NHS
North Tyneside
Clinical Commissioning Group

Annual Report

Quarter 1 of 2022/23

[Page left intentionally blank]

All CCGs final 3 month annual reports and accounts (2022/23) were required to use the updated annual report template 2022-23 (published in February 2023). Therefore the draft CCG annual report was populated by the CCG prior to the CCGs responsibilities transferring to North East and North Cumbria Integrated Care Board (NENC ICB). The final version of the CCG annual report has been further updated and sign off under the oversight of the chief executive for the NENC ICB in line with national guidance.

Contents

NHS
North Tyneside
Clinical Commissioning Group

Performance Report

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.

Performance overview

This section includes a statement from the Clinical Chair and Chief Officer and information about North Tyneside Clinical Commissioning Group (CCG). All performance and quality data are sourced from validated national sources, including NHS England, NHS Digital and Department of Health.

Statement from the Clinical Chair and Chief Officer

Welcome to the NHS North Tyneside Clinical Commissioning Group Annual Report for April to June 2022/23.

Until July 2022, North Tyneside Clinical Commissioning Group (CCG) was a clinically led organisation delivering high quality health services for the 222,000 people in the borough. The CCG was responsible for commissioning (planning and buying) the majority of health services for people across North Tyneside.

The Department of Health and Social Care issued a new White Paper in 2021 called 'Integration and Innovation: working together to improve health and social care for all'. The White Paper worked its way through the legislative system and was enshrined in law in July 2022. The new legislation describes how the health system will become more integrated and therefore Integrated Care Systems, which work at a regional level were established from 1 July 2022. These new organisations are statutory bodies responsible for commissioning healthcare services. The legislation also describes how "place based" working will be key which is local areas working together with key partners such as local authorities. This means that while the CCG itself has ceased from July 2022, our work will continue through the Integrated Care Board (ICB), building on the innovations we have developed and the relationships we have forged over the years.

With the challenges and impacts of the COVID-19 pandemic continuing to be felt, it has been more important than ever for partnership working to pull together to safely respond to the pressures of the pandemic.

Despite these challenges that we continue to experience in the health and social care system due to the pandemic, the CCG continued to work with our partners and stakeholders to implement exciting and innovative new services as well as work to improve the quality of services. Some of our key achievements include:

- Our COVID-19 vaccination roll-out are higher than most areas in the North East and North Cumbria. This achievement has been due to the tireless work of our GP Practice staff, our Primary Care Networks and the pharmacists in North Tyneside.

- A very positive inspection of North Tyneside's Special Educational Needs and Disability (SEND) provision. The inspectors acknowledged significant strengths in the effectiveness of the North Tyneside offer in identifying and meeting needs and improving outcomes for children and young people with SEND.
- Establishment of the first mental health support teams in 22 schools in North Tyneside, providing support to individual and groups of children and young people who have mild to moderate mental health presentations. The team also offers support and advice to teachers, parents and carers. A second team will be coming on-stream in September 2022.
- We rolled out a digital access research project in partnership with the Local Authority, HealthWatch North Tyneside, the Citizens Advice Bureau, VODA, Community Healthcare Forum and AGE UK North Tyneside to evidence where in North Tyneside there are issues about digital access. We undertook a survey and are currently gathering and analysing the results. We will then identify the issues about digital access and work with our partners to strategically plan how we address these issues.
- The CCG was the first area in the country to develop a new Advanced Care Practitioner Programme. Sixteen Community Care Practitioners are being deployed across the hub and spoke models which will be available to each Primary Care Network in North Tyneside. A delirium at home model has also been developed as part of this Programme.
- Working on the success of the HowFit programme to reduce the number of falls that our population experience, we have introduced another Falls Prevention programme in North Tyneisde, working with Age UK North Tyneside. The new CHEAT – Frailty teams provide a bespoke quality improvement training programme for carers and activity co-ordinators, based on the HowFit Plan for home exercise for care homes and deliver that programme in a systemised manner to cover all care nursing and specialist homes across the borough.

We would like to thank all of our partners people and organisations we work with who have been involved in helping us to continue to improve health services for the people of North Tyneside.

Dr Richard Scott
Clinical Chair

Mark Adams
Accountable Officer

About NHS North Tyneside Clinical Commissioning Group

NHS North Tyneside CCG had overall responsibility for the development and planning of healthcare services for the borough for the period 1 April 2022 to 30 June 2022, covering a population of 222,000 (based on the 2020 NHS England allocations). This changed from 1 July 2022 when the Integrated Care Board took over statutory responsibility for the work CCGs previously did. North Tyneside is part of the North East and North Cumbria Integrated Care System (NENC ICS).

The NHS is facing a continuing period of unprecedented challenges. For North Tyneside, these challenges include:

- Managing patients' healthcare needs arising as a result of the COVID-19 pandemic and ensuring health services can meet those needs
- An ageing population with increasing health needs
- Health inequalities across the area, which have been exacerbated by the COVID-19 pandemic
- Levels of smoking, alcohol consumption and obesity higher than the national average
- Over-reliance on hospital-based services
- Increasing high-cost drugs and cost of new medical technologies

All 25 GP practices in North Tyneside were members of the CCG, supported by healthcare professionals and managers.

As a CCG, and moving towards the Integrated Care Board, we are dedicated to providing the best possible patient care to our community. We place the needs of our patients at the heart of every decision, which means we are constantly looking for ways to improve healthcare and health outcomes for the borough.

Our strategic principles:

The CCG's strategic principles were:

- High quality care that is safe, effective, and focused on patient experience
- Services coordinated around the needs and preferences of our patients, carers, and their families.
- Transformation in the delivery of health and wellbeing services provided jointly with the local authority, other public sector organisations and the private and voluntary sector.
- Best value for taxpayers’ money and using resources responsibly and fairly

- Right services in the right place delivering the right outcomes.

The CCG had the quality of patient provision at its heart and constantly sought to ensure that, through the work with our partners, we continued to improve the quality of services for the patients in North Tyneside.

Our Vision, Plans and Priorities

Our vision was**:**

> "Working together to maximise the health and wellbeing of North Tyneside communities by making the best use of resources"

We strove to find and implement new ways of working which will mean that care will be closer to home and people will only be in hospital when it is really needed. Our strategic priority themes for changing the health care system were:

- Keeping healthy, self-care
- Caring for people locally
- Hospital when it is appropriate

Our strategic vision was supported by ambitious plans to change the way that health care is delivered for the people of North Tyneside. These plans will continue into the remainder of 2022/23 as part of local system transformation through which many of the traditional boundaries between providers and commissioners are being removed as part of an integrated care approach. This includes work being undertaken at a wider, strategic level as well as at a local level.

During the first quarter of 2022/23 we continued to work across three levels of scale, building on the work that started during 2020/21. More refinement of work at a larger scale and how this will be implemented will be ongoing during 2022/23:

Integrated Care System

The keystone of the wider, regional strategic work is that of the Integrated Care System (ICS). In June 2019, the North East and North Cumbria area was confirmed by NHS England as an ICS.

Since then, the Government has issued a White Paper which has progressed through the necessary parliamentary stages and is now enshrined in law with the ICSs becoming statutory organisations with formal status from July 2022.

Currently the North East and North Cumbria ICS is focused on 'at scale' priorities that multiply our collective impact around overarching clinical strategy and clinical networks, strategic commissioning (e.g. for ambulance services) and shared policy development.

Integrated Care Partnership

In previous years and during the first quarter of 2022, North Tyneside, Northumberland, and Newcastle Gateshead NHS organisations came together with local authorities, to lead and plan care for their population in a coordinated way as the North of Tyne and Gateshead Integrated Care Partnership (ICP). These were different to the new Integrated Care Partnerships which are described in the new legislation and are statutory committees jointly formed between the NHS integrated Care Board and all upper-tier local authorities that fall within the Integrated Care System area

The previous partnership was an informal arrangement where we worked together at scale when it makes most sense to do so, focusing on developing care models that support the balancing of capacity and demand across the health economy.

The North of Tyne and Gateshead Integrated Care Partnership developed a plan for working together on key areas identified in the NHS Long term Plan which has been agreed by each of the partners.

Much of our work focused on managing the impact of COVID-19 on our health services, maintaining those services where it has been possible to do so or to restart them if they did have to stop during the pandemic. This included services like outpatient services and some surgical services where changes were needed across the health system to manage the pressures of the pandemic. We worked together to reduce waiting list and waiting times for planned care services and for cancer services. We have also worked together on urgent and emergency care services which was particularly important due to the high level of demand for these services experienced over the past couple of years.

We also continued to work at an ICP level for mental health services recognising that the CCGs in the North of Tyne and Gateshead ICP all commission mental health provision from Cumbria, Northumberland Tyne & Wear Mental Health Foundation Trust. Working in this way has meant that the potential for “postcode lottery” situations to arise are minimised and there is equal access to the services that are commissioned.

Place Based Care

In North Tyneside, we have established our Future Care Programme, which brings together strands of work across the health and social care system in North Tyneside to deliver sustainable care closer to home.

North Tyneside’s Future Care Place Based Transformation Board and its sub committees have worked collaboratively over a number of years. There is a wide-ranging membership across health and social care, Fire & Rescue Services, community and voluntary organisations and Healthwatch and patient forum members.

During 2021/22 and continuing into the first quarter of 2022/23, we implemented many of the initiatives and service developments that we described in our Place Based Transformation Plan August 2020 - March 2022 which describes our response to future service delivery and recovery recognising the impact that the COVID-19 pandemic has had and continues to have on the needs of our population and staff.

Going forward, this local approach towards integrated services will ensure that community and primary care will meet future demand, while integration of health and social care will be one of the priority areas for both the Integrated Care system and local authority to enable us to achieve the new model.

Joint working and collaboration between the CCG, Trusts, Public Health, the community & voluntary sector as well as other partners, has meant that our response to providing health and social support has been, and will continue to be, strong and resilient.

Engaging People and Communities

The CCG was committed to working with system partners, patients, carers and the public to improve patient safety, patient experience, health outcomes and, in doing so, support people to optimise their health and wellbeing. This will continue to be a priority for the new Integrated Care Board. Important decisions that affect patients will be made by us in partnership with key stakeholders at the heart of which are local people.

Like many other areas, North Tyneside has an ageing population, an increase in public expectations and an increasing demand for services. To ensure that we have person centred sustainable services, the CCG worked with partners and the public to continue to develop a shared decision-making approach to service change and development.

We undertook demographic monitoring to ensure that inclusive participation across the borough and that the nine protected characteristics of the Equality Act 2010 are covered. As in previous years, the CCG's patient and public participation engagement report 2021/22 details all of the ways we work with local people to improve access, service delivery and quality. It also includes evidence of local people acting as a catalyst for innovation and change.

Patient Forum development session

Developing the infrastructure for engagement and participation

The CCG always aimed to listen to our patients and local communities, and to hear their views about healthcare and wider commissioned services so that we could use them to inform our commissioning decisions. We recognised this is underpinned by the legal obligation to offer opportunities to be involved at different stages of the commissioning process.

The CCG had a Communications and Engagement Strategy which was kept under constant review by our Communications & Engagement Committee to ensure it was fit for purpose and underpinned all CCG activity. It should be read in conjunction with other

key documentation including the Equality Strategy, Operating Plan, and Information & Technology Strategy.

The CCG developed stronger links with the voluntary sector including developing joint communication plans to ensure consistency of health messages which partners could amplify across their groups and platforms.

We used a range of methods to ensure involvement and engagement, which are summarised in this section. We also took the opportunity to demonstrate patient and public engagement and participation throughout this document in relation to specific initiatives and developments.

A key element of how we operated was by providing information in accessible formats. The CCG continuously offered assistance for those who require communication or other support to enable them to engage. This included translation into other languages, cover transport costs to engagement events as well as providing an independent external facilitator to capture their story.

We also created ‘easy read’ versions of our previous Annual Reports to make them more accessible for a wider audience. We asked for feedback from members of the Patient Forum, as well as an easy read specialist in health to ensure that the report was suitable before publishing it on the CCG’s website. NHS England highlighted our easy read Annual Report as an example of best practice in patient and public participation.

The CCG also commissioned a number of videos to help us share information with patients and the community in an exciting and accessible way. This included an animation summary of the annual report which was fully narrated by a local resident so the voice was in a local accent to feel more inclusive to our readers. These videos are played in a number of locations such as GP practice waiting rooms and CCG buildings to help us reach a wide audience.

The CCG also had a ‘Get Involved’ section on our website. This was to help people to get more involved in the CCG’s work in a variety of ways. For example, people could find out more about the Patient Forum, various working groups, individual practice patient forums and the CCG’s meetings which were held in public.

We encouraged people to get involved in these areas of work and have had members of the public contact us through these methods who have subsequently been involved in some specific areas of work, for example the CCG’s Cancer Plan.

Online forms were available for people to make complaints or to share compliments or comments about services or their experiences.

We also gathered intelligence from our partner organisations to help us gain early feedback on issues as they were emerging. An operational weekly group involving the CCG, the Community and Health Care Forum, VODA, Healthwatch North Tyneside, Tynehealth, North Tyneside Council and Northumbria Healthcare

Foundation Trust was established. This group met to discuss live feedback from patients to provide answers or discuss solutions which could be put in place. This could be from social media platforms such as Twitter, Facebook or Instagram. All partners agreed to amplify key health messages using the same text and imagery to support consistent and unified messaging across North Tyneside. This helped the reader to recognise key messages so that they were familiar and supported a trusted network of messages across health, social care and the voluntary sector.

For example, the CCG, practices and other partners were receiving calls from residents seeking help and advice on their vaccine status, COVID-19 passports for travel and COVID-19 vaccination clinics. Many patients had contacted their GP practice and 111 with no resolution to their query. The national NHS 111 helpline gave advice to patients but it did not reflect how the COVID-19 vaccine roll-out was being undertaken within North Tyneside. This led to an increased number of complex COVID-19 data related calls which required detailed operational knowledge to resolve. The CCG therefore commissioned TyneHealth GP Federation to provide a North Tyneside-wide COVID-19 Helpline service for patients and professionals. TyneHealth was ideally positioned to step up a telephone and email helpline to help resolve issues much more quickly than patients would have done themselves and also diverted unnecessary activity from primary care. This was a far more efficient service for our residents and a central source of information which was invaluable when the programme moved down the different eligible groups for vaccinations. The Helpline was able to direct patients to bespoke 11- 5 year old clinics when the National Booking System (NBS) was not able to. This was an agile service which could help support maximizing uptake of the vaccination programme.

Every year the CCG produced a document, jointly with the Local Authority, describing key priority areas for commissioning services. The Patient Forum takes the opportunity to influence the CCG’s priorities by considering its Commissioning Intentions document as well as receiving regular commissioning updates throughout the year. The joint Commissioning Intentions are also shared with Healthwatch North Tyneside and the Health and Wellbeing Board as partners across the system.

The Better Together Strategy sets out how the NHS, North Tyneside Council, and the Voluntary and Community Sector will work together to build strong and sustainable partnerships that makes North Tyneside a better place to live, work and visit.

The CCG had and now the Integrated Care Board (ICB) has, amongst others, two Living Well programmes of work. The Living Well North Tyneside booklet was created to provide health and well-being information aimed at residents aged 65 and over. The booklets were distributed to people whilst visiting a vaccination centre. With the early vaccinations where patients had to have a monitored 15 minute recovery period, it was an ideal opportunity to read something with a captive audience. The second edition of the booklet was aimed at residents aged up to 65 with a focus on preventative health messages. With the removal of monitoring

periods for all vaccine doses, partners agreed to fund a door drop of the magazine to over 105,000 households within North Tyneside to maximise its reach.

Patient Forum

The Patient Forum was a constituted sub-committee of the CCG's Governing Body. Patient and public involvement was reported to every meeting of the CCG Governing Body that was held in public. This provided evidence that the Governing Body was assured about public involvement activity and the difference it has made.

The Patient Forum will continue its work with the ICB from 1 July 2022. It is a strong and robust group and acts as a critical friend to the Integrated Care Board. Members are encouraged to challenge and debate throughout all engagement processes.

The aim of the Patient Forum is to have membership from each of the 25 GP practices in North Tyneside who come from practices' own patient participation groups. Most practices have active patient groups with scheduled meetings throughout the year and others run virtual groups to engage with their patient population.

The forum is coordinated and supported by the Community and Health Care Forum.

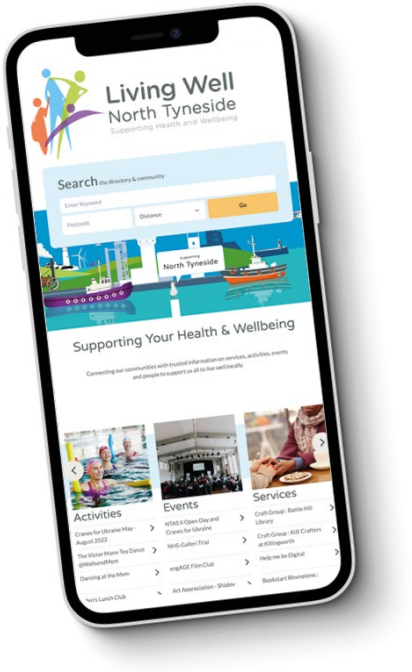
Agenda items for the forum are a mixture of health-related areas for discussion, and member-led issues for meetings. Some members had areas of special interest which are identified within development sessions and inductions and these were matched with CCG priorities until July 2022 and, from July 2022, Integrated Care Board priorities. A series of smaller working groups have therefore been established to enable more in-depth discussion and influence.

The Patient Forum sub-committee meets every two months and are involved in a series of health discussions, giving an opportunity to share their experiences of services in North Tyneside.

Topics for discussion during 2021/22 and the first quarter of 2022/23, which have influenced commissioning decision-making, included NHS North Tyneside CCG commissioning intentions, online GP appointments pilot and supporting key messages for the COVID-19 vaccination programme. During 2021/22, agenda items for the forum have been varied: Carers during COVID, Urgent Care provision, and the Health and Wellbeing Strategy have all been considered by members.

Additionally, over the past year, the forum has been involved in:

- Living Well North Tyneside website testing – a resource for the community and professionals
- Talking Therapies patient letters
- Death Café – not morbid or a funeral plan sales pitch, more an opportunity to talk through the one thing we have in common
- Care Homes research – safe transition of care
- Digital Inclusion research – survey testing



Each year, Patient Forum members have an additional development session to reflect on their influence and impact on services and initiatives. The viability of the forum and working groups is discussed and reviewed at length with recommendations arising to ensure the groups are in line with health and Integrated Care Board priorities and member's expectations.

Patient Forum Working Groups

The Patient Forum has a series of smaller working groups and members with areas of special interest join these to work on specific areas of development. These groups are outlined below.

Mental health

This group debates and informs mental health service developments and, post COVID, will continue to take part in service visits to enhance members knowledge. Community Mental Health Transformation has been at the heart of this group.

Communications

Members support the CCG with matters relating to communications. This includes the CCG website, publications, and the quarterly production of the Patient Forum newsletter.

Engagement

This group was created to ensure North Tyneside has a voice in engagement plans for the new Integrated Care System being established and the engagement strategy has had member input.

Future Care

Members visited Age UK North Tyneside's Havelock Place in Backworth which offers specialist housing for those living with dementia and complex needs. There was also the opportunity to comment on the proposed Backworth Ageing Well Village plans, a development to support older people to live well and healthy. Considerable testing of the resident's digital research survey was also undertaken by members.

End of life care

A draft Coroner leaflet on expected deaths was shared with members for their views and proposed amendments. Over many months the group supported the production of the End of Life Care Strategy.

Innovations

The Innovations group has provided input into initiatives such as Strata which is a capacity and demand system, GP Access and patient behaviors, the development of the Living Well North Tyneside website and a one stop site for health and social care information and activities.

The CCG would like to take the opportunity to acknowledge the excellent work of the NHS North Tyneside CCG Patient Forum. The Forum as a critical friend plays a key role in keeping patient and public engagement at the core of our work, and the efforts of the members is invaluable to the CCG.

Hear My Voice North Tyneside

This remains the vehicle for residents to share their views on healthcare in the borough and is also the banner title for specific survey work.

Performance summary

The NHS Long Term Plan continues to be a key driver for improvement in the NHS. Launched in 2019, the national NHS Long Term Plan is focused on improving the quality of patient care and health outcomes. Its aim is to build an NHS fit for the future by enabling everyone to get the best start in life, helping communities to live well, and helping people to age well.

The Long-Term Plan aims to improve outcomes for major diseases, including cancer, heart disease, stroke, respiratory disease, and dementia, and also includes measures to:

- Improve out-of-hospital care, supporting primary medical and community health services.
- Ensure all children get the best start in life by continuing to improve maternity safety including halving the number of stillbirths, maternal and neonatal deaths, and serious brain injury by 2025.
- Support older people through more personalised care and stronger community and primary care services.
- Make digital health services a mainstream part of the NHS, so that in 5 years, patients in England will be able to access a digital GP offer.

To find out more see the NHS Long Term Plan website.

Quality of services was always a key priority for the CCG. To this end, robust structures and systems were in place to ensure that the services commissioned were of high quality and are safe for patients and staff.

The CCG continued to oversee quality improvements through its support for the various quality systems and processes in place to provide assurance that the CCG's requirements are being met.

Where areas were identified areas for improvement, the CCG implemented changes to increase standards, minimise waiting lists and improve waiting times through joint working with the organisations that provide the services for North Tyneside residents.

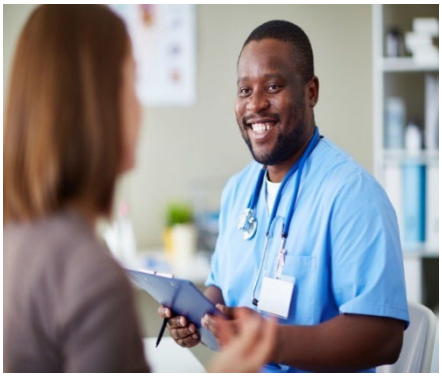
The CCG was represented on the quality review groups which are in place for all Foundation Trusts and local private hospital providers. These provide a focus on

assurance relating to the clinical quality of commissioned services. The CCG also continued with its schedule of quality assurance visits, in partnership with the Local Authority, to all independent nursing homes in North Tyneside.

The CCG had a range of methods to ensure services were delivered to a quality standard and provide value for money. These included processes to manage performance against the range of indicators including a mechanism to work with internal and external colleagues to identify areas of risk, and implementation of action plans to mitigate these.

In addition, the CCG considered the risks and areas of uncertainty identified on its Risk Assurance Framework which ensured that performance in these areas was closely monitored, e.g. Referral to Treatment times and cancer waiting times. Where possible and appropriate, we used national data sets as our Key Performance Indicators (KPIs) to help us monitor and improve performance, as well as locally determined KPIs.

Regular performance reports were provided to the CCG's Governing Body, which detail the North Tyneside performance against the agreed local and national measures. This provided reassurance that the standards are being met or, if they were not being met, the Governing Body could request assurance about the measures being put in place to progress towards achieving the standards.



Monitoring performance also helped to understand the effectiveness of services, together with the role of quality assurance and financial management.

Robust systems were in place to effectively manage complaints received by the organisation in accordance with NHS complaints regulations. Responsibilities and processes for receiving, handling, investigating and resolving complaints relating to the actions of North Tyneside CCG, its staff and services, as well as commissioning services and independent sector providers, were set out in the CCG's Complaints Policy and Procedure document which was approved by the CCG's Governing Body.

The CCG commissioned the North of England Commissioning Support Unit (NECS) to provide a complaint handling service on the CCG's behalf. NECS undertake to work within the parameters of the above policy and procedure and discuss with the complainant creation of a complaint plan which outlines agreed actions and deadlines.

There are two stages to the NHS complaints procedure:

- Local resolution of complaint through investigation and response by the CCG or provider.

- Independent Review of complaint by the Parliamentary and Health Service Ombudsman.

Provider complaints are managed under the provider's complaints procedures and were reported to the CCG through their board level patient experience report, which was shared at the CCG's Quality Review Group meetings. CCG complaints were presented to the Quality and Safety Committee as part of the Integrated Performance and Quality Report as well as through an annual report.

Key issues and risks

During 2021/22, the COVID-19 pandemic continued to impact upon on the CCG's ability to meet some of its objectives. However, the CCG worked closely with partners to reduce the effect of COVID-19 and therefore not all areas were impacted to the same extent.

The risks associated with COVID-19 were:

- That the response to COVID-19 would impact on the system's ability to deliver healthcare to meet the needs of the population.
- The ability to support the NHS & social care system to deliver appropriate care to the residents of North Tyneside throughout the COVID-19 pandemic.
- That COVID-19 posed a risk to staff health and CCG operations.

Although steps were taken to minimise these risks, the CCG took the decision to continue to identify the first two risks into 2022/23. This is because the pandemic was continuing and all the effects and impacts of the pandemic are yet to emerge. The third risk also remained on the risk register for continuous monitoring purposes, but it has been noted that it is being managed with necessary steps taken to protect staff and innovative new ways of working to ensure that CCG business continued into the first quarter of 2022/23 and as the Integrated Care Board took over responsibility for previous CCG staff from 1 July 2022 .

The following risks were also included on the CCG's Risk Register in Quarter 1 of 2022/23 and will be managed through the ICB's risk management processes:

- Failure to clearly demonstrate compliance with NHS Constitution rights and pledges.
- Commissioned services are not of sufficiently high quality.
- The risk of adult or child safeguarding incident/s or other significant quality failure incident.

- Failure to deliver control total and to financially support services effectively because of activity over performance; failure to make efficiency savings; and/or other factors.
- Nursing homes are rated inadequate by CQC and/or are in organisational safeguarding, resulting in reduced availability of beds in nursing homes to meet demand.
- Risk of not being able to respond to surges in demand leading to a failure to respond effectively to local healthcare needs.
- That delayed ambulance handovers impacts negatively on patient safety and patient flow.
- Risk of not being able to implement New Models of Care to meet the needs of the population.
- The timetable, uncertainty, and the use of existing resources to manage the business transfer from the CCG to the (proposed) Integrated Care Board and to ensure arrangements at 'Place' are ready, may result in delayed delivery of day-to-day CCG business, adversely impacting patients and public, and staff morale.

Performance Standards as at Quarter 1 of 2022-23

The tables below provide an overview of the CCG's performance during quarter 1 of 2022-23. Where the CCG's performance has dipped below the national standard, we have provided additional detail to describe how we are working to improve performance.

Maternity performance

All performance and quality data reported is for June 2022 and is sourced from validated national sources, including NHS England, NHS Digital and Department of Health.

Neonatal mortality and stillbirths	G
Maternal smoking at delivery	**G**

Mental health performance

All performance and quality data reported is for June 2022 and is sourced from validated national sources, including NHS England, NHS Digital and Department of Health .

Improving Access to Psychological Therapies – Recovery	G
Improving Access to Psychological Therapies (IAPT) – Access	**A**
The CCG achieved 1% against a standard of 2.1% and therefore did not achieve the standard in June 2022. The ICS Mental Health Steering Group (Board) is leading on a review of psychological therapies to reduce health inequalities and maximise the health and well-being of the local population. Additionally, the CCG has met with NHSE/I to discuss the impact of primary mental health workers in Primary Care Networks (PCNs) on the IAPT access rates as this work is not recorded on the electronic system which captures IAPT activity.	

Early intervention of psychosis (EIP)	G
Mental health out of area placements	**G**
Estimated diagnosis rate for people with dementia	**A**
The CCG achieved 65.3% against a standard of 66.7% and therefore did not achieve the standard in June 2022. Although the CCG did not achieve the standard, the rate of 65.3% is above the national average. The CCG undertook a deep dive of dementia data which led to a number of practices being audited to identify any data quality issues and ensure referrals and assessment outcomes were being recorded. An Action Plan has been developed by the North Tyneside Mental Health in later life Board for 2022/23.	
Dementia care planning and post-diagnostic support	**G**

Learning Disabilities performance

All performance and quality data reported is for June 2022 and is sourced from validated national sources, including NHS England, NHS Digital and Department of Health.

Proportion of people with a learning disability on the GP register receiving an annual health check	G

Planned care performance

All performance and quality data reported is for June 2022 and is sourced from validated national sources, including NHS England, NHS Digital and Department of Health.

The pandemic has had significant detrimental impact on the provision of elective services and improving elective waiting times is a national priority. Commissioners and providers have continued to work together to review and understand the continued impact of COVID-19 on elective recovery.	

CCGs and Trusts in the North ICP established a Referral to Treatment working group which identifies areas of particular concern and develops options to improve pathways and provision to reduce waits. Regular Recovery Reports were shared, activity closely monitored and fed back to NHSE	
Referral to treatment times	**A**
The CCG achieved 75.4% against a standard of 92% in June 2022.	
Number of patients waiting more than 52 weeks for treatment	**A**
The CCG had 714 patients waiting over 52 weeks for treatment in June 2022 against a standard of zero	
Number of patients waiting more than 104 weeks for treatment	**A**
The CCG had 2 patients waiting over 104 weeks for treatment in June 2022 against a standard of zero.	
Patients waiting less than 6 weeks for the 15 diagnostic tests	**A**
The CCG achieved 75.487.9% against a standard of >99% in June 2022. Diagnostic testing delivered in a COVID-19 safe way is challenging due to the requirements for additional cleaning, social distancing, etc. therefore the overall number of patients seen per clinic reduced compared to pre-COVID-19 clinics. The main diagnostic tests which took longer than the 6 weeks standard were at Newcastle Hospitals Trust - audiology assessment and echocardiography. Newcastle Hospitals Trust has opened a diagnostic community hub in Blaydon which has relieved some diagnostic pressures. The Trust is also exploring internally ways to increase capacity and staffing levels to improve echocardiography activity.	

Cancer performance

All performance and quality data reported is for June 2022 and is sourced from validated national sources, including NHS England, NHS Digital and Department of Health .

During the pandemic, the number of patients attending General Practice significantly reduced which impacted on the number of cancer referrals going through the system. However, cancer referrals to Northumbria Healthcare Trust are now above pre-pandemic levels while at Newcastle hospitals, referral are at the same level as before the pandemic. Cancer delivery has been a priority throughout the pandemic to ensure that patient outcomes are the best they can be. Pathway changes had to be made to ensure strict	

infection and prevention measures were followed during the COVID-19 pandemic which resulted in some longer patient pathways. Both Trusts experienced staffing issues with staff testing positive for COVID-19 or having to self-isolate. Several initiatives and measures were put in place to improve services and outcomes for patients, including:- • Faecal Immunochemical Test (FIT Test) standardised approach to identifying patients • Lung Cancer Case Finding involving the use of low dose CT scanning • Cervical Screening with additional capacity in North Tyneside • Cancer personalised care with every cancer patient receiving four key interventions	
Two week wait all cancers	**A**
The CCG achieved 89.7% in June 2022 against a standard of 93% and therefore did not achieve the standard.	
Two week wait for an urgent referral for breast symptoms	**A**
The CCG achieved 79.7% in June 2022 against a standard of 93% and therefore did not achieve the standard.	
31-day treatment – all cancers	**A**
The CCG achieved 83.2% in June 2022 against a standard of 96% and therefore did not achieve the standard.	
31-day treatment – surgery	**A**
The CCG achieved 64.7% in June 2022 against a standard of 94% and therefore did not achieve the standard.	
31-day treatment - anti-cancer drugs	**G**
31-day treatment – radiotherapy	**G**
Patients treated within 62 days - urgent GP referral for suspected cancer	**A**
The CCG achieved 59.7% in June 2022 against a standard of 85% and therefore did not achieve the standard.	
62 days screening to first treatment for cancer – screening service	**A**
The CCG achieved 59.7% in June 2022 against a standard of 85% and therefore did not achieve the standard.	

Cancers diagnosed at an early stage	A
One year survival from all cancers	**A**
The CCG achieved 71.6 against an England average of 73.3% for 2017. The CCG has worked closely with Newcastle Trust and Northumbria Healthcare Trust to progress that every cancer patient received four key interventions: Health Needs Assessment, Health and Wellbeing information and support, risk stratification pathways and a Primary Care Cancer Care Review.	

Urgent care performance

All performance and quality data are sourced from validated national sources, including NHS England, NHS Digital and Department of Health.

Four hour waits in A&E	A
The CCG had two main providers for A&E. In June 2022, Newcastle Hospitals Trust achieved 79% against a target of 95% while Northumbria FT achieved 89.5% in June 2022. Neither Trust therefore achieved the standard of 95%. However, both Trusts did perform higher than the England average. Staff sickness due to COVID continued to impact upon capacity levels and throughput of patients. Both hospitals coped with high numbers of COVID-19 positive patients during the pandemic and provided national and regional support to treat some out of area patients. Both Trusts also experienced very high numbers of patients accessing the ED, many with high acuity needs.	
Ambulance response times	**A**
Ambulance response time measures cover 4 standards which are category 1, 2, 3 and 4 response times. The North East Ambulance Service (NEAS) did not achieve any of the four response times standards in June 2022. High levels of sickness absence due to COVID-19 impacted upon capacity of ambulance crews and call handlers. The Trust received extra funding to recruit to additional posts for call handling and to increase clinical triage of calls. This has resulted in some recent improvements in call handling rates and proportion of patients who were treated without being taken to hospital. System were implemented to improve ambulance handover delays which continue into 2022/23.	
Category 1 response time	**A**

Category 2 response time	A
Category 3 response time	**A**
Category 4 response time	**A**

Performance Measures

All performance and quality data reported is for June 2022 and is sourced from validated national sources, including NHS England, NHS Digital and Department of Health .

MRSA	G
Clostridium Difficile	**G**

Mixed-sex accommodation	G

Contracting and Finance Summary April to June 2022

The NHS 2022/23 priorities and operational planning guidance was published on 22nd February 2022. The guidance described the four strategic purposes of Integrated Care Systems (ICS) for the year ahead:

• improving outcomes in population health and healthcare

• tackling inequalities in outcomes, experience and access

• enhancing productivity and value for money

• supporting broader social and economic development.

From 1 April CCGs became responsible once again for agreeing and funding both NHS Trust contracts and Independent Sector (IS) contracts. Our contract management of these providers continues to focus on reducing waiting lists/times and enabling providers to deliver their services in the safest environment.

The CCG reported a breakeven position as of 30 June 2022 and delivered on all of its required financial targets. Delivery of financial targets is important because it will allow the healthcare system in the future to commission high quality care for patients on a sustainable basis.

Performance analysis

In this performance analysis section, we will give an overview on three key areas:

- North Tyneside Health & Wellbeing Overview and Strategy
- CCG Financial Overview
- Corporate Performance Overview

North Tyneside Health and Wellbeing Overview & Strategy 2021/22 and April – June 2022/23

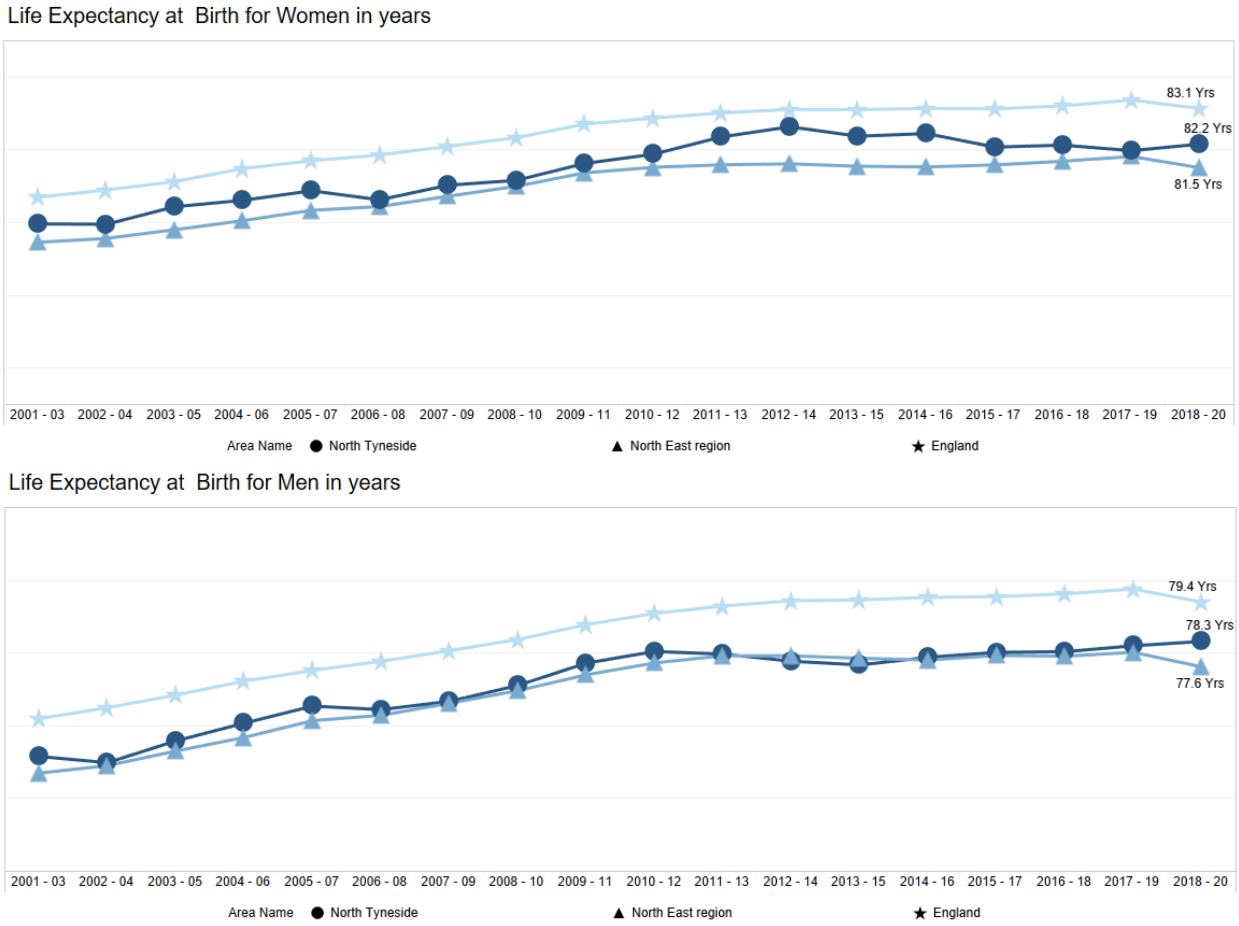
In the last two decades, many of the indicators of health and wellbeing have improved significantly in North Tyneside. However, today, they are on average worse than those for England. Health inequalities persist within the borough and, as a result, the overall picture of health and wellbeing across North Tyneside is mixed.

In the 2019 English Indices of Deprivation, North Tyneside was ranked 128 out of 317 (where 1 was the worst and 317 was the best). As a relative measure of multiple deprivation experienced by people living in an area, it provides a place-based insight into deprivation. Whilst overall North Tyneside's ranking does not lie within the two most deprived quintiles (a quintile is when a range of data has divided into 5 equal parts) as some other North East authorities, there are some neighbourhoods within the borough that lie within the most deprived decile (a decile is when a range of data has been divided into 10 equal parts) of neighbourhoods in England. It is these inequalities which drive the different experience of health and wellbeing across our communities.

The COVID-19 pandemic has had a dramatic impact worldwide. It has presented and continues to present an unprecedented challenge to public health. Declared a public health emergency of international concern by the WHO in 2020, there is no aspect of life in the UK that has not been significantly affected. The direct and indirect impacts of the pandemic have exposed the pre-existing inequalities that existed across the borough and, in fact, have amplified them.

The average life expectancy in North Tyneside over the last decade for both men and women has stalled. Average life expectancy for women in North Tyneside at the time of producing the report was 82.2 years. This was better than the North East average but was 0.9 years lower than the average for England. There has been a small overall increase of 1 year for women over the last 10 years but, worryingly, since 2014 life expectancy for women has declined by 0.3 years.

The average life expectancy for men at the time of producing the report was 78.3 years which was higher than the average for the North East but was significantly lower (1.1 years) than that for England. There has been a small overall increase of 1.2 years over the last 10 years. Since 2014 average life expectancy for men has shown a small increase of 0.4 years.



Figures 1 & 2: Average life expectancy in North Tyneside (years) 2000-2020 (source ONS and PHE/OHID)

Healthy life expectancy is the number of years a person can expect to live in good health.

For men, healthy life expectancy was 60.6 years and, in comparison, the average for women was 59.3 years. Due to the way that these figures are calculated they are based on data from 2017-2019 and do not yet include any data relating to health and wellbeing during the COVID-19 pandemic. Healthy life expectancy had previously seen an improvement for women in North Tyneside, but there was a decrease of 4 years from 63.3 years in 2016-2018 to the most recent value. There has also been a decrease in healthy life expectancy for men, but this was not as stark as for women, with a decrease of 0.1 years from 60.7 years in 2016-2018, but a decrease of 1.6 years when this indicator peaked at 62.2 years in 2015-2017.

There is a relationship between lower healthy life expectancy and levels of deprivation. Men in our least deprived areas have on average 14.7 more years spent in good health compared to our most deprived communities. Women in our most deprived areas have an average of 14.4 years spent in good health compared to women in the most deprived areas.

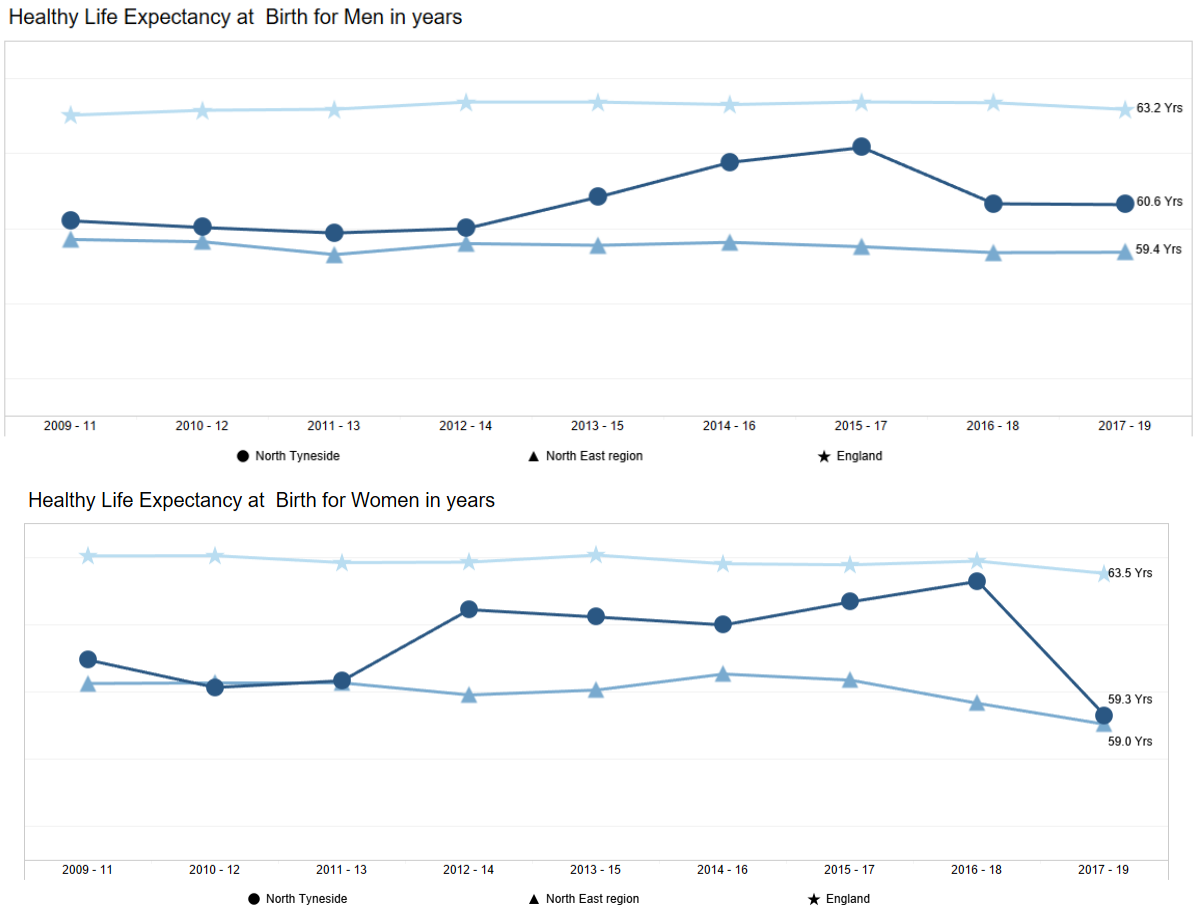


Figure 3 & 4: Healthy life expectancy in North Tyneside (years) 2009-2019 (Source ONS and PHE/OHID)

There are wide inequalities across the borough, with persistent pockets of deprivation particularly in the wards of Riverside and Chirton.

Men and women from our least deprived areas live longer, compared to residents from our most deprived areas. For men they live 11.4 years longer and for women 9.9 years longer.

Data for 2018-2020 shows the health inequality gap has closed for both men and women since 2017-2019. However since data started to be collected in 2010-2012 the gap has widened by 0.8 years for men and by 0.6 years for women.

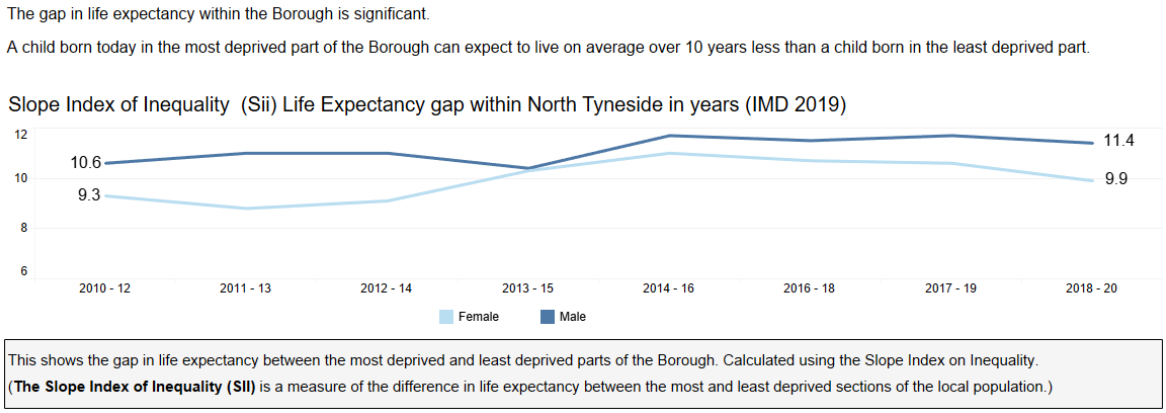


Figure 5: Life expectancy gap

Premature mortality

Cancer, cardiovascular disease (CVD) and respiratory disease remain the leading causes of premature death in North Tyneside. Age standardised mortality rates for all three diseases are higher than the England rate.

Cancer remains the most significant cause of premature mortality in North Tyneside with 876 deaths between 2017 and 2019 in under 75s, and over 40% of these deaths were from cancers that were considered preventable.

Although CVD mortality has declined faster than cancer; there were still 461 premature deaths (i.e., adults aged under 75) between 2017 and 2019 from CVD.

Chronic Obstructive pulmonary Disease (COPD) is one of the major respiratory diseases and smoking is a major cause of COPD. In North Tyneside there were 420 deaths in the period 2017 to 2019 from COPD. There were also 464 deaths recorded as “smoking attributable deaths from cancer” and 134 deaths recorded as “smoking attributable deaths from heart disease” in the same period.

People are also dying from liver disease at a younger age compared to the national average. Deaths due to liver disease are heavily influenced by both alcohol and obesity. In North Tyneside there were 144 deaths between 2017 and 2019 in those aged under 75.

Social factors, behavioural risk factors and late presentation, diagnosis and treatment contribute to the premature mortality. However, much of this premature mortality is preventable. In total there were 1,034 deaths in under 75-year-olds in North Tyneside that were considered as preventable between 2017 and 2019.

Almost half of the gap in life expectancy between the most and least deprived areas in England is due to excess deaths from circulatory disease (heart disease and stroke) and cancer in the most deprived areas.

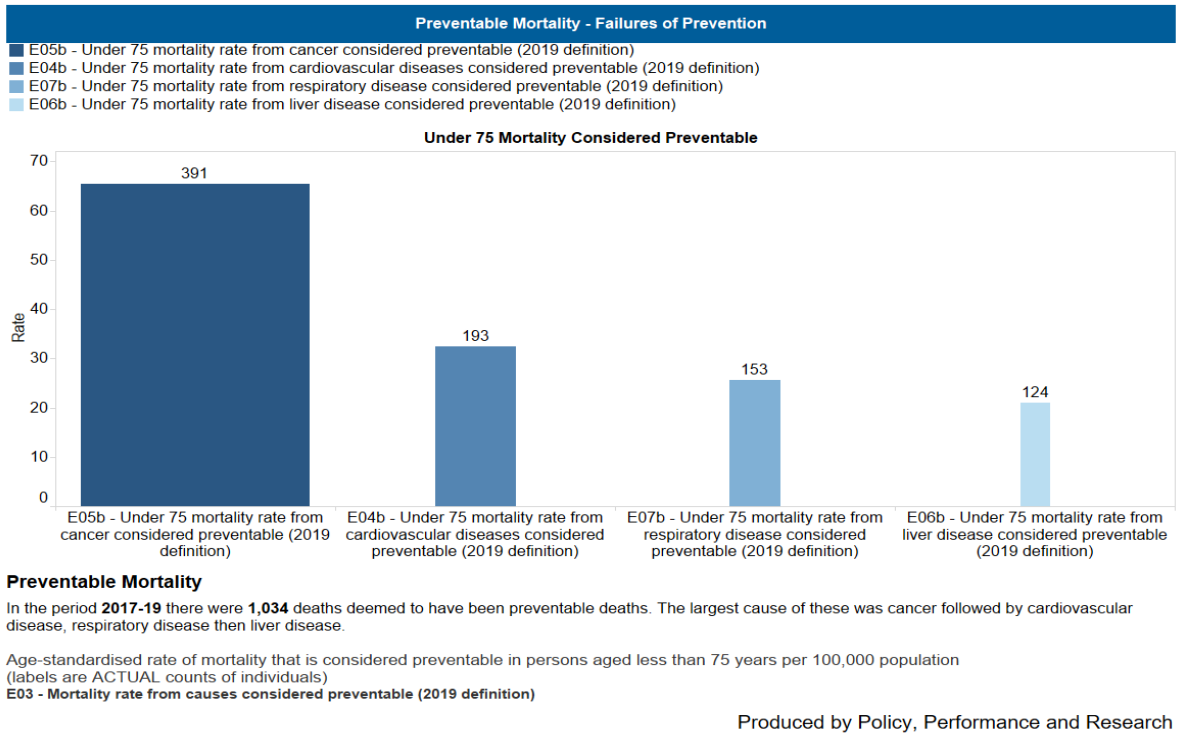


Figure 6: Preventable mortality in North Tyneside

Behavioural risk factors

Major risk factors for poor health include unhealthy diets, smoking, drinking too much alcohol and physical inactivity.

71.6% of adults are classified as physically active (2019-2020). However, just under two thirds (65.7%) of adults in North Tyneside are overweight or obese (2019-20). Consequently, there are increasing numbers of people who have type 2 diabetes. There are 14,241 individuals in North Tyneside recorded with diabetes on a GP practice disease register (7.8%) (2020-2021), which is higher than the England value of 7.1%. In 2015 it was estimated that 11.4% of adults (19,505) had non-diabetic hyperglycemia (NDH) and thus representing an opportunity to prevent development of type 2 diabetes. The most recent data suggests 8,826 adults in North Tyneside have a record of NDH in their GP records.

The numbers of adults smoking in North Tyneside has significantly declined over the last decade with 14.3% of adults currently smoking (2020). However, there is variation in North Tyneside: 1 in 4 of adults in the most deprived areas of North Tyneside smoke compared to only 1 in 6 in our least deprived areas.

Alcohol-specific admissions to hospital are higher in North Tyneside compared to the national average. In 2020-2021 there were 2,300 hospital admissions for alcohol-related conditions, which is higher than the previous year. 25.2% of the population is drinking at levels that risk damaging health (2015-2018 data) and 1.6% of the population are estimated to be dependent on alcohol (2014-2015 data).

Children and young people

Similar to adults, the behavioural risk factors for children and young people relate to unhealthy diets, physical inactivity and smoking.

18.7% of children in North Tyneside are living in low-income families. There is a persistent gap in educational attainment between disadvantaged children and other children in the borough. This is important when considering the behavioural risk factors and how these should be tackled.

The rate of obese children doubles between five-year-olds and 10-year-olds. Over one in 10 children are obese aged 4-5 (11%), and over one in five by aged 10 (22.5%) (2019-2020). There is a clear relationship between deprivation and obesity.

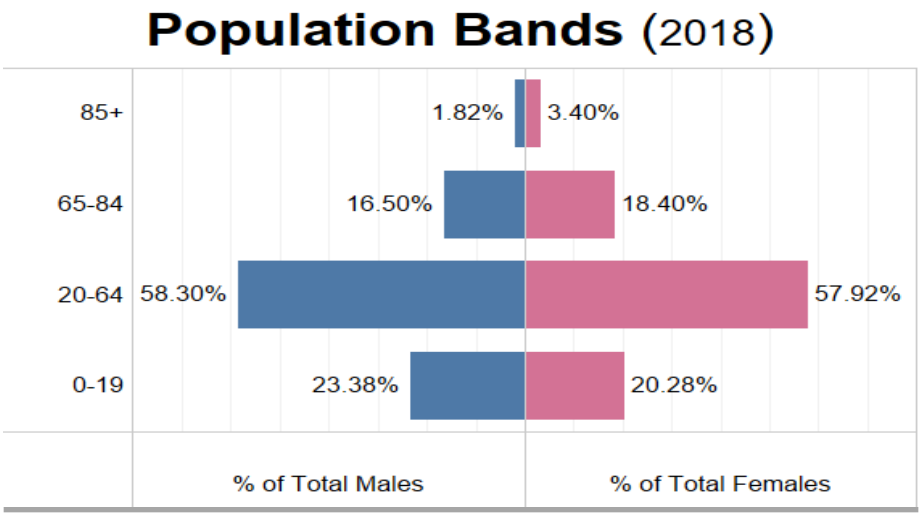
10.5% of 15-year-olds are regular smokers. This is similar to the England average.

An ageing population

North Tyneside's population is getting older and we can see that the numbers of people with multiple long-term conditions and frailty are growing. By 2040, we predict there will be 12,184 (32.7% increase) more people aged between 65-84 and 3,556 (65% increase) more people aged over 85 years living in North Tyneside.

There are over 14,000 older people over the age of 65 who live alone and it is predicated that the the number of people aged over 75 living alone will rise by 50.6% by 2040.

More than one in 10 of the adult population has a caring responsibility with an estimated 15% of people over 65 years old in North Tyneisde caring for someone.



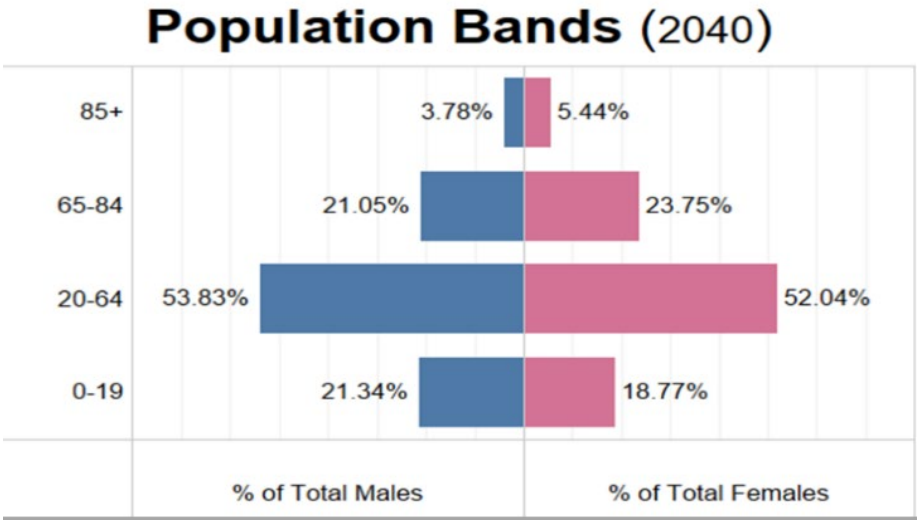


Figure 7 & 8: Population bands by age and projected change by 2040

Impact of COVID-19 Pandemic in North Tyneside

There have been a range of impacts on health and wellbeing as a result of the COVID-19 pandemic. As well as the direct impacts of COVID-19, the social distancing and lockdown measures have had a huge and unequal impact of their own on individuals, households and communities through the restrictions imposed on our everyday social and economic activities. We have yet to understand the full extent of the impacts on health and wellbeing, but some detailed work has been undertaken by North Tyneside Council to explore this further1, particularly the impact on inequalities.

The first case of COVID-19 reported in North Tyneside was 2 years ago, on 5 March 2020. Since then, a total of 70,695 positive cases have at the time of writing, been reported in North Tyneside, including re-infections. Of these positive cases, almost 54% were female, and 46% were male.

The rate of infection across the population has not been experienced evenly. The 0-19 population represents 25% of cases, with the 20-59 population accounting for 61%, and the over 60's almost 14%.

COVID-19 had a direct and indirect on children in the borough and their access to education. From September 2020 to July 2021 1,441 pupils tested positive for COVID-19 and there were also over 26,500 instances where a pupil had to self-isolate because of a COVID-19 case in their school. This disruption led to missed school-based education and social contact and meant that many parents were forced to take unpaid leave.

---

[1] **North Tyneside Council (2021).** Impact of the COVID-19 pandemic on health and socio-economic inequalities in North Tyneside. Available online

Issues such as food poverty, safeguarding incidents, mental health issues and loneliness were also exacerbated by the pandemic. Again, many of these issues were not evenly distributed, and the impacts were often greater for those people living in more deprived areas or already experiencing other inequalities or vulnerability factors.

Throughout the pandemic, unemployment rates rose in North Tyneside, with 24-year-olds being disproportionately affected, and there was a 90% increase in Universal Credit claimants. The borough's more deprived wards experienced higher levels of unemployment benefit than those areas that are less deprived. There were also inequalities in how the pandemic affected household income, with people already experiencing inequalities more likely to have seen their income decrease.

The COVID- 19 pandemic has impacted upon the achievement of several healthcare targets. These include:

- Referral to treatment times
- Diagnostic waits
- A&E waits
- Cancer waits
- Ambulance response times
- Annual health checks and access to other screening programmes

When the national declaration of a Level 4 National Incident was made in January 2020, all statutory health and social care organisations triggered the operationalisation of their own system and local plans. In North Tyneside, a response team was created consisting of lead officers from the local NHS hospitals, CCG, Local Authority and Public Health.

Within the CCG itself, we identified a Senior Responsible Officer and set up an incident room with a senior incident manager and a loggist. This continued 7 days per week during 2021/22. An incident team consisting of clinical, IT, transformation and commissioning staff supported the delivery of the required actions.

As of 28 February 2022, 85.24% of the population of North Tyneside aged 9 years and over have received two doses of the COVID-19 vaccine and 67.56% of the eligible population have also received a booster dose. Again, this was not evenly distributed, with differences by age group. For example, almost 100% of 75–79-year-olds received two doses compared to 86% of 20–24-year-olds.

COVID-19 Mortality

Overall, there have been 592 Covid -19 deaths recorded for North Tyneside residents, but only 171 of these are for the period from 20 February 2021 to 18 February 2022. These figures include a total of 171 Care Home deaths overall, 27 of which were in 2021-2022.

The Office for National Statistics have recorded 126 excess deaths in North Tyneside for the period 6 February 2021 to 18 February 2022, where deaths are those recorded above the expected 5-year average. Not all deaths were linked to COVID-19 and deaths were not evenly distributed across the time period (there were 19 weeks where there were fewer deaths than expected and 32 weeks where there were more deaths than the 5-year average).

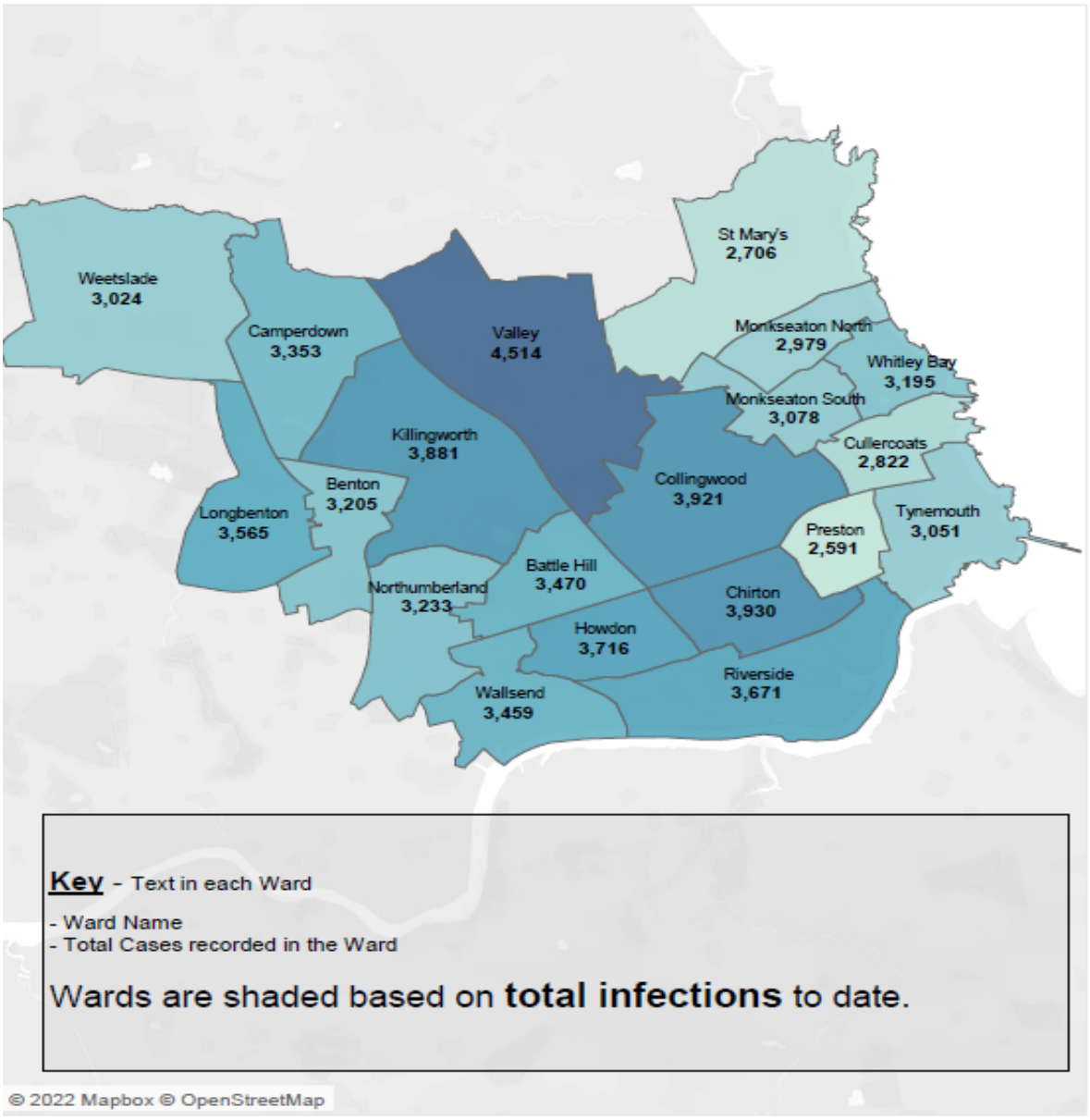


Figure 9: Cumulative COVID-19 infection rate by ward (on 27 February 2022)

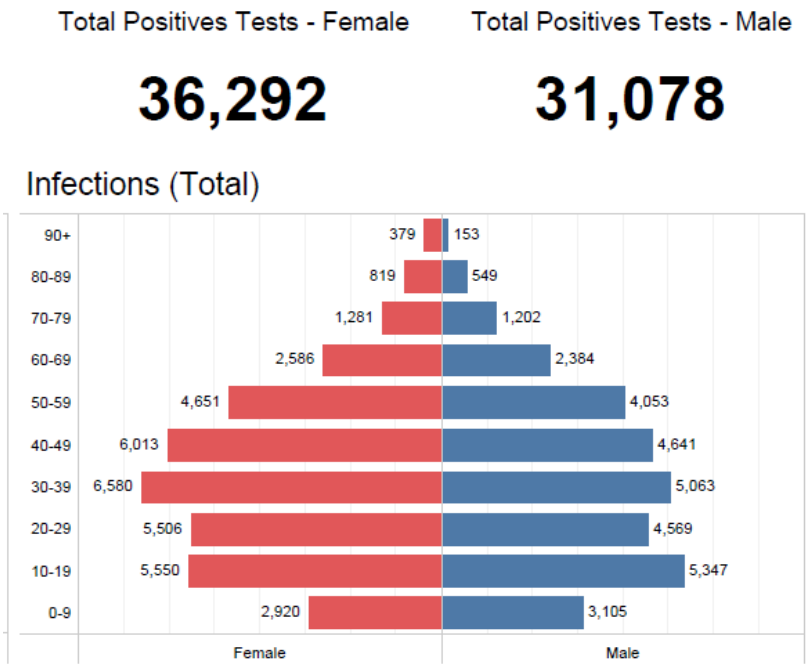


Figure 10 Cumulative number of positive cases of COVID-19 by gender (on 27 February 2022)

Health and Wellbeing Strategy

The CCG worked in close partnership with North Tyneside Council and actively supports the development and delivery of the joint health and wellbeing strategies.

The CCG's plans were aligned with the objectives and priorities of the Health and Wellbeing Strategy. The Local Authority Director of Public Health attends the CCG Governing Body meetings and provided updates to the committee as well as supporting the CCG with public health advice and support.

The CCG's Clinical Chair and the Chief Operating Officer/ Executive Nurse Director were members of the North Tyneside Health and Wellbeing Board and attend these meetings.

A new Joint Health and Wellbeing Strategy has been developed for 2021-2025 and focuses on building a healthier, fairer future North Tyneside and reducing inequalities2. The strategy was published by the Health & Wellbeing Board in November 2021 and includes work to ensure that all children are given the best start in life, to strengthen the role and impact of ill health prevention and to embed an integrated health and care system to enable all parts the system to work together effectively in a way that will improve outcomes and address inequalities.

---

[2] **North Tyneside Health and Wellbeing Board.** Equally Well: A healthy, fairer future for North Tyneside. 2021-2025. Available online

The Future Care Place Based Plan and the North Tyneside Children & Young Peoples Plan together contain the cross-system programmes of work for 2021-22 and going forward will align to the new ICS health and wellbeing strategy.

In addition to regular attendance at the HWBB throughout 2021/22, the CCG has led or been directly involved in the following HWBB agenda items:

- Future Care Programme & Plan.
- North Tyneside Children and Young People's Mental Health and Wellbeing and Emotional Wellbeing Strategy 2016-2021.
- Special Educational Needs and Disability (SEND)
- Joint Inequalities Strategy and Action Plan
- Joint Mental Health & Wellbeing Strategy for Working Age Adults.
- Mental Wellbeing in Later Life Strategy.
- The CCG continues to be the regional lead for the National Diabetes Prevention Programme.
- Urgent care.
- North Tyneside Better Care Fund.
- North Tyneside commitment to carers – meeting statutory duties.
- Multi-Agency Safeguarding Arrangements.
- Health, wellbeing and social care commissioning intentions 2021-22.

Financial performance

Key financial performance indicators April - June 2022

North Tyneside CCG met the statutory requirement to ensure expenditure in a financial year did not exceed its allocated resource for the period April to June 2022. The CCG achieved a break-even position for the three-month period which maintained the brought forward surplus at £8.2m as at 30 June 2022.

Financial performance targets are reported in the notes of the annual accounts. CCGs had a number of financial duties under the NHS Act 2006 (as amended). North Tyneside CCG's performance against those duties was as follows:

Table 1: Financial performance targets

Target	April – June 2022
Expenditure not to exceed income	Achieved
Capital resource use does not exceed the amount specified in Directions	Achieved
Revenue resource use does not exceed the amount specified in Directions	Achieved
Revenue administration resource use does not exceed the amount specified in Directions	Achieved

In addition to the commissioning budget, the CCG had an annual running costs budget of £1.1m for the period. This was spent on CCG staff and associated costs and on services from North of England Commissioning Support (NECS). The CCG operated from premises in North Shields leased from NHS Property Services.

Financial outturn

The CCG Quarter 1 of 2022-23 annual accounts are provided in full as part of the Annual Report. During the year, the CCG commissioned healthcare services to the value of £97.0m and incurred expenditure of £1.1m in respect of running costs. The overall closing position of the CCG was breakeven, aligned to services below.

Table 2: CCG quarter 1 of 2022-23 expenditure

Acute health services
Mental health services
Community health services
Continuing health care
Prescribing
Primary care
Other programme costs
Total programme (commissioning) costs
Total running costs

The majority of the CCG's expenditure was spent with NHS organisations, purchasing healthcare for the benefit of North Tyneside residents. Funds were also used to purchase healthcare from non-NHS bodies, as indicated in the accounts.

Table 3: CCG Quarter 1 of 2022-23 acute expenditure

Northumbria Healthcare NHS Trust
Newcastle upon Tyne NHS Trust
North East Ambulance Service NHS Trust
Other NHS Acute Services
Other Non-NHS Acute Services

Better Payment Practice Code

The Better Payment Practice Code requires all CCGs to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. North Tyneside CCG has met the requirements of the code, as reported in the annual accounts and indicated in notes to the accounts.

Financial Plans 2022/23

From July 2022 financial plans have been prepared at an ICB level. Contracts have been re-established with NHS providers with effect from April 2022 and will transfer to the ICB on 1 July 2022.

Corporate Performance Overview

Respect for Human Rights

The CCG was committed to equality, diversity, and human rights (EDHR) in everything we do, whether that is commissioning services, employing people, developing policies, communicating, consulting, or involving people in our work.

Social matters

The CCG took its social responsibilities seriously.

The Better Together Strategy set out how North Tyneside Council, North Tyneside CCG and the Voluntary & Community Sector work together to build strong and sustainable partnerships that makes North Tyneside a better place to live, work and visit. We describe this in more detail in the Voluntary & Community Sector section further in this Annual Report.

During 2018/19 the CCG approved the introduction of a voluntary and community sector (VCS) grant scheme which enabled the VCS to apply for grants to support the delivery of CCG objectives. The first wave of the grant scheme was successfully launched in 2019/20, which resulted in four organisations receiving grants of up to £300,000 each for a three-year period and five organisations receiving a small grant of up to £20,000 each. This has been an innovative and exciting opportunity in North Tyneside.

The CCG intended to roll the scheme out further during 2020/21 but this had to be halted due to the COVID-19 pandemic. Instead, we worked with those organisations who had received a grant to agree different ways they could work and provide support with their communities during the pandemic. The CCG also extended the grant period to provide funding to enable this work. However, in 2021/22, in response to the pandemic, the CCG increased VCS Grant Programme funding by £80,000 so it could continue to fund four of its existing small grant projects for another year.

Development work is continuing into 2022/23, in January 2022, a new fund was announced to support voluntary, community and social enterprise (VCSE) sector organisations active in North Tyneside to address existing health inequalities in the borough. Grants were awarded with the intention to address one or more of the following objectives highlighted in the Equally Well Strategy, published by North Tyneside's Health and Wellbeing Board:

- Equal life chances for all
- Thriving places and communities
- Maintaining independence

The process for reviewing the applications and awarding the grants was continuing at the time of writing.

The CCG also worked with Barnardo's to develop an apprenticeship scheme to encourage young people into the workplace and continues to be committed to this scheme. The CCG also encouraged apprenticeships from the ‘Project Choice’ scheme for people with autism and learning disabilities. Two posts were made permanent within the CCG following successful completion of the apprenticeships and a third apprentice post has been recruited to.

The CCG also routinely included a question on social value when it is undertaking procurements and bidders are evaluated as to their response to this question. This helped us to understand how new services being procured in North Tyneside can add a level of social value, such as increasing employment opportunities.

The intended impact was to have a mutually agreed, coordinated, and holistic ‘whole-system’ approach to proactively sustain and improve the health of the population, reducing health inequalities and prevent illness. More detail on reducing health inequalities is given below.

Reducing Health Inequality

Our commitment to equality and diversity was driven by the principles of the NHS Constitution, the Equality Act 2010 and the Human Rights Act 1998, and by the duties of the Health and Social Care Act 2012 (section 14T) to reduce health inequalities, promote patient involvement and involve and consult with the public.

We have demonstrated our commitment to taking Equality, Diversity and Human Rights (EDHR) in everything we do, whether that is commissioning services, employing people, developing policies, communicating, consulting, or involving people in our work as evidenced below.

We were fully cognizant of our duty to reduce inequalities between patients in accessing health services for our local population and this has been increasingly highlighted as one of the impacts of the COVID-19 pandemic.

We understood 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 worked in partnership with local NHS Trusts as well as local voluntary sector organisations and community groups to identify the needs of the diverse local community we serve to improve health and healthcare for the local population.

Managing health inequalities was a key feature of the national planning guidance issued during 2021/22, with systems required to demonstrate how health inequalities will be addressed at all levels of service, including in urgent and emergency care, elective recovery and at primary care level. The CCG worked with our Trusts, other providers and neighbouring CCGs to describe how we would take this forward during 2021/22. This narrative helped inform the ICS level narrative which was ultimately submitted to NHS England.

We sought 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, focus groups and through Healthwatch.

As the local commissioners of health services, we sought to ensure that the services that are purchased on behalf of our local population reflect their needs. We appreciate that to deliver this required 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.

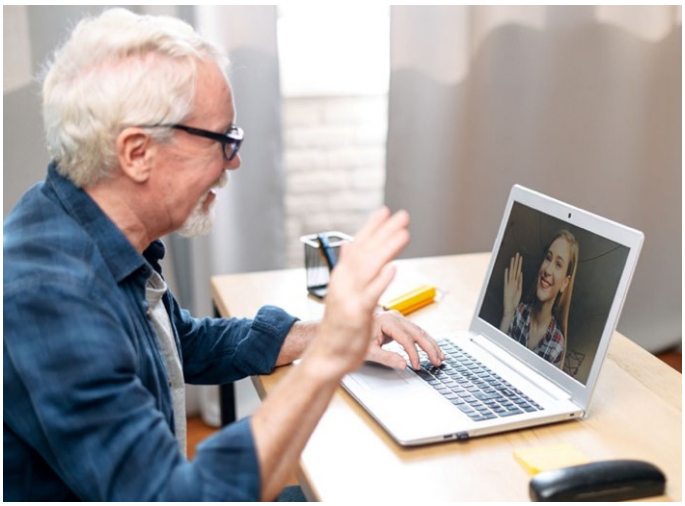
As well as the work being undertaken described above, as we move forward and learn more from the outcomes for people during the Covid -19 pandemic, we were increasingly conscious of health inequalities experienced during the pandemic.

Tackling health inequalities required actions to be embedded across the system and at all levels. It required greater collaboration and actions to address underlying root causes. This relies on collaboration with local government and the voluntary, community and social enterprise sector.

In North Tyneside, a joint Health Inequalities Strategy was developed during 2021/22 and work on the Action Plan has started.

As part of the NHS response to COVID-19, eight areas have been set out intending to systematically tackle health inequalities. Population Health Management approaches started during 2020/21 and continued to be used going forward to

combine medical with social vulnerability to identify and shield people at the greatest risk from direct and indirect impacts of COVID-19. This will include supporting localities and GP practices to implement the national risk stratification tool and integrating this with other health and social care data to segment and risk stratify patients to identify vulnerability.



PCNs are using data to look at how we can deliver improvements in health and wellbeing, making the best use of our collective resources. This is enhanced by the links with public health colleagues including those based in foundation trusts, the business intelligence support from NECS and national, regional, and local intelligence and feedback.

As a result of COVID-19, we saw, during 2020/21, a significant rise in the use of virtual patient appointments. This continued during 2021/22 and there is a national expectation that access to virtual appointments will continue in both primary and secondary care provision.

We know that for many patients, their expectations regarding how they interact with services has changed, but many are reporting very positive experiences of digital solutions. However, we are also aware that some of our most vulnerable communities are living in situations of very low income, which means a choice often must be made between purchasing data instead of other essentials, potentially restricting access to digital health services. Digital skills for those with poor literacy or ability/knowledge to enable access has been an issue for certain groups including people with a learning disability, those with a learning difficulty and some minority population groups.

Feedback from a number of sources in relation to the issues experienced in North Tyneside in relation to digital poverty prior to COVID-19 led to a call to action by Future Care Programme Board members to find out more. The North East has the second highest proportion of non-internet users (12.1%) across the UK. The COVID-19 pandemic and the rapid shift in which many services across a range of sectors defaulted to online access to health services has impacted on all three levels of this digital divide - access, skills and usage, and benefits both on and offline.

We have developed a project group from all sectors in North Tyneside, including the Local Authority, Health Watch North Tyneside, the Citizens Advice Bureau, VODA, Community Healthcare Forum and AGE UK North Tyneside to develop a detailed twelve-month research project to evidence where in North Tyneside there are issues with digital access. The scope involves identifying the issues through an academic

research process and working with our partners to strategically plan how we improve these issues. The project went live in February 2022, and we are currently gathering and analysing the results of a survey which had been sent to every household in North Tyneside. This work is continuing into 2022/23.

PCNs in North Tyneside worked with partners to develop a health inequalities plan to address an identified health inequality for their local population. These plans will be delivered in 2022/23.

Mental ill-health is a significant contributor to long-term health inequalities, and we know that the immediate and longer-term social and economic impacts of COVID-19 will contribute to or exacerbate mental health problems. Work on an ambitious plan started in 2020/21 in North Tyneside, in line with the national programme, to transform community mental health provision for adults with serious mental health needs. This work had progressed during 2021/22. It is expected that this work and the new pathways will help to advance equalities in access, experience and outcomes for groups facing inequalities across different mental health pathways.

Through our Commissioning Support Unit, we have continued to work closely with other local NHS organisations to support the regional working that has been a legacy of the Equality, Diversity and Human Rights Regional Leads Meetings. Also, nationally we have continued to work closely with NHS Employers Equality & Diversity partners' alumni programme.

We continued to monitor the health profiles and data available which detail the health challenges of our population including the Joint Strategic Needs Analysis (JSNA) and Public Health Profiles. Further information can be found at:

Health Profiles:https://fingertips.phe.org.uk/profile/health-profiles/data#page/13/gid/1938132696/pat/6/par/E12000001/ati/202/are/E08000022/cid/4

Public Health England – Local Health: http://www.localhealth.org.uk

North Tyneside Joint Strategic Needs Assessment (JSNA) Health Inequalities and Local Community documents:

http://www.northtyneside.gov.uk/pls/portal/NTC_PSCM.PSCM_Web.download?p_ID=564404

http://www.northtyneside.gov.uk/pls/portal/NTC_PSCM.PSCM_Web.download?p_ID=564405

http://www.northtyneside.gov.uk/pls/portal/NTC_PSCM.PSCM_Web.download?p_ID=565071

Public Sector Equality Duty (PSED)

We understood that we were 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 were 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

Equality, Diversity and Inclusion (EDI) reports were made to the CCG's Quality & Safety Committee and its Governing Body.

Both of these Committees ensured the CCG was compliant with legislative, mandatory, and regulatory requirements regarding equality and diversity and inclusion. National and regional diversity related initiatives were made within the CCG and provided a forum for sharing issues and opportunities as well as monitoring the achievement of key EDI objectives.

Equality Strategy

The CCG's Equality Strategy for 2020-2024 was developed and was applicable for the first quarter of 2022/23. The revised strategy highlights the aims set out within the ‘We are the NHS: People Plan 2020/21 – action for us all’ and outlines our strategic direction in how we foster a culture of inclusion and belonging, take action to develop a diverse workforce that is representative of the communities it serves, train our people, and work together differently to deliver patient care. This commitment will be taken on by the Integrated Care Board from 1 July 2022.

The Equality Delivery System 2 – Our Equality Objectives

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

The CCG used the NHS Equality Delivery System 2 (EDS 2) to continue monitoring our equality objectives outlined below:

Objective 1 – Provide evidence that commissioned services are meeting the needs of patients and providing positive outcomes.

Objective 2 - Monitor and review staff satisfaction to ensure they are engaged, supported and feel valued in their workplace.

Objective 3 – Ensure that the CCG Governing Body actively leads and promotes Equality and Diversity throughout the organisation.

Our Staff – Encouraging Diversity

The CCG 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 continued to offer guaranteed interviews to applicants with a disability who are identified as meeting the essential criteria for any advertised roles. Reasonable adjustments under the Equality Act 2010 were considered and implemented during the recruitment process and during employment.

By working closely with Department for Work & Pensions, the CCG maintained its 'Level 2 Disability Employer' status for 2021/22 by demonstrating commitment to employing the right people for the CCG's business and continually developing CCG's staff.

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 has shown due regard to the Workforce Race Equality Standard (WRES). We did this by seeking assurance of compliance from Trusts and aiming to improve workplace experiences and representation at all levels for black and minority ethnic staff.

Equality Impact Assessments

The CCG's Equality Impact Assessment (EIA) Toolkit was reviewed in 2020. The process was embedded into core business processes and used to provide a comprehensive insight into our local population, patients, and staff's diverse health needs.

The tool covered 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.

The EIA Toolkit was embedded into our governance process and sign off from the relevant committee is required for monitoring and completion.

Accessible Information Standard

The Accessible Information Standard aims 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 (PRGs) in relation to how we can improve our communication methods and make them more accessible for all.

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

Sustainable development

Sustainability is about the effective use of natural resources and behaving in a way that manages and minimises the impact we have on our environment. It required us to pay particular attention to energy, travel, waste, procurement, water, infrastructure and buildings.

As a commissioner of healthcare services and as an employer, the CCG recognised the need to minimise our impact on the environment. Use of technical solutions for meetings (i.e., video/teleconferencing and webinars) are promoted to reduce travel, which in turn reduces the CCG's carbon footprint.

Carbon footprint

The CCG was supported by NHS Property Services to ensure plans to reduce the carbon footprint are in line with the recommendations of the Sustainability Development Unit of NHS England.

Travel

We can improve local air quality and improve the health of our community by promoting active travel to our staff. The CCG supported its staff through a cycle to work scheme.

Initiatives

The CCG and its staff worked hard to identify where we could minimise the impact we have on our environment. We introduced waste recycling, stopped the use of plastic straws and stirrers and witched the purchase of milk in plastic cartons to milk deliveries in glass bottles (which are washed and returned).

These measures are in addition to those already incorporated into our working, such as purchasing recycled photocopying paper and the use of light sensors which detect movement and switch off soon after staff leave their desk.

The CCG was committed to working with its partners on climate change and sustainability. The previous North Integrated Care Partnership (ICP) brought together NHS and Local Authority partners in North Tyneside, Newcastle, Gateshead and Northumberland and had a Forum which is formed of Chief Executives and Accountable Officers of each organisation. The strategic ICP priorities agreed by the North ICP Forum were as follows:

- Climate change and sustainability
- Workforce, employment, and skills
- Healthcare Prevention

The Forum identified climate change and sustainability as one of three top priorities for the area. Climate change organisational leads were identified with a view to sharing best practice and are working on opportunities for local supply, sustainability issues and identification of priority areas for joint working.

Key Issues & Risks

The COVID-19 pandemic has continued to impact on the CCG's ability to meet some of its objectives. However, the CCG worked closely with its partners to reduce the effect of COVID-19 and therefore not all areas were impacted to the same extent.

The risks associated with COVID-19 were:

- That the response to COVID-19 would impact on system's ability to deliver healthcare to meet the needs of the population.
- The ability to support the NHS & social care system to deliver appropriate care to the residents of North Tyneside throughout the COVID-19 pandemic.
- That COVID-19 posed a risk to staff health and CCG operations.

Although steps were taken to minimise these risks during 2020/21, the CCG took the decision to continue to identify the first two risks into 2021/22. This is because the pandemic was continuing and all the effects and impacts of the pandemic were starting to emerge. The third risk also remained on the risk register for continuous monitoring purposes, but it has been noted that it is being managed with necessary steps taken to protect staff and innovative new ways of working to ensure that CCG business has continued.

The following risks were included on the CCG's Risk Register for Quarter 1 of 2022-23:

- Failure to clearly demonstrate compliance with NHS Constitution rights and pledges.
- Commissioned services are not of sufficiently high quality.
- The risk of adult or child safeguarding incident/s or other significant quality failure incident.
- Failure to deliver control total and to financially support services effectively because of activity over performance; failure to make efficiency savings; and/or other factors.
- Nursing homes are rated inadequate by Care Quality Commission (CQC) and/or are in organisational safeguarding, resulting in reduced availability of beds in nursing homes to meet demand
- Risk of not being able to respond to surges in demand leading to a failure to respond effectively to local healthcare needs.
- That delayed ambulance handovers impacts negatively on patient safety and patient flow.
- Risk of not being able to implement New Models of Care to meet the needs of the population
- The timetable, uncertainty, and the use of existing resources to manage the business transfer from the CCG to the (proposed) Integrated Care Board and to ensure arrangements at 'Place' are ready, may result in delayed delivery of day-to-day CCG business, adversely impacting patients and public, and staff morale.

These risks will continue into 2022/23 and will form part of the Integrated Care Board's Risk Register

Accountability Report

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.

Accountability Report

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

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during Quarter 1 of 2022/23, 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

Members Report

Member profiles

Membership of the CCG Governing Body is summarised in table four.

If you would like more information relating to, the CCG profiles of members please email your request to; nencicb-nt.enquiries@nhs.net

Member practices

The CCG was made up of the 25 GP practices in North Tyneside, as listed below:

Table 4: List of GP practices in North Tyneside

North Shields	**Wallsend**
Collingwood Health Group	Bewicke Medical Centre
Nelson Medical Group	Park Road Medical Practice
Redburn Park Medical Centre	Portugal Place Health Centre
Spring Terrace Health Centre	The Village Green Surgery
The Priory Medical Group	
North West	**Whitley Bay**
Lane End Surgery	Beaumont Park Medical Group
Mallard Medical Group	Monkseaton Medical Centre
Northumberland Park	Park Parade Surgery
Stephenson Park Health Group	Bridge Medical
Swarland Avenue Surgery	49 Marine Avenue Surgery
Wellspring Medical Practice	Whitley Bay Health Centre
West Farm Surgery	Marine Avenue Medical Centre
Wideopen Medical Centre	
Woodlands Park Health Centre	

CCG Council of Practices

The Council of Practices comprises a nominated GP from each of the 25 GP practices that form the CCG. Its terms of reference require it to meet at least four times a year. In Quarter 1 of 2022/23 the Council of Practices met once.

Composition of Governing Body

The membership of the CCG Governing Body was set out in the CCG constitution. The composition of the Governing Body for Quarter 1 of 2022/23 is shown in table five.

Table 5: Membership of the CCG Governing Body

Title	Name	Gender
Clinical Chair	Dr Richard Scott	Male
Chief Officer	Mr Mark Adams	Male
Deputy Lay Chair	Ms Mary Coyle MBE DL	Female
Lay Member (audit and governance)	Mr David Willis OBE	Male
Lay Member (patient and public involvement)	Mrs Eleanor Hayward	Female
Secondary Care Specialist Doctor	Dr Neela Shabde	Female
Executive Director of Nursing & Chief Operating Officer (registered nurse)	Dr Lesley Young-Murphy	Female
Chief Finance Officer	Mr Jon Connolly	Male
Medical Director	Dr Alexandra Kent	Female

Table 6: Non-voting members of the Governing Body

Title	Name	Gender
Director of Commissioning & Planning	Mrs Anya Paradis	Female
Director of Contracting & Finance	Mr Jeff Goldthorpe	Male
Director of Quality and Patient Safety	Mrs Maureen Grieveson	Female
Head of Governance	Mrs Irene Walker	Female
Director of Public Health	Mrs Wendy Burke	Female

Committee(s), including Audit Committee

Membership of the CCG Audit Committee

Table 7: Audit Committee

Title	Name	Gender
Chair of Audit Committee	Mr David Willis OBE	Male
Member of Audit Committee	Ms Mary Coyle MBE DL	Female
Member of Audit Committee	Dr Shaun Lackey	Male

Membership of the Clinical Commissioning and Contracts Committee

The Clinical Commissioning and Contracts Committee reported directly to the Governing Body and assists the Governing Body in its duties to promote a comprehensive health service, reduce inequalities and promote innovation.

Table 8: Clinical Commissioning and Contracts Committee

Role	Name of post holder	Gender
Chief Officer	Mr Mark Adams	Male
Executive Director of Nursing & Chief Operating Officer	Dr Lesley Young-Murphy	Female
Medical Director	Dr Alexandra Kent	Female
Chief Finance Officer	Mr Jon Connolly	Male
Clinical Director	Dr Shaun Lackey	Male
Clinical Director	Dr Steve Parry	Male
Director of Commissioning & Planning	Mrs Anya Paradis	Female
Director of Quality and Patient Safety	Mrs Maureen Grieveson	Female
Director of Contracting & Finance	Mr Jeff Goldthorpe	Male
Practice Manager	Mr Philip Horsfield	Male
Deputy Director of Transformation	Mr Walter Charlton	Male
Deputy Director Commissioning and Corporate Development	Mr Gary Charlton	Male
Deputy Director of Commissioning	Mrs Janet Arris	Female
Head of Governance	Mrs Irene Walker	Female

Role	Name of post holder	Gender
Head of Planning & Commissioning	Mr Steve Rundle	Male
Head of Contracting	Mrs Kaye McEntee	Female

More details about the work of the CCG, its Governing Body and its committees are given in the Governance Statement.

Register of Interests

The CCG had arrangements in place for the effective management of conflicts of interest. Details of company directorships and other significant interests held by members of the Governing Body and other CCG committees are recorded in the Register of Interests.

If you would like any further information relating to the CCG Register of Interests please email your request to - nencicb-nt.enquiries@nhs.net

Personal Data Related Incidents

There were no Serious Untoward Incidents relating to data security breaches in Quarter 1 of 2022/23. No data incidents were reported to the Information Commissioner's Officer during Quarter 1 of 2022/23.

Modern Slavery Act

North Tyneside CCG fully supported 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.

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Officer to be the Accountable Officer of North 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 Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

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

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

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

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

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

Disclosures:

- The CCG reported three breaches in relation its to conflicts of interest of interest policy and this was reported to the auditors.

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 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

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

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

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.

Scope of responsibility

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

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

Governance arrangements and effectiveness

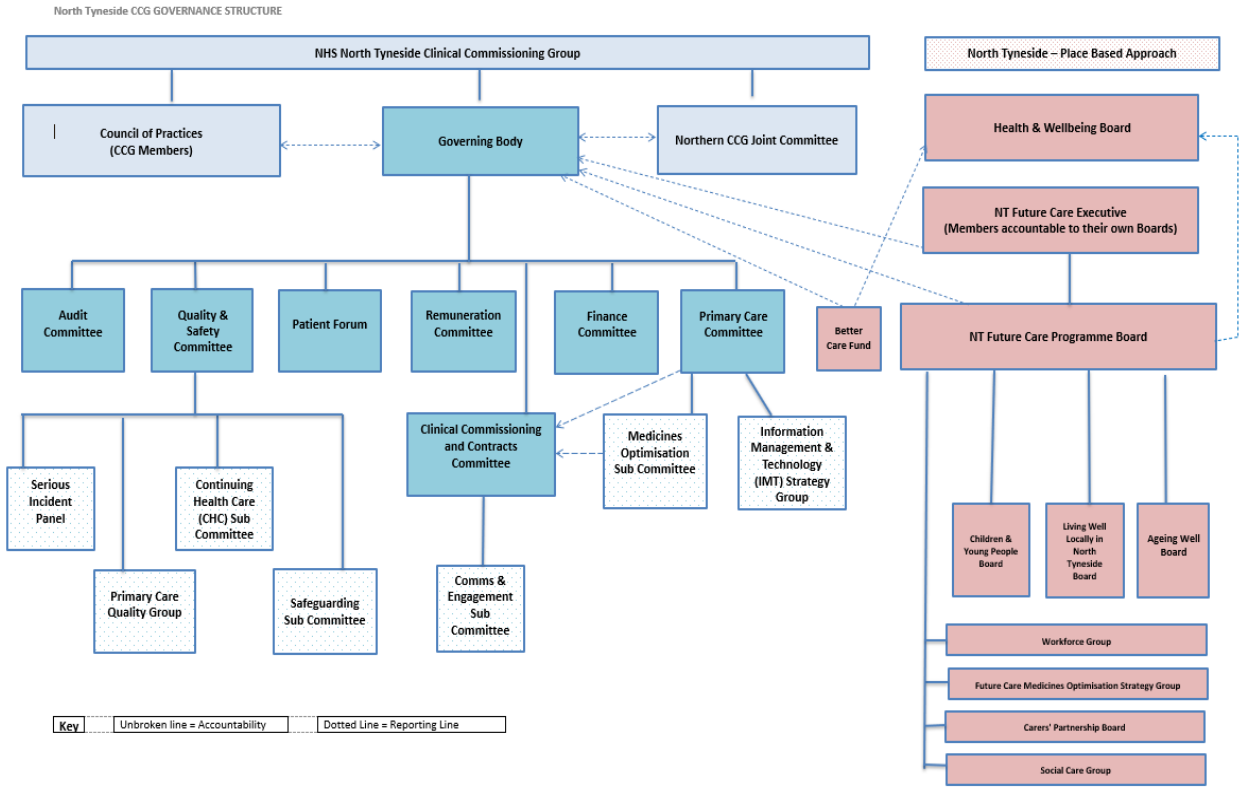
The main function of the governing body was to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

CCG constitution

The CCG had a fully compliant constitution at the time of authorisation, endorsed by the member practices and approved by NHS England. The CCG Constitution was updated to version 17.1, approved by NHS England on 10 May 2021, and is available here www.northtynesideccg.nhs.uk/news-media/publications/constitution/ .

The CCG governance structure is shown in figure 11.

Figure 11: North Tyneside CCG Governance Structure



The scheme of reservation and delegation was part of the CCG's constitution and sets out the split of responsibilities and decision making between the membership body (Council of Practices) and the Governing Body.

Council of Practices

The 25 nominated member practice representatives met as the Council of Practices. The responsibilities of the Council of Practices are set out in the CCG Constitution and there are agreed terms of reference.

The Council of Practices acted as a forum for clinical engagement and provides an area for members to give input and insight into the development of ongoing clinical transformation, new models of care and primary care.

On behalf of the CCG, the Council of Practices held to account the Governing Body through two-way communication about the overall performance of the Group. The Council of Practices was chaired by the Clinical Chair of the CCG, who was also chair of the Governing Body. GP practice managers attend the Council of Practices but are not voting members.

The Council of Practices was required by its terms of reference to meet no less than four times a year. It met once in Quarter 1 of 2022/23.

In Quarter 1 of 2022/23 discussions at meeting of the Council of Practices included:

- Performance
- Finance
- Celebrating Wins in Primary Care
- Public Health and Primary Care
- Penicillin Leaflet

The Council of Practices reviewed its effectiveness at its meeting in March 2022 and determined that it had been effective in the discharge of its duties during 2021/2022.

CCG Governing Body

The Governing Body was constituted in line with the Health and Social Care Act 2012, and associated CCG regulations.

The membership of the NHS North Tyneside CCG Governing Body was set out in the CCG Constitution.

The membership of the Governing Body between 1 April 2022 and 30 June 2022 was set out in the accountability report.

The Governing Body was the main decision-making committee of the CCG. A list of voting members is shown at table five and the non-voting members are shown at table six.

The Governing Body usually held meetings in public thereby ensuring accountability and transparency of decision making. However, this has not been possible during the COVID-19 pandemic: the CCG continued to provide the agendas, papers, and minutes of each meeting on its website.

The Governing Body developed, implemented, and delivers the strategic priorities of the Group, working with the Council of Practices, and the Accountable Officer.

The Governing Body had delegated authority for all decisions of the CCG, except those explicitly reserved to the Council of Practices. It was accountable to the CCG for all decisions which it makes and was held to account by the CCG through its representative committee, the Council of Practices.

The Standing Orders stated that the Governing Body would meet no less than four times per year. During the quarter ending 30 June 2022, the CCG Governing Body met three times with papers posted in public in advance of the meeting. The Chair was present at all of these meetings.

The 2021/22 Annual Accounts and Annual Report were presented in public at the CCG Annual Public Meeting on 28 June 2022. Following the dissolution of the CCG on 30th June 2022, the Quarter 1 of 2022/23 Annual Accounts and Annual Report will be presented in public by the North East & North Cumbria Integrated Care Board.

Throughout Quarter 1 of 2022/23, the CCG Governing Body was supported by seven committees, each chaired by a lay member of the Governing Body (except the Clinical Commissioning and Contracts Committee which is chaired by the Chief Officer): the Audit Committee, the Remuneration Committee, the Clinical Commissioning and Contracts Committee, the Quality and Safety Committee, the Patient Forum, the Finance Committee and the Primary Care Committee.

The CCG Governing Body received regular reports from its committees on the quality of commissioned services, finance, performance, public & patient involvement, and governance. Other items of business discussed by Governing Body in Quarter 1 of 2022/23 have included:

- COVID-19
- Performance, quality and safety
- Finance
- Patient Forum
- Risk and assurance
- Ockenden Report on Maternity Services
- Use of Seal: 2021/22 & QUARTER 1 OF 2022/23

The Governing Body reviewed its effectiveness at its meeting in January 2022 and determined that it had been effective in the discharge of its duties during 2021/2022.

Audit Committee

The Audit Committee was a committee of the Governing Body. It was in operation throughout the 3-month period ending 30 June 2022.

The committee was established in April 2013 and remained in place until CCG dissolution on 30 June 2022. The roles and responsibilities of the committee were set out in the CCG Constitution.

The committee provided the CCG Governing Body with an independent and objective view of the CCG's system of internal control, including financial systems, business systems, performance information, financial information and compliance with laws, regulations and directions governing the CCG.

The Audit Committee had agreed terms of reference, which is incorporated into the CCG's Constitution. The committee is comprised of two independent members, and one other member with the relevant skills and experience as nominated by the Governing Body - as follows:

- CCG Lay Member for Governance and Audit (Chair) - David Willis OBE
- CCG Deputy Lay Chair - Mary Coyle MBE DL
- Dr Shaun Lackey

All three had been members of the Audit Committee during Quarter 1 of 2022/23.

The CCG's internal and external auditors, Chief Finance Officer, Director of Contracting & Finance, and Head of Governance routinely attend the Audit Committee. The Chief Officer attends at least annually, and the Counter Fraud Officer has a standing invitation.

In accordance with the terms of reference, the Audit Committee met not less than five times per financial year. In Quarter 1 of 2022/23 the Audit Committee met once 'virtually'. The Audit Committee members met privately and then with the internal and external auditors prior to the CCG officers joining the meeting. The Chair was present at the meeting.

The Audit Committee Chair provided a written briefing to all members of the CCG Governing Body after each meeting of the Audit Committee.

The Audit Committee received assurances from the Quality & Safety Committee (written) and the Finance Committee (verbal).

The Audit Committee's main activities throughout Quarter 1 of 2022/23 have been:

- Internal Audit: Progress report
- Head of Internal Audit Opinion 2021/22
- External Audit: Completion Report
- Chief Finance Officer's update
- Annual Accounts (draft) 2021/22
- Receiving assurances on Quality and Safety

The Audit Committee reviewed its effectiveness at its meeting in January 2022 and determined that it had been effective in the discharge of its duties during 2021/2022.

Remuneration Committee

The Remuneration Committee was in operation throughout Quarter 1 of 2022/23.

The committee was established in April 2013 and remained in place until CCG dissolution on 30 June 2022.

The Remuneration Committee was an advisory committee which made recommendations to the CCG Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the group and on determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme.

The committee was comprised entirely of lay members, as follows:

- CCG Deputy Lay Chair (Chair) - Mary Coyle MBE DL
- CCG Lay Member for Patient and Public Involvement - Eleanor Hayward
- CCG Lay Member for Governance and Audit - David Willis OBE

All members were in post at the time of CCG authorisation. All members were in post during Quarter 1 of 2022/23.

The CCG Head of Governance attended the Remuneration Committee, and the Chief Officer, Executive Director of Nursing & Chief Operating Officer and Head of Human Resources (from the Commissioning Support Unit) were in attendance as required.

When an individual was the subject matter of discussion at any time during the committee meeting, that individual is excluded from that part of the meeting. The quorum for the meeting was two members. As there are three members the committee remained quorate even when a member is excluded. The Chair was present at all meetings.

The roles and responsibilities of the committee are set out in the committee's terms of reference, which was incorporated into the CCG's Constitution. Meetings were held as and when required, but not less than once per financial year. The committee met once during Quarter 1 of 2022/23.

The principal items of business were:

- Remuneration and staff report
- Staff Reward on GGC Close Down

Clinical Commissioning and Contracts Committee

The Clinical Commissioning and Contracts Committee was a committee of the Governing Body. The responsibilities of the Clinical Commissioning and Contracts Committee were set out its agreed terms of reference.

The Clinical Commissioning and Contracts Committee assisted the Governing Body in its duties to promote a comprehensive health service, reduce inequalities and promote innovation. It was chaired by the Chief Officer. The membership of the Clinical Commissioning and Contracts Committee is shown at table eight.

The Clinical Commissioning and Contracts Committee meet not less than four times each year.

The Clinical Commissioning and Contracts Committee met two times in Quarter 1 of 2022/23. The main items of business were:

- Mental Health Support Teams for Schools
- Hydroxychloroquine Screening
- CCG CVS Small Grants Scheme – End of Scheme Report and Future Investments
- Committee Attendance Record
- Risk Assurance Framework Q4 2021/22
- Hospice Funding Re-alignment & Sustainability
- St Oswald's Hospice Residential Short Breaks for Children
- Ophthalmology
- Coping with Cancer

The Clinical Commissioning and Contracts Committee reviewed its effectiveness at its meeting in February 2022 and determined that it had been effective in the discharge of its duties during 2021/2022.

Quality and Safety Committee

The Quality and Safety Committee was in operation throughout Quarter 1 of 2022/23. The roles and responsibilities of the committee are set out in its agreed terms of reference.

The Quality and Safety Committee was responsible for ensuring 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. The Quality and Safety Committee provided assurances to Governing Body and Audit Committee.

The Quality and Safety Committee membership comprises:

Deputy Lay Chair (Chair of the Committee)	Ms Mary Coyle MBE DL
Secondary Care Specialist Doctor	Dr Neela Shabde
Member Practice GP Representative/GP Safeguarding Lead	Dr Riaan Swanepoel
Executive Director of Nursing & Chief Operating Officer	Dr Lesley Young-Murphy
Medical Director	Dr Alexandra Kent
Head of Planning & Commissioning	Mr Steve Rundle
Director Patient Quality & Safety	Mrs Maureen Grieveson
Head of Governance	Mrs Irene Walker
Designated Nurse Safeguarding Children	Mrs Jan Hemingway
Designated Nurse Safeguarding Adults	Mr Adrian Dracup
Deputy Director Commissioning & Corporate Development	Mr Gary Charlton
Deputy Director Commissioning & Performance	Mrs Janet Arris

The Quality and Safety Committee has met a total of two times in Quarter 1 of 2022/23. The Chair was present at all of the meetings. The Quality and Safety Committee provides regular reports to the Governing Body.

The main items of business throughout Quarter 1 of 2022/23 have been:

- Mental Health Support Teams for Schools
- Hydroxychloroquine Screening
- CCG CVS Small Grants Scheme – End of Scheme Report and Future Investments
- Committee Attendance Record
- Risk Assurance Framework Q4 2021/22
- Quality & Risk Update
- Procurement Progress Report: January, February & March 2022
- Hospice Funding Re-alignment & Sustainability
- St Oswald's Hospice Residential Short Breaks for Children
- Ophthalmology
- Coping with Cancer
- Finance Update

Patient Forum

The Patient Forum was in operation throughout Quarter 1 of 2022/23.

There was one meeting of the Patient Forum during Quarter 1 of 2022/23, and the Chair of the Committee attended the meeting.

The Patient Forum assisted the CCG in its duty to secure public involvement and engagement in the planning, development, and operation of commissioning arrangements, providing a clear patient and carer voice direct to the Governing Body.

The Patient Forum was chaired by the CCG Lay Member for Public and Patient Involvement, Mrs Eleanor Hayward and is facilitated by the North Tyneside Community and Health Care Forum. Dr Lesley Young-Murphy, Executive Director of Nursing and Chief Operating Officer, was the lead officer for the Patient Forum.

The Patient Forum aimed to have membership from each of the 25 GP Practices in North Tyneside. Agenda items for the Forum are a mix of CCG areas for discussion and member-led issues.

The Patient Forum was strong, robust and acts as a critical friend to the CCG and its Governing Body. Members were encouraged to challenge and debate throughout all engagement processes. The strength of the Forum is the dedication and commitment within the membership as well as their passion for local health services.

The Patient Forum was supported by a range of working groups. The topics are decided by Forum members and were compatible with CCG plans and priorities.

Finance Committee

The Finance Committee was in place during Quarter 1 of 2022/23. There were agreed terms of reference for the committee. The remit of the committee was to oversee the financial position of the CCG.

The committee's agenda was driven by the priorities identified by the CCG and the associated risks.

The committee membership was as follows:

- Lay Member for Patient and Public Involvement (Chair) – Mrs Eleanor Hayward
- Lay Member for Governance and Audit – Mr David Willis OBE
- Chief Finance Officer - Mr Jon Connolly
- Clinical Director – Dr Alexandra Kent (Medical Director)

The terms of reference required that the Finance Committee will meet a minimum of four times each year. The committee met once during Quarter 1 of 2022/23. The Chair was present at the meeting.

The principal item of business was:

- Finance update

Primary Care Committee

The Primary Care Committee was a committee of the Governing Body.

The committee functions as a corporate decision-making body for the management of delegated functions. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions as set out in Schedule 2 (delegated functions) and in accordance with section 13Z of the NHS Act.

The committee was established in April 2015 and was in place during Quarter 1 of 2022/23. The roles and responsibilities of the committee are set out in the CCG Constitution.

The committee membership was as follows:

- CCG Deputy Lay Chair - Ms Mary Coyle MBE DL **(Chair and voting member)**
- A Director from North Tyneside CCG – Dr Lesley Young Murphy, or deputy **(voting member)**
- Chief Finance Officer – Mr Jon Connolly or deputy **(voting member)**
- Director (or designate) from NHS England (**non-voting member**)
- Clinical Director or their nominated GP (**non-voting member**)
- Practice Manager – Mr Philip Horsfield (**non-voting member**)

There was a standing invitation to the meetings of this committee to specified partners in a non-voting capacity, namely the North Tyneside Health and Wellbeing Board and Healthwatch North Tyneside.

The terms of reference required that the Primary Care Committee met not less than four times per year in public. The committee met once in public during Quarter 1 of 2022/23. The Chair was present at the meeting.

The principal items of business were:

- Operational Update
- Prescribing Engagement Scheme
- North Tyneside Induction Pilot Report
- Finance Update
- Primary Care Quality Update
- Internal Audit

The Committee reviewed its effectiveness at its meeting in January 2022 and determined that it had been effective in the discharge of its duties during 2021/2022.

Attendance records for CCG Governing Body and committees

Table 9: Attendance records for the Governing Body and committees for Quarter 1 of 2022/23

Meetings for Q1 2022/23		Governing Body		Audit Committee		Q&S Committee		Remuneration Committee		Finance Committee		Primary Care Committee		Patient Forum		Clinical Commissioning & Contracts Committee	
Name	**Post Held**	**No. of Meetings held**	**No. of Actual Attendances**	**No. of Meetings held**	**No. of Actual Attendances**	**No. of Meetings held**	**No. of Actual Attendances**	**No. of Meetings held**	**No. of Actual Attendances**	**No. of Meetings held**	**No. of Actual Attendances**	**No. of Meetings held**	**No. of Actual Attendances**	**No. of Meetings held**	**No. of Actual Attendances**	**No. of Meetings held**	**No. of Actual Attendances**
Mr Jon Connolly	Chief Finance Officer	3	3							1	1	1	1			2	0
Mr Dave Willis OBE	Lay member (Audit)	3	2	1	1			1	1	1	1						
Mrs Eleanor Hayward	Lay member (PPI)	3	3					1	1	1	1			1	1		
Dr Neela Shabde	Secondary Care Specialist Doctor	3	3			1	1										
Dr Lesley Young-Murphy	Executive Director of Nursing & Chief Operating Officer	3	3			1	1					1	1			2	1
Dr Alex Kent	Medical Director	3	2			1	1			1	0					2	1
Dr Shaun Lackey	Clinical Director/Audit Committee Member			1	0											2	2
Mr Philip Horsfield	Practice Manager Clinical Commissioning & Contracts Committee Member											1	0			2	1
Mrs Maureen Grieveson	Director of Quality & Patient Safety					1	1									2	0
Mrs Irene Walker	Head of Governance					1	0									2	1
Mrs Anya Paradis	Director of Commissioning & Planning															2	2
Mrs Jan Hemingway	Designated Nurse Safeguarding Children					1	1										
Director NHS England or Designate	Director, NHS England											1	0				
Mr Steve Rundle	Head of Planning & Commissioning					1	1									2	2
Mr Wally Charlton	Deputy Director of Transformation															2	1
Dr Riaan Swanepoel	GP representative					1	1										
Dr Steve Parry	Clinical Director															2	0
Mr Jeff Goldthorpe	Director of Contracting & Finance															2	2
Clinical Director NTCCG or Nominated GP	Clinical Director, NTCCG											1	1				
Mrs Kaye McEntee	Head of Contracting															2	2
Mr Gary Charlton	Deputy Director of Commissioning & Corporate Development					1	0									2	1
Mrs Janet Arris	Deputy Director of Commissioning					1	0									2	2
Mr Adrian Dracup	Designated Nurse Safeguarding Adults					1	1										

UK Corporate Governance Code

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

Discharge of Statutory Functions

In light of recommendations of the 2013 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations.

As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

Risk management arrangements and effectiveness

The CCG's risk management strategy was underpinned by a risk management policy approved by Governing Body. The aims of the policy were to:

- Ensure that the CCG assesses its risk appetite
- Ensure that risks to the achievement of the CCG's objectives are understood and effectively managed
- Ensure that the risks to the quality of services that the organisation commissions from healthcare providers are understood and effectively managed
- Assure the public, patients, staff, and partner organisations that the CCG is committed to managing risk appropriately
- Protect the services, staff, reputation, and finances of the CCG through the process of early identification of risk, risk assessment, risk control and mitigation

Risk was identified by the relevant director and is recorded on the Risk Assurance Framework, which captures how the risk was evaluated and controlled.

The Risk Assurance Framework was reviewed quarterly by committees of the Governing Body, each reviewing and agreeing the risks which fall under their remit to ensure that risks are properly identified, assessed and are being managed in line

with the CCG's risk appetite. This approach ensured that risks are managed effectively towards achieving their target risk score.

As the CCG focused on its role as a commissioner of safe and high-quality services, it also sought to embed the principles and practice of risk management into its commissioning function.

As a commissioner, the CCG sought to ensure that all services commissioned meet nationally identified standards and were managed through the contracting process.

Equality Impact Assessments were completed for all CCG policies and projects, thereby ensuring integration into core business.

Incident reporting was openly encouraged and reported through the Quality and Safety Committee. All projects and Quality, Innovation Productivity & Prevention (QIPP) schemes were risk assessed and managed appropriately through the Clinical Commissioning and Contracts Committee. Financial risk was overseen by the Finance Committee, and clinical risk by the Clinical Commissioning and Contracts Committee and Quality and Safety Committee.

The CCG's Patient Forum worked with the CCG to identify risks to services. Public stakeholders are involved in managing risks contributing to CCG engagement, consultations, and plans.

Capacity to handle risk

Governance structures ensure responsibility for the identification, evaluation and management of risk was embedded.

The Governing Body provides clear direction and leadership through approval of the risk policy, setting the risk appetite, receiving assurances from its committees that risk is properly managed and escalated through the Risk Assurance Framework (RAF). The RAF identifies the risks to compliance with statutory obligations and these are categorised as strategic risks.

The Governing Body received assurance on the effective management of risk by receiving the RAF every quarter. The RAF aligned each corporate risk to the CCG's corporate objectives and explains the controls in place to achieve the target risk level (target risk score). Assurances were recorded on the RAF using the 'three lines of defense' methodology.

The governance structure assigned the oversight of corporate risks to the relevant Governing Body committee, i.e., Clinical Commissioning and Contracts Committee, Quality and Safety Committee and Finance Committee. In this way the CCG was assured that risks are reviewed by those with expert subject knowledge and the authority to drive the management of risk. These were then then reviewed by the Audit Committee who provided assurance to the Governing Body that the RAF reports the effective identification and management of risk.

Risk management training was provided on an ongoing basis through instruction from the Head of Governance on induction and thereafter through the continuous interpretation and application of the risk policy, supported by the Head of Governance.

The organisation has learned from best practice and its approach to risk management includes a frequent reporting cycle; the consolidation of the corporate risk register and assurance framework into one document, i.e., the RAF; the separate identification of strategic risks and corporate risks; the recording of target risk scores; and inclusion of the 'three lines of defence' assurance methodology in the RAF. Internal Audit provided substantial assurance in Quarter 1 of 2022/23 for the CCG's Governance Structures and Risk Management Arrangements.

Risk assessment

Our risk policy set out how risks are assessed and scored including gross, residual and target risk scores.

Key risks managed throughout Quarter 1 of 2022/23 are summarised as follows:

- Risk of failure to clearly demonstrate compliance with NHS Constitution rights and pledges
- Risk that commissioned services are not of sufficiently high quality
- Risk of adult or child safeguarding incident or other significant quality failure incident
- Risk that delayed ambulance handovers impacts negatively on patient safety and patient flow
- Nursing homes are rated inadequate by CQC and/or are in organisational safeguarding, resulting in reduced availability of beds in nursing homes to meet demand
- Children coming into care may not receive a timely statutory health assessment resulting in potential unmet health needs and the CCG breaching its statutory duties
- Possible delayed payments to Nursing Home and domiciliary care providers in respect of CHC patients due to the Local Authority giving notice on CHC case management, and payments. This may impact the CCG/ICB, patients and LA both in terms of making payments, transition between social care and CHC and cash flow for providers.
- Risk of closure of Beaumont Park GP surgery due to premises issues, resulting in potential disruption to primary care services to patients if unresolved. A site for relocation has been identified but the land sale has not been agreed leaving no viable alternative or solution to practice issues

- Risk of respiratory infections affecting public and patients' health and putting pressure on health and care services
- Failure to deliver control total and to financially support services effectively because of activity over performance; failure to make efficiency savings; and/or other factors
- Risk of not being able to implement New Models of Care to meet the needs of the population
- The timetable, uncertainty, and the use of existing resources to manage the business transfer from the CCG to the (proposed) Integrated Care Board and to ensure arrangements at 'Place' are ready, may result in delayed delivery of day-to-day CCG business, adversely impacting patients and public, and staff morale.
- Unable to respond effectively to surges in demand leading to a failure to respond effectively to local healthcare needs

The CCG had risk mitigation plans in place to reduce risks to the target level and these are documented on the RAF and assured by Audit Committee.

The CCG had effectively managed its risks in Quarter 1 of 2022/23. Its systems have been in place for the quarter under review.

The ICB will continue to manage risks associated with patient safety and the quality of services and achievement of performance targets with rigor.

Other sources of assurance

Internal Control Framework

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

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

The CCG system of internal control includes:

- A Governing Body that ensures that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently, and economically and in accordance with the CCG's principles of good governance
- An approved CCG constitution, incorporating standing orders, scheme of delegation and prime financial policies
- A Governance Handbook

- A committee structure, where each committee has a vital role in contributing to the establishment of an effective governance infrastructure
- An appointed Accountable Officer who is responsible (amongst other duties) for ensuring that the clinical commissioning group fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money
- The Accountable Officer, working closely with the chair of the Governing Body, ensures that proper constitutional, governance and development arrangements are put in place to assure the members (through the Governing Body) of the organisation's ongoing capability and capacity to meet its duties and responsibilities
- An appointed Chief Finance Officer who is responsible for (amongst other duties) overseeing robust audit and governance arrangements leading to propriety in the use of the CCG's resources; and
- Staff members who are responsible for reporting problems of operations, monitoring and improving their performance, and monitoring non-compliance with the corporate policies and various professional codes, or violations of policies, standards, practices, and procedures.

Internal audit service

One important feature of the system of internal control is the work of the internal audit service. Through a systematic programme of work, internal audit provide assurance on key systems of control.

The Head of Internal Audit reports to the Audit Committee and had direct access to the Audit Committee Chair as required.

Policies

Another key feature of the system of internal control is the application of a range of policies and procedures.

The CCG had a suite of policies in place, including corporate policies, HR policies, and Information Governance policies. Each policy has a named director lead and staff are advised and reminded of the CCGs polices. Polices are reviewed at their due date.

The CCG Quality and Safety Committee received assurance reports relating to statutory and mandatory training, compliance with health and safety, fire safety and first aid at work, information governance, equalities and diversity, and business continuity planning. There was commitment to continuing professional development,

with robust processes in place for staff supervision, training, objective setting, performance review and appraisal.

The CCG had a Freedom to Speak Up: Raising Concerns (Whistleblowing) policy which was monitored by the Audit Committee.

Annual audit of conflicts of interest management

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

> The CCG has carried out an annual internal audit of conflicts of interest for 2021/22 and received substantial assurance for this audit. No issues were identified with the design of or compliance with the control framework in the areas reviewed.

This audit report was issued March 2022.

Data Quality

The CCG had a data quality policy. This policy defines data and explains data standards and the importance of data validation.

Robust data was provided to the Council of Practices, the Governing Body, and other committees of the CCG.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information.

We established an information governance management framework and developed, information governance processes and procedures in line with the Data Security and Protection toolkit.

We ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff were aware of their information governance roles and responsibilities.

There were processes in place for incident reporting and investigation of serious incidents.

We had in place information risk assessment and management procedures and continued to fully embed an information risk culture throughout the organisation against identified risks.

The CCG submitted its 'Standards Met' Data Security and Protection toolkit for 2021/22 on 30th June 2022.

The CCG complied with its statutory duty to respond to requests for information. During the reporting period April to June 2022 , the CCG received 39 requests under the Freedom of Information Act 2000 and 9 subject access requests under the Data Protection Act 2018. All the requests were responded to within the statutory timescales.

Business Critical Models

The CCG had a Business Continuity Management Plan, approved by the Quality and Safety Committee in July 2021. The CCG did not have any business-critical models as defined by Macpherson.

Third party assurances

The CCG relied on several external support services providers, including:

The NHS Shared Business Service (SBS)

Electronic Staff Records (ESR) (McKesson)

NHS Business Services Authority (BSA)

Table 10: Third-party assurances

Assurance Source	Commentary
Payroll Services	The auditors have not identified, as part of their internal audit work for 2021/22, any fundamental weaknesses in the systems reviewed that would put the achievement of the systems' objectives at risk and / or major and consistent non-compliance with the control framework that require management action as a matter of urgency. Bridging Letter Q1 2022/23
North of England Commissioning Support Unit (NECS)	The Report on Internal Controls (Type II) Finance and Payroll 1 April 2021 to 31 March 2022, provides a qualified opinion. This is because the following control objectives were not achieved:

Assurance Source	Commentary
	• Credit notes raised are valid, accurate and processed in a timely manner. • Amendments to user access rights are subject to the appropriate level of approval. • Leavers access rights are removed from the system in a timely manner. • Changes processed by the CSU to staff standing data are valid and are processed accurately, completely and in a timely manner. <u>Bridging Letter Q1 2022/23</u> For the period 1st April 2022 to 30th June 2022 and for the control environment: • There have been no significant changes to the Description within the latest report. • There have been no changes to the risks within the in-scope control environment that would give rise to changes to any of the control objectives listed in the last report. • There has been no reduction in the coverage of risk provided by the control objectives for the services covered per the last report. • There have been no changes to the control activities within our control environment, significant enough to cause one or more of the existing control objectives not to be met. • Control activities listed within the report have been operationally effective.
The NHS Shared Business Service (SBS)	The Independent service auditor's assurance report (ISAE 3402) on controls at NHS Shared Business Services Limited for the period 1st April 2021 to 31st March 2022 provided a qualified opinion. This is because the following control objective was not achieved: • Controls exist to provide reasonable assurance that equipment and facilities are protected from damage by fire, flood and other similar environmental hazards and that physical security is adequate. <u>Bridging Letter Q1 2022/23</u> For the period of 1st April 2022 through to 30th June 2022, to our knowledge, there have been no changes to the internal controls for Finance and Accounting or Procurement (NHS SBS), which were described in the ISAE3402 21/22 Reports, that could materially or adversely affect such internal controls subsequent to the date of the ISAE3402 2021/22 Reports that have not been previously disclosed within the ISAE3402 21/22 Reports.

Assurance Source	Commentary
Primary Care Support Services (Capita Business Services Limited)	The ISAE3402 Service Auditor Report in respect of primary care support England (PCSE) services from 1 April 2021 to 31 March 2022 provides a qualified opinion. This is because the auditors identified a qualification relating to the following control objectives: • Controls provide reasonable assurance that GPs and Other Medical Practitioners (OMPs) pensions are calculated and deducted / paid completely and accurately based on a signed request form / authorised request. • Controls provide reasonable assurance that the upload process of the payment files generated from PCSE Online to ISFE is performed completely and accurately. • Controls provide reasonable assurance that logical access by internal Capita staff to NHAIS, Ophthalmic System (OPS) and PCSE Online is restricted to authorised individuals. • Controls provide reasonable assurance that logical access by internal Capita staff to ISFE, Local Pharmacy Application (LPA), PCSE Online and Pensions Online (POL) are restricted to authorised individuals. <u>Bridging Letter Q1 2022/23</u> For 2021/22, the auditors noted exceptions on 8 out of 17 control objectives. The report provided a Qualified Opinion that the exceptions were minor. NHS England continue to work with Capita to assure the control measures in place are applied consistently by the operational teams and to address the improvement actions identified.
NHS Business Service Authority (prescription payment process)	The Type II ISAE 3402 Report for the period 1 April 2021 to 31 March 2022 relating to the NHS Business Services Authority: Prescription Payments Process provides a qualified opinion because controls were not suitably designed and did not operate effectively during the period 1 April 2021 to 31 March 2022 to achieve the following control objective: • Controls are in place to provide reasonable assurance that access to systems is appropriately restricted. <u>Bridging Letter Q1 2022/23</u> There have been no changes to the control environments of the stated services.
NHS GP Payment Service (NHS Digital)	The Independent service auditor's assurance report (Type II ISAE 3000 Report) for General Practitioners for the period 1 April 2021 to 31 March 2022 provided a qualified opinion. This is because the following control objectives were not achieved:

Assurance Source	Commentary
	• Controls are in place to provide reasonable assurance that system change cannot be undertaken unless valid, authorised and tested. • Controls are in place to provide reasonable assurance that access to systems is controlled. Bridging Letter Q1 2022/23
Local Counter Fraud Specialist	The CCG's Local Counter Fraud Specialist is required to submit an annual Counter Fraud Functional Standard Review (CFFSR) to the NHS Counter Fraud Authority (NHSCFA) in relation to the CCG's anti-fraud, bribery and corruption arrangements, which provides an overview of the CCG's counter fraud activity, progress against NHSCFA requirements and assists the CFO and audit committee in monitoring and managing the counter fraud service. The completed SRT for 2021/2022, with an overall rating of 'green' was reviewed and approved by both the audit committee chair and chief finance officer prior to submission by the deadline of 17 June 2022. The CCG has not been subject to an NHSCFA quality inspection in 2021/22. Bridging Letter Q1 2022/23
Electronic Staff Records (ESR) (McKesson)	The Electronic Staff Record Programme (ESR) ISAE 3000 Type II Report: 01 April 2021 to 31 March 2022 provided a qualified opinion. This is because the controls necessary to ensure that access to the development and production areas of the NHS hub was controlled and appropriately restricted, were not in place from 1 April 2021 to 6 June 2021 but were implemented on 7 June 2021. As a result, there were insufficient logical access controls in place to appropriately restrict access to the development and production area of the NHS hub for part of the reporting period and therefore controls were not suitably designed to achieve Control Objective 2 "Controls provide reasonable assurance that security configurations are created, implemented and maintained to prevent inappropriate access" during the period 1 April 2021 to 6 June 2021. Bridging Letter Q1 2022/23 There have been no changes to the control environments of the stated services.

Control Issues

Significant control issues are those issues that might prejudice the achievement of priorities; undermine the integrity or reputation of the CCG and/or wider NHS; make it harder to resist fraud or other misuse of resources; have a material impact on the accounts; or put data integrity at risk.

The CCG had in place a robust system of internal control. The CCG had assurances from the Head of Internal Audit and from other sources to support this assessment.

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

The Governing Body received reports from its relevant committees (Finance Committee, Clinical Commissioning and Contracts Committee, Quality & Safety Committee and Audit Committee) providing assurance that the CCG uses its resources economically, efficiently and effectively.

The CCG budget comprised of the commissioning budget and the operating budget. The Governing Body received regular budget reports throughout the year.

The CCG commissioning budget was deployed to commission healthcare for the population of North Tyneside, in line with national guidance.

During Quarter 1 of 2022/23 the CCG worked in close partnership with local healthcare providers and other CCGs within the Integrated Care Partnership (ICP) to ensure that resources were utilised in the most effective way possible.

The CCG external auditors have concluded that ‘in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.’

The Head of Internal Audit Opinion provided 'substantial assurance' for Q1 2022/23.

In respect of the CCG operating budget, there was an agreed staffing structure, balancing the roles of clinical leaders, including the Clinical Chair, Medical Director, Executive Director of Nursing and Chief Operating Officer, Clinical Directors and Clinical Leads. CCG staff are organised into three Directorates.

During Quarter 1 of 2022/23 the CCG had an efficiency target which was delivered in full.

A summary of our financial planning (including central management costs) and in-year performance monitoring is shown in the Performance Analysis – Financial Performance report.

The Remuneration Committee recommends the remuneration of Very Senior Managers and Clinical Leaders (for whom there are no national pay scales). The

Senior Management Team ensured that remuneration for posts in the CCG structure was in line with national guidance, to ensure consistency between posts.

The CCG was rated 'Outstanding' for two years for the NHS Oversight Framework for 2018/219 and 2019/20 - details are available at the following link: www.england.nhs.uk/commissioning/regulation/ccg-assess/iaf/

This is the latest information available and is updated periodically. NHS England undertook a narrative-based assessment focusing on the operational priorities for 2020/21 and how well CCGs discharged their duties. This approach did not result in a rating for any CCG. The CCG Assessment for Quarter 1 of 2022/23 provided substantial assurance that there was a sound system of internal control, governance and risk management designed to meet the orgnaisation's objectives and that controls are being consistently applied.

Delegation of functions

The CCG contracted with several 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 included:

- The provision of Oracle financial system and financial accounting support from NHS Shared Business Services. The use of NHS Shared Business Services is mandated by NHS England for all CCGs and is fundamental in producing NHS England 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 Unit
- The provision of payroll services from Northumbria Healthcare NHS Foundation Trust
- The provision of the ESR payroll systems support from McKesson
- The provision of Primary Care Support Services from Capita Business Services Limited

Assurance on the effectiveness of the controls is described under the Other Sources of Assurance section (Table 10: Third-party assurances) and the outcome of these audits is reported to the Audit Committee.

The CCG's external auditors have reviewed all the type 2 service auditor reports of the outsourced bodies and have not identified any further risks to the CCG.

Counter fraud arrangements

Our counter fraud activity plays a key part in deterring risks to the organisation's financial viability and probity.

An annual counter fraud plan is agreed by the Audit Committee, which focuses on the deterrence, prevention, detection, and investigation of fraud.

Through our contract with Audit One, we have counter fraud arrangements in place that comply with the NHS Counter Fraud Authority Standards for Commissioners: Fraud, Bribery and Corruption.

An accredited counter fraud specialist is contracted to undertake counter fraud work proportionate to identified risks.

There was executive support and direction for a proportionate proactive work plan to address identified risks.

A member of the Governing Body is proactively and demonstrably responsible for tackling fraud, bribery, and corruption.

The CCG's Local Counter Fraud Specialist was required to submit an annual Counter Fraud Functional Standard Review (CFFSR) to the NHS Counter Fraud Authority (NHSCFA) in relation to the CCG's anti-fraud, bribery and corruption arrangements. The CCG Audit Committee received a report against each of the Standards for Commissioners at least annually. For 2021/2022, all of the standards were rated 'green'.

There was one case of potential fraud reported during Quarter 1 of 2022/23 relating to Personal Health Budgets. Following an investigation by the Counter Fraud Service it was concluded that an act of fraud had not been committed.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period Q1 2022/23 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 issued the following audit reports:

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 Risk
Design and operation of the Assurance Framework and supporting processes	The Risk Assurance Framework was presented to both the Audit Committee and the Governing Body. The Governing Body Assurance Framework was last presented to the Audit Committee on 14 January 2022 and to the Governing Body on both 24th May and 14th June 2022. The Risk 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 Risk 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 Safety Committee, together with the Audit Committee, oversee the risk management agenda and report to the Governing Body. They provide assurance to the Governing Body on the systems and processes

Opinion Area	Commentary
	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: • 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 (16th February 2022) and a further, more formal check and challenge session covering North Cumbria and the North places which was held on 10th May 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 an update on the CCG Closedown Due Diligence process was reported to the Governing Body on the 24th of May 2022, including a check and challenge outcome report and requirements for sign-off by the Accountable Officer of the relevant assurance to confirm completion of the due diligence requirements
Brought forward Internal Audit assurances	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.
Response to Internal Audit recommendations	The implementation of internal audit recommendations is a key indicator of the organisation's engagement with ourselves and the importance it places on the recommendations we have made and have been agreed to be implemented. The Audit Committee receives updates on the progress of agreed actions for all high and medium issues raised, but it does not require updates in relation to low priority issues, so these are not subject follow-up by AuditOne. At 30th June 2022, there was only one high priority recommendation which remained outstanding. This had not passed the original target date for implementation and will be shared with the ICB as part of the due diligence process. This demonstrates that the CCG has continued to have a positive approach 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

Opinion Area	Commentary
	of its functions, 7 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 2022

Key

Assurance levels	
Substantial	Governance, risk management and control arrangements provide substantial assurance that the risks identified are managed effectively. Compliance with the control framework was found to be taking place.
Good	Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. A high level of compliance with the control framework was found to be taking place. Minor remedial action is required
Reasonable	Governance, risk management and control arrangements provide reasonable assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required.
Limited	Governance, risk management and control arrangements provide limited assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place. Immediate and fundamental remedial action is required.

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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group 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 annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

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

- The Governing Body
- The Audit Committee
- The Clinical Commissioning and Contracts Committee
- The Quality and Safety Committee
- The Finance Committee
- Internal Audit

The Governing Body developed, implemented and delivered the strategic priorities of the Group and received assurances from the Audit Committee, the Quality and Safety Committee and the Clinical Commissioning and Contracts Committee. Substantial assurance has also been received from the Head of Internal Audit.

Conclusion

The system of control described in this report has been in place in the CCG for the quarter ended 30 June 2022 and up to the date of the approval of the annual report and accounts. I have concluded that the CCG did have a generally sound system of internal control in place continuously throughout Quarter 1 of 2022/23, designed to meet the organisation’s objectives and that the controls are being applied consistently. No significant internal control issues have been identified.

Remuneration and staff report

The remuneration and staff report gives details of CCG staff and remuneration. It sets out the CCG'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 roles and responsibilities of the committee are set out in the CCG Constitution. The Remuneration Committee has agreed terms of reference.

The Remuneration Committee is an advisory committee which makes recommendations to the CCG Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the group and on determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme.

The committee is comprised entirely of lay members, as follows:

- CCG Deputy Lay Chair (Chair) – Ms Mary Coyle MBE DL
- CCG Lay Member for Governance and Audit – Mr David Willis OBE
- CCG Lay Member for Patient and Public Involvement – Mrs Eleanor Hayward

All members were in post at the time of CCG authorisation. All have been in post continuously from 1 April 2022 and were in post at 30 June 2022.

Policy on the remuneration of senior managers

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 committee is comprised entirely of independent members. Details of remuneration committee membership, meeting frequency, items of business and meeting attendance are given at page 62. Further details about the committee are provided in the governance statement within this report, e.g. frequency of meetings and attendance.

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. 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.

Contracts of employment in relation to all very senior managers (VSMs) (except clinicians) employed by the CCG are permanent in nature and subject to 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.

Remuneration of Very Senior Managers

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

During the period from 1 April to 30 June 2022 North Tyneside CCG had 7 senior managers (2021/22, 6) who were paid more than £150,000 per annum on a pro-rata basis. The senior managers were in part time roles and were not paid more than £150,000 by North Tyneside CCG.

The remuneration for senior managers for current and future financial years is determined in accordance with relevant guidance, best practice and national policy.

The Remuneration Committee critically reviews the salary of very senior managers when making recommendations to Governing Body regarding their remuneration.

Senior manager remuneration (including salary and pension entitlements)

Table 1: North 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
Permanent:							
Dr Richard Scott	Clinical Chair	15-20	-	-	-	-	15-20
Mr Mark Adams	Accountable Officer	5-10	-	-	-	-	5-10
Dr Lesley Young-Murphy	Executive Director of Nursing & Chief Operating Officer	30-35	-	-	-	-	30-35
Mr Jon Connolly	Chief Finance Officer	20-25	4	-	-	-	20-25
Dr Neela Shabde	Secondary Care Doctor	0-5	-	-	-	-	0-5
Mrs Anya Paradis	Director of Commissioning & Planning	20-25	14	-	-	2.5-5	30-35
Mrs Irene Walker	Head of Governance	20-25	-	-	-	0-2.5	20-25
Dr Shaun Lackey	Clinical Director	15-20	-	-	-	-	15-20
Dr Alexandra Kent	Medical Director	20-25	3	-	-	-	20-25
Mr Jeff Goldthorpe	Director of Contracting and Finance	20-25	-	-	-	-	20-25
Mrs Maureen Grieveson	Director of Quality and Patient Safety	5-10	-	-	-	-	5-10
Dr Steve Parry	Clinical Director	25-30	-	-	-	-	25-30
Lay members:							
Ms Mary Coyle MBE DL	Deputy Lay Chair	0-5	-	-	-	-	0-5
Mrs Eleanor Hayward	Lay Member (patient and public involvement)	0-5	-	-	-	-	0-5
Mr David Willis OBE	Lay Member (audit and governance)	0-5	-	-	-	-	0-5

Notes for senior manager remuneration table:

The information reported covers the period for the 3 months to 30 June 2022.

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.

Expense payments are shown in £00 and include lease car allowances and mileage claims.

Mr Mark Adams is employed by Newcastle Gateshead CCG and works for North Tyneside CCG as part of a staff-sharing arrangement. The salary disclosed above shows North Tyneside CCG's share of remuneration of 25%. Pension benefits are reported in full by Newcastle Gateshead CCG.

Mr Jon Connolly is employed by North Tyneside CCG and works for Northumberland CCG as part of a staff-sharing arrangement. The salary disclosed above shows North Tyneside CCG's share of remuneration of 50%.

Mrs Wendy Burke, Director of Public Health is in attendance at Governing Body only. She is not employed by North Tyneside CCG and receives no remuneration from the CCG for her Governing Body role.

Pension related benefits for 3 months to 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

Mr Mark Adams is employed by Newcastle Gateshead CCG and works for North Tyneside CCG, Northumberland CCG and North Cumbria CCG as part of a staff sharing arrangement.

Mr Jon Connolly is employed by North Tyneside CCG and works for Northumberland CCG as part of a staff sharing arrangement.

The total remuneration earned for all work across all organisations in the 3 month period to 30 June 2022 is shown below:

Table 2: North Tyneside CCG staff sharing arrangement 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	**TOTAL** (bands of £5,000) £ 000
Mr Mark Adams	Accountable Officer	35-40	-	35-40
Mr Jon Connolly	Chief Finance Officer	40-45	4	40-45

Senior manager remuneration (including salary and pension entitlements)

Table 3: North 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
Permanent:							
Dr Richard Scott	Clinical Chair	65-70	-	-	-	17.5-20	80-85
Mr Mark Adams	Accountable Officer	40-45	-	0-5	-	-	40-45
Dr Lesley Young-Murphy	Executive Director of Nursing & Chief Operating Officer	120-125	-	0-5	-	30-32.5	145-150
Mr Jon Connolly	Chief Finance Officer	70-75	7	0-5	-	22.5-25	105-110
Dr Neela Shabde	Secondary Care Doctor	10-15	-	-	-	-	10-15
Mrs Anya Paradis	Director of Commissioning & Planning	90-95	50	-	-	22.5-25	120-125
Mrs Irene Walker	Head of Governance	70-75	-	-	-	17.5-20	90-95
Dr Shaun Lackey	Clinical Director	75-80	-	-	-	22.5-25	100-105
Dr Alexandra Kent	Clinical Director	85-90	-	-	-	20-22.5	110-115
Mr Jeff Goldthorpe	Director of Contracting and Finance	90-95	-	-	-	65-67.5	160-165
Mrs Maureen Grieveson	Director of Quality and Patient Safety	90-95	-	-	-	55-57.5	145-150
Dr Steve Parry	Clinical Director	110-115	-	0-5	-	32.5-35	145-150
Lay members:							
Ms Mary Coyle MBE DL	Deputy Lay Chair	15-20	-	-	-	-	15-20
Mrs Eleanor Hayward	Lay Member (patient and public involvement)	10-15	-	-	-	-	10-15
Mr David Willis OBE	Lay Member (audit and governance)	10-15	-	0-5	-	-	10-15

Notes for senior manager remuneration table 2021/22:

Expense payments are shown in £00 and include lease car allowances and mileage claims.

Performance pay relates to a non-consolidated payment payable to senior managers that are not on a national pay framework and capped at no more than 2% of VSM pay bill per NHS England recommendations based upon assessment and recommendation by Remuneration Committee and approval by Governing Body.

Mr Mark Adams is employed by Newcastle Gateshead CCG and works for North Tyneside CCG as part of a staff-sharing arrangement. The salary disclosed above shows North Tyneside CCG's share of remuneration of 25%. Pension benefits are reported in full by Newcastle Gateshead CCG.

Mr Jon Connolly is employed by North Tyneside CCG and works for Northumberland CCG as part of a staff-sharing arrangement. The salary disclosed above shows North Tyneside CCG's share of remuneration of 50%.

Mrs Wendy Burke, Director of Public Health is in attendance at Governing Body only. She is not employed by North Tyneside CCG and receives no remuneration from the CCG for her Governing Body role.

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

Mr Mark Adams is employed by Newcastle Gateshead CCG and works for North Tyneside CCG, Northumberland CCG and North Cumbria CCG as part of a staff sharing arrangement.

Mr Jon Connolly is employed by North Tyneside CCG and works for Northumberland 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: North 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) £000	**TOTAL** (bands of £5,000) £ 000
Mr Mark Adams	Accountable Officer	170-175	-	170-175
Mr Jon Connolly	Chief Finance Officer	140-145	7	140-145

Pension benefits as at 30 June 2022

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

Name	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 Richard Scott	-	-	15-20	40-45	360	-	317	-
Dr Lesley Young-Murphy	-	-	35-40	105-110	-	-	-	-
Mr Jon Connolly	-	-	40-45	110-115	937	-	682	-
Mrs Anya Paradis	0-2.5	0-2.5	20-25	35-40	396	4	404	-
Mrs Irene Walker	0-2.5	-	5-10	-	150	2	155	-
Dr Shaun Lackey	-	-	20-25	45-50	405	-	402	-
Dr Alexandra Kent	-	-	10-15	-	146	-	146	-
Dr Steve Parry	0-2.5	-	50-55	155-160	1,303	-	1,022	-

Notes for senior officer pension benefits at 30 June 2022:

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 judgment.

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

Name	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 Richard Scott	0-2.5	0-2.5	20-25	45-50	326	14	349	-
Dr Lesley Young-Murphy	0-2.5	5-7.5	35-40	105-110	834	-	-	-
Mr Jon Connolly	0-2.5	0-2.5	40-45	115-120	856	34	909	-
Mrs Anya Paradis	0-2.5	0-2.5	20-25	35-40	354	19	384	-
Mrs Irene Walker	0-2.5	-	5-10	-	117	18	146	-
Dr Shaun Lackey	0-2.5	0-2.5	20-25	45-50	362	17	393	-
Dr Alexandra Kent	0-2.5	-	10-15	-	124	6	142	-
Mr Jeff Goldthorpe	2.5-5	10-12.5	45-50	140-145	1,075	-	-	-
Mrs Maureen Grieveson	2.5-5	7.5-10	40-45	130-135	999	-	-	-
Dr Steve Parry	0-2.5	2.5-5	50-55	150-155	1,188	59	1,263	-

Notes for senior officer pension benefits 2021/22:

Pensions information is provided by NHS Pensions.

Cash equivalent transfer value at 1 April 2021 has been inflated by 0.5% 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 judgment.

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

The CCG has not made any payment for compensation on early retirement or for loss of office in the 3 months to June 2022.

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

The CCG has not made any payments to past members in the 3 months to June 2022.

Fair Pay Disclosure (this has been subject to audit)

Percentage change in remuneration of highest paid director

Table 7: 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	(2.3)	(31.5)

Highest paid director calculation is based upon mid-point of the band.

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 the full time equivalent number of employees.

The percentage change from previous financial year for performance pay and bonuses has reduced as no performance pay was payable to employees in the 3 months to June 2022. A £200 (pro-rata) non-consolidated bonus was paid in both years.

Pay ratio information

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

Table 8: Staff remuneration and salary component percentiles

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)	£40,749	£50,643	£85,039
Salary component of 'all staff' remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£40,589	£48,526	£79,592
2021/22			
All staff remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£39,227	£53,299	£90,538
Salary component of 'all staff' remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£39,027	£53,219	£85,332

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. The range includes staff in part time roles.

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 and individual non-consolidated payments of £200 which are included in the remuneration value. Benefits-in-kind and non-consolidated pay are excluded from the salary component value.

The annualised banded remuneration of the highest paid director in North 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 table below.

Table 9: Remuneration Ratios

Period	25th percentile remuneration ratio	Median remuneration ratio	75th percentile remuneration ratio
3 months to 30 June 2022	3.0:1	2.4:1	1.4:1
2021/22	3.1:1	2.3:1	1.4:1

In the period 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 £21,000 to £170,000 (2021/22: £20,000 to £170,000). 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.

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

Staff Report

Number of senior managers

The CCG had 15 senior managers in post at 30 June 2022.

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 Chair and lay members of the Governing Body.

Table 10: Staff Numbers and Costs (this has been subject to audit)

	Permanent Employees	Other	Total
Average number of people employed	57.66	0.01	57.67

Average number based upon full time equivalent and excludes staff on outward secondment

	Permanent Employees £'000	Other £'000	Total £'000
Salaries and wages	874	-	874
Social security costs	93	-	93
Employer Contributions to NHS Pension scheme	145	-	145
Other Pension Costs	1	-	1
Apprenticeship Levy	1	-	1
Total Staff costs	**1,114**	**-**	**1,114**

Staff composition

The CCG staff gender profile at 30 June 2022 is based upon information relating to permanently employed staff as follows:

Table 11: Staff composition

	Female	Male	Total
Very Senior managers	2	1	3
Other staff	52	23	75
Total staff	54	24	78

	Female	Male	Total
Governing Body members and attendees	9	5	14

* The Governing Body figures are provided as standalone figures; they do not contribute to the total figure for the whole CCG 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 is reported for each year. Total days lost for 2022 relates to the 3 month period from 1 April to 30 June 2022 compared to the 12 month period reported in 2021/22.

Table 12: Staff sickness absence

	2022 Q1 Number	2021/22 Number
Total days lost	182	934
Average working days lost	3	14

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 20% (2021/22, 18%)

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 a suite of staff policies in place. The CCG has taken positive steps throughout the year to maintain and develop the provision of information to, and consultation with employees, including:

- Providing employees systematically with information on matters of concern to them as employees
- Consulting employees and their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests
- Encouraging the involvement of employees in the CCG's performance
- Taking actions throughout the year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the CCG

- Membership of the North East Partnership Forum, where staff representatives and CCG managers from across the region meet together

The CCG has a positive attitude to the recruitment, employment, training and development of disabled persons and has achieved accreditation as a Level 2 Disability Confident employer. The symbol, awarded by the Department of Work and Pensions, in partnership with Job Centre Plus, demonstrates our commitment to employ, retain and develop the abilities of disabled staff.

Trade Union Representation

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.

During the 3 months to June 2022 there were no employees of NHS North Tyneside Clinical Commissioning Group who were trade union representatives.

Expenditure on consultancy

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

Off-payroll engagements

There were no off-payroll engagements as at 30 June 2022, for more than £245 per day and that last longer than six months.

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 longer than six months:

Off-payroll engagements of Board members and senior officials with significant financial responsibility for the 3 months to 30 June 2022.

Table 13: Off-payroll engagements / senior official engagements

Number of off-payroll engagements of board members, and/or senior officers 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 on payroll and off-payroll engagements.	16

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 June 2022.

Reward & Recognition

The CCG was pleased to award its staff a £200 (pro rata) non-consolidated bonus in June 2022, in recognition of their work during the lifetime of the CCG and the resultant benefits to North Tyneside patients and public.

Parliamentary Accountability and Audit Report

North Tyneside CCG was 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 125.

ANNUAL ACCOUNTS

NHS North Tyneside CCG - Annual Accounts 3 months to 30 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 revenue	2	-	(85)
Total operating revenue		**-**	**(85)**
Staff costs	3	1,114	4,244
Purchase of goods and services	4	96,939	394,386
Depreciation charges	4	12	-
Other operating expenditure	4	10	146
Total operating expenditure		**98,075**	**398,776**
Comprehensive Net Expenditure for the period		**98,075**	**398,691**

The notes on pages 112 to 124 form part of this statement

Statement of Financial Position as at 30 June 2022

	Note	30 June 2022 £'000	31 March 2022 £'000
Non-current assets:			
Right-of-use Assets	6	45	-
Total non-current assets		**45**	**-**
Current assets:			
Contract and other receivables	7	945	767
Cash and cash equivalents	8	0	318
Total current assets		**945**	**1,085**
Total assets		**990**	**1,085**
Current liabilities:			
Trade and other payables	9	(15,988)	(22,138)
Lease liabilities	6	(45)	
Borrowings	10	(8)	-
Total current liabilities		**(16,041)**	**(22,138)**
Assets less liabilities		**(15,051)**	**(21,053)**
Financed by Taxpayers' Equity			
General fund		(15,051)	(21,053)
Total Taxpayers' Equity		**(15,051)**	**(21,053)**

The notes on pages 112 to 124 form part of this statement

The financial statements on pages 108 to 124 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
Changes in taxpayers' equity for the three months to 30 June 2022	
Balance at 01 April 2022	(21,053)
Changes in CCG taxpayers' equity for the three months to 30 June 2022	
Net operating expenditure for the financial period	(98,076)
Net Recognised CCG expenditure for the Financial Period	**(98,076)**
Net funding	104,078
Balance at 30 June 2022	**(15,051)**

	General fund £'000
Changes in Taxpayers' Equity for 2021-22	
Balance at 01 April 2021	(20,274)
Changes in CCG taxpayers' equity for 2021-22	
Net operating costs for the financial year	(398,691)
Net Recognised CCG Expenditure for the Financial Year	**(398,691)**
Net funding	397,912
Balance at 31 March 2022	**(21,053)**

The notes on pages 112 to 124 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		(98,075)	(398,691)
Depreciation and amortisation	4	12	0
(Increase) / decrease in trade & other receivables	7	(177)	22
Increase / (decrease) in trade & other payables	9	(6,152)	1,016
Net Cash Outflow from Operating Activities		**(104,392)**	**(397,653)**
Net Cash Outflow before Financing		**(104,392)**	**(397,653)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		104,078	397,912
Repayment of lease liabilities	6	(12)	0
Net Cash Inflow from Financing Activities		**104,066**	**397,912**
Net Increase / (Decrease) in Cash & Cash Equivalents	9	**(326)**	**259**
Cash & Cash Equivalents at the Beginning of the Financial Period		**318**	**59**
Cash & Cash Equivalents at the End of the Financial Period		**(8)**	**318**

The notes on pages 112 to 124 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 a going concern basis**.**

The Health and Care Bill was introduced into the House of Commons on 6 July 2021. The Bill will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish CCGs. ICBs will take on the commissioning functions of CCGs. The Bill was given Royal Assent and became an Act of Parliament on the 28th April 2022. It is the intention that the CCG functions, assets and liabilities will therefore transfer to an ICB on the 1st July 2022.

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

Where a 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. The statement of financial position has therefore been drawn up at 30 June 2022 on a going concern basis.

1.2 **Accounting Convention**

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

1.3 **Pooled Budgets**

The CCG has entered into a pooled budget arrangement with North Tyneside Council, under Section 75 of the National Health Service Act 2006 the CCG accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. See Note 12 for further details.

1.4 **Revenue**

The majority of the CCG's funding is via Resource Allocation. Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.5 **Employee Benefits**

1.5.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments 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.

1.5.2 **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 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.

1.6 **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.

Notes to the financial statements

1.7 **Leases**

Under IFRS16, the distinction between finance leases and operating leases is only applicable where the CCG is lessor. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.7.1 **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.

1.8 **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. Cash, bank and overdraft balances are recorded at current value.

1.9 **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 the CCG.

1.10 **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.

1.11 **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 for the CCG are classified at amoritised cost.

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

1.11.1 **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.

Notes to the financial statements

1.11.2 **Impairment**

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

The CCG adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

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

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

1.12 **Financial Liabilities**

Financial liabilities are recognised 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.

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

1.13 **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.

1.14 **Losses & Special Payments**

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

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

1.15 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the CCG's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.15.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the CCG's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- Determining whether income and expenditure should be disclosed as either administrative or programme expenditure; and
- Determining whether a substantial transfer of risks and rewards has occurred in relation to leased assets

1.15.2 **Sources of estimation uncertainty**

The following assumption 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 main estimate is in relation to prescribing expenditure which is two months in arrears and is based on BSA profiling. The accrual within the accounts is for May and June and is £5.9m (21-22 was £3.4m but was for one month only).

1.16 **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.

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 £57k of right-of-use assets and lease liabilities of £57k. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was nil 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.

2 Other Operating Revenue

	3 months to 30 June 2022 Total	12 months to 31 March 2022 Total
	£'000	£'000
Other non contract revenue	-	85
Total other operating revenue	**-**	**85**

The majority of the CCG's funding is via Resource Allocation. The revenue in this note does not include cash in respect of this, which is received from NHS England, drawn down directly into the bank account of the CCG and credited to the General Fund.

3 Employee benefits and staff numbers

3.1 Employee benefits

	3 months to 30 June 2022		
	Total	Permanent Employees	Other
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	874	874	0
Social security costs	93	93	0
Employer Contributions to NHS Pension scheme	145	145	0
Other pension costs	1	1	0
Apprenticeship Levy	1	1	0
Gross employee benefits expenditure	**1,114**	**1,114**	**0**

	12 months to 31 March 2022		
	Total	Permanent Employees	Other
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	3,262	3,259	3
Social security costs	356	356	0
Employer Contributions to NHS Pension scheme	623	623	0
Other pension costs	1	1	0
Apprenticeship Levy	2	2	0
Gross employee benefits expenditure	**4,244**	**4,241**	**3**

3.2 Average number of people employed

	3 months to 30 June 2022			12 months to 31 March 2022		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Total	**57.67**	57.66	0.01	**57.19**	57.12	0.07

3.3 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:

3.3.1 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.

3.3.2 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			12 months to 31 March 2022		
	Total	Admin	Programme	Total	Admin	Programme
	£'000	£'000	£'000	£'000	£'000	£'000
Purchase of goods and services						
Services from other CCGs and NHS England	811	293	518	2,572	982	1,590
Services from foundation and other NHS trusts	68,288	0	68,288	266,149	0	266,149
Purchase of healthcare from non-NHS bodies	6,991	0	6,991	39,615	0	39,615
Purchase of social care	3,112	0	3,112	11,651	0	11,651
Prescribing costs	8,708	0	8,708	37,098	0	37,098
Pharmaceutical services	16	0	16	56	0	56
GPMS/APMS and PCTMS	8,752	0	8,752	35,784	0	35,784
Supplies and services – general	145	10	135	709	11	698
Establishment	6	8	-2	264	47	217
Transport	0	0	0	2	2	0
Premises	57	18	39	355	132	223
Audit fees	45	45	0	45	45	0
Non-audit services	0	0	0	3	3	0
Other professional fees	13	13	0	59	59	0
Legal fees	-5	-5	0	12	12	0
Education, training and conferences	0	1	-1	12	12	0
Depreciation	12	12	0	0	0	0
Chair and Non Executive Members	36	36	0	142	142	0
Clinical negligence	1	1	0	4	4	0
Research and development (excluding staff costs)	-27	-27	0	0	0	0
Total operating expenses	**96,961**	**405**	**96,556**	**394,532**	**1,451**	**393,081**

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

The external auditor of the Clinical Commissioning Group is Mazars LLP. The audit fee for the three months to 30 June 2022 including VAT, was £45k (£45k in 2021-22).

GPMS/APMS and PCTMS relates to Primary Care Commissioning.

Non-audit services contains the costs of Mental Health Investment Standard with an estimated accrual for 2021-22 of £12k including Vat.

The expenditure within Other Professional fees includes £12k for internal audit services provided by AuditOne (£50k in 2021-22).

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	1,208	24,261	4,578	85,972
Total Non-NHS Trade Invoices paid within target	1,190	23,658	4,516	85,568
Percentage of Non-NHS Trade invoices paid within target	**98.51%**	**97.51%**	**98.65%**	**99.53%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	88	69,189	279	268,734
Total NHS Trade Invoices Paid within target	88	69,189	277	268,733
Percentage of NHS Trade Invoices paid within target	**100.00%**	**100.00%**	**99.28%**	**99.99%**

6 Leases

6.1 Right-of-use assets

3 months to 30 June 2022	Buildings excluding dwellings £'000
Cost or Valuation at 01 April 2022	
IFRS 16 Transition Adjustment	57
Cost/Valuation at 30 June 2022	**57**
Depreciation 01 April 2022	-
Charged during the period	12
Depreciation at 30 June 2022	**12**
Net Book Value at 30 June 2022	**45**

6.2 Lease Liabilities

3 months to 30 June 2022	Buildings excluding dwellings £'000
IFRS 16 Transition Adjustment	57
Interest expense relating to lease liabilities	(12)
Lease liabilities at 30 June 2022	**45**

Following implementation of IFRS16 on 1 April 2022 the CCG has recognised a right of use asset for an operating lease held with NHS Property Services for its headquarters.

6.3 Lease liabilities - Maturity analysis of undiscounted future lease payments	30 June 2022 £'000
Within one year	(45)
Between one and five years	-
After five years	-
Balance at 30 June 2022	**(45)**
Effect of discounting	-
Included in:	
Current lease liabilities	(45)
Non-current lease liabilities	-
Balance at 30 June 2022	**(45)**

6.4 Amounts recognised in Statement of Comprehensive Net Expenditure	3 months to 30 June 2022 £'000
Depreciation expense on right-of-use assets	12
Interest expense on lease liabilities	0

6.5 Amounts recognised in Statement of Cash Flows	3 months to 30 June 2022 £'000
Total cash outflow on leases under IFRS 16	(12)

7 Contract and other receivables	Current 30 June 2022 £'000	Current 31 March 2022 £'000
NHS receivables: Revenue	74	63
NHS prepayments	2	-
NHS accrued income	-	328
Non-NHS and Other WGA receivables: Revenue	50	5
Non-NHS and Other WGA prepayments	788	247
Non-NHS and Other WGA accrued income	14	88
VAT	16	35
Other receivables and accruals	1	0
Total contract and other receivables	**945**	**768**

7.1 Receivables past their due date but not impaired

	30 June 2022 £'000	31 March 2022 £'000
By up to three months	50	-
By three to six months	-	-
By more than six months	-	2
Total	**50**	**2**

£50k of the amount above has subsequently been recovered post the statement of financial position date.

8 Cash and cash equivalents

	30 June 2022 £'000	31 March 2022 £'000
Balance as at 01 April	318	59
Net change in period	(326)	259
Balance at end of period	**(8)**	**318**
Made up of:		
Cash with the Government Banking Service	-	318
Cash and cash equivalents as in statement of financial position	**-**	**318**
Bank overdraft: Government Banking Service	(8)	-
Total bank overdrafts	**(8)**	**-**
Balance at end of period	**(8)**	**318**

9 Trade and other payables

	Current 30 June 2022 £'000	Current 31 March 2022 £'000
NHS payables: Revenue	54	86
NHS accruals	1,156	1,110
Non-NHS and Other WGA payables: Revenue	854	4,494
Non-NHS and Other WGA accruals	12,657	14,928
Social security costs	58	54
Tax	48	52
Other payables and accruals	1,161	1,412
Total trade & other payables	**15,988**	**22,136**

Other payables and accruals includes £482,632 outstanding pension contributions at 30 June 2022 (£394,344 in 2021-22) - £65,141 for CCG employees (£68,065 in 2021-22) and £417,491 for Primary Care through Delegated Co-Commissioning (£326,279 in 2021-22).

10 Borrowings

	Current 30 June 2022 £'000	Current 31 March 2022 £'000
Bank overdrafts:		
Government banking service	8	-
Total Borrowings	**8**	**-**

The CCG completed a BACS payments run on 30 June 2022 which was due to clear the bank account 05 July 2022 to enable it to clear balances owed to suppliers prior to the merger. This resulted in the CCG having a credit ledger cash position of £8k. This is acceptable and only reflects a timing difference between the drawdown process and cash being available in the bank account on 1 July 2022. This is only a technical adjustment and the amount that the CCG has overdrawn its bank account is recorded in note 10 Borrowings above.

11 Financial instruments

11.1 Financial assets

	Financial Assets measured at amortised cost 30 June 2022 £'000	Financial Assets measured at amortised cost 31 March 2022 £'000
Contract and other receivables with NHSE bodies	74	381
Contract and other receivables with other DHSC group bodies	-	10
Contract and other receivables with external bodies	65	93
Cash and cash equivalents	-	318
Total financial assets	**139**	**802**

11.2 Financial liabilities

	Financial Liabilities measured at amortised cost 30 June 2022 £'000	Financial Liabilities measured at amortised cost 31 March 2022 £'000
Loans with external bodies	8	-
Trade and other payables with NHSE bodies	101	63
Trade and other payables with other DHSC group bodies	1,211	1,324
Trade and other payables with external bodies	14,614	20,645
Total financial liabilities	**15,934**	**22,032**

It is the CCG's assessment that it is not exposed to any material financial instrument risk.

As the cash requirements of NHS England are met through the estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements, therefore the CCG are not exposed to any material credit, liquidity or market risk.

12 Pooled Budgets

Under s75 of the 2006 NHS Act, the CCG has entered into a pooled budget agreement with North Tyneside Council in relation to the Better Care Fund. For accounting purposes management has assessed that joint control does not exist.

The Better Care Fund is designed to integrate health and social care services, reduce hospital based care and promote community based services.

The CCG shares of the income and expenditure handled by the pooled budget in the financial year were:

	3 months to 30 June 2022 £'000	12 months to 31 March 2022 £'000
Expenditure	4,832	18,291

13 Related parties transactions

Details of related parties transactions with individuals are as follows:

		3 months to 30 June 2022				12 months to 31 March 2022			
Governing Body / Executive Member GP Practices	**Governing Body / Executive Members**	**Expenditure with Related Party £'000**	**Income from Related Party £'000**	**Creditors owed to Related Party £'000**	**Debtors due from Related Party £'000**	**Expenditure with Related Party £'000**	**Income from Related Party £'000**	**Creditors owed to Related Party £'000**	**Debtors due from Related Party £'000**
Marine Avenue Medical Centre	Dr Richard Scott	218	0	96	0	1,015	0	94	0
The Priory Medical Group	Dr Alex Kent	496	0	102	0	2,075	0	140	0
NHS North of England CSU	Mark Adams	629	0	77	0	2,934	-337	1	0
Goalseeker Ltd	Mark Adams	0	0	0	0	457	0	0	0
49 Marine Avenue Surgery		383	0	185	0	1,540	0	243	0
Beaumont Park Medical Group		201	0	0	-12	841	0	58	0
Bewicke Medical Centre		281	0	71	0	1,443	0	102	0
Bridge Medical		157	0	52	0	772	0	85	0
Collingwood Health Group		748	0	57	0	3,336	0	254	0
Lane End Surgery		224	0	143	0	1,151	0	153	0
Mallard Medical Group		179	0	11	0	666	0	48	0
Monkseaton Medical Centre		325	0	0	-19	1,280	0	54	0
Nelson Medical Group		128	0	36	0	657	0	96	0
Northumberland Park Medical Group		350	0	0	-2	1,265	0	125	0
Park Parade Surgery		131	0	23	0	640	0	45	0
Park Road Medical Practice		312	0	0	-13	1,244	0	81	0
Portugal Place Health Centre		379	0	33	0	1,522	0	97	0
Redburn Park Medical Centre		228	0	0	-25	859	0	26	0
Spring Terrace Health Centre		506	0	237	0	1,837	0	221	0
Stephenson Park Health Group		591	0	45	0	2,604	0	156	0
Swarland Avenue Surgery		672	0	332	0	2,050	0	438	0
Village Green Surgery		656	0	129	0	2,389	0	194	0
Wellspring Medical Practice		227	0	18	0	908	0	62	0
West Farm Surgery		-79	0	292	0	500	0	335	0
Whitley Bay Health Centre		363	0	42	0	1,626	0	112	0
Wideopen Medical Centre		259	0	16	0	1,089	0	63	0
Woodlands Park Health Centre		193	0	29	0	887	0	70	0

The Council of Practices comprises of a nominated GP from each of the 25 GP practices that form the CCG. They meet at least four times a year to decide on the strategic direction of the CCG. As such the GP Practices have been included within the Related Parties note above.

Members of the North Tyneside GP Practices have carried out functions for the CCG and any remuneration received for these has been paid to the practice in recognition of their contribution. GP Practices are also entitled to additional payments in relation to extra services for patients and these are based on practice sizes and if the practice has delivered.

The GPs within North Tyneside are split into 4 Primary Care Networks (PCN) based on locality. Within each PCN there is a nominated Practice who co-ordinates the receipt and distribution of funding on behalf of the PCN. The nominated GPs are as follows – Swarland Avenue Surgery (North West), 49 Marine Avenue Surgery (Whitley Bay), Spring Terrace Health Centre (North Shields) and Village Green Surgery (Wallsend).

The Department of Health and Social Care is regarded as the parent Department. During the year the CCG has had a significant number of material transactions with entities for which the DHSC is regarded as the parent Department which included Northumbria Healthcare NHS FT; Newcastle upon Tyne Hospital NHS FT; Cumbria, Northumberland, Tyne & Wear NHS FT; and the North East Ambulance Services NHS FT amongst others.

The CCG also had a number of transactions with NHS England, NHS Litigation Authority and NHS Business Services Authority amongst others. The transactions with these entities were not material.

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 North Tyneside Council in respect of joint enterprises £7.9m transacted in the three months to 30 June 2022 (£35.5m in 2021-22).

TyneHealth Ltd is a provider of healthcare services. Its members are the current 25 GP Practices in North Tyneside. There was £322k transacted in the three months to 30 June 2022 (£1,600k in 2021-22).

The CCG has not received revenue or capital payments from charitable funds.

The CCG maintains formal registers of interests, and the appropriate registers are referred to at each of its Council of Practice, Governing Body, and Committee meetings, providing a mechanism for handling any conflicts of interest.

14 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 will be abolished and the functions, assets and liabilities of NHS North Tyneside CCG will transfer 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.

15 Financial performance targets

CCGs have a number of financial duties under the NHS Act 2006 (as amended).
The CCG performance against those duties was as follows:

National Health Service Act Section Duty	Duty	3 months to 30 June 2022 Target	3 months to 30 June 2022 Performance	12 months to 31 March 2022 Target	12 months to 31 March 2022 Performance	Duty Achieved
223H(1)	Expenditure not to exceed income	98,076	98,076	402,998	398,774	Yes
223I(2)	Capital resource use does not exceed the amount specified in Directions	-	-	-	-	Yes
223I(3)	Revenue resource use does not exceed the amount specified in Directions	98,076	98,076	402,913	398,689	Yes
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	Yes
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	Yes
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	1,078	1,078	4,342	3,831	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 North 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 North 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 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 14 (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 14 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 North 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 North 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 orth 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

Date 30 June 2023