework (RMF) provides a guideline and strategy for the development of a robust risk management system across MHCC. The framework looks to guide MHCC in its approach to the

management of risk in all its activities and provides a structural framework with clear definitions and roles of responsibility.

The framework sets out how to identify, assess and report risks and how risks are governed within MHCC through an effective committee structure, which feeds up to the Board.

MHCC designates its risks in three categories:

- Strategic risks – the small number of high-level risks identified by the Board as those which present the most significant risk to achieving MHCC's strategic objectives. These risks are the key feature of the Board Assurance Framework, which is scrutinised by the Board quarterly at its meetings.
- Corporate risks – all risks with the potential to affect achievement of MHCC's strategic objectives. Corporate risks are reported through the committee structure with each risk being attached to a single committee for scrutiny and review.
- Programme risks – risks with the potential to affect achievement of a particular programme of work, which will be reported through Programme Management structures.

If a risk to a Programme of work becomes so significant that it becomes a risk to delivery of the organisation objectives, then it should also be recorded as a Corporate Risk. It is the role of the Programme lead to escalate it in this way with support, where necessary, from the Corporate Governance Team.

If a Committee believes that a Corporate Risk becomes so significant it should be escalated to become a Strategic Risk, the Committee will recommend it through their report to the next Board meeting.

Capacity to Handle Risk

The purpose of our Risk Management Framework (RMF) is to provide guidance to all staff working for or on behalf of MHCC on the management of risk. It describes the methods to be used in the identification, assessment and monitoring of risk.

The RMF seeks to meet the following objectives:

- To understand risks, their causes, costs and how best to control them

- To maintain risk registers that detail all MHCC's risks
- To provide assurance to the Board that risk management issues are being addressed locally and corporately
- To establish risk management plans of action based on CCG risk registers
- To ensure compliance against statutory requirements
- To be open, transparent and publicly accountable about what may hinder us in the achievement of our aims

It is the responsibility of all staff to contribute to the implementation of this policy through effective and appropriate identification, assessment and management of all risks to the organisation. The three categories of risks in our RMF are managed and publicised through the maintenance of risk registers (in a standardised format), with senior managers individually named as the risk owner and lead in ensuring that mitigations are identified and actioned.

The Board is responsible for overseeing the risks identified within the organisation and for gaining assurance that the CCG is addressing risks that are considered serious to its strategic objectives. Additionally, the Governance Committee is responsible for monitoring risks deemed as serious and escalating as necessary for consideration by the MHCC Board. The Committee is also responsible for monitoring all Governance risks for MHCC.

Risk Assessment

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

Risks are categorised by their risk score as 'acceptable', 'manageable' or 'serious'.

Realistically it is never possible to eliminate all risks. There will always be a range of risks identified within the organisation that would require us to go beyond 'reasonable' action to reduce or eliminate them, i.e. the cost in time or resources required to reduce the risk would outweigh the potential harm caused. These risks, with a risk score of below 8, would be considered 'acceptable'. We consider risks scored above 8 but

below 15 to be ‘manageable’ and are monitored through MHCC’s Committee Structure. They can realistically be reduced within a reasonable time scale through cost effective measures, such as training or new equipment purchase. Risks that have a score of 15 or above are considered ‘serious’. The consequences of the event could seriously impact on the organisation and threaten its objectives. This category might include risks that are individually manageable but cumulatively serious, such as a series of similar incidents or quality issues. Serious risks are considered at each Governance Committee meeting and escalated to the Board as a Strategic risk if necessary.

The Board is responsible for oversight and management of MHCC’s Strategic Risks.

In 2018, the Board considered its appetite for risk, using an accepted definition of “risk appetite” as ‘The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time’. (HMT Orange Book definition 2004)

Consequently, the Board adopted the following statement of its risk appetite, which recognised that we are prepared to take accept differing levels of risk to its objectives: “As MHCC, we recognise that there will be elements of risk in all that we do, and that risks will present challenges and opportunities. In the light of the enormous changes in health and social care that we are endeavouring to make in the city, we believe it would be a risk *not* to take a risk.” This Risk Appetite Statement was last reviewed by the MHCC Board in September 2021.

As a result of the broad scope of our work, we also recognise that the level of risk that we are prepared to accept is not consistent across all our objectives. In light of this, our appetite for risk in delivering our strategic aims is as follows:

- In ensuring that providers’ services are safe and of high quality we have a **low** appetite, being aware of the risks to patient and public safety and the potential for reputational damage to providers and commissioners.
- In our aim to improve the health and wellbeing of the local population we are prepared to accept a **moderate to high** appetite, as we, necessarily, aim for transformational change.
- In demonstrating the leadership required to strengthen the wider determinants of health, we have a **high** level of appetite.

- In enabling people to be active partners in managing their health, we have a **high** level of appetite, seeking to invest in their strengths and to capacity build.
- Finally, to ensure we have robust and financially sound decision-making by a workforce with appropriate levels of capability, we have a **low** level of risk appetite for our financial objectives.

All risks on the Strategic Risk Register are assessed for the level of risk the Board is willing to accept, tolerate, or be exposed to and assessments are used to inform the target risk score. This allows managers to understand the extent and limits of their 'risk-taking' and to develop appropriate mitigation plans.

MHCC's Strategic Risks (the Board Risk Assurance Framework) for the first half of the 2021/22 financial year were as follows:

- Service capacity
- Inequity
- Community resources
- Strategic Partnerships
- Coronavirus - COVID-19
- Financial pressures as a result of COVID 19 adversely affect health and care partners
- MHCC finances may not meet demand over medium/ long term
- Health Inequalities
- Impact of COVID-19 on health of population
- Transition to New ICS Arrangements
- The requirement to address the recurrent financial gap on health-related budgets.

A review of MHCC's strategi risks was conducted between July and September 2021, and to ensure that MHCC had a clear focus on key strategic risk areas leading up to transition to Integrated Care Systems in 2022, the MHCC Board agreed the strategic risks for the organisation would be:

- Transition to New ICS Arrangements
- Inequity and inequality
- Finances
- System Resilience and Recovery
- Strategic and Local Partnerships

The Governance Committee has a central role in ensuring that managers are following risk management policies and in acting as an assurance body for the Board, by reviewing high level risks and deciding on any escalation of risks required.

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 and the impact should they be realised, and to manage them efficiently, effectively and economically.

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

MHCC's Governance Framework

MHCC's system of internal control has a key role in the management of governance issues and risks that are significant to the fulfilment of its business objectives. A sound system of internal control contributes to safeguarding the organisation's business interests. In September 2017, MHCC adopted a Governance Framework which was developed to:

- articulate all different aspects of the partnership's governance-related work
- identify the lead committees with an overview of each aspect
- describe how the Board receives assurance that each aspect is being delivered
- store evidence for each aspect of the framework

The Governance Framework covers the main elements of our management and leadership:

- Strategic Leadership
- Partnership working
- Membership involvement
- Public Engagement
- Quality and Safety
- Focus on Outcomes
- Decision making
- Transparency and Accountability
- Financial Stewardship
- Control systems
- Compliance
- Capacity, capability and management
- Equality and Diversity

The Framework sets out the aims of each element and the Committee responsible for its oversight. It provides where the Board and Committees can obtain their assurance and what evidence exists for such assurance.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

As required by the guidance, an audit of conflicts of interest was completed following the prescribed framework issued by NHS England. The following compliance levels were assigned to each scope area:

	Scope Area	RAG Rating	Level
1.	Governance Arrangements	● (green)	PC
2.	Declarations of interests and gifts and hospitality	● (amber)	FC
3.	Register of interests, gifts and hospitality and procurement decisions	● (green)	FC
4.	Decision making processes and contract monitoring	● (green)	FC
5.	Reporting concerns and identifying and managing breaches / non-compliance	● (green)	FC

Compliance levels in relation to conflicts of interest management remain the same level as in the previous year. The amber rating for 'Declarations of Interest and Gifts and Hospitality' related to the obtaining declarations of interest from staff new in their roles within 28 days of starting with the organisation. A recommendation was made as part of the internal audit report, with a proposed action in place to address this.

Data Quality

MHCC recognises that decision making at every level within the health and care system, whether it be for commissioning or direct care purposes, needs to be based on information which is of the highest quality.

MHCC has well established systems and processes to validate the completeness, accuracy, validity and timeliness of the information that it uses. Where they exist MHCC uses national data standards and expects its health and care providers to do the same. Where required local standards are agreed and reviewed on an annual basis.

Having assessed the quality of data submitted to and reviewed by the Board (with advice taken from my fellow Board members), I am assured that the data is of sufficient quality that the Governing Body can carry out its duties.

Information Governance

The NHS Information Governance (IG) Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The new NHS Data Security and Protection Toolkit forms part of a new IG Framework for assuring that organisations are implementing the 10 data security standards and meeting their statutory obligations on data protection and data security. The Data Security and Protection Toolkit enable us to measure our compliance against the data protection legislation and the National Data Guardians Data Security Standards and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an Information Governance Management Framework and have developed information governance processes and procedures in line with the Data Security and Protection Toolkit. We have ensured all staff undertake annual Data Security Awareness Training and have relevant information governance policies and procedures in place to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We have developed information risk assessment and management procedures and a programme has been established to fully embed an information risk culture throughout the organisation against identified risks.

Business Critical Models

The CCG has produced and maintains an organisational Information Asset Register which identifies business critical assets, HR assets, PCD assets and financial assets for each service within the CCG. Information Asset Owners and Information Asset Administrators have been assigned and all information assets are regularly

reviewed. The SIRO is responsible for identifying and managing the information risks. The SIRO received regular reports highlighting any risks.

Data Flow mapping is in the process of being completed which will enable an understanding of the flows of information related to all information assets with the Information Asset Register. Information Asset Owners are responsible for providing updates and highlighting any risks to the SIRO.

Business continuity plans are in place and regularly reviewed to ensure that controls exist, and any risks are mitigated appropriately. Business continuity arrangements and processes will be reviewed as part of the transition into the new ICS arrangements later in 2022.

Third party assurances

The CCG has received third party assurance from NHS Greater Manchester Shared Services (GMSS) through the Head of Internal Audit Opinion & Annual Report for 2021/2022. The overall opinion for the period 1st April 2021 to 31st March 2022 provides Substantial Assurance, in that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The Internal Audit arrangements in 2021/22 were well established and audit coverage was approved through the GMSS Governance Committee and Senior Management Team. The reviews within the service have concluded that, as an entity, robust internal controls are operating in respect of GMSS. In addition, the follow up of audit recommendations confirmed good progress being made in implementing previously agreed actions.

GMSS provide a number of support services to NHS Manchester CCG. During 2021/22 GMSS have had a number of internal audits and advisory pieces of work undertaken including People's Services, Key Financial Controls, Data Security & Protection Toolkit, and Governance, Risk Management & Internal Control Review. These contribute to the substantial assurance given in the Head of Internal Audit Opinion for 2021/22 for GMSS.

Service Auditor Reports

The CCG also receives services from a number of other organisations. The information relating to the service auditor reports for these organisations are set out in the table below:

NHS Shared Business Services Ltd: Finance and Accounting Services	The 2021/22 service auditor report has been qualified.
NHS Digital GP Payments	The 2021/22 service auditor report has been qualified.
East Lancashire Financial Services	The 2021/22 service auditor report has been qualified.
Capita Primary Care Support Services	The 2021/22 service auditor report has been qualified.
Electronic Staff Record Programme	The 2021/22 service auditor report has been qualified.
NHS Business Services Authority: Prescription payments	The 2021/22 service auditor report has been qualified.

Control Issues

No significant internal control issues have been identified in the reporting period.

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

The CCG has an obligation to use its resources efficiently, effectively and economically. In addition, it must meet financial requirements as set out by NHS England. This includes delivering a breakeven financial position. In order to mitigate and control risks associated with the CCG’s use of resources, organisational financial health is checked and reported to the MHCC Board on a monthly basis. The Board has also delegated responsibility for some aspects of financial internal control to the Finance Committee.

During the 2021-22 financial year the CCG returned to a more ‘business as usual’ approach, the financial year was split into H1 (April – September) and H2 (October to March), with the CCG working within a system control total for financial performance. The CCG produced two plan submissions covering the H1 and H2 periods, in line

with NHSE planning guidance and both period budgets were agreed by the MHCC Board. The CCG has worked within a system control total, working with partners to produce a health economy financial plan, to support the locality plan for Manchester and the overall Greater Manchester Sustainability and Transformation plan. These have been reported to the Finance Committee and the Board, providing assurance to the Board and myself that the organisation is effectively managing its resources and understanding the key financial risks.

A number of the measures introduced in 2020-21 remained in place for 2021-22:

- Calculated block contracts payable to NHS bodies, adjusted for local agreements. Ceased the majority of inter-NHS invoicing
- The Greater Manchester system managed the Independent Sector directly to secure capacity and this was funded on a system agreement
- Ceased NHS Non-Contract Activity, with the financial impacts covered within the block contracts
- Although COVID funding reduced in year, the Hospital Discharge Programme and the vaccination programme continued
- Remove the requirement to negotiate contracts for 2021/22 and suspended CQUIN
- Investments were allowable dependent on system agreement, Mental Health Investment standard delivery was fully supported

NHS England has a legal duty to annually assess the performance of each Clinical Commissioning Group (CCG). The assessment must consider the duties of CCGs to improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The results of this assessment can be found on page 25 of this report. As of February 2022, MHCC's rating for Quality of Leadership was 3 (Good), ranking the organisation 17th out of 137.

Delegation of functions

The Governing Body of the CCG retains oversight of those functions which statute dictates it must and delegates responsibility for managing all other aspects of its

business to the CCG's Commissioning Board and Partnership Board which meet as 'committees in common', forming the 'Board' of the CCG. The Board is supported in its work by a range of sub-committees which oversee specific aspects of commissioning (see the governance structure diagram in the Members' Report, above).

The Board receives regular reports from each sub-committee, including our Patient and Public Advisory Committee, detailing the delivery of work, and associated risks, within their specific remit. Risks can be escalated by committees to become included in the Board Assurance Framework if appropriate.

The internal audit process is used to provide an in-depth examination of any areas of concern and the Governance Framework, overseen by the Governance Committee, provides assurance that the statutory duties of the CCG are being managed appropriately at the different levels of the organisation.

The organisation has a Freedom to Speak Up (Including Whistleblowing) Policy in place. The Policy is provided to all staff and confirms the organisation's Freedom to Speak Up Guardian and how they can be contacted, and identifies how issues may be raised and addressed.

Counter fraud arrangements

The CCG has made the following arrangements regarding its managing of counter-fraud:

- An Accredited Counter Fraud Specialist is contracted from MIAA to undertake counter fraud work proportionate to identified risks
- There is an annual risk-based counter fraud proactive work plan that is agreed and signed off by the Audit Committee. This is developed by the Local Counter Fraud Specialist and the Chief Finance Officer on a risk-based approach.
- The CCG's Audit Committee receives, at each meeting, an indication as to current levels of compliance with the requirements set out in Government Functional Standard 013 for Counter Fraud. In addition, an annual self-assessment against the requirements of the standard is submitted to the NHS

Counter Fraud Authority. There is the commitment to provide executive support and direction for a proportionate proactive work plan should this assessment identify any increased fraud risks to the CCG.

- All members of staff and GP practices have responsibility for raising concerns around fraud, bribery and corruption but the Executive responsibility within the CCG lies with the Chief Finance Officer
- All NHS quality assurance recommendations are reviewed and acted on as appropriate. The CCG also regularly distributes NHS Counter Fraud Authority Fraud Prevention Notices and Intelligence Bulletins to relevant staff.

Head of Internal Audit Opinion

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

> The overall opinion for the period 1st April 2021 to 31st March 2022 provides **Substantial Assurance**, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

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

Area of Audit	Level of Assurance Given
Assurance Framework	The organisation's Assurance Framework is structured to meet the NHS requirements, is visibly used by the organisation, and clearly reflects the risks discussed by the MHCC Board.
Conflicts of Interest	Fully compliant in four of the five scope areas. The CCG was partially compliant in the 'Declarations of interest and gifts and hospitality' scope area, with further detail available in the 'Annual audit of conflicts of interest management' section of this governance statement.
Covid-19 Governance	Substantial
End User IT Asset Lifecycle - Phase 2	Substantial
Data Protection and Security Toolkit	Substantial

Continuing Healthcare: Financial Arrangements	Moderate

During the year, a review of the 2021/22 Primary Medical Care Commissioning and Contracting focused upon Commissioning and Procurement of Primary Medical Services was conducted and provided Substantial Assurance (assurance rating provided as per the NHSE guidance). Overall, the review identified that the arrangements in place were effectively designed as described and where design was observable, however it was not always possible to test the operation of the arrangements due to command-and-control arrangements imposed in response to the Covid-19 pandemic.

A review of the CCG's Closedown and Transition to ICS arrangements provided assurance that effective processes have been established for the completion and monitoring of the Due Diligence Checklists / Programme Plan. (*Note: the assurance provided did not provide confirmation of the accuracy and completeness of the Due Diligence Checklist/Transition Plan).*

Follow Up

During the course of the year, follow up reviews concluded that the organisation has made good progress with regards to the implementation the previous year's recommendations.

Ian Williamson

Accountable Officer

16 June 2022

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The Remuneration Committee is a committee of the NHS Manchester CCG. It has those executive powers, delegated to it by the Governing Body within the CCG's Scheme of Reservation and Delegation, contained in its terms of reference, which are reviewed on an annual basis. It does not set the remuneration, fees and other allowances for the members of the Committee. All recommendations made by the Committee are referred to the Governing Body for decision.

Information on the Committee's membership can be found in the Members Report (under the heading 'Committee(s), including Audit Committee').

The following may be expected to attend as non-voting members:

- Chief Accountable Officer
- Chief Finance Officer
- Director of Workforce and OD
- Senior Human Resources Business Partner
- Associate Chief Finance Officer

Policy on the remuneration of senior managers

The Remuneration Committee has responsibility for recommending general principles to the Governing Body and Board in relation to the determination of the remuneration, fees and other allowances for Governing Body members.

When considering pay awards, the Remuneration Committee will consider national awards, affordability and benchmark data for similar size organisations to enable a recommendation to be reached.

The pay of the Governing Body is not currently directly linked to performance, that is, there is no performance related pay. However, both the Governing Body and its individual members are subject to performance evaluation through an annual appraisal.

The contract for senior managers states that:

If the employee wishes to terminate their employment, they must give the CCG an appropriate period of notice in writing – a minimum of 6 months. The CCG will give a period of 6 months' notice.

The CCG shall be entitled to terminate the individual's employment summarily, i.e. without notice or pay in lieu of notice, without prejudice to any rights or claims it may have against them, if at any time they are guilty of gross misconduct or if they commit any serious breach of a material term of their contract of employment.

If the individual is employed on a fixed term contract, their employment will terminate on the expiry of the fixed term without the need for the CCG to give any additional notice.

The CCG may require an individual to take any outstanding annual leave entitlement during their notice period, whether notice to terminate is given by them or by the CCG.

Once the individual or the CCG have served notice to terminate an employment contract, the CCG may require the individual to remain away from work and to cease to carry out normal duties for the whole or any part of the notice period (known as "garden leave").

During any period of garden leave:

- The CCG shall be under no obligation to provide the individual with any work but may require them to carry out alternative duties
- The individual will remain an employee of the CCG, bound by the terms of their contract and will continue to receive their salary in the usual way
- The CCG may exclude the individual from any of its premises but may require the individual to ensure that their line manager knows where they will be and how they can be contacted during each working day (except when they are on authorised annual leave, booked in the usual way)
- The CCG may require the individual not to contact (or attempt to contact) any employee, client or supplier without the consent of their line manager

There are no special provisions for termination due to redundancy other than those stated for all employees in the CCG's Organisational Change policy.

Senior Managers Service Contracts

There are members of the Governing Body whose services are via a Contract for Services. The termination arrangements for these individuals are as follows:

- Continuation of their appointment is contingent on their continued satisfactory performance and re-election/selection by the members as required by the Constitution. If the members do not re-elect the individual as a Governing Body Member in accordance with the Constitution, their appointment shall terminate automatically and with immediate effect.
- The individual may resign from the CCG at any time by giving written notice to the Chair.
- The CCG reserves the right to terminate their appointment with immediate effect and without payment of compensation by written notice.
- On termination of the appointment, the individual shall only be entitled to accrued fees as at the date of termination, together with the reimbursement of any expenses properly incurred prior to that date.

Due to the terms in the contract for service there is no liability to the CCG in the event of early termination.

Remuneration of Very Senior Managers

The CCG has 7 senior leaders who would have been paid more than £150,000 per annum had they worked on a full-time basis. 6 of these are clinicians who provide clinical leadership and the CCG has satisfied itself that the remuneration is reasonable through the application of its remuneration policy. The application of the nationally agreed pay award moved a VSM into the position of being paid more that £150,000 per annum had they worked on a full-time basis. This was notified to and agreed by NHS England. The disclosure excludes any payments which related to the prior financial year.

Senior manager remuneration (including salary and pension entitlements)

The following tables and the associated financial values have been audited and validated.

Salaries and Allowances for Manchester CCG Governing Body 2021/22

Name and Title	2021/2022						
	(a) Salary & Fees for Governing Body	Other Salary for additional posts (not related to the Governing Body post)	(b) Expense Payments (Taxable)	(c) Performance Pay and bonuses	(d) Long-term performance pay and bonuses	(e) All Pension Related Benefits	TOTAL (a-e)
	(bands of £5,000)	(bands of £5,000)	(Rounded to nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
	£000	£000	£	£000	£000	£000	£000
Dr Ruth Bromley, GP Chair	85-90		0			n/a	85-90
Mr Ian Williamson, Chief Accountable Officer	150-155		0			37.5-40	190-195
Mrs Claire Yarwood, Chief Financial Officer	140-145		0			35-37.5	175-180
Mr Ed Dyson, Executive Director of Planning and Operations	105-110		0			25-27.5	135-140
Dr Manisha Kumar, Medical Director	140-145		0			n/a	140-145
Dr Murugesan Raja, GP Member	30-35		0			n/a	30-35
Dr Geeta Wadhwa, GP Member	30-35		0			n/a	30-35
Dr Denis Colligan, GP Member GP Member	30-35		0			n/a	30-35
Dr Peter Williams, Secondary Care Doctor	30-35		0			n/a	30-35
Christine Pearson, Board Nurse Board Nurse	20-25		0			n/a	20-25
Mr Grenville Page, Lay Member - Governance	05-10		0			n/a	05-10
Mr Chris Jeffries, Lay Member - Finance and Audit	10-15		0			n/a	10-15
Atiha Chaudry, Lay Member - Patient and Public Involvement	20-25		0			n/a	20-25

**Note: Taxable expenses and benefits in kind are expressed to the nearest £100.

1 -	Mr Grenville Page	Resigned September 2021
2 -	**MHCC Members not listed above, employed by City Council**	
	Cllr Bev Craig - Deputy Chair	Executive Councillor as nominated by Manchester City Council
	Cllr Garry Bridges	Executive Councillor as nominated by Manchester City Council
	Bernie Enright	Director of Strategic Commissioning / DASS
	David Regan	Executive Director of Population Health and Wellbeing
	Joanne Roney	Chief Executive, Manchester City Council
3 -	n/a	Pensions information n/a

Salaries and Allowances for Manchester CCG Governing Board 2020/2021

Name and Title	2020/2021						
	(a) Salary & Fees for Governing Body	Other Salary for additional posts (not related to the Governing Body post)	(b) Expense Payments (Taxable)	(c) Performance Pay and bonuses	(d) Long-term performance pay and bonuses	(e) All Pension Related Benefits	TOTAL (a-e)
	(bands of £5,000)	(bands of £5,000)	(Rounded to nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
	£000	£000	£	£000	£000	£000	£000
Dr Ruth Bromley, GP Chair	80-85		0			n/a	80-85
Mr Ian Williamson, Chief Accountable Officer	151-155		200			37.5-40	190-195
Mrs Claire Yarwood, Chief Financial Officer	135-140		200			40-42.5	180-185
Mr Ed Dyson, Executive Director of Planning and Operations	105-110		0			35-37.5	185-190
Dr Manisha Kumar, Medical Director	135-140		100			n/a	135-140
Dr Murugesan Raja, GP Member	30-35		0			n/a	30-35
Dr Geeta Wadhwa, GP Member	10-15		0			n/a	10-15
Dr Denis Colligan, GP Member GP Member	30-35		0			n/a	30-35
Dr Claire Lake, GP Member	5-10		0			n/a	5-10
Dr Peter Williams, Secondary Care Doctor	35-40		0			n/a	35-40
Christine Pearson, Board Nurse Board Nurse	30-35		0			n/a	30-35
Mr Grenville Page, Lay Member - Governance	15-20		0			n/a	15-20
Mr Chris Jeffries, Lay Member - Finance and Audit	10-15		100			n/a	10-15
Atiha Chaudry, Lay Member - Patient and Public Involvement	15-20		0			n/a	15-20

**Note: Taxable expenses and benefits in kind are expressed to the nearest £100.

1 - Dr Geeta Wadhwa — Appointed October 2020

Dr Claire Lake — Resigned July 2020

2 - **MHCC Members not listed above, employed by City Council**

Cllr Bev Craig - Deputy Chair	Executive Councillor as nominated by Manchester City Council
Cllr Garry Bridges	Executive Councillor as nominated by Manchester City Council
Bernie Enright	Director of Strategic Commissioning / DASS
David Regan	Executive Director of Population Health and Wellbeing
Joanne Roney	Chief Executive, Manchester City Council

3 - n/a — Pensions information n/a

4 - Dr Ruth Bromley, Dr Manisha Kumar, and Dr Denis Colligan salary banding has been revised for the year 2020/21.

Pension benefits as at 31 March 2022

Name and Title	Real Increase in Pension at age 60 (bands of £2,500)	Real Increase in Pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2022 (bands of £2,500)	Lump sum at age 60 related to accrued pension at 31st March 2022 (bands of £2,500)	Cash Equivalent Transfer Value at 31 March 2022	Cash Equiv 1st April 2021	Real increase in CETV	Employers Contn to Stakeholders pension
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Mr Ed Dyson, Executive Director of Planning and Operations	0-2.5	0	37.5-40	70-72.5	590	550	22	16
Mrs Claire Yarwood, Chief Financial Officer	2.5-5	0-2.5	65-67.5	155-157.5	1,438	1,359	52	20
Mr Ian Williamson, Chief Accountable Officer	2.5-5	0-2.5	57.5-60	92.5-95	1,083	1,011	44	22
Dr Ruth Bromley *, GP Chair	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Manisha Kumar *, Medical Director	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* Non Pensionable as per Pensions Authority

Note 1 – As Lay Members do not receive pensionable remuneration, there will be no entries in respect of pensions for them.

Note 2 – The pensions information has been supplied by NHS Pensions Agency and it has been confirmed that the figures disclosed relate only to the officer role within the CCG and excludes any pension information associated with GP Practitioner service.

Note 3 – Certain Members do not receive pensionable remuneration therefore there will be no entries in respect of pensions for certain 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 Value) Regulations 2008.

Real increase in CETV

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

Compensation on early retirement of for loss of office

There were no such payments in 2021-22 (2020-21: £nil) which is subject to validation by external audit.

Payments to past members

There were no such payments in 2021-22 (2020-21: £nil), which is subject to validation by external audit.

Fair Pay Disclosure

Reporting bodies are required to disclose pay ratio information and detail concerning percentage change in remuneration concerning the highest paid director. This is subject to validation by external audit.

This includes the relationship between the remuneration of the highest-paid director/member in their organisation and the median, 25th Percentile and 75th Percentile remuneration of the organisation's workforce.

The midpoint of the banded remuneration of the highest paid Director is £152,500. The midpoint of banded remuneration of the highest paid director/Member for the financial year 2021-22 is £150-155k (2020-21, £150-155k). This is 3.62 times (2020-21 was 3.71 times) the median remuneration of the workforce, is £42.1k (2020-21, £41.1k). The range is from £7.6k lowest to £152.4k highest.

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

Percentage change in remuneration of highest paid director

	Percentage Change for Highest Paid Director	Percentage Change for Employees as a Whole
Salary and Allowances	0.53%	9.6%
Performance Pay/ Bonuses	n/a	n/a

Pay ratio information

Remuneration of NHS Manchester CCG staff is shown in the table below:

	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£34k	£43k	£54k
salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£32k	£42k	£53k

Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

Note: 25th Percentile - Also known as the first, or lower quartile, the 25th percentile is the value at which 25% of the values in the salary distribution of the CCG lie

below, and therefore 75% of the values lie above. The 50th Percentile - also known as the Median, is the point in the middle of the salary distribution of the CCG.

The banded remuneration of the highest paid director/member in NHS Manchester CCG in the financial year 2021/22 was £150k-£155k (2020/21: £150k-£155k) and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th percentile total remuneration ratio	25th percentile salary ratio	Median total remuneration ratio	Median salary ratio	75th percentile total remuneration ratio	75th percentile salary ratio
2021/22	04.43: 1	4.72: 1	3.50: 1	3.62: 1	2.78: 1	2.87: 1

In 2021/22, no employees received remuneration in excess of the highest-paid director/member (in 2020/21: £nil).

Staff Report

Number of senior managers

The information on the number of senior managers presented in the table below is subject to validation by external audit. The numbers include staff hosted on behalf of the Greater Manchester Health & Social Care Partnership. These numbers are as at 31 March 2022.

Pay Grade	Headcount	FTE
Band 8 - Range C	21	20.40
Band 8 - Range D	20	18.43
Band 9	6	6.13
Other	16	12.98
Grand Total	63	57.94

Staff numbers and costs

The staff numbers and costs information disclosed in the following two tables (staff costs and average staff numbers) are subject to validation by external audit. This information includes the average staff numbers associated with hosting the Greater Manchester Health & Social Care Partnership.

	Permanent £000s	**Others £000s**	**Total £000s**
Salaries & Wages	17,364	5,276	22,640
Social Security costs	2,342		2,342
Employer Contribution to the NHS Pension Scheme	3,711		3,711
Other Pension Costs			-
Apprenticeship Levy	93		93
Other post-employment benefits			-
Other employment benefits			-
Termination Benefits	44		44
Total Staff Costs 2021/22	**23,554**	**5,276**	**28,830**

The categorised average staff numbers in 2021/22 are presented in the following table: These are averaged over 2021/22:

Average Staff Numbers			
	Permanent	**Other**	**Total**
Admin & Estates	300.81	49.97	350.78
Medical & Dental	8.67		8.67
Nursing, midwifery and health visiting staff	16.06		16.06
Scientific, therapeutic & technical staff	63.86		63.86
Total	**389.40**	**49.97**	**439.37**

Staff composition

The numbers included within the staff composition table include staff numbers associated with the hosting the Greater Manchester Health & Social Care Partnership. These are as at 31 March 2022.

Pay Band	Female	Male	Total
All Senior Managers	41	22	63
Comprising:			
Executive Team	2	2	4
Senior Managers	39	20	59
Other Employees	272	92	364
Total	**313**	**114**	**427**

Sickness absence data

The numbers contained in the sickness absence data have been validated by external audit.

	2021-22 Number
Total Days lost	4,064
Total staff years	645
Average working days lost	6

During the COVID-19 pandemic there were no reporting requirements in relation to sickness absence data, meaning there is no comparative data from the previous year available.

Staff turnover percentages

Staff turnover data can be found via the NHS Digital publication series on NHS Digital's NHS Workforce Statistics.

Staff policies

The CCG, operating as MHCC, commits to being a fully inclusive organisation with a culture and environment which promotes equality of access and treatment for all employees, contractors, visitors and members of the public. We have a published Equality, Diversity and Human Rights Policy, a Disability Policy and an Inclusive Values Based Recruitment Policy and Code of Practice. All these policies are fully accessible to all employees and support is provided to Line Managers to ensure that all policies are implemented in a fair and inclusive way across the organisation.

The coronavirus (COVID-19) pandemic shifted the way we live and work and the CCG had to quickly adopt new initiatives and technologies to ensure employee safety whilst maintaining productivity. Working from home and adapting to new ways of working has continued to be the norm during the past twelve months. Employees have been required to operate a remote working strategy, supported by technology and teamwork that has enabled continued communications and effective service delivery. This led to the introduction of the CCG's Hybrid Working Policy and Toolkit in July 2021 following extensive engagement with key stakeholders.

Our commitment to addressing workforce inequalities is managed within the framework of our Addressing Inequalities programme and our Ten Point Talent Plan. This has set out aspirational targets for us to ensure that we better reflect our diverse communities at all levels of our organisation, including at Board level. Involvement of people with lived experience is an essential part of this approach, both through our Inclusion Staff Network and through engagement with external groups such as the Our Manchester Disability, Equality and Inclusion Board. Our Inclusion Staff Network has been instrumental in supporting us to achieve our Disability Confident Level 3 leader accreditation for example. Our Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap Report, Public Sector Equality Duty Report (PSED) and Equality Delivery System (EDS2) Report published on our website provide further detail on our aspirations and progress towards them.

We chose to focus on workforce inequalities within our EDS2, to allow us to review what has worked well and what we need to take with us into the ICS. These reports

also set out the challenges and barriers to achieving our aspirations. Overall, we are pleased to report positive trends across many areas within our workforce equalities programmes, although we continue to need to take action to address disparities in terms of ethnicity and disability at senior and Board levels. One example of this is that the engagement of Black and Asian minority staff within our staff survey has overtaken that of White staff, which is linked to the proactive response that we have taken to engage with staff who experience racial inequality through targeted Listening in Action events and other initiatives.

Retention

The organisation is committed to retaining in employment wherever possible any employee who acquires a temporary or long-term impairment or health condition. This process is facilitated through a dedicated Occupational Health provision available to all employees.

As a reasonable adjustment to the Attendance Management processes, any absence related to a disability, or the management of a disability, will be recorded separately as “disability related absence” to ensure that a disabled employee is not taken through the Attendance Management processes more quickly in comparison to a non-disabled employee.

Whilst the organisation reserves the right to set an expected level of attendance for all employees, including disabled staff, in this instance, individual triggers and targets will be discussed and agreed with the employee and monitored and reviewed in line with the usual processes taking into account the on-going needs of the employee and of the organisation.

A period of paid Disability Leave may be agreed on an individual basis with an employee to support them to manage their health and wellbeing effectively. This would be discussed as part of the usual Attendance Management process and would be considered in consultation with Occupational Health. Paid Disability Leave would be up to 1 week in any 12-month period. Our refreshed flexible working policy will also support disabled staff to stay in work.

The organisation also operates a re-deployment register which means that any employee, who is unable to continue in their existing role despite support and the implementation of reasonable adjustments, will be given priority consideration for other roles in the CCG. Where appropriate, external support and guidance is sought including Occupational Health, DWP Access to Work and other Disability specific support.

We have recently introduced a Reasonable Adjustment and Access to Work (ATW) register. This captures relevant and appropriate information on employees regarding their access requirements. This register allows us to identify how many employees are receiving support and accessing ATW services for the purposes of pro-active budget setting and provision. We will use this information to support any accommodation and staff moves to ensure that staff are continually supported and that any moves will accommodate ongoing reasonable adjustments.

Training, career development and promotion

The CCG is committed to ensuring that all employees are developed and encouraged to meet the basic requirements of the job, perform to the standards expected and fulfil their potential. This involves making clear what is expected within clear timeframes, setting clear identifiable targets, monitoring performance, and providing appropriate training support and development. We also consider any reasonable adjustments to ensure disabled employees are not adversely impacted by job requirements.

The CCG commits to providing fairness and consistency in the treatment of all employees. The CCG is committed to ensuring that all employees have equal access to opportunities to develop their full potential. All career progression opportunities are made widely available to all employees in line with the best practice guidelines, also ensuring that any unfair bias and discrimination is eliminated. Full monitoring takes place and is reported on in the annual public sector equality duty report.

Employees learning and development needs are discussed through the quarterly Reflect, Review & Refocus Process. This includes a discussion about reasonable adjustments in regards to learning and development opportunities. Reasonable

adjustments are considered for all aspects of working arrangements to support employees in reaching and maintaining their potential.

In additional to the CCGs existing provision this year all staff were given access to a virtual career management portal. The portal was a comprehensive resource designed to enable staff to feel better equipped to manage their career and future as the CCG goes through large scale change. To encourage and support staff to make use of this resource all staff were offered half a day a month protected time for their own development.

Other employee matters

Staff Survey

Several changes were made to the survey this year to ensure it remained relevant to the current context for MHCC. As a result, direct comparison with results from previous years was not possible for all sections of the survey. However, aggregated trend data continued to provide a good indication of changes in staff perceptions and experiences.

The response rate for the survey was 61.9% which, whilst slightly lower than previous years, remained a reasonable response rate, indicating that the results can be considered representative of the views of MHCC. The results from the 2021 Staff Opinion Survey continued the overall trend of improvement seen over the last few years. Again, this year the results highlighted a number of positive improvements for MHCC as a whole with an increase seen in four out of the seven areas surveyed indicating some real areas of strength for the Partnership.

Engagement levels remained relatively high and once again demonstrated a consistent positive trend over the last 3 years. The engagement score for MHCC this year was 3.73 out of 5, compared to 3.69 last year and 3.57 in 2019.

The highest scoring area of the survey was ‘My Manager’ scoring a positive score of 4.17 out of 5. This has been the strongest area for MHCC consistently over the past 3 years highlighting line management capability as a significant area of strength for MHCC.

- Of particular note this year, was the improved perceptions of Black, Asian and Minority Ethnic colleagues. In 2019 there was an engagement gap between white and Black, Asian And Minority Ethnic staff in the Partnership of 4.8%, with Black, Asian And Minority Ethnic staff reporting lower levels of engagement. In 2020 this gap reduced to 2.2%. This year, for the first time Black, Asian And Minority Ethnic colleagues have reported a slightly higher overall engagement score by 1.4%. Overall, in 14 out of 20 questions, Black, Asian and Minority Ethnic employees scored higher than their white counterparts. This was a tremendous result and reflected the consistent effort and investment that has been made over the last few years to address inequalities particularly in tackling racism. There now remains further work to do to extend this positive trend to all groups with protected characteristics.

Positive highlights included:

- ‘My Manager’ continued the trend of the last three years as the highest scoring area of the survey with an increase again from last year.

- ‘Leadership and Direction’ also saw a large improvement this year with an overall score of 3.73 out of 5 compared with 3.38 last year. The highest scoring question in this category was “The Senior Leaders have been visible” which scored 3.9 out of 5.

- ‘Inclusion and Workplace Civility’ highlighted a number of improvements compared to last year’s survey. In particular the responses of Black, Asian and Minority Ethnic staff were higher for all 3 questions in this category compared with their white colleagues with an overall score for this category of 4.17 for Black, Asian and Minority Ethnic staff and 3.99 for white staff.

- Areas for development included:

- The results for ‘Health & Wellbeing’ suggested a decline from last year. This decline was reflected in a number of comments made by staff which highlighted concerns about returning to work on-site and is in stark contrast to a significant improvement seen to the same question in last year’s survey.

- Staff experiences of the transition which was a new category this year.

Staff Health and Wellbeing

The CCG is committed to ensuring the health and wellbeing of its staff, and the approach to wellbeing and the support for staff continued to evolve over this period as the health and wellbeing of all staff remained a key priority.

The offer to staff included:

- The development and embedding of Hybrid Working across the organisation giving staff the opportunity to work flexibly and create a work life balance that best suits their individual circumstances.

- The development of further safety measures for staff including quarterly risk assessments and guidance on living with Covid.

- The development and extension of the staff Health and Wellbeing Group. In addition to ensuring health and wellbeing is an agenda item at all team meetings the group provides a valuable source of feedback that informs the development of the overall wellbeing offer. This year feedback resulted in the establishment of a virtual Book Club and a Menopause Café.

- The incorporation of wellbeing conversations as part of regular one to ones and the quarterly Review, Reflect and Refocus process.

- In partnership with Greater Manchester colleagues the roll out of a comprehensive menu of wellbeing masterclasses.

- A weekly health and wellbeing newsletter containing advice, guidance and signposting.

- Having a comprehensive employee assistance programme available for all staff and their families offering counselling, as well as financial and legal advice.

- Working in partnership with the Greater Manchester Resilience Hub to enhance the wellbeing offer to staff and to managers. This has included an

organisation wide session, workshops and access to professional psychological support for any staff member.

- Ongoing inclusion of wellbeing sessions as a regular part of directorate time outs and organisation wide virtual events.

The Inclusion Staff Network

The Inclusion Staff Network was launched in June 2019 and is made up of staff from across the organisation that are passionate about promoting the principals of the Equality Act and raising awareness of inclusion, equality and diversity and contributing to organisational culture by:

- Providing a safe supportive space to discuss inclusion issues and concerns
- Establish programmes of activity to promote, educate encourage and celebrate all elements of inclusion and engagement
- Help to shape and deliver the Inclusion and Social Value Strategy and other MHCC policies and practices
- Hold the organisation to account where there are inequalities in terms of recruitment and / or progression for staff from communities experiencing racial inequalities.
- Work towards improving career prospects and personal development opportunities for a diverse workforce.

The priorities for the Inclusion Staff Network for the next year include ensuring that the views of all staff are considered as part of the transition to the GM Integrated Care System, that the focus on reducing inequalities particularly for people from communities experiencing racial inequality and for those with disabilities which has been an MHCC priority is continued across Greater Manchester.

Trade Union Relationships and Consultation

The organisation works closely with Trade Union partners through a Social Partnership Forum. The Forum provides an environment for positive engagement of employees through their accredited union and other representatives for negotiation where appropriate of such variations of Agenda for Change Terms and Conditions

that are open to local determination. The Forum also provides an environment for consultation and discussion between partners on collective matters relating to general employee relations matters within the CCGs such as approaches to managing organisational change; it provides a formal vehicle for the agreement of information and consultative communications between management and employees in addition to developing and implementing joint problem solving approaches, the purpose of which is to encourage an open, honest and transparent working environment, minimising grievances and avoiding disputes.

The Forum is attended by all local accredited representatives of recognised Trade Unions with a standing invitation to full time officers of recognised Trade Unions.

Health and Safety

The CCG recognises and fully accepts its responsibilities as an employer to provide a safe and healthy workplace and wider working environment for all its employees and to provide any necessary resources, information, supervision and training for them to carry out their duties in a safe manner. The CCG maintains a Health and Safety Policy which is reviewed regularly and operates a Health and Safety Sub-Committee (a sub-committee of our Governance Committee), which provides assurance to the Board and its Committees on MHCC matters relating to health, safety, security and wellbeing of those who may be affected by its activities insofar as they relate to CCG legalities, duties and services commissioned via MHCC. The sub-committee meets on a bi-annual basis. The CCG is also an active participant in regular Building User Group meetings to discuss any health and safety related matters with co-tenants of our Parkway 3 office.

During the year, quarterly staff risk assessments have continued to be completed for all staff, along with a request for all staff to complete Display Screen Equipment (DSE) assessments for their home and office working environments. The organisation has also refreshed its Fire Risk Assessment and Building Evacuation Plan following the adoption of new hybrid working arrangements.

Expenditure on consultancy

The expenditure on consultancy in 2021-22 for the CCG totals £649k (2020-21: £850k), of which £624k (2020-21: £711k) relates to the hosting arrangement for Greater Manchester Health & Social Care Partnership. The CCG's expenditure on consultancy totalled £25k (2020-21: £139k).

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2022 for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2022	1
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	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 2: New off-payroll engagements

Where the reformed public sector rules apply, entities must complete Table 2 for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022, for more than £245 per day and that last for longer than 6 months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022	1
Of which*:*	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	1

Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	1
Number of engagements that saw a change to IR35 status following the consistency review	0

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)	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements. (2)	12

Greater Manchester Health and Social Care Partnership

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2022 for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2022	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

The worker is deemed as outside of IR35 and invoices continue to be paid via the Accounts Payable system.

Table 2: New off-payroll engagements

Where the reformed public sector rules apply, entities must complete Table 2 for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022, for more than £245 per day and that last for longer than 6 months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

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 01 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)	n/a
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year.	n/a

This figure should include both on payroll and off-payroll engagements. (2)	

Exit packages, including special (non-contractual) payments

Table 1: Exit Packages

In 2021/22 the following redundancies were made, which were not to individuals named within the Remuneration Report. This redundancy was not as a result of organisational change but due to the fixed term contract ending with no suitable alternatives emerging in the notice period.

Exit packages documented in the table below are validated by external audit.

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	-	-	-	-	-	-	-	-
£10,000 - £25,000	-	-	-	-	-	-	-	-
£25,001 - £50,000	1	44,230	-	-	-	-	-	-
£50,001 - £100,000	-	-	-	-	-	-	-	-
£100,001 - £150,000	-	-	-	-	-	-	-	-
£150,001 – £200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
TOTALS	1	44,230	-	-	-	-	-	-

Redundancy costs have been paid in accordance with the provisions of the Agenda for Change Terms and Conditions. Exit costs in this note are the full costs of departures agreed in year.

Trade Union Facility Time Reporting Requirements

We are required by The Trade Union (Facility Time Publication Requirements) regulations 2017 to report on trade union facility time in our organisation. Facility time is paid time off for union representatives to carry out trade union activities. The tables below provide the information to be published as specified in the regulations.

Table 1: Relevant union officials

What was the total number of our employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	***Full-time equivalent employee number***
1	1

Table 2: Percentage of time spent on facility time

How many of our employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

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

Table 3: Percentage of pay bill spent on facility time

The percentage of our total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

Total cost of facility time	£2,108

Total pay bill	£28,830k
Percentage of the total pay bill spent on facility time	0.01%

Table 4: Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours	100%

Ian Williamson

Accountable Officer

16 June 2022

Parliamentary Accountability and Audit Report

NHS Manchester CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on losses, special payments, fees and charges are included as notes in the Financial Statements in the Annual Accounts section of the report (from page 131). An audit certificate and report is also included at the end of this Annual Report at page 172.

Audit Report

External audit

The CCG’s external auditor is Grant Thornton LLP.

The fees for 2021-22 are £66.5k plus VAT, giving a total cost of £79.8k (2020-21: £69.2k plus VAT, total cost £83.1k).

Internal Audit and Counter Fraud is provided by Mersey Internal Audit Agency, hosted by Liverpool University Hospitals NHS Foundation Trust, so there is no conflict of interest.

Ian Williamson

Accountable Officer

16 June 2022

ANNUAL ACCOUNTS

Foreword to the Accounts

NHS Manchester Clinical Commissioning Group was licensed from 1st April 2017. The CCG was licensed under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

These accounts for the twelve months ending 31st March 2022 have been prepared by NHS Manchester Clinical Commissioning Group under Section 17 of schedule 1A of the National Health Service Act 2006 (as amended) in the form which the Secretary of State has, with approval of the treasury directed.

The National Health Service Act 2006 (as amended) required Clinical Commissioning Groups to prepare their Annual Report and Annual Accounts in accordance with the Directions issued by NHS England.

Ian Williamson

Accountable Officer

16 June 2022

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

	Note	2021-22 £000	2020-21 £000
Income from sale of goods and services	2	(15,751)	(9,030)
Other operating income	2	-	-
Total operating income		**(15,751)**	**(9,030)**
Staff Costs	4	28,830	24,198
Purchase of goods and services	5	1,899,955	1,383,859
Depreciation and impairment charges	5	0	0
Provision expense	5	0	0
Other Operating Expenditure	5	3,319	1,841
Total operating expenditure		**1,932,104**	**1,409,898**
Net operating expenditure		**1,916,353**	**1,400,868**
Finance income		0	0
Finance expense		-0	0
Total Net expenditure for the year		**1,916,353**	**1,400,868**
Net (Gain)/Loss on Transfer by Absorption		0	0
Total Net Expenditure for the Financial Year		**1,916,353**	**1,400,868**
Comprehensive Expenditure for the year		**1,916,353**	**1,400,868**

The notes on pages 152-159 form part of this statement.

NHS Manchester CCG Statement of Financial Position as at 31 March 2022

	Note	31 March 2022	31 March 2021
		£000	£000
Non-current assets:			
Other financial assets	9	200	200
Total non-current assets		**200**	200
Current assets:			
Trade and other receivables	8	14,589	8,416
Cash and cash equivalents	10	40	18
Total current assets		**14,629**	8,434
Total assets		**14,829**	8,634
Current liabilities			
Trade and other payables	11	(72,924)	(79,717)
Provisions	12	(512)	(512)
Total current liabilities		**(73,436)**	(80,229)
Total Assets Less Current Liabilities		**(58,607)**	(71,595)
Non-current liabilities			
Trade and other payables		-	-
Other financial liabilities		-	-
Other liabilities		-	-
Borrowings		-	-
Provisions		-	-
Total non-current liabilities		**-**	-
Assets Less Liabilities		**(58,607)**	(71,595)
Financed by Taxpayers' Equity			
General fund		(58,607)	(71,595)
Total taxpayers' equity:		**(58,607)**	(71,595)

The notes on pages 161-165 form part of this statement.

The financial statements on pages 134-171 were approved by the Governing Body on the 16 June 2022 and signed on its behalf by:

Ian Williamson

Accountable Officer

16 June 2022

NHS Manchester CCG Statement of Changes in Taxpayers Equity for the twelve months ended 31 March 2022

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Changes in taxpayers' equity for 2021-22				
CCG Balance at 1 April 2021	(71,595)			**(71,595)**
Transfer between reserves in respect of assets transferred from closed NHS bodies				
Adjusted Balance at 1 April 2021	**(71,595)**			**(71,595)**
Changes in CCG Taxpayers' equity for 31 March 2022				
Total Net expenditure for the financial year	(1,916,353)			**(1,916,353)**
Net gain/(loss) on revaluation of property, plant and equipment				**-**
Net gain/(loss) on revaluation of intangible assets				**-**
Net gain/(loss) on revaluation of financial assets				-
Total revaluations against revaluation reserve	**-**	**-**	**-**	**-**
Net gain (loss) on available for sale financial assets				
Net gain (loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain (loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
68Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	-
Transfers by absorption to (from) other bodies	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Net Recognised CCG Expenditure for the financial year	**(1,916,353)**	**-**	**-**	**(1,916,353)**
Net funding	1,929,341	-	-	**1,929,341**
Balance at 31 March 2022	**(58,607)**	**-**	**-**	**(58,607)**

NHS Manchester CCG Statement of Changes in Taxpayers Equity for the year ended 31 March 2021

	General fund	Revaluation reserve	Other reserve s	Total reserves
	£000	£000	£000	£000
Changes in taxpayers' equity for 2020-21				
CCG Balance at 1 April 2020	(69,215)	0	0	(69,215)
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	0
CCG Balance at 31 March 2020	(69,215)	**0**	**0**	(69,215)
Changes in CCG Taxpayers' equity for 2020-21				
Net operating expenditure for the financial year	(1,400,868)			(1,400,868)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
68Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised CCG Expenditure for the financial year	**(1,400,868)**	**0**	**0**	**(1,400,868)**
Net funding	1,398,488	0	0	1,398,488
Balance at 31 March 2021	**(71,595)**	**0**	**0**	**(71,595)**

NHS Manchester CCG Statement of Cash Flows for the twelve months ended 31 March 2022

	Note	2021-22 £000	2020-21 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(1,916,353)	(1,400,868)
Depreciation and amortisation		-	-
Impairments and reversals		-	-
(Increase)/decrease in trade & other receivables	8	(6,173)	(1,519)
(Increase)/decrease in other current assets		-	-
Increase/(decrease) in trade & other payables	11	(6,793)	3,905
Increase/(decrease) in other current liabilities		-	-
Provisions utilised	12	-	(74)
Increase/(decrease) in provisions	12	-	-
Net Cash Inflow (Outflow) from Operating Activities		**(1,929,319)**	**(1,398,558)**
Cash Flows from Investing Activities			
(Payments) for other financial assets		-	-
Net Cash Inflow (Outflow) from Investing Activities		**-**	**-**
Net Cash Inflow (Outflow) before Financing		**(1,929,319)**	**(1,398,558)**
Cash Flows from Financing Activities			
Net Funding Received		1,929,341	1,398,488
Net Cash Inflow (Outflow) from Financing Activities		**1,929,341**	**1,398,488**
Net Increase (Decrease) in Cash & Cash Equivalents	10	**22**	**(70)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**18**	**88**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**40**	**18**

NHS Manchester CCG 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 the going concern basis.

The Health and Care Act received royal assent on 28 April 2022. The Act will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities will transfer to NHS Greater Manchester Integrated Care.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. 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 the 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 modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Joint Arrangements

Arrangements over which the clinical commissioning group has joint control with one or more other entities are classified as Joint Arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties who 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. This applies to the clinical commissioning group in relation to the pooled budget with Manchester City Council as detailed in note 1.4 below.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method. The clinical commissioning group does not have any joint ventures.

1.4 Pooled Budgets

Manchester Health and Care Commissioning (MHCC) was formed in 2017 and has been instrumental in driving the integration of health and social care in the City.
The scope of the Section 75 between MHCC and MCC in 2021/22 has been reduced to be in line with Better Care Fund planning,

MHCC will:

- Retain the population health and wellbeing and health function as part of its working arrangements;
- Act as the engine room for Manchester Partnership Board and co-ordinator of the Locality Plan; and
- Connect the strategic/policy agenda between health and the wider City Strategy

The pool is hosted by NHS Manchester CCG as in previous financial years. 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. The clinical commissioning group and Manchester City Council have reviewed the accounting treatment and agreed that it is a Joint Operation.

Note 15 provides details of the income and expenditure which has not materially changed from prior years.

For 2022-23, MHCC wish to ensure that this integrated approach to improvement continues and the MHCC functions are safely passed on to successor organisations and structures which are emerging over the next quarter as a result of the creation of Integrated Care Boards. The S75 arrangement has been approved to continue during 2022-23 and will novate to the Integrated Care Board on establishment.

1.5 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 performance completed to date.

- The FreM has mandated the exercise of the practical expedient offered in C7 (a) of the Standard, that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the clinical commissioning group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period it is received as opposed to be being shown as income in Note 2.

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 activity that is to be delivered in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

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

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the

service is received from employees, including bonuses earned but not yet taken.

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

1.6.2 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 recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsba.nhs.uk/pensions.

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

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

1.7 Other Expenses

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

1.8 Grants Payable

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

1.9 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.

1.9.1 The Clinical Commissioning Group as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.10 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.11 Provisions

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

All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

- A nominal short-term rate of 0.47% (2020-21: -0.02%) for all inflation adjusted expected cash flows up to and including 5 years from the 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 cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

- A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

1.12 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 group.

1.13 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.

1.14 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.

1.15 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.

1.15.1 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 payment 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.

1.15.2 Financial Assets at fair value through other comprehensive income

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

1.15.3 Financial Assets at fair value through profit and loss

Financial assets measured at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short-term.

1.15.4 Impairment

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

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contracts assets at an amount equal

to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, and 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 which 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.

1.16 Financial Liabilities

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

1.16.1 Financial Guarantee Contract Liabilities

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

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.16.2 Financial Liabilities at Fair Value Through Profit and Loss

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

1.16.3 Other Financial Liabilities

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

1.17 Value Added Tax

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

1.18 Losses & Special Payments

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

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

1.19 Critical Accounting Judgements and key source 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.

1.19.1 Critical Judgements in Applying Accounting Policies

The clinical commissioning group has reviewed its application of accounting policies and concluded that there are no critical judgements in 2021-22 (2020-21: None).

1.19.2 Key Sources of Estimation

The clinical commissioning group has assessed that there are no key sources of estimation within the 2021-22 financial statements (2020-21: None).

1.20 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Department of Health and Social Care Group accounting manual does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These standards are still subject to HM Treasury FReM adoption, with IFRS

16 being for implementation in 2022-23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged
IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The clinical commissioning group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

  On transition to IFRS 16 on 1 April 2022, the clinical commissioning group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the clinical commissioning group's incremental borrowing rate. The clinical commissioning group's incremental borrowing rate will be a rate defined by HM Treasury. 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.

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

2. Other Operating Revenue

	2021-22 Total	2020-21 Total
	£000	£000
Income from sale of goods & services (contracts)		
Non patient care services to other bodies	7,226	4,999
Prescription fees and charges	2	2
Other contract income	8,523	4,029
Total Income from sale of goods and services	**15,751**	**9,030**
Other Operating Income		
Other non-contract revenue	-	-
Total other operating revenue	**0**	**0**
Total operating income	**15,751**	**9,030**

3. Disaggregation of Income – Income from sales of goods and services (contracts).

2021-22

	Non-patient care services to other bodies	Prescription fees and charges	Other Contract income	2021-22
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	371	-	7,867	8,238
Non-NHS	6,855	2	656	7,513
Total	7,226	2	8,523	**15,751**

	Non-patient care services to other bodies	Prescription fees and charges	Other Contract income	2021-22
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	7,226	2	8,523	15,751
Over time	-	-	-	-
Total	**7,226**	**2**	**8,523**	**15,751**

4.0 Employee Benefits and Staff Numbers

4.1.1 Employee benefits

	2021-22			2020-21
	Total	Permanent Employees	Other	Total
	£'000	£'000	£'000	£'000
Employee Benefits				
Salaries and wages	22,640	17,364	5,276	19,236
Social security costs	2,342	2,342	-	1,877
Employer Contributions to NHS Pension scheme	3,711	3,711	-	2,998
Apprenticeship Levy	93	93	-	71
Termination benefits	44	44	-	16
Gross employee benefits expenditure	**28,830**	**23,554**	**5,276**	**24,198**
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**-**	**-**	**0**
Total - Net employee benefits including capitalised costs	**28,830**	**23,554**	**5,276**	**24,198**
Less: Employee costs capitalised				**0**
Net employee benefits excluding capitalised costs	**28,830**	**23,554**	**5,276**	**24,198**

4.1.2 Recoveries in Respect of Employee Benefits

The clinical commissioning group had no recoveries in respect of employee benefits disclosed separately in 2021-22 (2020-21: £nil).

4.2.2 Average Number of People Employed

	2021-22			2020-21		
	Total	**Permanently employed**	**Other**	**Total**	**Permanently employed**	**Other**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Total	439.37	389.40	49.97	390.36	349.74	40.62
Of the above: **Number of whole time equivalent people engaged on capital projects**	0	0	0	0	0	0

4.3 Exit Packages Agreed in the Financial Year

There has been one redundancy in 2021-22, which is not related to the individuals named within the Remuneration Report. The redundancy was not as a result of organisational change, but due to the fixed term contract ending with no suitable alternatives emerging in the notice period. These costs were paid in accordance with the provision of the Agenda for Change scheme used for compulsory redundancies.

The redundancy in 2020-21 was also a compulsory redundancy related to the hosted Greater Manchester Health & Social Care Partnership, which was not related to individuals within the Remuneration Report. The redundancy was not as a result of organisational change, but due to the fixed term contract ending with no suitable alternatives emerging in the notice period. These costs were paid in accordance with the provision of the Agenda for Change scheme used for compulsory redundancies.

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	Total £
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	1	44,231	0	0	1	44,231
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0

Total	1	44,231	0	0	1	44,231

	2020-21 Compulsory redundancies		2020-21 Other agreed departures		2020-21 Total	
	Number	£	Number	£	Number	Total £
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	1	16,000	0	0	1	16,000
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**1**	**16,000**	**0**	**0**	**1**	**16,000**

* As a single exit package can be made up of several components each of these will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part of full in a previous period.

The redundancy costs have been paid in accordance with the provisions of the Agenda for Change scheme used for compulsory redundancies.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

There are no exit packages or departures where special payments have been made within the clinical commissioning group during 2021-22 (2020-21: £nil.)

4.4 Pension Costs

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal

valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) 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.

b) Full actuarial (funding) valuation

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

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

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

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

5. Operating Expenses

	2021-22 Total £000	2020-21 Total £000
Purchase of Goods and Services		
Services from other CCGs and NHS England	1,131	1,088
Services from foundation trusts	1,409,002	825,348
Services from other NHS trusts	97,016	171,389
Services from other WGA Bodies	165	124
Purchase of healthcare from non-NHS bodies	124,432	128,186
Purchase of social care	17,103	16,200
Prescribing costs	98,650	97,928
Pharmaceutical services	19	49
General ophthalmic services	481	96
GPMS/APMS and PCTMS	107,928	93,953
Supplies and services – clinical	116	111
Supplies and services – general	30,905	34,978
Consultancy services	649	850
Establishment	2,741	3,376
Transport	29	34
Premises	7,467	9,152
Audit fees	83	83
Other non-statutory audit expenditure		
· Internal audit services	-	-
· Other services	18	12
Other professional fees	1,154	603
Legal Fees	337	162
Education and training	529	139
Funding to other group bodies	-	-
CHC Risk Pool contributions	-	-
Total Purchase of Good and Services	**1,899,955**	**1,383,861**
Depreciation and impairment charges	-	-
Depreciation		
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets	-	-
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and Impairment Charges	**0**	**0**
Provision Expense		
Change in discount rate	-	-
Provisions	-	-
Total Provision Expense	**0**	**0**
Other Operating Expenditure		
Chair and Non-Executive Members	155	197

Grants to other public bodies	2,570	1,023
Clinical negligence	-	-
Expected credit loss on receivables	-	13
Expected credit loss on other financial assets (Stage 1 and 2 only)	-	-
Non-cash apprenticeship training grants	-	-
Other expenditure	594	606
Total other operating expenditure	**3,319**	**1,839**
Total Operating Expenditure	**1,903,274**	**1,385,700**

The clinical commissioning group has continued to operate in 2021-22 as the lead clinical commissioning group for Greater Manchester, with all system allocations reflected in the expenditure within Note 5 above. The system expenditure in 2020-21 totalled £308m, of which £261m related to Foundation Trusts and £47m related to NHS Trusts. Within 2021-22 system funding received totalled £673.7m covering both H1 (April – September) and H2 (October to March). The £673.7m was split £622.7m related to Foundation Trusts and £51m related to NHS Trusts.

In 2020-21 the CCG incurred £23m of costs directly applicable to the COVID pandemic response, the costs have reduced to £8m in 2021-22 and relate to the continuation of the Hospital Discharge Programme.

Within the prescribing costs disclosed for 2021-22, the clinical commissioning group has included an estimated cost of £10.7m relating to prescribing activity not yet presented to the NHS Business Services Authority.

The clinical commissioning group's contract with its auditors provides for the limitation of the auditor's liability to £2m. The external audit costs disclosed above are inclusive of VAT.

The CCG commissions Internal Audit and Counter Fraud services from a third party. In 2021-22 the costs have been covered within mandated block contracts, as internal audit is hosted by an NHS organisation, as was the case in 2020-21 (2019-20: £53.7k, which was included within the Supplies & Services General line in Note 5).

NHS Manchester CCG hosts the Greater Manchester Health & Social Care Partnership (GMH&SCP) team on behalf of the 10 Greater Manchester CCGs and Manchester City Council. As the system moves towards the ICB and in line with the hosting of the GMH&SCP, the organisation also hosts the ICB Chair designate and two recently appointed non- executive members on behalf of the Greater Manchester

ICB, with key appointments in the process of recruitment. The costs of the hosting arrangements are included in Notes 2,4 and 5.

6. Better Payment Practice Code

The clinical commissioning group has achieved the Better Payment Practice Code in all areas up to month 12 2021-22.

During the pandemic NHS organisations were encouraged to make payments within 7 days, or 14 days if there were queries on the invoice, but this change was not reflected in the target.

6.1 Measure of Compliance

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	23,599	295,308	20,859	269,432
Total Non-NHS Trade Invoices paid within target	22,793	293,887	20,424	268,314
Percentage of Non-NHS Trade invoices paid within target	**96.58%**	**99.52%**	**97.91%**	**99.59%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,108	1,524,512	1,922	1,007,196
Total NHS Trade Invoices Paid within target	1,076	1,524,464	1,810	1,007,200
Percentage of NHS Trade Invoices paid within target	**97.11%**	**100.00%**	**94.17%**	**100.00%**

The Better Payment Practice Code is summarised as below:

Target: to pay all NHS and non-NHS trade creditors within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Compliance: at least 95% of invoices paid (by the bank automated credit system or date and issue of a cheque) within thirty days or agreed contract terms.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Clinical Commissioning Group has incurred no late payment charges within 2021-22. (2020-21: £nil).

7. Operating Leases

A new reporting standard for leases will be adopted by the CCG from 1 April 2022. The change in financial reporting will mean that a single model for all leases will be adopted by lessees that includes recognising a 'Right of Use' asset and lease payment obligations reported on the Statement of Financial Position. An initial assessment of the impact that the new standard will have on the financial statements is outlined as follows:

The impact on Comprehensive net expenditure is £166k.

The impact on the Statement of Financial Position is an asset of £549k with a liability of the same amount.

7.1 As Lessee

The clinical commissioning group leases buildings from NHS Property Services and Community Health Partnerships, with the transactions conveying the right to use the asset in return for a payment or series of payments, in the absence of formal lease documentation.

During the pandemic the CCG rationalised its headquarters estate and vacated one of the previous buildings occupied. The CCG currently pays £548k per annum for its headquarters, with the balance of costs due to non-recurrent vaccination site costs / space hire costs which are not anticipated to continue in the longer term.

7.1.1 Payments Recognised as an Expense

				2021-22
	Land	**Buildings**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
Payments recognised as an expense				
Minimum lease payments	0	674	0	**674**
Contingent rents	0	0	0	**0**
Sub-lease payments	0	0	0	**0**
Total	**0**	**674**	**0**	**674**

				2020-21
	Land	Buildings	Other	Total
	£000	£000	£000	£000
Payments recognised as an expense				
Minimum lease payments	0	1,134	0	1,134

Contingent rents	0	0	0	0
Sub-lease payments	0	0	0	0
Total	**0**	**1,134**	**0**	**1,134**

Whilst our arrangements with Community Health Partnerships and NHS Property Services fall within the definition of operating leases, rental charges for future years have not yet been agreed. Consequently, this note does not include future minimum lease payments for the arrangements.

In preparation for the implementation of IFRS 16 Leases, all the premises expenditure has been reviewed to ensure that void/subsidy costs are correctly reflected.

7.2 As Lessor

The clinical commissioning group did not own any assets in 2021-22 (2020-21: £nil) and was not a lessor in 2021-22 (2020-21: £nil).

8. Trade and Other Receivables

	Current 2021-22 £000	Non-current 2021-22 £000	Current 2020-21 £000	Non-current 2020-21 £000
NHS receivables: Revenue	5,988	-	878	-
NHS prepayments	18	-	-	-
NHS accrued income	808	-	3,072	-
Non-NHS & Other WGA receivables: Revenue	1,562	-	1,251	-
Non-NHS & Other WGA prepayments	1,774	-	2,337	-
Non-NHS & Other WGA accrued income	4,573	-	893	-
Expected Credit loss allowance - receivables	(189)	-	(189)	-
VAT	45	-	168	-
Other receivables	10	-	6	-
Total Trade & other receivables	**14,589**	**0**	**8,416**	**0**
Total current and non-current	**14,589**		**8,416**	
Included above:				
Prepaid pensions contributions	0		0	

The great majority of trade is with NHS England. 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.

8.1 Receivables Past their Due Date but not Impaired

	2021-22	2021-22	2020-21	2020-21
	£000 DHSC Group Bodies	£000 Non DHSC Group Bodies	£000 DHSC Group Bodies	£000 Non DHSC Group Bodies
By up to three months	5,929	1,544	784	1,263
By three to six months	29	3	37	(77)
By more than six months	(12)	(24)	56	64
Total	**5,946**	**1,523**	**877**	**1,250**

£4.8m (2020-21: £647k) of the amount above has subsequently been recovered post the statement of financial position date.

8.2 Loss Allowance on Asset Clauses

	Trade & Other Receivables Non DHSC 2021-22	Other Financial Assets 2021-22	Total 2021-22
	£000	£000	£000
Balance at 1 April 2021	(189)	-	(189)
Lifetime expected credit loss on credit impaired financial assets	-	-	-
Lifetime expected credit losses on trade and receivables – Stage 2	-	-	-
Lifetime expected credit losses on trade and receivables – Stage 3	-	-	-
Credit losses recognised on purchase originated credit impaired financial assets	-	-	-
Amounts written off	-	-	-
Financial assets that have been derecognised	-	-	-
Changes due to modifications that did not result in derecognition	-	-	-
Other Changes		-	
Allowance for credit losses at 31 March 2022	**(189)**	**-**	**(189)**

The loss allowance relates to Non-NHS organisations only.

9. Non-Current Assets

	2021-22	2020-21
	£'000	£'000
Balance at 1 April 2021	200	200

Additions	-	-
Balance at 31 March 2022	**200**	**200**

The clinical commissioning group has maintained the £200k investment originally made in the Corporate Services Delivery Vehicle.

10. Cash and Cash Equivalents

	2021-22	2020-21
	£000	£000
Balance at 1 April 2021	18	88
Net change in year	22	(70)
Balance at 31 March 2022	**40**	**18**
Made up of:		
Cash with the Government Banking Service	39	17
Cash with Commercial banks	-	-
Cash in hand	1	1
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**40**	**18**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**0**	**0**
Balance at 31 March 2022	**40**	**18**
Patients' money held by the clinical commissioning group not included above	0	0

11. Trade and Other Payables

	Current 2021-22 £000	Non-current 2021-22 £000	Current 2020-21 £000	Non-current 2020-21 £000
NHS payables: revenue	1,296	-	2,744	-
NHS accruals	641	-	2,083	-
Non-NHS & Other WGA payables: Revenue	5,103	-	10,081	-
Non-NHS & Other WGA accruals	24,387	-	26,813	-
Social security costs	463	-	292	-
VAT	-	-	-	-
Tax	357	-	253	-
Payments received on account	-	-	-	-
Other payables and accruals	40,677	-	37,451	-
Total current and non-current	**72,924**		**79,717**	

Included in payables are liabilities of people due in Future years under arrangements to buy out the liability for early retirement over 5 years

Included in Other payables are outstanding pension coı

Included in Other Payables are outstanding pension contributions of £1,411k (2020-21: £990k).

12. Provisions

	Current 2021-22 £000	Non-current 2021-22 £000	Current 2020-21 £000	Non-current 2020-21 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	0	0	0	0
Other	512	0	512	0
Total	**512**	**0**	**512**	**0**
Total current and non-current	**512**		**512**	

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Restructuring £000s	Redundancy £000s	Agenda for Change £000s	Equal Pay £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Total £000s
Balance at 1 April 2021	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**512**	**512**
Arising during the year	0	0	0	0	0	0	0	0	0	0
Utilised during the year	0	0	0		0	0	0	0	0	
Reversed unused	0	0	0	0	0	0	0	0	0	0
Unwinding of discount	0	0	0	0	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2022	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**512**	**512**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	0	512	512
Between one and five years	0	0	0	0	0	0	0	0	0	0
After five years	0	0	0	0	0	0	0	0	0	0

Balance at 31 March 2022	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**512**	**512**

The £512k provision relates to dilapidations on buildings, which is in line with 2020-21.

Under the Accounts Directions issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before the establishment of the CCG. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of Manchester Clinical Commissioning Group is £64k (2020-21: £82k).

13. Financial Instruments

13.1 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 the 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.

13.1.1 Currency Risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations and therefore has low exposure to currency rate fluctuations.

13.1.2 Credit Risk

Because the majority of the NHS clinical commissioning group's revenue comes through parliamentary funding, the clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

13.1.3 Liquidity Risk

The NHS 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.

13.1.4 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

13.2 Financial Assets

	Financial Assets measured at Amortised Cost	Equity Instruments designated at FVOCI	Total
	2021-22 £000	2021-22 £000	2021-22 £000
Trade and other receivables with NHSE bodies	4,900	-	4,900
Trade and other receivables with other DHSC bodies	4,932	-	4,932

Trade and other receivables with external bodies	3,109	-	3,109
Other financial assets	200	-	200
Cash and cash equivalents	40	-	40
Total at 31 March 2022	**13,181**	**-**	**13,181**

	Financial Assets measured at Amortised Cost	Equity Instruments designated at FVOCI	Total
	2020-21	**2020-21**	**2020-21**
	£000	£000	£000
Trade and other receivables with NHSE bodies	3,150	-	3,150
Trade and other receivables with other DHSC bodies	1,490	-	1,490
Trade and other receivables with external bodies	1,460	-	1,460
Other financial assets	200	-	200
Cash and cash equivalents	18	-	18
Total at 31 March 2021	**6,318**	**0**	**6,318**

13.3 Financial Liabilities

	Financial liabilities measured at amortised cost	**Other**	**Total**
	2021-22	**2021-22**	**2021-22**
	£000	**£000**	**£000**
Trade and other payables with NHSE Bodies	412	-	412
Trade and other payables with other DHSC group bodies	3,420	-	3,420
Trade and other payables with external bodies	68,272	-	68,272
Total at 31 March 2022	**72,104**	**-**	**72,104**

	Financial liabilities measured at amortised cost	**Other**	**Total**
	2020-21	**2020-21**	**2020-21**
	£000	**£000**	**£000**
Trade and other payables with NHSE Bodies	1,172	-	1,172
Trade and other payables with other DHSC group bodies	6,498	-	6,498
Trade and other payables with external bodies	71,501	-	71,501
Total at 31 March 2021	**79,171**	**0**	**79,171**

14. Operating Segments

The clinical commissioning group considers they have only one segment: commissioning of healthcare services, which is consistent with 2020-21.

15. Pooled Budgets

NHS Manchester CCG has a pooled budget arrangement with Manchester City Council for health and social care spend in line with arrangements for the Better Care Fund.

The aims and benefits of the partners in entering into this agreement are to:

- improve the quality and efficiency of the services in scope;
- meet the Local Objectives and the National Conditions which are as follows:
    - deliver a jointly agreed plan between the partners, signed off by the Health and Wellbeing Board;
    - ensure that the CCG financial contribution to adult social care is maintained in line with the uplift to the CCG minimum contribution;
    - investing in NHS-commissioned out-of-hospital services, and
    - delivering a plan for improving outcomes for people being discharged from hospital.
- make more effective use of resources through the establishment and maintenance of the BCF Pooled Fund for revenue expenditure on the Services.

The clinical commissioning group hosts the pool and its share of income and expenditure are outlined in the table below. Of the £81.9m (2020-21: £80.1m), £64.8m (2020-21: £63.9m) pool for 2021-22 relates to healthcare spend, £17.1m (2020-21: £16.3m) was an allocation for Social Care. For a further breakdown of expenditure please see the Better Care Fund Section within the Performance Report.

	2021-22 £000	2020-21 £000
Income	0	0
Expenditure	81,915	80,190

The accounting treatment agreed with Manchester City Council is that this arrangement is a Joint Operation, and as a result the partners account for their share of the funds' assets, liabilities, expenditure and income.

There are no outstanding assets or liabilities as at 31 March 2022 (31 March 2021: £nil) relating to the Better Care Fund.

16. Related Party Transactions

Details of the related party transactions with entities are as follows:

Related Party Name	**Payments to Related Party £'000**	**Receipts from Related Party £'000**	**Amounts owed to Related Party £'000**	**Amounts due from Related Party £'000**
Whitley Road Medical Centre (Denis Colligan)	1,073	-	57	-
The Maples Medical Centre (Claire Lake)	1,354	-	91	
Cornishway Group Practice (Geeta Wadhwa)	1,380	-	62	-
Total	**3,807**	**-**	**210**	**-**

Other declared interests that are not classed as Related Party Transactions can be found on the Register of Interests for Manchester CCG: https://www.mhcc.nhs.uk/about-us/how-we-manage-conflicts-of-interest/

The disclosure identifies the governing body member and the total transactions with the related party organisation identified within the declaration of interests.

The Department of Health and Social Care is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with the entities for which the Department is regarded as the parent department. For example:

- NHS England (including commissioning support units);
- NHS Foundation Trusts (i.e. Manchester Universities NHS Foundation Trust, Greater Manchester Mental Health Foundation Trust, Salford Royal Foundation Trust etc);
- NHS Trusts (i.e. North West Ambulance NHS Trust);
- NHS Resolution (previously NHS Litigation Authority); and
- NHS Business Services Authority.

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 Manchester City Council.

17. Events After the End of the Reporting Period

There are no post balance sheet events in this period which will have a material effect on the financial statements of the clinical commissioning group.

The Health and Care Act received royal assent on 28 April 2022. Subject to the issue of an establishment order by NHS England, the CCG will be dissolved on 30 June 2022. On 1 July the assets, liabilities and operations will transfer to NHS GM Integrated Care.

18. Losses and Special Payments

18.1 Losses

There are no losses recorded in the accounts for 2021-22 (2020-21: £13k).

There has been an asset write off agreed in year with an external provider, this totalled £10,408 with the financial impact reflected in the financial statements of the provider.

	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £'000	Total Number of Cases 2020-21 Number	Total Value of Cases 2020-21 £'000
Administrative write-offs	-	-	1	13
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Bookkeeping	-	-	-	-
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total	**-**	**-**	**1**	**13**

	2021-22	2021-22	2020-21	2020-21	
	Target	Performance	Target	Performance	Achieved?
	£000	£000	£000	£000	
Expenditure not to exceed income	1,932,298	1,932,104	1,410,099	1,409,898	✔
Capital resource use does not exceed the amount specified in Directions	-	-	-	-	n/a
Revenue resource use does not exceed the amount specified in Directions	1,916,547	1,916,353	1,401,070	1,400,869	✔
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	n/a
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	n/a
Revenue administration resource use does not exceed the amount specified in Directions	11,880	11,811	11,735	11,349	✔

18.2 Special Payments

There were no special payments in 2021-22 (2020-21: £nil).

19. Financial Performance Targets

NHS Clinical Commissioning groups have a number of financial duties under the NHS Act 2006 (as amended).

The clinical commissioning group's performance against those duties was as follows:

Independent auditor's report to the members of the Governing Body of NHS Manchester Clinical Commissioning Group (CCG)

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of NHS Manchester 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 17 to the financial statements, which indicates The Health and Care Act received Royal Assent on 28 April 2022. The Act will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish CCGs. ICBs are due to take on the commissioning functions of CCGs from 1 July 2022. On this date the CCGs functions, assets and liabilities are due to transfer to Greater Manchester Integrated Care.

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.

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

In our opinion, 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.

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.

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 76 and 77, 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, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls, revenue and expenditure recognition. We determined that the principal risks were in relation to:

  - material year end journals and manual journals posted during the year with high risk characteristics
  - potential management bias in determining estimates for the year end prescribing accrual.

- 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 the material year end transactions and manual journals posted during the year with high risk characteristics;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the prescribing accrual;
  - 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, including the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to the prescribing accrual.

- 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.

We have nothing to report in respect of the above matter.

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 – Certificate

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

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.

Gareth Kelly

Gareth Kelly, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Glasgow

21 June 2022