NHS
Wigan Borough
Clinical Commissioning Group

Annual Report and Accounts

April to June 2022

Happy, Healthy People

Making health and care information accessible

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Performance Report

Statement from the Accountable Officer

Welcome to the 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 NHS Wigan Borough Clinical Commissioning Group.

Performance overview

The purpose of this performance overview is to present a brief summary about the CCG to help patients, stakeholders, and the public to understand the organisation including its purpose, the key risks to the achievement of its objectives, and how it has performed during the reporting period.

Who we are and what we do

NHS Wigan Borough Clinical Commissioning Group (the CCG) was a clinically led statutory NHS body responsible for commissioning most of the health services for local people.

The CCG commissioned (paid for) local health services including mental health care, urgent and emergency care, primary care, elective hospital services, and community care.

Its ambition was to make sure that local people had access to the highest quality health and care services they needed, when they needed them, and in the most appropriate place for them, in line with the latest NHS Operational Planning Guidance.

The impact of COVID-19 continued during the quarter and this made a difference to services, with some services temporarily paused, and many offering more remote access and fewer face-to-face appointments. The CCG continued to support local providers, and GP practices in particular, to make sure that they maintained high quality services throughout.

The CCG continued to prioritise patient feedback and had the desire to co-design services in partnership with patients, the public, and partners to make sure they met the needs of local people. This meant that everyone using these services should have had a positive experience and felt supported to make active decisions about their own care.

This was reflected in the corporate priorities which were:

Priority 1: Commissioning Health and Care Services	
Our Part	**Your Part**
⇒ We will commission health and care services that meet the needs of local people, delivering high quality, clinically viable, affordable, efficient, and responsive services that improve the overall experience for each person at every contact, across their life course.	⇒ You will make use of the most appropriate services provided within your community to help you gain positive benefits for your health and happiness.
Priority 2: Equality and Inclusion - Everyone Counts	
Our Part	**Your Part**
⇒ We will, as a health and social care partnership, ensure that everyone has fair and equitable access to health and care services, in order for each person to fulfil their individual potential to live longer, and have a happy and healthy life.	⇒ You will be aware of the services available in your local community that can support you in making positive healthy choices and to promote good health.
Priority 3: Innovation and Sustainability	
Our Part	**Your Part**
⇒ We will develop, implement, and sustain effective initiatives that will lead to improvements in quality and experience for local people, whilst ensuring that we make the best use of the 'Wigan Pound'.	⇒ You will take the opportunity to work with us in shaping your future services. You will tell us about your thoughts on plans for new services and on changes to the existing services.
Priority 4: Financial Affordability	
Our Part	**Your Part**
⇒ We will commission high quality health and care services within the allocated financial resources that are available to the Borough.	⇒ You will make positive healthy choices to promote good health. ⇒ You will use the right services to meet your health and care needs, and not use emergency services unless you have an urgent health need. ⇒ You will attend your appointments or advise services when you are unable to attend to ensure the appointment can be reallocated.

The organisation had four directorates to deliver these priorities:

- Commissioning and Transformation
- Finance
- Nursing and Quality
- Primary Care

These corporate priorities were delivered by working with the other partners in Healthier Wigan. This meant:

- Supporting services across the whole NHS to adapt to make sure they were still accessible to all residents during the pandemic
- Ensuring that infection prevention and control was properly implemented, so that when people needed to use services they felt safe and confident to do so
- Promoting positive wellbeing and supporting mental health services as people faced unimaginable challenges in their personal life
- Supporting residents to be well and empowering them to look after their own health and wellbeing
- Helping residents to take advantage of digital technology and its benefits during the pandemic
- Running the biggest vaccination programme ever delivered within the Borough
- Continuing to improve the quality of community and mental health services with a focus on creating an integrated health and care service, working in partnership with providers and Council colleagues
- Working closely with partners and providers to create a joined up, sustainable service that focuses on people's strengths and the assets in their communities to support them to be well and stay independent for as long as possible
- Supporting changes to urgent and emergency care services to make sure that patients can still get emergency care when they need it
- Working with Council colleagues to integrate further commissioning and make the most of the money available to the area
- Commissioning services which are the best they can be, all working together to make sure services are safe, sustainable, and delivering high quality care
- Preparing for transition to the Greater Manchester Integrated Care Partnership and Board and being a key partner in the development of the new ways of working, making sure that the needs of local residents are at the heart of everything that is done

Going concern

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

The Health and Care Act (2022) received Royal Assent on 28 April 2022. The Act allowed for the establishment of integrated care boards (ICBs) across England and the abolition of CCGs. From 1 July 2022 ICBs took on the commissioning functions of CCGs. As a result the functions, assets, and liabilities of the CCG transferred to NHS Greater Manchester Integrated Care.

As the CCG's functions will continue to be delivered by NHS Greater Manchester Integrated Care, the CCG has therefore determined that it remained a going concern as at 30 June 2022.

Performance appraisal

The CCG had two main areas of focus during this period of time. First was the focus on restoring services following the pandemic of the last couple of years, and ensuring that as many patients as possible could access the treatment they needed in a timely manner.

The CCG continued its work with services, and with its member GP practices in particular, to keep and improve the best of the new ways of working which help with seeing patients more quickly and in a more convenient way. Performance against the national NHS Constitutional Standards remained challenging, and the impact of people having waited until after the pandemic to present their symptoms was reflected in the waiting lists. Demonstrable progress was being made in several areas including the number of patients receiving their first definitive treatment for cancer following a GP referral being above the levels seen pre-pandemic, and the number of people waiting longer than 52 weeks to start treatment decreased from the number as at June 2021. More detail on this is provided in the performance analysis section following.

The second area of focus for the CCG was to manage a safe and effective closedown and transition to Greater Manchester Integrated Care. There was tremendous work across all of the directorates to ensure that patient services were not adversely affected whilst the reorganisation was taking place. This was an area of significant potential risk for the CCG, and a Transition Board was established which was supported by a Transition Working Group. Robust closedown and transition plans were put into practice including the monitoring and reporting of a specific transition-focused risk register. These arrangements were subject to independent scrutiny by the CCG's internal auditors who found that the CCG continued to meet all of its statutory duties during this three month period.

Performance Analysis

The purpose of this performance analysis is to present information about the CCG to help patients, stakeholders, and the public to understand the organisation including its purpose, the key risks to the achievement of its objectives, and how it has performed during the year.

This overview includes detail of how the CCG has met its statutory duties to:

- Have regard to the need to reduce health inequalities
- Improve the quality of services
- Involve the public in commissioning activities and to explain the impact of that engagement activity

Quality and safety

Improving Quality

The CCG recognised its statutory duty to improve the quality of care that it commissioned under Section 14R of the Health and Social Care Act (2012). As reflected in the CCG's Corporate Priorities its ambition was to make sure that local people had access to the highest quality health and care services they needed, when they needed them: **Right Care, Right Place, Right Time.**

The Quality Assurance and Improvement Frameworks were refreshed on 1 April 2022 and remained integral to the CCG's internal governance arrangements for ensuring proactive oversight and monitoring of provider quality in line with the following domains:

Safe	People are protected from avoidable harm and abuse. When mistakes do occur lessons will be learnt and shared across the system to prevent recurrences wherever it is practicable to do so.
Effective	People's care and treatment achieve good outcomes, promote a good quality of life, and are based on the best available evidence.
Experience	*Caring:* Service staff support people to make informed decisions about their care and treatment and treat people with compassion, dignity, and respect. *Responsive and person-centred:* services respond to people's needs and choices, enabling them to be equal partners in their care.

In addition, the CCG also recognised the following additional domains as being essential if it was to ensure that the improvements in quality were sustainable.

Well-Led	Commissioners and providers are open, collaborate internally and externally, and are committed to learning and improvement.
Sustainable	Commissioners and providers will continue to work collaboratively to ensure resources are used responsibly and efficiently, providing equitable access to all, according to need, and promoting an open and fair culture.
Equitable and Inclusive	Commissioners and providers will work together to ensure inequalities in health outcomes are a focus for quality improvement, making sure the quality of care does not vary due to characteristics such as gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity, or marital or civil partnership status.

Clinical Governance

The Quality Sub-committee was comprised of representatives from across the locality's health and social care system and reported to the Wigan Borough Integrated Commissioning Committee (ICC). The Quality Sub-committee continued to meet during the quarter in compliance with its agreed terms of reference and received a range of quality assurance and improvement reports including Provider Quality and Safeguarding Group (QSG) Chairperson's Reports and quarterly reports for Quality, Safeguarding, and Continuing Healthcare.

Assuring the Quality of Commissioned Services

In this quarter the CCG continued to maintain quality oversight and monitoring of each of its main NHS providers: Wrightington, Wigan, and Leigh Teaching Hospitals NHS Foundation Trust (WWLFT) and Greater Manchester Mental Health NHS Foundation Trust (GMMHFT).

Oversight continued to be maintained via the Quality and Safeguarding Groups, the GMMHFT Quality and Performance Group, and the relevant contract groups. At the meetings evidence and assurance relating to specific quality and patient safety outcomes were received and discussed in detail with the provider, any gaps in assurances identified, and appropriate remedial actions and timescales agreed.

Quality Assurance and Improvement Frameworks were also agreed and put into place for the Independent Provider contracts including Wigan and Leigh Hospice and independent mental health hospitals.

Quality and Safety Metrics used by the CCG

In order to measure and monitor the quality improvements associated with its quality priorities, the CCG continued to ensure that national and local quality standards and priorities were accurately reflected within the contracts held with providers and that these standards were monitored effectively.

This was done by monitoring and reviewing a wide range of quality and safety metrics and by using the agreed Quality Assurance and Improvement Framework. This enabled the CCG to maintain effective oversight of the standards set out within the provider contracts.

Key measures were used as indicators for delivery against contractual quality requirements and improvements associated with the key priorities. These included,

but were not restricted to, Serious Incidents (inclusive of Never Events), mortality metrics, complaints, national benchmarks such as patient and staff survey results, workforce metrics including safer staffing performance, Care Quality Commission (CQC) reports, and intelligence from NHS England (NHSE) and any other key stakeholders.

Care Quality Commission

The borough's main NHS providers (WWLFT for acute and community services and GMMHFT for mental health services) continued to be rated by the CQC as 'Good' overall although GMMHFT is rated as 'Requires Improvement' in the 'Safe' domain. That provider has an agreed improvement plan in place. Oversight of the plan was via the CCG's Quality and Safeguarding Group (QSG) and the GMMHFT Commissioner-wide Quality and Performance Group.

There were 57 GP practices in the borough; six were rated as 'Outstanding' (10.5%) and 51 were rated as 'Good' (89.5%) overall. The intermediate care providers Richmond House and Alexandra Court were also rated by the CQC as 'Good' overall and 'Good' across all of the CQC's domains.

COVID-19 Response and Recovery

Following a significant period of secondment the CCG's Assistant Director for Infection Prevention and Control (IPC) was appointed to the post of Deputy Director of IPC at WWLFT.

IPC advice and support continued to be provided to Alexandra Court, the Wigan Borough COVID-19 designated care setting, to promote patient flow across the system in collaboration with local providers and Public Health colleagues.

IPC support and advice was also provided to GP practices, Wigan and Leigh Hospice, and Local Authority colleagues in response to COVID-19 variants and to assist with the interpretation and operationalisation of the frequently updated UK Health Security Agency and NHSE guidance.

In regards to the COVID-19 vaccination programme delivery the CCG's Quality Leads continued to support the development of new and updated processes, procedures, and resources to meet the changing national IPC requirements within the vaccination sites.

Due to the significant increase in waiting times for elective surgery as a direct consequence of the COVID-19 pandemic, the CCG sought assurances from providers that robust systems were in place to review people on waiting lists to ensure they were prioritised appropriately to prevent harms. Where harms were identified they were escalated, reported, and investigated to identify and share learning in line with the Trust's policy.

Learning from Serious Incidents and Never Events

The CCG continued to support providers to learn from Serious Incidents (SIs) and Never Events (NEs), and ensured robust challenge through the CCG Serious Incident and Never Events Panel and by attendance at the providers' Serious Incident Requiring Investigation Panel. Focused pieces of work included the prevention of hospital-acquired pressure ulcers, the recognition, escalation, and treatment of deteriorating patients, and patient harms as a direct result of treatment delays.

The CCG also continued to participate in the GMMHFT, NHS Bolton, NHS Manchester, and NHS Trafford CCGs' SI process to ensure a coordinated approach to the review of and learning from SIs in mental health services.

Suicide Prevention

The CCG continued to work directly with GMMHFT to ensure that lessons were robustly learnt from all suicides and cases of self-harm. The CCG's Quality Team was represented on the Wigan Borough Suicide Prevention Group and the CCG remained a member of the Zero Suicide Alliance.

Management of Healthcare Associated infections (HCAI)

The HCAI process continued but at a reduced pace due to the commitment required to respond to the COVID-19 pandemic and other priority areas. A background focus was maintained on all of the mandatory reportable infections: Clostridioides *difficile* (C.*difficile*); bloodstream infections (BSI) including meticillin resistant *Staphylococcus aureus* (MRSA); meticillin sensitive *Staphylococcus aureus* (MSSA) and Gram-negative blood stream infections; *Escherichia coli* (*E.coli*); *Klebsiella* species; and *Pseudomonas aeruginosa*.

Patient Safety Specialists

Patient Safety Specialists (PSSs) had been identified who had a lead role in regards to patient safety and acted as a source of expert advice and support. The PSSs continued to work collaboratively with the specialists from provider organisations locally, regionally, and nationally to share good practice and learning.

Mortality

The CCG continued to monitor mortality data such as the Summary Hospital Level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) and ensured robust challenge through provider QSG meetings. It is positive to be able to report that WWLFT remained within the 'expected range' for SHMI with a reported rate of 1.0794 in June 2022.

Quality Improvement in Primary Care

The CCG continued to support colleagues across the Primary Care Networks (PCNs). Examples of this include the support provided to the Lead Practice Nurses' development, the Practice Nurse and Health Care Assistants' Forums, clinical supervision for nursing staff within general practice, 'Enhancing Patient Safety – Significant Event Analysis' training, and the Primary Care Practice Nurse Newsletter.

Promoting Quality and Safety within Care Homes

The CCG Quality team continued to work collaboratively with Wigan Council and local providers to support quality improvement in care homes. This work included:

Service Improvement Plans (SIPs) where the CCG continued to work collaboratively with Wigan Council colleagues on the development, implementation, and monitoring of provider SIPs to support the required quality improvements in response to concerns identified through CQC inspections, complaints, and third party sources.

Implementation of the Restore2™//Restore2Mini™ which is a physical deterioration and escalation tool for care homes. The training for this programme was led jointly by Health Innovation Manchester and the CCG. The project commenced in January 2022 and rollout has continued through quarter one.

Service User Experience of Care

The CCG continued to review on a weekly basis service user experience data reported by general practice. Themes from the reports were shared with system colleagues and discussed at the provider QSG meetings. This data was triangulated with other quality data sources and provide an ‘early warning system’ that supported the identification of services that were deteriorating. Issues addressed in quarter one included discharge communications, patients’ experiences of urgent and emergency care services, and ‘askmyGP’.

Healthwatch Wigan & Leigh (HWW&L)

HWW&L works on behalf of local people to provide advice and guidance on health and social care services. The CCG Quality team had developed a close and positive working relationship with the HWW&L team and continued to work collaboratively to improve services and people’s experiences whenever they come into contact with health and care services. In quarter the CCG Quality Leads engaged with HWW&L to Improve Safe Discharge from Hospital as both were core members on WWLFT’s Discharge Improvement Group. The Quality team also supported the development and implementation of the new HWW&L Quality and Performance Report.

HWW&L continues to be represented on the local transformation programme boards which contribute to the delivery of the Wigan Locality Plan and the Wigan Deal 2030.

Reducing health inequalities

The CCG aimed to reduce inequalities in health outcomes and experience between patient groups by planning its strategic aims and working in partnership with Wigan Council and others to address the needs of protected groups as shown in the Joint Strategic Needs Assessment.

As a commissioner of health care, the CCG had a duty to ensure that all its local healthcare service providers were meeting their statutory duties under the Public Sector Equality Duty. As well as regular monitoring of performance, patient experience, and service access the CCG worked with providers to consider their progress on their equality objectives and the Equality Delivery System. Each provider organisation is subject to the specific duty and publishes its own data.

The CCG undertook face-to-face engagement in one of the more deprived areas of Wigan. 650 residents' households were spoken with and encouraged to be vaccinated, information was provided of the booking line number, and conversations were held to understand reasons for not being vaccinated. A local GP spoke at a Wigan Mosque to provide information about the vaccine and to answer any questions.

When the requirements of the COVID-19 lockdowns became apparent for all the population they presented a significant challenge for the homeless community and Wigan's local authority moved swiftly to temporarily rehouse everybody in the Mercure Hotel in central Wigan.

With most of the borough's homeless community temporarily residing in one place this offered the perfect opportunity to wrap service around them. The CCG approved a proposal for two GP practices situated in the Central Wigan Primary Care Network to provide an in-reach service to provide primary medical services to this population with the option of permanent registration and an enhanced health check.

Furthermore, due to other key services being located within the building, it was a great opportunity to establish holistic care planning in a more integrated way. Access to key services on the ground included Primary Care, Drug & Alcohol, Mental Health, Housing and Benefits, The Brick Charity, and Community Services such as District Nursing and Podiatry and Dental Services.

The learning gained from the pandemic is to be translated into a borough-wide integrated service offering for vulnerable people, including those who are deemed homeless, with the aim of addressing inequalities.

Engaging people and communities

The CCG had a legal duty to ensure the services it commissioned met the needs of the local population. It did this by engaging with and involving patients, carers, communities, and the wider public to make sure the commissioned services were responsive to need and delivered the best possible outcomes and standards of care.

From April to June 2022 the work of the CCG's Engagement team focused on supporting the transition from NHS Wigan Borough CCG to NHS Greater Manchester.

The team reported its patient and public involvement activity to both the Quality Committee and the Governance and Audit Committee on a regular basis. There were patient representatives on key groups including on the Primary Care Commissioning Committee.

Throughout these engagement and involvement activities the approach was to:

- Work with partners to do things once
- Go digital first for most, to free up time to reach out to those communities which experience the worst health inequalities
- Make the most of every contact
- Have continuous engagement and conversations with patients and residents
- Produce better information to support staff and patients
- Work closest with those from diverse, potentially excluded, and disadvantaged groups

During this quarter, the team continued to support the following groups and activities:

Equality Reference Group

The Equality Reference Group brought together community groups, individuals, and services. Together they reviewed equality impact assessments and programmes of work, and offered specific and tailored advice and information on how work would impact upon people with protected characteristics. This quarter the group reviewed plans for NHS Greater Manchester's work and for breast and bowel screening services.

Maternity Voices Partnership

The Maternity Voices Partnership (MVP) restarted its face-to-face activities, attending the National Play Day at Haigh Hall and bringing new parents together to discuss their experiences and services. The MVP was key this year in improving the information that was provided to people when they first find out that they are pregnant, including support services and community groups.

Wigan Borough Engagement Group

The Wigan Borough Engagement Group, bringing together patient group members, Trust Governors, and Healthwatch Wigan & Leigh, continued to meet monthly, offering advice and support to help the Engagement team plan for the transition of

engagement functions to the new organisation. The Group was instrumental in supporting the development of a Healthier Wigan Partnership engagement event with residents and the third sector about how the CCG engaged as it moved into the Integrated Care System (ICS).

The event, delivered in partnership with Healthwatch Wigan & Leigh, brought together over 120 people and partners, including senior leaders from across the Borough, to discuss how the ICS will engage in the future. Attendees highlighted the need for a culture of openness, transparency, and equal partnership between services, residents, and the third sector. The 'Ten Principles of Engagement' as set out by NHSE were discussed. It was considered important that this event was accessible and so two BSL sign language interpreters were engaged, information was provided in easy read format, and a quiet space was made available for prayer or for those in need of space away. This work will be followed up by further engagement across the Borough.

Big Conversation

To support the development of a People and Communities Strategy for NHS Greater Manchester, a 'Big Conversation' was held across Greater Manchester utilising an online survey. Within the Borough this was promoted across networks through the Shape Your NHS community group, Healthwatch volunteers and members, and local Trust Governors and members. Wigan saw the largest response rate across Greater Manchester with over 300 responses.

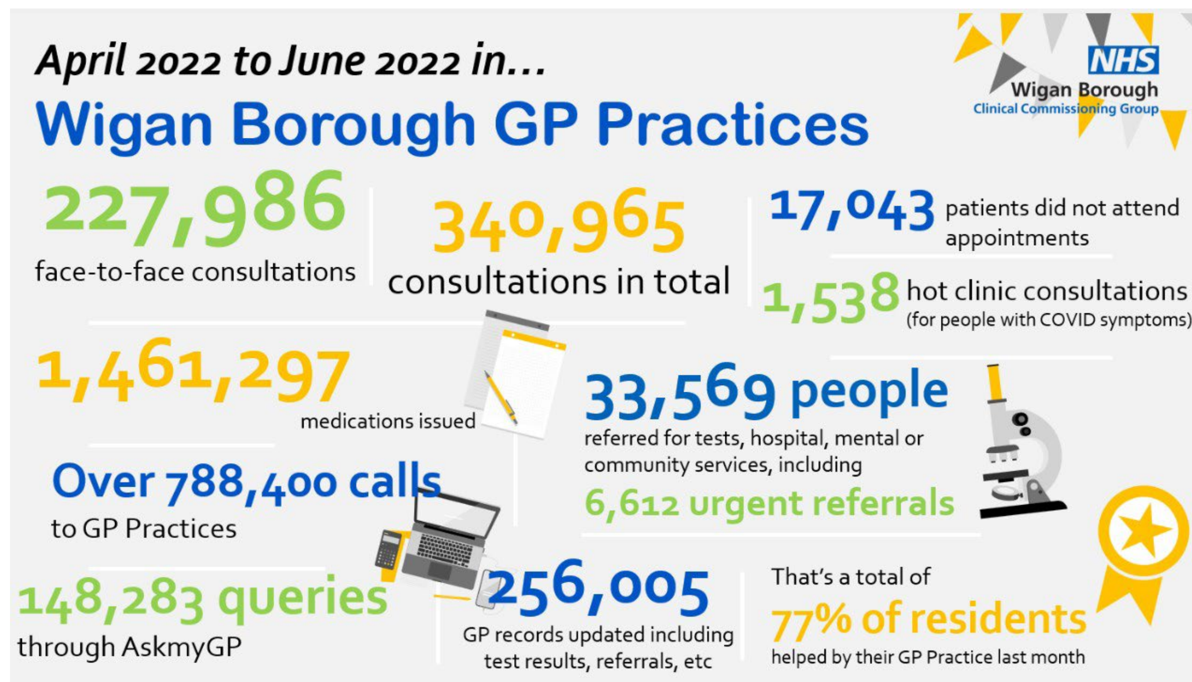
Shape Your NHS Community

The team continued to promote and engage with the Shape Your NHS Community sending regular newsletters about engagement opportunities and services to hundreds of people who signed up to be involved. The newsletter is sent predominantly by email but was posted to those who preferred to receive it physically.

As the CCG transitioned its approach was focused on working in partnership with the Healthier Wigan partners and the other localities across Greater Manchester. The focus was on continuing to reach into communities, working with the voluntary sector and community leaders to help improve services and reduce health inequalities. The immediate local focus included diabetes services and children's services with specific engagement on Special Educational Needs services for those aged under 25 years.

General Practice and Primary Care Networks

General Practice in the Borough had a busy quarter with some of the key activities and achievements shown in the following infographic:



Health and Wellbeing Strategy

The ambition of the Wigan Health and Wellbeing Board (HWBB) is to transform the health, social care, and wellbeing system and its outcomes through working together with partners in a mutually respectful way. The HWBB had 16 voting members; six from the CCG including the Joint Chair, eight from the Council, one GP representative, and one from Healthwatch Wigan. In this way the CCG demonstrated its active contribution to the delivery of the health and wellbeing strategy.

Since its establishment the HWBB set out to make a real difference to improving the health and wellbeing of the people of the Wigan Borough. This meant taking action to deliver practical improvements and change that residents can perceive and appreciate, and that narrow the health inequalities gap within the borough and in comparison with other parts of the country.

In September 2021 Prof. Craig Harris took a forward plan to the HWBB outlining how its objectives would be achieved and how it would frame its agenda in a systematic way using the following categorisation:

- Transforming population health and addressing wider determinants of dependency and inequality
- Transforming health and social care systems
- Protecting population health and safeguarding the vulnerable

The HWBB's priorities and objectives were set out as:

- Develop and ensure the continuous review of population and neighbourhood level data to understand the Wigan Borough story, and residents' and patients' experiences, to enable the creation of a high-level strategy and plans to support positive population health outcomes
- Develop a high-level 'Joint Health and Wellbeing Strategy' based on an analysis of need that spans the NHS, social care, and public health and considers how to secure influence on the wider determinants of health, wellbeing, and health inequalities. The partnership will contribute to work to improve the overall health of the people of Wigan Borough, whilst striving to reduce the inequalities in life expectancy that exist in the borough
- Agree the investment framework for joint commissioning and pooled budget arrangements, in order to secure whole system transformational change in service provision and planned, targeted, and preventative services. The HWBB will ensure there is a clear alignment between the objectives and priorities of the HWBB, Wigan Locality Plan, and the Council's Corporate Strategy, 'The Deal 2030', and the Commissioning Intent of NHS Wigan Borough CCG
- Hold the system to account for the delivery of the Wigan Locality Plan through oversight of the wider health and care governance and programmes

- Ensure the commissioning activities of NHS England (Primary Care and Specialised Commissioning) and Public Health England Greater Manchester are making a contribution to the agreed Health and Wellbeing Strategy and the strategic intent of local partners
- Respond to national and Greater Manchester consultations on any proposed changes to the health and care system, ensuring that they meet the needs of Wigan residents
- Support the development of integrated working arrangements across providers and commissioners to improve services to the residents of Wigan, such as Healthier Wigan Partnership, and oversee the transition arrangements and local implementation of the legislative changes for health and care
- Enable wider place-based initiatives relevant to the achievement of the objectives of the Health and Wellbeing Strategy to be shared, agreed, and implemented by all partners at scale
- Establish and disestablish task and finish groups that are necessary to pursue and deliver the objectives of the Health and Wellbeing Strategy and receive reports on the work of the groups as required
- Continue to develop and publicise its ambitions for health and wellbeing in the Wigan borough, assuring itself that the underlying measures are in place to actively performance manage progress on key indicators

Performance against national standards

The CCG was required to measure its performance against a number of national and local indicators. The operational standards monitored are defined in the NHS Constitution. The NHS Constitution brings together details of what patients, the public, and staff can expect from the NHS.

COVID-19 IMPACT

NHS services had to change significantly to meet the challenges of COVID-19. During the first wave of the COVID-19 pandemic in the spring of 2020, almost all routine elective surgery was paused resulting in delays to referrals, screenings, tests, and appointments. During April to June 2022 elective care was prioritised to ensure people with urgent medical conditions, including cancer, were still seen and treated. As a result of this and subsequent waves of COVID-19, there was an increase in the numbers of patients waiting for hospital treatment. The CCG worked with NHS and independent sector providers to develop plans for the full recovery of elective services and a reduction in the number and length of waits.

URGENT CARE ATTENDANCES

During the period April to June 2022 the volume of Type 1 A&E attendances at Royal Albert Infirmary increased to being above the levels seen pre-COVID-19; the daily average number of attendances was 282. In comparison to the last year before COVID-19 the daily average number of attendances were 14% higher than those between April and June 2019 (247). When comparing with the same period last year, the daily average number of attendances were almost 6% lower than those in April to June 2021 (299).

REFERRAL TO TREATMENT (RTT) WAITING TIMES

During the pandemic non-urgent planned care was de-prioritised to focus on urgent and critical conditions and procedures. This resulted in an increased backlog of people waiting to start treatment and longer waiting times. As of the end of June 2022, there were 43,776 people waiting for treatment in comparison with June 2021 when 33,671 people were waiting for treatment. In addition, 1,865 people were waiting longer than 52 weeks at the end of June 2022 in comparison with June 2021 when 1,960 people were waiting longer than 52 weeks.

DIAGNOSTIC ACTIVITY AND WAITING TIMES

Diagnostic test activity and waiting times have been impacted by the COVID-19 pandemic. As at the end of June 2022 the number of patients waiting was 8,505 with 2,040 waiting longer than six weeks, in comparison with June 2021 when 7,856 patients were waiting with 1,253 waiting longer than six weeks.

CANCER ACTIVITY AND TREATMENTS

The number of patients seen following an urgent GP referral for suspected cancer were above the levels seen pre-COVID-19. During the period April to June 2022 a monthly average of 1,460 patients were seen compared with the monthly average (1,243) during April to June 2021. In addition, the number of patients receiving their first definitive treatment following a GP referral were also above the levels seen pre-COVID-19. During the period April to June 2022 a monthly average of 99 patients were treated compared with the monthly average of 70 during April to June 2021.

MENTAL HEALTH: IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT) TREATMENTS

Since the start of COVID-19 there had been widespread concern about the impact of the pandemic and lockdown measures on mental health. Mental health services continued to work hard to ensure that people could receive the care they needed. During the period April to May 2022 the monthly average number of patients who received their first IAPT treatment was 763, in comparison with the same period last year (April to May 2021) when the monthly average was 750.

PEOPLE WITH A LEARNING DISABILITY AND AUTISTIC PEOPLE

The CCG continued to work collaboratively with system partners to support people with a learning disability and autistic people in Wigan, overseen by the Borough's Learning Disability Partnership Board which is informed by the local needs assessment. Good progress was made between April and June 2022 towards achieving the annual target for the number of people with a learning disability receiving an annual health check and health action plan. Work also continued to reduce reliance on inpatient care for adults, children, and young people, maintaining relatively low numbers of people with a learning disability and / or who are autistic being cared for in inpatient units. Where people were receiving inpatient care, there was a focus on making sure that they were receiving high quality care.

COVID-19 VACCINATIONS

The NHS COVID-19 vaccination programme has continued to take place in key locations throughout the Wigan Borough. As of 3 July 2022 the total number of vaccines administered to Wigan residents was 671,359. Of these, 249,792 were first doses, 237,149 were second doses, and 184,418 were booster doses.

The older population, along with others considered extremely vulnerable, were the first to be offered vaccinations. Of Wigan residents over the age of 70 years, 97% have received their first dose, 97% have received their second dose, and 94% have received their booster dose. Considering the wider population over the age of 12 years, 84% have received their first dose, 81% have received their second dose, and 63% have received their booster dose.

Key issues and risks

The Governing Body Assurance Framework (GBAF) was the means of identifying and quantifying strategic risks within the organisation and was the means by which the Governing Body monitored and controlled the risks which may have impacted upon the organisation's capacity to achieve its objectives.

The GBAF identified the corporate priorities of the organisation and the principal risks related to the delivery of these objectives. Key controls were made explicit together with the assurances on these controls. In addition, the GBAF identified linkages with interrelated areas of assurance.

The GBAF and the monthly performance report were the two primary tools used by the Governing Body to measure and monitor the CCG's performance.

The GBAF was presented to the Governing Body on a quarterly basis and was usually submitted following presentation to the Governance and Audit Committee which fulfilled its role by focusing on risks, controls, gaps in control, and resultant action plans.

The Annual Governance Statement within the Accountability Report section below provides more detail on the risks that the CCG faced in the year and how these were managed.

Financial review

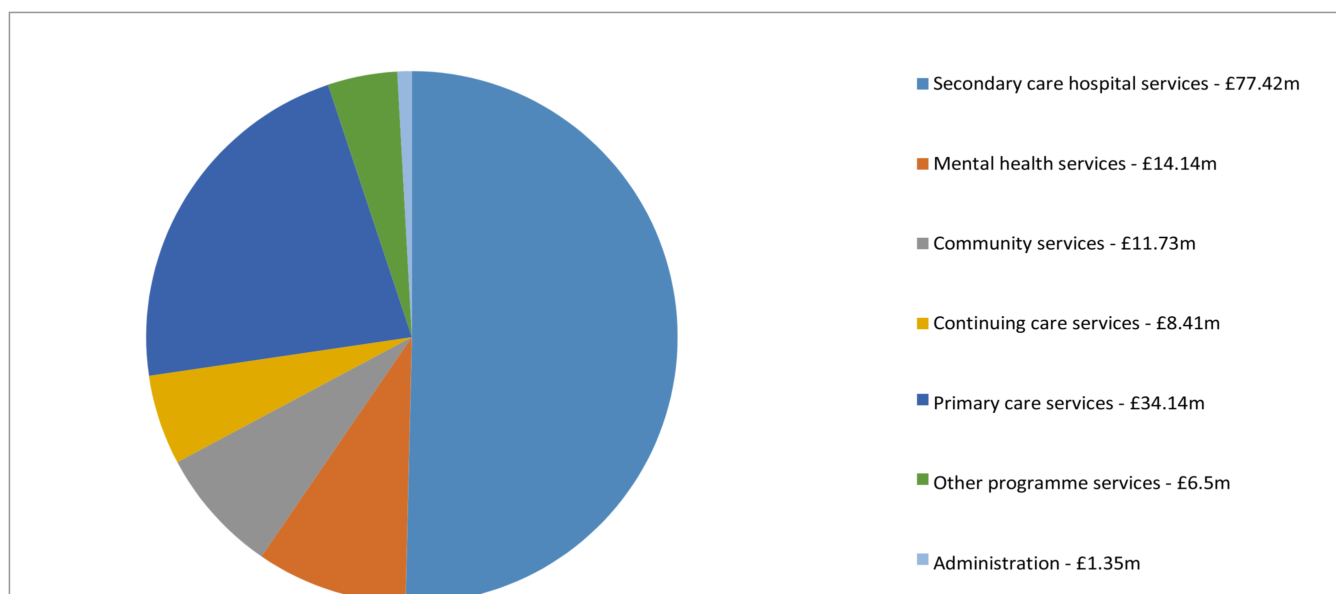
CCGs had a number of financial duties under the National Health Service Act 2006 (as amended). The CCG met all of its statutory financial duties in the period 1 April to 30 June 2022, and its financial control total as set by NHSE and the Greater Manchester Health and Social Care Partnership.

As the local leader of NHS services in Wigan Borough, the CCG:

- Achieved operational financial balance
- Achieved its cash target
- Maintained the costs of CCG administration below its budget of £1.35m
- Spent £153.7m in the period on healthcare services for the population of Wigan Borough
- Invested in mental health services to meet national investment standards

The areas of total CCG expenditure are shown in the following graphic:

Chart: CCG expenditure 1 April to 30 June 2022



Secondary care services provided by NHS hospitals such as accident and emergency, maternity, general medicine, and surgery represented almost half of the CCG's expenditure. Such services provided by independent hospitals and accessed by residents are also included as are the costs for ambulance services.

The CCG was also responsible for commissioning £34.14m of primary care services from NHSE's delegated budgets. These included payments to local GP practices for General Medical Services, Personal Medical Services, and Alternative Provider Medical Services contracts, performance under the Quality and Outcomes Framework, and enhanced services commissioned for Wigan Borough patients.

The category of 'Community Health Services' includes the cost of the services provided in a community setting or in patients' own homes, such as District Nurses, Therapists, and community clinics. The contract costs for the Out of Hours service and Walk-In Centre are also included here.

Mental Health services include the costs of providing Mental Health and Learning Disability support within the Borough including psychological therapies (counselling services) and inpatient medical care for patients with mental health conditions.

Another area of significant investment on behalf of residents was in Continuing Healthcare (CHC), which are packages of medical care arranged and funded solely by the NHS for the most vulnerable patients. These can be delivered in any setting and can include the full cost of a place in a nursing home if the needs of the patient meet a rigorous set of criteria. The CCG had a considerable number of residents who met these criteria and had been assessed as eligible for fully funded NHS care, which the CCG paid for and monitored; in this three month period this amounted to £8.41m. The CCG was also responsible for Funded Nursing Care for those patients who did not meet the CHC criteria but still required nursing care when in a care home environment.

'Other programme services' includes the £6.5m that the CCG invested in conjunction with Wigan Council to the nationally mandated Better Care Fund as well as the costs of paying for clinical premises and the NHS 111 service.

Environmental Matters

The CCG implemented the principles of sustainable development and worked with other organisations and the public in the Wigan Borough in a collaborative approach.

The CCG reduced its carbon footprint by:

- Planning and buying sustainable services
- Making sure it did not waste energy or supplies
- Implementing a Green Travel plan
- Making sure that Governing Body members and staff were aware of the importance of sustainability
- Adapting to the changing environmental, social, and financial climates
- Making sure it had plans in place to deal with adverse events such as flooding and power failures
- Advising on procurement and disposal of pharmaceuticals
- Assessing its performance on sustainability
- Embracing smarter working which can improve patient experience, clinical effectiveness, and reduce carbon and waste

The CCG also monitored the performance of its providers through contract management protocols. The NHS standard contract requires providers to report performance against their carbon reduction management plans.

Performance Report

Mark Fisher
Accountable Officer
21 June 2023

SECTION 2:

ACCOUNTABILITY REPORT

Accountability Report

The Accountability Report describes how the CCG met key accountability requirements and embodied best practice to comply with corporate governance norms and regulations.

It comprises three sections:

- The **Corporate Governance Report** sets out how the CCG governed the organisation during the period 1 April to 30 June 2022 including the membership and the organisation of the governance structures and how they supported the achievement of objectives
- The **Remuneration and Staff Report** describes its remuneration policies for executive and non-executive directors including salary and pension liability information. It also provides further information on workforce, remuneration, and staff policies
- The **Parliamentary Accountability and Audit Report** brings together key information to support accountability including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate

Corporate Governance Report

This section of the Annual Report enables the CCG to meet key accountability requirements to Parliament. In this section you will find the Corporate Governance Report, which includes:

- The Members' Report
- The Statement of Accountable Officer's Responsibilities
- The Governance Statement.

Members' Report

The CCG was formed of 57 member GP practices. The following shows the practices that made up the membership of the CCG.

Hindley Service Delivery Footprint

Alexander House Surgery, Platt Bridge Health Centre, Rivington Avenue, Platt Bridge, Wigan

Rivington Surgery (SSP Health Ltd), Platt Bridge Health Centre, Rivington Avenue, Platt Bridge, Wigan

Dr Tun & Partners, Hindley Health Centre, 17 Liverpool Road, Hindley, Wigan

Dr Ullah's Practice, Platt Bridge Health Centre, Rivington Avenue, Platt Bridge, Wigan

Higher Ince Surgery (SSP Health GPMS Ltd), Manchester Road, Ince-in-Makerfield, Wigan

Lower Ince Surgery (SSP Health GPMS Ltd), Claire House, Lower Ince Health Centre, Phoenix Way, Lower Ince, Wigan

Pennygate Medical Centre, 109 Ladies Lane, Hindley, Wigan

Leigh Service Delivery Footprint

Brookmill Medical Centre, College Street, Leigh

Foxleigh Surgery, Bridgewater Medical Centre, Henry Street, Leigh

Grasmere Surgery, Leigh Health Centre, The Avenue, Leigh

Leigh Family Practice (SSP Health Ltd), Bridgewater Medical Centre, Henry Street, Leigh

Leigh Sports Village Practice (SSP Health Ltd), Leigh Sports Village, Leigh

Lilford & Pennington Park Surgery, Leigh Health Centre, The Avenue, Leigh

Old Henry Street Medical Practice, Henry Street, Leigh

Premier Health, Bridgewater Medical Centre, Henry Street, Leigh

The Avenue Surgery (Dr Esa Surgery Ltd), Leigh Health Centre, The Avenue, Leigh

Westleigh Medical Centre, 4-12 Westleigh Lane, Westleigh, Leigh

LIGA Service Delivery Footprint

Ashton Medical Centre (SSP Health GPMS Ltd), 120 Wigan Road, Ashton-in-Makerfield, Wigan

Braithwaite Road Surgery (SSP Health GPMS Ltd), 36 Braithwaite Road, Lowton, Warrington

Bryn Street Surgery (SSP Health Ltd), Ashton Health Centre, Queens Road, Ashton-in-Makerfield, Wigan

High Street Medical Practice, Kidglove House, Golborne Health Centre, Kidglove Road, Golborne

Modern Avenue (SSP), Kidglove House, Golborne Health Centre, Kidglove Road, Golborne

Dr Shahbazi Family Medical Practice, Kidglove House, Golborne Health Centre, Kidglove Road, Golborne

Lowton Surgery (SSP), 208c Newton Road, Lowton, Warrington

Slag Lane Medical Centre, 216 Slag Lane, Lowton, Warrington

North Wigan Service Delivery Footprint

Aspull Surgery, Haigh Road, Aspull, Wigan

Beech Hill Medical Practice, 278a Gidlow Lane, Beech Hill, Wigan

Shevington Surgery, Houghton Lane, Shevington, Wigan

Standish Medical Practice, 49 High Street, Standish, Wigan

SWAN Service Delivery Footprint

Bryn Cross Surgery, 246 Wigan Road, Ashton-in-Makerfield, Wigan

Kumar Family Practice, Chandler House, Worsley Mesnes Health Centre, Poolstock Lane, Wigan

The Grange Practice, Chandler House, Worsley Mesnes Health Centre, Poolstock Lane, Wigan

Hawkley Brook Medical Practice, Chandler House, Worsley Mesnes Health Centre, Poolstock Lane, Wigan

Marus Bridge Practice, Chandler House, Worsley Mesnes Health Centre, Poolstock Lane, Wigan

Medicentre, Ashton Health Centre, Ashton-in-Makerfield, Wigan

Shakespeare Surgery (Shakespeare Surgery Ltd), Chandler House, Worsley Mesnes Health Centre, Poolstock Lane, Wigan

Winstanley Medical Centre, Holmes House Avenue, Winstanley, Wigan

TABA+ Service Delivery Footprint

Astley General Practice (SSP Health GPMS Ltd), 391a Manchester Road, Astley

Bee Fold Lane Surgery (SSP), Bee Fold Lane, Atherton

Boothstown Medical Centre, 239 Mosley Common Road, Boothstown

Coldalhurst Lane Surgery, The Surgery, 1 Coldalhurst Lane, Astley

Dr K.K. Chan, & Partners, Seven Brooks Medical Centre, 21 Church Street, Atherton

Dr Vasanth & Partner, Bag Lane Surgery, Atherton Health Centre, Nelson Street, Atherton

Elliott Street Surgery, 145 Elliott Street, Tyldesley

Meadow View Surgery, Atherton Health Centre, Nelson Street, Atherton

Poplar Street Surgery, Tyldesley Health Centre, Poplar St, Tyldesley M29 8AX

The Surgery, Astley, 10 Higher Green Lane, Astley

The Surgery, Tyldesley, High Street, Tyldesley

Wigan Central Service Delivery Footprint

Bradshaw Medical Practice, Bradshaw Street, Wigan

Dicconson Group Practice, Boston House, Wigan Health Centre, Frog Lane, Wigan

Longshoot Medical Practice, Scholes, Wigan

Marsh Green Medical Practice (SSP Health Ltd), Harrow Road, Marsh Green, Wigan

Mesnes View Surgery, Mesnes Street, Wigan

Newtown Medical Practice, Sherwood Drive, Wigan

Pemberton Surgery, Sherwood Drive, Wigan

Sullivan Way Surgery, Sullivan Way, Scholes, Wigan

Wrightington Street Surgery, Wrightington Street, Wigan

The Governing Body

The Governing Body oversaw the decisions that the CCG made about local health services, ensuring its activities met the best standards of quality for the local population. The members of the Governing Body as at 30 June 2022 are shown below.

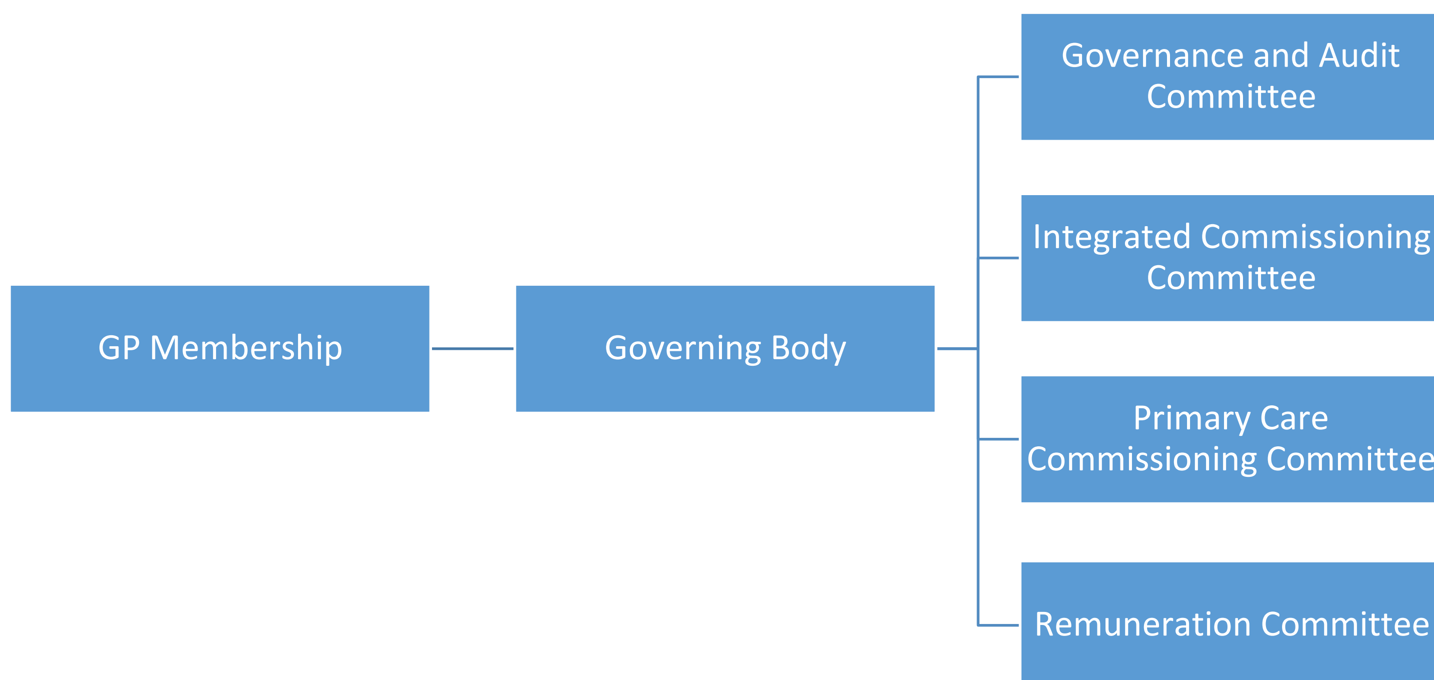
Governing Body Members:

- Dr Tim Dalton, Chair
- Professor Craig Harris, Managing Director and Accountable Officer
- Mr Paul McKevitt, Chief Finance Officer
- Dr Gen Wong, Clinical Executive
- Dr Jayne Davies, Clinical Executive
- Dr Adam Jolles, Clinical Executive
- Mr Frank Costello, MBE, Lay Member with responsibility for Transformation and Innovation (Deputy Chair); Other Responsibility: Covering vacant post for Lay Member with responsibility for Patient and Public Engagement and Inclusivity
- Mr Peter Armer, Lay Member with responsibility for Financial Management, Audit, Governance, and Conflicts of Interest.
- Professor Marios Adamou, Secondary Care Clinician Governing Body Member
- Ms Morag Olsen, Executive Nurse Governing Body Member

CCG Committee Structure

The Governing Body was supported by a robust committee structure; this is illustrated in the following diagram.

CCG Governance Structure



Within this structure, consistent with governance best practice, each committee had a robust set of terms of reference describing its membership and the scope of its authority and had a detailed work programme. These terms of reference were reviewed at least annually and amended in respect of the evolving needs of the CCG. As part of the review of each committee's work, a record of attendance of the committee's membership was maintained. These records of attendance may be found later on in this report.

Governing Body

In April 2013 the GP membership of the CCG established a Governing Body in order to undertake the business of the CCG and to discharge its statutory functions. Membership of the Governing Body was in line with statute and was representative of the membership through the elected neighbourhood clinical executives.

The main function of the Governing Body was to ensure that the CCG had 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.

The Governing Body had a membership of ten voting members including the Chair and was clinically led with a majority of clinicians as members. The clinical executive members were practising GPs within the CCG area and GP members were either on the performers list for Wigan Borough or the subsequent arrangements.

Highlights of the work of the Governing Body over the period:

- Review of the draft Constitution of the NHS Greater Manchester Integrated Commissioning Board
- Reviewed the Governing Body Assurance Framework
- Received a due diligence assurance report on closedown and transition
- Received the Chair's report from the Governance and Audit Committee
- Approved the Section 75 Agreement and Pooled Budget arrangements for 2022 / 23
- Received the Governing Body closedown statement

Governance and Audit Committee

The Governance and Audit Committee reviewed the establishment and maintenance of an effective system of integrated governance, financial oversight, internal control, and risk management across the whole of the CCG's activities (both clinical and non-clinical) that supported the achievement of the corporate priorities.

Highlights of the work of the Governance and Audit Committee over the period:

- Received assurance reports on CCG closedown and transition
- Received the Internal Audit Progress Report
- Received the External Audit Progress Report
- Received the Anti-fraud Progress Report and the Counter Fraud Functional Standards return
- Reviewed the revised Gifts and Hospitality policy
- Received the Governing Body Assurance Framework
- Received updates on Human Resources, Communications and Engagement, Information Governance, Information Management and Technology, and Corporate Governance
- Approved the Annual Report and Accounts 2021 / 22
- Received the Head of Internal Audit Opinion
- Received the Internal Auditors' Transition Review final briefing note
- Received the handover report from the committee to Greater Manchester Integrated Care

Integrated Commissioning Committee

The Committee, along with the Health and Wellbeing Board and the HWP Alliance Board, led local developments within the context of the Greater Manchester

Integrated Care System and the emerging Greater Manchester Operating Model, ensuring strong connectivity and alignment with the Locality Operating Model.

Highlights of the work of the Integrated Commissioning Committee over the period:

- Received a refresh of the locality plan
- Received a presentation on the System-wide Patient Flow and Discharge Transformation programme 'Better at Home'
- Received an update on the Community Services Transformation programme
- Received the Borough Performance report
- Received a report on the Greater Manchester Budget Alignment
- Received a report on the CCG Closedown
- Accepted a report on the locality budget

Primary Care Commissioning Committee

The Committee was established in accordance with statutory provisions to enable the members to make collective decisions on the review, planning, and procurement of primary care services in the borough of Wigan, under delegated authority from NHS England. The majority of members were drawn from existing lay members and executive officers of the Governing Body. The operation of the Committee was consistent with NHSE guidance.

Highlights of the work of the Primary Care Commissioning Committee over the period:

- Received updates on the Primary Care Commissioning Programme, on the Primary Care Quality Improvement Programme, on the Primary Care Infrastructure Programme, and on Finance
- Received the Primary Care Commissioning Committee CCG Closedown report
- Approved Locally Commissioned Service specifications for:
  - Gynaecology service
  - Ring pessary
- Approved the practice merger of Higher Ince and Lower Ince
- Approved the Enhanced General Practice Service Specification 2022 / 23

Remuneration Committee

The Remuneration Committee was established to:

- Exercise delegated authority on behalf of the CCG's Governing Body to set remuneration, fees and other allowances for employees and for other people working on behalf of the CCG who were not employed on Agenda for Change terms and conditions which included clinical leads and / or others on contracts for / of services or office holder agreements

- Make recommendations to the CCG's Governing Body on the allowance under any pension scheme that the group may have established as an alternative to the NHS pension scheme.

Highlights of the work of the Remuneration Committee over the period:

The Remuneration Committee did not meet during the period.

Annual Review of Committee Effectiveness

The CCG acknowledged that it is consistent with good governance practice for the committees of the Governing Body to undertake an effectiveness review; doing so ensures that the committees promoted a cycle of continuous improvement.

These annual reviews considered the committees' functioning and their work in discharging their responsibilities, delivering their objectives, and complying with their terms of reference.

During this three month period no such annual reviews were undertaken.

Register of interests

In order to demonstrate that the CCG was operating with due transparency in its decision-making in accordance with its Conflicts of Interest Policy all Governing Body members, CCG staff, committee members, and any other individuals involved in the CCG's decision-making processes were required to make an annual declaration of interests. These declarations were updated whenever an individual's situation subsequently changed during the year.

This is a link to the register of interests.

Personal data related incidents

There were no data security (information governance) related incidents at NHS Wigan Borough CCG which required reporting to the Information Commissioner's Office during this reporting period.

Modern Slavery Act

NHS Wigan Borough CCG fully supported the Government's objectives to eradicate modern slavery and human trafficking but did not meet the requirements for producing an annual Modern Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group (CCG) shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England appointed the Managing Director to be the Accountable Officer of NHS Wigan Borough 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 CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- For safeguarding the CCG's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- The relevant responsibilities of accounting officers under Managing Public Money
- Ensuring the CCG exercises its functions effectively, efficiently, and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended))
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England directed each CCG 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 CCG 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
- Prepare the accounts on a going concern basis
- Confirm that the Annual Report and Accounts as a whole is fair, balanced, and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced, and understandable.

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

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Greater Manchester'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

NHS Wigan Borough CCG was a body corporate established by NHS England on 1 April 2013 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 population.

Between 1 April 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 (as amended).

Scope of responsibility

The Accountable Officer had the responsibility for maintaining a robust system of internal control that supported the achievement of the CCG's corporate responsibilities, 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 CCG was administered properly and economically and that resources were applied efficiently and effectively, safeguarding financial propriety and regularity. In addition they had responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

Governance arrangements and effectiveness

The 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 D8elegation which was within its governance handbook.

The member practices were organised to work together in neighbourhood models (Primary Care Networks) to deliver some of the CCG's responsibilities. This structure was an essential vehicle for the delivery of the CCG's business and was seen as a

conduit between the practices, the Governing Body of the CCG, and the wider partners. They were an essential engagement forum for both GPs, practice staff, patients, and the people of Wigan.

In April 2013 the GP membership of the CCG established a Governing Body in order to undertake the business of the CCG and to discharge its statutory functions. The membership of the Governing Body was in line with statute and was representative of the membership through the elected neighbourhood clinical executives.

The main function of the Governing Body was to ensure that the CCG had 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.

The Governing Body had a membership of eleven voting members including the Chair and was clinically led with a majority of members being clinicians. The clinical executive members were practising GPs within the CCG area and GP members were on the performers list of Wigan Borough or the subsequent arrangements. The Governing Body membership comprised:

a) the Chair
b) three neighbourhood clinical executives elected by and representing all seven groups of member practices
c) three Lay Members:
- one leading on financial management, audit, governance, and conflicts of interest
- one leading on transformation and innovations including the annual QIPP programme
- there was a vacancy for the third lay member who would lead on Patient and Public Engagement and Inclusivity
d) one Registered Nurse
e) one Secondary Care Clinician
f) the Accountable Officer
g) the Chief Finance Officer

The Governing Body met twice during this three month period. A minimum of two thirds (67%) of members and at least two of the three neighbourhood clinical executives needed to attend for meetings to be quorate. The quorum was achieved at both meetings to enable decisions to be made.

It was crucial that any interest or involvement in the local healthcare system did not also involve a vested interest in terms of financial or professional bias towards or against particular solutions or decisions. For this reason the CCG demanded that GP members, Governing Body members, officers, and those wishing to provide services to the CCG declared any actual conflict or potential conflict in relation to a decision to be made by the Group, and these were recorded in published registers.

The CCG's Constitution was not subject to any amendments during this period.

UK Corporate Governance Code

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

Discharge of Statutory Functions

The CCG reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the CCG was clear about the legislative requirements associated with each of the statutory functions for which it was responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power was clearly allocated to a lead Director. Directorates had confirmed that their structures provided the necessary capability and capacity to undertake all of the CCG's statutory duties.

Risk management arrangements and effectiveness

The CCG recognised that risk management is an integral part of good management practice and the content of the CCG's risk management arrangements replicated best practice principles.

Capacity to handle risk

The key elements of the CCG's risk management framework were:

- the Governing Body
- the Committees of the Governing Body
- CCG Senior Leadership team
- Governance and Quality teams
- Operational and department teams
- Risk Management Strategy and Policy
- Governing Body Assurance Framework (GBAF)
- Directorate and department risk registers

The GBAF was a means of identifying and quantifying strategic risks within the organisation and was the means by which the Governing Body monitored and controlled the risks which might have impacted on the organisation's capacity to achieve its objectives.

The GBAF identified the corporate priorities of the organisation and the principal risks related to the delivery of these objectives. Key controls were made explicit together with the assurances on these controls. In addition, the GBAF identified linkages with interrelated areas of assurance.

The GBAF and the monthly Performance report were the two primary tools used by the Governing Body to measure and monitor the CCG's performance. The GBAF was presented to the Governing Body quarterly and was usually submitted following presentation at the Governance and Audit Committee which fulfilled its role by focusing on risks, controls, gaps in control, and resultant action plans.

The CCG defined acceptable risk following risk assessment as follows:

- The likely consequences were insignificant
- A higher risk consequence was outweighed by the chance of a much larger benefit
- The likelihood of occurrence was remote
- The potential financial costs of minimising the risk outweighed the cost consequences of the risk itself
- Mitigation of the risk could lead to further unacceptable risks in other ways

It was therefore possible that a risk with a high rating might have been acceptable to the organisation, but that decision was reserved to the Governing Body or Senior Management. The risk appetite was also represented by a numerical value and referred to as the 'target risk' in the GBAF.

In addition to the GBAF (containing those risks assessed as high or extreme) there were a number of operational risk registers managed at Assistant Director level focusing on risks assessed as medium or low.

Risk assessment

Of the nine risks included in the GBAF at the end of the period one was rated extreme. This was:

Risk seven: If a solution is not found to the shortage of dermatology consultants, patients will not receive an appropriate standard of care. The rating for this risk had been increased to 20 during quarter one.

Other sources of assurance

Internal Control Framework

The system of internal control was the set of processes and procedures in place in the CCG to ensure it delivered its policies, aims, and objectives. It was 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 allowed risk to be managed to a reasonable level rather than eliminating all risk; it could therefore only provide reasonable and not absolute assurance of effectiveness.

The control environment within the CCG was established and led by the Governing Body which reserved powers for itself and delegated powers to its committees and officers of the CCG. These controls were described in the CCG's Constitution and included the Standing Orders, the Scheme of Reservation and Delegation, and the Prime Financial Policies. Internal controls operated over the strategic, planning, organisational, monitoring, measuring, and improvement elements of the management cycle. The Governing Body received assurance that the organisation and commissioned providers were meeting the defined set of standards across domains of performance, safety, quality, and patient experience through the Performance report. These reports provided detailed information on performance in key areas of activity commissioned by the CCG.

The Prime Financial Policies were part of the CCG's control environment for managing the organisation's financial affairs. They contributed to good corporate governance, internal control, and the management of risks. They reduced the risk of irregularities and supported the commissioning and delivery of effective, efficient, and economical services. They also helped the Accountable Officer and Chief Finance Officer to perform their responsibilities effectively. They were used in conjunction with the Scheme of Reservation and Delegation.

The above control environment was underpinned by an extensive portfolio of Human Resources policies which provided, in considerable detail, instructions to members, staff, and contractors how to carry out their duties as well as providing guidance on conduct and behaviour conducive to effective and efficient working.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2017) required the CCG to be subject to an annual internal audit of its management of conflicts of interest. To support CCGs to undertake this task, NHSE published a template audit framework.

The CCG's internal auditors did not undertake an annual internal audit review of conflicts of interest during this quarter. A review was most recently carried out in 2021 / 22 and provided an assessment of 'substantial assurance'.

Freedom to speak up (whistleblowing)

The CCG was committed to ensuring the highest possible standards of service and the highest possible ethical standards in delivering this service. It was the responsibility of all staff to ensure that, if they became aware that the actions of other employees or officers of the CCG or anyone working for, with, or connected to it might compromise this objective, they would be expected to raise the matter.

The CCG's Whistleblowing Policy was endorsed by the Staffside forum and the Governance and Audit Committee. Prior to this it was reviewed by the Anti-Fraud Specialist employed by Mersey Internal Audit Agency and it was then rolled out to all staff by internal communication and posted on the CCG's intranet.

Data quality

Following delegation by the Governing Body the Integrated Commissioning Committee (ICC) received at each of its meetings performance and finance reports which detailed finance and operational performance. The data contained in the reports were subject to significant scrutiny and review, both by management and by various Governing Body committees. The Governing Body through the ICC was confident that the information with which it was presented had been through appropriate review and scrutiny.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal data. The framework is supported by the 'Data Security & Protection Toolkit' (DSPT). The DSPT is an online annual self-assessment tool that requires organisations to measure their performance against the National Data Guardian's (NDG) 10 Data Security Standards. Submission of the DSPT provides assurance to the CCG, to other organisations, and to individuals that personal information is dealt with legally, securely, efficiently, and effectively. The CCG DSPT was successfully completed and published on 27 June 2022 achieving 'Standards Exceeded'.

The CCG placed high importance on ensuring there were robust data security and protection systems and processes in place to help protect personal, special category, business sensitive, and corporate information. No reportable data security or information governance (IG) related breaches or incidents occurred at the CCG during this reporting period. There were processes in place for incident reporting and investigation of serious incidents. The CCG developed information risk assessment

and management procedures and fostered a culture to address information security that was fully embedded throughout the organisation.

The CCG ensured all staff undertook annual data security training and implemented data security and information governance related policies, procedures, and guidance to ensure staff were aware of their roles and responsibilities in relation to information governance and data security.

Business critical models

No business critical models were introduced at the CCG during April to June 2022. The CCG was aware that, had it done so, it would have ensured that quality assurance took place in line with the recommendations in the Macpherson report.

Third party assurances

The CCG used service organisations to carry out services on its behalf and these often impacted upon the CCG's internal controls. Consequently, there was the need to receive assurance that control procedures at the service organisations complemented those operated by the CCG. In addition, the CCG's auditors might have sought information about the control procedures surrounding those services which affected the entity's financial statements. In order to deliver assurance over the internal controls and control procedures operated by a service organisation to its customers and their auditors, many organisations engaged a Reporting Accountant to prepare a report on internal controls. The objective of this was to provide assurance in a cost-effective manner through reducing the duplication which would likely arise from multiple CCGs' internal and external auditors separately assessing the same controls.

For the period 1 April to 30 June 2022 NHSE has permitted these service organisations to issue bridging letters confirming the arrangements in place rather than the usual service auditor reports. The following have been received:

- A bridging letter from NHS Business Services Authority providing assurance of the control environments for dental payments, prescription payments, Electronic Staff Record, and Human Resources Shared Services
- An Assurance Letter of Comfort from Capita in respect of Primary Care Support Services
- A service auditor report bridging letter from NHS Shared Business Services
- The Head of Internal Audit Opinion Quarter One 2022 / 23 for Greater Manchester Shared Service

Control issues

No control issues were identified which would undermine the integrity or reputation of the CCG or wider NHS, which would put at risk the standards expected of the Accountable Officer, which increased the risk that the CCG would be susceptible to fraud, which would have a material impact on the accounts, which would put at risk the security of data integrity, or which were likely to be prejudicial to the CCG's ability to meet its objectives other than the meeting of the NHS Constitutional Standards which is reflective of the national picture.

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

The CCG recognised and applied the principles of economy (minimising the cost of resources used or required while having regard to quality), efficiency (the relationship between the output from services and the resources required in order to produce them), and effectiveness (the extent to which objectives were achieved and the relationship between the intended and actual results of spending).

The CCG's internal auditors utilised an approach which was based on best practice and had been developed in accordance with professional standards. The principles of achieving value for money were included in the scope of each audit.

The Accountable Officer had responsibility for reviewing the effectiveness of the system of internal control within the CCG.

NHSE had a statutory duty (under the Health and Social Care Act (2012)) to conduct an annual assessment of every CCG. The annual assessment would include an end-of-year meeting between the CCG's leaders and the NHSE regional team focused on:

- The key lines of enquiry
- Performance against the oversight metrics
- As assessment of how the CCG worked with others (including the Health and Wellbeing Board) to improve quality and outcomes for patients.

During the period April to June 2022 NHSE did not undertake an annual assessment of the CCG.

Delegation of functions

The CCG had not made any significant arrangements to delegate its functions either internally or externally. The CCG had a Scheme of Reservation and Delegation within its Standing Financial Instructions. The Governing Body received reports from its established committees and any concerns or risks were identified and escalated as appropriate. The performance of functions operated by Greater Manchester Shared Service was quality assured through an established and regular reporting arrangement.

Counter fraud arrangements

The CCG's arrangements for countering fraud and corruption were characterised by:

- An Accredited Anti-Fraud Specialist was contracted to undertake counter fraud work proportionate to identified risks and in accordance with the NHS Standard Contract Service Condition 24 and NHS Counter Fraud Authority's Standards for Commissioners
- The Governance and Audit Committee received a report against each of the Standards for Commissioners annually and progress reports at each of its meetings. There was executive support and direction for a proportionate proactive work plan to address identified risks
- The Chief Finance Officer was the member of the executive team proactively and demonstrably responsible for tackling fraud, bribery, and corruption
- NHS Counter Fraud Authority's most recent inspection of the CCG's arrangements (in March 2018) resulted in the following conclusion: "Based on the evidence supplied during the assessment process, all 13 standards were given a green rating. This meant the overall ratings for Strategic Governance and Inform and Involve were also green."

Head of Internal Audit Opinion

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (that is, the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Governance and Audit Committee, which can provide assurance, subject to the inherent limitations described below.

Our overall opinion for the period 1 April to 30 June 2022 is:

Substantial Assurance can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The basis for forming our opinion is as follows:

- An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken into account the relative materiality of systems reviewed and management's progress in respect of addressing control weaknesses identified

- An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented

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 objectives had been reviewed.

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

- The Governing Body
- The Governance and Audit Committee
- The Integrated Commissioning Committee
- The Primary Care Commissioning 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 there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are 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.

Mark Fisher
Accountable Officer

Attendance by members at formal Governing Body and Committee meetings between 1 April and 30 June 2022

Governing Body meetings were held on 18 May and 15 June 2022

Name	Position	Attended / Eligible to Attend
Dr Tim Dalton	Chair	1 / 2
Professor Craig Harris	Managing Director and Accountable Officer	2 / 2
Frank Costello MBE	Lay Member	2 / 2
Paul McKevitt	Chief Finance Officer	2 / 2
Dr Jayne Davies	GP Clinical Executive	2 / 2
Morag Olsen	Interim Chief Nurse	2 / 2
Dr Gen Wong	GP Clinical Executive	2 / 2
Peter Armer	Lay Member	2 / 2
Professor Marios Adamou OBE	Independent Member: Secondary Care Clinician	2 / 2
Dr Adam Jolles	GP Clinical Executive	1 / 2

The Governance and Audit Committee met on 1, 17, and 29 June 2022

Name	Position	Attended / Eligible to Attend
Peter Armer	Committee Chair, Lay Member	3 / 3
Frank Costello MBE	Lay Member	3 / 3

The Primary Care Commissioning Committee met on 3 May and 28 June 2022

Name	Position	Attended / Eligible to Attend
Frank Costello MBE	Committee Chair, Lay Member	2 / 2
Linda Scott	Director of Primary Care	2 / 2
Jonathan Kerry	Associate Director of Primary Care	2 / 2
Debbie Szwandt	Assistant Director of Primary Care	2 / 2
Professor Marios Adamou OBE	Governing Body Independent Member: Secondary Care Clinician	0 / 2
Paul McKevitt (or representative)	Chief Finance Officer	2 / 2

The Integrated Commissioning Committee met on 6 April and 18 May 2022

Name	Position	Attended / Eligible to attend
Dr Tim Dalton	ICC Joint Chair, CCG Clinical Chair	1 / 2
David Molyneux	ICC Joint Chair, Council Executive Leader and Portfolio Holder for Economic Development and Regeneration	2 / 2
Dr Jayne Davies	CCG GP Clinical Executive	2 / 2
Frank Costello MBE	CCG Lay Member	2 / 2
Jennie Gammack	CCG Interim Director of Commissioning and Transformation	2 / 2
Linda Scott	CCG Director of Primary Care	1 / 2
Peter Armer	CCG Lay Member	2 / 2
Morag Olsen	CCG Interim Chief Nurse	2 / 2
Cllr Paul Prescott	Council Portfolio Holder for Planning, Environmental Services and Transport	2 / 2
Professor Kate Ardern	Council Director of Public Health	1 / 2
Stuart Cowley	Council Director of Adult Social Services	2 / 2
Collette Dutton	Council Director of Children's Services	1 / 2
Paul McKevitt	Council Director of Finance and CCG Chief Financial Officer	2 / 2
Professor Craig Harris	CCG Managing Director and Accountable Officer	0 / 2
Alison McKenzie-Folan	Council Chief Executive	0 / 2
Councillor Keith Cunliffe	Council Portfolio Holder for Adult Social Care	1 / 2

Name	Position	Attended / Eligible to attend
Councillor Jennifer Bullen	Council Portfolio Holder for Children and Families	1 / 2
Dr Gen Wong	CCG GP Clinical Executive	1 / 2
Dr Adam Jolles	CCG GP Clinical Executive	0 / 2
Professor Marios Adamou OBE	CCG Independent Member: Secondary Care Clinician	0 / 2

The Remuneration Committee did not meet during this period.

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The Remuneration Committee had the following membership:

- Mr Frank Costello - Lay Member and Remuneration Committee Chair
- Mr Peter Armer - Lay Member
- Professor Marios Adamou – Independent Member: Secondary Care Clinician
- Morag Olsen – Interim Chief Nurse

Percentage change in remuneration of highest paid director

	Salary and allowances	**Performance pay and bonuses**
The percentage change from the previous financial year in respect of the highest paid director	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	(8.90%)	0%

The percentage change from the previous year for the highest paid director is 0.00% for both salary and allowances including and excluding performance pay and bonuses.

The percentage change from the previous year for salary is a negative 10.17% for both salary and allowances including and excluding performance pay and bonuses. This is due to a reduction in FTE and staff paid at a higher salary.

Pay ratio information

Reporting bodies are required to disclose the relationship between the total 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 of the employee at the 25th percentile, median, and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in NHS Wigan Borough CCG in the reporting period 2022 / 23 was £137,500 (2021 / 22, £137,500). This was 3.43 times (2021 / 22: 3.6 times) the median remuneration of the workforce, which was £39,027 (2021 / 22: £39,027).

In the period 1 April to 30 June 2022 no employees received remuneration in excess of the highest-paid director / member. Remuneration ranged from £20,000 to £137,500 (2021 / 22: £20,000 to £137,500).

The relationship to the remuneration of the organisation's workforce is disclosed in the below table. This table is subject to audit.

2022 / 23	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	31,534	40,057	47,126
Salary component of total remuneration (£)	31,534	40,057	47,126
Pay ratio information	4.36	3.43	2.92
2021 / 22			
Total remuneration (£)	31,534	39,027	54,764
Salary component of total remuneration (£)	31,534	39,027	54,764
Pay ratio information	4.36	3.52	2.51

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.

The pay ratio change is due to lower headcount and a reduction in higher salaried staff.

Policy on the remuneration of senior managers

The Remuneration Committee had responsibility for:

- Establishing an appropriate appraisal system for elected members who were employees of the group, for the Accountable Officer, Chief Finance Officer, and other senior employees who were not employed on Agenda for Change terms and conditions and the level of annual rewards for elected members who were employees of the CCG, for the Accountable Officer, Chief Finance Officer, Executive Nurse, and other senior employees who were not employed on Agenda for Change terms and conditions

- Reviewing the performance of the Accountable Officer and other senior employees and making recommendations for salary awards where applicable

- Determining the severance payment of Governing Body members' posts seeking HM Treasury approval as appropriate in accordance with the guidance "Managing Public Money" where appropriate to the office held

- Setting allowances under any pension scheme that the group established as an alternative to the NHS pension scheme and, where the group had discretion, recommending other benefits which may form part of a total reward system

- Approving relocation allowances above the CCG's policy limit

In considering pay awards the Remuneration Committee considered all relevant guidance, national pay awards, affordability, and benchmarked against data for similarly sized organisations to enable a recommendation to be reached.

The pay of the Governing Body and Clinical Leads was not directly linked to performance; that is, there was no specific performance-related pay. However, both the Governing Body and its individual Clinical Lead members were subject to performance review.

Remuneration of Very Senior Managers

No senior manager of the CCG was paid more than £150,000 per annum.

Senior manager remuneration (including salary and pension entitlements)

For each member of the Governing Body who served during the period 1 April to 30 June 2022, remuneration and pension benefits are shown in the table below. Pension related benefits data is provided by the NHS Pensions Scheme in line with Greenbury reporting guidance on an annual basis. This table is subject to audit.

Name and Title	1 April to 30 June 2022					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Dr T Dalton - Chair	20-25	0	0	0	2.5-5.0	25-30
Prof. C Harris – Accountable Officer	35-40	0	0	0	10-12.5	45-50
Mr P McKevitt – Chief Finance Officer (1)	10-15	0	0	0	0	10-15
Mr F Costello – Lay Member (2)	0-5	0	0	0	0	0-5
Mr P Armer – Lay Member (2)	0-5	0	0	0	0	0-5
Prof M Adamou – Secondary Care Clinician (2)	0-5	0	0	0	0	0-5
Dr J Davies – Clinical GB Member (3)	15-20	0	0	0	0*	15-20
Dr A Jolles – Clinical GB Member (3)	15-20	0	0	0	0*	15-20
Dr G Wong – Clinical GB Member (4)	10-15	0	0	0	0*	10-15
Mrs M Olsen – Nurse Member (5)	25-30	0	0	0	0	25-30

** The calculation of pension related benefits resulted in a negative value which is shown as zero for reporting purposes.*

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

(1) Mr P McKevitt is also remunerated through Wigan Council for his position as Treasurer. His total salary band over both organisations is £200k - £205k. He is not part of the NHS pension scheme

(2) The Lay Members and Secondary Care Clinician are not part of the NHS pension scheme

(3) Dr J Davies' and Dr A Jolles' remuneration also include roles as Service Delivery Footprint (SDF) leads and Clinical Director posts

(4) Dr G Wong's remuneration also includes his role as a Service Delivery Footprint (SDF) lead

(5) Mrs M Olsen is not part of the NHS pension scheme

Remuneration and pensions benefits for the prior year 2021 / 22 are shown below. (This table has been subject to audit):

Name and Title	2021 / 22					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Dr T Dalton - Chair	90-95	0	0	0	0*	90-95
Prof. C Harris – Accountable Officer	140-145	0	0	0	32.5-35.0	170-175
Mr P McKevitt – Chief Finance Officer (1)	45-50	0	0	0	0	45-50
Mr F Costello – Lay Member (2)	10-15	0	0	0	0	10-15
Mr P Armer – Lay Member (2)	15-20	0	0	0	0	15-20
Prof. M Adamou – Secondary Care Clinician (2)	5-10	0	0	0	0	5-10
Mrs S Forshaw – Nurse Member (3)	0-5	0	0	0	0*	0-5
Dr J Davies – Clinical GB Member (4)	65-70	0	0	0	0-2.5	70-75
Dr A Jolles – Clinical GB Member (4)	75-80	0	0	0	2.5-5.0	75-80
Dr G Wong – Clinical GB Member (5)	45-50	0	0	0	87.5-90.0	135-140
Mrs M Olsen – Nurse Member (6)	125-130	0	0	0	0	125-130

** The calculation of pension related benefits resulted in a negative value which is shown as zero for reporting purposes.*
***Taxable expenses and benefits in kind are expressed to the nearest £100.*
(1) Mr P McKevitt is also remunerated through Wigan Council for his position as Treasurer. His total salary band over both organisations is £200k - £205k. He is not part of the NHS pension scheme
(2) The Lay Members and Secondary Care Clinician are not part of the NHS pension scheme

(3) Mrs S Forshaw's remuneration also includes her officer role of Director of Nursing & Quality. This amount represents 11 days as in post until 11 April 2021
(4) Dr J Davies' and Dr A Jolles' remuneration also include roles as Service Delivery Footprint (SDF) leads and Clinical Director posts
(5) Dr G Wong's remuneration also includes his role as a Service Delivery Footprint (SDF) lead
(6) Mrs M Olsen is not part of the NHS pension scheme

Pension benefits

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 1 April 2022	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 30 June 2022	(h) Employers' Contribution to partnership pension
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Dr T Dalton – Chair	0-2.5	0	30-35	55-60	543	3	554	0
Prof. C Harris – Accountable Officer	0-2.5	0	35-40	65-70	547	5	562	0
Dr G Wong – Clinical GB Member	0	0	25-30	60-65	607	0*	572	0
Dr J Davies – Clinical GB Member	0	0	10-15	20-25	212	0*	193	0
Dr A Jolles – Clinical GB Member	0-2.5	0	10-15	25-30	204	0	207	0

** The calculation of pension related benefits resulted in a negative value which is shown as zero for reporting purposes.*

*** Whilst the column states 30 June 2022 the figures are as at 31 March 2023 as only full year figures can be provided*

The CCG was only able to obtain confirmation of the movement in the cash equivalent transfer values for the directors' pension entitlements for the period 1 April 2022 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 30 June 2022. This is considered to be a reasonable approximation of the movement 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 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 have been no payments for early retirement or loss of office for the period 1 April to 30 June 2022. If the CCG agreed to early retirement, the additional costs are met by the CCG and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS Pension scheme.

Payments to past directors

No payments have been made to past directors or senior managers.

Staff Report

Number of senior managers

The CCG has the following numbers of senior managers:

	Headcount	FTE
Band 8 – Range A	13	12.31
Band 8 – Range B	14	14.00
Band 8 – Range C	8	8.00
Band 8 – Range D	1	1.00
Band 9	1	1.00
Other / Governing Body / Very Senior Manager	8	2.69
Total	45	39.00

Staff numbers and costs

Staff costs 2022 / 23 (this table is subject to audit).

2022 / 23 Employee Benefits	2022 / 23 total			Admin			Programme		
	Total £'000	Perm £'000	Other £'000	Total £'000	Perm £'000	Other £'000	Total £'000	Perm £'000	Other £'000
Employee Benefits									
Salaries and Wages	**1,647**	1,566	80	**726**	702	23	**921**	864	57
Social Security Costs	**128**	128	0	**32**	32	0	**96**	96	0
Employer Contributions to the NHS Pension Scheme	**273**	273	0	**175**	175	0	**98**	98	0
Other Pension Costs	**0**	0	0	**0**	0	0	**0**	0	0
Apprenticeship Levy	**4**	4	0	**2**	2	0	**2**	2	0
Termination Benefits	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits Expenditure	**2,052**	1,972	80	**935**	912	23	**1,117**	1,060	57
Less Recoveries in Respect of Outward Secondments	**(31)**	(31)	0	**(31)**	(31)	0	**0**	0	0
Net Employee Benefits	**2,021**	1,941	80	**904**	881	23	1,117	1,060	57

2021 / 22 Employee Benefits	2021 / 22 total			Admin			Programme		
	Total	Perm	Other	Total	Perm	Other	Total	Perm	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and Wages	**6,600**	6,416	184	**2,972**	2,927	46	**3,627**	3,489	138
Social Security Costs	**692**	692	0	**317**	317	0	**376**	376	0
Employer Contributions to the NHS Pension Scheme	**1,237**	1,237	0	**830**	830	0	**406**	0	406
Other Pension Costs									
Apprenticeship Levy	**19**	19	0	**9**	9	0	**10**	10	0
Termination Benefits	**128**	128	0	**128**	128	0	**0**	0	0
Gross Employee Benefits Expenditure	**8,675**	8,491	184	**4,256**	4,210	46	**4,419**	4,281	138
Less Recoveries in Respect of Outward Secondments	**(66)**	(66)	0	**(26)**	(26)	0	**(40)**	(40)	0
Net Employee Benefits	**8,609**	8,425	184	**4,230**	4,184	46	4,379	4,241	138

Staff composition

The staff composition, based on contracted Whole Time Equivalent of staff in post as at 30 June 2022, is as follows:

Staff Group	Headcount	FTE	Female Headcount	Male Headcount
Governing Body	10	2.83	2	8
Senior Managers	37	36.31	27	10
Additional Professional, Scientific and Technical	7	6.60	7	0
Administrative and Clerical	67	60.89	47	20
Allied Health Professionals	1	1.00	0	1
Medical and Dental	12	2.27	2	10
Nursing and Midwifery Registered	21	16.33	21	0
Grand Total	**153**	**126.08**	**105**	**48**

Staff Group	Assignment Category	FTE by Month 2022/04	2022/05	2022/06
Additional Professional, Scientific, and Technical	Permanent	9.60	9.60	9.60
Administrative and Clerical	Fixed Term Temp	1.40	1.40	1.40
Administrative and Clerical	Permanent	84.89	84.89	84.89
Allied Health Professionals	Permanent	2.00	2.00	2.00
Medical and Dental	Fixed Term Temp	3.04	3.04	3.04
Medical and Dental	Non-Exec Director / Chair	0.21	0.21	0.21
Medical and Dental	Permanent	0.27	0.27	0.27
Nursing and Midwifery Registered	Fixed Term Temp	0.91	0.91	0.91
Nursing and Midwifery Registered	Permanent	27.73	25.73	24.73
Grand Total		**130.05**	**128.05**	**127.05**

Sickness absence data

Detail of the CCG's sickness absence data can be accessed via the NHS Digital website at the following link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff turnover percentages

Detail of the CCG's staff turnover percentages can be accessed via the NHS Digital website at the following link: NHS workforce statistics - NHS Digital This data series is an official statistics publication complying with the UK Statistics Authority's Code of Practice.

Staff engagement percentages

During the reporting period the CCG staff did not participate in the NHS Staff Survey. Later in the financial year the staff did participate in the NHS Greater Manchester staff survey; those results are reported in the NHS Greater Manchester Annual Report 2022 / 23.

During the closedown programme for the CCG there were regular staff briefings held to provide support and information during the organisational change.

Staff policies

NHS Wigan Borough CCG's workforce policies were available to all staff on the intranet and referenced as part of the induction checklist. All workforce policies had

scheduled reviews and, through its staff side representatives and the health and wellbeing group, all staff were invited to provide input into these reviews. The policies covered a wide range of topics including recruitment and selection, organisational change, pay progression, and Equality, Diversity, and Human Rights.

With the exception of the Accountable Officer, Chief Finance Officer, Clinical Chair, Clinical Leads, and Lay Members all contracted staff were employed on the Agenda for Change pay scales which are linked to the NHS Wigan Borough CCG pay progression policy.

In respect of disability and access, and in line with CCG policies, staff who have declared a disability were assessed, supported, and had appropriate equipment provided to enable continuation of employment. Throughout quarter 1 2022 / 23 the Recruitment and Selection Code of Practice policy was adhered to and as such each new recruit regardless of disability was treated equally.

As a CCG positive about employing disabled people, all applicants with a disability who met the essential criteria were shortlisted and invited to interview. If a disabled candidate was selected for appointment, the need for reasonable adjustments to the role was discussed with the individual concerned. Where it was agreed that reasonable adjustments needed to be made this was discussed with our Health, Safety, and Wellbeing Lead and Occupational Health, and advice taken from the HR team.

The CCG had been working collaboratively with all its partners to develop an integrated approach to Equality, Diversity, and Inclusion. This included working towards a joint strategy which covered:

- Reducing inequalities and improving outcomes
- Embedding equality and inclusion in its ways of working and meeting its statutory and mandatory requirements
- Actively consulting, engaging, involving, and communicating with its communities
- Developing an inclusive and reflective leadership, workforce, and culture
- Improving access to information services and data collection and usage

As part of the requirement of the Public Sector Equality Duty, organisations with over 150 employees are required to publish information relating to their employees. Its Public Sector Equality Duty report 2021 / 22 provided information of the activities taking place across the CCG. Also during 2021 / 22 the CCG produced its Equality Report.

Occupational Health support was available to all employees throughout their employment and appropriate funding and support was also available from Access to Work. All employees' training and career development was assessed and reviewed through their Personal Development Plan and regular support sessions.

Staff continued to be supported to work from home. The CCG had Agile Working and Flexible Working policies to support staff with changes made as a result of their work

base moving from office to home. Regular Health, Safety, and Welfare and HR Guidance was provided and shared with staff to reflect any changes in the local and national situation relating to COVID-19. This provided managers and employees with clear guidance on the expectations, management, and deployment of staff including attendance, deployment to other duties, conditions of service, health, safety, and welfare. In addition to the HR guidance, a number of wellbeing events were made available to staff to support them with their mental health, anxiety, and personal fitness in addition to the GM Wellbeing Toolkit.

Trade Union Facility Time Reporting Requirements

This disclosure is not required as this report covers a period of only three months and is for a demising NHS body.

Other employee matters

All formal staff consultations were conducted in accordance with local policy provisions and with prevailing national and NHS good practice guidance. In doing so, effective partnership working was maintained with Trades Unions and staff representatives.

The CCG employed a staff member whose role included providing support and guidance to CCG staff and to wider partners in the sphere of health and safety.

Expenditure on consultancy

The CCG spent £2,063 during the period on consultancy fees for governance support.

Off-payroll engagements

The CCG policy, set by the Remuneration Committee, was that any senior official of the CCG will be contracted as an employee and paid through payroll. There are no senior officials or members of the Governing Body employed via off-payroll arrangements.

The CCG put provisions in place to receive formal assurance that anyone paid at more than £245 per day and employed off payroll for more than six months was meeting their income tax and National Insurance Contribution obligations in full. If that reassurance was not provided when requested, the contracts would be terminated.

The CCG had one off-payroll arrangement for two specialist or interim contractors as at 30 June 2022 that met the criterion of being for more than £245 per day. The roles were to support the Continuing Health Care team and transition support due to team pressures.

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

For all off-payroll engagements as at 30 June 2022 for more than £245* per day:

	Number
Number of existing engagements as at 30 June 2022	2
Of which, the number that have existed:	
for less than one year at the time of reporting	2
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

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

For all off-payroll engagements between 1 April and 30 June 2022 for more than £245[1] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April and 30 June 2022	2
Of which:	
No. not subject to off-payroll legislation[2]	2
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	0
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	0
The number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

[1] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

[2] A worker who provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Off-payroll engagements / senior official engagements

The CCG had no off-payroll engagements of Governing Body members and / or senior officials with significant financial responsibility between 1 April and 30 June 2022.

Exit packages, including special (non-contractual) payments

For the reporting period the CCG had no exit packages including special (non-contractual) payments.

Parliamentary Accountability and Audit Report

NHS Wigan Borough CCG is not required to produce a Parliamentary Accountability and Audit Report.

Accountability Report

Mark Fisher
Accountable Officer
21 June 2023

ANNUAL ACCOUNTS

(FINANCIAL STATEMENTS)

Independent auditor's report to the members of the Governing Body of NHS Greater Manchester Integrated Care Board in respect of NHS Wigan Borough Clinical Commissioning Group

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Wigan Borough Clinical Commissioning Group (the 'CCG') for the period ended 30 June 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 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 to the financial statements, which indicates that the Health and Care Bill allowed for the establishment of Integrated Care Boards (ICBs) and abolished Clinical Commissioning Groups (CCGs). The functions, assets, and liabilities of NHS Wigan Borough CCG transferred to NHS Greater Manchester ICB on 1 July 2022. When NHS Wigan Borough CCG ceased to exist on 30 June 2022, its services continued to be provided by NHS Greater Manchester ICB from 1 July 2022.

Conclusions relating to going concern

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

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, 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 set out on pages 28 to 29, 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 audit committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls, revenue recognition and expenditure recognition. We determined that the principal risks were in relation to:
  - material post year end journals including the prescribing accrual.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on material year end transactions and manual journals posted during the year with high risk characteristics;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of prescribing;
  - 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 the prescribing accrual.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation;
  - knowledge of the health sector and economy in which the CCG operates;
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The CCG's operations, including the nature of its 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 is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources 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 plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we 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 the financial statements of NHS Wigan Borough CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Governing Body of NHS Greater Manchester ICB, as a body, in respect of NHS Wigan Borough 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 Governing Body of NHS Greater Manchester ICB 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 ICB and the CCG and the members of the Governing Bodies 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

Foreword to the Accounts

The Clinical Commissioning Group was licensed from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

These accounts for the year ended 30 June 2022 have been prepared by NHS Wigan Borough CCG under section 17 of schedule 1A of the National Health Service Act 2006 (as amended) in the form which the Secretary of States has, with the approval of the Treasury, directed.

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

Statement of Comprehensive Net Expenditure for the Year Ended 30th June 2022

	Note	**2022-23 £'000**	2021-22 £'000
Income from sale of goods and services	2	(224)	(745)
Other operating income	2	(2)	(16)
Total operating income		**(226)**	**(761)**
Staff costs	4	2,052	8,675
Purchase of goods and services	5	151,735	599,502
Depreciation and impairment charges	5	75	177
Provision expense	5	0	(48)
Other Operating Expenditure	5	40	163
Total operating expenditure		**153,902**	**608,468**
Net Operating Expenditure		**153,676**	**607,707**
Finance expense		10	0
Net expenditure for the Year		**153,686**	**607,707**
Total Net Expenditure for the Financial Year		**153,686**	**607,707**
Comprehensive Expenditure for the year		**153,686**	**607,707**

Notes 1 to 21 also form part of this statement.

Statement of Financial Position as at 30th June 2022

	Note	2022-23	2021-22
		£'000	£'000
Non-current assets:			
Right-of-use assets	7	4,328	0
Total non-current assets		4,328	0
Current assets:			
Trade and other receivables	8	1,306	853
Cash and cash equivalents	9	2,155	11
Total current assets		**3,461**	864
Total assets		**7,789**	864
Current liabilities			
Trade and other payables	10	(21,410)	(26,998)
Lease liabilities	7	(283)	0
Provisions	11	(278)	(282)
Total current liabilities		**(21,971)**	(27,280)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(14,182)**	(26,416)
Non-current liabilities			
Lease liabilities	7	(4,050)	0
Total non-current liabilities		(4,050)	0
Assets less Liabilities		**(18,232)**	(26,416)
Financed by Taxpayers' Equity			
General fund		(18,232)	(26,416)
Total taxpayers' equity:		**(18,232)**	(26,416)

Notes 1 to 21 also form part of this statement.

The financial statements were approved by the NHS Greater Manchester Integrated Care Board on 7 June 2023 and signed on its behalf by:

Signed by:

Mark Fisher
Accountable Officer
21 June 2023

Statement of Changes in Taxpayers' Equity for the Year Ended 30th June 2022

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2022-23		
Balance at 01 April 2022	(26,416)	(26,416)
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(26,416)**	**(26,416)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23		
Total transition adjustment for initial application of IFRS 16	0	0
Net operating expenditure for the financial year	**(153,686)**	**(153,686)**
Net gain/(loss) on revaluation of property, plant and equipment	0	0
Net gain/(loss) on revaluation of right-of-use assets	0	0
Net gain/(loss) on revaluation of intangible assets	0	0
Net gain/(loss) on revaluation of financial assets	0	0
Total revaluations against revaluation reserve	0	0
Net gain (loss) on available for sale financial assets	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	0	0
Net gain (loss) on revaluation of assets held for sale	0	0
Impairments and reversals	0	0
Net actuarial gain (loss) on pensions	0	0
Movements in other reserves	0	0
Transfers between reserves	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0
Transfers by absorption to (from) other bodies	0	0
Reserves eliminated on dissolution	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(153,686)**	**(153,686)**
Net funding (1)	161,870	161,870
Balance at 30 June 2022	**(18,232)**	**(18,232)**

(1) Cash funding received in year 2022-23

Statement of Changes in Taxpayers' Equity for the Year Ended 31st March 2022

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(26,838)	(26,838)
Transfer of assets and liabilities from closed NHS bodies	0	0
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(26,838)**	**(26,838)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22		
Net operating costs for the financial year	(607,707)	(607,707)
Net gain/(loss) on revaluation of property, plant and equipment	0	0
Net gain/(loss) on revaluation of right-of-use assets	0	0
Net gain/(loss) on revaluation of intangible assets	0	0
Net gain/(loss) on revaluation of financial assets	0	0
Total revaluations against revaluation reserve	0	0
Net gain (loss) on available for sale financial assets	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	0	0
Net gain (loss) on revaluation of assets held for sale	0	0
Impairments and reversals	0	0
Net actuarial gain (loss) on pensions	0	0
Movements in other reserves	0	0
Transfers between reserves	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0
Transfers by absorption to (from) other bodies	0	0
Reserves eliminated on dissolution	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(607,707)**	**(607,707)**
Net funding	608,129	608,129
Balance at 31 March 2022	**(26,416)**	**(26,416)**

(1) Cash funding received in year 2021-22

Notes 1 to 21 also form part of this statement.

Statement of Cash Flows for the Year Ended 30th June 2022

	Note	**2022-23 £'000**	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(153,686)	(607,707)
Depreciation and amortisation	5	75	177
(Increase)/decrease in trade & other receivables	8	(453)	373
Increase/(decrease) in trade & other payables	10	(5,588)	(876)
Provisions utilised	11	(5)	(40)
Increase/(decrease) in provisions	11	0	(48)
Net Cash Inflow (Outflow) from Operating Activities		**(159,656)**	(608,122)
Cash Flows from Investing Activities			
Interest received		10	0
Net Cash Inflow (Outflow) from Investing Activities		10	0
Net Cash Inflow (Outflow) before Financing		**(159,646)**	(608,122)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		161,870	608,129
Repayment of lease liabilities		(80)	0
Net Cash Inflow (Outflow) from Financing Activities		161,790	608,129
Net Increase (Decrease) in Cash & Cash Equivalents	9	**2,144**	7
Cash & Cash Equivalents at the Beginning of the Financial Year		**11**	4
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**2,155**	11

Notes 1 to 21 also form part of this statement.

Notes to the Financial Statements

Whilst many of the Notes to the Financial Statements can be directly cross referenced to the Statement of Net Comprehensive Expenditure and the Statement of Financial Position, some provide additional information and cannot be directly cross referenced (Note 3, 6, 7,14,15,16,17,18,19, 20 and 21).

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care.

Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 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 (IFRS) 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 (CCG) are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

Going Concern

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 are due to take on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities are due to transfer to NHS GM ICB.

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 financial position has therefore been drawn up at 31 March 2022, on a going concern basis.

1.2 Accounting Convention

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

1.3 Pooled Budgets

Better Care Fund

The CCG has entered into a pooled budget with Wigan Council under Section 75 of the National Health Service Act 2006 to support integrated health and social care, known as the Better Care Fund (BCF), hosted by Wigan Council. This is a nationally mandated scheme that commenced in 2015-16.

The pool is jointly controlled by Wigan Borough CCG and Wigan Council. The Integrated Commissioning Committee, made up of Council and CCG representatives, govern the use of the fund. The fund is used to commission services that support the integration of health and social care, which seeks to ensure support for people to be well, independent and in control of their own care.

The CCG has taken into account and considered IFRS 10, *Consolidated Financial Statements* and IFRS 11, *Joint Arrangements*.

Under IFRS 10, the CCG considers the pool to be under the joint control of the CCG and Wigan Council. The S75 agreement states that the pool will be classified as a joint operation under IFRS 11. The CCG believe this to be consistent with the governance and control arrangements of the pool.

Whilst there is no single overall organisational lead, the CCG and Wigan Council have accounted for the pool under lead commissioning arrangements.

Each scheme within the BCF has been allocated a lead commissioner (either the Council or the CCG) and accounting for the pool reflects these arrangements. Details are included in Note 1.4 and 19.

The CCG accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

The CCG recognises:

- The assets the CCG controls;
- The liabilities the CCG incurs;
- The expenses the CCG incurs; and
- The CCG's share of the income from the pooled budget activities.

In addition to the above, the CCG recognises:

- The CCG's share of the jointly controlled assets (classified according to the nature of the assets);
- The CCG's share of any liabilities incurred jointly; and
- The CCG's share of the expenses jointly incurred.

1.3.1 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside

the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfer of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the CCG's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimated and the methods of estimation and underlying assumptions are continually reviewed.

Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Key Sources of Estimation Uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year. Due to the NHS England deadline for the submission of the accounts, actual information is not available for the full twelve months for some significant expenditure, the largest of which is prescribing expenditure. The CCG therefore estimates one or two months of expenditure in some areas using historical information, in year trends and any other available information sources. The CCG has continued to use established estimation techniques, based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and underlying assumptions are continually reviewed.

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 that form part of a contract that has an original expected duration of one year or less,

• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

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

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

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

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

Payment terms are standard reflecting cross government principles. The CCG has no revenue that has been impacted by IFRS 15, therefore has no significant terms to include.

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. The CCG has seconded staff that are recharged to the Local Authority which is recovered in year.

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 cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales.

The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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

1.7 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 Property, Plant & Equipment

1.8.1 Recognition

Property, plant and equipment is capitalised if:

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

1.8.2 Measurement

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

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

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

1.8.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Intangible Assets

1.9.1 Recognition

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

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

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.9.2 Measurement

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

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

1.9.3 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.10 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.

1.10.1 The CCG 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 HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16. Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

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 or 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.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.11 Cash & Cash Equivalents

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

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

1.12 Provisions

Provisions are recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the CCG will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

1.13 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 CCG.

1.14 Non-Clinical Risk Pooling

The CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the CCG pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising.

The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.15 Continuing Healthcare Risk Pooling

In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. The risk pool is controlled and accounted for by NHS England.

1.16 Contingent liabilities and contingent assets

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

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

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

Where the time value of money is material, contingencies are disclosed at their present value.

1.17 Financial Assets

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

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets are classified into the following categories:

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

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

1.17.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments.

After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.17.2 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.

1.17.3 Impairment

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

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

recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

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

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

1.18 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the CCG becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received.

Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.18.1 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.

1.18.2 Financial Liabilities at Fair Value through Profit & Loss

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

The net gain or loss incorporates any interest payable on the financial liability.

1.18.3 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.

1.19 Value Added Tax

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

1.20 Losses & Special Payments

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

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

1.21 Joint Operations

Joint operations are activities undertaken by the CCG in conjunction with one or more other parties but which are not performed through a separate entity. The CCG records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.22 Adoption of New Standards

On 1 April 2022, the clinical commissioning group adopted IFRS 16 ‘Leases’. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.

Under IFRS 16 the group will recognise a right-of-use asset representing the group’s right to use the underlying asset and a lease liability representing its obligation to

make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Right of use asset - Impact assessment

The clinical commissioning group has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.

As of 1 April 2022, the group recognised [£4.445m] of right-of-use assets and lease liabilities of [£4.403m]. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was an [£0.42m] impact to tax payers’ equity.

The group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.

The following table reconciles the group’s operating lease obligations at 31 March 2022, disclosed in the group’s 21/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

	Total £000
Operating lease commitments at 31 March 2022	-4,445
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	42
Operating lease commitments discounted used weighted average IBR	-4,403
Add: Finance lease liabilities at 31 March 2022	0
Add: Peppercorn leases revalued to existing value in use	0
Add: Residual value guarantees	0
Add: Rentals associated with extension options reasonably certain to be exercised	0
Less: Short term leases (including those with <12 months at application date)	0
Less: Low value leases	0
Less: Variable payments not included in the valuation of the lease liabilities	0
Lease liability at 1 April 2022	-4,403

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

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

This would have no impact on the 2022-23 reporting.

2 Other Operating Revenue

	2022-23 Total £'000	2021-22 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**12**	70
Non-patient care services to other bodies	**86**	330
Other Contract income	**94**	279
Recoveries in respect of employee benefits	**31**	66
Total Income from sale of goods and services	**223**	**745**
Other operating income		
Non cash apprenticeship training grants revenue	**3**	16
Total Other operating income	**3**	**16**
Total Operating Income	**226**	**761**

(1) Recoveries in respect of employee benefits are seconded staff to NHS England as per IFRS 15 the income is classified as contract income in 2022/23.

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

2022/23

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Source of Revenue				
NHS	0	0	0	31
Non NHS	12	86	94	0
Total	**12**	**86**	**94**	**31**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Timing of Revenue				
Point in time	12	86	94	31
Total	**12**	**86**	**94**	**31**

2021/22

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Source of Revenue				
NHS	0	0	37	0
Non NHS	70	330	242	66
Total	**70**	**330**	**279**	**66**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Timing of Revenue				
Point in time	70	330	279	66
Total	**70**	**330**	**279**	**66**

The CCG's service income for 2022/23 all related to performance obligations satisfied at a point in time and therefore all recognised in year in line with IFRS 15.

4 Employee Benefits and Staff Numbers

4.1 Employee benefits

4.1.1 Employee benefits expenditure 2022-23

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**1,566**	**80**	**1,647**
Social security costs	**128**	**0**	**128**
Employer Contributions to NHS Pension scheme	**273**	**0**	**273**
Apprenticeship Levy	**4**	**0**	**4**
Gross employee benefits expenditure	1,972	80	2,052
Less recoveries in respect of employee benefits (note 4.1.2)	**(31)**	**0**	**(31)**
Total - Net admin employee benefits including capitalised costs	1,941	80	2,021
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	1,941	80	2,021

Employee benefits includes an increase to the annual leave accrual from £55k to £95k. This is the allowance to carry over the annual leave to the future year and is not a payment to staff.

Employee benefits expenditure 2021-22

	Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**6,416**	**184**	**6,600**
Social security costs	**692**	**0**	**692**
Employer Contributions to NHS Pension scheme	**1,237**	**0**	**1,237**
Apprenticeship Levy	**19**	**0**	**19**
Termination benefits (note 4.3)	**128**	**0**	**128**
Gross employee benefits expenditure	8,491	184	8,675
Less recoveries in respect of employee benefits (note 4.1.2)	**(66)**	**0**	**(66)**
Total - Net admin employee benefits including capitalised costs	8,425	184	8,609
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	8,425	184	8,609

4.1.2 Recoveries in respect of employee benefits

	Permanent Employees £'000	Other £'000	2022-23 Total £'000	2021-22 Total £'000
Employee Benefits - Revenue				
Salaries and wages	(24.39)	0	(24.39)	(52.29)
Social security costs	(3.18)	0	(3.18)	(6.08)
Employer contributions to the NHS Pension Scheme	(3.65)	0	(3.65)	(7.39)
Total recoveries in respect of employee benefits	**(31.22)**	**0**	**(31.22)**	**(65.76)**

The table above relates to staff seconded to NHS England.

4.2 Average number of people employed

2022-23 Permanently employed Number	Other Number	Total Number	2021-22 Permanently employed Number	Other Number	Total Number
123.18	5.34	128.52	132.53	4.00	136.53

Other includes seconded staff. This is based on contracted Whole Time Equivalents (WTE).

4.3 Exit packages and severance payments agreed in the financial year

No Redundancy in 2022-23.

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	£
£10,001 to £25,000	**0**	**0**	1	1	1	1
£100,001 to £150,000	1	106,667	**0**	**0**	1	106,667
Total	**1**	**106,667**	**1**	**1**	**2**	**106,668**

Analysis of Other Agreed Departures

	2022-23 Other agreed departures		2021-22 Other agreed departures	
	Number	**£**	Number	£
Contractual payments in lieu of notice	**0**	**0**	1	20,955
Total	**0**	**0**	**1**	**20,955**

As a single exit package can be made up of several components each of which 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 or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme and Agenda for Change.
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 non-contractual severance payments made following judicial mediation, relating to non-contractual payments in lieu of notice in 2022-23. Therefore no non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.

No early retirements have been agreed by the CCG for 2022-23. Ill-health retirement costs are met by the NHS Pension Scheme and would not be included in the CCG tables.

4.4 Pension Costs

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

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

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

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

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

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

HMT published valuation directions dated 7 October 2021 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

For 2022-23, employers' contributions of £189,333 were payable to the NHS Pensions Scheme (2021-22: £878,911) they were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay.

These costs are included in the NHS pension line of note 4.1. The costs also include the 6.3% previously transacted through NHS England at a value of £83,842. In addition to the costs shown on note 4.1, the CCG pay pension on the Chairman's costs which is included as part of the Chair and Non-Executive members costs in note 5 as these are not classed as pay and staff costs in the CCG accounts.

5. Operating Expenses

	2022-23 Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	86	398
Services from foundation trusts(1)	89,637	347,257
Services from other NHS trusts	5,140	20,407
Purchase of healthcare from non-NHS bodies	18,177	69,924
Purchase of social care	5,563	24,934
Prescribing costs	15,565	63,345
Pharmaceutical services	2	15
General Ophthalmic services	56	207
GPMS/APMS and PCTMS	12,667	52,327
Supplies and services – clinical	561	2,448
Supplies and services – general	2,141	9,833
Consultancy services	2	2
Establishment	266	1,415
Transport	1	2
Premises (2)	1,709	6,660
Audit fees (3)	64	65
Other non statutory audit expenditure		
· Other services (4)	18	4
Other professional fees (5)	21	58
Legal fees	52	110
Education, training and conferences	4	75
Non cash apprenticeship training grants	2	16
Total Purchase of goods and services	**151,735**	**599,502**
Depreciation and impairment charges		
Depreciation	75	53
Amortisation	0	123
Total Depreciation and impairment charges	**75**	**177**
Provision expense		
Provisions	0	(48)
Total Provision expense	**0**	**(48)**
Other Operating Expenditure		
Chair and Non Executive Members	40	157
Clinical negligence	0	1
Expected credit loss on receivables	0	5
Total Other Operating Expenditure	**40**	**163**
Total operating expenditure	**151,850**	**599,794**

1. A significant proportion of CCG expenditure is for services provided by NHS Foundation trusts including Acute, Community and Mental Health service provision.

2. Premises costs include all costs payable to NHS Property Services and Community Health Partnerships. This includes the costs of the CCG's administrative headquarters, and the payments that cover the subsidised and void space within clinics and health centres, paid by the CCG as commissioner of those health services within these properties.

3. Audit fees is the accrual for the fee to be paid to Grant Thornton UK LLP for External Audit Services. This will be paid by NHS GM ICB.

4. Other Non-Statutory audit expenditure - Other services relates to the Mental Health Investment audit completed by Grant Thornton.

5. Other Professional fees - Internal audit fees are paid through a host NHS organisation, payments were not included in the Other professional fee as in previous years. The largest expenditure relates to Valuation Office Agency costs

In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, where a Clinical Commissioning Group contract with its auditors provides for a limitation of the auditor's liability, the principal terms of this limitation must be disclosed in a note to the accounts. The liabilities of the external auditor are limited to £2m.

6 Better Payment Practice Code

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	2,762	48,255	10,618	231,012
Total Non-NHS Trade Invoices paid within target	2,721	47,866	10,177	228,147
Percentage of Non-NHS Trade invoices paid within target	**98.52%**	**99.19%**	**95.85%**	**98.76%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	169	31,303	577	303,857
Total NHS Trade Invoices Paid within target	169	31,303	575	303,838
Percentage of NHS Trade Invoices paid within target	**100%**	**100%**	**99.65%**	**99.99%**

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date, or within 30 days of receipt of a valid invoice, whichever is later.

6.1 Late Payment of Commercial Debt

The CCG did not incur any expenses as a result of the late payment of commercial debt.

7. Right-of-use assets

2022-23	Buildings excluding dwellings	Total
	£'000	£'000
Cost or valuation at 01 April 2022	0	0
IFRS 16 Transition Adjustment	4,403	4,403
Cost/Valuation at 30 June 2022	4,403	4,403
Depreciation 01 April 2022	0	0
Charged during the year	75	75
Depreciation at 30 June 2022	75	75
Net Book Value at 30 June 2022	4,328	4,328

The leases include;

- Wigan Life Centre South – CCG Head Quarters
- Bridgewater Medical Centre - Administration Medicine Management

	2022-23	2021-22
	£'000	£'000
Lease liabilities at 01 April 2022	0	0
IFRS 16 Transition Adjustment	4,403	0
Repayment of lease liabilities (including interest)	10	0
Lease remeasurement	(80)	0
Modifications	0	0
Lease liabilities at 30 June 2022	**4,333**	0

7.1 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2022-23	2021-22
	£'000	£'000
Within one year	(322)	0
Between one and five years	(1,287)	0
After five years	(3,025)	0
Balance at 30 June 2022	**(4,634)**	0
Effect of discounting	301	0
Included in:		
Current lease liabilities	(283)	0
Non-current lease liabilities	(4,050)	0
Balance at 30 June 2022	**(4,333)**	0

8 Trade & Other Receivables

	Current 2022-23 £'000	Current 2021-22 £'000
NHS receivables: Revenue	100	162
NHS prepayments	190	112
Non-NHS and Other WGA receivables: Revenue	81	419
Non-NHS and Other WGA prepayments	895	127
Non-NHS and Other WGA accrued income	8	0
Expected credit loss allowance-receivables	(9)	(9)
VAT	41	41
Other receivables and accruals	0	0
Total Trade & other receivables	**1,306**	**853**
Total current and non current	**1,306**	**853**

The majority of trade is with NHS England. As NHS England is funded by Government to provide funding to CCGs to commission health services, no credit scoring of them is considered necessary.

No financial assets that would otherwise be past due or impaired have had terms renegotiated.

8.1 Receivables Past their Due Date but not Impaired

	2022-23 DHSC Group Bodies £'000	**2022-23 Non DHSC Group Bodies £'000**	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	137	2	32	217
By three to six months	0	0	0	0
By more than six months	0	37	48	37
Total	**137**	**39**	**80**	**254**

The above table shows the monies owed to the CCG that are over 30 days overdue. The debt over six months relates to premises costs for a GP Practice which is being actively progressed to resolution with support of the Local Medical Committee (LMC) and a debt with an NHS Organisation which is close to resolution.

The CCG has provided for impairments for all receivable from non DHSC bodies in line with IFRS 9 in 2022-23.

9 Cash & Cash Equivalents

	2022-23	2021-22
	£'000	£'000
Balance at 01 April 2022	11	4
Net change in year	2,144	7
Balance at 30 June 2022	**2,155**	**11**
Made up of:		
Cash with the Government Banking Service	2,155	11
Cash in hand	0	0
Cash and cash equivalents as in statement of financial position	**2,155**	**11**
Total bank overdrafts	0	0
Balance at 30 June 2022	**2,155**	**11**
Patients' money held by the clinical commissioning group, not included above	0	0

10 Trade & Other Payables

	Current 2022-23 £'000	Current 2021-22 £'000
NHS payables: Revenue	164	157
NHS accruals	1,585	212
Non-NHS and Other WGA payables: Revenue (1)	165	4,108
Non-NHS and Other WGA accruals (2)	16,034	18,149
Social security costs	105	103
Tax	87	90
Other payables and accruals (3)	3,270	4,179
Total Trade & Other Payables	**21,410**	**26,998**
Total current and non-current	**21,410**	**26,998**

(1) The Non-NHS and other payables, Revenue includes payments to the Local Authority, Care homes and General Practice.
(2) Non-NHS and Other WGA accruals includes the June 2022 prescribing accrual (£29k).
(3) Other payables include outstanding pension contributions at 30 June 2022 (£111k) and General Practice contract payments through Co-Commissioning (£3,196k).

There are no liabilities included above for payments due in future years under arrangements to buy out the liability for early retirement over 5 years.

11 Provisions

	2022-23	2021-22
	£'000	£'000
Continuing care	278	282
Total	**278**	**282**
Total current and non-current	**278**	**282**

A provision has been made in the CCG's accounts for an estimate of the likely future costs of NHS Continuing Healthcare claims, where patients have submitted a request to the CCG for a review of their continuing healthcare eligibility for periods of care from 1 April 2013.

The provision is based upon claims made against the CCG which have not yet been fully assessed, and where the likelihood of success is greater than 50%, a provision is made. The likelihood of success is estimated by the Continuing Care team responsible for assessing claims. The costs are then estimated based on the average cost of nursing care per week.

There are no costs included in the provisions for NHS Resolution as at 30 June 2022 in respect of clinical negligence liabilities of the CCG.

Under the Accounts Directions issued by NHS England on 24 February 2015, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to previously unassessed periods of care before the establishment of CCGs. The legal liability to discharge these claims remains with the CCG.

The total value of legacy NHS Continuing Healthcare provisions to 31 March 2013, which is accounted for by NHS England on behalf of the CCG is £100,919 as at 30 June 2022 and a contingent liability of £125,600.

11.1 Provisions

The table below shows the breakdown of the provisions made by the CCG in 2022-23 and expected timing for discharge.

	Continuing Care £'000	**Total £'000**
Balance at 01 April 2022	**282**	**282**
Utilised during the year	(4)	**(4)**
Balance at 30 June 2022	**278**	**278**
Expected timing of cash flows:		
Within one year	278	**278**
Balance at 30 June 2022	**278**	**278**

12 Contingencies

	2022-23 £'000	2021-22 £'000
Contingent liabilities		
Continuing Healthcare	97	97
Net value of contingent liabilities	**97**	**97**
Contingent assets		
GL Hearn Rates Rebates	160	160
Net value of contingent assets	**160**	**160**

The CCG has a contingent liability relating to the NHS Continuing Healthcare claims on the CCG for periods of care from 1st April 2013. This is based upon the claims that are less than 50% probable as assessed by the Continuing Healthcare team.

The CCG has a contingent asset relating to GP rates rebates which are being managed by GL Hearn and NHS England.

13 Financial Instruments

13.1 Financial Risk Management

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

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the CCG's Standing Financial Instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the CCG and internal auditors.

13.1.1 Credit Risk

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

13.1.2 Liquidity Risk

The CCG is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament.

The CCG draws down cash to cover expenditure, as the need arises. The CCG is not, therefore, exposed to significant liquidity risks.

13.1.3 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.

14 Financial Assets

	Financial Assets measured at amortised cost 2022-23 £'000	Total 2022-23 £'000
Trade and other receivables with NHSE bodies	15	15
Trade and other receivables with other DHSC group bodies	93	93
Trade and other receivables with external bodies	81	81
Cash and cash equivalents	2,155	2,155
Total at 30 June 2022	**2,344**	**2,344**
Items not Classified as Financial Instruments		1,117
Total Trade and other Receivables, cash and cash equivalents		**3,461**

	Financial Assets measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Trade and other receivables with NHSE bodies	73	73
Trade and other receivables with other DHSC group bodies	90	90
Trade and other receivables with external bodies	418	418
Cash and cash equivalents	11	11
Total at 31 March 2022	**593**	**593**
Items not Classified as Financial Instruments		272
Total Trade and other Receivables, cash and cash equivalents		**864**

These balances are reported within the Statement of Financial Position and also Note 8 and Note 9. The Fair Value cost is as above.

15 Financial Liabilities

	Financial Liabilities measured at amortised cost 2022-23 £'000	Total 2022-23 £'000
Trade and other payables with NHSE bodies	19	**19**
Trade and other payables with other DHSC group bodies	1,730	**1,730**
Trade and other payables with external bodies	23,802	**23,802**
Total at 30 June 2022	**25,551**	**25,551**

In 2022/23 the trade and other payables with external bodies figure of £23,802 includes £4.333m in relation to lease liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Trade and other payables with NHSE bodies	17	**17**
Trade and other payables with other DHSC group bodies	352	**352**
Trade and other payables with external bodies	26,436	**26,436**
Total at 31 March 2022	**26,805**	**26,805**

These balances are those reported within the Statement of Financial Position and also Note 10. The Fair Value cost is as above.

As required to report, the CCG has no payables to the Department of Health, and all liabilities are expected to discharge in one year or less.

16. Operating Segments

The CCG considers that they have only one segment which is commissioning of healthcare services which is consistent with internal reporting.

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
NHS Wigan Borough CCG	153,912	(226)	**153,686**	7,789	(26,021)	**(18,232)**
Total	**153,912**	**(226)**	**153,686**	**7,789**	**(26,021)**	**(18,232)**

17. Joint arrangements - interests joint operations

Pooled Budget – Better Care Fund

The CCG has entered into a pooled budget with Wigan Council to support integrated health and social care, known as the Better Care Fund (BCF), hosted by Wigan Council and governed through the Section 75 agreement. This is a nationally mandated scheme that commenced in 2015-16.

The pool is jointly controlled by Wigan Borough CCG and Wigan Council. The Wigan Health and Wellbeing Board, made up of Wigan Council and CCG representatives, govern the use of the fund. The fund is used to commission services that support the integration of health and social care, which seeks to ensure support for people to be well and independent and in control of their own care.

Each scheme within the BCF has been allocated a lead commissioner (either the Council or the CCG) and accounting for the pool reflects these arrangements. This is transacted on a net basis.

The total value of the pool in 2022-23 is £12,458k (£47,811k in 2021-22). The CCG contribute £7,129k (£26,987k in 2021-22) to the pool which provides funding to the revenue schemes of the pool. The Council contribute £5,329k (£20,824k in 2021-22) to the pool of which £1,139k (£4,554k in 2021-22) is from the Disabled Facilities Grant, which pays for the capital schemes of the pool.

The CCG lead commission schemes to the value of £1,556k in 2021/22 (£5,854k in 2021-22). The remainder of the schemes are lead commissioned by Wigan Council.

Better Care Fund Pooled Budget Memorandum 2022-23

	CCG	Wigan Council	Pool
	£000	£000	£000
Income			
Revenue	7,129	4,191	11,320
Capital Grant		1,139	1,139
Capital Grant Underspend from 2020/21			0
Total Income	**7,129**	**5,329**	**12,458**
Expenditure			
Revenue expenditure	1,566	9,753	11,319
Capital expenditure		1,139	1,139
Total Expenditure	**1,566**	**10,892**	**12,458**
Total Underspend			**0**
Revenue Underspend / Overspend			**-1**
Capital Underspend			**1**

Due to the management of resources being achieved no additional contribution was required by either organisation.

Better Care Fund Pooled Budget Memorandum 2021-22

	CCG	Wigan Council	Pool
	£000	£000	£000
Income			
Revenue	26,987	16,270	43,257
Capital Grant		4,554	4,554
Total Income	**26,987**	**20,824**	**47,811**
Expenditure			
Revenue expenditure	5,854	37,403	43,257
Capital expenditure		3,385	3,385
Total Expenditure	**5,854**	**40,788**	**46,642**
Total Underspend			**-1,169**
Revenue Underspend / Overspend			**0**
Capital Underspend			**-1,169**

18 Related Party Transactions

Governing Body Members

The following are members of the NHS Wigan Borough CCG Governing Body, who have declared interests with organisations that the CCG conduct business with. For Governing Body members only organisations that the CCG have transacted with are listed within the payments section of this note, although all interests declared are listed in the narrative.

Mr McKevitt (Chief Finance Officer) is the Treasurer/Chief Finance Officer at Wigan Council.

Dr Dalton (Chair) is a GP, GP Trainer and GP Appraiser. He is a director at Shakespeare Surgery Ltd and Shakespeare Services Ltd. He is also a minor shareholder in Shakespeare Surgery Ltd, a company that provides GMS GP services to the NHS and a minority shareholder in Shakespeare Services that provides services to Non-NHS organisations and private individuals in the area of travel, training and health advice. Shakespeare Surgery is a shareholder of Health First ALW Community Interest Company, which acts as a provider of various health services and a mechanism for GP federated working. Dr Dalton is also a member of the North West Leadership Academy Board.

Dr Davies (Clinical Governing Body Member) is a GP partner in the Dicconson Group Practice.

Dr Wong (Clinical Governing Body Member) is a partner GP at Old Henry Street Medical Practice.

Dr Jolles (Clinical Governing Body Member) Shareholder and Director at Shakespeare Surgery

Mr Armer (Lay Member) was the Voluntary, Community and Social Enterprise (VCSE) representative at Lancashire and South Cumbria Integrated Community Service (ICS) until November 2021.

Mr Costello (Lay Member) was the former Deputy Chief Executive of Wigan Council and is the Chair of Wigan & Leigh College from January 2017.

Details of related party transactions in 2022-23 are as follows:

	Payments made to Related Party (Expenditure)	Receipts from Related Party (Income)	Of which amounts owed to Related Party (Creditors)	Of which amounts due from Related Party (Debtors)
	£000	£000	£000	£000
P92003 - The Dicconson Group Practice	464	0	169	(9)
P92007 - Dr Spielman and Partners	228	0	52	(15)
P92653 - Shakespeare Surgery	132	0	34	0
Wigan Council	6,226	146	313	45

During the year, the CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent department.

The most significant of these, not already listed above, are listed below.

	Payments made to Related Party (Expenditure)	Receipts from Related Party (Income)	Of which amounts owed to Related Party (Creditors)	Of which amounts due from Related Party (Debtors)
	£000	£000	£000	£000
Wrightington Wigan And Leigh NHS Foundation Trust	64,069	0	523	29
Greater Manchester Mental Health NHS Foundation Trus	9,857	0	584	0
Northern Care Alliance NHS Foundation Trust	4,999	0	35	0
Bolton NHS Foundation Trust	4,759	0	33	0
North West Ambulance Service NHS Trust	3,620	0	25	0

2021-22 Related Party transactions are listed below for comparative purpose.

	Payments made to Related Party (Expenditure)	Receipts from Related Party (Income)	Of which amounts owed to Related Party (Creditors)	Of which amounts due from Related Party (Debtors)
	£000	£000	£000	£000
P92003 - The Dicconson Group Practice	2,134	0	298	(2)
P92007 - Old Henry Street Medical Practice	998	0	92	(1)
P92653 - Shakespeare Surgery	443	0	37	0
Wigan Council	31,534	557	5,639	310

	Payments made to Related Party (Expenditure)	Receipts from Related Party (Income)	Of which amounts owed to Related Party (Creditors)	Of which amounts due from Related Party (Debtors)
	£000	£000	£000	£000
Wrightington Wigan And Leigh NHS Foundation Trust	251,758	0	250	151
Salford Royal NHS Foundation Trust	20,395	0	32	0
Royal Bolton NHS Foundation Trust	18,643	0	0	0
Manchester University NHS Foundation Trust	11,101	1	0	1
North West Ambulance Service NHS Trust	14,573	0	0	0

The CCG had no material transactions with other government department and other central and local government bodies that have not been listed above.

19 Events after the Reporting Period

There are no adjusting post balance sheet events on the financial statements of the CCG.

20 Financial Performance Duties

CCGs have a number of financial duties under the National Health Service Act 2006 (as amended).

In accordance with the financial rules set by NHS England the CCG has spent £608m so generating a break even position.

The CCG's performance against those duties was as follows:

Revenue Resource Limit	154 m
Net Operating Resources	(154)m
Break even	0

The table below shows the year on year comparable of the Financial Performance of the CCG.

	2022-23	**2022-23**	2021-22	2021-22
	Target	**Performance**	Target	Performance
Expenditure not to exceed income	153,912	153,912	608,472	608,468
Revenue resource use does not exceed the amount specified in Directions	153,686	153,686	607,711	607,707
Revenue administration resource use does not exceed the amount specified in Directions	1,349	1,349	6,592	5,831

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

21 Losses and Special Payments

21.1 Losses

There have been no losses in 2022/23.

21.2 Special payments

There were no special payments made in 2022/23.