NHS
South Tyneside
Clinical Commissioning Group

Annual report
and accounts

1 April - 30 June 2022

Contents

PERFORMANCE REPORT[1]

Samantha Allen

Chief Executive for the North East and North Cumbria Integrated Care Board

Accountable Officer

30th June 2023

[1] The ICB Chief Executive was not the Accountable Officer of the CCG, however as per the NHS England annual report and accounts guidance, is the required signatory for this report.

Performance Overview

This section includes a statement from our Clinical Chair and the Accountable Officer, information about our CCG including our vision, and the areas we have focused on in the past year, including an outline of the work carried out to manage the COVID-19 pandemic and vaccine rollout in South Tyneside.

Statement from the Clinical Chair and Accountable Officer

Welcome to NHS South Tyneside Clinical Commissioning Group's (CCG) tenth and final annual report covering April 2022 to June 2022. This report provides an insight into our work during our last three months as a CCG, ahead of the transition to the North East and North Cumbria Integrated Care Board (ICB) on 1 July 2022.

While it may be unusual to publish an 'annual' report for a three-month period, this underlines the importance of accountability in our NHS to which we must abide as commissioners of NHS services.

Within this report we can now look back on nine years of hard work and achievements, as well as looking ahead to a new future as part of the ICB.

Improved mental health services, a big reduction in smoking during pregnancy, and improvements to stroke care that have saved lives.

Primary care is more closely connected to hospitals since the introduction of Health Pathways, and we have made progress in removing some of the bureaucracy faced by our clinicians.

South Tyneside's health and care services now operate as a single system, with old organisational barriers replaced by a spirit of shared purpose and energy. The impressive response to Covid- 19 and the vaccine programme are testament to that shared purpose, which leaves our area in a strong position for new 'place-based' local working arrangements within the ICB.

Our heartfelt thanks go to everyone who has been part of the CCG's work – colleagues, partners and our communities have all played their part. We are proud of what we have achieved together and will continue to work for better health and the best possible services as part of the ICB.

The past two years have seen an incredible level of courage, commitment and creativity from colleagues across our health and care system as we worked to manage Covid-19 and the vaccine programme, as well as maintaining day-to-day services and working to enhance care in several areas.

This has included hospital staff managing waves of Covid-19 in spite of significant challenges with staff sickness. Practices and patients adapted to new ways of working, including telephone triage, phone consultations and greater use of eConsult.

The impressive Covid vaccine programme – a true partnership effort – helped well over 80% of eligible people to have at least one dose. South Tyneside was one of the first areas to vaccinate care home residents, while housebound patients received their jabs from community pharmacists working weekends. Additional outreach work also helped to reach groups like asylum seekers and homeless people, as well as targeting areas with lower take-up.

The first phase of the Path to Excellence programme made a range of changes, including improvements to stroke care that have undoubtedly saved lives. Following a pause due to Covid-19, phase two's focus on planned procedures could help with the backlog of patients awaiting surgery due to the pandemic and make us better equipped for higher demand in periods of 'surge'.

The programme was preparing for a full public consultation as the period covered by this report came to an end.

Other areas of achievement by the CCG and its partners included enhancements to Long Term Conditions care, greater early intervention in areas like weight management, hypertension and diabetes, and new models for cardiac and heart failure rehabilitation.

Our mental health services are among the best in the country, with initiatives like the healthy minds team, who support young people in schools. South Tyneside has also made great progress in extending annual physical health checks for people with learning disabilities or severe mental illness, which can make a huge difference for people who often find it difficult to raise health concerns.

A range of improvements to musculoskeletal (MSK) services has included adoption of a first contact physiotherapy model by all our primary care networks. Further enhancements have been made within cancer services and healthy ageing support.

Meanwhile, our palliative and end of life care model has continued to develop, offering a range of high-quality services and greater choice for patients and families, whatever their circumstances. This includes increased domiciliary care, nursing and palliative care support in the community, while the new Cedar Unit began offering care in a suite of 'home from home' bedrooms at Haven Court during April 2022.

Dr Neil O’Brien
Accountable Officer

Dr Matthew Walmsley
Clinical Chair

Statement of purpose

This section outlines our business model and environment, organisational structure, objectives, and strategies.

About NHS South Tyneside Clinical Commissioning Group

NHS South Tyneside CCG represented 21 GP practices, serving a population of 151,133 people (2020 ONS mid-year estimates). Led by doctors, nurses and other health professionals working alongside experienced healthcare managers, it was responsible for planning and commissioning (buying) of local healthcare services, including:

- Planned hospital care
- Urgent and emergency care
- Rehabilitation care
- Community health services
- Mental health and learning disability services

The CCG's Clinical Chair was Dr Matthew Walmsley, who chaired the Council of Practices and the Governing Body. The CCG Council of Practices comprised of a GP nominated lead from each of the 21 member practices, giving the CCG a strong mandate from clinical leaders.

The CCG's vision has been to work collaboratively across South Tyneside to improve health and commission excellent health care, supported by three high level strategic objectives:

- People are able to take greater responsibility for their own health
- People are able to stay well in their own homes and communities
- People receive timely and appropriate complex care

The CCG, and now the ICB, work with a wide range of partners, including:

- South Tyneside Health and Wellbeing Board
- South Tyneside Safety Children and Adults Partnership
- Community Safety Partnership
- Domestic Abuse Partnership board
- South Tyneside Council – working with adult social care, housing and public health and other committees in the council, including Overview and Scrutiny and People Select Committees, as well as special commissions
- NHS providers of healthcare – South Tyneside and Sunderland NHS Foundation Trust and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- North East Ambulance Service

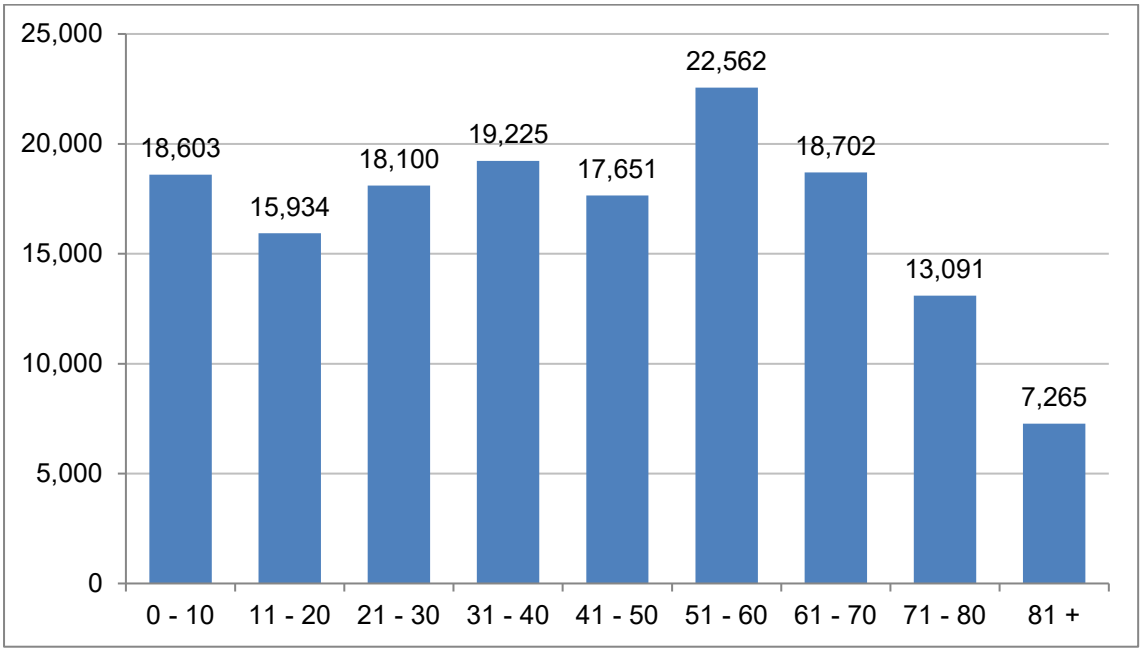
- Other providers of NHS healthcare – independent sector, community and voluntary sector
- South Tyneside Healthwatch
- Local people

On 1 July 2022, our region's CCGs were replaced by the new North East and North Cumbria (NENC) Integrated Care Board (ICB).

Overview of South Tyneside

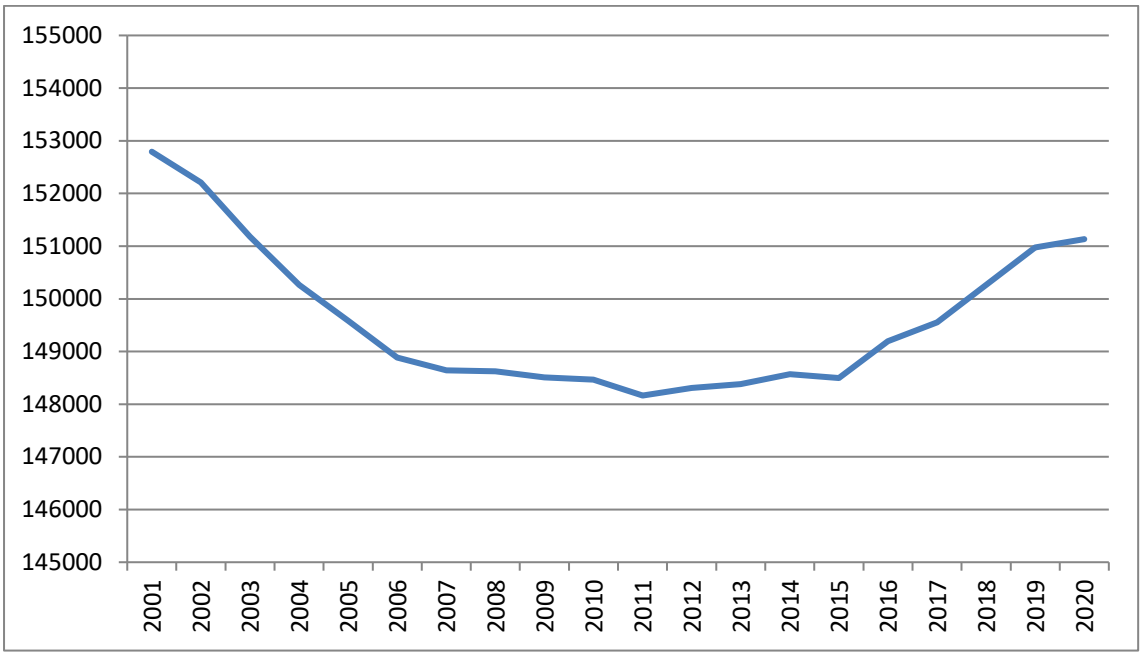
The current population of South Tyneside is 151,133 (2020 ONS Mid-Year Estimates).

Figure 1: 10-year band age profile for South Tyneside (2020 ONS MYE)



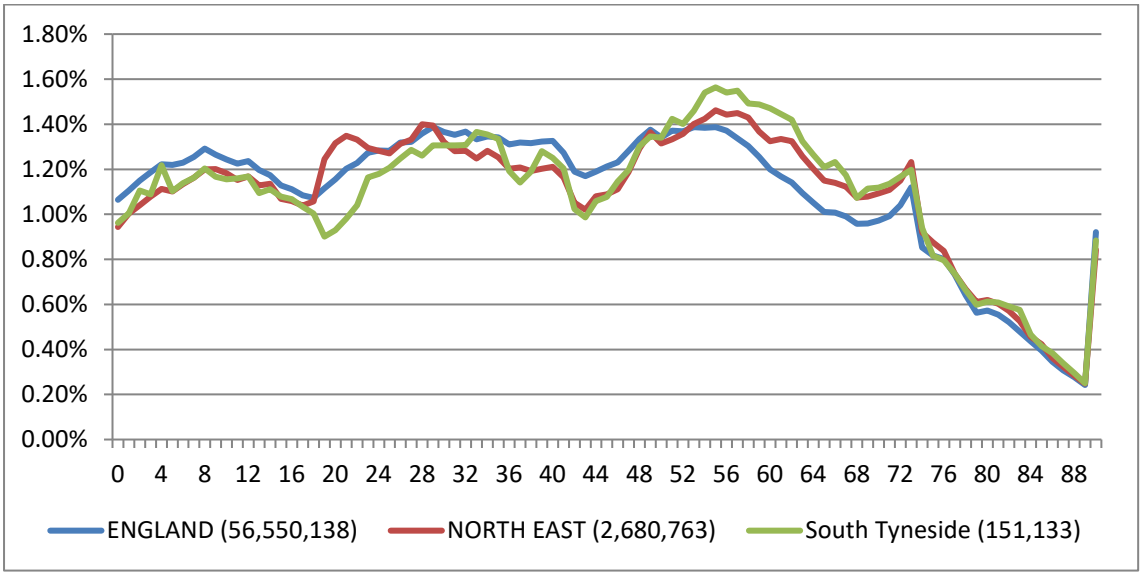
The population for South Tyneside fell up until 2011. However, this decline has recently levelled off and the population is forecast to rise over the next 20 years.

Figure 2: Total population for South Tyneside 2001 - 2020 (ONS MYE)



Compared to England, the population of South Tyneside has a higher proportion of older people, in line with the North East average. Older people use health and social care services more intensively than any other age group, which we take into consideration in planning services.

Figure 3: Age population for South Tyneside, the North East, and England (2020 MYE)



NHS

If **South Tyneside** was a village of 1,000 people

Deprivation

245 Living in 'Most Deprived'

11 Living in 'Least Deprived'

Population

486 Male

514 Female

Ethnicity

27	Asian or Asian British
6	Black, African, Caribbean or Black British
6	Mixed or Multiple Ethnic Groups
24	Other Ethnic Group
732	White
205	Unknown

Vaccinations & Screening

Vaccinated/Screened

Not Vaccinated/Screened

Flu (65+ Yrs)	169	35
MMR (2 Doses 2-18 Yrs)	159	32
Cervical Screening (50-64 Yrs)	84	28
Cervical Screening (50-64 Yrs)	120	38

Obesity

71 Obese adults

9 Overweight 10-11 year olds (Inc. obese)

2 Severely obese 10-11 year olds

5 Overweight 4-5 year olds (inc. obese)

1 Severely Obese 4-5 year olds

Physical activity

452 Physically active adults

232 Physically inactive adults

Household

14 Housebound

48 Under 16 in **low income** families

Smoking

155 Smokers aged 15+

133 Smoking at delivery (per 1000 maternities)

Alcohol

1 Alcohol admissions (under 18)

12 Alcohol admissions (all ages)

Frailty

27 Moderately frail

15 Serverely frail

Long Term Conditions*

44 Age 18+ with CVD

38 With cancer

63 Aged 17+ with diabetes

*Data represents at least one long term condition, if someone has numerous long term conditions only one counts towards the data in this instance.

Cardio

156 With hypertension

14 With heart failure

24 With AF

21 Had stroke/ TIA

Respiratory

37 With COPD

70 With asthma

Mental health

137 Age 18+ with depression

8 With dementia

7 With learning disability

10 With serious mental illness

Admissions

20 Emergency admissions

1 Hip fracture aged 65+

Key challenges

Covid-19 pandemic

Like the whole of our country, our paramount concern over the past two years has been to support patients, staff and our wider health and care system through the Covid-19 pandemic.

After the first cases appeared locally in March 2020, NHS staff, our partners and our local community have all made immense contributions to keeping South Tyneside as safe as possible through a situation that none of us have experienced before.

Frontline health and care staff have worked incredibly hard and with great courage, as well as showing immense creativity in quickly finding new ways of working under the pressure of Covid-19. Hospital staff managed winter challenges at the same time as dealing with immense pressure as the pandemic peaked with around 50% of beds used by Covid-19 patients. At the same time, GPs and their teams had to drastically change their working models to keep staff and patients as safe as possible.

Furthermore, our frontline teams in primary care came together to deliver thousands of Covid vaccinations to our local communities and vulnerable groups. Vaccination services remain ongoing and a testament to the dedication and skilled teamworking across the whole of the primary care sector to deliver a programme of this scale alongside delivery of core services.

One of the best examples of the innovation and energy of the pandemic response was the 'Sats Squad'. This team of volunteers stayed on standby to deliver oxygen saturation tests to Covid-19 patients at short notice.

When a test was urgently needed, a GP would text the address and a trained volunteer would then head straight out, leaving the kit on the patient’s doorstep before stepping back safely.

The patient then tested their own oxygen saturation level, with the GP helping by phone or video link. The kits often helped doctors decide when someone needed hospital care – or helped them avoid being admitted unnecessarily.

New ways of working

The Covid-19 pandemic forced GP practices to make major changes to the way they see patients, moving to safer methods like phone, online and video consultations almost overnight, except where patients needed to be seen face to face for clinical reasons.

Many patients welcomed these changes, like cutting out travel and time spent in the waiting room, but they also bring challenges like internet access and the possibility of missing body language that would be more apparent in a face-to-face consultation.

There are clear benefits, for example in more efficient use of staff time, reducing infection risk and

enabling patients to be seen quicker, as well as understanding issues like internet access and confidence.

All practices are now providing a mix of face-to-face and remote (telephone, video or eConsult) consultations.

Practices are in the main triaging the patient (usually by telephone) and then if the patient requires further services, they are booked into a consultation slot. The type of appointment slot is determined by clinical need and patient choice.

Many patients are also using eConsult, where you complete a form on the practice website, and a member of the practice team sends advice or arranges an appointment if you need one.

Covid-19 vaccine programme

South Tyneside's Covid-19 vaccine programme began in December 2020 and has delivered many thousands of vaccines to people across the borough.

The three local vaccine centres operated by Primary Care Networks at Flagg Court, The Glen and Cleadon Park health centres have continued to play a central role, alongside local pharmacies who have run regular clinics as well as leading the housebound vaccine work.

Primary care staff have worked exceptionally hard both on supporting the demands of the vaccine programme and keeping core services operating at the same time.

South Tyneside was one of the first areas in England to start vaccinating housebound patients and people in care homes, and this success had a significant impact in keeping many of our more vulnerable patients safer. The housebound service was provided by 22 community pharmacists from across the borough. South Tyneside and Sunderland NHS Foundation Trust also ran a programme to bring the vaccine to its own staff.

The programme has also relied on the hundreds of local people who have volunteered to work as marshals, helping the vaccine process run smoothly, and guiding patients through the centres.

In addition, regular visits to the borough by the Melissa bus and the Nightingale Hospital's vaccine bus helped to bring the vaccine right into the community, making it easier for people to keep themselves safe. The buses have provided jabs at a range of public places including King Street, South Shields market place, Hebburn Central, South Shields FC, Caesar's Den restaurant and the library building in Jarrow.

Following the success of the care home and housebound programmes, an outreach programme was established to protect a range of health inclusion groups. These included asylum seekers, homeless people, traveller communities, sex workers, mental health inpatients, looked after children and those in out of area placements, specialist care homes, Black, Asian and Minority Ethnic communities, people with disabilities, and patients with serious mental illness.

This programme offered a range of interventions including:

- Outreach clinics in places of worship
- Specialised 'no booking required clinics' at local vaccination sites available for identified patient groups – supported by Voluntary and Community Sector partners
- Hosting specific outreach clinics for patients with learning disabilities, at a familiar setting, including vaccination for carers whilst offering an annual health check at the same facility
- Outreach clinics within commissioned services, targeting high risk patients including people who are homeless or experiencing issues with drugs or alcohol

Following analysis of vaccine data, a second phase of this work reached people in industrial workplaces, people from Asian or Asian British backgrounds, and residents in ward areas with the lowest take-up (Simonside and Rekendyke, Westoe and West Park).

The vaccine programme has been underpinned by an ongoing promotional campaign with clinic dates available at the widely advertised www.getyourjab.uk. This has been supported by regular media coverage (in outlets like the Shields Gazette, Newcastle Chronicle, Tyne Tees and BBC Look North) and digital advertising campaigns.

The covid vaccination programme continues at pace with an extensive autumn booster programme likely in September 2022 (subject to national guidance).

Statement of activity

North East and North Cumbria transition and development

In the North East and North Cumbria (NENC) Integrated Care System (ICS), we have been working at three broad areas of scale:

- Place and Neighbourhood
- Four Integrated Care Partnership areas
- Integrated Care System

During 2021/22 we developed our System Development Plan which set out our approach, governance, workstreams and plans to transition to the NENC ICS.

This set out areas such as outcomes and priorities, establishing the ICB and Integrated Care Partnership (ICP), arrangements for Place Based Partnerships, commissioning arrangements, provider collaboratives, data and digital transformation and engagement with system partners.

The NENC ICS established an ICS Development & Transition Programme Board with a series of workstreams to manage this transition. CCG staff were involved in these workstreams, providing valuable expertise in planning for the transition and looking at opportunities for improving ways of

working in the future.

Partners were also linked in where appropriate. All workstreams shared the approach of building on what is already working well at place and will be sharing this with wider stakeholders.

We have worked with partners to collectively explore the best way to deliver ICB priorities across the ICS, ensuring we retain and strengthen the very best local, placed based working.

The ICP at NENC level will operate as a statutory committee, bringing together the NHS and local authorities as partners to focus more widely on health, public health and social care. It will include representatives from the ICB, local authorities and other partners such as NHS providers, public health, social care, and voluntary, community and social enterprise (VCSE) organisations.

Our NENC ICP will be responsible for developing an integrated care strategy to set out how the wider health and wellbeing needs of the local population will be met.

We also have a provider collaborative, a partnership arrangement involving our North East and North Cumbria provider trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements. This worked across a range of programmes and help our providers work together to plan, deliver and transform services.

Our region's new ICB assumed its role on 1 July 2022, under the leadership of Professor Sir Liam Donaldson (Chair) and Samantha Allen (Chief Executive).

North East and North Cumbria Integrated Care Board

Over recent years, our CCG has been part of the NENC ICS, which was a regional partnership between the organisations that meet health and care needs across the area, to coordinate and plan services that improve the health of the people of our region and reduce health inequalities.

The NENC ISC area is the largest in England and is responsible for the health services of more than three million people across 5,313 square miles. It is one of the most geographically diverse areas, from the Lake District in the west to large urban areas in the north east and more rural areas.

We have a strong history of working together across health and care in our region. The quality of some of our health and care services is consistently rated amongst the best in the NHS and we have an abundance of great care delivered by highly committed teams of health and care staff.

Despite this, overall public health faces some of the most significant challenges. Our ambition is to change this by working together. Although there have been many improvements in recent years - for example, the number of people dying from cancer or heart disease has decreased, fewer people are smoking and many are living longer - healthy life expectancy remains amongst the poorest in England.

We have high levels of unemployment, lower than average levels of decent housing, and significant areas of deprivation. These contribute to some of the starkest health inequalities, early death rates

and highest sickness levels in England, driving much of the pressure that health and social care services have to manage.

Health and Care Act (2022)

Shortly after the end of 2021-22, the Health and Care Act received royal assent, confirming that Clinical Commissioning Groups would be replaced by Integrated Care Boards on 1 July 2022. ICBs are now accountable for NHS spending and performance, taking on the planning functions of CCGs.

Putting ICSs on a statutory footing can empower them to better join up health and care services, improve population health and reduce health inequalities.

Each ICS is led by an NHS Integrated Care Board (ICB), an organisation with responsibility for NHS functions and budgets, and an Integrated Care Partnership (ICP), a statutory committee bringing together all system partners to produce a health and care strategy.

CCG – Closedown and due diligence assurance arrangements

Background

Due diligence was necessary to enable safe and effective transfer from sending organisations to receiving organisations. The CCG Closedown due diligence process was supported by a bespoke checklist provided by NHSE specifically designed for the ICS implementation programme. A staff and property transfer scheme was the legal instrument used for the transfer.

CCG Accountable Officers were accountable for CCG closedown due diligence. As the accountable persons CCG Accountable Officers agreed to a joint coordinated approach for due diligence, working together / sharing information, as appropriate to prevent duplication.

Joint coordinated approach

A CCG Closedown Due Diligence Sub-Group was established and assurance reporting arrangements were agreed to ensure that the group have oversight and are cited on all risks and issues identified, as part of the due diligence perspective process.

It was recognised that there were opportunities for some of the due diligence areas to be coordinated from a central and where specific functions have been identified as being a locally led CCG function

CCG due diligence assurance was also provided to the ICB Programme Board, ICB Work-stream meetings (monthly) and through CCG local Committee arrangements (bi-monthly).

NENC CCGs Closedown Due Diligence Progress and Visibility Report was shared with NHSE in May 2022. The report outlined progress made in relation to the NENC CCGs close-down due diligence activities. The report was split by CCG, with an overview of progress against each due diligence sub-heading, key messages and a summary of outcomes from CCG Check & Challenge

Workshops (held in May 2022). The report also highlighted any high risk / shared risks / issues identified by ICS workstreams or individual CCGs

As part of the NENC CCGs Closedown a Due Diligence Report was also presented to the NENC ICB on 01.07.2022 to provide assurance to the ICB with regards to the NENC CCGs closedown and due diligence process and activities that have taken place over the last six months.

The NENC CCGs Closedown a Due Diligence Report also provided an update of progress against CCG closedown activities and summarises all CCG closedown high level and shared risk/issues and areas of concern expressed to date. As part of the agreed approach to NENC CCGs closedown due diligence, all CCGs were asked to identify local operational transitional risks /issues (via their strategic and corporate risk registers and / or programme / project risk registers / issue logs).

As part of the NHS England stipulated ICB establishment timeline, all NENC CCGs provided formal assurance of CCG closedown due diligence activities to the ICB Chief Executive on 30 June 2022.

It was also recognised that there are several CCG closedown activities that transferred to the ICB (due to time-bound constraints) and the ICB Executive would have oversight of these transitional activities. All CCG closedown transitional activities have been recorded in an action log and the ownership transferred to the ICB Executive for oversight and monitoring purposes on 1 July 2022.

Path to Excellence

We have continued our partnership with NHS South Tyneside CCG and South Tyneside and Sunderland NHS Foundation Trust on the Path to Excellence programme, a five-year transformation of hospital healthcare provision across South Tyneside and Sunderland.

During April, May and June 2022, the programme continued its pre-consultation processes and involving staff, patients, and stakeholders in helping to assess the working ideas and the continuation development of the pre-consultation business case.

Recognising the disestablishment of the clinical commissioning groups and the establishment of the Integrated Care Board for the North East and North Cumbria, a key element of the programme's focus has been around ensuring continuity of governance and ensuring the programme maintains focus during the transition of commissioning responsibilities.

Joint committee of CCGs and Integrated Care Board for the North East and North Cumbria

A joint committee from the three CCG governing bodies and the incoming ICB was established in February to provide the opportunity for members to familiarise themselves with the case for change.

Four meetings were planned so that members could review key elements of the programme to provide challenge and assurance as outgoing and incoming statutory NHS commissioners.
In June 2022, the Joint Committee reviewed the key elements of the programme and progress on

their achievements, to support work to date and provide assurance on key elements of the programme as part of handover arrangements to the ICB.

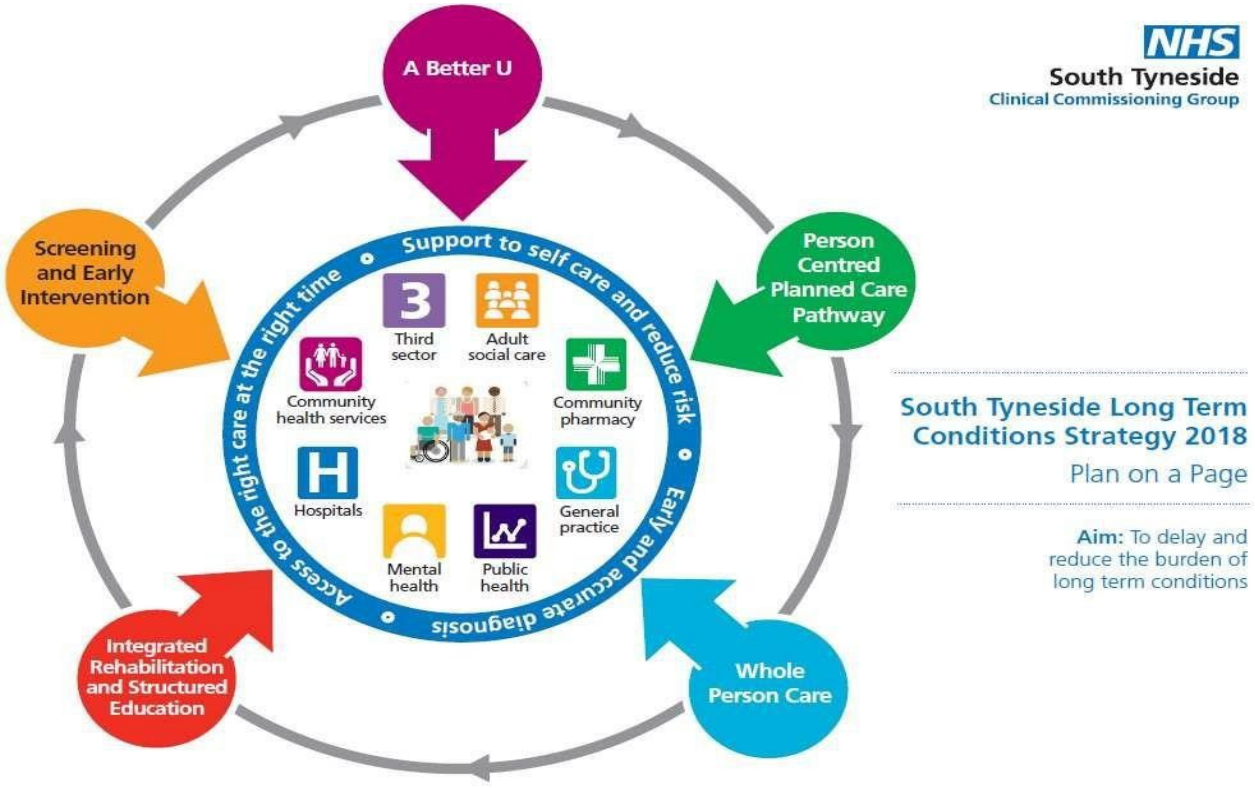
The Joint Committee noted the progress of the programme and the proposals developed under Phase 2 in meeting the best practice checks set out under national guidance for clinical quality and strategic fit, assurance on best practice communications and engagement, integrated impact assessments and NHSE strategic tests.

The Committee expressed appreciation to the programme group and to staff involved for the commendable work achieved to date and foremost supporting the health needs of the population.

Long-term conditions

The Long-Term Conditions (LTC) Alliance launched in 2018, bringing together health and care partners from across the South Tyneside system to work together across organisational boundaries. The Alliance works to support and encourage active collaboration across the system, ensuring the implementation of evidence-based and innovative interventions, so that people with LTCs are supported to take control over their conditions, where disease management is optimised, and where accessible alternatives to hospital admissions are in place ensuring parity of esteem with non-medical interventions.

Launched in autumn 2018, the Long-Term Conditions Strategy sets out our ambition to delay and reduce the burden of long-term conditions.



We have made significant progress in a range of areas since the launch of the strategy:

A Better U

A range of **social prescribing** roles are now in place within South Tyneside (link workers, health and wellbeing coaches and care coordinators) and are supporting a range of patients and services. The teams can offer emotional and psychosocial support, as well as coaching, to encourage self-management of health and wellbeing.

Having captured learning from the initial testing of the **Peer Pals** model in stop smoking services, the CCG and its partners are now recruiting new peer pals to support a range of services including weight management, musculoskeletal and cardiac rehabilitation. This model, promoted under the UCan brand, allows people with lived experience to offer support, advice, and guidance (where appropriate) to those who are accessing services.

Screening and early intervention

We have supported implementation of a range of new **weight management services**, including a digital weight management programme. The services aim to help people lose weight and become more physically active to reduce the risk of diseases associated with obesity.

We have implemented a new **BP@Home** model across general practice, which enables people to measure and share blood pressure readings with their GP from home. This ensures patients can manage their hypertension well and remotely.

We have continued to work with GP practices to increase referrals and uptake of the **NHS Diabetes Prevention Programme**. We have seen a significant increase in referrals in 2021-22.

We have been working with primary and secondary care partners to develop and implement a new quality assured integrated diagnostic spirometry model to support **diagnosis of a range of respiratory conditions**. The new service launched in March 2022.

Integrated rehabilitation and structured education

We have worked with South Tyneside and Sunderland NHS Foundation Trust to implement new models for cardiac and heart failure rehabilitation, aiming to deliver equity of access and reduce health inequalities. This has included new apps and virtual classes to allow patients to complete their rehabilitation programmes at home, as well as face to face sessions at a range of community venues.

The programme has had fantastic uptake, with all face-to-face classes at full capacity and waiting times reduced to 1-2 weeks (from 6-7 weeks).

Person-centred planned care pathway

We are continuing to implement Year of Care, which aims to provide personalised care and support planning for people with long term conditions, by working in partnership with patients and care professionals. All South Tyneside practices have signed up to implement this new model.

We have developed and updated a South Tyneside long-term conditions toolkit to support our practices to signpost patients to information that will help them self-manage at home.

Whole person care

We have continued to work with South Tyneside and Sunderland health and care organisations to improve our local Post-Covid Assessment Clinic (also known as Long Covid). The service brings together an integrated team offering patients assessment and treatment, delivered in local communities.

Mental health and learning disabilities

Mental health

The CCG and its partners continued to work towards enhancing our mental health and learning disabilities services, with progress on a range of areas.

Older people in the borough now benefit from a bespoke Talking Therapies (IAPT) service, which brings together Age Concern Tyneside South and South Tyneside and Sunderland NHS Foundation Trust.

Age Concern Tyneside South has now mobilised a wellbeing caller service, for people presenting with low mood, while the new primary care mental health network is fully operational, making it easier for people to access mental health support through their GP practice.

In 2021/2022, the primary health hub exceeded national targets in providing health checks for people with learning disabilities or severe mental illness (86% of people with learning disabilities on the register accessing a health check (national target 75%) and 75% of people on the SMI register accessing a health check (national target 60%).

Mental Health Concern have been commissioned to expand the reach of the physical health hub in proactive case finding of people who have been previously unable to access a health check.

The service providers also support people to utilise the outcomes of the health check and to work on a personalised health action plan to address any areas of physical health which could be improved. Staff are currently being recruited to these posts. Further planning and mobilisation will to be developed.

Your Voice Counts has been commissioned to provide similar support to people with learning disabilities, with the aim of working in tandem with Mental Health Concern and staff from the trust. An initial meeting has already occurred to explore the mobilisation model, with the posts going out to advertisement in July 2022.

Local people are an important part of these improvements. We are supporting two groups of residents in their work to develop community mental health hubs, while more than 90 people have taken part in engagement and co-production work to create a new mental health transformation plan

for the borough. In addition, over 90 people from ethnic minority groups have participated in mental health awareness sessions.

Across May/June 2022, commissioning of the new CABIS service has progressed, in line with the transformation plan. While the offer is similar to that in other places, it will also support people who present with mild/moderate head injuries and at this time it is not proposed that this will be managed through the lead commissioning arrangement within other place-based systems.

Learning disabilities and autism

Service user engagement has also been at the heart of our work to improve services for people with learning disabilities and autism. A new Rex Wiki platform was launched to help people with learning disabilities and/or autism to tell their stories and articulate their needs.

The New Learning Disabilities Strategy has been launched. The strategy, which was developed by people with learning disabilities, aims to hold us to account and deliver on a number of key elements, including access to equitable health interventions

Meanwhile, four people with learning disabilities have been employed to conduct quality checks on health services, and a new integrated working group is co-chaired by a person with learning disabilities, progressing priorities which are genuinely co-produced with our residents with learning disabilities as well as their carers.

A new service is currently being mobilised by Autism In Mind South Tyneside (AIMS) to support autistic people being discharged from hospital. A review of the IAPT (talking therapies) services for autistic people is currently underway, with the results expected in the summer. Sensory profiling is now available through the Autism Hub for autistic adults.

We publish an annual report and an easy read document relating to Learning Disability and autistic people (LeDeR), so we are supporting learning from lives and deaths of people with learning disability and autistic people.

In 2022/23, there is an expectation that autistic people will have access to a health check. Autism In Mind has been commissioned to support this, with a staff member in post, who has already reached out to over 150 people with autism.

Children and young people

Annual health checks – mentioned above – are now being rolled out in our special schools for children aged 14 and over, helping to protect their physical health. The Rainbow Flag Award - a national quality assurance framework for primary schools, secondary schools, SEND schools and colleges – has been implemented in all local schools, with a recent BBC news report showing the impact it has had on LGBT+ inclusivity in Forest View Primary School.

The Healthy Minds Team, which supports children and young people in school and college with common mental health issues, continues to receive positive feedback from pupils, schools and

parents alike.

A new ARFID (avoidant restrictive food intake disorder) pathway has been developed locally to provide an additional offer for children who struggle with their food intake.

Musculoskeletal (MSK) services

We work with our partners with the aim of ensuring the best possible musculoskeletal services are provided to patients in South Tyneside. This has included:

Community rehabilitation

The service has returned and expanded its provision of community rehabilitation into local leisure and community venues and developed a ‘Fit for Life’ exercise class to increase physical activity and promote positive lifestyle changes. Data collection has demonstrated that provision of rehabilitation in community gym spaces is leading to an increase in uptake of gym memberships, thus improving the health of the population.

Personalised care

The team has completed the Personalised Care Institute Shared Decision Making (SDM) modules, and measurement of SDM has been the focus of records audits, patient surveys and assessment during clinical supervision. Choice has also been added to include follow-ups in person, over the phone or via video. The greater emphasis on patient choice has resulted in an increase in the Friends and Family Test to 95% of service users reporting positive experiences.

Making Every Contact Count (MECC)

The service has been shortlisted for the best public health initiative and commended by the NHS Chief AHP Officer for its work to ensure MECC is at the heart of the service. This has been achieved by team education and the development of data reporting to ensure MECC conversations are recorded. Closer integration with smoking cessation services, local IAPT teams and others has enabled signposting to expertise when patients express an interest in pursuing such services.

First Contact Physiotherapy (FCP)

Following a successful pilot of the FCP service, all three Primary Care Networks have now adopted this model. Provision of FCP has increased and plans are in place to increase the resource further. This will help in reducing pressures on general practice and ensure patients with MSK disorders can consult with specialist MSK clinicians at the very start of the pathway.

Health inequalities

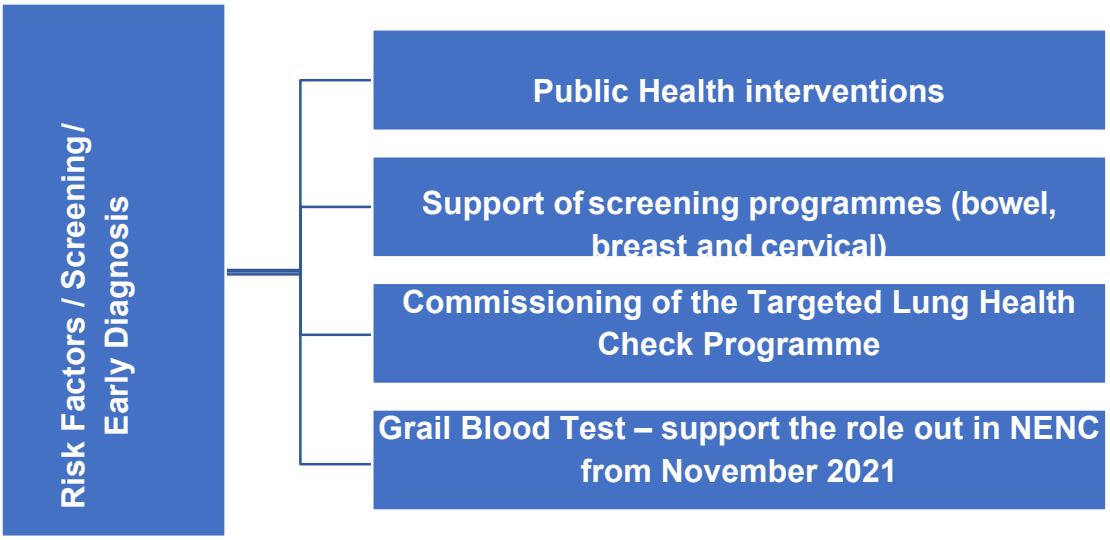
The service has noted the relevance of health literacy in reducing inequalities and introduced a ‘Write to me’ initiative which now ensures all clinical letters are written to the patient. Training and subsequent audit has found improvement in some key metrics related to health literacy such as

readability rating and reduction of in the use of medical terminology which patients may not understand.

Cancer

We continue to work with colleagues across the Northern Cancer Alliance (NCA) and NENC ICS and South Tyneside Primary Care networks (PCN's) in response and recovery of cancer services from Covid-19 including the reduction in referrals, diagnosis and treatments.

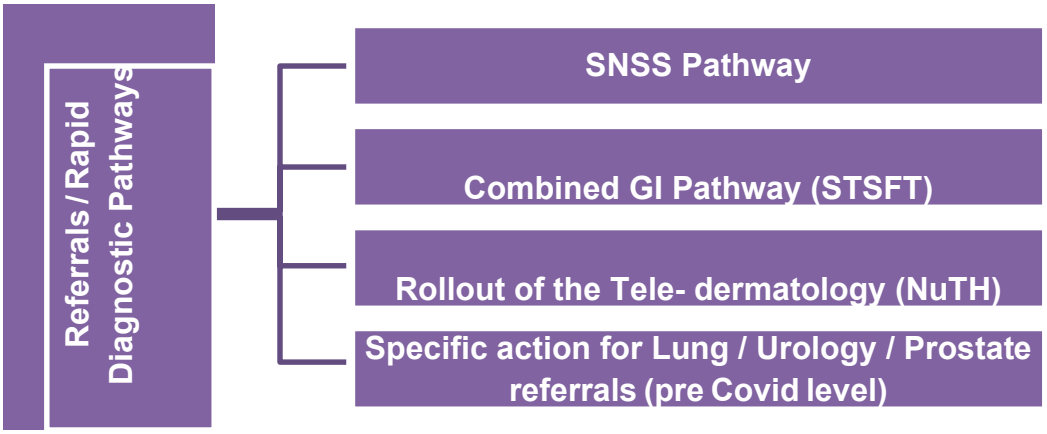
The cancer work programme has been delivered across a number of workstreams:



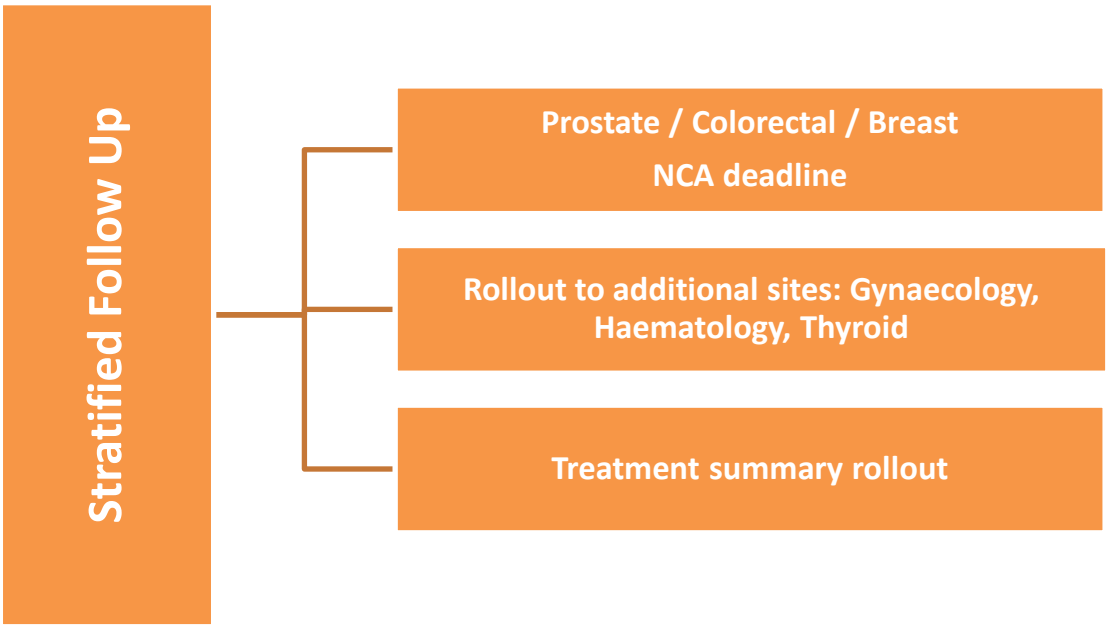
Alongside the named projects we have:

- Worked with Primary Care Networks to implement the Early Cancer Diagnosis DES
- Delivered a Community Cancer Champions programme
- Supported CRUK to deliver non-clinical cancer champions training to GP practices
- Commissioned FIT symptomatic service

During 2022 we have continued to work closely with providers to embed a number of pathways.



Work across primary care, acute care and community services also focused on raising referral rates across tumour groups where we had seen a decline in referrals.



The personalised care programme across cancer services continues to build, and we work with providers across a range of programmes to deliver person-centred care and support. Our focus within the programmes is on what matters to the patient and how both their clinical and wider needs can be met.

Throughout this reporting period we have supported the Northern Cancer Alliance to deliver targeted cancer campaigns.

The South Tyneside cancer bulletin continues to be shared monthly, bringing together national, regional, and local updates across a range of agencies, professionals and community groups.

Healthy ageing

Within South Tyneside, 19.8% of the population are over 65 years old, which demonstrates the significance of the Healthy Ageing agenda.

South Tyneside Healthy Ageing Alliance (STHAA), formerly the Frailty Alliance, has continued to work collaboratively with key partners on delivery of local and national initiatives to ensure that people can age well. The focus has been on supporting proactive and preventative initiatives, providing care closer to home and supporting people in a crisis to prevent avoidable hospitalisation.

National Ageing Well Programme

In the past year, the STHAA have worked on the 2021-22 priorities within the three-year transformational Ageing Well Programme, which aims to deliver new standards of care and support people who are living with frailty.
The three elements of the Ageing Well Programme are:

Urgent community response model

This model, which enhances existing services, was health-led and integrated with social care services and Age Concern Tyneside South (ACTS). The service aims to support people in a health or social care crisis and deliver care close to home by providing a rapid response assessment, diagnosis and immediate access to short-term nursing, therapy, or social support. The model was agreed by the Alliance Executive Committee in January 2022, and went live on 4 July 2022, with regular monitoring and feedback into the STHAA.

Enhanced Health in Care Homes (EHCH)

The EHCH model has been developed further to provide a more proactive care model centred on the needs of individual residents. This model is now well established in South Tyneside and aligned to Primary Care Networks, with weekly multidisciplinary team meetings and annual reviews in place. The EHCH model has also been pivotal in the highly successful delivery of the Covid-19 and flu vaccination programmes to care home residents.

Frailty and keeping people active

The Alliance has also worked collaboratively to improve the lives of people living with frailty, and help to keep people active by:

- Supporting the ICS Pre-Frailty and Social Isolation Project (PFSIL). As part of this project, South Tyneside was successful in a bid for funding for a project to look at the existing range of support options and activities available locally. This work will inform the development of a Loneliness and Social Isolation Strategy for South Tyneside to enable people at a pre-frail stage to remain fit and active.
- Implementation of the Ageing Well Frailty Toolkit – a resource to support the workforce to make the most effective use of the Rockwood Clinical Frailty Scale in South Tyneside. The toolkit also provides options to support the person achieve their goals, and reverse or maintain their current levels of frailty.
- Establishment of the Escape Pain rehabilitation programme, which aims to reduce pain and disability for people over 50 with knee and/or hip pain. This programme, which is delivered by Age Concern Tyneside South and South Tyneside Leisure, has received very positive feedback from attendees and has been shown to bring improvements for many people on both a physical and psychological level.
- Funding Age Concern Tyneside South to deliver a balance and stability programme for people with mobility issues. Classes are taken by qualified exercise instructors and are intended to strengthen joints and enable better stability.

End of life

During this reporting period work across the palliative and end of life workstreams has continued to progress with developments at national, regional and 'place' (local) levels.

We continue to work aligned to NHS England (September 2021) case for change and National Delivery Programme and structure, including workstreams at integrated care system and local levels.

The work is focused on meeting a range of needs, including:

- An increase in the number of people with long-term conditions or palliative care needs due to the Covid-19 pandemic
- Inequality in provision and access to palliative and end of life care, particularly for people without cancer, the oldest old, people living in deprived areas, those experiencing homelessness and the LGBTQ+ community & writing about ethnicity
- Nationally unsustainable commissioning models in the charitable sector delivering NHS services
- The need for the offer of universal care to be in place across all areas

North East and Yorkshire Strategic Clinical Network

The Strategic Clinical Network for the North East and Yorkshire was launched on 5 October 2021. NENC ICS was represented by Dr Lucy Lowery (consultant in palliative medicine) who has been appointed as joint clinical lead for the ICS's palliative and end of life care to work alongside Dr Kathryn Hall (GP end of life lead, North Tyneside). Dr Sarah Mitchell (Sheffield GP) will be regional clinical lead for the North East and Yorkshire.

North East and North Cumbria Strategic Clinical Network

Dr Nousha Ali (clinical director, South Tyneside CCG) and Dr Ann Paxton (palliative care consultant, South Tyneside and Sunderland NHS Foundation Trust) are the representatives for South Tyneside at the NENC Palliative and End of Life Care Strategic Clinical Network. Updates and feedback from the meeting are provided at the South Tyneside Palliative and End of Life Care Alliance, including:

- Updates from regional networks – cardiac, mental health, urgent and emergency care, cancer
- Update from children and young people palliative network
- Deciding Right group
- Response to CQC report – respect, protect, connect

Updates from the Clinical Network were reported into the South Tyneside Palliative and End of Life Care Alliance.

South Tyneside Palliative and End of Life Care Alliance

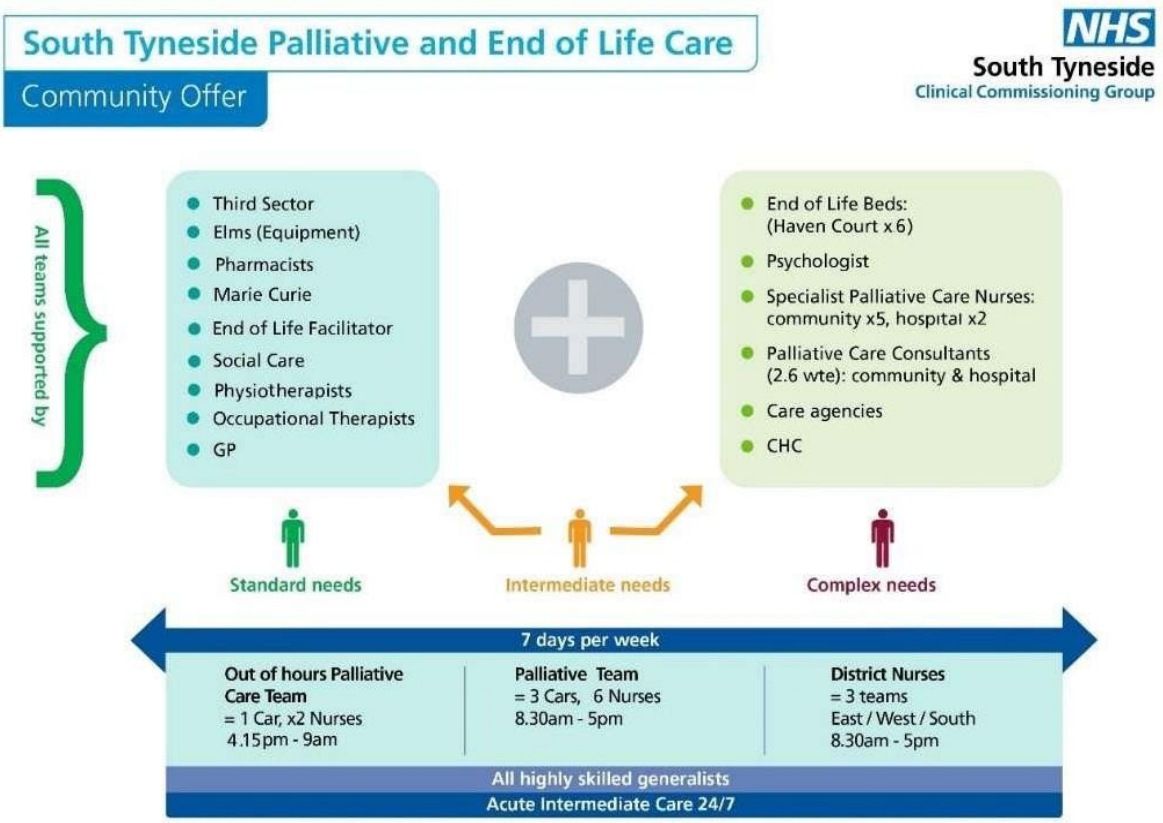
Over the past year, various workstreams have been progressed through the Alliance (set out in the diagram below). The workplan for 2022/23 was agreed and Alliance members who worked on several task and finish groups including:

- Care home – admissions and deaths in hospital

- Patients with drug and alcohol dependencies
- Care of the Dying document – launch in the community

Community Service Offer

We have worked with South Tyneside and Sunderland NHS Foundation Trust and other local stakeholders to define and develop the service model to meet the requirements of all South Tyneside residents who have palliative and end of life needs.



The model provided a range of high-quality services, with increased domiciliary care, nursing and palliative care support in the community for patients who prefer to die at home, alongside a suite of 'home from home' bedrooms based at Haven Court, on the South Tyneside district hospital site.

Cedar Unit at Haven Court

At the end of the 2021-22, building work was completed on the new end of life and palliative care bedrooms at Haven Court. The Cedar Unit began a phased opening from 12 April 2022 and has already supported a number of patients, families and carers.

The unit provides a homely, welcoming environment for patients and all six of the ensuite bedrooms are well-equipped. The unit is situated on the ground floor, in a quiet area with a high level of privacy.

Each room is newly decorated, has a TV and access to a garden area via patio doors. Accommodation is also available for relatives or carers who wish to stay overnight.

There is a communal lounge for use by residents and visitors. It has a small kitchen area to prepare drinks and snacks, a television and it access to our quiet garden.

Capacity Tracker

Our area used Capacity Tracker, which was built by our partners at NHS North of England Commissioning Support (NECS) in partnership with NHS England, local authority representatives and care home providers.

Capacity Tracker provided a platform for care homes, in-patient community rehabilitation, substance misuse and hospice providers to make visible their vacancies and other critical information through minimum input to provide rich information across health and social care organisations, to help reduce the time taken to discharge individuals from hospital, PPE to enable rapid response from local/regional teams.

The Capacity Tracker enables care homes to make their vacancies instantly visible to all discharge teams across England in real-time and is accessible from any desktop or mobile device and is used by 99% of all care homes in England. This helps individuals make the right choice, ensuring they don't stay in hospital any longer than is necessary when discharge to their own home is not possible. The simplified process reduces stress and anxiety for the individual and their families at a time when they need care and support.

Capacity Tracker continues to evolve, thanks to the input from health and social care partners and users of the system. By having close engagement with user groups drawn from local authorities and health care commissioners, this enables the system to meet the changing and ongoing needs and priorities of its users.

Great North Care Record

The Great North Care Record (GNCR) is a way of sharing health and care information between practitioners and with individuals.

GNCR digitally shares patient information from a range of health and social care providers together across the NENC safely and securely, helping to make care better and safer.

GNCR provides access to potentially life-saving patient information at the click of a button, such as diagnoses, allergies, medications, test results, visits and treatments. This means health and social care staff didn't have to depend upon a patient's understanding when they are feeling unwell. They also do not need to spend time making a number of phone calls or reaching out to other organisations to pull together a complete view of the patient's history.

- One hundred per cent of primary care data is being shared – this covers 3.2 million patient records from 413 GP practices

- Out-of-hours providers have access
- Eight acute trusts view GNCR and six trusts contribute data to HIE (health information exchange)
- Both mental health trusts view and one shares data
- Over 200 community services are both viewing and sharing data including Child Health Information Services
- North East Ambulance Service view (crews and service centre) and share crew reports into GNCR
- Five local authorities view GNCR with two also sharing information regionwide
- Across the region, the HIE is now supporting nearly 400,000 patient encounters every month

GNCR is the most-used Cerner HIE in the country with staff in the NENC with access to the system viewing shared records more than 377,000 times a month (as of May 2022) – the highest figure yet.

The next stage, the MyGNCR development, will see GNCR integrate with the NHS App by providing patients with a single digital front door to access secondary care services. It will include appointments and correspondence, which will be sent to the NHS app allowing patients to add these to their calendar and receive reminders.

For more information, please visit www.greatnorthcarerecord.org.uk.

Performance analysis

Performance measures

Accident and Emergency (A&E) performance

Most people from South Tyneside who need urgent, or emergency care attend South Tyneside Hospital which is part of the South Tyneside and Sunderland NHS Foundation Trust (the Trust). South Tyneside Urgent Treatment Centre is co-located with the emergency care department and receives patients who are appropriate for primary care, advised to attend by 111 as well as those who choose to walk in and are streamed to this service

Provider organisations have several targets related to emergency care. Although the performance measures for A&E are currently under review, one key target is that 95% of patients should wait no longer than four hours for treatment in an emergency department.

Figure 1 on the following page shows how South Tyneside Hospital has performed for 4 hour waits since July 2018 with the solid orange line highlighting performance of the Trust overall.

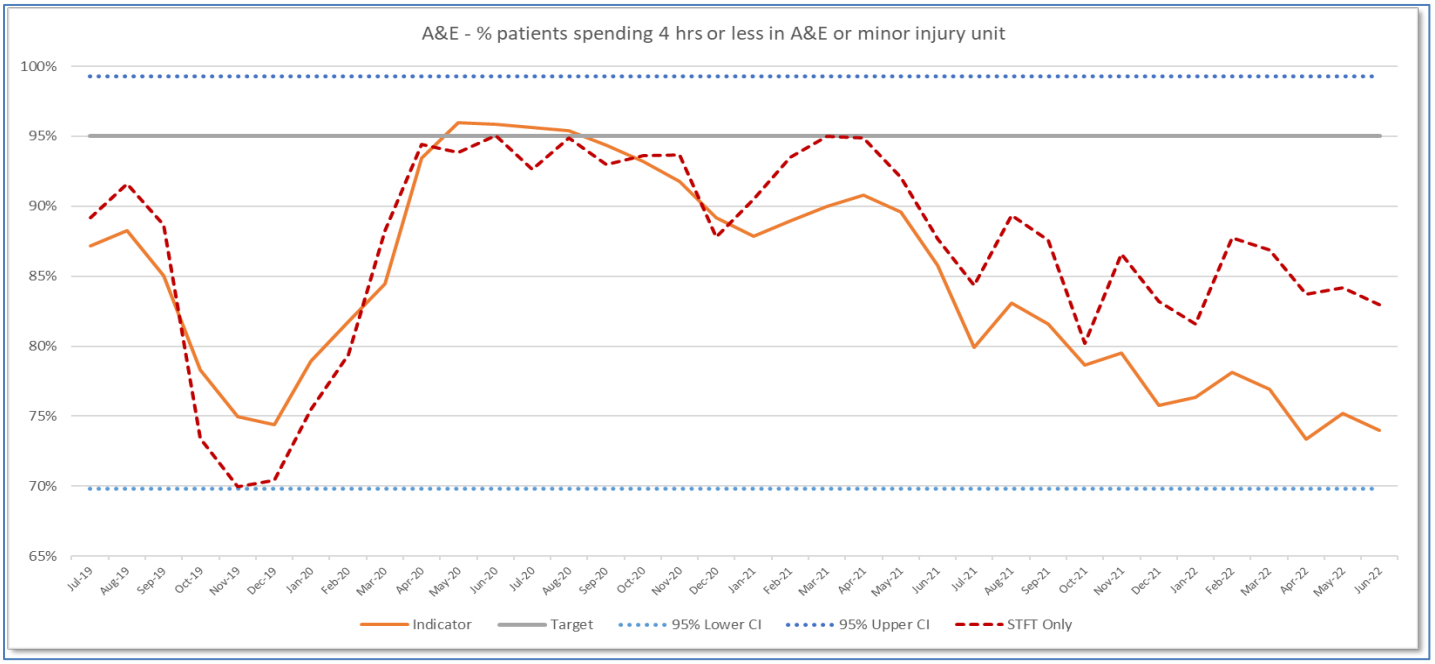
From April 2021, there has been a decline in overall A&E performance although South Tyneside Hospital is better than the Trust average and is beginning to stabilise. In June 2022, the percentage of people seen within 4 hours in South Tyneside was 82.9% compared to 87.7% in June 2021.

Performance continues to be significantly impacted by the impact of the pandemic with continued staffing challenges and an increasing proportion of people requiring hospital admission.

The flow of patients through South Tyneside NHS Foundation Trust (STSFT) has also had an impact on A&E performance with new patterns of attendance emerging, limited bed availability and the rate of discharges slowed by lack of availability of packages of care. The Trust and wider South Tyneside system partners are working together to improve patient flow through the system and maintain bed availability.

In South Tyneside, there is already a well-established process for a system wide response to deal with surge pressures supported by escalation where appropriate. Initiated by operational leads, most challenges are dealt with by system partners, and this has been especially successful over the last year.

Figure 1: Patients spending 4 hours or less in and A&E or Minor Injuries Unit at South Tyneside Hospital



Ambulance Response Times and Integrated Urgent Care (IUC)

As with other services, the COVID-19 pandemic has had a significant impact on ambulance services due to increases in staff absence and increased patient acuity.

Handover times at hospitals remained challenging and STSFT worked with local and regional partners to identify and implement schemes to support improvement.
CCGs across the ICS together with NECS contracting team have been working in partnership with the North East Ambulance Service (NEAS) to implement an action plan to evaluate current schemes and funding put in place to deliver improved response times and patient outcomes. These include recruitment schemes for both call handlers and clinical staff, increasing third party providers and the implementation of a Quality and Performance desk. These schemes focused on both managing increased current demand and building resilience into the system to improve future capacity.

Cancer waiting times

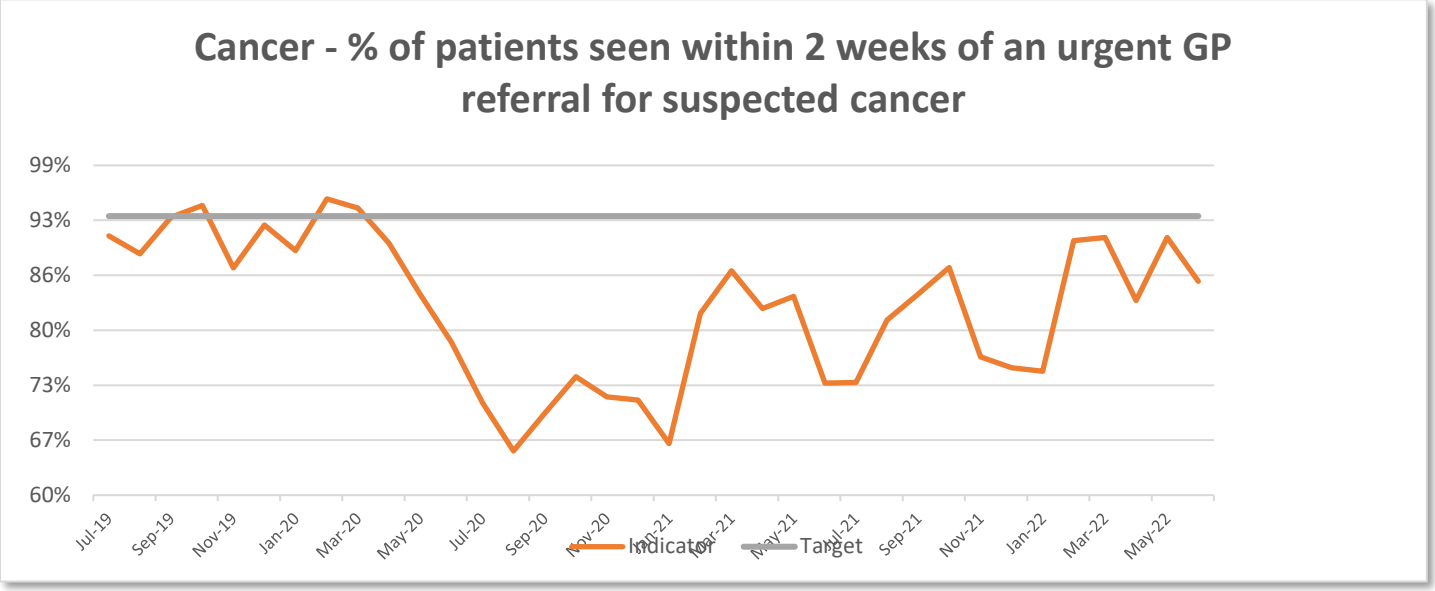
During this period several cancer performance indicators were in place which have been in place for some time. Two new consultations have recently begun, one in relation to the cancer waiting times standard and the second on how to raise awareness of the signs and symptoms of cancer and improving access to and experiences of cancer treatment. The outcomes of the consultations will be used to shape the development of future cancer services and are being promoted locally to encourage responses. NHS South Tyneside CCG has shared comments on both consultations via the Northern Cancer Alliance (NCA).

We are aware from research carried out by Cancer Research UK that the pandemic has had an impact on people's help-seeking behaviour and attitudes. The research found that people had delayed getting help for a variety of reasons, such as not wanting to waste healthcare professional's time, worry about catching Covid-19 or difficulty in getting an appointment with a particular healthcare professional. The pandemic, therefore, had a significant effect on referrals and in combination with different ways of working and capacity within teams meant that performance last year was deteriorating.

We are worked very closely with the NCA and colleagues across the NENC ICS to improve cancer performance and this is demonstrated in the gradually improving rates over the year.

The following is a summary of two cancer standards for South Tyneside residents.

Figure 2: Percent of patients from South Tyneside seen within 2 weeks of an urgent GP referral for suspected cancer



These charts show that overall performance is improving, and the recovery plans put in place are beginning to work. The CCG worked with the Northern Cancer Alliance and providers on this indicator to continue this improvement.

Referral to treatment

Patients have the right to start their NHS consultant led treatment within a maximum of 18 weeks from referral.

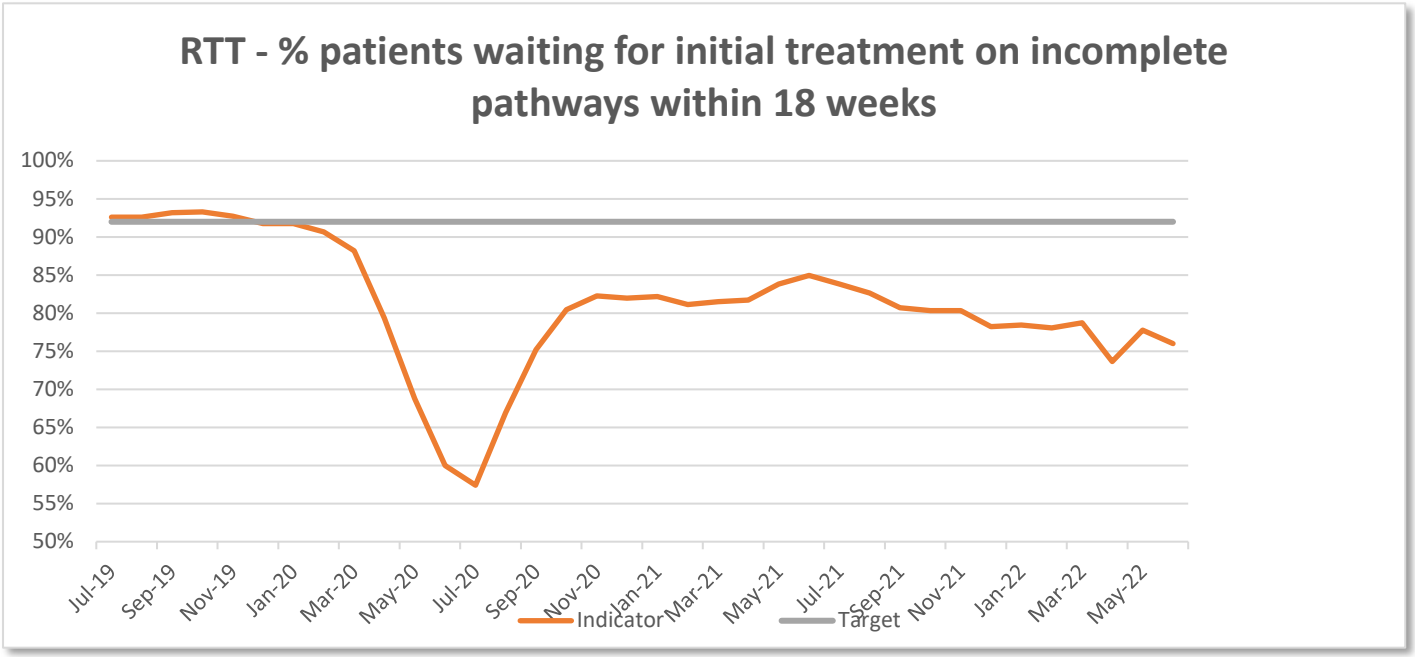
This, and not having to wait more than 52 weeks for treatment, are further indicators where the pandemic continues to have significant impact upon access to care and treatment.

Prior to the pandemic, South Tyneside CCG met the referral to treatment target of 18 weeks for several years. Figure 3 demonstrates the impact of the pandemic on waiting times, for example by reducing the number of people who could be seen, as well as dealing with the consequences of additional referrals into the system.

By increasing the number of patients being seen, performance remained steady at around 80% since December 2021 despite increasing numbers of referrals.

The CCG worked with our providers both locally, and across the ICP and ICS to build and put in place a recovery plan to manage these increases to begin to bring things back to previous levels.

Figure 3: South Tyneside Patients waiting for 18 weeks



Diagnostic Waiting times

For South Tyneside residents, the COVID-19 pandemic continues to impact diagnostic waiting times due to initial stand down of non-urgent diagnostics followed by reduced throughput as a consequence of infection prevention and control measures and staffing challenges. Main challenges for South Tyneside have been in radiology and echocardiography where plans are in place to manage pressures with additional capacity.

Long term solutions for the local community are currently being implemented via the national community diagnostic centre initiative and Path to Excellence Programme led by South Tyneside and Sunderland NHS Foundation Trust (STSFT).

Mental Health and Learning Disabilities

The impact of the COVID-19 pandemic continues to be seen within mental health services, with a significant increase in the number of people presenting to mental health services across the lifespan. In addition, in 2021/22 South Tyneside has experienced an increased level of complexity of need in respect to people presenting to mental health services, which has continued to place a strain on services. This has been further compounded by a lack of resilience within the mental health workforce, across organisations, and whilst this is not particular to South Tyneside, this has had an impact on the delivery model.

Whilst the mental health offer has been stretched within the borough with an increase in waiting times across some of our children and adults' diagnosis services, South Tyneside has demonstrated some improvements in outcomes for people with mental health presentations.

Diagnostic Waiting times

For South Tyneside residents, the COVID-19 pandemic continues to impact diagnostic waiting times due to initial stand down of non-urgent diagnostics followed by reduced throughput as a consequence of infection prevention and control measures and staffing challenges. Main challenges for South Tyneside have been in radiology and echocardiography where plans are in place to manage pressures with additional capacity.

Long term solutions for the local community are currently being implemented via the national community diagnostic centre initiative and Path to Excellence Programme led by South Tyneside and Sunderland NHS Foundation Trust (STSFT).

Mental Health and Learning Disabilities

The impact of the COVID – 19 pandemic continues to be seen within mental health services, with a significant increase in the number of people presenting to mental health services across the lifespan. In addition, in 21/22 South Tyneside has experienced an increased level of complexity of need in respect to people presenting to mental health services, which has

continued to place a strain on services. This has been further compounded by a lack of resilience within the mental health workforce, across organisations, and whilst this is not particular to South Tyneside, this has had an impact on the delivery model.

Whilst the mental health offer has been stretched within the borough with an increase in waiting times across some of our children and adults' diagnosis services, South Tyneside has demonstrated some improvement in outcomes for people with mental health presentations.

In 2021, the three primary care networks in South Tyneside embraced a new way of working with the introduction of a new primary care mental health offer, aiming to bring support to people, rather than people having to seek services. This builds on the model of the health hub, with 75% of people on the Severe Mental Illness register accessing a health check which is an increase on 2020/21.

In 2021/22, we published our Adult Mental Health Strategy and worked with partners on implementation with the aim of improving outcomes for people, using additional resources and service mobilisation in 2021, including:

- A lifespan bereavement service, which has initially demonstrated effective recovery rates
- Two people led mental health support groups
- The mobilisation of a new mental health recovery college
- Additional link posts for people with autism, severe mental illness, and dual diagnosis

Improving access to psychological therapies (IAPT)

National predictive data indicated an expected increase in the need for talking therapy, which has not translated to local access rates. On review of the data and performance, analysis indicates that levels of access are significantly lower for people with higher levels of deprivation, underserved populations, and older adults.

In response to these findings we have taken the following actions:

- Development of an alternative older person pathway, which sees Age Concern Tyneside South ACTS partnering with STSFT to mobilise a tailored pathway, aimed at proactively reaching out to people who may benefit from support
- Navigator service introduced in an area of high deprivation

Learning disabilities

Joint work between the 3 Primary Care Networks and Cumbria, Northumberland, Tyne and Wear (CNTW) continues. There has been an increase in 2021/22 on the uptake of annual health checks, with 86% of people on the learning disabilities register accessing this service.

Children and young people’s services (CYPS)

Referrals across the children's service remain significantly higher than pre-pandemic levels which has had an impact on waiting times for both diagnosis pathways and the mental health services.

Children and young people's mental health remain a key priority for the CCG, and we are working closely with our Primary Care Network to mobilise a new mental health offer. This will be accessible in a similar way to GP referrals and breaks down the barriers related to waiting for services on referral lists.

Due to the pressures facing services in 2021/22, the CCG provided additional support to increase the workforce, particularly in voluntary care services service.

Summary

The above information gives an overview of the ongoing consequences of the pandemic on CCG performance and its impact on the health care of the population of South Tyneside. Fewer people attending their GP for consultations has led to a delay in potential diagnosis of conditions or related complications and fewer outpatient appointments and constraints brought on by social distancing has left more people in the health and social care system.

All systems are in a similar position and the CCG worked closely with providers and other teams locally and regionally on recovery plans to bring our performance and positive health benefits in line with previous years.

Sustainable Development

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental, and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition of reducing the carbon footprint of the NHS, public health and social care system. We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint. As a region we are focused on preventing ill-health and improving the overall health of communities with NHS organisations, and our partners, working together to deliver our ambition to be the greenest region in England by 2030.

By demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met. We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint and while we committed to this, we have not yet issued a statement on meeting the requirements of the Public Services (Social Value) Act.

Across the North East and North Cumbria as part of the Integrated Care system we are working together to deliver our ambition to be the greenest region in England by 2030 and have contributed to the plan development. Across our region, NHS organisations and our partners are already working to reduce our environmental footprint from how we are reducing waste, supporting active travel, using electric vehicles, re-thinking our supply chain and switching to more sustainable products

In response to the pandemic, and with the adoption of hybrid working across the CCG, we know that we have significantly reduced our use of paper resources and other office utilities.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a commissioner, evidence of this commitment will need to be provided in part through contracting mechanisms.

Travel

We can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services. Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport. The CCG actively encouraged

the use of electric vehicles by its staff and has shower facilities to encourage cycling to work and we also had a salary sacrifice scheme for cycling equipment available to staff.

One of the beneficial unintended consequences of the pandemic has been the shift in how we work. Most employees have been working from home for the past year, utilising digital tools such as Microsoft Teams to meet colleagues virtually and to continue to deliver business. This has drastically reduced our travel to work mileage and associated emissions.

Improve quality

Quality is defined as care that is safe, effective and provides as positive an experience as possible for patients. Commissioning high-quality, person-centred healthcare has been at the heart of everything we strive to achieve for the residents of South Tyneside.

To achieve this, we work collaboratively with partners and stakeholders from across the health and social care economy to ensure continuous improvements in clinical effectiveness and outcomes, quality and safety, patient experience, safeguarding and infection, prevention and control.

All providers of healthcare strive to deliver high quality and safe care to patients. As commissioners of healthcare, the CCG has played an important role in gaining assurance on the quality of care delivered by our commissioned organisations.

Quality Strategy 2018-22

Our Quality Strategy underpins our work and reflects the NHS Five Year Forward View, the National Quality Boards '*Shared commitment to quality'* publication and the 2019 national patient safety framework. It describes our responsibilities, approach, governance and systems to enable and promote quality across the local health economy.

Our strategy retained a focus on both quality assurance and improvement and remains in place while we await further direction from the ICB on future ways of working.

Quality and Safety Committee

The Quality and Safety Committee (QSC) had delegated functions from the Governing Body. This committee included CCG representatives, lay members and practice representatives. The purpose of the committee is to ensure appropriate quality governance systems and processes are in place to commission, monitor and ensure the delivery of high quality, safe patient care in commissioned services. This includes Acute and Mental Health Trusts, Care Homes, Ambulance and Community services.

As part of collaborative developments, the committee is run jointly with Sunderland CCG and enables collaborative working, avoids unnecessary duplication of assurance processes and ensures a harmonised approach to the monitoring of quality across commissioned services.

Quality and Safeguarding Team

The Quality and Safeguarding team was led by the CCG Executive Director of Nursing, Quality and Safety who, along with the Head of Quality, and Safeguarding Designates provide strategic and operational leadership for key components of the quality and safeguarding work streams.

Quality Review Groups

Our interface with providers remains through our Quality Review Group meetings (QRGs). These were formal meetings held with our main providers to monitor and discuss all aspects of their quality-of-care delivery; this includes patient experience data, complaints, concerns and the review of themes and trends from incidents. The QRGs allowed a transparent and open discussion of issues to take place and for improvements to be monitored. There was also a key focus on ensuring innovation and service improvement across the health and social care sector. Membership includes Executive leads and NHSI, NHSE and CQC colleagues are invited to support a single approach to assurance.

Particular areas of focus this year have been on mortality and maternity services. Especially following the publication of the Ockenden reports and in light of the pressures that are being felt both locally and nationally on maternity services.

Quality Impact Assessments

In order to assure ourselves that commissioning decisions don't have a detrimental effect on quality, the CCG has a quality impact assessment (QIA) policy, and the process is embedded across the CCG. Commissioning leads review proposed changes to services and assess whether there will be a positive, neutral, or negative effect on safety, patient experience, and effectiveness. This process was managed by the quality team, with the Executive Director of Nursing, Quality and Safety reviewing and approving any completed QIAs.

Learning from Serious Incidents

Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant a comprehensive response. The occurrence of a serious incident can demonstrate weaknesses in a system or process that need to be addressed to prevent future incidents.

The CCG was responsible for gaining assurance that when a serious incident occurs either within providers or within commissioned services that there are measures in place which safeguard patients.

Robust governance processes were in place to monitor serious incidents through a combined CCG Serious Incident Panel held jointly with NHS Sunderland CCG. This panel was led by the CCG Executive Directors of Nursing, Quality and Safety who ensure sufficient rigor has been applied to

the investigations and that learning has been elicited and embedded into practice. Providers were invited to attend the panel to provide further assurances and clarity around their investigation reports.

Serious incident reports and action plans were reviewed and only signed off during the panel once appropriate assurance has been received. The panel also monitor serious incident themes and trends across the year and work with providers to manage and respond to any emerging themes.

Healthcare Associated Infections

The CCG had in place a commissioned infection prevention and control (IPC) team operating across South Tyneside which provides an essential service to primary medical services and the care home sector across the borough. Work has been completed in identifying and training care home champions in IPC to help support the delivery of key messages and ensure ongoing IPC standards. The IPC team continue to play a key role in supporting our care homes with advice and support in outbreak situations and in addressing themes and lessons learned.

The Healthcare Associated Infections (HCAI) Improvement Group was a joint collaborative group that meets quarterly across South Tyneside and Sunderland and includes representation from the two CCGs, provider organisations and Public Health England. The group provided leadership and oversight and ensures a whole system approach to preventing and controlling healthcare associated infections. The HCAI group had robust reporting mechanisms and receives regular assurance reports and updates on key metrics. Any identified quality or patient safety issues are escalated to the quality review groups or regional IPC forums such as the regional Board.

We had a whole system HCAI joint action plan in place with progress being reported to the HCAI Improvement Group and the QSC. Our plan is reflective of current IPC challenges with infections such as Clostridium Difficile, Methicillin-resistant Staphylococcus aureus (MRSA) and Gram-Negative bacteraemia infections (GNBSI). It also supports delivery of the recommendations outlined in the governments Antimicrobial Resistance (AMR) 5-year plan.

Quality surveillance group (QSG)

The CCG had remained an active member of the Cumbria and North East Quality Surveillance Group (QSG) along with other peer colleagues across the North East and key partners and stakeholders.

Quality Surveillance Groups are an important mechanism for sharing and analysing significant information and intelligence about commissioned services. This enables early detection of deteriorating quality and an ‘early warning’ of potential risks to patient safety. Where necessary, the QSG and CCG conducted enhanced surveillance of providers until evidential assurance of sustained quality improvement is demonstrated.

Quality in Primary Care

The CCG had delegated responsibility from NHS England for the commissioning of general medical services. We support NHS England in relation to our duty to improve the quality of primary medical services through agreements and processes with our member practices regarding quality and safety. The CCG had a well-established Primary Care Quality Business Group which reported to the Primary Care Commissioning Committee. Any quality exceptions are also reported formally to the Quality and Safety committee. The PCQB meeting occurred monthly and included representation from NHS England as well as a representative from general practice and is where we assess, measure and benchmarking the quality of care within general practice.

General Practices were assessed against a range of national and local quality indicators which are triangulated with soft intelligence, complaints, incident data and the outcome of reports following CQC inspection.

Research and Development

To fulfil our statutory duty to ensure research was carried out for benefit of the population we serve; we are committed to ensuring that research activity is undertaken rigorously and ethically under the governance framework established by our Research and Evidence Group.

The findings of our research and information gained from research and evaluation undertaken across the system are used as evidence to inform commissioning decisions. Additionally, findings were presented to the Executive Committee and Governing Body and written up for publication in healthcare journals, lay summaries produced and disseminated to the public and patients to ensure transparency and understanding of research activities.

Patient Experience

Improving patient experience has continued to be a key area of focus for the CCG and we triangulate patient experience from National surveys, engagement events and complaints and enquires, addressing any themes and trends. Patient experience was vital in shaping and influencing improvements in the quality of care being provided.

Safeguarding

The CCG had a statutory responsibility to promote the safety and welfare of adults and children in all commissioned services. Due to this the CCG have in place robust structures, systems, standards, and an assurance framework which enable compliance with legal duties and local governance arrangements.

Executive leadership for safeguarding was provided via the Executive Director of Nursing, Quality and Safety. Other statutory lead roles are delivered by the role of Designated Nurse Safeguarding Children, Designated Nurse Safeguarding Adults, Designated Nurse Looked after Children and

Transitional Safeguarding, and Designated Doctor functions of Safeguarding Children, Looked After Children and Child Death. The named GP for Adult Safeguarding and Child Safeguarding offer support on a sessional basis. The Named Nurse for Primary Care provided additional resource to strengthen safeguarding within primary care and facilitate robust information sharing pathways across the health economy and addresses key issue and risk.

The South Tyneside Safeguarding Children and Adult Partnership (STSCAP) was a combined partnership recognising the importance of 'Think Family' in safeguarding the most vulnerable members of our community. The partnerships Independent Scrutineer is at the centre of this review to provide impartial challenge and appraisal of safeguarding arrangements to judge the effectiveness of the multi-agency arrangements to safeguard and promote the welfare of residents of South Tyneside. The partnership has continued to meet virtually throughout the challenges of the pandemic to ensure safeguarding activity continued throughout and systems remain robust to provide support at such a critical time.

The CCG provided safeguarding leadership and assurance across the health economy incorporating safeguarding children, safeguarding adults, Mental Capacity Act, Deprivation of Liberty Safeguards and Prevent. The CCG was also a key partner within the statutory processes for facilitating the embedding of the learning from Safeguarding Adult Reviews (SAR) Domestic Homicide Reviews (DHR) and Child Safeguarding Practice Reviews (CSPR) through supporting provider organisations in the borough.

Training provision has continued throughout the year, albeit in virtual format to ensure training standards are upheld. This has been provided to primary care via formal sessions during the GP education sessions and informal safeguarding leads meetings. Assurance has been gained from the provider organisations, through dashboard data, that training has continued to be delivered despite significant clinical pressures due to the pandemic. The effect of the pandemic has been seen to impact on numbers trained across the system however every effort is being made by all involved to ensure training remains high on the agenda.

Engaging people and communities

The CCG was committed to collecting views from a range of South Tyneside residents, including patients, the public, and carers. This includes listening to the views from protected characteristic groups.

Specialist advice and external benchmarking is obtained from the national Consultation Institute. This support ensures that all engagement and consultation work undertaken by the CCG follow best practice.

A lay member with responsibility for patient and public involvement (PPI) sat on the CCG Governing Body and oversaw PPI at the CCG.

Involvement Strategy for the NENC ICB

As we move into greater collaborative working arrangements, NHS South Tyneside CCG worked together with involvement leads across the new ICB footprint to develop stronger partnership arrangements. Through this partnership work, we have held conversations with our stakeholders to understand what has worked well for involvement, what could work better, and in an ideal world, how involvement will work once we become the North East and North Cumbria ICB (NENC ICB).

We have collectively shared this feedback to identify principles for engagement to take forward, and an aspiration for involvement which was built into a strategy for involvement for the ICB. This strategy was built upon conversations with our stakeholders, and a shared commitment to continue to involve patients, public, carers, and wider stakeholders in shaping, evaluating, and improving the services we commission.

Citizens' Panel engagement for the NENC ICB

The NENC ICB wanted to explore a future enduring citizens' engagement model, where consideration was given to approaches such as citizens' panels, juries, and assemblies. An independent research company was commissioned to carry out some research with a range of stakeholders to better understand appropriate citizens engagement for the ICB and to support the work across the ICS. The aim of the research was to:

1. explore the benefits, drawbacks, and resource requirements of differing models of Citizen's engagement.
2. provide recommendations on an approach that will meet the needs of the ICS on an ongoing and enduring basis.

The was conducted in three phases.

Phase one: desk research and horizon scanning. Desk research was conducted to identify engagement models that have been successfully employed both within and out of the health sector. As part of the horizon scanning, interviews were also conducted with individuals identified within the desk research as being involved in areas of best practice. Ultimately, the aim of these conversations was to add further context to any identified case studies.

Phase two: qualitative interviews and surveys with key stakeholders. Building upon phase one, in-depth interviews were conducted with key stakeholders. They sought to understand stakeholder's views about engagement, with specific emphasis on the following:

- the purpose of engagement.
- how they think the ICB should undertake engagement.
- how they perceive rigor and success in engagement.

In addition to the in-depth interviews, a survey was developed that consisted of six open-ended questions that were aligned to ones asked during in-depth interviewing. This approach ensured that a broader sample of stakeholders was involved in the research than would have been facilitated by interviews alone.

The discussion guide employed in the interviews and the survey are detailed within Appendix one and two of this report, respectively,

For both interviews and surveys, stakeholders were identified by the ICB and partner organisations. This approach ensured that involved stakeholders held an interest in citizens engagement and that the research involved those operating in diverse regions across the ICB.

Phase three: synthesis. In this final phase of the research, all strands of evidence (horizon scanning, interviews, and survey) have been brought together to form one cohesive body evidence. From this, a series of recommendations have been drawn regarding future Citizen's engagement for the ICB.
Notes on analysis

During analysis it became clear that the was a high degree of consistency in thoughts and opinions from stakeholders undertaking interviews and those completing the survey. For this reason, and to avoid repetition, the findings from phase two have been merged and presented according to emergent theme.

Involvement strategy for NHS South Tyneside CCG

An Involvement strategy was produced in coproduction with partner organisations in 2021. Based on research with partner organisations, the strategy is based around the following five themes:

- We will reach out to people to involve them in the right way to increase participation.
- We will promote equality and diversity and encourage and respect different beliefs and opinions.
- We will take the time to plan for involvement, including how we can work with partners, and feeding back.
- We will continue to build on our partnership relationships, in particular to ensure knowledge and capability is shared for the future.
- We will use a range of best practice involvement methods including both on-line and off-line methods.

https://sunderlandccg.nhs.uk/get-involved/involving-the-public-in-governance/involvement- strategy/

This strategy ensures that NHS South Tyneside CCG had a clear plan in place to meet legal duties to engage and consult the public and pledges set out in the NHS constitution.

The strategy was also produced as an easy read version, and in BSL.

Path to Excellence –transforming hospital services across South Tyneside and Sunderland

The programme continues to work with The Consultation Institute to follow a best practice pre-consultation and public consultation processes and is committed to open, transparent patient and public involvement.

The programme continues to regularly assess the strategic timeline for consultation, which is interdependent on the availability of capital to finalised options and the completions of the pre-consultation business case to progress to NHS England regulatory assurance.

Democratic engagement also continues with informal sessions with the South Tyneside, Sunderland and County Durham Joint Health Overview and Scrutiny Committee, including sharing of working ideas. Formal sessions would be arranged in line with proposed programme timetable. In addition to this, updates on the programme and information on the working ideas has been provided to all three local authority health and wellbeing boards.

The programme continues to progress impact assessments including travel and transport and equality. Meetings to consider travel and transport impact continue to develop a standalone business case on how travel and transport impacts could be mitigated, to include tangible suggestions.

The communications and involvement plan was developed with partners via the Stakeholder Panel and the communications and engagement task and finish group and builds on the pre- consultation involvement activities and case for change publications and the best practice service change solutions development carried out in 2021/22.

During this three-month period, further work has been done to progress the operational planning elements of the communications and involvement plan, which builds on the learning from Phase One public consultation. Procurements have been carried out to appoint providers for the research and analysis elements of the consultation.

The plan is in line with best practice consultation. It meets legal duties to involve patients, case law on public consultation, legal duties to consult with Health Overview and Scrutiny and legal duties in relation to reducing health inequalities. The main elements of the plan are highlighted below.

Involvement and research activities

To make it as easy as possible for people to take part in the consultation activities, a blend of different involvement and research activities have been developed with the stakeholder panel and communications and involvement task and finish group. Robust research methods of targeting demographics and sampling, question setting is provided by an independent research organisation appointed via the procurement process as mentioned above.

Main consultation questionnaire

This was main way anyone who wishes to take part in the consultation and give their views. It will be hosted both on-line and paper copies will be made available. This method is self-selecting so open to all, including past, current, and future patients. Paper copies include a freepost address and includes the opportunity to provide a telephone response.

Patients with lived experiences survey

Patients who have lived experiences of both planned surgery and emergency surgery at South Tyneside and Sunderland NHS Foundation Trust will be targeted via a sampling method with survey specifically to ask their views on the proposals. Sampling advice is provided by the independent research organisation. The correspondence will include the opportunity to take part in patient experience focus groups.

Patient focus group sessions

Participants recruited via the lived experience patient survey as above will provide the opportunity to explore in depth the findings from the lived experience survey in relation to the proposals. The focus groups were independently conducted and reported upon.

Public events

A range of public events have been arranged allowing questions, answers, and feedback. The key issues and themes from each event were reported on a template so it could be included in the overall feedback.

On street interception survey

The purpose of the on-street interception survey is to reach out to the wider community who may not take the opportunity to participate in the main consultation questionnaire otherwise.

Staff engagement

In advance of the consultation commencing there was proactive staff engagement activity. This includes specific dedicated sessions and attendance at key meetings and groups across the trust. A video and other communications materials have been prepared and ready to go live depending on consultation timescales.

The main consultation survey was available to complete online, on paper or via telephone and promoted extensively. These are all self-selective methodologies and are more likely to be completed by individuals with specific views in relation to any proposed service changes.

By conducting an on-street intercept survey allows to eliminate self-selection bias and engage with a representative sample of the Sunderland, South Tyneside, and North/East Durham populations. This then means the decision makers were able to consider the results of street inception survey alongside all other research elements of the programme.

Work is ongoing regarding an impact analysis of the proposed options and a decision has been taken to align the on-street intercept survey with the outputs of this work to ensure that the survey reaches those most impacted by the changes.

Voluntary and community sector (VCSO) focus groups and other involvement

The programme very much values the input and support of the voluntary, community and social enterprise sector and has actively engaged with the sector throughout the programme in several ways.

VCSO's were asked to support involvement activities to target people and communities who may be more impacted, in recognition of their abilities to reach further into communities.
Mechanisms include events, completing an agreed set number of surveys with service users, running relaxed informal sessions, holding focus groups, or carrying our one-to-one interviews. The programme provided different tools and resources to help for example:

- Focus group packs, reporting templates, monitoring forms
- Discussion guides, show cards
- Surveys
- Alternative formats as needed (easy read, different languages etc)
- A session with the programme to support your activities (e.g., train the trainer)

It should be noted that VCSOs were also be asked to provide their own organisational response.

Written submissions from stakeholders

Stakeholders and partners were identified and written to at the start of the consultation and specifically asked to provide an organisational response to the proposals. Key partners such as other local NHS organisations were be invited, and individuals were also be encouraged to take part.

Social media comments

A detailed social media plan to support the promotion of events and all activities was in place. Public comments made on social media will be collected and included as part of the public feedback.

Publications

Full public consultation documents were developed and are accessible to the public via CCG website.

Communications activities

A range of communications activities took place in support of the consultation. In addition to the above publications which provide the content of the issues, other plans include:

- Set of supportive assets will include animation, graphics, social media etc
- Media briefing and media release
- Supplements in Gazette and Echo
- On-line and paper distribution of surveys
- Promotional materials, posters and leaflets distributed to local venues

Public events

Public events were an important element of the consultation; however, they are one element of a more integrated research methodology being undertaken.

Research methods and reporting public feedback

A research partner was appointed and the public feedback reporting included:

- Draft report to programme team
- Finalised draft report made available to the public for final comments before report is finalised through an on-line event
- Final report available

Report included:

- Executive summary
- Full report with appendices
- Slide set - summary
- Video presentation of the summary findings

Looking to the future

In the summer of 2022, along with all NHS organisations in England are waiting to hear the outcomes of bids for capital funding from HM Government. Once this is known options can be finalised and along with the pre-consultation business case.

Patients' stories

NHS South Tyneside CCG were committed to hearing about the experiences of local health services, both good and bad, to help us shape future services.

The CCG collected patient stories to learn about the experiences and needs of people accessing health services in South Tyneside, and to put patients at the heart of service development and decision making. This allowed the CCG to identify where systems and processes may need to be improved, as well as sharing areas of good practice, to improve people's experiences and access to health care.

From April 2021, these stories were taken to Quality Safety Committee and Governing Body meetings.

An animation has been developed to help collect patient stories https://youtu.be/r7FxVj_r8GU. This has been included on the CCGs website and promoted through social media.

Patient Reference Group

The Patient Reference Group was a bi-monthly meeting where patients from practices in South Tyneside meet to find out about the work of the Clinical Commissioning Group (CCG). Patients could also influence the work of the CCG by discussing and giving their opinions and views about plans and progress. One of the aims of the group was that members will take the information they have gained from the meetings back to patient forums in their own practices to share and discuss.

This group met virtually providing independent assurance and challenge aligned to CCG objectives, in particular objective 3) 'improving patient experience' and objective 4) 'ensuring that the CCG was a well led organisation'.

All agenda, minutes and presentations from the group can be found at https://www.southtynesideccg.nhs.uk/get-involved/involve-me/patient-participation-groups/.

HealthNet

HealthNet is a local umbrella organisation with representatives from diverse South Tyneside voluntary and community organisations. The CCG attended monthly HealthNet meetings. These meetings provide an opportunity for people from the local community to discuss, question and give suggestions to the CCG, as well as facilitate discussions amongst partner organisations.

More information can be found by going to: https://inspiresouthtyneside.co.uk/healthnet/

Communicating with stakeholders

Our team uses a range of methods to share information with local people and partners. These include regular news releases and statements, linking with media to share updates and information, as well as responding to concerns. Our news releases can be found on the CCG's website.
Check link
A range of press releases were produced in 2021-22 which continue to benefit our local community . These included:

- Vaccine drop-in opportunity for priority groups in South Tyneside. If you're in one of the Covid-19 vaccine priority groups and haven't had your first jab yet, it's not too late.
- Don't miss your vaccine because of a wrong number! Don't miss out on your second vaccine dose because your contact details have changed!
- Drop-in clinics to speed South Tyneside vaccine effort. South Tyneside's successful vaccine effort is stepping up a gear with the start of regular drop-in clinics at three sites across the borough from next week.
- Young people need vaccine, South Shields GP tells Five Live Breakfast. Young people should get the Covid-19 vaccine as soon as possible, a South Tyneside doctor told a national radio audience today.
- It's never been easier to get your Covid jab, as South Tyneside's NHS vaccine teams hit the road. It's never been easier – or more important – to get your Covid jab, local doctors have said as South Tyneside's local vaccine programme gets set for a busy few days.
- Caesar's Den restaurant backs vaccine effort with prize draw and mocktails. A popular South Tyneside restaurant is offering prizes and free non-alcoholic mocktails to help with the borough's Covid-19 vaccine effort.
- South Tyneside end of life care plans progress despite Covid delay. Plans for new end of life care services in South Tyneside are moving ahead despite the pressures of the Covid-19 pandemic, NHS leaders will hear next week.
- **New NHS counselling and emotional wellbeing service for South Tyneside** People in South Tyneside will be able to get NHS mental health support with just a few clicks when a new digital service launches next week.
- NHS announce more vaccine drop-ins – as stats show two thirds of people in their 20s have had first dose. Almost two-thirds of South Tyneside residents in their twenties have had at least one dose of the Covid-19 vaccine, NHS leaders confirmed today, as they announced a range of new drop-in clinics for the jab.
- **South Tyneside singer and TikTok star Lauren urges young people to get jabbed** South Tyneside-based singer and TikTok star Lauren Amour (@musicbyamour) is encouraging other young people to get jabbed and help protect the community.
- **S**outh Tyneside return for Covid-19 vaccine bus. A popular Covid-19 vaccine bus is making a return trip to South Tyneside after a successful visit last month, NHS leaders have confirmed.
- Vaccine bus returns after South Tyneside jab success. The Covid-19 vaccine bus is heading

back to South Tyneside after more than 300 people got their jabs at the mobile facility last month.

- NHS leader hails borough's spirit as he moves on to regional role. A senior leader in South Tyneside's NHS has hailed the borough's shared energy and community spirit, as he prepares to leave for a new regional job.
- 25,000 extra jabs available in South Tyneside booster push. Around 25,000 extra Covid jabs will be provided in local vaccine centres and pharmacies as South Tyneside's NHS ramps up its booster programme.
- Minibus boost for South Tyneside vaccine effort. South Tyneside's Covid-19 effort is hitting the road again, with vaccine teams from the region's Nightingale Hospital visiting South Shields and Jarrow next week.
- Vaccine team targets home win at South Shields FC clinic. South Tyneside's Covid vaccine team will be on the ball this weekend, hosting a walk-in vaccine clinic at South Shields Football Club before the home game on Saturday 15 January.
- Vaccine bus returns to South Tyneside to boost Covid efforts. The NHS Covid-19 vaccine bus is heading back to South Tyneside after more than 300 people got their jabs at the mobile facility last month.
- Vaccine buses boost for South Tyneside. South Tyneside's Covid-19 vaccine effort will get a further boost this month with the return of two vaccine popular buses.
- Last call for South Tyneside's life-saving Covid volunteers. Covid-19 volunteers who saved lives by bringing vital oxygen tests to patients' homes are set to complete their final shift this week.

Other methods include:

Social media and video - The CCG is active on Facebook and Twitter, sharing updates and responding to issues. We currently have 4,197 followers on Twitter, and 1,700 people following our Facebook profile, which was established more recently. Where appropriate, we also draw on the support of partner organisations and at times digital advertising to increase our reach.

Council newsletter - The CCG regularly takes a double-page spread in South Tyneside Council's resident newsletter, which is delivered to every household.

Campaigns - For key priorities, advertising campaigns can provide a powerful way to share vital information with local people. The CCG teamed up with South Tyneside Council using a range of tools to promote the Covid-19 vaccine programme. These have included roadside banners, outdoor advertising, plasma screens, digital and social media advertising, pointing people to the web address www.getyourjab.uk for further details.

In addition, the CCG's bulletin for practices was relaunched with a new approach and a monthly publication cycle during the year.

Reducing health inequality

South Tyneside CCG has consistently displayed a clear commitment to equality, diversity, and inclusion under the guidance of the principles of the NHS Constitution, the Equality Act 2010, and the Human Rights Act 1998. In addition, the Health and Social Care Act 2012 states that it is a 'power' of CCGs to arrange services that will *'secure improvement in the prevention, diagnosis and treatment of illnesses (for those whom it has responsibility)'*

The CCG has ensured Equality, Diversity and Human Rights (EDHR) is woven throughout commissioning services, employing people, developing policies, communicating, consulting, and engaging with individuals in the communities we serve, making it all our responsibilities.

Public Sector Equality Duty (PSED)

As a public sector organisation South Tyneside CCG is statutorily required under the Public Sector Equality Duty (PSED), which is set out in s149 of the Equality Act 2010, to have due regard to:

- Eliminate unlawful discrimination, harassment, victimisation, and other conduct prohibited by the (Equality) Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

We are also required as part of the Specific Duties Regulations 2011 to publish:

- Equality objectives, at least every four years
- Information to demonstrate our compliance with the public sector equality duty

Governance

The Audit & Risk Committee and the Executive Team govern Equality, Diversity, and Health Inequalities. The board ensured compliance with legislative, mandatory, and regulatory requirements regarding equality and diversity, develops and delivers national and regional diversity-related initiatives within the CCG, provides a forum for sharing issues and opportunities, functions as a two-way conduit for information dissemination and escalation, monitors progress against the equality strategy and supports us in the achievement of key equality and diversity objectives.

A quarterly Governance Assurance Report was submitted to the Executive Committee outlining relevant updates in relation to Equality, Diversity and Health Inequalities.

Equality, Diversity, & Inclusion Strategy

Our Equality Strategy for 2021-2024 was developed at the start of 2021 and incorporates the aims set out within the 'We are the NHS: People Plan 2020/21 – action for us all'. It outlines our strategic direction in fostering a culture of inclusion and belonging, to take action to develop a diverse workforce that is representative of the communities we serve, in effectively training our people, and how we can work together differently to deliver patient care.

The Equality Delivery System 2 - Our Equality Objectives

We have continued to utilise the Equality Delivery System (EDS2) framework and have been using the tool to support the mainstreaming of equalities into all our core business functions to support us in meeting the Public Sector Equality Duty (PSED) and to improve our performance for the community, patients, carers, and staff with protected characteristics that are outlined within the Equality Act 2010.

We have used the NHS Equality Delivery System 2 (EDS2) to continue monitoring our equality objectives outlined below:

Objective 1 – Continuously improve engagement, ensure that services are commissioned and designed to meet the needs of patients from at least 9 protected groups.

Objective 2 – Improve and simplify the complaints process ensuring that complaints are handled efficiently and effectively for at least 6 protected groups.

Objective 3 – Continuously monitor and review staff satisfaction to ensure they are engaged, supported, and have the tools to carry out their roles effectively.

Objective 4 – Ensure that the CCG Governing Body actively leads and promotes Equality and Diversity throughout the organisation.

Our Staff - Encouraging Diversity

We encouraged a diverse range of people to apply to and work for us as we recognise the benefits such diversity brings to the quality of our work and the nature of our organisation.

We offered guaranteed interviews to applicants with a disability who are identified as meeting the essential criteria for any advertised roles; and reasonable adjustments under the Equality Act 2010 are considered and implemented during the recruitment process and during employment.

By working closely with DWP, we have maintained our 'Level 2 Disability Employer' status for 2020 - 2022 by demonstrating our commitment to employing the right people for our business and continually developing our people.

Workforce Race Equality Standard

In accordance with the Public Sector Equality Duty and the NHS Equality and Diversity Council's agreed measures to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace, the CCG completes the Workforce Race Equality Standard (WRES) reporting on an annual basis to assess itself against the nine WRES indicators.

In 2021, the corresponding WRES action plan was implemented across all North-East and North Cumbria CCGs in readiness for bringing the organisations together as an Integrated Care Board in July 2022.

Equality Impact Assessments

The Equality Impact Assessment (EIA) Toolkit was in place so any potential negative impact on any of the protected groups set out within the Equality Act 2010, can be identified at the start of development for a new, proposed service, policy, or process.

The tool covers all equality groups offered protection under the Equality Act 2010 (Race, Disability, Gender, Age, Sexual Orientation, Religion/Belief, Marriage and Civil Partnership and Gender Re-assignment) in addition to Human Rights and Carers, as well as including prompts for engagement with protected groups the tool also aids compliance with the Accessible Information Standard.

In addition to complying with the Public Sector Equality Duty, the EIA supports the culture of recognising that people are different, and our services should be inclusive for all.

Accessible Information Standard

The Accessible Information Standard aimed to make sure that people with a disability or sensory impairment have access to information that they can understand, and access to any communication support they might need.

The CCG had due regard to the standard by obtaining feedback from Patient Reference Groups (PRG's) in relation to how we can improve our communication methods to make them more accessible.

Further information on the standard can be found at:
https://www.england.nhs.uk/ourwork/accessibleinfo/

Health inequalities

There are variances in the levels of deprivation and affluence across South Tyneside, and whilst correlation is not evidence of causality, there is a clear correlation between higher levels of deprivation and health inequality.

Addressing inequalities in health, to ensure that health services are made accessible and available for everyone, not just the few, was one of the main focuses of the CCG.

We understand our local population and local health needs, using joint strategic needs assessments (JSNAs) and we collate additional supporting data including local health profiles as well as qualitative data through our local engagement initiatives which aim to engage hard to reach groups.

We gained the views of patients, carers and the public through individual feedback/input, consultations, working with other organisations and community groups, attendance at community events and engagement activity including patient surveys, the Patient Reference Group and Healthwatch.

As the local commissioners of health services, we wanted to ensure that the services that are purchased on behalf of our local population reflect their needs. We appreciate that to deliver this requires meaningful consultation and involvement of all our stakeholders. We aimed to ensure that comments and feedback from our local communities are captured and, where possible, giving local people the opportunity to influence local health services and enable people to have their say using a variety of communication methods enabling them to influence the way NHS health services are commissioned.

Further information can be found at:

- Health Profiles: Local Authority Health Profiles
- Public Health England – Local Health: http://www.localhealth.org.uk
- Sunderland JSNA: https://www.sunderland.gov.uk/article/15183/Joint-Strategic-Needs-Assessment-JSNA-
- Sunderland CCG RightCare Health Inequalities Data Pack: https://www.england.nhs.uk/wp-content/uploads/2018/12/ehircp-ney-sunderland-ccg-dec-18.pdf

Health and wellbeing strategy

The CCG was a key member of South Tyneside Health and Wellbeing Board, which had statutory duties and powers to encourage integrated work of both commissioners and providers to improve the health and wellbeing of the local population, reduce inequalities, and improve the quality and experience of services for local people.

The Health and Wellbeing Board worked to improve the health and wellbeing of the people of South

Tyneside and reduce health inequalities, as well as providing ‘whole system leadership’ for our local health economy.

The CCG was represented on the Board by Dr Matthew Walmsley (the CCG's Clinical Chair and Vice Chair of the Health and Wellbeing Board), Dr Jim Gordon (Clinical Director) and Kate Hudson (Chief Finance Officer/Chief Officer), with other CCG officers supporting meetings as and when required.

The Board focused its work around the five outcomes in the Health and Wellbeing Strategy, which means we regularly discuss issues such as economic wellbeing and community resilience.

A key priority for the Board during the past year has been to drive the response to, and recovery from the Covid-19 pandemic, through a multi-agency Covid-19 Leadership Board. This has overseen the NHS response to Covid-19, as well as its impact on the economy, community and society, and key elements of compliance with the rules, testing and the vaccine programme.

The Board supported the development of the Joint Health and Wellbeing Strategy for South Tyneside, building on the previous version that ran from 2017 to 2021. The Health and Wellbeing Strategy was launched in May 2022 and is structured around four priorities and two cross-cutting themes:

Four priorities:

- Best start for life
- Financial security to lead healthy, fulfilling lives
- Good mental health and social networks throughout life
- Safe and healthy places to live, learn andwork Two cross-cutting themes:
- Public Involvement and Community Engagement (PICE), and
- Tackling intervention-generated inequalities

Our shared commitment to working together as a single system in South Tyneside goes well beyond the statutory requirements of the Board. This was based on our early success as a Health and Care Pioneer area and our partnership with the Canterbury (New Zealand) District Health Board – the first of its kind in the country.

This led us to develop our own shared local leadership approach called alliancing. Alliancing shapes the behaviours of our system leaders, from chief executives to frontline practitioners. This way of working has led to further improvements in trust and practical service improvements, such as a significant reduction in delayed transfers of care, smoking in pregnancy, and an improvement in mental health service standards.

In particular, our work around children's mental health has been of vital importance throughout the challenges of Covid-19 and lockdown. We have invested heavily in support to children, parents, families, teachers and schools, to try to ensure that our children have the best possible chance to

thrive as we move through the next period of this pandemic.

A particular focus for the Board this year has been to deepen our understanding of the challenges of poverty in our borough, many of which have been greatly exacerbated by the pandemic. This will be a key priority in the years ahead, to ensure that all partners take action on poverty together to improve local people's health.

A priority of the Board was to promote proactive, personalised and fair health and care services. The board was therefore driving reforms around integrated commissioning of health and care. We have continued to develop our formal governance structures for integrated commissioning (the South Tyneside Alliance Commissioning Board and Alliance Executive Committee – described in more detail in the governance statement section later in this annual report), in support of the existing Joint Commissioning Unit and jointly appointed senior commissioners.

We are confident that by working in partnership to address these issues we will make South Tyneside a healthier and more equitable place to live, invest and bring up families.

Financial review

In accordance with NHS England planning guidance for 2022/23, system financial envelopes have been set at an ICB level. The expectation from NHS England is financial balance at an ICB level over the full 2022/23 financial year. Prior to the ICB establishment on the 1ˢ July 2022, CCG financial positions were monitored in aggregate against the overall ICB allocation.

As part of closure of the CCGs accounts for the three-month period 1 April 2022 to 30 June 2022, NHS England provided an allocation to cover the resource consumed for the period. The NENC ICB on establishment was allocated any remaining funding for the period 1 April 2022 to 30 June 2022 to be utilised over the remaining months of 2022/23. As a result of this arrangement the CCG was expected to report an overall breakeven position for the three-month period 1 April 2022 to 30 June 2022. Following a late audit adjustment, the CCG has reported a small surplus in the annual accounts for the period.

ACCOUNTABILITY REPORT[2]

Samantha Allen

Chief Executive for the North East and North Cumbria Integrated Care Board

Accountable Officer

30th June 2023

[2] The ICB Chief Executive was not the Accountable Officer of the CCG, however as per the NHS England annual report and accounts guidance, is the required signatory for this report.

Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1st April to 30th June 2022, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our 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

The purpose of the corporate governance report is to explain the composition and organisation of the CCG's governance structures and how they support the achievement of our objectives.

Members Report

The CCG's Constitution set out the terms by which we, through our appointed members, elected GP executives and governing body, implement all statutory obligations including the commissioning of secondary health care and other services for South Tyneside. The Constitution contained the main governance rules of the CCG and Governing Body.

The Constitution was agreed and signed by all member practices as part of the CCG authorisation process and has subsequently been updated, including reflecting the changes in relation to additional primary medical care commissioning responsibilities the CCG.

The CCG covers the whole of the borough of South Tyneside and details of our member practices can be found on at pages 62 &63.

Governing Body Profiles

Dr Matthew Walmsley, GP Member and Chair

Matthew trained in the North East and has spent over twenty years working in the region. He has been a partner at Marsden Road Health Centre for 18 years with clinical interests in mental health, substance misuse and safeguarding. Matthew has chaired South Tyneside CCG since its inception. His time in post has seen the CCG gain a growing reputation for innovation and integration, overseeing significant service reconfiguration in areas such as mental health, urgent care, paediatrics, and maternity.

Dr Neil O'Brien, Chief Clinical Officer and Accountable Officer

Dr O'Brien has been a local GP in Chester-Le-Street for over 20 years. He has developed a special interest in cardiology and has previously worked as a GP with special interest in this area. Neil is a practicing clinician, which strengthens his influence with local practices and other clinicians. Neil is also the Clinical Accountable Officer for two other CCGs in Sunderland and South Tyneside. Neil is a member of the Integrated Care System (ICS) Management Group representing the needs of local populations at the North East and North Cumbria ICS. During the last year Neil has chaired the ICS vaccination board overseeing the roll out of the flu vaccination programme and the COVID-19 vaccination programme, Neil is also a member of the national clinical advisory group advising the national roll out of the COVID-19 vaccination.

Ms Jeanette Scott, Executive Director of Nursing, Quality and Patient Safety

Jeanette is passionate about the quality and safety of care experienced by patients and making improvements to care where appropriate, as well as addressing inequalities.

Jeanette trained as a nurse in South Tyneside and has held several senior positions in both provider and commissioning organisations during her 43 years NHS experience. She is a qualified Nurse and Health Visitor, with a strong focus on community services, and has completed an Executive MBA as well as numerous leadership programmes.

Jeanette is also a Visiting Professor at the University of Sunderland.

When not at work Jeanette enjoys spending time with her grandchildren and in the garden and is an avid reader and follower of The Archers. She is also a Trustee for a North East charitable organisation.

Ms Kate Hudson, Chief Finance Officer / Chief Officer

Kate is the Chief Finance Officer/Chief Officer for South Tyneside CCG and has been in post since its inception in 2013. Having originally joined the NHS graduate training scheme she has significant NHS experience, including 18 years at senior management level. Her predominant experience is within commissioning and she is committed to improving healthcare by working with partners to

secure efficient and effective services.

Ms Deborah Cornell, Associate Director of Operations

Deborah has over 20 years' experience of working in the public sector. She started her career in HM Prison Service in London in 1997, moving to the Home Office in 1999 and then back to the North East in 2001 to join the NHS. Deborah has held several senior level corporate governance roles within the NHS and is now undertaking role of Associate Director of Operations for South Tyneside CCG since January 2022. She has also been an affiliated member of the Institute of Chartered Secretaries and Administrators since 2016.

Jo Farey, Associate Director – Primary Care Commissioning

Jo has worked for over 25 years in the North East NHS across a variety of acute and primary care settings. She has an extensive background in operational, contractual and strategic management, and is a recent graduate of the NHS Rosalind Franklin leadership programme. Jo is currently working as the Associate Director of Primary Care Commissioning within the CCG.

Lisa Dodd, Associate Director of Integration and Commissioning

Lisa has over 29 years' experience of working in the NHS. She started her career in secondary care and moved into primary care and commissioning in 2000. Lisa has held many senior roles within the NHS developing a wealth of knowledge in commissioning and service transformation. Lisa spent over 10 years working within Public Health and holds her registration as a Public Health Defined Specialist with the UKPHR. Since 2022, Lisa has been in the role of Associate Director of Integration and Commissioning for South Tyneside CCG.

Mr Tom Hall, Director of Public Health, South Tyneside Council

Tom Hall has worked in public health since 2003 and he has been the Director of Public Health for South Tyneside since May 2017. He is the Statutory Lead Officer for health and wellbeing and the South Tyneside Health & Wellbeing Board, and strategic lead for the implementation of the Joint Health and Wellbeing Strategy. Tom plays a key role in the South Tyneside Alliance system leadership approach, developing an integrated health and care system and leads A Whole Council Public Health approach. Tom is also involved in academic leadership at the regional level with the Applied Research Collaboration and Public Health Clinical Research Network.

Ms Louise Lydon, Primary Healthcare Professional Member

Louise has worked as a community pharmacist in South Tyneside for over 20 years since graduating from Sunderland School of Pharmacy in 2000. Louise is passionate about tackling local health inequalities and sits on various alliancing boards / groups including long-term conditions, flu and COVID-19, smoking, drug and alcohol. She is an independent prescriber and a champion for extending the role of the community pharmacist, working outreach within communities. Louise's other professional roles include being the South Tyneside and Gateshead Local Pharmacy

Committee secretary, and a visiting lecturer at Sunderland University, School of Pharmacy. Louise enjoys cooking, reading, gardening, and growing as well as paddle boarding with her sister and daughters.

Dr Tarquin Cross, Secondary Care Consultant

Tarquin moved from London to Newcastle in 1991 to study medicine and has stayed in his adopted North East ever since. He has trained and worked in numerous hospitals across the region before taking up a consultant post in Elderly Medicine with Northumbria Healthcare NHS Foundation Trust in 2007. He is currently one of the Deputy Business Unit Directors for Clinical Integration within the Trust and has been on the Governing Body since 2012.

Mr Paul Cuskin, Lay Member, Public & Patient Involvement, Deputy Chair

Paul had a 30-year career with the UK Civil Service during which time he worked with both the public and private sectors in the development of Employment & Skills to deliver Welfare to Work, and between 1999 and 2011 worked as Strategic Director for the North-East Employer Coalition working with employers and agencies to tackle long-term unemployment. Previously, Paul was the inaugural Chair of Healthwatch South Tyneside, and was appointed to the committee of Healthwatch England to help represent the views of patients, care users and the public at a national level. Paul is Co Chair of South Tyneside Admiral Nurse Dementia research group - responsible for recruiting three admiral nurses working and providing clinical support to people living with dementia, their carers and families. Paul is a former international athlete representing Great Britain at road, cross-country and track racing. He was also a dementia carer.

Mr John Whitehouse, Lay Member for Governance

John is a qualified public finance accountant. In a career spanning 37 years he has worked in local government, the private sector, and the NHS. Within the NHS he held several senior roles in finance but most significantly in internal audit. He lives in Hartlepool with his wife. He has two daughters and a growing number of grandchildren with whom he spends a great deal of his time. In addition to chairing the Audit and Risk Committee, John is our Conflicts of Interest Guardian in accordance with our Standards of Business Conduct Policy. He is also a governing body member at North Cumbria CCG and County Durham CCG.

Mrs Pat Harle MBE, Lay Member

Pat has over 40 years NHS experience, in acute, community, teaching hospital, and consultancy, the last 20 years at board level in NHS commissioning and provider services and is passionate about ensuring high quality services. Pat has held a number of national offices, and was awarded an MBE, a ‘Probe Lifetime achievement award ‘and presented with a Medal of Distinction from the British Dental Association.

Member Practices and Council of Practices

As a membership organisation the CCG comprises 21 practices that make up the membership, represented through the Council of Practices. The Member Practices that comprise the CCG are as follows:

Practices in NE31	
Victoria Medical Centre	NE31 1NU
The Glen Medical Group	NE31 1NU
Ellison View Surgery	NE31 2SP

Practices in NE32	
Drs Dowsett and Overs	NE32 3UX
East Wing Surgery	NE32 3UX
Albert Road Surgery	NE32 5AG
Mayfield Medical Centre	NE32 5SE

Practices in NE33	
Ravensworth Surgery	NE33 3ET
Wawn Street Surgery	NE33 4DX

Practices in NE33	
Imeary Street	NE33 4EG
West View Surgery	NE33 4JP
Farnham Medical Centre	NE33 4QY
Trinity Medical Centre	NE33 5DU
St George and Riverside Practice	NE33 5DU

Practices in NE34	
Talbot Medical Centre	NE34 0BX
Marsden Road Health Centre	NE34 6RE
Central Surgery	NE34 7QD
Drs Haque and Haque	NE34 9BP

Practices in NE35	
Dr Thorniley-Walker and Partners	NE35 9AN
Colliery Court Medical Group	NE35 9AN

Practices in SR6	
Whitburn Surgery	SR6 7EE

In keeping with the CCG as a membership organisation, there was an established Council of Practices which has reserved a limited number of matters to itself (as specified in the CCG's Scheme of Reservation and Delegation) having delegated many functions and duties of the CCG, through the means of the Constitution, to the Governing Body.

Composition of Governing Body

The main functions of the Governing Body are described in section 14L of the 2006 Health Service Act (inserted by section 25 of the Health and Social Care Act 2012). The Governing Body's principal aim was to ensure that the group has made appropriate arrangements for ensuring that it complies with its obligations to exercise its functions effectively, efficiently, economically and in line with relevant generally accepted principles of good governance. The CCG's Constitution specifies the arrangements made by the CCG for the discharge of functions by the Governing Body.

Membership of the Governing Body must include:

- at least six members (including its chair and deputy chair)
- accountable officer
- at least one each of the following:
    - an employee of the CCG who has a professional qualification in accountancy and the expertise or experience to lead the financial management of the CCG
    - a registered nurse
    - an individual who is a secondary care specialist
    - a lay person who is qualified for membership
    - another lay person who is qualified for membership

The CCG's Constitution specifies that "each member of the Governing Body should share responsibility as part of a team to ensure that the group exercises its functions effectively, efficiently, and economically, with good governance and in accordance with the terms of its constitution. Each brings their unique perspective, informed by their expertise and experience. Notwithstanding this, all members of the governing body have joint responsibility for every decision of the governing body regardless of their individual skills and experience."

The Governing Body was also supported by a number of committees which it has established, and which provide regular reports to it. Details for these committees are set out in the Annual Governance Statement below. The executive team is responsible for the day-to-day running of the organisation and implementing decisions taken at a strategic level by the Board.

Division of responsibilities

The Governing Body was satisfied that there is a clear division of responsibilities between the Chair and Chief Executive.

Committee(s), including Audit and Risk

Details of the CCG's committees can be found in the governance statement of this annual report.

Register of Interests

The CCG's register of interests is available to members of the public, should you require any information relating to the register please email your information request to - nencicb-tv.enquiries@nhs.net

The CCG has carried out an annual audit of conflicts of interest and received a rating of Substantial from the CCG's internal auditors, AuditOne in June 2022. The CCG continued to operate with the same controls as during 2021/22 and no breaches have been identified during the period covered by this report.

Personal data related incidents

The CCG did not have any serious incidents or serious information breaches during 1st April -30th June 2022.

Modern Slavery Act

NHS South Tyneside Clinical Commissioning Group fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Principles of Remedy

The CCG complaints policy and procedure was developed and updated in line with current legislation and statutory requirements and best practice. This includes adopting the principles as outlined in the Parliamentary and Health Service Ombudsman's principles of good complaints handling, principles of good administration and principles of remedy.

Emergency Preparedness, Resilience and Response

The CCG had a business continuity plan in place which is fully compliant with NHS England's Emergency Preparedness Framework. The plan set out the necessary process for staff to follow in the event of a business continuity incident and includes key contacts to support this. In addition, the CCG has completed business impact analysis for all its key functions and used these to prioritise which activities would need to be continued in the event of such an incident. The CCG was also a member of the Local Health Resilience Forum, however, as a category 2 responder, is not required to have a major incident plan.

Statement of Accountable Officer's Responsibilities

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

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the CCG 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 has 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;

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial

Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,

- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced, and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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

Governance Statement

Introduction and context

NHS South Tyneside Clinical Commissioning Group (the CCG) was a body corporate established by NHS England on 1st April 2013 under the National Health Service Act 2006 (as amended).

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

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

The geographical area covered by the CCG is coterminous with the boundary of South Tyneside Council and commission's health care on behalf of a population of 151,133 As a membership organisation the CCG comprises of 21 practices that make up the membership, represented through the Council of Practices.

The Governing Body and its formal sub-committees were responsible for the day-to-day governance of the organisation in accordance with the delegated functions set out in the CCG's Constitution.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS South Tyneside Clinical Commissioning Group policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money.* I also acknowledge my responsibilities as set out in my Accountable Officer Appointment Letter.

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

Governance arrangements and effectiveness

The main function of the Governing Body is to ensure that the Group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

The CCG's Constitution sets out the terms by which the CCG, through its appointed members, elected GP executives and Governing Body, implements all statutory obligations including the commissioning of secondary health care and other services in South Tyneside. The Constitution

contains the main governance rules of the CCG and Governing Body.

The Constitution was agreed and signed by all member practices at the inception of the CCG. It has been reviewed and updated on a regular basis to ensure it remains fit for purpose and takes into account any subsequent guidance, as well as key elements such as:

- specifying the arrangements made by the CCG for the discharge of its functions
- specifying the arrangements made by the CCG for the discharge of the functions of the Governing Body
- the procedures to be followed by the CCG in making decisions
- the arrangements it has made to secure those individuals to whom health services are being or may be provided pursuant to its commissioning arrangements are involved
- arrangements made by the CCG for discharging its duties in respect of registers of interests and management of conflicts of interests
- arrangements made by the CCG for ensuring that there is transparency about the decisions of the group and the manner in which they are made.

Throughout 1 April to 30 June 2022, the CCG has continued to operate with a governance structure that reflects guidance and best practice, including Governing Body, Audit & Risk Committee, Remuneration Committee and Primary Care Commissioning Committee

As a membership organisation, the CCG has an established Council of Practices which has reserved a limited number of matters to itself (as specified in the CCG's Scheme of Reservation and Delegation) having delegated the majority of functions and duties of the CCG, through means of the Constitution, to the Governing Body.

The CCG has met regularly with its member practices through its Council of Practices and Educational Forums, moving these to virtual meetings from May 2020 due to the impact of the pandemic and which continued virtually throughout 2021/22. Through these sessions, we kept our members up to date on key developments both nationally and locally across the CCG, as well as obtaining their views and feedback on key issues, improvements and future developments.
Due to the transition of CCGs to ICB from July 2022, we will share our key achievements during the year with member practices and the public via this annual report. We will also share our key achievements during the year with member practices and the public via this annual report. We will include an overview of the CCG's financial performance to demonstrate we have met our statutory duties in relation to these

The NHS Operational Planning and Contracting Guidance 2020/21 set out the requirement for practices to work as part of local primary care networks. Primary care Networks (PCNs) are based on GP registered lists, typically serving natural communities of around 50,000, being small enough to provide the personal care valued by both patients and GPs but large enough to have impact and economies of scale through better collaboration between practices and others in the local health and social care system.

The CCG had three PCNs covering the East, West and South localities of South Tyneside. The PCNs continue to build on the core of current primary care and enable greater provision of proactive, personalised, coordinated and more integrated health and social care.

Governance Framework

We used our governance framework to lead and manage the achievement of our vision to work collaboratively across South Tyneside to improve health and commission excellent health care. We also use governance to lead and manage through our core values and the public sector values of accountability, probity and openness and our systems (such as governance structures and risk management systems). Details of our strategic objectives can be found in the performance report section of CCG's annual report.

We also use governance as the system of control, accountability and decision-making at the highest level of the organisation. The CCG governance framework comprises of the systems and processes and culture and values by which the CCG is directed and controlled. It enables us to monitor the achievement of our strategic objectives and ensure we deliver our vision of commissioning appropriate, cost-effective services for the residents of South Tyneside.

The CCG's system of internal control is a significant part of the governance framework and is designed to manage risk to a reasonable level. It cannot eliminate all risk of failure to achieve policies, aims and objectives and therefore can only provide reasonable and not absolute assurance of effectiveness.
Our system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of policies, aims and objectives
- Evaluate the likelihood of those risks materialising and the impact should they materialise,
- Manage risks efficiently, effectively and economically

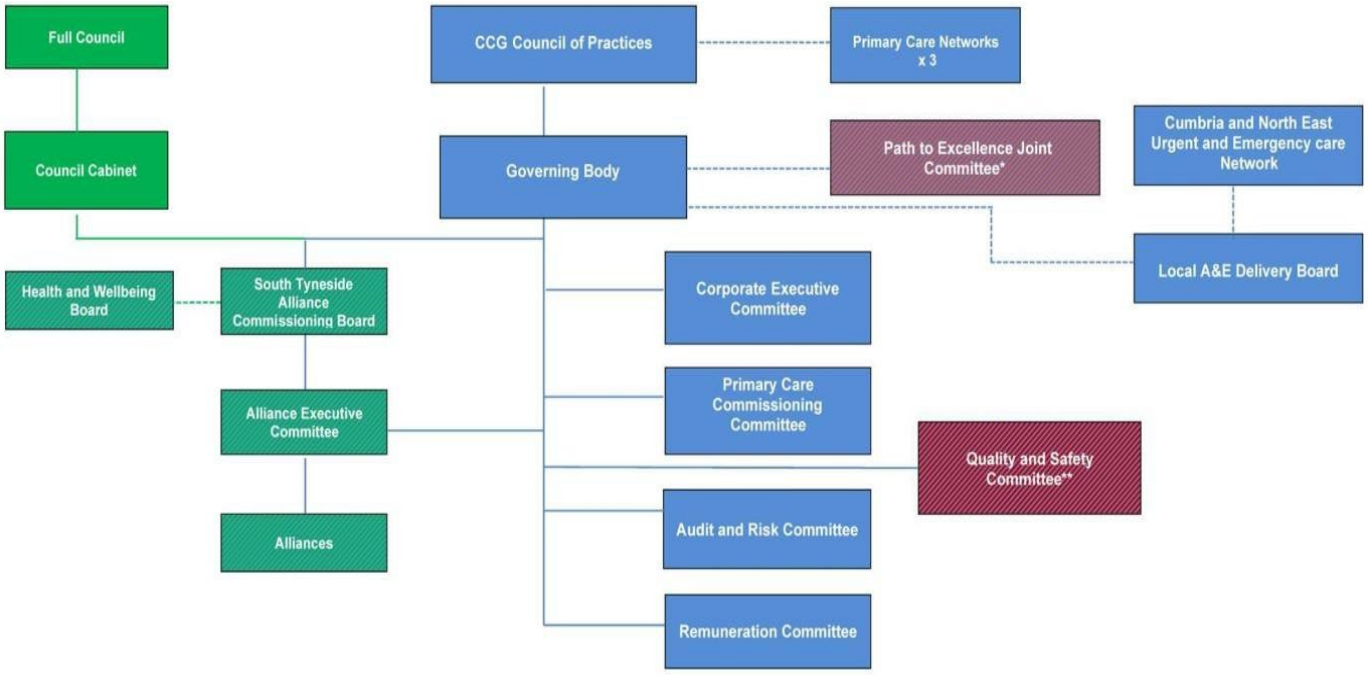
The governance framework has been in place in the CCG until 30th June 2022.

To ensure effective governance arrangements were in place within the CCG, the Governing Body and its sub-committees operate in such a way as to ensure it discharges its functions appropriately and are managed effectively. The Governing Body and committee agendas were structured to ensure key risks and issues were addressed and ensure continued delivery of our corporate objectives and priorities throughout the pandemic.

The Governing Body had an agreed assurance framework in place (described in more detail in the control mechanisms section of this statement) which is supported by clear risk management processes to place for identifying, analysing, evaluating, controlling, monitoring and communicating risk. The Audit and Risk Committee oversees the risk management function on behalf of the Governing Body.

The Governing Body has used its assurance framework to ensure delivery of the corporate objectives and has received regular updates on progress for assurance. The Audit and Risk Committee also supported this work and undertook regular reviews of the framework and process associated with it to ensure it remained robust throughout the year.

Governing Body and Committee Structure



In the first quarter of 2022/23, the Governing Body met on 1 occasion via virtual meetings which was streamed live to the public.

The Governing Body membership is set out in the members report of this annual report
The Governing Body's committee structure reflects guidance and best practice and includes a Corporate Executive Committee, Alliance Executive Committee, Audit and Risk Committee, Joint Quality and Safety Committee (with Sunderland CCG), Primary Care Commissioning Committee, Remuneration Committee and a Path to Excellence Joint Committee (with County Durham and Sunderland CCGs).

Each committee had agreed terms of reference to outline their key areas of responsibility and accountability to the Governing Body. These terms of reference are reviewed on a regular basis to ensure they remain relevant and reflect the committee's role and responsibilities.

Agendas are structured to deal with strategic, performance, quality, assurance, risk and governance issues, as well as patient experience via patient stories at public governing body meetings. These arrangements meet the requirements of best practice guidance in respect of risk management and ensure that a robust assurance framework is in place and consistently reviewed. They also reflect the public service values of accountability, probity and openness and specify, as Accountable Officer, my responsibility for ensuring these values are met within the CCG.

Governing Body and Committee Attendance Record 1.04.22 to 30.06.22

Member Role	Audit and Risk Committee	Joint Quality and Safety Committee	Governing Body	Alliance Executive Committee	Primary Care Commissioning Committee	Remuneration Committee
Dr Matthew Walmsley – Chair*		2/2	2/2	2/3	0/1	1/1
Dr Neil O'Brien – Accountable Officer*		0/2	0/2			
Dr Tarquin Cross – Secondary Care Consultant*		1/2	2/2		1/1	
Ms Kate Hudson – Chief Officer/Chief Finance Officer*	1/1		2/2	2/3	1/1	1/1
Mrs Jeanette Scott – Executive Director of Nursing, Quality and Safety*		2/2	2/2	2/3	1/1	
Ms Deborah Cornell – Associate Director of Operations		0/2	2/2	1/3	1/1	
Ms Jo Farey – Associate Director of Primary Care Commissioning			2/2	2/3	1/1	
Ms Lisa Dodd – Associate Director of Integration and Commissioning			2/2	2/3		
Mr Paul Cuskin – Lay Member, Patient and Public Involvement / Deputy Chair*	1/1	2/2	2/2		1/1	1/1
Mr John Whitehouse – Lay Member for Governance*	1/1		2/2			1/1
Mrs Pat Harle – Lay Member, Primary Care Commissioning and Quality*	1/1	2/2	2/2		1/1	0/1
Ms Louise Lydon - Primary Care Health Professional*			0/2		0/1	0/1
Mr Tom Hall – Executive Director of Public Health, South Tyneside Council			2/2	2/3		
Ms Vicki Pattison – Director of Adult Services, South Tyneside Council			2/2	3/3		

denotes does not attend Committee/Governing Body

* denotes voting right on the Governing Body

Description of Established Governing Body Committees

The roles of each of the Governing Body Committees are set out broadly below. The Governing Body committees have authority under the Scheme of Reservation and Delegation to establish sub committees or sub-groups to enable them to fulfill their role. Each of the Governing Body Committees has detailed terms of reference and was authorised by the Governing Body to pursue any activity as set out in its terms of reference and within the scheme of reservation and delegation.

Remuneration Committee

The Committee was established to advise on and recommend to the Governing Body the appropriate remuneration and terms of service for the Chief Officer and other staff paid through the Very Senior Manager Pay Framework. The Committee also advises on and makes recommendations to the Governing Body on the remuneration for the role of Chair, remuneration and terms of service of any independent lay members and clinical directors and reviews any business cases for early retirement and redundancy.

Audit and Risk Committee

In line with the requirements of the NHS Audit Committee Handbook and NHS Codes of Conduct and Accountability, the Committee provides the organisation with an independent and objective review of their financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities. An annual Counter Fraud Plan is agreed by the Committee which focuses on the deterrence, prevention, detection and investigation of fraud. The Committee is a non-executive committee of the Governing Body and has no executive powers, other than those specifically delegated in its terms of reference. Annually the Committee also carries out a self-assessment of its effectiveness.

The Committee's cycle of business enabled the Audit and Risk Committee to carry out its key objectives necessary to support its assurances regarding the effectiveness of the organisation's internal controls.

In accordance with the Local Audit and Accountability Act 2014, the Audit and Risk Committee has also had the responsibility for the appointment of external auditors as an Auditor Panel.

Joint Quality and Safety Committee

The principal purpose of the Quality and Safety Committee, which has been re - established as a joint committee with Sunderland CCG since April 2021, was to ensure that the appropriate governance systems and processes are in place to commission, monitor and ensure the delivery of high-quality safe patient care in commissioned services and to facilitate, monitor and ensure quality improvement in general medical practice working with the NHS England and Improvement.

Significantly, during the year through its cycle of business, the committee and its associated sub-committees have considered a number of quality and patient safety matters including monitoring provider quality and patient safety performance using a range of metrics. In

addition, the committee has reviewed assurance reports regarding quality of care in nursing homes, safeguarding and commissioning for quality and innovation schemes.

Alliance Executive Committee

The Alliance Executive Committee was responsible for the strategic planning, delivery and oversight of the committee's delegated functions by working collaboratively across the South Tyneside system with partners to improve health and wellbeing of the people of South Tyneside through improved commissioning of health and care services. It made decisions in line with its delegated authority to support alignment of health and care, including developing and enacting integrated commissioning.

Primary Care Commissioning Committee

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England delegated responsibility for the commissioning of primary care services to the CCG. Accordingly, in April 2017 the CCG established a Primary Care Commissioning Committee with delegated functions for the commissioning of primary care services. The Committee's terms of reference and a supporting schedule provide details of the extent of the delegation.

In accordance with guidance and in order to avoid any conflicts of interests, the meetings are held in public, and it is chaired by the Lay Member of Primary Care Commissioning and Quality. The GP membership on the committee is in an advisory capacity only and non-voting.

Path to Excellence Joint Committee

The Path to Excellence Joint Committee was established in accordance with the NHS Act 2006 (as amended) which allows two or more Clinical Commissioning Groups (CCGs) to form joint committees and exercise certain
functions jointly and to take collective binding decisions as to the exercise of these functions and in accordance with the Constitutions of the CCGs of the Committee.

The Committee was responsible for the delivery and management of the overall Path to Excellence transformation programme and will support the member CCGs to work efficiently, effectively and economically, ensuring effective clinical engagement and patient and public involvement, as well as promoting the involvement of all member CCGs and their practices in the work of the CCGs in securing improvements in applicable services through the Path to Excellence programme.

Joint Committee Arrangements

The CCG had the following joint and collaborative arrangements in place to make commissioning decisions through delegation arrangements. These are as follows:

- South Tyneside Health and Wellbeing Board
- South Tyneside Council (section 75) agreement in place forjoint commissioning arrangements for the Better Care Fund
- Joint Committee with NHS County Durham and Sunderland CCGs to manage the Path

to Excellence acute transformation programme
- Collaborative arrangements with the other North East and North Cumbria CCGs with regards to commissioning arrangements for contracts with NHS healthcare providers across the North East and Cumbria
- Joint arrangements with the North East CCGs to determine commissioningfor health gain policies and to review and approve individual funding requests, including conducting an appeals process
- Joint arrangements with the North East CCGs to advise upon and make recommendations to CCGs on high-cost cancer drugs and high-cost treatments
- Joint arrangements with the North East CCGs to provide a partnership forum to work together with trade union and professional organisation representatives to discuss issues relating to employment matters affecting their employees

The groups identified above have an agreed governance structure in place with specific roles, responsibilities and accountabilities or are covered by individual CCGs' governance arrangements where appropriate and agreed. Any investments and decisions made by these groups were formally documented and reviewed regularly as part of the CCG contracting and performance arrangements.

We continue to work closely with our partner organisations across the local health community to ensure we commission high quality services for the residents of South Tyneside. A significant part of this partnership working continues to be with South Tyneside Metropolitan Borough Council in the delivery of the Better Care Fund (BCF). The combined total for the BCF Fund was £14.8m in 2021/22 which is being used to enable much needed changes to improve services across both the health and care sectors whilst making maximum use of the combined resources. Robust governance arrangements are in place around the BCF and demonstrate the strength of the links that we have with the Council.

Health and social care integration

The CCG and Council have worked in partnership over a number of years to transform the delivery of care across South Tyneside. We have established robust alliancing arrangements (the South Tyneside Alliance) with other key partners, such our acute providers and voluntary and community sector organisations, to strengthen the connections between local health and social care services and improve the health and wellbeing of all people in South Tyneside.

The South Tyneside Alliance journey began in 2015 and goes from strength to strength. It is becoming a national and international exemplar of how to approach partnership working. The shared behaviours that have been established through our alliancing principles (such as the concept of the South Tyneside Pound; best for person, best for system; and high trust, low bureaucracy) are becoming deeply engrained and embedded amongst all levels from our most senior managers to our frontline staff.

This work supports the future direction of the NHS commissioning landscape with the establishment of an ICB across the NENC ICB which will be supported by place-based arrangements, coterminous with local authorities. It also supports the requirements set out in the NHS Long Term Plan (Jan 2019) which were reiterated in NHS England's operational planning guidance issued in December 2021. The Integration White Paper 'Joining up care for

people, places and populations' published in February 2022, also provides further direction for our place-based arrangements. Going forward collaboration is a key factor in bringing together those organisations who commission and deliver care across a local place-based system, making collective decisions on how to achieve the best outcomes for local residents.

The ongoing development of our alliance ways of working fits with the national direction of travel associated with system working but for us is simply a continuation of the South Tyneside Alliance journey to date. We will continue to go further to drive greater health and social care integration to make better use of resources, better outcomes and less fragmented care for residents.

During 2022, the Alliance Commissioning Board and Executive Committee continued to meet virtually to act on behalf of the South Tyneside system by working, efficiently, effectively, and economically to improve commissioning of local health and care services. Through our collaborative model, we aim to support the alignment of health and care services, ensuring effective clinical engagement and promoting the involvement of all key stakeholders in improving the health and wellbeing of local people.

By strengthening the governance framework for partnership arrangements, we are taking the next step in the transition to the ICS approach and will continue to build upon the well-established and successful joint working already in place with key partners across the Borough. These partnership arrangements will continue to evolve over the coming months as the CCG transitions into the new ICS.

Governance during Covid-19 pandemic

As a result of the Covid-19 pandemic and the national guidance on how NHS organisations need to respond is changing rapidly, the CCG needed to adapt its internal decision making and assurance processes to ensure it could respond quickly and appropriately whilst still ensuring good governance.

Emergency powers and urgent decisions – Governing Body and sub-committees

The Standing Orders contained within the CCG Constitution allow for emergency powers and urgent decisions to be taken. These arrangements contained within the CCG's Standing Orders apply also to sub-committees within the CCG's committee structure, with chair's action(s) allowing for urgent decisions to be taken out with agreed meeting structures (where circumstances demand it), with the resulting action and decision recorded and ratified at the next meeting of that sub-committee. These include the Corporate Executive Committee, Alliance Executive Committee, Audit and Risk Committee, Primary Care Commissioning Committee and the Joint Quality and Safety Committee.

Assessment of Governing Body Effectiveness

We have reported on our corporate governance arrangements by drawing upon best practice available. During this reporting period the Governing Body has continuously reviewed feedback on the effectiveness of each of its meetings using a standard template and criteria including evidence of constructive challenge, evidence of contributions beyond member disciplines, behavior, pace and enthusiasm.

We continuously monitor our process for managing conflicts of interest to ensure any actual or potential interests are managed effectively and robustly. The CCG was not required to submit quarterly assurance returns to NHS England and Improvement during April – June 2022 as this process was stepped down due to the impact of the pandemic. However, the CCG has continued to manage conflicts of interest during this period and has not had any breaches at the time of writing this statement. Our register is publicly available on the CCG's website.

The Governing Body has held regular virtual development sessions throughout the year to continuously review, develop and enhance its effectiveness. The sessions covered a range of key topics such as:

- Continued Covid-19 response and recovery
- System-wide development of the integrated care systems and partnerships
- Phase two of the Path 2 Excellence transformation programme
- Strategic priorities and operational planning
- Financial planning
- Joining up care for people, places and populations

Having reviewed the effectiveness of the Governing Body's governance framework and associated guidance, I consider that the organisation has followed and applied the principles and standards of best practice.

UK Corporate Governance Code

As an NHS body we are not required to comply with the UK Corporate Governance Code. However, we have reported on our corporate governance arrangements by drawing on best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the clinical commissioning group and best practice.

For the period 1st April – 30th June 2022, and up to the date of signing this statement, we had regard to the provisions set out in the code, and applied the principles of the code.

Discharge of Statutory Functions

The arrangements put in place by the CCG and explained within the corporate governance framework were developed with extensive expert external legal input, to ensure compliance with all relevant legislation. That legal advice also informed the matters reserved for membership body and Governing Body decision and the scheme of delegation.

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

Responsibility for each duty and power was allocated to a lead director. The director teams have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

Risk management arrangements and effectiveness

Effective risk management is an integral part of the work of the CCG in delivering against its corporate objectives and strategic priorities in the stewardship of public funds. The Governing Body had the responsibility to maintain a strategic view of the organisation's risk appetite, as set out in the CCG's risk management framework, and to set boundaries to guide staff on the limits of risk they are able to accept in the pursuit of achieving its organisational objectives.

The CCG risk management framework took into account current guidance on risk management as well as established best practice. The framework set out the CCG's approach to risk and the management of risk in the fulfilment of its overall objective to commission high quality and safe services. In addition, the adoption and embedding of an effective risk management framework and processes helps to ensure that the reputation of the CCG was maintained and enhanced, and its resources are used effectively to reform services through innovation, large-scale prevention, improved quality and greater productivity.

Key elements of the framework included:

- Clear statements on the responsibilities of the Governing Body and its sub committees as well as individual accountability for delivery of the framework
- Clear principles, aims and objectives of the risk management process
- Clear processes for the management of risk in commissioned services, partnership working and the delivery of the quality, innovation, productivity and prevention programme
- A clearly defined process for assessing and managing risks, including implementation and dissemination of the framework to all staff
- Details of the approach to be undertaken to assess and report risks, including incident reporting, serious incidents and safeguarding
- Confirmation of the arrangements for reporting of and managing risks through the risk register process
- Arrangements for monitoring and review of the framework

Risk management was embedded in the activity of the CCG through:

- The risk management framework and its supporting policies and procedures
- The committee structure described earlier in this statement
- A risk management workshop including directors and senior team
- The management processes (e.g. a risk-based approach to help prioritise strategic planning, identify risks to the achievement of organisational objectives and the delivery of work programmes)
- The Governing Body assurance framework
- Risk management skills training, including risk assessments of various types and the mandatory and statutory training programme for all staff
- A robust incident reporting system through which staff are actively encouraged to report incidents to help identify risks
- A clear policy and process in place for staff to raise any concerns in relation to potential fraud risks

Understanding, monitoring and mitigating risks are fundamental tasks in a successful organisation, as well as basic aspect of good governance. As such, it was the responsibility of the Governing Body to determine the best place for risk management to positioned ensuring effective management and assurance processes are in place. The overall risk management approach ensured that the framework was coordinated across the whole organisation.

As a formal sub-committee of the Governing Body, the Audit and Risk Committee provided the Governing Body with an independent and objective view of the CCG's financial systems, financial information, and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance. The Committee also provides assurance to the Governing Body that systems were in place and operating effectively for the identification, assessment and prioritisation of risks, potential and actual, and to report on any major strategic issues and any associated financial implications to the Governing Body and other external agencies as appropriate.

The Committee's specific responsibilities relating to risk management were to:

- Oversee the risk management system and obtain assurances that there is an effective system operating across the CCG
- Report to the Governing Body any significant risk management issues

The Committee also reviewed the Governing Body assurance framework (GBAF) to ensure the Governing Body received assurances that effective controls were in place to manage all strategic risks aligned to the corporate objectives. It provided assurance with regards to risks to the services being commissioned ae well as overall risks to the organisation's strategic and operational plans.

Dedicated risk management workshops are held throughout the year with executive and senior leads to maintain a robust focus on risks. This included an in-depth review of all risks to enable further scrutiny and challenge on the assurances and mitigating actions identified in the risk register and GBAF.

The Executive, Alliance Executive and Joint Quality and Safety Committees review and manage any strategic or operational risks pertaining to the committee's area of focus on a regular basis.

Capacity to Handle Risk

The responsibility for risk management is identified at all levels across the CCG, from Governing Body members, directors and to all managers and staff.

As Accountable Officer, I have overall responsibility to ensure the implementation of the framework with supporting risk management systems and internal control. I also ensure an appropriate committee structure is in place to meet all the statutory requirements and ensure positive performance towards the achievement of the CCG's strategic priorities. Day to day responsibility for risk management is delegated to the Head of Corporate Affairs, now the Associate Director of Operations with effect from 3rd January 2022.
The Chief Officer/Chief Finance Officer provided expert professional advice to the Governing Body on the efficient and economic use of the CCG's financial resources. This includes ensuring the CCG has appropriate arrangements in place for audit and identifying risks and

mitigating actions in the delivery of agreed quality improvement programmes.

Each director of the CCG had responsible for:

- Co-ordinating operational risk in their specific areas in accordance with the risk management framework
- Ensuring that all areas of risk are assessed appropriately, and action taken to implement improvements
- Ensuring that staff under their management are aware of their risk management responsibilities in relation to the Risk Management Framework
- Incorporating risk management as a management technique within the performance management arrangements for the organisation
- Promoting risk management processes with the CCG's member practices.

All managers within the CCG had a responsibility to incorporate risk management within all aspects of their work in line with the requirements set out in the risk management framework. Appropriate training has also taken place over the year to enable managers to undertake their risk management duties appropriately and enable them to share best practice.

The structure within the CCG to manage risk is detailed as follows:

Committee	Responsibility for Risk Management	Role
Governing Body	Maintains oversight of the internal control and risk management frameworks	Seek assurance on behalf of the CCG membership that risks are being managed appropriately within delegated limits, with specific objectives and robust action plans to ensure the CCG meets its statutory duties and functions.
Audit and Risk Committee	Main committee with responsibility for oversight of the risk management	Receives regular information on risks and provides assurance to the Governing Body progress is being made towards mitigating these. Reviews the Governing Body Assurance Framework and provides assurance to the Governing Body that the CCG is discharging its functions appropriately.
Risk management workshops	Supports the Audit and Risk Committee in managing risk across the CCG.	Provides assurance to the Audit and Risk Committee on the embedding of the CCG's risk management policy and framework, with a particular focus on the risk register system and process.
Other formal sub-committees	Review risks and key issues on an exceptional basis (relevant to each committee terms of reference).	Undertakes this role for additional scrutiny when required.

Risk Assessment

The CCG has ensured that its risk management processes are embedded throughout the organisation and provide a clear process for identifying, analyzing, evaluating, managing, controlling, monitoring and communicating risk. The types of risks the CCG faces include corporate (accountability to the public), clinical (associated with our commissioning responsibilities), reputational and financial risks.

The CCG continued to use a standard matrix methodology in the application of a risk rating to ensure a consistent approach to the prioritisation of risks and effective targeting of resources. Risks were assessed using the consequence and likelihood of that risk occurring, giving an overall rating of extreme, high, moderate or low. This rating is recorded against the identified risk and managed via a serious of controls and actions and progress is monitored via the CCG's governance processes.

Risks were aligned to the CCG's corporate objectives and assurance framework, with appropriate director leads and supporting risk leads, to identify existing or prospective risks to the organisation.

The corporate register focuses on the extreme and high risks that had been identified to the delivery of the CCG's strategic objectives and a strategic risk register supports the GBAF (as described in the controls mechanisms section previously). In addition, risks were identified through our strategic planning process and monitored via our performance management system that rates all objectives for risk to delivery.

The CCG service line agreement with NECS also includes further support, advice and training in relation risk assessment.
By using the risk register framework, this enabled the CCG to maintain a continued focus on those risks with a potential greater impact on the organisation at both committee and Governing Body level and ensure mitigating action plans were put in place to address these. Progress has been monitored closely by the Audit and Risk Committee and Governing Body.

Additional risk management support

The CCG has a service line agreement in place with North of England Commissioning Support (NECS) to provide specialist support and advice in relation to risk management in conjunction with the Associate Director of Operations. NECS support included the management of the Safeguard Incident and Risk Management System which was the system the CCG uses to record and analyses all identified risks.

Other risk management processes

The equality and quality impact assessment processes were well established within the CCG and staff receive regular training and updates to ensure any risks associated with these are identified and managed. The Governing Body and committee report cover sheets also include reference to both processes to demonstrate compliance with this duty and highlight any potential issues.

The CCG involved key stakeholders and the public in the management of risks through its public Governing Body meetings. The risk register was a regular item on the public agenda and there is an opportunity for questions to be asked on the register as a whole or any specific risks during the meeting. In addition, key stakeholders and the public were invited to specific

events such to discuss issues and topics in detail, which includes identifying and assessing relevant risks.

There is also the opportunity through the CCG's involvement and engagement activities and collaborative working across the health economy to discuss risks openly and to help identify ways in which they should be managed. By working in an inclusive way with the public, this ensures the CCG considers the views of the public and key stakeholders. Any such views form a crucial part of developing robust mitigating action plans for any identified risks.

Risk Appetite

Risk appetite is the organisation's unique attitude towards risk as it is the amount of risk that the organisation is prepared to accept, tolerate or to be exposed to at any point in time. It can be influenced by personal experience, political factors, and external events. Risks were considered in terms of both opportunities and threats and not confined to money.

The CCG aimed to reduce risks to the lowest level reasonably practicable. Where risks could not reasonably be avoided, every effort is made to mitigate the remaining risk. However, an understanding of the organisation's risk appetite ensured the CCG supported a varied and diverse approach to commissioning, to work proactively and to improve quality, efficiency, and value.

Other Sources of Assurance

Internal Control Framework

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

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control has been in place in the CCG for 1st April – 30th June 2022.

The committee structure within the CCG was established to ensure there are robust reporting mechanisms and clear lines of accountability in place to provide assurance to the Governing Body, and ultimately our members, that the CCG is discharging its activities and functions effectively.

The scheme of delegation and reservation set out the responsibilities of the membership, Governing Body and its sub-committees, the Accountable Officer and other directors to ensure the CCG discharges its functions appropriately. The scheme was explicit in defining where the responsibilities lie in delivering each of these key functions and provides a framework by which the Governing Body, on behalf of the members, can seek assurance these are being done so appropriately.

The controls identified within the GBAF (described earlier in this governance statement) were

assessed as the key elements needed to mitigate risks to delivery of the corporate objectives as far as possible, act as a deterrent to risks occurring and provide a structured approach by which identified risks can be managed. The GBAF and risk management framework both support the delivery of the corporate objectives and form part of the internal control framework.

The CCG financial framework also forms part of the internal control framework and includes a number of approved policies and procedures as well as a financial scheme of delegation. This ensures these individuals have a clear framework in place within which they can make financial decisions. Compliance with the scheme was monitored by the Audit and Risk Committee and Governing Body to ensure delegated limits are being adhered to.

The CCG had delegated authority for primary medical care commissioning function from NHS England and Improvement and has robust control mechanisms in place to ensure the CCG delivers the requirements of the delegated function appropriately. A signed delegation agreement between the CCG and NHS England and Improvement was in place and set out the roles and responsibilities of each organisation. The Primary Care Commissioning Committee oversees this function as set out in the CCG's Constitution.

In relation to the Better Care Fund, the CCG had a signed agreement in place with South Tyneside Council to set out the roles and responsibilities for each organisation and the delivery requirements for the programme. Delivery of this was monitored through the Health and Wellbeing Board and through regular reporting to the Governing Body.

Control Mechanisms

The CCG's corporate objectives were reviewed by the Governing Body during the year and no changes were made for 2021-22. The CCG's corporate objectives are:

Corporate Objectives 2021/22
1. Developing and delivering the CCG's key strategic priorities: 1a: Ensuring integrated commissioning and delivery of services 1b: Enabling people to take greater responsibility for their own health 1c: Enabling people to receive timely, safe and appropriate care 1d: Enabling people to stay well in their own homes and communities
2. Making the best use of resources
3. Improving patient experience and wellbeing
4. Ensuring the CCG is a well-led organisation

The Governing Body maintained oversight of the internal control and risk management frameworks and seeks assurance that these are being managed within appropriate delegated limits, with specified objectives and robust action plans. Whenever risks to the achievement of the CCG's objectives are identified, an assessment was undertaken to ensure the appropriate controls were put in place (using any existing strategic risks identified on the risk register and aligning these to the corporate objectives).

Supporting action plans were also identified and implemented to mitigate these risks materialising as far as possible. A number of controls and assurances, along with associated gaps in assurance and controls, were also identified and together these form the Governing Body Assurance Framework (GBAF).

The GBAF was reviewed six-monthly by the Audit and Risk Committee which provides the

Governing Body with assurance on the adequacy and effectiveness of the GBAF.

Some gaps in assurance and controls were identified in reviewing and agreeing the assurance framework. These have been monitored as appropriate within the committee structure to ensure progress was being made to address these.

Due to the nature of the shorter reporting period for the closure of CCG accounts at 30th June 2022 it has not been possible for suppliers to commission service auditor reports or internal audit assurances for this period only. As a result, third party suppliers have requested to provide bridging letters to provide assurance on the continued effectiveness of controls. In addition, CCG internal controls continued to operate throughout this period.

The CCG's commissioning plans described the long-term vision for health and social care of South Tyneside. Risks to delivery of this plan have been systematically identified and managed as part of the detailed planning process and in collaboration with all relevant partners, using a risk-based assessment of likelihood and consequence.

The CCG's financial framework was developed using a risk-based approach to ensure a balanced financial plan year on year. Contingencies are normally identified within the financial framework to ensure high level financial risks can be addressed. Within a more normal year the CCG uses local prioritisation process to enable the balance of investments and disinvestments to be robustly assessed and reviewed.

The NENC geographical area has been established as an integrated care system (ICS). The NENC ICS aim is to develop and work towards a shared local vision regarding care both inside and outside our hospitals underpinned by better integration with local authority services in respect of prevention, early intervention, and social care.

We are part of the South Tyneside and Sunderland Partnership leading the Path to Excellence programme which includes NHS South Tyneside CCG and South Tyneside and Sunderland NHS Foundation Trust. This is a transformational programme in relation to acute (in hospital) services across South Tyneside and Sunderland. Further information on this work programme can be found on the Path to Excellence website (https://pathtoexcellence.org.uk/).

As a CCG, we had a duty to work with partners to improve the health of the local population. Partnerships can involve high levels of risk due to their complexities making robust risk management an essential element of partnership governance. We have ensured that any work carried out across the health and social care economy adhered to the CCG's principles of robust risk management, focusing on those areas considered to be of highest risk and undertaking appropriate risk assessments and mitigating action plans, as necessary.

Annual audit of conflicts of interest management

The statutory guidance on managing conflicts of interest for CCGs requires an annual internal audit of conflicts of interest management to be undertaken. The CCG has carried out an annual audit of conflicts of interest and received a rating of Substantial from the CCG's internal auditors, AuditOne in June 2022. The CCG continued to operate with the same controls as during 2021/22 and no breaches have been identified during the period covered by this report.

Data Quality

The Governing Body and member practices were aware of the importance of maintaining high standards of information governance and securing confidentiality of patients' information. As the Accountable Officer, I receive assurance from the Associate Director of Operations as Senior Information Risk Owner (SIRO) and the Clinical Chair as Caldicott Guardian that this function is discharged appropriately, with the Executive Committee maintaining oversight of this. Both are supported in their roles by the Head of Corporate Affairs and via a service line agreement with NECS to provide specialist advice, support and training on information governance issues.

The Governing Body and member practices were satisfied with the quality of data used to inform decision-making and planning to deliver the commissioning agenda and to ensure the CCG meets its statutory requirements.

Information Governance and Data Security

The NHS information governance framework sets out the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS information governance framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.
The Data Security and Protection Toolkit has been provided by NHS Digital to support performance monitoring of progress on Information Governance in the NHS. The CCG has undertaken a self-assessment against the specified assertions within the toolkit and assessed ourselves as being fully compliant by 31st March 2022.

NECS IG team and IT team supported CCGs with their Toolkits; this included collecting evidence and uploading this to the CCG Toolkits ready for final publication by 30th June 2022. The CCG reported a 'Standards Met' performance and published on time. Due to the abolition of the CCGs on 1st July 2022, NHS Digital made the requirement for internal audit optional.

A new DSPT has been set up for the NENC ICB for 2022/23. NECS IG team will be continuing to provide support to the ICB in collation of evidence and quality checking

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have an established information governance framework, including an approved strategy, both of which are reviewed on an annual basis, and have developed information governance processes and procedures in line with the information governance toolkit.

There are processes in place for incident reporting and investigation of serious incidents and a programme of mandatory training for information risk management and incident management. The CCG's information governance framework helps to ensure all staff are aware of their information governance roles and responsibilities and it is embedded into everyday practice of the CCG.

We have ensured all staff undertake annual information governance training and have a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities. The handbook is reviewed periodically to ensure it remains up to

date and relevant.

NECS as the provider of IT services to the CCG has a range of controls in place to ensure data security. Control objectives include physical access, logical access, segregation of duties, data transmissions, data centre environmental controls, IT processing, data integrity and backups, change management procedures, network security measures, data migration, problem and incident resolution, system recovery and disaster recovery pans.

I can confirm the CCG has had no serious information governance breaches 1st April to 30th June 2022.

Business Critical models

I can confirm that an appropriate framework and environment is in place to provide quality assurance of business- critical models, in line with the recommendations in the Macpherson report.

Third Party Assurances

The CCG currently contracts with a number of external organisations for the provision of back-office services and functions and as such has established an internal control system to gain assurance from these. These external services include:

- The provision of Oracle financial system and financial accounting support from NHS Shared Business Services. The use of NHS Shared Business Services is mandated by NHS England and Improvement (NHSEI) for all CCGs and is fundamental in producing NHSEI group financial accounts through the use of an integrated financial ledger system
- The provision of financial accounting services from the North of England Commissioning Support
- The provision of payroll services from Northumbria Healthcare NHS Foundation Trust
- The provision of the ESR payroll systems support from McKesson
- The provision of practice payment services via the Exeter system processed by NHSEI

Each financial year assurance on the effectiveness of the controls is received in part from annual service audit reports and internal audit assurance reports from the relevant service providers as well as additional testing of controls by the CCG's internal auditors. The outcome from these audits was reported to the Audit and Risk committee and subsequently the Governing Body via the committee's minutes. Due to the nature of the shorter reporting period for the closure of CCG accounts at 30th June 2022 it has not been possible for suppliers to commission service auditor reports or internal audit assurances for this period only. As a result, third party suppliers have requested to provide bridging letters to provide assurance on the continued effectiveness of controls. In addition, CCG internal controls have continued to operate throughout this period.

Whistleblowing arrangements

The CCG had in place an effective system for the raising of concerns. The CCG had a dedicated Freedom to Speak Up Policy, which is promoted to staff and is also available on the CCG's public-facing website. This Policy identifies how concerns can be raised with the Freedom to Speak Up Guardian.

Control Issues

No significant control issues have been identified during the year requiring disclosure within this governance statement.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

NHS England published its finance and contracting arrangement for 2022/23 and confirmed within that, that the financial envelopes would be set at an ICB level. NHS England also set out an expectation that financial balance would be achieved at an ICB level for the full 2022/23 financial year.

The arrangements for 2022/23 have seen a reset to move CCGs (and subsequently ICBs) back towards a fair distribution of resource i.e. pre-pandemic allocation approach. System envelopes will continue to be the key unit for financial planning purposes with collaboration across CCGs/ICBs and FTs. System envelopes have been set at an ICB level and disaggregated to areas to complete financial plans. The 'central' area has encompassed NHS County Durham CCG, NHS South Tyneside CCG, NHS Sunderland CCG, County Durham and Darlington NHS Foundation Trust and South Tyneside and Sunderland NHS Foundation Trust.

A Memorandum of Understanding (MoU) was agreed by Durham, South Tyneside and Sunderland CCG Governing Bodies in a meeting in common on the 5 April 2022 to cover the 2022/23 financial year. This MOU set out the financial management principles across the three CCG areas and agreement on how system level funding would be allocated. The majority of the system funding was already identified at an individual organisational level with the remaining 'system funding' being agreed to be distributed to the Foundation Trusts.

As part of closure of the CCGs accounts for the three-month period 1st April 2022 to 30th June 2022, NHS England have provided an allocation equal to the resource consumed for the period. The ICB on establishment will allocated any remaining funding for the period 1st April 2022 to 30th June 2022 to be utilised over the remaining months of 2022/23. As a result of this arrangement the CCG reported an overall breakeven position for the three-month period 1st April 2022 to 30th June 2022.

AuditOne undertook a review during the 2021/22 financial year of the CCG's financial controls and the CCG report gave a qualified opinion. For the period 1st April 2022 to 30th June 2022 the CCG has continued to operate with the same financial controls.

Under the VFM external audit approach applying from 2020-21 onwards, the external auditors (Mazars) were required to be satisfied that the body "has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources" and report any significant weaknesses in arrangements in its Annual Auditor's Report. No significant weaknesses in arrangements have been identified to date.

Delegation of functions

The CCG has delegated decision-making on an aspect of its expenditure through a pooled funding arrangement with South Tyneside Council - the Better Care Fund. Additionally, separate arrangements exist in relation to NHS continuing healthcare, funded nursing care and personal health budgets, as well as an integrated budget and risk share arrangement for learning disabilities. Governance processes have been clearly outlined in a formal agreement and control of resources remains within the CCG. The CCG interfaces with the Council on these arrangements in a range of ways, such as at officer, director and committee levels.

Primary Care Delegated Functions

NHS England delegated authority to the CCG to exercise primary medical care commissioning functions from April 2015 (often referred to as 'level 3 delegated co- commissioning').

For 2021-22 the following sources of assurances relating to the financial reporting with the CCG's accounts are as follows:

- ISA3402 report - NHS Digital – this report provides assurance in relation to processes used to maintain demographic data on populations used to calculate GMS / PMS payments for the period 2021-22
- ISAE3402 report - NHS Shared Business Services (SBS)ISFE service auditor report - this report covers financial processes operated by NHS SBS, including controls on the National Health Applications and Infrastructure Services interface between Exeter and the ISFE ledger
- ISAE3402 report – Capita service auditor report – this report covers the services of all primary care support in 2021-22
- CCG controls - control mechanisms that are in place to review and approve recharges posted into the CCG ledger by CCG senior officers
- Financial reporting - review of financial reporting against budget by the Primary Care Commissioning Committee on a monthly basis.

North of England Commissioning Support Service (NECS)

The CCG contracts with NECS for the provision of several commissioning support functions such as human resources, information technology and some finance services. The CCG has established an internal control system to gain assurance from NECS on these functions.

Service auditor reports from NECS provided assurance on the internal controls and control procedures operated by this service organisation to its customers and their auditors. A separate finance and payroll Service Auditor Report (SAR) is provided to NECS. NHS England and NECS appoint Deloitte LLP to undertake the SAR on their behalf.

The SAR has been prepared in accordance with the guidance set out in the International Standards on Assurance Engagements 3000 (revised) and 3402 (ISAE 3000 and 3402) and the Institute of Chartered Accounts in England and Wales Technical Release AAF 01/06 (AAF 01/06). The SAR provides the CCG with assurance over the suitability of the design and

operating effectiveness of controls to achieve the related control objectives of the services provided by NECS.

When reporting on the internal controls and control procedures for 2021/22, Deloitte issued a qualified opinion and noted four control exceptions. Following publication of the SAR, NECS reviewed those control exceptions and formulated actions to ensure compliance in future periods.

All the control exceptions were applicable to the CCG and related to accuracy and processing of credit notes, user access controls for the Oracle system and amendments carried out in the ESR system. Following a review by the CCG of these control exceptions, it has been confirmed that the CCG had in place other financial and governance control systems that mitigated the control exceptions identified within NECS. These in house controls were audited by internal audit as part of the financial systems audit in 2021/22 gaining substantial assurance.

For the period 1st April 2022 to 30th June 2022 NECS have been unable to provide a specific Service Auditor report and as such, have provided a bridging letter to provide assurance on the continued operation of controls in line with the reported performance for 2021/22 noted above. The CCG has continued to operate mitigating in house controls during the reporting period.

Counter fraud arrangements

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

The CCG adheres to NHS Counter Fraud Authority Standards for NHS Commissioners: Fraud, Bribery and Corruption. A comprehensive counter fraud service, including an accredited Counter Fraud Specialist, is commissioned through our internal auditors (AuditOne) to undertake counter fraud work proportionate to identified risks.

The CCG's counter fraud work plan generally runs from 1st April 2021 to 31st March 2022. This period was extended to take into account the upcoming formation of the NENC ICB 1st July 2022. This extension ensured that the CCG continued to receive Counter Fraud Services as well as updates at the Audit and Risk Committee.

The CCG continued to operate in line with the Counter Fraud and Bribery Policy, which clearly articulates NHS requirements and expectations for the management of fraud, bribery and corruption in government organisations, including the NHS Standard Contract

Counter-fraud requirements and regulations have been specifically discussed during the year to cement their knowledge and understanding of counter-fraud arrangements, with all employees also required to complete e-learning training. In addition, notifications and briefings regarding actual and potential fraud are circulated to key staff to ensure counter-fraud vigilance is maintained and enable payment systems to be reviewed for emerging risks.

Any issue relating to tackling fraud, bribery and corruption was managed in accordance with the Counter-Fraud Policy would report such incidents to the Audit & Risk Committee.

There have been no incidents of fraud by way of prosecution or civil recovery during 1 April -30 June 2022.

The Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1st April 2022- 30th June 2022 for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

Overall Opinion

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

During the period Internal Audit issues the following audit reported:

Opinion Area	Commentary
Audit Coverage	Internal Audit coverage in Quarter 1 2022/23 focused on: • Assurance Framework & supporting processes • Transition Programme • Outstanding Audit Recommendations and Risks
Design and operation of the Assurance Framework and supporting processes	The Governing Body Assurance Framework and an updated Strategic Risk Register was presented to the Governing Body on 26th May 2022. The Audit and Risk Committee received the corporate risk register on 8th June 2022. The Governing Body Assurance Framework is based on the CCG's strategic objectives and an analysis of the principal risks to achieving those objectives. It continued to reflect the impact of the transition to an ICB and managing the Covid-19 pandemic in alignment with the CCG's corporate objectives. The key controls that have been put in place to manage the risks have been documented, and the sources of assurance for individual controls have been identified. The Governing Body Assurance Framework therefore provides the CCG with a comprehensive mechanism for the management of the principal risks to meeting its strategic objectives and supports the compilation of the Annual Governance Statement. The CCG has developed risk management processes that are operating within the organisation. The Quality and Patient Safety Committee, together with the Audit and Risk Committee, oversee the risk management agenda and report to the Governing Body. They provide assurance to the Governing Body on the systems and processes by which the organisation leads, directs and controls its functions in order to achieve its strategic objectives
Transition Programme	AuditOne continued to have involvement during the transition period through:

<table>
<tr><th>Opinion Area</th><th>Commentary</th></tr>
<tr><td></td><td>• Attendance at two weekly ICS steering group meetings and liaison with NECS who provided project support.
• Attendance at a checkpoint meeting with lead officers at the CCG (2nd March 2022) and a further, more formal check and challenge session covering South Tyneside and Sunderland CCGs which was held on 21st April 2022. Through attendance and receipt of supporting papers, it was observed that risks and issues were being reported through the project groups supported by NECS. No concerns were raised around completion of the activities required to sign off on due diligence process.

• It could be confirmed that the outcome of the CCG Closedown Due Diligence process was reported to the Governing Body on the 26 th May 2022, seeking authorisation for the Accountable Officer to sign the relevant declarations confirming completion of the due diligence requirements.</td></tr>
<tr><td>Brought forward Internal Audit assurances</td><td>The Head of Internal Audit Opinion given for the year ended 31st March 2022 gave a level of assurance of ‘substantial’. There were no material issues identified to be brought forward for consideration in this opinion statement</td></tr>
<tr><td>Response to Internal Audit recommendation s</td><td>The implementation of internal audit recommendations is a key indicator of the organisation’s engagement with ourselves and the importance it places on the recommendations we have made and have been agreed to be implemented. The Audit and Risk Committee receives updates on the progress of agreed actions for all high and medium issues raised, but it does not require updates in relation to low priority issues, so these are not subject follow-up by AuditOne.

At 30th June 2022, there were nine medium and one high priority outstanding audit recommendations.

One of the outstanding recommendations has been delayed by more than 12 months since the original target implementation date. This is highlighted below, and although no further update was received the recommendation continued to be reported and monitored by the Audit and Risk Committee until the conclusion of the CCG

<table>
<tr><th>Unique Reference</th><th>Recommendation</th><th>Latest update</th><th>Priority</th><th>Target Implementation Date</th><th>Revised Target Date</th></tr>
<tr><td>20200</td><td>Ensure the S75 in respect of Continuing Healthcare is signed by both parties and that an annual review is undertaken in line with the Agreement requirements.</td><td>Implementation of the recommendation / management action is on-going. S75 is currently being quality reviewed prior to final sign off from the relevant parties within the LA and CCG. This should be finalised by the 30th April.</td><td>Medium</td><td>31st March 2021</td><td>30th April 2022</td></tr>
</table>

For the other nine recommendations, the original or revised target date for implementation had not yet passed at 30th June 2022. One of these related to the mechanisms for targeting staff overdue for training and upon the conclusion of the CCG will be superseded. The remaining recommendations continue to be relevant and will be passed to the ICB as part of the due diligence process.

This demonstrates that the CCG has continued to have a positive approach</td></tr>
</table>

Opinion Area	Commentary
	to internal audit recommendations, which improves the strength of its system of internal control, risks and governance
Significant factors outside the work of internal audit	While the Head of Internal Audit Opinion provides the CCG with assurances in relation to the areas covered by the internal audit plan, it is only one of the sources of assurance available to the CCG. As the CCG outsourced many of its functions, assurances from third parties are equally as important when the CCG draws up its Governance Statement. Assurances are provided on an annual basis therefore nothing is available at this time for the Q1 period

Carl Best
Associate Director of Audit, AuditOne Date: 1st March 2023

Recommendation and assurance definitions

Head of Internal Audit Opinion Levels	
Substantial	I am providing substantial assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives. Controls are being consistently applied.
Good	I am providing good assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives. Controls are generally being applied consistently.
Reasonable	I am providing reasonable assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives. Controls are not applied in a consistent manner.
Limited	I am providing limited assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives. Controls are not applied and immediate and fundamental remedial action is required.

Review of effectiveness of governance, risk management and internal control

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

Our Governing Body assurance framework itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles have been reviewed. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by:

- Governing Body
- Audit and Risk Committee
- Joint Quality and Safety Committee
- System of internal control mechanisms
- Internal Audit

The Governing Body, Audit and Risk Committee and Joint Quality and Safety Committee have concluded through their annual review processes that the CCG has effective governance, risk management and internal control mechanisms in place to ensure the CCG to meet its statutory duties.

The internal control section earlier in this statement describes in detail the process that has been applied in maintaining and reviewing the effectiveness of the CCG's system of internal control.

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit Opinion has been included in the previous section.

Conclusion

No significant internal control issues have been identified.

Remuneration and Staff Report

The remuneration and staff report sets out the organisation's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers and where relevant the link between performance and remuneration.

Remuneration Report

Remuneration Committee

The remuneration committee was established to advise the Governing Body about pay, other benefits and terms of employment for the Chief Officer and other senior staff.

The remuneration committee is established in accordance with the CCG's constitution, standing orders and scheme of delegation. The committee membership is as follows:

- Mrs Patricia Harle MBE Chair of Remuneration Committee/Lay Member
- Dr Matthew Walmsley CCG Chair
- Ms Louise Lydon Member of Governing Body
- Mr Paul Cuskin Governing Body Lay Member
- Mr John Whitehouse Governing Body Lay Member

The remuneration committee has delegated authority from the Governing Body to make recommendations on determinations about pay and remuneration for employees of the CCG and people who provide services to the CCG.

Policy on the remuneration of senior managers

The remuneration for senior managers for current and future financial years is determined in accordance with relevant guidance, best practice and national policy. Continuation of employment for all senior managers is subject to satisfactory performance. Performance in post and progress in achieving set objectives is reviewed annually.

There were no individual performance review payments made to any senior managers during the year and there are no plans to make such payments in future

years. This is in accordance with standard NHS terms and conditions of service and guidance issued by the Department of Health.

Contracts of employment in relation to all senior managers employed by the CCG are permanent in nature and subject to between three and six months' notice of termination by either party.

Termination payments are limited to those laid down in statute and those provided for within NHS terms and conditions of service and under the NHS Pension Scheme Regulations for those who are members of the scheme. No awards have been made during the year to past senior managers.

For the purpose of this remuneration report, the definition of 'senior managers' is as per the CCG Annual Reporting Guidance published by NHS England:

Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the clinical commissioning group.
This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments.

It is considered that the Governing Body and Executive Committee members represent the senior managers of the CCG.

Remuneration of Very Senior Managers (VSM)

Where one or more senior managers of a CCG are paid more than a pro rata of £150,000 per annum information is disclosed in the remuneration report.

During the period from 1 April to 30 June 2022 South Tyneside CCG had 8 senior managers (2021/22, 9) in clinical roles that were paid more than a pro rata of £150,000 per annum. The senior managers were in part time roles and were not paid more than £150,000 per annum.

VSM Salaries were set at the establishment of the CCG in line with nationally mandated pay scales. The Remuneration Committee reviews the level of pay award applied to VSM on an annual basis and has determined that VSM pay award should not be inconsistent with that applied to non VSM staff, i.e. the nationally determined pay award for staff on 'agenda for change' pay scales is applied to VSM.

Senior manager remuneration (including salary and pension entitlements)

Table 1: South Tyneside CCG remuneration report for the 3 months to 30 June 2022 (this has been subject to audit)

Name	Title	Salary (bands of £5,000) £000	Expense payments (taxable) (to nearest £100) £00	Performance pay and bonuses (bands of £5,000) £000	Long-term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Dr Matthew Walmsley	GP Chair	10-15	-	-	-	-	10-15
Mr Paul Cuskin	Deputy Chair/Lay Member	0-5	-	-	-	-	0-5
Mrs Patricia Harle MBE	Lay Member	0-5	-	-	-	-	0-5
Mr John Whitehouse	Lay Member	0-5	-	-	-	-	0-5
Dr Tarquin Cross	Secondary Care Clinician	0-5	-	-	-	-	0-5
Ms Louise Lydon	Primary Healthcare Professional Member	0-5	-	-	-	-	0-5
Dr Neil O'Brien	Chief Clinical Officer and Accountable Officer	10-15	4	-	-	0-2.5	10-15
Ms Deborah Cornell	Associate Director of Operations	15-20	-	-	-	-	15-20
Ms Jo Farey	Associate Director of Primary Care Commissioning	15-20	-	-	-	-	15-20
Ms Lisa Dodd	Associate Director of Integration and Commissioning	See note below					
Ms Kate Hudson	Chief Finance Officer/Deputy Accountable Officer	25-30	-	-	-	-	25-30
Mrs Jeanette Scott	Executive Director of Nursing, Quality & Safety	15-20	-	-	-	-	15-20
Dr James Gordon	Clinical Director (Mental Health & Learning Disability)	10-15	-	-	-	-	10-15
Dr David Julien	Clinical Director (Long Term Conditions)	15-20	-	-	-	-	15-20
Dr Nousha Ali	Clinical Director (Planned Care, Medicines Management, Palliative Care)	10-15	-	-	-	-	10-15
Dr Jennifer Hunter	Clinical Director (Primary Care and Cancer)	10-15	-	-	-	-	10-15
Mrs Ros Whitehead	Practice Manager Lead	0-5	-	-	-	-	0-5

Notes to senior manager remuneration table:

Salary includes an estimate for an NHS Agenda for Change backdated non-consolidated pay award for 2022/23 payable to senior managers in accordance with their contracted hours as of 31 March 2023.

Expenses payments (taxable) relate to lease car allowances and mileage claims.

Dr Neil O'Brien is employed by County Durham CCG and works for South Tyneside CCG and Sunderland CCG as part of a staff sharing arrangement. The salary disclosed above shows South Tyneside CCG's share of remuneration of 33.3%. Pension benefits are reported in full by County Durham CCG.

Dr Tarquin Cross is employed by Northumbria Healthcare NHS Foundation Trust. Pension related benefits information is not reported by Northumbria Healthcare NHS Foundation Trust because Dr Cross is not a senior manager of that organisation.

Deborah Cornell is employed by Sunderland CCG. Pension related benefits information is not reported by Sunderland CCG because Deborah Cornell is not a senior manager of that organisation.

Lisa Dodd is employed by North of England Commissioning Support Unit and recharged to South Tyneside CCG as part of a Service Level Agreement. Salary and pension related benefits are not reported because Lisa Dodd is not a senior manager of that organisation.

Tom Hall, Executive Director of Public Health and Vicki Pattinson, Director of Adult Services are invited to be in attendance at the Governing Body in a non-voting capacity. Both are employed by South Tyneside Council and receive no remuneration from the CCG for the CCG Governing Body role.

Pension related benefits for 3 months to 30 June 2022 have been estimated using full year information provided by NHS Pensions. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.
The pension benefit table provides further information on the pension benefits accruing to the individual.

Staff sharing arrangement for senior manager remuneration for the 3 months to 30 June 2022

Dr Neil O'Brien is employed by County Durham CCG and works for South Tyneside CCG and Sunderland CCG as part of a staff sharing arrangement.

The total remuneration earned for all work across all CCGs for the 3 months to 30 June 2022 is shown below:

Table 2: South Tyneside CCG staff sharing arrangement at 30 June 2022 (this has been subject to audit)

Name	Title	Salary (bands of £5,000) £ 000	Expense payments (taxable) (to nearest £100) £00	**TOTAL** (bands of £5,000) £ 000
Dr Neil O'Brien	Chief Clinical Officer and Accountable Officer	40-45	13	40-45

Senior manager remuneration (including salary and pension entitlements)

Table 3: South Tyneside CCG remuneration report 2021/22 (this has been subject to audit)

Name	Title	Salary (bands of £5,000) £000	Expense payments (taxable) (to nearest £100) £00	Performance pay and bonuses (bands of £5,000) £000	Long-term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Dr Matthew Walmsley	GP Chair	45-50	-	-	-	12.5-15	55-60
Mr Paul Cuskin	Deputy Chair/Lay Member	10-15	-	-	-	-	10-15
Mrs Patricia Harle MBE	Lay Member	10-15	-	-	-	-	10-15
Mr John Whitehouse	Lay Member	10-15	-	-	-	-	10-15
Dr Tarquin Cross	Secondary Care Clinician	5-10	-	-	-	-	5-10
Ms Louise Lydon	Primary Healthcare Professional Member	5-10	-	-	-	-	5-10
Dr Neil O'Brien	Chief Clinical Officer and Accountable Officer	50-55	17	-	-	12.5-15	70-75
Mr Matt Brown	Director of Operations	75-80	6	-	-	10-12.5	85-90
Ms Deborah Cornell	Associate Director of Operations	15-20	-	-	-	-	15-20
Ms Jo Farey	Associate Director of Primary Care Commissioning	17.5-20	-	-	-	30-32.5	50-55
Ms Lisa Dodd	Associate Director – Integration and Commissioning	See note below					
Ms Kate Hudson	Chief Finance Officer/Chief Officer	120-125	1	-	-	25.27.5	145-150
Mrs Jeanette Scott	Director of Nursing, Quality & Safety	70-75	-	-	-	-	70-75
Dr James Gordon	Clinical Director (Mental Health & Learning Disability)	50-55	-	-	-	7.5-10	60-65
Dr David Julien	Clinical Director (Long Term Conditions)	60-65	-	-	-	20-22.5	80-85
Dr Nousha Ali	Clinical Director (Planned Care, Medicines Management, Palliative Care)	45-50	-	-	-	80-82.5	125-130
Dr Jennifer Hunter	Clinical Director (Primary Care and Cancer)	45-50	-	-	-	25-27.5	75-80
Mrs Ros Whitehead	Practice Manager Lead	20-25	-	-	-	-	20-25

Notes to senior manager remuneration table 2021/22:

Expenses payments (taxable) are shown in £00 and relate to lease car allowances and mileage claims.
Dr Neil O'Brien is employed by County Durham CCG and works for South Tyneside CCG and Sunderland CCG as part of a staff sharing arrangement. The salary disclosed above shows South Tyneside CCG's share of remuneration of 33.3%. Pension benefits are reported in full by County Durham CCG. Dr Neil O'Brien received £1k of back pay relating to 2020/21 which was paid by South Tyneside CCG in 2021/22 and excluded from the salary reported for 2021/22.

Dr Tarquin Cross is employed by Northumbria Healthcare NHS Foundation Trust. Pension related benefits information is not reported by Northumbria Healthcare NHS Foundation Trust because Dr Cross is not a senior manager of that organisation.

Matt Brown left the Director of Operations role on 3 January 2022.

Jo Farey commenced the Associate Director of Operations role on 4 January 2022. Remuneration relates to the Associate Director role.

Deborah Cornell commenced the Associate Director of Primary Care role on 4 January 2022. Deborah Cornell is employed by Sunderland CCG. Pension related benefits information is not reported by Sunderland CCG because Deborah Cornell is not a senior manager of that organisation.

Lisa Dodd commenced the Associate Director – Integration and Commissioning role on 4 January 2022. Lisa Dodd is employed by North of England Commissioning Support Unit and recharged to South Tyneside CCG as part of a Service Level Agreement. Salary and pension related benefits are not reported because Lisa Dodd is not a senior manager of that organisation.

Tom Hall, Director of Public Health and Vicki Pattinson, Director of Adult Social Care are invited to be in attendance at the Governing Body in a non-voting capacity. Both are employed by South Tyneside Council and receive no remuneration from the CCG for the CCG Governing Body role.

Pension related benefits information is provided by NHS Pensions. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.
The pension benefit table provides further information on the pension benefits accruing to the individual.

Staff sharing arrangement for senior manager remuneration 2021/22

Dr Neil O'Brien is employed by County Durham CCG and works for South Tyneside CCG and Sunderland CCG as part of a staff sharing arrangement.

The total remuneration earned for all work across all CCGs in 2021/22 is shown below:

Table 4: South Tyneside CCG staff sharing arrangement 2021/22 (this has been subject to audit)

Name	Title	Salary (bands of £5,000) £ 000	Expense payments (taxable) to nearest £100 £00	**TOTAL** (bands of £5,000) £ 000
Dr Neil O'Brien	Chief Clinical Officer and Accountable Officer	165-170	51	170-175

Pension benefits as at 30 June 2022

Table 5: South Tyneside CCG senior officers pension benefits at 30 June 2022 (this has been subject to audit)

	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 30 June 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 30 June 2022 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2022 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 30 June 2022 £000	Employer's contribution to stakeholder pension £000
Dr Matthew Walmsley	-	-	5-10	10-15	138	-	138	-
Ms Jo Farey	-	-	20-25	35-40	337	-	326	-
Ms Kate Hudson	-	-	40-45	80-85	752	-	747	-
Dr James Gordon	-	-	15-20	30-35	263	-	261	-
Dr David Julien	-	-	10-15	20-25	243	-	241	-
Dr Nousha Ali	-	-	10-15	30-35	182	-	180	-
Dr Jennifer Hunter	-	-	15-20	-	187	-	185	-

Benefits at 30 June 2022 have been estimated using full year information provided by NHS Pensions. Real increases are a proportion for time in post to 30 June 2022.

The Consumer Prices Index up to September 2021 was 3.1%, therefore, an increase of 3.1% has been applied to pensions and CETV at April 2022 in accordance with NHS Business Services Authority instructions.

The pension figures shown relate to the benefits that individuals have accrued as a consequence of their total membership of the scheme. Benefits and related Cash Equivalent Transfer Values do not allow for a potential future adjustment arising from the McCloud judgement.

Non executives and lay members are not members of the NHS Pension scheme.

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023 to 24 CETV figures.

Pension benefits as at 31 March 2022

Table 6: South Tyneside CCG senior officers pension benefits 2021/22 (this has been subject to audit)

	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2021 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Employer's contribution to stakeholder pension £000
Dr Matthew Walmsley	0-2.5	-	5-10	10-15	121	9	134	-
Mr Matt Brown	0-2.5	-	10-15	5-10	301	3	315	
Ms Jo Farey	0-2.5	0-2.5	15-20	35-40	293	26	327	-
Ms Kate Hudson	0-2.5	-	40-45	80-85	689	24	729	-
Dr James Gordon	0-2.5	-	15-20	30-35	240	8	255	-
Dr David Julien	0-2.5	-	10-15	20-25	213	14	236	-
Dr Nousha Ali	2.5-5	7.5-10	10-15	30-35	118	51	177	-
Dr Jennifer Hunter	0-2.5	-	15-20	-	162	12	182	-

Pension information is provided by NHS Pensions.
Cash equivalent transfer value at 1st April 2021 has been inflated by 0.5%.

The pension figures shown relate to the benefits that individuals have accrued as a consequence of their total membership of the scheme. Benefits and related Cash Equivalent Transfer Values do not allow for a potential future adjustment arising from the McCloud judgement.

Non executives and lay members are not members of the NHS Pension scheme.

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, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The method used to calculate CETVs changed, to remove the adjustment for Guaranteed Minimum Pension (GMP) on 8 August 2019. If the individual concerned was entitled to a GMP, this will affect the calculation of the real increase in CETV. This is more likely to affect the 1995 Section and the 2008 Section

Compensation on early retirement or for loss of office (this has been subject to audit)

There was no compensation on early retirement or for loss of office in the 3 months to 30 June 2022.

Payments to past members (this has been subject to audit)

There were no payments to past members in the 3 months to 30 June 2022.

Fair Pay Disclosure (this has been subject to audit)

Percentage change in remuneration of highest paid director

	Salary and allowances %	Performance pay and bonuses %
The percentage change from the previous financial year in respect of the highest paid director	0	0
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	1.1	0

The highest paid director calculation is based upon mid-point of the band and does not reflect actual percentage change. There was no percentage change in the highest paid director salary from the previous financial year.

Average percentage change from previous financial year for employees as a whole is calculated on an annualised salary basis and is impacted by the movement in annualised salary and an increase in full time equivalent number of employees.

No performance pay and bonuses have been paid.

Pay ratio information

Remuneration of South Tyneside CCG staff is shown in the table below:

3 months to 30 June 2022	25th percentile	Median	75th percentile
All staff remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£41,660	£71,825	£140,400
Salary component of 'all staff' remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£41,660	£71,825	£140,400
2021/22			
All staff remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£36,182	£68,525	£127,123
Salary component of 'all staff' remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£36,182	£68,525	£127,123

Total annualised 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.

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

The staff remuneration and salary component are consistent as the CCG have only a small number of employees with benefits-in-kind relating to lease cars included in the remuneration value. Benefits-in-kind are excluded from the salary component value.

The annualised banded remuneration of the highest paid director in South Tyneside CCG in the 3 months to 30 June 2022 was £120-125k (2021/22: £120-125k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Period	25th percentile ratio	Median ratio	75th percentile ratio
3 months to 30 June 2022	2.9:1	1.7:1	0.9:1
2021/22	3.4:1	1.8:1	1.0:1

In the 3 months to 30 June 2022, no employee (2021/22, no employee) received remuneration in excess of the highest paid director, excluding shared staff posts; where shared staff posts are senior managers of the CCGs, these are disclosed separately in the 'Shared Arrangements' disclosure. Remuneration ranged from £23,000 to £180,000 (2021/22: £22,000 to £171,000). The range does not reflect actual values paid as this includes the annualised remuneration for part time employees and employees from other organisations employed in shared staff posts and joint management arrangements.

The 3 months to 30 June 2022 annualised remuneration ratios remain at a consistent level to 2021/22 ratios due to marginal changes to the overall number, composition and remuneration of the workforce.

Staff Report

Number of senior managers

The CCG had 17 senior managers in post at 30 June 2022. This includes 1 very senior manager.

Staff numbers and costs (this has been subject to audit)

Staff numbers and costs are analysed by permanent employees and 'other' for the 3 months to 30 June 2022.

Permanently employed refers to members of staff with a permanent (UK) employment contract directly with the CCG. Other refers to any staff engaged that do not have a permanent (UK) employment contract with the CCG. This includes employees on short term contracts of employment and agency/temporary staff. The figures exclude lay members of the Governing Body.

	Permanent Employees	Other	Total
Average number of people employed	22.99	1.52	24.51

Staff costs	Permanent Employees £'000	Other £'000	Total £'000
Salaries and wages	1,541	168	1,709
Social security costs	163	-	163
Employer Contributions to NHS Pension scheme	253	-	253
Other pension costs	3	-	3
Total staff costs	**1,960**	**168**	**2,128**

Trade Union Facility Time

Under the terms of the Trade Union (Facility Time Publication Requirements) Regulations 2017, we are required to publish the number of employees who were trade union officials during this period, and information and details of paid facility time and trade union activities.

For the 3 month period to 30 June 2022 there were no employees of NHS South Tyneside CCG who were trade union representatives.

Staff composition

The CCG staff gender profile at 30 June 2022 is based upon headcount of permanently employed staff.

	Female	Male	Total
Very senior managers	1	-	1
Other staff	28	11	39
Total staff	**29**	**11**	**40**
Governing Body members	8	6	14

*The Governing Body figures are provided as standalone figures as some members are employed by other organisations.

Staff Sickness Absence

The CCG has an agreed policy on the management of staff absence which ensures all staff are treated fairly and equitably, with the relevant support from line managers and HR advisors. The CCG also has access to occupational health services. The staff sickness absence data is reported for each year. Total days lost for 2022 relates to the 3 month period to 30 June 2022 compared to the 12 month period reported in 2021/22.Total days lost has reduced in the 3 month period as total days lost in 2021/22 were impacted by a small number of long term absences which were actively supported and managed.

	2022 Q1	2021/22
Total days lost	3	140
Average working days lost	0.1	5.2

Staff Turnover

Staff turnover of permanent employees is reported as a percentage of the average number of people employed. The staff turnover for the 3 months to 30 June 2022 was 13%. (2021/22: 13%)

Staff Engagement

We encourage staff to take part in the annual NHS staff survey annually. This provides a staff with an anonymous channel to provide comments on a number of questions and gives the CCG essential feedback to ensure the CCG remains a great place to work.

Staff Policies

The CCG has policies in place relating to staff available on the CCG intranet and website.

The policies support and assist all employees with guidance and policy information relating to wide range of human resources functions.

The promotion of equality and diversity is actively pursued through these policies and ensures that employees receive fair, equitable and consistent treatment and ensure that employees, and potential employees, are not subject to direct or indirect discrimination.

The CCG is committed to equality of opportunity for all employees and is committed to employment practices, policies and procedures which ensure that no employee, or potential employee, receives less favourable treatment on the grounds of gender, race, colour, ethnic or national origin, sexual orientation, marital status, religion or belief, age, trade union membership, disability, offending background, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or any other personal characteristic.

Diversity is viewed positively and, in recognising that everyone is different, the unique contribution that each individual's experience, knowledge and skills can make is valued equally.

Expenditure on consultancy

The CCG did not incur consultancy expenditure in the 3 months to 30 June 2022 (2021/22, nil).

Off-payroll engagements

Length of all highly paid off-payroll engagements

All off-payroll engagements as at 30 June 2022, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 30 June 2022	1
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	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	1

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

For all off-payroll engagements between 1 April 2022 and 30 June 2022, for more than £245(1) per day

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	1

Of which,	
No. not subject to off-payroll legislation(2)	0
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
No. of engagements reassessed for compliance or assurance purposes during the year	1
Of which: no. of engagements that saw a change to IR35 status following review	0

Note
(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
(2) A worker that 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.

New off-payroll engagements

There were no new off-payroll engagements, or those that reached six months in duration, between 1 April 2022 and 30 June 2022, greater than £245 per day and that last for longer than six months.

Off-payroll engagements / senior official engagements

Off-payroll engagements of Board members and senior officials with significant financial responsibility, between 1 April 2022 and 30 June 2022.

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the 3 months to 30 June 2022.	0
Total no. of individuals that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the 3 months to 30 June 2022. This figure should include both off-payroll and on-payroll engagements.	17

Exit packages, including special (non-contractual) payments (this has been subject to audit)

No exit packages including special (non-contractual) payments were made in the 3 months to 30 June 2022.

Parliamentary Accountability and Audit Report

South Tyneside CCG is not required to produce a Parliamentary Accountability and Audit Report. Where relevant, disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the annual accounts.

An audit report is also included in this Annual Report from page 135.

ANNUAL ACCOUNTS

NHS South Tyneside Clinical Commissioning Group - Annual Accounts for the period to 30th June 2022

CONTENTS **Page Number**

The Primary Statements:

Statement of Comprehensive Net Expenditure for the three months ended 30 June 2022

	Note	3 months to 30 June 2022 £'000	12 months to 31 March 2022 £'000
Other operating income	2	(50)	(247)
Total operating income		**(50)**	**(247)**
Staff costs	3	463	2,127
Purchase of goods and services	4	79,365	323,549
Other Operating Expenditure	4	30	121
Total operating expenditure		**79,857**	**325,797**
Comprehensive Expenditure for the period		**79,807**	**325,550**

The notes on pages 5 to 17 form part of this statement

Statement of Financial Position as at 30 June 2022

	Note	30 June 2022 £'000	31 March 2022 £'000
Current assets:			
Contract and other receivables	7	1,572	358
Cash and cash equivalents	8	0	185
Total current assets		**1,572**	543
Total assets		**1,572**	543
Contract and other receivables			
Trade and other payables	9	(26,231)	(32,495)
Borrowings	10	(3,392)	-
Total current liabilities		**(29,623)**	(32,495)
Assets less Liabilities		**(28,051)**	(31,952)
Financed by Taxpayers' Equity			
General fund		(28,051)	(31,952)
Total taxpayers' equity:		**(28,051)**	(31,952)

The notes on pages 122 to 134 form part of this statement

The financial statements on pages 118 to 134 were approved and authorised for issue by the Board on 27th June 2023 and signed on its behalf by:

Samantha Allen
Chief Executive for the North East and North Cumbria Integrated Care Board
Accountable Officer
30th June 2023

The ICB Chief Executive was not the Accountable Officer of the CCG, however as per the NHS England annual report and accounts guidance, is the required signatory for this report.

Statement of Changes In Taxpayers' Equity for the three months ended 30 June 2022

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for the three months to 30 June 2022:		
Balance at 01 April 2022	(31,952)	**(31,952)**
Changes in CCG taxpayers' equity for the three months to 30 June 2022		
Net operating expenditure for the financial period	(79,807)	**(79,807)**
Net recognised CCG expenditure for the financial period	**(79,807)**	**(79,807)**
Net funding	83,708	**83,708**
Balance at 30 June 2022	**(28,051)**	**(28,051)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(28,463)	**(28,463)**
Changes in CCG taxpayers' equity for 2021-22		
Net operating costs for the financial year	(325,550)	(325,550)
Net Recognised CCG Expenditure for the Financial Year	**(325,550)**	**(325,550)**
Net funding	322,061	322,061
Balance at 31 March 2022	**(31,952)**	**(31,952)**

The notes on pages 5 to 17 form part of this statement

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

	Note	3 months to 30 June 2022 £'000	12 months to 31 March 2022 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial period		(79,807)	(325,550)
(Increase)/decrease in trade & other receivables	7	(1,214)	408
Increase/(decrease) in trade & other payables	9	(6,264)	3,133
Net Cash Inflow/(Outflow) from Operating Activities		**(87,285)**	(322,009)
Net Cash Inflow/(Outflow) before Financing		**(87,285)**	(322,009)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		83,708	322,061
Net Cash Inflow (Outflow) from Financing Activities		**83,708**	322,061
Net Increase/(Decrease) in Cash & Cash Equivalents	8	**(3,577)**	52
Cash & Cash Equivalents at the Beginning of the Financial Period		**185**	133
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Period		**(3,392)**	185

The notes on pages 5 to 17 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Clinical Commissioning Groups (CCGs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on the going concern basis. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

As set out in note 15 - Events after the end of the reporting period, on 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, CCGs were abolished and the functions, assets and liabilities of NHS South Tyneside CCG transferred to the North East and North Cumbria Integrated Care Board from the 1 July 2022. ICBs will take on the commissioning functions of CCGs.

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

In April 2022, NHS England and NHS Improvement (NHSE/I) published the final planning guidance and related system financial envelopes set at Integrated Care Board (ICB) level for 2022/23, confirming CCGs will receive an allocation from 1 April 2022 and ICBs will be established with the remaining amounts for the financial year. This means the aggregate full year ICB allocations will be reduced by the amount of resources the CCG have consumed. Therefore, the CCG expects to receive sufficient funding for the continued commissioning of relevant health services. CCG published allocations can be found on the NHS England website for 2022/23 and 2023/24. The commissioning of health services (continuation of service) will continue after 1 July 2022 but will be through the North East and North Cumbria Integrated Care Board, rather than NHS South Tyneside CCG.

Mergers or a change to the NHS Structure, such as the transfer of CCG functions to the ICB, are not considered to impact on going concern. Our considerations cover the period through to 30 June 2023, being 12 months beyond the date of authorisation of these financial statements. Taking into account the information summarised above, there is a reasonable expectation that the CCG and successor NENC ICB will have adequate resources to continue in operational existence for the foreseeable future. For this reason, we continue to adopt the going concern basis in preparing these financial statements.

1.2 **Accounting Convention**

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

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

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care 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 transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Joint Arrangements**

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

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the CCG is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts. The CCG has assessed that it does not have joint arrangements as joint control does not exist.

1.5 **Pooled Budgets**

The CCG has five pooled budget arrangements hosted by South Tyneside Council in accordance with section 75 of the NHS Act 2006. Under the arrangements, funds are pooled for Better Care Fund, the care of Learning Disabilities clients, Community Equipment Store, the delivery of legal advice for the Mental Capacity Act and the Joint Commissioning Unit. The CCG accounts for its share of the income and expenditure of the pools as determined by the pooled budget agreement and can be seen in Note 13.

1.6 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note (Note 13) and are reported in line with management information used within the CCG.

1.7 **Revenue**

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

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

1.8 **Employee Benefits**

1.8.1 **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.

1.8.2 **Retirement Benefit Costs**

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

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

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

1.9 **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.

1.10 **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. The CCG assesses whether a contract is or contains a lease, at inception of the contract.

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

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs 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.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

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.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

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.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

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.

1.12 **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.

1.13 Cash, bank and overdraft balances are recorded at current values.

1.14 **Clinical Negligence Costs**

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

1.15 **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.

1.16 **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 and the CCG has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

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. The CCG only holds financial assets at amortised cost.

1.16.1 **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 **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 extinguished – that is, the obligation has been discharged or cancelled or has expired. Financial liabilities are measured at amortised cost.

1.18 **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.

1.19 **Critical accounting judgements and 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 estimates and the estimates 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.

1.19.1 **Critical accounting judgements in applying accounting policies**

There are no critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the CCG's accounting policies that have the most significant effect on the amounts recognised in the financial statements.

1.19.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year. The majority of transactions reported are based upon actual charges. In some cases estimates are required when actual charges have not yet been received
The following are the key estimations that management has made in the process of applying the CCG's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

The main estimate for the 3 months to June 2022 related to prescribing expenditure which is two months in arrears and is based on BSA profiling. The estimate accrual within the accounts is for the months of May and June and is £4.534m (2021/22: £2.605m - this only relates to one month accrual).

1.20 **Adoption of new standards**

On 1 April 2022, the CCG 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 CCG will recognise a right-of-use asset representing the CCG'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 CCG will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the CCG will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

1.20.1 **Impact assessment**

The CCG 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 CCG has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The CCG has utilised three further practical expedients under the transition approach adopted:
a) The election to not make an adjustment for leases for which the underlying asset is of low value.
b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

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 CCG recognised £'000k of right-of-use assets and lease liabilities of £'000k. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was an £0m impact to tax payers' equity.

The CCG 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.

1.21 **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.

2 Other Operating Revenue

	3 months to 30 June 2022 Admin	3 months to 30 June 2022 Programme	3 months to 30 June 2022 Total	12 months to 31 March 2022 Total
	£'000	£'000	£'000	£'000
Other operating income				
Other non contract revenue	-	50	**50**	247
Total Other operating income	**-**	**50**	**50**	**247**
Contract and other receivables				
Total Operating Income	**-**	**50**	**50**	**247**

Administration revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare service

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

All other revenue is deemed to be non-contract revenue by the CCG.

3. Employee benefits and staff numbers

3.1.1 Employee benefits	Total Permanent Employees £'000	Other £'000	3 months to 30 June 2022 Total £'000
Employee Benefits			
Salaries and wages	**394**	**(32)**	**362**
Social security costs	**42**	**0**	**42**
Employer Contributions to NHS Pension scheme	**58**	**0**	**58**
Other pension costs	**1**	**0**	**1**
Gross employee benefits expenditure	495	(32)	463
Less recoveries in respect of employee benefits	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	495	(32)	463

	Total Permanent Employees £'000	Other £'000	12 months to 31 March 2022 Total £'000
Employee Benefits			
Contract and other receivables	**1,541**	**167**	1,708
Social security costs	**163**	**0**	163
Employer Contributions to NHS Pension scheme	**253**	**0**	253
Other pension costs	**3**	**0**	3
Gross employee benefits expenditure	1,960	167	2,127
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	1,960	167	2,127

3.2 Average number of people employed

	3 months to 30 June 2022			12 months to 31 March 2022		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**22.99**	**1.52**	**24.51**	**23.38**	**1.83**	**25.21**

3.3 Exit packages agreed in the financial period

There were no exit packages agreed in the three months to 30 June 2022 or during 2021/22.

3.4 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:

3.4.1 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 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 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.

3.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members.

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 actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

4. Operating expenses

	3 months to 30 June 2022 Admin £'000	3 months to 30 June 2022 Programme £'000	3 months to 30 June 2022 Total £'000	12 months to 31 March 2022 Total £'000
Purchase of goods and services				
Services from other CCGs and NHS England	266	302	568	1,866
Services from foundation trusts	-	54,925	54,925	208,766
Services from other NHS trusts	-	39	39	1
Purchase of healthcare from non-NHS bodies	-	7,593	7,593	49,364
Purchase of social care	-	2,165	2,165	4,603
Prescribing costs	-	7,004	7,004	29,823
Pharmaceutical services	-	33	33	126
GPMS/APMS and PCTMS	-	6,130	6,130	24,947
Supplies and services – general	6	196	202	1,198
Establishment	22	(0)	22	110
Premises	43	590	633	2,577
Audit fees	39	-	39	39
Other non statutory audit expenditure				
Contract and other receivables	-	-	-	3
Other professional fees	8	-	8	64
Legal fees	1	-	1	3
Education, training and conferences	2	(0)	2	60
Total Purchase of goods and services	**387**	**78,977**	**79,364**	**323,549**
Other Operating Expenditure				
Chair and Non Executive Members	30	-	30	118
Clinical negligence	1	-	1	3
Total Other Operating Expenditure	**31**	**-**	**31**	**121**
Total operating expenditure	**418**	**78,977**	**79,395**	**323,670**

Administration expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

The external auditor of the CCG is Mazars LLP. The audit fee accrued for the three months to 30 June 2022 was based on an estimate - the actual fee paid was £37,440 (including VAT).

Included within Other professional fees is £8,396 (2021/22: £33,708) for internal audit services, for the 3 months to 30 June 2022.

5 Better Payment Practice Code

Measure of compliance	3 months to 30 June 2022 Number	3 months to 30 June 2022 £'000	12 months to 31 March 2022 Number	12 months to 31 March 2022 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	1,051	20,228	4,135	76,756
Total Non-NHS Trade Invoices paid within target	1,042	20,121	4,117	76,642
Percentage of Non-NHS Trade invoices paid within target	**99.14%**	**99.47%**	**99.56%**	**99.85%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	83	55,044	313	212,072
Total NHS Trade Invoices Paid within target	83	55,044	313	212,072
Percentage of NHS Trade Invoices paid within target	**100.00%**	**100.00%**	**100.00%**	**100.00%**

6 Leases

6.1 Amounts recognised in Statement of Comprehensive Net Expenditure

	3 months to 30 June 2022 £'000	12 months to 31 March 2022 £'000
Expense relating to short-term leases	14	-

The expense relating to short-tem leases relates to the Rent element of the costs for Monkton Hall. No lease has been signed or rental charges agreed for future years.

7 Contract and other receivables

	Current 30 June 2022 £'000	Current 31 March 2022 £'000
NHS receivables: Revenue	30	43
NHS prepayments	32	4
NHS accrued income	3	16
Non-NHS and Other WGA receivables: Revenue	813	41
Non-NHS and Other WGA prepayments	612	164
Non-NHS and Other WGA accrued income	61	74
VAT	21	16
Total Contract & other receivables	**1,572**	**358**
Total current	**1,572**	**358**

7.1 Receivables past their due date but not impaired

	30 June 2022 DHSC Group Bodies £'000	30 June 2022 Non DHSC Group Bodies £'000	31 March 2022 DHSC Group Bodies £'000	31 March 2022 Non DHSC Group Bodies £'000
By up to three months	-	-	-	-
By three to six months	-	-	-	-
By more than six months	-	-	-	-
Total	**-**	**-**	**-**	**-**

8 Cash and cash equivalents

	30 June 2022 £'000	31 March 2022 £'000
Balance at start of period	185	133
Net change in period	(3,577)	52
Balance at end of period	**(3,392)**	**185**
Made up of:		
Cash with the Government Banking Service	0	185
Cash and cash equivalents as in statement of financial position	**0**	**185**
Bank overdraft: Government Banking Service	(3,392)	-
Total bank overdrafts	**(3,392)**	**-**
Balance at end of period	**(3,392)**	**185**

9 Trade and other payables	Current 30 June 2022 £'000	Current 31 March 2022 £'000
NHS payables: Revenue	206	126
NHS accruals	470	76
Non-NHS and Other WGA payables: Revenue	535	4,389
Non-NHS and Other WGA accruals	24,628	27,300
Social security costs	25	24
Tax	38	39
Other payables and accruals	329	541
Total Trade & Other Payables	**26,231**	**32,495**
Total current and non-current	**26,231**	**32,495**

Other payables include £154,918 outstanding pension contributions at 30 June 2022 (£303,035 at 31 March 2022).

10 Borrowings	Current 30 June 2022 £'000	Current 31 March 2022 £'000
Bank overdrafts:		
· Government banking service	3,392	-
Total overdrafts	**3,392**	**-**
Total Borrowings	**3,392**	**-**

10.1 Repayment of principal falling due

	Department of Health 30 June 2022 £'000	Other 30 June 2022 £'000	Total 30 June 2022 £'000
Within one year	-	3,392	3,392
Total	**-**	**3,392**	**3,392**

11 Financial instruments

It is the CCG's assessment that it is not exposed to any material Financial Instruments risk.

11.1 Financial assets

	Financial Assets measured at amortised cost 30 June 2022 £'000	Total 30 June 2022 £'000	Financial Assets measured at amortised cost 31 March 2022 £'000	Total 31 March 2022 £'000
Contract and other receivables with NHSE bodies	33	33	16	16
Contract and other receivables with other DHSC group bodies	61	61	61	61
Contract and other receivables with external bodies	813	813	97	97
Cash and cash equivalents	0	0	185	185
Total financial assets	**907**	**907**	**359**	**359**

11.2 Financial liabilities

Trade and other payables	Financial Liabilities measured at amortised cost 30 June 2022 £'000	Total 30 June 2022 £'000	Financial Liabilities measured at amortised cost 31 March 2022 £'000	Total 31 March 2022 £'000
Loans with group bodies	-	**-**	-	**-**
Loans with external bodies	3,392	**3,392**	-	**-**
Trade and other payables with NHSE bodies	63	**63**	133	**133**
Trade and other payables with other DHSC group bodies	613	**613**	77	**77**
Trade and other payables with external bodies	25,492	**25,492**	32,222	**32,222**
Total financial liabilities	**29,560**	**29,560**	**32,432**	**32,432**

12 Operating segments

The CCG considers they have only one segment: commissioning of healthcare services.

13 Joint arrangements - interests in joint operations

Under s75 of the 2006 NHS Act, the CCG has entered into pooled budget agreements with South Tyneside Council in relation to :

- Better Care Fund
- care of Learning Disabilities Clients
- delivery of legal advice for Mental Capacity Act package
- Community Equipment Store
- Joint Commissioning Unit

For accounting purposes, management has assessed that joint control does not exist.

The CCG's share of the expenditure handled by the pooled budgets in the financial period are shown below. No income has been handled by the pooled budgets in relation to the CCG.

13.1 Interests in joint operations

			Amounts recognised in Entities books ONLY	
			3 months to 30 June 2022	12 months to 31 March 2022
Name of arrangement	Parties to the arrangement	Description of principal activities	Expenditure	Expenditure
			£'000	£'000
Section 75	South Tyneside Council and South Tyneside CCG	Better Care Fund	1,292	4,603
Section 75	South Tyneside Council and South Tyneside CCG	Care of Learning Disability Clients	3,278	11,883
Section 75	South Tyneside Council and South Tyneside CCG	Delivery of legal advice in respect to CHC, Joint packages and S117	6	25
Section 75	South Tyneside Council and South Tyneside CCG	Equipment Store	107	773
Section 75	South Tyneside Council and South Tyneside CCG	Joint Commissioning Unit	157	627

14 Related party transactions

Details of related party transactions with individuals are as follows:

		3 months to 30 June 2022				12 months to 31 March 2022			
Governing Body / Executive Committee member	Related Party	Expenditure with Related Party £000	Income from Related Party £000	Payables to Related Party £000	Receivables from Related Party £000	Expenditure with Related Party £000	Income from Related Party £000	Payables to Related Party £000	Receivables from Related Party £000
Dr Matthew Walmsley	Marsden Road Health Centre	459	-	343	-	2,246	-	381	-
Dr Matthew Walmsley	South Tyneside Health Collaboration	456	(179)	250	(179)	3,685	-	1,607	-
Dr Matthew Walmsley	Wawn Street Surgery	310	-	23	-	1,122	-	43	-
Dr Tarquin Cross	Northumbria Healthcare NHS Foundation Trust	151	-	-	-	585	-	17	-
Dr Jon Tose (left 6/9/20)	Central Surgery	934	-	382	-	3,582	-	416	-
Dr James Gordon	Imeary Street Surgery	134	-	17	-	538	-	32	-
Dr James Gordon	South Tyneside Health Collaboration	456	(179)	250	(179)	3,685	-	1,607	-
Dr David Julien	First Contact Clinical	86	-	41	-	239	-	82	-
Ms Ros Whitehead	South Tyneside Health Collaboration	456	(179)	250	(179)	3,685	-	1,607	-
Ms Pat Harle	NHS Sunderland CCG	184	(12)	-	-	449	(90)	29	-
Ms Pat Harle	South Tyneside and Sunderland NHS Foundation Trust	37,591	-	74	-	144,964	(42)	49	(42)
John Whitehouse	NHS County Durham CCG	18	-	-	-	136	(1)	-	-
John Whitehouse	NHS North Cumbria CCG	-	-	-	-	-	(0)	-	0
Dr Neil O'Brien	County Durham and Darlington NHS Foundation Trust	339	-	-	-	1,575	-	-	-
Dr Neil O'Brien	NHS County Durham CCG	18	-	-	-	136	(1)	-	-
Dr Neil O'Brien	NHS Sunderland CCG	184	(12)	-	-	497	(90)	29	-
Dr Nousha Ali	Newcastle Upon Tyne Hospitals NHS Foundation Trust	3,957	-	84	-	15,253	-	-	-
Dr Nousha Ali	Dr Thorniley-Walker and Partners	274	-						
Jo Farey (from 03/01/22)	Intrahealth Ltd	287	-	106	-	1,404	-	157	-
Deborah Cornell (from 03/01/22)	NHS Sunderland CCG	184	(12)	-	-	515	(90)	29	-
Contract and other receivables	NHS North of England CSU	477	-	62	-	1,877	-	43	-
Ms Kate Hudson (from 2021/22)	Changing Lives	-	-	-	-	85	-	60	-
Ms Louise Lydon	Gateshead and South Tyneside LPC	-	-	100	-	200	-	-	-

All payments are made to the Related Party, not to the individual Governing Body member.

The details of the Member Practices of the CCG are listed below :

	3 months to 30 June 2022				12 months to 31 March 2022			
	Expenditure with Related Party £000	Income from Related Party £000	Payables to Related Party £000	Receivables from Related Party £000	Expenditure with Related Party £000	Income from Related Party £000	Payables to Related Party £000	Receivables from Related Party £000
Albert Road Surgery	117	-	24	-	513	-	36	-
Central Surgery	934	-	382	-	3,582	-	416	-
Colliery Court Medical Group	621	-	18	-	1,011	-	73	-
Dr Dowsett and Overs	178	-	44	-	762	-	61	-
Dr Haque	199	-	9	-	585	-	69	-
West View Surgery (previously Dr Kulkarni)	81	-	44	-	379	-	47	-
Dr Thorniley-Walker and Partners	217	-	43	-	765	-	57	-
East Wing Surgery	162	-	19	-	604	-	23	-
Ellison View Surgery	474	-	292	-	1,712	-	304	-
Farnham Medical Centre	465	-	95	-	2,479	-	264	-
Imeary Street Surgery	134	-	17	-	538	-	32	-
Marsden Road Health Centre	459	-	343	-	2,246	-	381	-
Mayfield Medical Group	276	-	2	-	1,263	-	36	-
Ravensworth Surgery	230	-	12	-	890	-	40	-
St George and Riverside	287	-	106	-	1,237	-	157	-
Talbot Medical Group	259	-	55	-	1,107	-	62	-
The Glen Medical Group	271	-	(26)	-	1,353	-	26	-
Trinity Medical Centre	386	-	232	-	1,732	-	249	-
Victoria Medical Centre	124	-	40	-	547	-	75	-
Wawn Street Surgery	310	-	23	-	1,122	-	43	-
Whitburn Surgery	152	-	21	-	640	-	40	-

The Department of Health and Social Care is regarded as a related party as the CCG's parent Department. 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. For example:

- NHS England (including North of England Commissioning Support Unit);
- NHS Foundation Trusts, including;

South Tyneside and Sunderland NHS Foundation Trust
Gateshead Health NHS Foundation Trust
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
County Durham and Darlington NHS Foundation Trust
North East Ambulance Service NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust

- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

In addition, the CCG has had a number of material transactions with other Government departments and other central and local government bodies. Most of these transactions have been with South Tyneside Council.

	3 months to 30 June 2022				12 months to 31 March 2022			
	Expenditure with Related Party £000	Income from Related Party £000	Payables to Related Party £000	Receivables from Related Party £000	Expenditure with Related Party £000	Income from Related Party £000	Payables to Related Party £000	Receivables from Related Party £000
South Tyneside Council	9,673	(650)	12,721	(669)	38,126	(337)	13,676	(56)

Transactions and balances are shown on an Accruals basis, rather than cash based.

15 Events after the end of the reporting period

On 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, Clinical Commissioning Groups were abolished and the functions, assets and liabilities of NHS South Tyneside CCG transferred to the North East and North Cumbria Integrated Care Board from the 1 July 2022. This constitutes a non-adjusting event after the reporting period. This does not impact the basis of preparation of these financial statements.

16 Financial performance targets

CCG's have a number of financial duties under the NHS Act 2006 (as amended).

CCG performance against those duties was as follows:

	3 months to 30 June 2022			
Duty	**Target**	**Performance**	**Variance**	**Duty Achieved**
Contract and other receivables	**£'000**	**£'000**	**£'000**	
Expenditure not to exceed income	80,758	79,857	901	Yes
Revenue resource use does not exceed the amount specified in Directions	80,708	79,807	901	Yes
Revenue administration resource use does not exceed the amount specified in Directions	709	709	0	Yes

	12 months to 31 March 2022			
Duty	**Target**	**Performance**	**Variance**	**Duty Achieved**
	£'000	**£'000**	**£'000**	
Expenditure not to exceed income	327,674	325,797	1,877	Yes
Revenue resource use does not exceed the amount specified in Directions	327,427	325,550	1,877	Yes
Revenue administration resource use does not exceed the amount specified in Directions	2,991	2,964	27	Yes

Independent auditor's report to the Members of the NHS North East and North Cumbria Integrated Care Board acting as the Governing Body of NHS South Tyneside Clinical Commissioning Group

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of NHS South Tyneside 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 Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2022/23 as contained in the Department of Health and Social Care Group Accounting Manual 2022/23, and the Accounts Direction issued by the NHS England with the approval of the Secretary of State as relevant to Clinical Commissioning Groups in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 and of its net expenditure for the period then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been properly prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

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

Emphasis of Matter – transfer of the CCG's functions to the Integrated Care Board

We draw attention to notes 1.1 (going concern) and 15 (events after the end of the reporting period) of the financial statements, which highlight that the Health and Care Act 2022 gained Royal Assent on 28 April 2022. As disclosed in notes 1.1 and 15 of the financial statements, the CCG's functions transferred to a new Integrated Care Board from 1 July 2022. Given services continue to be provided by another public sector entity, the financial statements are prepared on a going concern basis. Our opinion is not modified in respect of this matter.

Conclusions relating to going concern

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

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

We have nothing to report in this regard.

Opinion on regularity

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

Responsibilities of the Accountable Officer for the financial statements

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

The Accountable Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2022/23 and prepare the financial statements on a going concern basis, unless the CCG is informed of the intention for dissolution without transfer of services or function to another entity. The Accountable Officer is responsible for assessing each year whether or not it is appropriate for the CCG to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

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

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

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the CCG, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risks of override of controls) and determined that the principal risks related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, significant one-off or unusual transactions and the risk of fraud in financial reporting relating to expenditure recognition due to the potential to inappropriately record expenditure in the wrong period.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit Committee, the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the CCG which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud;
- addressing the risks of fraud through management override of controls by performing journal entry testing;
- addressing the risk of fraud in expenditure recognition through testing payments in the pre and post year end period to ensure they were recognised in the right year, sample testing material period-end payables and provisions and reviewing intra-NHS reconciliations and data matches provided by the Department of Health and Social Care.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit

of financial statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in December 2021.

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the nine-month period ended 31 March 2023.

We have not completed our work on the CCG's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in January 2023, we have not identified any significant weaknesses in arrangements for the period ended 31 March 2023.

We will report the outcome of our work on the CCG's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Responsibilities of the Accountable Officer

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

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

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

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Health and Social Care Act 2012; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Use of the audit report

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

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources and complete the work necessary to provide assurance to the NAO on the whole of government accounts return.

Cameron Waddell,
Partner
For and on behalf of Mazars LLP

The Corner
Bank Chambers
26 Mosley Street
Newcastle upon Tyne
NE1 1DF

3 July 2023