NHS
Manchester
Clinical Commissioning Group

NHS Manchester Clinical Commissioning Group (CCG) Annual Report

1 April – 30 June 2022

Contents

This is the Month 1-3 2022/23 Annual Report and Accounts for NHS Manchester Clinical Commissioning Group (MCCG) covering the period from 1 April 2022 to 30 June 2022. MCCG was 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 continued to work closely to ensure the health needs of the people of Manchester are met. On 1 July 2022, CCGs were disestablished following the enactment of the Health and Care Act 2022. CCGs have been replaced by Integrated Care Boards (ICBs), with Manchester making up part of the Greater Manchester ICB.

**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.*

PERFORMANCE REPORT

Mark Fisher

Accountable Officer

21 June 2023

Introduction

Welcome to Manchester CCG's annual report for the period 1 April to 30 June 2022.

It's important to recognise the incredible efforts undertaken by each and every member of staff in the run up to transition; and for their commitment to building and growing our common purpose and strengthening our progress to date. It's testimony to the strength of partnerships and relationships in Greater Manchester that we have successfully transitioned into one organisation 'NHS Greater Manchester Integrated Care'.

This has not been without its challenges, and a huge amount of work to shape functions, leadership, and governance has taken place and is ongoing. We will now build on this legacy of collaboration and trust, with localities being central to our work, as we tackle inequalities and look to improve outcomes for the populations we serve.

As we look to the future, we are developing a shared organisational plan, underpinned by public involvement. It will look at the actions we can take together to enable people and communities to lead healthy lives and be confident in their ability to care for themselves and others. We know that, in order to achieve this, working with our wider integrated care partnership including the voluntary sector will be key. By working together across health and care, council and NHS, voluntary and independent providers, we can provide high quality and joined-up services which residents deserve.

As we move forward, it's important to reflect on what has been achieved in the first quarter of the year and the next few pages will detail these milestones for Manchester CCG.

Below is a summary of our achievements over the period, under each of Manchester CCG's strategic aims. In each case the most recent data available was 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 were developed which 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.
- 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. A new PQRRS programme has been developed for 2022/25 to support quality and improvement across primary care.

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.
- Supported agile working in Primary Care, ensuring all GP practices are able to deliver online support such as digital triage and consultation where required.
- 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.
- Continued to deliver a comprehensive anti-racism programme for MHCC staff, including the Executive Team and Senior Managers. This included fair and inclusive recruitment training for managers, which 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

- 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.
- Following a safe and wellbeing review, the CCG undertook a robust process review involving patients and carers with lived experience feeding back on the process. Consent was requested from patients and their families prior to the safe and wellbeing reviews being undertaken, families were given options for communication by phone or in person, advocacy was included for interviews and meetings held in person and feedback was provided to individuals and families around the results of the review. Actions and recommendations resulting from this review carried on into 2022/23.

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 up to March 2022, with a further 70 expected to be recruited in 2022/23.
- 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.
- MHCC ran a comprehensive transition and closedown programme to ensure the safe transfer of staff and transition of responsibilities into the newly formed Integrated Care Board.

Over the following pages, we detail the context we worked within, what we did, and how we did 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.

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 was accountable as a statutory organisation to NHS England/Improvement. This is the Annual Report (months 1-3 of 2022/23) of MCCG although the majority of references throughout this Performance Section of the report refer to MHCC. This reflects the way we worked and the integrated nature we worked with Manchester City Council.

Manchester Health and Care Commissioning (MHCC)

Manchester Health and Care Commissioning, formed on 1 April 2017, was 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 to 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 and the first quarter of 2022/23, the CCG continued to have MCC representation on the MHCC Board and relevant Committees.

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

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

We held MHCC Board meetings monthly in Manchester city centre, however some meetings were held virtually during 2021/22 and the first quarter of 2022/23 due to the government's COVID-19 pandemic restrictions. The meetings were open to the public and further information is available on the MHCC website at [ARCHIVED CONTENT] Board Meetings | Manchester Health & Care Commissioning (nationalarchives.gov.uk). These were followed by Governing Body meetings when matters reserved to the CCG required discussion.

MHCC oversaw 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 were 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 transferred to providers a number of resources and responsibilities, including service design, demand and capacity planning, and the subcontracting of services. This was 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 focused on long term objective setting and system-level transformation programmes.

MHCC operated across five directorates. The Clinical Directorate linked closely with primary care, acted as a key interface with providers on clinical matters, and worked to ensure patients across the city were 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 was primarily concerned with monitoring provider performance and facilitating improvement and reform of services. The Directorate of Population Health, Nursing and Safeguarding focused on public health, health intelligence, and nursing and safeguarding. The Directorate of Strategy was 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 were:

- 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 the first quarter of 2022/23, 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, whilst also preparing for the disestablishment of the CCG and transition to the GM ICB. 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.
- CCG Closedown and Transition to ICB – the organisation focused on a comprehensive Transition and Closedown Programme to ensure the safe transfer of people and responsibilities into the GM Integrated Care Board.

The Manchester Population

Manchester has a resident population of **578,500** according to the MCCFM 2020 (Manchester City Council Forecasting model) estimates. This is significantly higher than the **555,741** 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.

Published data from the 2021 Census gives a population count of **552,000** people residents in Manchester. This figure suggests that there remains a significant difference between local and national estimates of the size of the population currently living in the city. Manchester City Council and its partners are working closely with ONS to understand and evidence the reasons for this difference.

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 both men and women in Manchester is the 5th lowest in England - a boy born in Manchester can expect to live over 8 years less than a boy born in the most affluent parts of England. A girl can expect to live around 7 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 653,067 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 3.1 years for men and 1.9 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 worked 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 Making Manchester Fairer 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 was 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 was to monitor and manage the performance and quality of commissioned providers.

The team produced an operational framework every year which set out how the team would work and provide assurance to the CCG's Board and Committees.

In simple terms, this involved:

- 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 included, but was 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 formed the basis of assurance reporting and escalation where necessary via the governance structures described above.

Performance management for 2022 / 23 were formulated around the Manchester priorities which align with the 2022/23 priorities and operational planning guidance as follows;

1. Invest in the workforce
2. Effective Covid response
3. Provide support to enable the delivery of significantly more outpatient and elective care and a reduction in waiting times and backlogs
4. Expanding primary care and Supercharging MLCO
5. Support the delivery of major transformation programmes including improving community and urgent and emergency care
6. Improve Mental Health and Learning disability and Autism services
7. Develop the Build Back Fairer in Manchester Action Plan in line with the Marmot recommendations and support actions to reduce inequalities and improve population health
8. Exploit digital technologies to transform patient access and care
9. Effective use of resources including appropriate resource allocation and use of health infrastructure to drive economic regeneration
10. Development of Greater Manchester ICS and Manchester Local System arrangements.

Performance Analysis

Ensuring and driving quality, performance and improvement

At every meeting, the Board received 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 (MLCO)
- Greater Manchester Mental Health NHS Foundation Trust (GMMH)
- Independent sector providers (including voluntary sector)
- Primary care services.

Measurement of the CCG's effectiveness was underpinned by a range of monitoring frameworks that were 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, both nationally and locally, and is where recovery efforts will continue to be focussed moving forward into 2022/23. At CCG level, these included;

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

Performance against the 4 hour standard had improved slightly when comparing April – June 22 with March 22 – averaging 60.7% against 59.9%. Attendances at A+E were 3.24% higher in Q1 22 / 23 than in Q4 21 / 22.

The number of patients remaining in hospital following a "No Reason to Reside" decision is still a cause for concern, with April – June 22 showing a monthly average of

325 against a target of 240. This continues to be a focus of initiatives designed to improve the discharge process from hospital.

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

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

Increases in the numbers of people in hospital with COVID 19 during May and June 22 continued to negatively affect most elements of performance in relation to referral to treatment standards.

The waiting list size increased further to 82,704 at the end of June 22, up from 78,351 in March.

Performance against the 18 weeks 92% standard improved slightly – 51.2% at the end of June 22 compared with 50.7% at the end of March 22. The number of patients waiting more than 52 weeks at the end of June 22 had increased to 7,803 from 5,805 in March, but the numbers waiting 78 and 104 weeks had reduced to 1,035 (from 1,161) and 69 (from 473) respectively.

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

- Outpatient Reform
- Theatre capacity and demand modelling
- Elective hub modelling
- 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. Some recovery had since been made, but still stood at 28% at the end of June 2022.

The focus for improvement was 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, only 2 out of 9 cancer standards were met. This continued into 2022 / 23, with only 1 standard being met at the end of June (31 Day Radiotherapy). Of particular note was that providers had been unable to consistently deliver the 2 week wait and cancer treatment within the 62 day standards. Manchester's performance was 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 increasing activity levels and reducing the Patient Tracking List (PTL) size throughout 22 / 23.

- **Mental Health**

Children and Young People

There continues to be a gradual increase in the number of children and young people accessing mental health services. A total of 9,485 children received at least one contact with mental health services in the previous 12 months up to June 2020. This increased to 10,900 children accessing services in the previous 12 months up to June 2022.

The main provider of specialist mental health services is Manchester Foundation Trust (MFT) where average waiting time from referral to treatment (two contacts) was eight weeks in quarter one. The specialist Children's Eating Disorder Service was also provided by MFT and in quarter one, all children referred were seen within national target of four week for routine referral and one week for urgent referral.

Adults

In quarter one, 5,585 people accessed psychological therapy for common conditions such as anxiety and depression, which was above the national target. Manchester also consistently delivered against the national waiting times for therapy with over 75% seen within six weeks and 95% seen within 18 weeks. The main provider of psychological therapy in Manchester is Self Help Services and Greater Manchester Mental Health Trust. Also, several smaller providers are commissioned to provide therapeutic services to our most hard to reach communities.

Manchester continued to have low number of people being sent outside of Greater Manchester for acute inpatient care due to no beds available within the Trust. A focus on improving patient flow, reducing length of stay and the use of independent beds within GM is helping to ensure few people are sent outside of GM.

However, Community Mental Health Teams across the City continue to experience increased demand and patients presenting with increased complexities. Added to this is the ongoing difficulty in recruiting suitably qualified staff resulting in challenges with

delivering the targets in relation to waiting times, issuing timely discharge summaries to GPs, undertaking annual care plan reviews, and responding to complaints. The teams continued to actively review the referrals into the teams and prioritise the safety of service users, ensuring regular contact was made, particularly those awaiting assessment. The Trust developed a CMHT resilience plan with key areas addressing capacity and demand, effective care coordination, recruitment, and retention of staff, embedding learning from incidents, effective risk management and additional leadership support.

National and Local KPI's

Despite the ongoing disruption to all areas of service provision, in relation to national and local KPIs, there were some notable areas of achievement in the first quarter of 2022 / 23, namely;

- Ambulance Response for category 1 calls met the target of 15 minutes in April, May and June.
- No cancer patients waited more the 31 days for drug or radiotherapy treatment
- No Manchester patients acquired MRSA infection
- All children referred to the Healthy Young Minds eating disorder service start a National Institute for Clinical Excellence (NICE) treatment package within 1 week (urgent cases) and 4 weeks (routine cases)
- No patients referred for Psychological Therapy services waited longer than 6 weeks to be seen
- The proportion of women receiving specialist perinatal mental health care was 7% - more than double the national target of 3%.
- The dementia diagnosis rate was 71.5%, well ahead of the 67% target.
- The actual number of GP appointments for April – June 22 exceeded the plan by 18%.

NHS System Oversight Framework (SOF)

NHS England had a legal duty to assess annually the performance of each Clinical Commissioning Group (CCG). The assessment considered 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 was 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 was 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 were 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 consisted of 100 indicators, 22 of which were placeholders for future development. 39 of the indicators were 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 (**June 2022**) are:

Of the 39 indicators that were reported, MHCC had;

- 9 (23%) in the highest performing quartile
- 17 (44%) in the interquartile range
- 13 (33%) in the lowest performing quartile

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

Indicators in the highest performing quartile (9) are;

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**
Estimated diagnosis rate for people with dementia	**9 / 106**

People with severe mental illness receiving a full annual physical health check and follow up interventions	**16 / 106**
IAPT access (total numbers accessing services)	***17 / 106***
Children and young people (ages 0-17) mental health services access (number with 1+ contact)	***19 / 106***
Diagnostic activity levels – Endoscopy	***23 / 106***
Diagnostic activity levels – Imaging	***27 / 106***

Indicators in the lowest performing quartile (13) are;

Metric	**Rank**
Proportion of people that survive cancer for at least 1 year after diagnosis	**75 / 97**
Rate per 100,000 population of people in adult acute mental health beds with a length of stay ***over 90 days***	**83 / 106**
Overall size of the waiting list	***85 / 106***
Diabetes patients that have achieved all the NICE recommended treatment targets (Adults and children)	**88 / 106**

IAPT recovery rate (%)	**94 / 106**
Personal Health Budgets	***95 / 104***
Percentage of people aged 14+ on the GP learning disability register receiving an annual health check	**96 / 105**
Patients waiting more than 52 weeks to start consultant-led treatment	***96 / 106***
Population vaccination coverage – MMR for two doses (5 years old) to reach the optimal standard nationally (95%)	**99 / 106**
% Cancer Referrals meeting faster diagnosis standard	**100 / 106**
Percentage of people aged 65 and over who received a flu vaccination	**101 / 106**
Rate per 100,000 population of people in adult acute mental health beds with a length of stay ***over 60 days***	**102 / 106**
Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	**105 / 106**

It is important to note that some of the indicators were straight number counts, so the rankings for these should be treated with caution as they were dictated by organisation

size. Three of the lowest performing quartile indicators (written in *italics* in the above tables) came into this category whilst four of the highest performing quartile indicators did.

The number of organisations ranked against could also differ as some were not reporting data for certain indicators.

NHS Oversight Framework – changes for 2022 / 23.

The NHS Oversight Framework for 22/23 was published on the 28th June 2022 alongside a revised set of metrics.

The approach for 2021/22 provided a single, consistent NHS monitoring framework with the flexibility to support different system delivery and governance arrangements, as well as local partnership working. The updated framework continued that approach, but refreshed it to take account of:

a) the establishment of statutory Integrated Care Boards (ICBs) (and disbandment of CCGs) with commensurate responsibilities

b) NHS England's duty to undertake an annual performance assessment of these ICBs

c) early learning from the implementation of the System Oversight Framework during 2021/22

d) Revised NHS priorities as set out in 2022/23 planning documentation.

Ongoing oversight will focus on the delivery of the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of individual ICSs. To achieve this, the NHS Oversight Framework was built around:

a) Five national themes that reflect the ambitions of the NHS Long Term Plan and apply across trusts and ICBs: quality of care, access and outcomes; preventing ill-health and reducing inequalities; people; finance and use of resources; and leadership and capability

b) A set of high-level oversight metrics, at ICB and trust level, aligned to these themes

c) A sixth theme, local strategic priorities. This reflects the ICB's contribution to the wider ambitions and priorities of its ICS and recognises:

   I. that systems each face a unique set of circumstances and challenges in addressing the priorities for the NHS

   II. that each integrated care partnership will set out an integrated care strategy that its ICB must have due regard to in planning and allocating NHS resources

   III. the continuing ambition to support greater collaboration between partners across health and care, to accelerate progress in meeting the most critical health and care challenges and support broader social and economic development.

d) A description of how ICBs will work alongside NHS England to provide effective, proportionate oversight for quality and performance across the NHS.

e) A three-step oversight cycle that frames how NHS England teams and ICBs will work together to identify and deploy the right delivery support and intervention to drive improvement and address the most complex and challenging problems, respectively.

NHS England regional teams will lead the oversight of ICBs on delivery against the domains in the NHS Oversight Framework and, through them, gain assurance of place-based systems and individual organisations. Where necessary, regional teams will lead and co-ordinate support requirements identified for the ICB.

ICBs will lead the oversight of NHS providers, assessing delivery against these domains, working through provider collaboratives where appropriate. ICBs will consult with their NHS England regional team about any areas of concern identified, specific support requirements and, where necessary, issues requiring formal intervention by NHS England.

NHS England and ICBs will together agree the specific arrangements for each system to ensure effective and proportionate oversight, reflecting local delivery and governance arrangements.

As this will be the first year in which ICBs operate, NHS England will work with them during the first half of the year to develop further detailed guidance to support annual assessments for 2022/23. We expect to review and develop this approach for future years.

In addition, The Health and Care Act 2022 placed new duties on CQC to conduct reviews of the provision of health and adult social care in each ICS and assess the functioning of the ICS, including how its ICB, local authorities and registered service providers work together. NHS England and CQC will continue to work together to ensure synergy between the ICS reviews undertaken by CQC and the ICB assessments undertaken by NHS England.

The new framework came into effect from 1st July 2022.

The current position in relation to the CCG's performance against key indicators are as set out on the following page.

Summary

Org Name Full	Aggregation Source	Indicator	Period Frequency	Period	Value	National Value	Target / Standard (not met if)	Change from previous period	3 period continuous change	Rank
NHS MANCHESTER (SUB ICB LOCATION) (14L)	SubICB	S009a: Total patients waiting more than 52 weeks to start consultant led treatment	Month	2023 01	11,470	346,192		↑		103/106
	SubICB	S009b: Total patients waiting more than 78 weeks to start consultant led treatment	Month	2023 01	1,716	41,175		↑		104/106
	SubICB	S009c: Total patients waiting more than 104 weeks to start consultant led treatment	Month	2023 01	31	1,033	0	↑		102/106
	SubICB	S010a: Total patients treated for cancer compared with the same point in 2019/20	Month	2023 01	71%		100%	↑	↑	77/79
	SubICB	S012a: Proportion of patients meeting the faster cancer diagnosis standard	Month	2023 01	61.1%	67%	75%	↑	↑	85/106
	SubICB	S013a: Diagnostic activity levels: Imaging	Month	2023 01	123.2%	110.3%	120%	↑		10/106
	SubICB	S013b: Diagnostic activity levels: Physiological measurement	Month	2023 01	134.1%	106.7%	120%	↑		11/106
	SubICB	S013c: Diagnostic activity levels: Endoscopy	Month	2023 01	118.1%	94.1%	120%	↑		18/106
	SubICB	S013d: Diagnostic activity levels: Total	Month	2023 01	123.6%	108.7%	120%	↑		7/106
	SubICB	S044a: Antimicrobial resistance: total prescribing of antibiotics in primary care	Month	Jan 2022 - Dec 2022	100.9%	93%	87.1%	↑		56/106
	SubICB	S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Month	Jan 2022 - Dec 2022	7.88%	8.03%	10%	↓		48/106
	SubICB	S047a: Proportion of people over 65 receiving a seasonal flu vaccinatio	Month	2022 12	67.7%	78.4%	85%	↑	↑	102/106
	SubICB	S050a: Cervical screening coverage : % females aged 25 : 64 attending screening within the target period	Quarter	22-23 Q1	61.3%	70.6%	75%	↓		105/106
	SubICB	S053a: % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	Annual; financial year	2021 - 22	88%	89%	90%	↑		82/106
	SubICB	S053b: % of hypertension patients who are treated to target as per NICE guidance	Annual; financial year	2021 - 22	56.8%	60.4%	80%	↑		90/106
	SubICB	S053c: % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	Quarter	22-23 Q2	63.3%	57.9%	45%	↑		14/106
	SubICB	S055a: Number GP referrals to NHS Digital weight management services per 100k population	Quarter	22-23 Q3	29.4 per 100,000	45.4 per 100,000		↑		59/106
	SubICB	S081a: Access rate for IAPT services	Month	2022 12	103.6%		100%			4/106
	SubICB	S086a: Inappropriate adult acute mental health placement out of area placement bed days	Month	Oct 2022 - Dec 2022	1,020		0	↑	↑	89/106
	SubICB	S105a: Proportion of patients discharged from hospital to their usual place of residence	Month	2023 01	90.9%	91.9%		↑		63/106
	SubICB	S115a: Proportion of diabetes patients that have received all eight diabetes care processes	Quarter	21-22 Q4	40.1%	46.7%		↑	↑	82/106

Change Arrows (Direction)
↑ Increase
↓ Decrease
○

ContinualChange3Periods
↓
↑ Increase
Null

Rank Banding
Highest performing quartile
Interquartile range
Lowest performing quartile

Colour of change arrows
Null
Deterioration
Improvement

ContinualChange3Periods_Colour
Deterioration
Improvement

RateTextColour
N/App

Improvement in Quality of Services

Quality incorporated patient safety, clinical effectiveness and patient experience and is at the heart of everything we did. We recognised that strong clinical leadership and engagement was critical in improving quality and improving outcomes for patients. We worked 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 were under.

At every meeting the Board received updates on key issues in relation to quality. These included 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 and Q1 22 / 23, our providers prioritised work to support the COVID-19 pandemic but continued to keep a grip on quality. We 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 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.

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

The Care Gateway

Implementation of **Gateway**® software. The referral platform improves quality of referrals and automates patient demographic information as well as relevant past medical history including investigation and diagnostic results.

The software was implemented in November 2021 with **all** Manchester practices using Gateway® from February 2022.

Benefits to practices

- Fully integrates with the GP clinical system (EMIS Web)
- A more efficient process, Gateway® removes many of the existing steps by automatically extracting a pre-determined set of information / criteria
- Improves the quality of referrals sent to providers
- Smart Card integration making logging into the system quicker and easier (a separate log in will not be required)

Recent developments has seen the introduction of Gateway® Capture™. This is a mobile teledermatology app. Capture™ integrates with EMIS via the Gateway® platform. This allows the safe taking and storing of clinical photographs into the patient’s record.

Developing specialty specific referral templates

The aim is to collaborate clinically across Primary and Secondary Care and develop specialty specific referral templates which will further enhance the quality of referrals submitted.

Virtual Triage / Advice & Guidance

Manchester Locality has continued to work collaboratively with MFT to expand the number of specialties / services available via Referral Assessment Services (RAS) / Virtual Triage. MFT introduced electronic referral triage process as part of an initiative to optimise patient pathways within secondary care. A referral is reviewed by a senior clinician and outcomes of this triage includes:

- Optimise advice and guidance
- Directing referrals straight-to-test
- Straight to waiting list for a procedure
- Upgrade to 2ww
- Redirect to another clinic
- Out-patient appointment (face to face / virtual)

Patient initiated follow up (PIFU)

PIFU is a transformation priority identified by NHSE that all trusts have been asked to implement. This project is part of the collaborative Out-patients Recovery Programme led by MFT plus the Manchester Locality. 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.

For most specialties this is not new and is more of formalising of existing practice. Most of the MFT specialties offer a PIFU option to their patients who meet the PIFU criteria and the introduction of HIVE has helped to standardise the approach / model.

Gynaecology - 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 gynaecology education events were held on 2nd and 9th March 2022 for Manchester and Trafford Primary Care clinical staff. The sessions were led by consultant colleagues. Topics covered included:

Menstrual disorders

- Ovarian cysts
- Emergency gynaecology
- Gynaecology advice & guidance
- Urogynaecology
- Polycystic ovary syndrome

Gynaecology - Planned education session for Menopause Management

Primary Care is experiencing a significant demand from patients requesting menopause diagnosis, management and/ or the prescribing of HRT. Patients attend practice well informed of many of the treatment options available following recent significant media coverage. Currently in the planning phase the aim is to deliver two sessions to Primary Care and to provide clinicians with the expertise required when caring for their patients. The sessions will focus on the GMMMG HRT Guidance for Menopause Management (currently awaiting release of the guidelines – the education sessions will be timed to align with the release).

Dermatology – Planned education session

Dermatology services are experiencing significant demand and a critical point has been reached in relation to the delivery of the 14-day cancer standard (2ww), and the Faster Diagnosis standard. Currently in the final planning stages the aim is to deliver a joint secondary and community care education session. The purpose of the session is to provide clinicians with the expertise required to recognise, treat and improve the appropriateness and accuracy of referrals of Actinic Keratoses and Bowens Disease Squamous Cell Carcinoma, Basal Cell Carcinoma and Seborrhoeic Keratoses.

Dermatology - Teledermatology and Dermoscopy

To improve diagnosis, support referral and triage and all Primary Care practices across Manchester have received GM funded dermatoscope. In conjunction with Gateway C a GM Cancer funded Dermoscopy study day took place on 12 September. Attendees could attend in person or remotely and the day was recorded and will be shared across GM as to enable Primary Care to access the training as required. The introduction of Gateway® Capture™ will support the use of Tele-dermatology.

Dermatology - Pathways, Conditions Table and Referral Templates

Following a review and revision of the Severe Acne Pathway, the dermatology conditions table, a support tool for Primary Care, is under review. Once concluded the conditions table will be utilised to support specialty specific referral templates for dermatological conditions.

Cardiac Rehab

In the summer of 2021, the Greater Manchester Cardiac Strategic Clinical Network submitted an expression of interest on behalf of GM localities for targeted funding for Cardiac Rehabilitation available nationally. Manchester Health and Care Commissioning and Manchester University NHS Foundation Trust submitted a bid on behalf of Manchester locality for inclusion in the GM EOI. The EOI was submitted in August to the national team and subsequently was successful.

To provide equitable cardiac rehabilitation services across Manchester it was agreed on an additional cardiac rehabilitation service within a Central Manchester community setting would improve accessibility and provide equity in the provision, in line with

services currently provided in North and South. As part of the 21/22 funding provided to Manchester, a 12-month pilot began in July 22 at Hough End Leisure Centre to provide this service.

Equalities – MFT Outpatient Appointment Analysis

To support MFT, an analysis of Did Not Attend (DNA) / Cancellations was carried out with a particular focus on equalities. MFT provided data for Outpatient attends for 2019/20 and 2021/22. The analysis was aimed to identify potential inequities in access and was particularly focused on attends by Index of Multiple Deprivation decile (IMD) and Ethnicity.

One of the key findings was that the DNA risk increased with greater deprivation. 21/22 data showed a DNA rate of 11.6% for decile 1 (most deprived) compared to 5.7% for decile 10 (least deprived). Data also showed patients within the White ethnic group had a lower DNA rate than all other ethnic groups.

The data findings were presented at the Outpatient Programme Group Meeting. The data is currently being used to support the MFT programme of work on Did not Attends.

Community Diagnostic Centres (CDC) – Hub and Spoke Model

MHCC continued to fully support MFT with the rollout of the CDC programme of work across Manchester. There are various workstreams to this programme of work; equalities, estates, workforce, hub and spoke and pathway prioritisation and re-design. In Quarter one, various meetings were held to engage with Manchester clinicians to help map and develop the new onset of breathlessness pathway. This is still a work in progress.

Work also continued in locating 3 suitable spoke sites in Manchester to start spirometry activity. In terms of addressing health inequalities for this programme of work, Healthwatch Manchester were commissioned to produce a report highlighting the current barriers in accessing diagnostic tests and how these could be potentially addressed in order to improve access, reduce health inequalities and increase awareness of diagnostic services.

CDC funding for Year one (2021-22) was not approved by the national team until the end of September 2021 which meant mobilisation for the programme was delayed. Despite this, in terms of actual activity delivered, Ophthalmology has outperformed what we had expected to deliver over the last year - MFT have delivered 25,000 units rather than 23,000 forecast and was one of the top five Trusts who have delivered more activity than forecast.

An EIA (Equality Impact Assessment) was also completed and an action plan developed to address the key areas of inequality that have been highlighted.

Revenue funding was applied for during this year (2022) and has been approved for year two (2022-23) - £10.4million

Quarter 1 of 2022-23 focused on engaging with patients to get input around spoke sites and pathway prioritisation and re-design. A report was completed in this quarter and presented to the CDC programme board. The following key areas of improvement and focus were suggested by patients for the programme going forward:

- **Communication -** Patients require more accessible information, in pictorial or video format, with improved communication from practitioners regarding test results.
- **Accessibility & Equipment** - Patients require better access to, and consideration of, equipment needs such as wheelchairs, hearing aid loops, bariatric machines etc.
- **Transport** - Patients require better access to more regular and cheaper transport.
- **Environment** - Patients require a more understanding attitude from staff, less long wait times, as well as clearer signage to support their patient journey.
- **Culturally Appropriate Information -** Patients need staff to be culturally competent, with an understanding of hidden disabilities, common phobias/fears and the needs of different communities.

Three spoke sites were identified across north, south and central Manchester, where spirometry would be offered one day a week, to help address the backlog but focussing on diagnosis.

A substantial reduction in capital funding confirmed by NHSE will mean that the North Manchester General Hospital development (as a second CDC hub in year 4 of the original business case) will no longer happen – we will need to identify spoke sites for North and East Manchester which will need to comply with NHSE guidance.

Challenges around reduction in national funding, identifying suitable estates to run CDC activity as well as recruitment of additional workforce may hinder the ability of hub and spoke sites to offer 12 hour, 7 day working model (NHSE aim). The issue of estates has been highlighted and needs to be addressed.

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), had delegated responsibility for commissioning Primary Care services from NHS England (Greater Manchester Health and Social Care Partnership, GMHSCP). This included 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 was a key element of the overarching Performance and Quality Improvement (PQI) team's overarching Framework and describes how MHCC continued 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 linked 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 had a well-established Multi-disciplinary Team (MDT) approach, directing support, advice, and guidance from MHCC subject matter experts as appropriate. These experts included colleagues from the Medicines Optimisation Team, Safeguarding Leads, Nursing and Patient and Public Engagement, etc. The MDT was 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 worked closely with CQC inspectors to better understand how the strategy would be implemented locally and to support practices with how best practices could prepare for inspection.

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

In July 2022 the CQC published the new Single Assessment Framework that will start to be introduced in phases; the aim of the publication was for providers and other stakeholders to start to become familiar with this revised approach. Existing key lines of enquiry (KLOEs) will be replaced with prompts to new 'quality statements'. These will reduce the duplication currently in the CQC's four separate assessment frameworks to allow them to focus on specific topic areas under each key question; these will also link to the relevant regulations to make it easier for providers.

Mental Health

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.

Learning from Serious Incident Workshop

MHCC/Trafford CCG worked closely with GMMH to hold a Serious Incident Workshop in August of 2021. Colleagues from CCGs across the GMMH footprint were also in attendance, from various specialisms including medicines management, safeguarding, and commissioning.

The focus of the workshop was on the key themes arising from serious incidents, and the improvement work being carried out 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 was 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 developed an action plan to improve carer engagement which would 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, 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 2022. 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 gynae cancer will be implemented during 2022. Other pathways will be reviewed against faster diagnosis principles to ensure they are as efficient as possible.

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 provided additional resource to support laboratories with staffing and FIT analyser capacity to improve turnaround times in order to speed up the diagnostic pathway and wait for colonoscopy.

Primary Care

Manchester cancer team worked 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 Manchester cancer team meet regularly with the PCN leads and produce regular communications & updates.

Cancer & Health Inequalities

A review of cancer incidence by deprivation score and ethnicity has been carried out. In addition, an initial review of cancer screening coverage by Age, Gender, Deprivation Score, Ethnicity and LD/SMI/Autism was completed with further analysis to follow. All findings were shared with Manchester population health colleagues and GM cancer alliance.

Independent Providers

Over the past two years there had been a focus on improving recording of patient's race and sexual orientation. All services reporting against these KPIs are collecting both race and sexual orientation data from 100% of patients.

Environmental Matters

As an NHS organisation and a spender of public funds, MHCC had an obligation to work in a way that had a positive effect on the communities for which we commissioned and procured 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 acknowledged 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 shared their working time between office and home working, which reduced our utility costs, and staff's reduced travel to and from the office contributed to the lowering of emissions. As we approached the introduction of the GM Integrated Care System, MHCC worked with partners on the development of the GM Integrated Care System Green Plan.

The data below was provided by NHS Property Services (NHSPS) regarding the buildings in use by the CCG for the period April to June 2022, with a comparison of 2021/22 figures.

April – June 2022 Utilities Report

The following table provides utilities information relating to the CCG's occupied space at our Parkway 3 office building for April to June 2022:

Financial Data (Spend):	Units	Apr-Jun 2022
Total Energy Cost	£	9,878
Electricity Cost	£	8,963

Gas Cost	£	653
Water Cost	£	262
Resource Use:		
Electricity Consumed	kWh	56,428
Gas Consumed	kWh	11,379
Water/Sewerage Consumed	m^3	89

Data relating to gas costs and consumption for the CCG's occupied space at Parkway 3 are approximate based on total year usage, including as considered within the total energy cost figure.

2021/22 Utilities Report

The following tables provide utilities information relating to the CCG's occupied space at our Parkway 3 office building for 2021/22.

Financial Data (Spend):	Units	2020/21
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

Engaging people and communities

Manchester Health and Care Commissioning were committed to working with local people to improve health and secure high-quality healthcare for the people of Manchester.

We aimed for 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 were compassionate, inclusive, and constantly improving.

Co-production and public involvement enabled 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 provided opportunities for us 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 – developed 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 to meet the needs of our diverse population in the city.
- Commissioning of voluntary, community, faith and social enterprise organisations to deliver community engagement with a targeted approach for communities facing racial inequalities and inequity.
- Manchester Long COVID Peer Support Group – facilitated and supported people living with Long COVID to inform and influence development of services.
- Volunteer Marshals – continued to support the Manchester COVID Vaccination sites throughout 2021 and 2022.
- Engagement projects with voluntary, community and social enterprise sector organisations that have informed the commissioning of services.
- Community Explorers - working with voluntary, community and social enterprise organisation representatives.
- Social media surveys, polls and focus groups.
- Facilitated discussions and presentations at local groups.
- Developing patient and carer lived experiences as case studies to share with commissioners and inform and influence delivery of services.

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

We have only been able to 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 was a formal sub-committee of the Manchester Health and Care Commissioning Board governance and was chaired by a Lay Representative for Patient and Public Involvement. It provided assurance and feedback on patient and public involvement across all aspects of work of the organisation.

PPAC committee 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 continued to meet virtually for both social and formal committee meetings.

As part of the transition to the Manchester Integrated Care Partnership, the Patient and Public Advisory Committee developed into the Patient and Public Advisory Group as part of the new governance in place. A new Chair and Vice Chair were appointed.

Since April 2022, the Patient and Public Advisory Group member have:

- Used their lived experiences and knowledge to continue to promote the uptake of the COVID-19 vaccination programme and support the vaccination sites.
- Used their skills to develop and inform outcomes for commissioned services.
- Continued to provide feedback on the monitoring of commissioned services, understand where learning has taken place and provide additional feedback to providers.
- Discussed with commissioners, the development of new services, for example, community diagnostic services, and participated along with other patients, in a

workshop to share their lived experiences to inform the location of the new hub and spoke services, patient information and the support needed for patients.

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

- Developed a GP patient survey to understand the lived experiences of people using primary care. Over 300 people have responded to the survey and the feedback is being collated and will be presented to the Primary Care team and clinical leads in October/November 2022.

- Advised on new operating model for Manchester Integrated Care Partnership and the role of patients and the public in the governance of the organisation and the need to be open and transparent in its decision making.

Listening to our communities, patients, and the public

Throughout the last few months of Manchester Health and Care Commissioning, we carried out engagement activities 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 1,634 chats had taken place, meaning since July 2022 a total of 2,421 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 April to June 2022, we continued to commission 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.

Commissioning activity in this way acknowledges the knowledge and skills our 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 which is continuing into 2022/2023. The aim is to improve experiences of and outcomes for communities that suffered 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 into Phase 5 of the Manchester vaccination programme with a focus on health equity and partnership working with the Population Health Team, Primary Care vaccination sites and health and council neighbourhood teams.

The funded sounding boards are facilitated by voluntary, faith 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.

- We have funded voluntary, faith and community organisations to raise awareness of **Long COVID** and develop peer support groups in a culturally appropriate way across Manchester and Trafford. The development work is aimed at the following communities - Black African and Black Caribbean, Pakistani, Bangladeshi and Disabled People. Our thanks to the BHA for Equality, Big Life Group, Voice of BME Trafford, Breakthrough UK and LMCP Care UK.

- 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 2021/2022 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 funding, 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 **Long COVID Peer Support Group** was founded in 2020 and has continued to meet weekly throughout 2022 for people living with symptoms following a COVID-19 infection. The Peer Support Group members (n210) are reflective of the following protected characteristics - gender (60:40 split women and men), age, disability, and ethnicity.

Members have continued to use their lived experience to inform and influence the delivery of the Long COVID service for Manchester and Trafford. The Peer Support Group provided feedback on the development information leaflet to raise awareness of Long COVID in Manchester and Trafford. This leaflet has been translated into several languages and a BSL version developed. A peer support group member is also on the national NHS England Long COVID steering group and is sharing lived experiences at this level to inform and influence developments.

- **Breakthrough UK** is providing **accessible information** training with GP practices across Manchester and working with GP practices to implement changes to ensure their services are accessible.

- The **Communications and Engagement team** have been providing support to GP practices to enable them to engage with their patients during any service change or relocation of a GP practice. A toolkit has been developed to support the GP practice in meeting its contractual and statutory duty to engage with patients and the public.

- During June 2022, **14 Primary Care Networks** engaged with GP practice registered patients to inform their expressions of interest to deliver Extended

Hours and Enhanced Access services. A survey was shared by text to registered patients, conversations were held with Patient Participation Groups and wider stakeholders including voluntary sector groups working in the neighbourhood. Patients were asked what types of appointments they would you like to be able to access outside normal surgery hours, and to share their experiences of what is working well and what needs to improve. The feedback to each PCN has been used to inform their development plans to deliver the above services.

- **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 July and August 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 which has continued into 2022/2023. 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.

Development of grant programmes

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

- Young Manchester were commissioned to deliver the **COVID-19 Recovery Fund**.

This grants programme was a collaborative investment between Our Manchester Voluntary and Community Sector Grants Programme, One Manchester and Manchester Health and Care Commissioning. It 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. 19 organisations were funded at the end of 2021.

Monitoring from the January to April 2022 period shows that projects funded by the Covid Recovery Fund have started well, with the vast majority progressing as planned.

There are some exciting new projects taking shape, and interesting themes starting to emerge.

We are already seeing the emergence and formalisation of numerous partnerships because of this funding. Monitoring indicates this has already enabled multiple instances of pooled and shared resources, of joint recruitment campaigns and partnership fundraising bids. It's already clear how this support is strengthening the sustainability of the organisations in receipt of the funding and is helping them to do what they do best, better. Many grantees report increased activity, being able to diversify their service users, and allowing them the space to implement strategies, processes and practices that have been on the to-do list for a long time.

  - **Case Study:** African Caribbean Alliance Nurturing Foundations have launched the African and Caribbean Alliance (ACA), a new partnership based in north Manchester to strengthen the sustainability of small grassroot African and Caribbean-led organisations in their area. The peer

approach of the partnership is yielding great engagement so far, and they are working with other infrastructure organisations to ensure their support is widely available.

- **Case Study:** Manchester Carers Centre following the formal agreement establishing their Carers North Manchester Partnership, Manchester Carers Centre have recruited a new Business Development role who is now in post and supporting their work and engagement. This joint fundraising support is working well, and the group has already submitted four joint funding applications enabling them to strengthen and continue their vital work.

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 can inform and influence how services are developed, monitored, and redesigned by Manchester Integrated Care Partnership and Manchester Partnership board partners going forward.

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

An integrated locality system engagement approach will be developed that enables improved partnership working with people and communities.

The Health and Wellbeing Strategy and Reducing Health Inequality

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 was a statutory member of the Health & Wellbeing Board and discharged its duty, in partnership with other members of the Board, including MHCC which was represented by the Chair, GP Board members and the Director of Population Health.

During this time, our commissioned services continued to deliver and respond to increased demand during the pandemic. Activities 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 was 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), 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 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 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 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) was refreshed and refocused in collaboration with key stakeholders in the city to align with the Build Back Fairer approach (Marmot et al, 2021). The Building Back Fairer Action Plan provided 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 describes 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 included additional themes in recognition of Manchester's multicultural demographic, including 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, were active members of the Health and Wellbeing Board and provided strong leadership to both the development and implementation of our local strategy".

Financial Performance Overview

The implementation of the Health and Care Act 2022 meant that Manchester Clinical Commissioning Group (CCG) is no longer a statutory body post 30th June 2022, with all functions and services transferring to NHS Greater Manchester. This was a major NHS structural re-organisation, which saw 10 statutory bodies (former GM CCGs), Greater Manchester Shared Services and Greater Manchester Health & Social Care Partnership merge to create one statutory body from 1 July 2022.

Quarter One of 2022-23 saw the continuation of the return to 'business as usual' as operations, both financial and in terms of patients, started to return to pre-pandemic recovery, with only the vaccination programme receiving additional funding. There was a continuation of the changes in relation to financial management within the NHS, in terms of the way the organisation operates, which have remained in place. These are:

- There was a requirement to return to a more business as usual contracting round with signed contracts in place
- Payment systems for NHS Providers remained in place
- One Lead CCG for the Greater Manchester system, through which all system funding was transacted
- Financial Sustainability Programmes re-introduced
- Independent sector expenditure managed at a system level

Financially in Q1 2022-23, the CCG operated within a system control total covering providers and commissioners within Greater Manchester. National guidance ensured that the CCG achieved a breakeven financial position in Q1, with the balance of annual funding being transferred to the successor organisation. Financial plans were submitted which covered the full financial year and included finance, activity and workforce.

MHCC maintained Section 75 arrangements relating to the pooled budget for the Better Care Fund 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
- Connected the strategic/policy agenda between health and the wider City Strategy

Delivery of Financial Duties

The financial duties of a 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 £3,120k (Q1 only)
- To deliver a break-even financial position in year

The table below demonstrates that NHS Manchester CCG delivered all of its statutory duties in Q1 2022-23.

	Duty	Target (£k)	Actual (£k)	Variance (£k)	Duty Met?
Expenditure not to exceed Revenue Resource Limit**	Statutory	430,276	430,276	0	Y
Expenditure not to exceed income	Statutory	431,636	431,636	0	Y
Expenditure not to exceed Capital Resource Limit	Statutory	n/a	n/a	n/a	
To remain within its Cash Limit	Admin	432,283	427,845	(4,438)	Y
To remain within the running cost target of £22.07 per head	Admin	3,120	3,120	0	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 CCGs in year revenue resource limit for Q1 2022-23 was £430,276k. Against this, costs amounted to £430,276k and therefore the organisation has delivered a breakeven financial position in line with national policy.

Expenditure not to exceed capital resource limit

The CCG did not have a capital resource limit in Q1 202223 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 Q1 cash limit for the CCG was £432,283k and the organisation drew down cash from the government amounting to £427,845k. From the £427,845k cash drawn down, £58k was left as a balance in the bank at 30 June 2022, 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. The total allocation for NHS

Manchester CCG for Q1 2022/23 was £3,120k. During the period, the CCG spent £3,120k on administrative expenditure, generating a breakeven position, in line with national policy.

In addition to the financial duties, the CCG should comply with the national 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	**2022/23**	**2022/23**
	Number	**£000**
Non-NHS Payables		
Total Non-NHS trade invoices paid in the year	7,507	79,912
Total Non-NHS Trade invoices paid within target	7,296	79,912
Percentage of Non-NHS trade invoices paid within target	97.19%	100.00%
NHS Payables		
Total NHS Trade invoices paid in the year	280	325,965
Total NHS Trade invoices paid within target	266	325,965
Percentage of NHS trade invoices paid within target	95.00%	100.00%

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

Income

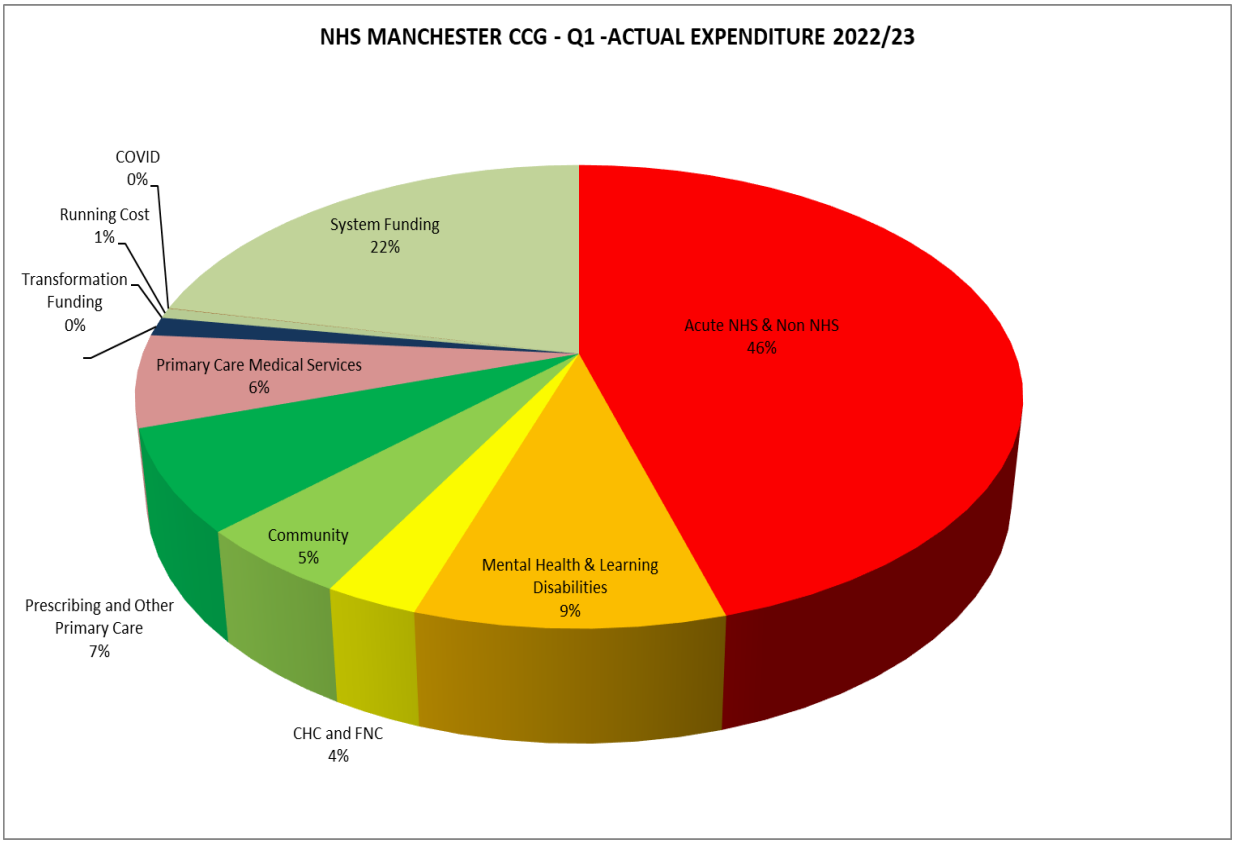
In total the CCG received funding of £431,636k in Q1 2022/23. The majority of this funding (£430,276k) is received directly from NHS England in the form of allocations. Other income of £1,360k has been received in the year from other organisations.

Expenditure

The total costs within Q1 2022/23 are £431,636k, of which £3,214k (gross costs excluding income) relates to administrative/running costs expenditure and £428,422k to healthcare (programme) spend. The numbers quoted are gross expenditure and exclude any income.

The CCG hosts the Greater Manchester Health & Social Care Partnership 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.

The chart below details a breakdown of expenditure for the CCG in Q1 2022-23, which separates out the system funding for which Manchester CCG was the lead CCG for GM.



	% age of Total Spend
Board Heading	
Acute NHS & Non NHS	34%
Mental Health & Learning Disabilities	10%
Continuing Health Care and FNC	3%
Community	5%
Prescribing and Other Primary Care	9%
Primary Care Medical Services	7%
Other	5%
Transformation Funding	2%
Running Cost	1%
COVID	2%
System Funding	22%
Net Expenditure Total	100%

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:

- Discharge to Assess beds in Care Homes
- Additional Roles - A major part of the PCN DES funding is to fund the continuing expansion of workforce via the Additional Roles Reimbursement Scheme (ARRS). Funding per PCN was based on weighted list size on 1st January 2022. In 2022/23 total funding is over £12m of which 62% is in baseline with the remainder being drawn down once the base funding is fully used. At the end of June 2022, the scheme continues to be well utilised with all of the CCG baseline funding being committed and a substantial drawdown of the centrally held funding expected.
- Vaccination Programme – the CCG funded infrastructure to support the delivery of the vaccination programme across multiple fixed and pop-up vaccination sites.

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 appointments were made into business-critical roles only.

Better Care Fund

NHS England required the CCG to contribute a minimum of £49,939k to the Manchester Better Care Fund in 2022-23, with the CCG contributing an additional £32,437k.

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 2022-23

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:

2022-23 Manchester BCF	**Budget £000s**	**Actual £000s**	**Variance £000s**
BCF – Minimum Contribution	49,939	49,939	0
BCF – Additional Contribution**	32,437	32,437	0
TOTAL	82,376	82,376	0
**Additional contribution is over and above the minimum contribution required by CCG			

There are no outstanding assets and liabilities as at 30 June 2022 relating to the Better Care Fund.

The table below details the MHCC total pooled budget and actual expenditure for 2022-23 by service description:

Full Year

2022/2023						
	Budget			Actual		
Service Description	CCG	Council	TOTAL	CCG	Council	TOTAL
	£'000	£'000	£'000	£'000	£'000	£'000
Adult Community Services	43,680		43,680	43,680		43,680
Care Act	2,116		2,116	2,116		2,116
Adult Social Care	15,956		15,956	15,956		15,956
Integrated Community Teams	6,078		6,078	6,078		6,078
Intermediate Care	1,950		1,950	1,950		1,950
Reablement	12,596		12,596	12,596		12,596
Sub Total	**82,376**	**0**	**82,376**	**82,376**	**-**	**82,376**
Care Act	- 2,116	2,116	-	- 2,116	2,116	-
Protection of Social Care	- 15,956	15,956	-	- 15,956	15,956	-
iBCF: Adult Social Care Grant		29,083	29,083		29,083	29,083
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	**64,304**	**58,304**	**122,608**	**64,304**	**58,304**	**122,608**

Quarter 1

2022/2023						
	Budget			Actual		
Service Description	CCG	Council	TOTAL	CCG	Council	TOTAL
	£'000	£'000	£'000	£'000	£'000	£'000
Adult Community Services	10,920		10,920	10,920		10,920
Care Act	529		529	529		529
Adult Social Care	3,989		3,989	3,989		3,989
Integrated Community Teams	1,519		1,519	1,519		1,519
Intermediate Care	487		487	487		487
Reablement	3,149		3,149	3,149		3,149
Sub Total	**20,594**	**0**	**20,594**	**20,594**	**-**	**20,594**
Care Act	- 529	529	-	529	529	-
Protection of Social Care	- 3,989	3,989	-	3,989	3,989	-
iBCF: Adult Social Care Grant	-	7,271	7,271		7,271	7,271
iBCF: Improved Better Care Fund	-	667	667		667	667
Disabled Facilities Grant	-	2,121	2,121		2,121	2,121
TOTAL	**16,076**	**14,576**	**30,652**	**16,076**	**14,576**	**30,652**

Balance Sheet

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 reviewed 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 and 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, with all statutory duties and functions transferring 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 June 2022. There has been a significant amount of system level working including the agreement of contract values, investments and the values of efficiency required and agreed across both providers and commissioners. NHSE has reinforced its commitment to the delivery of the Mental Health Investment Standard in 2022/23 and there is a separate planning submission for mental health covering the whole financial year.

ACCOUNTABILITY REPORT

Mark Fisher

Accountable Officer

21 June 2023

Corporate Governance Report

Members Report

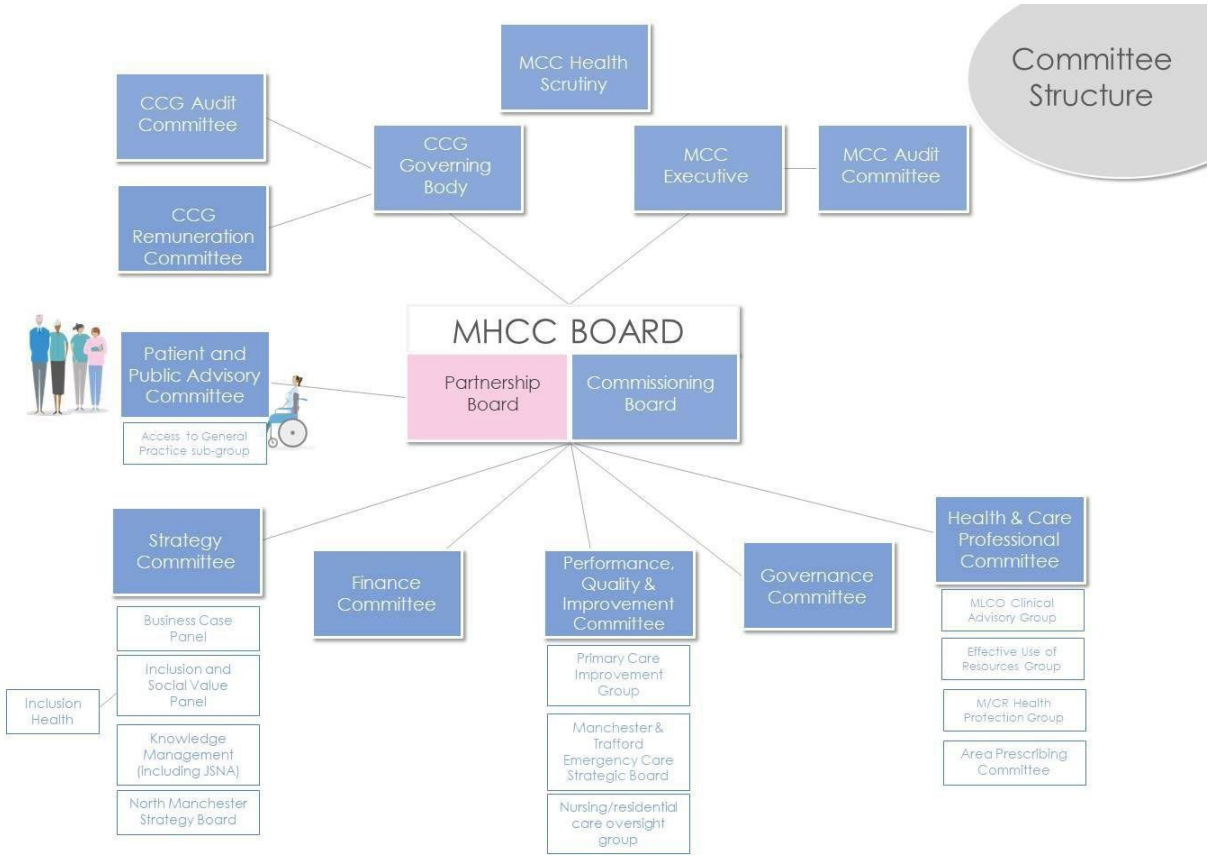
Member practices

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	

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

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 Joanna Midgley, Executive Councillor, MCC – MHCC Board Member

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 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 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 – Dr Ruth Thompson 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 Finance and Audit (Chair) – Chris Jeffries Secondary Care Doctor (Deputy Chair) – Dr Peter Williams Lay Member for Patient and Public Involvement – Atiha Chaudry Head of Finance, MHCC – Kaye Abbott Head of Corporate Governance, MHCC – Chris Gaffey Data Protection Officer (MHCC) – Shavarnah Purves
Finance & Contracting	Lay Member for Finance and Audit (Chair) - Chris Jeffries Lay Member for Patient and Public Involvement (Deputy Chair) – Atiha Chaudry Chief Finance Officer – Claire Yarwood Chief Accountable Officer – Ian Williamson Deputy Medical Director – Dr Claire Lake Executive Director of Strategy – Ed Dyson Executive Member of Adult and Social Care – Cllr Joanna Midgley Head of Strategy & Planning – Leigh Latham
Remuneration	Lay Member for Audit and Finance (Chair) – Chris Jeffries

	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 Joanna Midgley MHCC Board Lay member - Finance (Co-Chair) – Chris Jeffries Executive Director of Strategy – 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 Head of Reform and Innovation MCC – James Binks Public Health Consultant – Cordelle Mbeledogu Medical Director – Manisha Kumar
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 [ARCHIVED CONTENT] How we manage conflicts of interest | Manchester Health & Care Commissioning (nationalarchives.gov.uk)This was updated in May 2022. The register was refreshed and republished at least annually in line with NHSE requirements, however in reality the register was published more regularly to reflect changes in interests throughout the year. The register of interests of all staff, Board and Committee Members and practices was updated on a regular basis as interests arose (or ceased) and when other opportunities present themselves to update.

Personal data related incidents

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

Modern Slavery Act

Manchester CCG fully supported the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year was published on our website at [ARCHIVED CONTENT] Slavery and Human Trafficking Statement | Manchester Health & Care Commissioning (nationalarchives.gov.uk).

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group (CCG) 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, and, on the demise of the CCG when its responsibilities were transferred to the Integrated Care Board, the role of Accountable Officer passed to Mark Fisher as the Chief Executive Officer of Greater Manchester Integrated Care.

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.

As the Accountable Officer, I confirm that there was adequate and sufficient handover from the previous Accounting Officer to provide me with the assurances required to make these statements. I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Greater Manchester Integrated Care's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Mark Fisher

Accountable Officer 21 June 2023

Governance Statement

Introduction and context

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

Between 1 April 2022 and 30 June 2022, the CCG was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

The Accountable Officer had the 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 they were personally responsible, in accordance with the responsibilities assigned to them in Managing Public Money. The accountable officer acknowledged their responsibilities as set out under the National Health Service Act 2006 (as amended) and in their Clinical Commissioning Group Accountable Officer Appointment Letter.

The Accountable Officer was responsible for ensuring that the clinical commissioning group was administered prudently and economically and that resources were applied efficiently and effectively, safeguarding financial propriety and regularity. The Accountable Officer also had 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 NHS Act 2006 (as amended by the 2012 Act) provided the CCG with powers to delegate its functions and decisions to the Governing Body which, in turn, could delegate to certain groups (such as committees) and certain persons. These decisions and

delegations were contained in the CCG's scheme of reservation and delegation which was within its governance handbook.

The main function of the Governing Body was to ensure that the group made appropriate arrangements for ensuring that it exercised its functions effectively, efficiently and economically and complied with such generally accepted principles of good governance as were relevant to it.

Our Constitution stated that, in accordance with section 14L(2)(b) of the 2006 Act, the CCG would at all times observe "such generally accepted principles of good governance" in the way it conducted its business. These included:

- 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 was fully coterminous with Manchester City Council. Membership of the CCG was open to all practices that sat 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 formed the membership of NHS Manchester Clinical Commissioning Group. 83 practices made up the membership of the Group at the end of June 2022, 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 and the first quarter of 2022/23, 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 continued to be applied:

- MHCC would act like, and be treated as, a single organisation.
- Accountability for delivery of all MHCC's functions would 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 would be the primary decision-making body of MHCC and would be 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 would 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 controlled 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 demanded were within its control, were reserved to MCCG's Governing Body. These were:

- ensuring that the CCG had 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 considered 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 the 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 included 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 had 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 had been delegated to the MHCC 'Board' for management. To this end, we established two bodies, the Commissioning Board and the Partnership Board, which met at the same time, in the same place and shared the same membership. These acted together to form the MHCC Board which had a single agenda and set of minutes. All Governing Body members were members of the MHCC Board.

MHCC's Board had a full range of sub-committees to support it in its work. These were (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 was reported to the Governance Committee twice a year and the key actions taken by Committees were reported to the Board following their respective meetings.

MHCC regularly reviewed its governance structures, however there were no significant changes made to the substantive Board and Sub-Committee structures during the first quarter of 2022/23.

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 considered to be relevant to the clinical commissioning group, namely:

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

Discharge of Statutory Functions

Manchester Clinical Commissioning Group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the 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.

Risk management arrangements and effectiveness

Manchester Health and Care Commissioning's Risk Management Framework (RMF) provided a guideline and strategy for the development of a robust risk management system across MHCC. The framework looked to guide MHCC in its approach to the management of risk in all its activities and provided a structural framework with clear definitions and roles of responsibility.

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

MHCC designated its risks in three categories:

- Strategic risks – the small number of high-level risks identified by the Board as those which presented the most significant risk to achieving MHCC's strategic objectives. These risks were the key feature of the Board Assurance Framework, which was 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 were 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 were reported through Programme Management structures.

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

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

Capacity to Handle Risk

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

The RMF sought to meet the following objectives:

- To understand risks, their causes, costs and how best to control them
- To maintain risk registers that detailed all MHCC's risks
- To provide assurance to the Board that risk management issues were 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 have hindered us in the achievement of our aims

It was 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 were 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 were identified and actioned.

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

Risk Assessment

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

Risks were categorised by their risk score as ‘acceptable’, ‘manageable’ or ‘serious’.

Realistically it is never possible to eliminate all risks. There would 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 considered risks scored above 8 but below 15 to be ‘manageable’ and monitored these through MHCC’s Committee Structure. They could realistically be reduced within a reasonable time scale through cost effective measures, such as training or new equipment purchase. Risks that had a score of 15 or above were considered ‘serious’. The consequences of the event could seriously impact on the organisation and threaten its objectives. This category might have included risks that were individually manageable but cumulatively serious, such as a series of similar incidents or quality issues. Serious risks were considered at each Governance Committee meeting and escalated to the Board as a Strategic risk if necessary.

The Board was 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, which continued into the first quarter of 2022/23.

As a result of the broad scope of our work, we also recognised that the level of risk that we were prepared to accept was not consistent across all our objectives. In light of this, our appetite for risk in delivering our strategic aims was 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 were assessed for the level of risk the Board was willing to accept, tolerate, or be exposed to and assessments are used to inform the target risk score. This allowed managers to understand the extent and limits of their ‘risk-taking’ and to develop appropriate mitigation plans.

A review of MHCC’s Strategic Risks (the Board Risk Assurance Framework) 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

These continued to be the organisation's strategic risks up to the end of June 2022.

The Governance Committee had a central role in ensuring that managers were 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 had a key role in the management of governance issues and risks that were significant to the fulfilment of its business objectives. A sound system of internal control contributed 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 covered 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 set out the aims of each element and the Committee responsible for its oversight. It provided where the Board and Committees could 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) required CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England published a template audit framework.

As required by the guidance, an audit of conflicts of interest was completed in 2021/22 following the prescribed framework issued by NHS England. The following compliance levels were assigned to each scope area. Please note there was no annual internal audit conducted in the first quarter of 2022/23, therefore the latest audit results (2021/22) have been used:

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

Compliance levels in relation to conflicts of interest management remained the same level as in the previous year (2020/21). 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. Any open actions relating to internal audit reviews were transferred to NHS Greater Manchester on 1 July 2022.

Data Quality

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

MHCC had well established systems and processes to validate the completeness, accuracy, validity and timeliness of the information that it uses. Where they existed MHCC used national data standards and expected its health and care providers to do

the same. Where required local standards were agreed and reviewed on an annual basis.

Having assessed the quality of data submitted to and reviewed by the Board, I am assured that the data was of sufficient quality that the Governing Body could 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 NHS Data Security and Protection Toolkit forms part of an IG Management 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 enabled us to measure our compliance against the data protection legislation and the National Data Guardians Data Security Standards and to see whether information was handled correctly and protected from unauthorised access, loss, damage and destruction.

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

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

Business Critical Models

The CCG produced and maintained an organisational Information Asset Register which identified business critical assets, HR assets, PCD assets and financial assets for each service within the CCG. Information Asset Owners and Information Asset Administrators were assigned, and all information assets were regularly reviewed. The SIRO was responsible for identifying and managing the information risks. The SIRO received regular reports highlighting any risks.

Data Flow mapping enabled an understanding of the flows of information related to all information assets with the Information Asset Register. Information Asset Owners were responsible for providing updates and highlighting any risks to the SIRO.

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

Third party assurances

The CCG received third party assurance from NHS Greater Manchester Shared Services (GMSS) through the Head of Internal Audit Opinion for Quarter 1 2022/2023. The overall opinion for the period 1st April 2022 to 30th June 2022 provided Substantial Assurance, in that there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently.

The Internal Audit arrangements in Quarter 1 for 2022/23 continued to be well established and audit coverage was approved through the GMSS Governance Committee and Senior Management Team. The review undertaken concluded that, as an entity, robust internal controls were operating in respect of GMSS. In addition, the follow up of audit recommendations confirmed that all had been implemented and closed, which meant that no audit recommendations would be transferred to NHS GM Integrated Care.

GMSS provided a number of support services to NHS Manchester CCG. During Quarter 1 of 2022/23 GMSS were reviewed to ensure on-going compliance with governance arrangements, and this contributed to the substantial assurance given in the Head of Internal Audit Opinion for Quarter 1 of 2022/23 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	Bridging letter of assurance received for Q1 2022/23 confirming there were no changes from the service auditor reports issued in 2021/22 for the period. The 2021/22 service auditor report has been qualified.

East Lancashire Financial Services	Bridging letter of assurance received for Q1 2022/23 confirming there were no changes from the service auditor reports issued in 2021/22 for the period. The 2021/22 service auditor report has been qualified.
Capita Primary Care Support Services	Bridging letter of assurance received for Q1 2022/23 confirming there were no changes from the service auditor reports issued in 2021/22 for the period. The 2021/22 service auditor report has been qualified.
Electronic Staff Record Programme	Bridging letter of assurance received for Q1 2022/23 confirming there were no changes from the service auditor reports issued in 2021/22 for the period. The 2021/22 service auditor report has been qualified.
NHS Business Services Authority: Prescription payments	Bridging letter of assurance received for Q1 2022/23 confirming there were no changes from the service auditor reports issued in 2021/22 for the period. The 2021/22 service auditor report has been qualified.
NHS Digital GP Payments	Letter of assurance received for Q1 2022/23 confirming there were no changes from the service auditor reports issues in 2021/22 for the period. 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 2021-22 it was announced that CCG would be disestablished, with all services and functions transferring to a successor organisation (NHS Greater Manchester ICB) from 1 July 2022.

The CCG produced plans as part of a GM system approach, with the final submission in June 2022. The plan covered the whole of the financial year, and these were agreed by

the MHCC Board and Greater Manchester Planning and Delivery Committee. The CCG has worked within a system control total, working with partners to produce a health economy financial plan, which supports delivery of the locality plan for Manchester and the overall Greater Manchester Sustainability and Transformation plan

Within Quarter 1 NHS England confirmed within national guidance that the CCG allocations would be adjusted so that all CCGs delivered a breakeven position for Q1 2022-23.

A number of the measures introduced in previous financial years remained in place for Q1 2022-23:

- Calculated block contracts payable to NHS bodies, adjusted for local agreements. This has reduced the majority of inter-NHS invoicing
- Contracts for 2022-23 were agreed at a system level and the signature of contracts was reintroduced, although CQUIN remained suspended
- 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
- The CCG had previously accessed COVID funding which ceased at 31 March 2022, with a small element of additional funding for the continued delivery of the vaccination programme
- Investments were allowable dependent on system agreement with the Mental Health Investment Standard delivery 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 retained oversight of those functions which statute dictated it must and delegated responsibility for managing all other aspects of its business to the CCG's Commissioning Board and Partnership Board which met as 'committees in common', forming the 'Board' of the CCG. The Board was supported in its work by a range of sub-committees which oversaw specific aspects of commissioning (see the governance structure diagram in the Members' Report, above).

The Board received 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 could be escalated by committees to become included in the Board Assurance Framework if appropriate.

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

The organisation had a Freedom to Speak Up (Including Whistleblowing) Policy in place. The Policy was provided to all staff and confirmed the organisation's Freedom to Speak Up Guardian and how they could be contacted, and identified how issues may have be raised and addressed.

Counter fraud arrangements

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

- An Accredited Counter Fraud Specialist was contracted from MIAA to undertake counter fraud work proportionate to identified risks
- There was an annual risk-based counter fraud proactive work plan that was agreed and signed off by the Audit Committee. This was developed by the Local Counter Fraud Specialist and the Chief Finance Officer on a risk-based approach.
- The CCG's Audit Committee received, 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 was submitted to the NHS

Counter Fraud Authority. There was 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 had responsibility for raising concerns around fraud, bribery and corruption but the Executive responsibility within the CCG lied with the Chief Finance Officer
- All NHS quality assurance recommendations were reviewed and acted on as appropriate. The CCG also regularly distributed 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 period 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 2022 to 30th June 2022 provided **Substantial Assurance**, that that there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently.

The Quarter 1 2022/23 Internal Audit Plan was delivered with the focus on transition support and the provision of the Head of Internal Audit Opinion. Review coverage focused on:

- CCG Closedown/ICB Transition reviews and support;
- CCG compliance with statutory functions; and
- Follow up of outstanding internal audit recommendations.

Follow Up

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

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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers, and clinical leads within the CCG who had responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me.

The CCG's assurance framework provides me with evidence that the effectiveness of controls that managed risks to the CCG achieving its principles and objectives had been reviewed.

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

- The MHCC Board
- The CCG Governing Body
- The CCG Audit Committee
- The MHCC Governance Committee
- Internal Audit

The role of each of these mechanisms of internal control has been described previously in this governance statement.

Conclusion

In the period 1 April to 30 June 2022 no significant internal control issues had been identified. The CCG had continued to strengthen its governance structures and financial controls, and this is reflected in the Head of Internal Audit Opinion which states that the CCG can take ‘substantial assurance’ that that there was a good system of internal control designed to meet the organisation’s objectives, and that controls were generally being applied consistently.

The factors described in this statement have given me increased assurance and I am therefore satisfied that the CCG operated effective and sound systems of internal control.

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The Remuneration Committee was a committee of the NHS Manchester CCG. It had 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 were reviewed on an annual basis. It did not set the remuneration, fees and other allowances for the members of the Committee. All recommendations made by the Committee were 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 have been 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 had 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 considered national awards, affordability and benchmark data for similar size organisations to enable a recommendation to be reached.

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

The contract for senior managers stated the following:

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 were 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 were members of the Governing Body whose services are via a Contract for Services. The termination arrangements for these individuals were 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 was no liability to the CCG in the event of early termination.

Remuneration of Very Senior Managers

The CCG had 8 senior leaders who would have been paid more than £150,000 per annum had they worked on a full-time basis. 6 of these were clinicians who provided clinical leadership and the CCG satisfied itself that the remuneration was 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. 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 salary and pensions disclosures are subject to external audit validation.

Salaries and Allowances for Manchester CCG Governing Body 1 April to 30 June 2022 (subject to audit validation).

Name and Title		1 April to 30 June 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	20-25		0			n/a	20-25
Mr Ian Williamson	Chief Accountable Officer	35-40		0			5-7.5	45-50
Mrs Claire Yarwood	Chief Financial Officer	35-40		0			2.5-5	35-40
Mr Ed Dyson	Executive Director of Planning and Operations	25-30		0			7.5-10	35-40
Dr Manisha Kumar	Clinical Director	35-40		200			n/a	35-40
Dr Murugesan Raja	GP Member	5-10		0			n/a	5-10
Dr Geeta Wadhwa	GP Member	5-10		0			n/a	5-10
Dr Denis Colligan	GP Member	5-10		0			n/a	5-10
Dr Peter Williams	Secondary Care Doctor	5-10		0			n/a	5-10
Christine Pearson	Board Nurse	5-10		0			n/a	5-10
Mr Chris Jeffries	Lay Member - Finance and Audit	0-5		0			n/a	0-5
Atiha Chaudry	Lay Member - Patient and Public Involvement	5-10		0			n/a	5-10

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

The following footnote provides each senior manager's full year equivalent salary:

Name	*Title*	***Salary & Fees for Governing Body (bands of £5,000)***
Dr Ruth Bromley	*GP Chair*	*85-90*
Mr Ian Williamson	*Chief Accountable Officer*	*150-155*
Mrs Claire Yarwood	*Chief Financial Officer*	*140-145*
Mr Ed Dyson	*Executive Director of Planning and Operations*	*115-120*
Dr Manisha Kumar	*Clinical Director*	*140-145*
Dr Murugesan Raja	*GP Member*	*30-35*
Dr Geeta Wadhwa	*GP Member*	*30-35*
Dr Denis Colligan	*GP Member*	*30-35*
Dr Peter Williams	*Secondary Care Doctor*	*30-35*
Christine Pearson	*Board Nurse*	*25-30*
Mr Chris Jeffries	*Lay Member - Finance and Audit*	*10-15*
Atiha Chaudry	*Lay Member - Patient and Public Involvement*	*20-25*

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

Cllr Joanna Midgley	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 Body 2021/2022 (subject to audit validation)

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	30-35		0			n/a	30-35

GP Member							
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

Pension benefits as at 30 June 2022 (subject to audit validation)

Name and Title		(a) Real Increase in pension at pension age (bands of £2,500)	(b) Real Increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 30 June 2022 (bands of £5.000)	(d) Lump sum at pension age related to accrued pension at 30 June 2022 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 30 June 2022	(f) Cash Equivalent Transfer Value at 1 April 2022	(g) Real increase in CETV	(h) Employers Contribution to partnership pension
		£000	£000	£000	£000	£000	£000	£000	£000
Mr Ed Dyson	Executive Director of Planning and Operations	0-2.5	0	35-40	70-75	605	590	6	4
Mrs Claire Yarwood	Chief Financial Officer	0-2.5	0	65-70	155-160	1,462	1,438	8	5
Mr Ian Williamson	Chief Accountable Officer	0-2.5	0	55-60	90-95	1,106	1,083	10	5
Dr Ruth Bromley **	GP Chair	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Manisha Kumar **	Clinical 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 pension's 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.

Note 4 – The CCG was only able to obtain confirmation of the movement in the cash equivalent transfer values for directors pension entitlements for the period 1 April to 31 March 2023. As a result, the CCG has apportioned the movement on a straight line basis to estimate the cash equivalent transfer value at the 30 June 2022. This is considered to be a reasonable approximation of the movements in the value of the entitlements during the year.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023 to 24 CETV figur*es.*

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

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

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

Real increase in CETV

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

Compensation on early retirement of for loss of office

There were no such payments in Q1 2022-23 (2021-22:£nil) which is subject to validation by external audit.

Payments to past directors

There were no such payments in Q1 2022-23 (2021-22:£nil), which is subject to

validation by external audit.

Percentage change in remuneration of highest paid director

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 2022-23 Q1 is £150-155k (2020-21, £150-155k). This is 3.62 times (2021-22 was 3.62 times) the median remuneration of the workforce, is £42.1k (2021-22, £42.1k).

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 for Highest Paid Director	Percentage Change for Employees as a Whole
Salary and Allowances	0%	0.19%
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 pay ratio	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£32k	£42k	£55k
salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£40k	£53k	£68k

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. 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 2022/23 Q1 is £150k-£155k (2021/22: £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
2022/23	03.77: 1	4.72 : 1	2.87 : 1	3.62 : 1	2.24 : 1	2.78 : 1

In 2022/23, nil (2021/22, nil) employees received remuneration in excess of the highest-paid director/member.

Staff Report

Number of senior managers

The information on the number of senior managers is presented in the table below and is subject to external audit validation. The numbers include staff hosted on behalf of the Greater Manchester Health & Social Care Partnership. These numbers are as at 30 June 2022.

Pay Grade	Headcount	FTE
Band 8 - Range C	26	26.00
Band 8 - Range D	23	21.40
Band 9	5	4.80
Other	11	10.60
Grand Total	**65**	**62.80**

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. These numbers relate to Quarter 1 of 2022-23 only.

	Permanent £000s	Others £000s	Total £000s
Salaries & Wages	3,110	490	3,600
Social Security costs	859		859
Employer Contribution to the NHS Pension Scheme	1,337		1,337
Other Pension Costs			-
Apprenticeship Levy	34		34
Other post-employment benefits			-
Other employment benefits			-
Termination Benefits			-
Total Staff Costs 2021/22	**5,340**	**490**	**5,830**

The categorised average staff numbers in Q1 2022/23 are presented in the following table:

Average Staff Numbers			
	Permanent	**Other**	**Total**
Admin & Estates	281.14	50.58	331.72
Medical & Dental	7.86		7.86
Nursing, midwifery and health visiting staff	43		43
Scientific, therapeutic & technical staff	60.28		60.28
Total	**392.28**	**50.58**	**442.86**

Staff composition

The numbers included within the staff composition table include staff numbers associated with the hosting of the Greater Manchester Health & Social Care Partnership. These are as at 30 June 2022.

Pay Band	Female	Male	Total
All Senior Managers	40	25	65
Comprising:			
Executive Team	2	2	4
Senior Managers	38	23	61
Other Employees	303	94	397
	343	**119**	**462**

Sickness absence data

This data is published nationally and has not yet been made available, so has not been included here.

Staff turnover percentages

The turnover rate as at the 30 June 2022 for MCCG was 18.26% with a Stability Rate of 82.93%

Staff policies

The CCG, operating as MHCC, was committed to being a fully inclusive organisation with a culture and environment which promoted equality of access and treatment for all employees, contractors, visitors and members of the public. We had a published Equality, Diversity and Human Rights Policy, a Disability Policy and an Inclusive Values

Based Recruitment Policy and Code of Practice. These policies were reviewed and progress was monitored through our Inclusion and Social Value Strategy. We worked in partnership with local and national user led disability organisations to review all aspects of our recruitment process including the review and updating of our Recruitment Policy and Recruitment Best Practice Guidelines. The aim of this partnership work was to ensure best practice was incorporated with regards to all aspects of recruitment and selection including the fair treatment of disabled people. All recruitment and selection processes were undertaken in an inclusive way. All parts of the process were reviewed on a job by job basis to ensure that they were free from either direct or indirect discrimination including job adverts, job descriptions, person specifications, application process, testing, selection criteria, interviews, pre-employment checks and job offer. These processes were monitored and progressed through our 10 Point Talent Plan – aimed at reducing disparities in recruitment, retention and development for under – represented groups.

Training and support was provided to all recruiting managers to ensure the organisational policies and procedures were implemented effectively. Fair and inclusive training was mandatory for all recruiting managers, and our Inclusion Staff Group supported our recruitment and appointment process by providing enhanced diversity to our recruitment panels.

We provided regular events and information sharing for staff on how to recruit, retain and develop a diverse workforce, and our Staff Deal provided assurances and mechanisms for staff to raise concerns and issues, both in confidence and openly across a number of forums. We chose to promote inclusion and social value actively as we are aware of the disparities in our workforce by protected characteristic and have aspirational targets to remove them.

The CCG was a ‘Disability Confident’ Employer (level 3) which means the organisation was committed to the following:

- All disabled applicants would be offered an interview providing they met the minimum criteria for the job vacancy.
- Reasonable adjustments would be made to enable disabled people to access interviews and employment opportunities.

- All staff were invited to an annual meeting with their line manager to discuss their personal development needs and the CCG would make every effort to retain employees within the workplace if they were to become disabled.
- We actively promoted disability friendly working environments and trained staff in the social model of disability.

Pre-employment support

The organisation had undertaken a number of pre-employment initiatives with disabled people during this reporting period. This included working in partnership with a number of local organisations to identify work experience opportunities for disabled people across the organisation. We also jointly coordinated a jobs fair for disabled people in March 2019 with Manchester City Council and are part of a national 'easy read' application process.

Retention

The organisation was committed to retaining in employment wherever possible any employee who acquired a temporary or long-term impairment or health condition. This process was 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, would be recorded separately as "disability related absence" to ensure that a disabled employee would not be brought through the Attendance Management processes more quickly in comparison to a non-disabled employee.

Whilst the organisation reserved the right to set an expected level of attendance for all employees, including disabled staff, in this instance, individual triggers and targets would 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 have been 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 also supported disabled staff to stay in work.

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

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

Training, career development and promotion

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

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

Employees learning and development needs were discussed through the quarterly Reflect, Review & Refocus Process. This included 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.

Staff Health and Wellbeing

The CCG was 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:

- Embedding Hybrid Working across the organisation giving staff the opportunity to work flexibly and create a work life balance that best suits their individual circumstances.
- Quarterly risk assessments and guidance on living with Covid.
- A staff Health and Wellbeing Group, ensuring health and wellbeing was an agenda item at all team meetings and a valuable source of feedback to inform the development of the overall wellbeing offer e.g. the introduction of a virtual Book Club and a Menopause Café.
- Embedding wellbeing conversations into one to ones and the quarterly Review, Reflect and Refocus process.
- 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.
- Continued partnership working with the Greater Manchester Resilience Hub, enhancing the wellbeing offer to staff and to managers, including attendance at

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 was 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.
- Ensuring that the views of all staff are considered as part of the transition to the GM Integrated Care System,
- Continue to focus on reducing inequalities particularly for people from communities experiencing racial inequality and for those with disabilities across Greater Manchester.

Trade Union Relationships and Consultation

The organisation worked closely with Trade Union partners through a Social Partnership Forum. The Forum provided 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 provided 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 provided 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 was to encourage an open, honest and transparent working environment, minimising grievances and avoiding disputes.

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

Pre TUPE Transfer and Engagement and Consultation

In preparation of the planned transfer to the ICB from 1st July 2023 extensive engagement and consultation Trade Union representatives and employees took place.

Health and Safety

The CCG recognised and fully accepted 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 maintained a Health and Safety Policy which was reviewed regularly and operated a Health and Safety Sub-Committee (a sub-committee of our Governance Committee), which provided assurance to the Board and its Committees on MHCC matters relating to health, safety, security and wellbeing of those who may have been affected by its activities insofar as they related to CCG legalities, duties and services commissioned via MHCC. The sub-committee met on a bi-annual basis. The CCG was 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.

Quarterly staff risk assessments 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 also refreshed its Fire Risk

Assessment and Building Evacuation Plan following the adoption of new hybrid working arrangements.

Trade Union Facility Time Reporting Requirements

We were 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	£430
Total pay bill	£5,829k
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%

Other employee matters

The results of the staff survey relevant to the period from 1 April to 30 June are not yet available as at the time of reporting.

Expenditure on consultancy

The expenditure on consultancy in 2021-22 for the CCG totals £457k (2021-22: £649k), of which £453k (2021-22: £624k) relates to the hosting arrangement for Greater Manchester Health & Social Care Partnership. The CCG's expenditure on consultancy totalled £4k (2021-22: £25k).

Off-payroll engagements

The off-payroll engagements have been reported separately for the clinical commissioning group and any that existed due to the hosting arrangement for the Greater Manchester Health and Social Care Partnership.

Manchester CCG

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

For all off-payroll engagements as at 30 June 2023.

	Number
Number of existing engagements as of 30 June 2022	1
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	1
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 £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.*

Approval to appoint to off-payroll engagements was through the vacancy approval process. This included the appropriate IR35 checks subjecting off-payroll engagements to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

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

There were no new engagements that reached six months in duration, between 1 April 2022 and 30 June 2022, for more than £245 per day and that last for longer than 6 months.

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 2022 and 30 June 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

There are no off-payroll engagements in Quarter 1 2022-23 for NHS Manchester CCG as a result of hosting the Greater Manchester Health and Social Care Partnership on behalf of Greater Manchester.

Exit packages, including special (non-contractual) payments

Table 1: Exit Packages

In Q1 2022/23 there were no redundancies made, this is validated by external audit.

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 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	-	-	-	-	-	-

There are no Other Departures in Q1 2022-23 (2021-22: £nil)

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Parliamentary Accountability and Audit Report

NHS Manchester CCG was 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. An audit certificate and report is also included at the end of this Annual Report at page 163.

ANNUAL ACCOUNTS

FOREWORD TO THE ACCOUNTS

NHS Manchester Clinical Commissioning Group

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

These accounts for the period ended 30 June 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 the approval of the Treasury, directed.

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

NHS Manchester CCG - Part Year Accounts 2022-23 M1 - M3

CONTENTS

The Primary Statements:

Notes to the Accounts

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

	Note	2022-23 M1-M3 £000	2021-22 £000
Income from sale of goods and services	2	(1,360)	(15,751)
Other operating income		-	-
Total operating income		**(1,360)**	**(15,751)**
Staff Costs	4	5,830	28,830
Purchase of goods and services	5	425,455	1,899,955
Depreciation and impairment charges		50	0
Provision expense		-	0
Other Operating Expenditure	5	301	3,319
Total operating expenditure		**431,636**	**1,932,104**
Net operating expenditure		**430,276**	**1,916,353**
Finance income		-	0
Finance expense		1	0
Total Net expenditure for the year		**430,277**	**1,916,353**
Net (Gain)/Loss on Transfer by Absorption		-	0
Total Net Expenditure for the Financial Year		**430,277**	**1,916,353**
Comprehensive Expenditure for the year		**430,277**	**1,916,353**

The notes on pages 146-152 form part of this statement.

NHS Manchester CCG Statement of Financial Position as at 30 June 2022

	Note	30 June 2022 £000	31 March 2022 £000
Non-current assets:			
Right of Use Assets		297	-
Other financial assets	8	-	200
Total non-current assets		**297**	**200**
Current assets:			
Trade and other receivables	7	6,476	14,589
Cash and cash equivalents	9	58	40
Total current assets		**6,534**	**14,629**
Total assets		**6,831**	**14,829**
Current liabilities			
Trade and other payables	10	(67,060)	(72,924)
Lease Liabilities		(197)	
Provisions	11	(512)	(512)
Total current liabilities		**(67.769)**	**(73,436)**
Total Assets Less Current Liabilities		**(60,938)**	(58,607)
Non-current liabilities			
Trade and other payables		-	-
Other financial liabilities		-	-
Other liabilities		-	-
Lease liabilities		(100)	-
Borrowings		-	-
Provisions		-	-
Total non-current liabilities		**(100)**	**-**
Assets Less Liabilities		**(61,038)**	**(58,607)**
Financed by Taxpayers' Equity			
General fund		(61,038)	(58,607)
Total taxpayers' equity:		**(61,038)**	**(58,607)**

The notes on pages 153-155 form part of this statement.

The financial statements on pages 128 to 132 were approved by the NHS Greater Manchester ICB Board on 7 June 2023 and signed on its behalf by:

Mark Fisher
Chief Accountable Officer

NHS Manchester CCG Statement of Changes in Taxpayers Equity for the three months ended 30 June 2022

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Changes in taxpayers' equity for 2022-23 M1-3				
CCG Balance at 1 April 2022	(58,607)	-	-	**(58,607)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-	-	
Adjusted Balance at 1 April 2022	**(58,607)**	**0**	**0**	**(58,607)**
Changes in CCG Taxpayers' equity for 30 June 2022				
Total Net expenditure for the financial year	(430,277)			**(430,277)**
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	**(430,277)**	**-**	**-**	**(430,277)**
Net funding	427,846	-	-	**427,84**
Balance at 30 June 2022	**(61,038)**	**-**	**-**	**(61,038**

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)	0	0	(71,595)
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	
CCG Balance at 31 March 2022	(71,595)	**0**	**0**	(71,595)
Changes in CCG Taxpayers' equity for 2021-22				
Net operating expenditure for the financial year	(1,916,353)			(1,916,353)
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		
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	
Net Recognised CCG Expenditure for the financial year	**(1,916,353)**	**0**	**0**	**(1,916,353)**
Net funding	1,929,341	0	0	1,929,34
Balance at 31 March 2022	**(58,607)**	**0**	**0**	**(58,607**

NHS Manchester CCG Statement of Cash Flows for the three months ended 30 June 2022

	Note	2022-23 £000	2021-22 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(430,277)	(1,916,353)
Depreciation and amortisation		50	-
Impairments and reversals			-
(Increase)/decrease in trade & other receivables	7	8113	(6,173)
(Increase)/decrease in other current assets			-
Increase/(decrease) in trade & other payables	10	(5,864)	(6,793)
Increase/(decrease) in other current liabilities			-
Provisions utilised			-
Increase/(decrease) in provisions			-
Net Cash Inflow (Outflow) from Operating Activities		**(427,978)**	**(1,929,319)**
Cash Flows from Investing Activities			
(Payments) for other financial assets		1	-
Interest received		200	
Proceeds from disposal of other financial assets			
Net Cash Inflow (Outflow) from Investing Activities		**201**	**-**
Net Cash Inflow (Outflow) before Financing		**(427,777)**	**(1,929,319)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		427,846	1,929,341
Repayment of lease liabilities		(51)	-
Net Cash Inflow (Outflow) from Financing Activities		**427,795**	**1,929,341**
Net Increase (Decrease) in Cash & Cash Equivalents	10	**18**	**22**
Cash & Cash Equivalents at the Beginning of the Financial Year		**40**	**18**
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		**58**	**40**

NHS Manchester CCG Notes to the Financial Statements

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 2022-23 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 30 June 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 14 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

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The CCG assesses whether a contract is or contains a lease at inception of the contract.

1.9.1 The Clinical Commissioning Group as Lessee

A right-of use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs at an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment.

Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

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.

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 Q1 2022-23 (2021-22: None).

1.19.2 Key Sources of Estimation

The clinical commissioning group has assessed that there are no key sources of estimation within the Q1 2022-23 financial statements (2021-22: 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 2022-23. These standards are still subject to HM Treasury FReM adoption, with the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- 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 2025: early adoption is not therefore permitted.
- The CCG has considered the potential impact of the above new standards on its accounts and concluded that it does not expect them to have a material impact on the CCG's financial statements.

2. Other Operating Revenue

	2022-23 M1-3 Total	2021-22 Total
	£000	£000
Income from sale of goods & services (contracts)		
Education training and research	3	-
Non-patient care services to other bodies	1,051	7,226
Prescription fees and charges	121	2
Other contract income	185	8,52
Total Income from sale of goods and services	**1,360**	**15,75**
Other Operating Income		
Other non-contract revenue	-	
Total other operating revenue	**0**	
Total operating income	**1,360**	**15,75**

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

	Education training and research	Non-patient care services to other bodies	Prescription fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	-	-	-	44
Non-NHS	3	1,051	121	141
Total	**3**	**1,051**	**121**	**185**

	Education training and research	Non-patient care services to other bodies	Prescription fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	3	1,051	121	185
Over time	-	-	-	-
Total	**3**	**1,051**	**121**	**185**

4.0 Employee Benefits and Staff Numbers

4.1.1 Employee benefits

	2022-23			2021-22
	Total	Permanent Employees	Other	Total
	£'000	£'000	£'000	£'000
Employee Benefits				
Salaries and wages	3,600	3,111	489	22,640
Social security costs	859	859	-	2,342
Employer Contributions to NHS Pension scheme	1,337	1,337	-	3,711
Apprenticeship Levy	34	34	-	93
Termination benefits				4
Gross employee benefits expenditure	**5,830**	**5,341**	**489**	**28,830**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	-	(
Total - Net employee benefits including capitalised costs	**5,830**	**5,341**	**489**	**28,830**
Less: Employee costs capitalised	-	-	-	(
Net employee benefits excluding capitalised costs	**5,830**	**5,341**	**489**	**28,83(**

4.1.2 Recoveries in Respect of Employee Benefits

The clinical commissioning group had no recoveries in respect of employee benefits disclosed separately to the end of June 2022-23 (2021-22: £nil).

4.2.2 Average Number of People Employed

	2022-23			2021-22		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	Number	Number	Number	Number	Number	Number
Total	442.86	392.28	50.58	439.37	389.40	49.97
Of the above:						
Number of whole time equivalent people engaged on capital projects	0	0	0	0	0	0

Please note that this excludes the GMSS staff who are recharged to the Northern Care Alliance until the creation of the ICB on 1 July 2023.

4.3 Exit Packages Agreed in the Financial Year

There have been no redundancies to month 3 2022-23

There was one redundancy in 2021-22, which was 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.

	2022-23 Compulsory redundancies		2022-23 Other agreed departures		2022-23 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	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	**0**	**0**	**0**	**0**	**0**	**0**

	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**

* 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 to month 3 2022-23 (2020-21: £nil.)

The clinical commissioning group has not made any other agreed departures to June 2022-23, which is consistent with 2021-22.

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

	2022-23 Total £000	2021-22 Total £000
Purchase of Goods and Services		
Services from other CCGs and NHS England	188	1,131
Services from foundation trusts	325,437	1,409,002
Services from other NHS trusts	11,498	97,016
Services from other WGA Bodies	42	165
Purchase of healthcare from non-NHS bodies	28,411	124,432
Purchase of social care	4,518	17,103
Prescribing costs	23,748	98,650
Pharmaceutical services	7	19
General ophthalmic services	158	481
GPMS/APMS and PCTMS	27,160	107,928
Supplies and services – clinical	27	116
Supplies and services – general	1,976	30,905
Consultancy services	457	649
Establishment	288	2,741
Transport	1	29
Premises	1,265	7,467
Audit fees	83	83
Other non-statutory audit expenditure		
· Internal audit services		-

· Other services	18	18
Other professional fees	93	1,154
Legal Fees	73	337
Education and training	7	529
Funding to other group bodies		-
CHC Risk Pool contributions		-
Total Purchase of Good and Services	**425,455**	**1,899,955**
Depreciation and impairment charges	50	-
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	**50**	**0**
Provision Expense		
Change in discount rate	-	-
Provisions	-	-
Total Provision Expense	**0**	**0**
Other Operating Expenditure		
Chair and Non-Executive Members	37	155
Grants to other public bodies	125	2,570
Clinical negligence	-	-
Expected credit loss on receivables	-	-
Expected credit loss on other financial assets (Stage 1 and 2 only)	-	-
Non-cash apprenticeship training grants	-	-
Other expenditure	139	594
Total other operating expenditure	**301**	**3,319**
Total Operating Expenditure	**425,806**	**1,903,274**

The clinical commissioning group has continued to operate to June 2022 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 2021-22 totalled £673.7m, of which £622.7m related to Foundation Trusts and £51m related to NHS Trusts. Within the three months to June 2022 system funding received totalled £152.7m, which was split £149.8m related to Foundation Trusts and £2.9m related to NHS Trusts.

Within the prescribing costs disclosed to June 2022, the clinical commissioning group has included an estimated cost of £9.3m 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.

Audit feels relates to costs incurred for the provision of external audit services to the CCG. These costs include VAT that is not recoverable by the organisation. The audit feels reflect the costs of the audit for the period ending the 30 June 2022. The Other Audit fees relates to the certification of the CCG's Mental Health Investment Standards Compliance Statement.

The CCG commissions Internal Audit and Counter Fraud services from a third party. Since the pandemic and the block arrangements agreed by NHSE, these costs have been covered within mandated NHS block contracts, as internal audit is hosted by an NHS organisation, as was the case in 2020-21 and 2021-22 (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 3 of 2022-23.

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	2022-23 Number	2022-23 £000	2021-22 Number	2021-22 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	7,507	79,912	23,599	295,308
Total Non-NHS Trade Invoices paid within target	7,296	79,912	22,793	293,887
Percentage of Non-NHS Trade invoices paid within target	**97.19%**	**100.00%**	**96.58%**	**99.52%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	280	325,965	1,108	1,524,512
Total NHS Trade Invoices Paid within target	266	325,965	1,076	1,524,464
Percentage of NHS Trade Invoices paid within target	**95.00%**	**100.00%**	**97.11%**	**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 to month 3 of 2022-23. (2021-22: £nil).

7. Trade and Other Receivables

	Current 2022-23 £000	Non-current 2022-23 £000	Current 2021-22 £000	Non-current 2021-22 £000
NHS receivables: Revenue	566		5,988	-
NHS prepayments	14		18	-
NHS accrued income	193		808	-
Non-NHS & Other WGA receivables: Revenue	1,324		1,562	-
Non-NHS & Other WGA prepayments	1,227		1,774	-
Non-NHS & Other WGA accrued income	3,097		4,573	-
Expected Credit loss allowance - receivables	(170)		(189)	-
VAT	220		45	-
Other receivables	5		10	-
Total Trade & other receivables	**6,476**		**14,589**	**0**
Total current and non-current	**6,476**		**14,589**	
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.

7.1 Receivables Past their Due Date but not Impaired

	2022-23 £000 DHSC Group Bodies	2022-23 £000 Non DHSC Group Bodies	2021-22 £000 DHSC Group Bodies	2021-22 £000 Non DHSC Group Bodies
By up to three months	1,275	584	5,929	1,544
By three to six months	41	170	29	3
By more than six months	(14)	(19)	(12)	(24)
Total	**1,302**	**735**	**5,946**	**1,523**

£1.7m (2021-22: £4.8m) of the amount above has subsequently been recovered post the statement of financial position date.

7.2 Loss Allowance on Asset Clauses

	Trade & Other Receivables Non DHSC 2022-23	Other Financial Assets 2022-23	Total 2022-23
	£000	£000	£000
Balance at 1 April 2022	(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	19	-	19
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 2023	**(170)**	**0**	**(170)**

The loss allowance relates to Non-NHS organisations only.

8. Non-Current Assets

	2022-23	2021-22
	£'000	£'000
Balance at 1 April 2022	0	200
Additions	0	
Balance at 30 June 2022	**0**	**20**

The clinical commissioning group has released the £200k investment originally made in the Corporate Services Delivery Vehicle due to the closure of the CCG.

9. Cash and Cash Equivalents

	2022-23	2021-22
	£000	
Balance at 1 April 2021	40	18
Net change in year	18	22
Balance at 31 March 2022	**58**	**40**
Made up of:		
Cash with the Government Banking Service	57	39
Cash with Commercial banks	-	-
Cash in hand	1	1
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**58**	**40**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**0**	**0**
Balance at 30 June 2022	**58**	**40**

Patients' money held by the clinical commissioning group not included above	0

10. Trade and Other Payables

	Current 2022-23 £000	Non-current 2022-23 £000	Current 2021-22 £000	Non-current 2021-22 £000
NHS payables: revenue	35	-	1,296	-
NHS accruals	16,414	-	641	-
Non-NHS & Other WGA payables: Revenue	3,554	-	5,103	-
Non-NHS & Other WGA accruals	16,034	-	24,387	-
Social security costs	512	-	463	-
VAT	-	-	-	-
Tax	362	-	357	-
Payments received on account	-	-	-	-
Other payables and accruals	30,149	-	40,677	
Total Trade & Other Payables	**67,060**		**72,924**	

Other Payables include outstanding pension contributions of £1,534k at 30 June 2022 (2020-21: £1,411k).

11. Provisions

	Current 2022-23 £000	Non-current 2022-23 £000	Current 2021-22 £000	Non-current 2021-22 £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 2022	**0**	**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	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 30 June 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 30 June 2022	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**512**	**512**

The £512k provision relates to dilapidations on buildings, which is in line with 2021-22.

NHS Continuing Care Provisions accounted for by NHS England on behalf of the CCG totals £64k (2021-22: £64k)

12. Financial Instruments

12.1 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.

12.1.1 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.

12.1.2 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.

12.1.3 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.

12.1.4 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.

12.2 Financial Assets

	Financial Assets measured at Amortised Cost	Equity Instruments designated at FVOCI	Total
	2022-23 £000	2022-23 £000	2022-23 £000
Trade and other receivables with NHSE bodies	308	-	308
Trade and other receivables with other DHSC bodies	2,363	-	2,363
Trade and other receivables with external bodies	2,514	-	2,514
Other financial assets	-	-	-
Cash and cash equivalents	58	-	58
Total at 30 June 2022	**5,243**	**0**	**5,243**

	Financial Assets measured at Amortised Cost 2021-22 £000	Equity Instruments designated at FVOCI 2021-22 £000	Total 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	-	4
Total at 31 March 2021	**13,181**	**0**	**13,18**

12.3 Financial Liabilities

	Financial liabilities measured at amortised cost 2022-23 £000	Other 2022-23 £000	Total 2022-23 £000
Trade and other payables with NHSE Bodies	277	-	277
Trade and other payables with other DHSC group bodies	18,013	-	18,013
Trade and other payables with external bodies	48,193	-	48,193
Total at 31 March 2022	**66,483**	**-**	**66,483**

	Financial liabilities measured at amortised cost 2021-22 £000	Other 2021-22 £000	Total 2021-22 £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**

13. Operating Segments

The clinical commissioning group considers they have only one segment: commissioning of healthcare services, which is consistent with 2021-22.

14. 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 £20.5m (2021-22: £81.9m), £16.1m (2021-22: £64.8m) pool for 2022-23 relates to healthcare spend, £4.5m (2021-22: £17.1m) was an allocation for Social Care. For a further breakdown of expenditure please see the Better Care Fund Section within the Performance Report.

	2022-23 £000	**2021-22 £000**
Income	0	0
Expenditure	20,594	81,915

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 30 June 2022 (31 March 2022: £nil) relating to the Better Care Fund.

15. 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)	267	-	52	-
The Maples Medical Centre (Claire Lake)	298	-	74	
Cornishway Group Practice (Geeta Wadhwa)	297	-	98	-
Total	**862**	**-**	**224**	**-**

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 to month 3 2022-23 (2021-22: £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 2022-23 Number	Total Value of Cases 2022-23 £'000	Total Number of Cases 2021-22	Total Value of Cases 2021-22
Administrative write-offs	-	-	-	-
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Bookkeeping	-	-	-	-
Constructive loss	-	-	1	13
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total	**0**	**0**	**1**	**13**

18.2 Special Payments

There were no special payments to month 3 2022-23 (2021-22: £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:

	2022-23	2022-23	2021-22	2021-22	
	Target	Performance	Target	Performance	Achieved?
	£000	£000	£000	£000	
Expenditure not to exceed income	431,636	431,636	1,932,298	1,932,104	✔
Capital resource use does not exceed the amount specified in Directions	-	-	-	-	n/a
Revenue resource use does not exceed the amount specified in Directions	430,276	430,276	1,916,547	1,916,353	✔
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	3,120	3,120	11,880	11,811	✔

Independent auditor's report to the members of the Board of NHS Greater Manchester Integrated Care Board in respect of NHS Manchester CCG

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Manchester CCG (the 'CCG') for the period ended 30 June 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 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 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 and of its expenditure and income for the period 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 2022-23; 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 1.1 to the financial statements, which indicates that the Health and Care Act allowed for the establishment of Integrated Care Boards (ICBs) and abolished Clinical Commissioning Groups (CCGs). The functions, assets, and liabilities of NHS Manchester CCG transferred to NHS Greater Manchester Integrated Care Board on 1 July 2022. When NHS Manchester CCG ceased to exist on 30 June 2022, its services continued to be provided by NHS Greater Manchester Integrated Care Board.

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.

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 2022-23 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 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 2022) 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.

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

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

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the Annual Report for Quarter 1,1 April - 30 June 2022 other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. 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.

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 themselves. 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:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements the other information published together with the financial statements in the annual report for the financial period 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

As explained more fully in the Statement of Accountable Officer's responsibilities 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.

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.

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.

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. Irregularities, including fraud, are instances of non-compliance with laws and regulations. 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 2022-23).
- We enquired of management and the NHS Greater Manchester Integrated Care Board Audit Committee (ICB 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 Greater Manchester ICB 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. We determined that the principal risks were in relation to closing journal entries around expenditure in order to possibly manipulate the year-end financial performance.
- 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 unusual closing journal entries around expenditure that could manipulate the year-end financial performance
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of 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/or expenditure recognition, and the significant accounting estimates related to prescribing accruals.
- 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 other 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**.**

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.

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 made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 30 June 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 was 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 were operating effectively during the three month period ended 30 June 2022.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. 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 planned and managed its resources to ensure it could continue to deliver its services;
- Governance: how the CCG ensured that it made informed decisions and properly managed its risks; and
- Improving economy, efficiency and effectiveness: how the CCG used information about its costs and performance to improve the way it managed and delivered its services.

We have documented our understanding of the arrangements the CCG had 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 have considered whether there is evidence to suggest that there were significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit 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 Board of NHS Greater Manchester Integrated Care Board, as a body, in respect of the CCG, 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 Board of NHS Greater Manchester Integrated Care Board those matters we are required to state to them in an auditor's report in respect of the CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NHS Greater Manchester Integrated Care Board and the CCG and the members of the Board of both entities, as bodies, 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

27 June 2023