NHS
North East and North Cumbria

North East and North Cumbria Integrated Care Board

Board Meeting to be held in Public on:
Tuesday 27 September 2022, 09.45 - 13:00
In the Council Chambers, Northumberland County Council

AGENDA

NHS North East and North Cumbria Integrated Care Board Meeting					
This meeting will be recorded for minuting purposes. It is each member's responsibility to advise the Chair at the start of meeting if they object to the meeting being recorded. *A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by their involvement in another role or relationship. In some circumstances, it could reasonably be considered that a conflict exists even when there is no actual conflict. In these cases it is important to still manage these perceived conflicts in order to maintain public trust.*					
Ref	**Time**	**Item**	**Lead**	**Action to be taken**	**Document**
1.	09:45	Welcome and introductions	Chair	-	
2.	09:45	Apologies for absence	Chair	To be noted	
3.	09:45	Declarations of interest	Chair	To be declared and noted	
4.	09:50	Minutes of the previous meeting held on 1 July 2022	Chair	For approval	**ENC 1**
5.	09:55	Matters arising from the minutes of the previous meeting held on 1 July 2022: • Health Inequalities Task and Finish Group • Policy Review Schedule	Chair	-	
6.	10:00	Notification of items of any other business	Chair	-	
7.	10:00	Chief Executive's Report	Chief Executive	For information	**ENC 2**
Governance and Assurance					
8.	10:10	1 July Board meeting - feedback from Members	Executive Director of Corporate Governance, Communications and Involvement	For information	**VERBAL**
9.	10:15	Amendments to the Executive Committee Terms of Reference	Executive Director of Corporate Governance, Communications and Involvement	For approval	**ENC 3**

10.	10:20	Highlight report and minutes from the Executive Committee meeting held on 12 July 2022	Chief Executive	For assurance	**ENC 4**
11.	10:30	Highlight report from the Finance, Performance and Investment Committee held on 1 September 2022	Committee Chair	For assurance	**ENC 5**
Quality					
12.	10:40	Urgent and emergency care – Operational Resilience Plan	Executive Medical Director/ Executive Director of Strategy and System Oversight	For approval	**PRES**
13.	11:00	Ockenden Report – Immediate Actions Review	Executive Chief Nurse	For assurance	**ENC 6**
14.	11.20	**Break**			
15.	11:30	Safeguarding and Learning from Life and Death Reviews of People with Learning Disabilities and Autistic People Position Paper	Executive Chief Nurse	For assurance	**ENCs 7i and 7ii**
16.	11:50	Vaccination Plan: • Covid-19 • Flu • Monkey Pox • Childhood Immunisations	Executive Medical Director	For assurance	**ENC 8**
Strategy					
17.	12:00	Integrated Delivery Update Report	Executive Director of Strategy and System Oversight	For assurance	**ENCs 9i and 9ii**
18.	12:15	Roadmap to place based working	Executive Directors of Place Based Delivery	For discussion	**ENC 10**
19.	12:25	Risk Management Strategy	Executive Director of Corporate Governance, Communications and Involvement	For approval	**ENC 11**
Finance					
20.	12:30	Finance Update and Overview Report	Executive Director of Finance	For assurance	**ENCs 12i and 12ii**
Other Business					
21.	12:45	Presentation of the 21/22 Annual Reports of the former clinical commissioning groups of: • Durham • North Cumbria • Northumberland	Executive Directors of Place based Delivery	For information	**ENCs 13, 13i, 13ii and 13iii**
22.	12:50	Questions from the Public on Items on the Agenda	Chair	For discussion	
23.	12:55	Any Other Business from Members	Chair	For discussion	
24.	13:00	Close	Chair	-	

Item: 4
Enclosure: 1

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North East and North Cumbria Integrated Care Board

Minutes of the meeting held on 1 July 2022 at 12.30pm, City Hall, Sunderland.

Minutes

Present:

Professor Sir Liam Donaldson, Chair
Sam Allen, Chief Executive
Professor Eileen Kaner, Independent Non-Executive Member
John Rush, Independent Non-Executive Member
Claire Riley, Executive Director of Corporate Governance, Communications and Involvement
Jon Connelly, Executive Director of Finance
Professor Graham Evans, Executive Chief Digital and Information Officer
David Gallagher, Executive Director of Place Based Delivery (Central and South)
Mark Adams, Executive Director of Place Based Delivery (North and North Cumbria)
Annie Laverty, Executive Chief People Officer
Dr Neil O'Brien, Executive Medical Director
Jacqueline Myers, Executive Director of Strategy and System Oversight
Aejaz Zahid, Executive Director of Innovation
Ken Bremner, Foundation Trust Partner Member
Rajesh Nadkarni, Foundation Trust Partner Member
Tom Hall, Local Authority Partner Member (Designate)
Jacqui Old, attending for Cath McEvoy-Carr Local Authority Partner Member (Designate)
Ann Workman, Local Authority Partner Member (Designate)
Dr Mike Smith, Primary Medical Services Partner Member
Dr Saira Malik, Primary Medical Services Partner Member

In Attendance:

Jane Hartley, North East and North Cumbria Voluntary Organisations Network North East (VONNE)
David Thompson, North East and North Cumbria Healthwatch

Jan Thwaites (minutes)

B/2022/01 Welcome and Introductions

The Chair welcomed everyone to the North East and North Cumbria Integrated Care Board (the ICB) inaugural meeting. This was one of 42 such boards around the country which had been established by the Health and Care Act 2022 as part of Integrated Care Systems (ICSs), abolishing clinical commissioning groups (CCGs).

The Chair outlined that the ICB has responsibility for the planning and development of the organisation and funding of services with an NHS budget of circa £6bn to provide and plan care for a population of around 3 million people across the North East and North Cumbria (NENC). This responsibility had transferred from the former eight CCGs who had undertaken those functions for the past 10 years. Thanks were given to the chairs and governing bodies of the CCGs for all work they had undertaken and for all their achievements. The ICB was hoping to build on these achievements going forward and ensure the local population and neighbourhoods that made up the ICB were at the heart of its work.

Thanks were also given to the staff of the CCGs who were moving to the ICB and would continue to use their expertise in the new organisation.

The NHS had certain plans, goals and responsibilities to discharge and most would be delivered at a local level but some would be carried out on a larger scale.

The ICB had the opportunity to learn from developing innovations which included technology, medicine and the organisation of services. Whilst the focus would be on health locally, recognition would be given to the interconnectedness that would come from both local, national and a global perspective.

The challenge for this region was its health inequalities, high levels of preventative disease and premature deaths. The work on these issues would be assisted by a partner board that would be established as part of the new statutory arrangements – the Integrated Care Partnership. This would be set up with the local authority partners.

The Chair asked the members to introduce themselves.

B/2022/02 Apologies for Absence

Apologies were received from Hannah Bows, Independent Non-Executive Member Patient and Public Involvement, David Stout, Interim Independent Non-Executive Member (Audit), David Purdue, Executive Chief Nurse and Cath McEvoy-Carr, Local Authority Partner Member (Designate).

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B/2022/03 Declarations of Interest

Members had all submitted their declarations prior to the meeting and no additional declarations were raised.

The ICB had adopted the former CCG format for declarations of interest with the intention to extend these on the basis that they had been tied into the commissioning process with the ICB having a wider remit.

B/2022/04 Constitution and Standing Orders

The ICB's Constitution and Standing Orders had previously been formally approved by NHS England and provided for information only to members as the final version.

RESOLVED:

The Board **RECEIVED** the Constitution for information.

B/2022/05 Introduction to Governance Handbook and Functions and Decisions Map

An introduction to the governance handbook and its key documents was made, including the functions and decisions map.

Tribute was paid to the corporate governance leads for all the work they had put into this piece of work.

The functions and decisions map was part of a standard set of governance documents within the handbook that would require approval from the Board. The other documents detailed within the handbook would be covered by separate agenda items.

RESOLVED:

The Board **RECEIVED** the functions and decisions map for information and **NOTED** the other documents referenced in the handbook were to be covered as separate items on the agenda as they required formal approval.

B/2022/06 Standing Financial Instructions and Financial Limits

The standing financial instructions (SFIs) and proposed delegated financial limits were presented to the Board.

The SFIs are the financial framework that the ICB operates within and form a key part of the control environment. The SFIs were a standard national template.

The main change to the standard template was to post titles, for example Chief Finance Officer to Executive Director of Finance.

The financial limits had been prepared and led by the former CCG chief finance officers and were an aggregate of previous CCG arrangements. Caution had been undertaken with the limits as this was a new organisation. It was noted that these limits would be tested and develop over time.

RESOLVED:

The Board **APPROVED** the standing financial instructions and proposed financial delegated limits.

B/2022/07 Scheme of Reservation and Delegation

The Scheme of Reservation and Delegation were presented to the Board.

This was a standard document which set out the responsibilities and functions reserved to the Board and those that were to be delegated through either committees or individuals.

RESOLVED:

The Board **APPROVED** the Scheme of Reservation and Delegation.

B/2022/08 Establishment of Board Committee Structure

The proposed Board committee structure was presented to the Board.

A significant amount of work had been undertaken in proposing the committee structure along with considering the relevant national requirements and supporting guidance.

The proposal was to establish five committees of the Board as follows:

- Audit Committee
- Remuneration Committee
- Executive Committee
- Quality and Safety Committee
- Finance, Performance and Investment Committee

The paper set out the proposed chairing arrangements for the committees. Each committee would be chaired by an independent Non-Executive Member with the exception of the Executive Committee which would be chaired by the Chief Executive.

The naming convention for the Audit Committee would be checked to ensure it had been applied consistently throughout the document.

Clarification was sort in relation to the recruitment process to the committees and it was noted that this would be worked through with the corporate governance team and circulated to all members.

Action: The proposed committee membership to be circulated to all Board members for information.

RESOLVED:

The Board **APPROVED** the establishment of each of the committees, along with the proposed chairing arrangements and membership.

B/2022/09 Terms of Reference for agreed board committees

The terms of reference for each agreed Board committee were presented to the Board for approval.

These followed a standard template in line with NHS England guidelines and had been developed in partnership across the North East and North Cumbria by governance colleagues.

RESOLVED:

The Board **APPROVED** the terms of reference for the committees.

B/2022/10 Adoption of Key Policies

As part of ICB establishment, the Board was being asked to approve and ratify those corporate policies that were considered high-risk and substantive, as outlined in Schedule A of the paper, and agree a proposal to ensure the early approval of all other policies and strategies.

The policies had been adopted from the former clinical commissioning groups' procedures for continuity of business. They had not been reviewed fully in an ICB context and would require more detailed discussion and adjustment and need would need to be modernised. It was proposed to agree the policies for the moment but they would be brought back in a modified form in the near future.

Action: all policies to be reviewed within the first six months following the establishment of the ICB to ensure they reflected an ICB perspective.

RESOLVED:

The Board:

- **RATIFIED** the strategies, policies and plans outlined in Schedule A
- **DELEGATED** authority for Executive Directors to approve any minor/immaterial future updates, taking into account that the policies had been drafted by subject matter experts and governance colleagues

- **DELEGATED** the 'first approval' of HR related and other corporate related strategies, policies and plans to the Executive Committee. Subsequent approvals would be in line with the Scheme of Reservation and Delegation.

B/2022/11 The People and Communities Involvement and Engagement Framework (Strategy) 2022

The People and Communities Involvement and Engagement Framework (Strategy) outlined the ambition to develop a strategic approach and consistent standard across the region for the ICB, reflecting the following principles:

- Involving and engaging partners, stakeholders and the public in planning, design and delivery of our services is essential if we are to get this right.
- Wherever, and whenever, possible we will include meaningful involvement as part of our work. We want people to help us design, develop and improve services by sharing their views and experiences. The people we listen to and involve need to reflect the communities we serve.

Tribute was paid to the engagement leads across the North East and North Cumbria for the development of the comprehensive document.

Positive feedback had been received from NHS England in that the strategy was one of the most robust they had seen and set out the ambition, drive and motivation to achieve for the ICB and wider Integrated Care System (ICS). A lot of work was still to be done in conjunction with partners and Healthwatch.

The strategy set out a very comprehensive voice of the people with clear intentions, however this now needed to be translated into practice and to engage with the wider public. It was recognised that there was excellent work being undertaken at a place base level with voluntary sector organisations and communities that would continue to be built upon.

A process for development of an integrated care strategy would be taken to the first Integrated Care Partnership meeting along with a communication, engagement and co-production plan that would sit alongside the strategy. An offer was made from Healthwatch to assist with this in any possible.

The pressures on primary care were highlighted and how patient and public involvement could be improved in relation to these services. It was important to bring patients into the conversation to explain the issue and come up with solutions.

The framework presented an opportunity to share best practice, to ensure to listen and engage with all parts of the communities. It was acknowledged that

some parts of the community would not be accessing health services for active treatment.

In terms of mental health there were a number of policies looking at integrated community transformation bringing communities together and to look at mental wellbeing. The challenge was to draw upon these opportunities to make a significant impact.

There was an expectation that all business cases should have evidence of involvement and engagement, this it was noted was a positive step towards embedding the principles of the strategy.

The Board noted it was positive to hear of the existing engagement and involvement mechanisms and pockets of good practice across both the health and care system, however there may be some areas where messages had not yet reached and these needed to be focussed upon.

Staff had been involved in shaping the values and listening to communities in a respectful and compassionate way. An in depth engagement exercise had been undertaken with over 3,000 individuals asking what was important to them in terms of their health and wellbeing.

The Board was encouraged to hear the commitment from all partners and to have the opportunity to focus on this area of work.

RESOLVED:

The Board **APPROVED** the framework (strategy), understood the resource and governance implications and committed to a learning approach developing the strategy as the ICB matures and learn and develop with partners and communities.

B/2022/12 Confirmation of Special Lead Roles

The report set out the specialist lead roles and appointed board members roles that were required to be appointed by the Board. It was noted that Dr Nadkarni was from a mental health and learning disability organisation and as a member of the Board would fulfil the role of board mental health lead.

There were five further roles that had not been captured in the paper but were a specific request from NHS England as follows:

- Executive lead for children and young people - this would be the Executive Chief Nurse David Purdue who would also hold the role for the North East and North Yorkshire region
- Lead for children and young people with special education needs and disabilities and also the executive lead for safeguarding – this responsibility would also sit with David Purdue as Executive Chief Nurse

- Executive Lead for learning disability and autism - this would be Mark Adams Executive Director of Place Based Delivery (North and North Cumbria)
- Executive lead for Downs syndrome – this would be Dr Neil O'Brien, Executive Medical Director.

RESOLVED:

The Board **AGREED** the named leads as identified in the report to undertake the special Board roles as highlighted and **CONFIRMED** the mental health board level lead would be fulfilled by the foundation trust partner member Dr Nadkarni.

B/2022/13 Appointment of founder board member of the Integrated Care Partnership

The report provided the Board with an update on the development of the Integrated Care Partnership (ICP).

The ICP was made up of the constituent places across the North East and North Cumbria and the paper proposed that the founding member was to be Professor Sir Liam Donaldson.

The ICP would have a core role setting the strategy for the next five years and seek to address inequalities and wider social determinates of health.

The preference was for one large ICP and four small area ICPs to work on a more day to day basis to be more sensitive to local needs. These would be distributed nearer to local populations elements of the ICP which was still open to discussion.

RESOLVED:

The Board **APPOINTED** the ICB Chair as the founder member of the Integrated Care Partnership for the North East and North Cumbria Integrated Care System.

B/2022/14 Integrated Delivery Report

The peport provided an NENC ICS overview of quality, performance and outcomes. It was noted finance would be included in future reports. The report was a high-level and parallel view of performance and quality to ensure oversight and delivery of the 2022/23 planning priorities.

Thanks were given to all the staff involved in pulling the report together.

It was noted that going forward the report would be structured into categories of oversight, assurance, escalation and improvement support.

There was still work to do to ensure true intelligence with regards to the position of services and also to include health and inequalities throughout the report.

The NHS system oversight framework had been published recently and this would be brought to a future meeting following further work around its implementation with NHS England.

The outcome measures and health inequalities were discussed highlighting smoking prevalence, noting the lower and slight reduction in gaps from the highest to lowest. In regard to depression prevalence a higher level had been seen and a widening of inequalities. There was a national strategy around health and inequalities (Core20Plus5) which looked at the 20% of the population suffering the worst inequalities and focussing on delivering improvements in this area.

A summary was shown on the quality oversight work highlighting the significant workforce pressures and absence rates driven by the Covid-19 pandemic.

It was noted that a detailed report on the Ockenden maternity review would be brought to the next Board meeting.

In relation to primary care activity levels the following were highlighted:

- a trend rate for Did Not Attends (DNA) was identified
- the provision for face-to-face appointments
- a single data point to give a sense of scale 1.2m appointments had been delivered

The national A&E performance standard stood at 78% against the required 95% target. The national performance stood at 73% which was a cause for concern. There had been an increase in trolley waits and admittance to beds across the region.

Ambulance handovers and response times in May were highlighted as to what was being measured and where the issues were. An action plan had been put in place to address these.

Targets had been set for the referral to treatment (RTT) 18-week standard to progress the waiting times on these.

Waiting times were noted to be falling. The national ask was that no patients would wait for 104 weeks, however there were still a small cohort of patients awaiting complex spinal operations. Work was ongoing at a national level with NHS England to find a solution to this issue.

The national cancer standards in terms of faster diagnosis stood at 76% against a target of 75% across the region. Challenges were highlighted in regard to the 62-day pathway, there had been a backlog over this referral to treatment standard. A recovery plan had been put in place.

The increasing numbers of patient contacts, treatments and assessments taking place in relation to mental health, learning disabilities and autism was noted.

The Chair suggested a short break in the proceedings at this point.

The meeting was paused from 2.05 to 2.25pm.

On returning to the meeting the Chair asked for any comments on the integrated delivery report.

The report was welcomed acknowledging that it was work in progress. adding that this may be an opportunity to look at other data sets to add to the report including the voice of the citizens helping to identify any issues of concern going forward.

A point was made in relation to the primary care data set recognising the amount of activity throughout the pandemic and the face-to-face consultations that had continued. Also to recognise that 70% of the vaccinations given nationally were administered by primary care.

Going forward it will be important to look at the social care data and to analyse the data and the impact of this and highlighting inequalities.

Thanks were given to foundation trust colleagues for the collaboration shown in focussing on driving down waiting times. Thanks were also given to GP colleagues for their work in continuing to increase face to face appointments and address those patients who 'did not attend' their appointments.

Workforce was noted as a significant challenge and a discussion took place as to how this could be addressed as a system. The profile of the workforce was highlighted as a number of staff were reaching retirement age and some were leaving early due to the pressures of the role. It was noted that were a number of doctors in training in the area at the new Sunderland Medical School and would be encouraged to remain local. Workforce planning was also underway with Health Education England.

Recruitment work had been ongoing with Health Education North East (HENE) regarding the NHS campaign which focussed on attracting junior doctors into the region into specialty positions and GP training positions. There was more to be done to revitalise this and look at how to attract junior doctors into the area.

A plea was made in light of the increased use of technology to attract and retain people in data and technical careers.

Staffing issues were highlighted from a local authority perspective in relation to carers, home care and nursing homes. Work was underway to understand the position and the implications across the system.

RESOLVED:

The Board **RECEIVED** the report for information and assurance.

B/2022/15 ICS 2022/23 Operational Plan

A high-level overview of the ICS's operational plan for 2022/23 was presented.

In terms of context, the NHS had issued operational planning guidance to providers and the former CCGs (more latterly to ICS's) to lead the planning process on behalf of the NENC ICS involving all providers and commissioners. This process was concluded by 20 June and submitted.

A summary of the key points was given, these included:

- Finance – a balanced plan for the ICS had been submitted. In terms of capital expenditure, conversations were still being held with NHS England. The main drivers were increased pay costs, a reduction in income and exceptional inflationary costs. The planned efficiencies of 3.5% were challenging as the plans relied on some non-recurrent measures. The ICS was in a challenging environment and to deliver these plans would require careful management with a robust planning process to enable delivery
- Workforce plan – the aim was to increase the substantive workforce by 3.8% to recruit to existing vacancies and create additional posts. The corresponding reduction in agency and bank staff spend was highlighted. There was an ambition to grow the primary care workforce by 1.26%
- Activity plan – the plan met the 104% value weighted activity in numbers and value to reflect the complexity of activity and rise in demand. The plan included an ambition to increase diagnostic tests to 120% of the 2019/20 volume of activity
- Triangulation – to ensure a workforce plan that met the needs of the activity plan and a financial plan

The plan included an ambition to have a 25% reduction in outpatient follow ups by March 2023. This was a challenge due in part to the backlog caused by the pandemic but also increased activity however there were opportunities to undertake transformation work around this.

Key risks to the organisation were shared, these included the following:

- A challenging revenue position
- 104% activity by value
- A range of workforce issues including recruitment and retention issues
- The awaited development of the ICS clinical strategy
- Urgent and emergency care pressures remained high and a number of medically fit patients awaiting discharge

- Managing pressures on mental health services
- Sustaining elective recovery and deliver of planned activity.

It was noted that the planning process had been long and plans were usually produced earlier in year. Nationally, ICSs were in a similar balanced position although there were still issues to address.

It was recognised that a lot of work had been undertaken and had been very NHS focussed. In terms of ambition, the focus would be on the bigger picture to address health inequalities. There was, from a social care perspective, the need to understand the shift in activity from health to social care and to work jointly as a system avoiding duplication.

A discussion took place in relation to social care and care in homes. It was noted that additional funding was going into local authorities for adult social care and would be directed via the ICS. This would present an opportunity to understand the system issues and priorities to ensure resources were appropriately allocated.

It was noted that the Learning Disability Network were looking into the process for health checks and utilising learning from the voluntary sector on these.

The risks and priority challenges in the care sector were recognised. The data showed that the system required transformation due to a combined number of issues such as unprecedented levels of hospital occupancy; significant pressures on the elective recovery plan; and the implications of increasing activity for social care. A strategy to address this was important alongside identifying new ways of working within the constrained financial position.

RESOLVED:

The Board **RECEIVED** the presentation for information.

B/2022/16 ICB Budget 2022/23

The report provided the Board with an overview of the high-level commissioning budgets for the ICB for the financial year 2022/23 and reporting period July 2022-March 2023.

As set out in the standing financial instructions, the Board was required to approve budgets to allow the ICB to incur expenditure. The report acknowledged the wider NENC ICS but focussed on the ICB.

Highlights from the report included:

- The £4.9bn allocation for the remaining nine-month period for 2022/23, plus the £2.6m surplus in the plan for the whole year

- The report had been prepared under national guidance but informed by the local knowledge and expertise of the preceding CCGs.
- The continued focus on elective recovery and delivery of long term plan objectives
- The reduced Covid-19 funding compared with 2021
- The cessation of the hospital discharge recovery

In terms of risk for the ICB, the delivery of efficiencies and performance overall across the ICS were sufficient to earn the relevant elective recovery funding to cover the amount identified within the plan. The risks would be managed throughout the year and reported to the Board on a regular basis.

RESOLVED:

The Board **APPROVED** the high-level commissioning budgets for the period July 2022 to March 2023.

B/2022/17 Health inequalities and Sustainability for north East and North Cumbria ICS

The report presented an overview of the current health inequalities faced by communities across the North East and North Cumbria (NENC).

The report gave an overview of recovery from the Covid-19 pandemic and highlighted a 40 year high in terms of cost of living which had an increase in the number of families in poverty. From a NENC perspective, the significant work on prevention by Dr Guy Pilkington, Applied Research Collaboration and Amanda Healy, Director of Public Health in Durham, had been recognised. They had co-chaired the NENC Prevention Board and undertaken a number of prevention initiatives.

The report set out the circumstances that were particular to the NENC. Life expectancy was below average in the most deprived communities. There was a significant amount of work to be undertaken to address health inequalities and a recommendation made to establish a group to examine the work on health and inequalities and bring proposals back to a later Board meeting. The group would draw on the skills of key partners across our ICS to provide strategic leadership, support, challenge across the system to shape an inequalities strategy for the ICS and ensure the delivery of key local and national priorities.

A discussion took place as to how the Board would gain assurance on the strategy work and ensure health and inequalities were considered in every agenda item. It was noted there were existing ICS workstreams focussing on this agenda, although further connections could be made for this area of work. For example, the experience of the local universities and how to connect across the number of places across the NENC.

The Applied Research Collaboration (ARC) linked together universities across the NENC with all partners across NHS, social care and public health and had 58 organisations as part of the collaborative. The ARC had a budget of approximately £4m to take forward this work under health and care and prevention.

In Cumbria and Lancashire, a health equity commission had been initiated by the local authority and partners and this work should be considered by the relevant workstreams.

A note of caution was made in that there may be a number of organisations tackling the same agenda and this could lead to duplication. The Board noted that work should be coordinated to avoid this and the task and finish group needed to consider this.

There were clear priorities and outcomes in place and how these could be measured as to the impact on our communities was crucial. The task and finish group would be asked to bring their outcomes back to the Board at a later meeting and ensure work was not duplicated.

RESOLVED:

The Board **AGREED** to convene a task and finish group to review the current coordination arrangements for reducing health inequalities across our system, and to make recommendations to the ICB and ICP for the formation of a multi-agency expert advisory group to drive this work going forward.

B/2022/18 CCG Closedown due diligence handover report

The North East and North Cumbria CCGs' closedown report was presented to the Board, setting out the due diligence process and activities that had taken place over the previous six months.

RESOLVED:

The Board **NOTED** the content of the report and the outlined high level and shared CCG closedown activity risks and issues.

B/2022/19 Schedule of future meetings

To provide members with the Board meetings date for the remainder of the financial year for 2022/23.

It was noted that additional meetings would only be arranged if it was felt they were needed and would add value. For instance, a deeper dive into broader issues such as rural or coastal health, population health and access to services.

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RESOLVED:

The Board **RECEIVED** the Board dates for information.

B/2022/20 Any other business

There were no other items of business and the meeting closed at 15:35.

Item: 7
Enclosure: 2

NHS
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REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	
Official: Sensitive Commercial		Provides assurance	✓
Official: Sensitive Personal		For information only	✓

BOARD MEETING 27 September 2022	
Report Title:	**Chief Executive Report**
Purpose of report	
The purpose of this report is to provide an overview of recent activity carried out by the ICB Chief Executive and executive directors, as well as some key national policy updates.	
Key points	
The presented report covers national updates including cabinet changes and a range of North East and North Cumbria business updates.	
Risks and issues	
There is a constant cyber risk to the NHS. The report describes a recent cyber security incident.	
Assurances	
The presented report provides assurance to the board of recent business activity and development carried out by the ICB Chief Executive and executive directors.	
Recommendation/Action Required	
The Board is asked to receive the report for information and assurance.	
Sponsor/approving director	N/A
Report author	Samantha Allen, NENC ICB Chief Executive
Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓

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CA2: tackle inequalities in outcomes, experience and access						✓
CA3: Enhance productivity and value for money						✓
CA4: Help the NHS support broader social and economic development						✓
Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	None noted.
Has there been/does there need to be appropriate clinical involvement?	Not applicable – for information and assurance only.
Has there been/does there need to be any patient and public involvement?	Not applicable – for information and assurance only.
Has there been/does there need to be partner and/or other stakeholder engagement?	Not applicable – for information and assurance only.

Item: 7
Enclosure: 2

NHS
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Chief Executive Report

1. Introduction

The purpose of this report is to provide an overview of recent activity carried out by the North East and North Cumbria Integrated Care Board (the ICB) Chief Executive and executive directors, as well as some key national policy updates.

2. National Issues

2.1 Cabinet Update

Thérèse Coffey was appointed Secretary of State for Health and Social Care and Deputy Prime Minister, on 6 September 2022. The immediate priorities the Secretary of State has set out have been described as:

A – Ambulances
B – Backlogs
C – Care
D – Doctors / Dentists

2.2 Delegation of specialised services to ICBs

In May NHS England (NHSE) published a roadmap setting out which specialised services may be suitable and ready for greater local leadership from April 2023. Prior to delegation, in April 2023 there will be a pre-delegation assessment of each ICB to determine readiness to assume responsibility. The delegated services will include:

- All pharmaceutical, general ophthalmic and dental services (POD)
- Specialised services that have been identified as suitable and ready for further integration subject to system readiness (65 services have been deemed to be both suitable and ready for integrated care system (ICS) leadership from April 2023, with 106 reserved to NHSE (typically services for no more than 500 patients per year). A final version of this list (Annex A) will be issued later this year.

A formal system readiness assessment will be conducted during quarter three which the NHS England Board will consider before making any final decision to delegate the commissioning responsibilities from April 2023. Specialised services will be funded based on historical financial allocations ahead of the planned delegation of

services to ICBs from 2023/24 – with a needs-based weighted population-based funding allocation from April 2024 (at the earliest).

For other direct commissioning functions, NHSE have begun to determine potential future commissioning models from April 2023:

- Health and justice, sexual assault and abuse service (SAAS) functions will remain with NHS England. However, the ambition is to work towards a model of joint working with ICBs
- Section 7A NHS public health functions (screening, immunisations, and child health information systems) will remain with NHS England but with progress towards joint working and possible delegation from April 2024
- Healthcare for serving members of the Armed Forces and their families registered with defence medical services, veterans' mental health and prosthetic services will remain with NHSE.

The ICB has started to work closely with the NHSE Regional Team to scope out the work required prior to delegation of responsibility. Given the scale of the ICB it is likely we will take responsibility for commissioning these services across the North East and North Cumbria subject to ICB and NHSE approval. At this stage I would prefer to take shadow responsibility from April 2023 prior to taking full responsibility from 2024.

3. North East and North Cumbria Issues

3.1 Clinical Commissioning Groups

The ICB was created from eight separate clinical commissioning groups (CCGs) and the ICB inherited their workforce, policies and ways of working. Whilst there was some integration and joint working (mainly on Teesside) there are a number of issues to consolidate, review and establish new ways of working across the ICB to ensure consistency across the place-based teams and ICB. Given the extent of this work and lack of integration across the CCGs in the lead up to the ICB, I anticipate this will take 12 – 24 months to complete. Whilst there is internal work underway with regard to culture, embedding and our new structures there is also significant work required to ensure our population is able to access care in accordance with national guidelines e.g., NICE. An initial look at compliance with NICE guidance suggests there are differing approaches based on the former CCG footprints. An audit of compliance is underway to identify priority areas to address.

3.2 Developing a multi-professional clinical leadership framework

Engagement is taking place on the development of a multi-professional clinical leadership framework. Internally, this process will inform the proposals for the ICB clinical leadership structure that will enable consultation with affected clinicians. Planning and scoping work is underway for this consultation process to commence on 3 October 2022. Consultation will run for 30 days until 1 November, and we will move into the recruitment process from 11 November.

3.3 Health Inequalities

At our ICB meeting in July we acknowledged that we met for the first time against the backdrop of some of the most persistent and growing health inequality challenges in the country. The ICB agreed that we needed to redouble our efforts in this area and resolved to convene a task and finish group to review our current coordination arrangements for reducing health inequalities across our system, and to make recommendations to the ICB and Integrated Care Partnership (ICP) for the formation of a multi-agency expert advisory group to drive this work going forward.

Such a group will draw on the skills of key partners to provide strategic leadership, support, challenge across the system to shape an inequalities strategy and ensure the delivery of key local and national priorities.

Dr Neil O'Brien is leading this work and will ensure that the following issues are addressed in the review:

- Review of all our current governance arrangements to ensure clarity and consistency, including the future roles of the current Prevention Board, Health Inequalities Advisory Group, and Population Health Management Group
- Coordinated oversight of our current priority areas and programmes – including the existing tobacco, alcohol and obesity programmes, and the 'deep end' GP practices network
- Making the links to other ICS workstreams, including workforce, child health, and sustainability, as well as input from procurement, finance, education and training and policy development
- Agreeing a consistent model of population health management (PHM), and how PHM tools are best utilised at both system-wide and place level
- How we resource and coordinate this work with partners including the joint work we will need to coordinate with our local and combined authorities on economic development
- What capacity we need to effectively analyse latest national thinking from government, universities and thinktanks – for example the recent Health Foundation Report on this subject
- How we measure, evaluate and audit the outcomes and improvement that our joint work delivers so that we understand what works and how we can share spread best practice.

More broadly, I am keen to see how we can think differently regarding funding streams to support grass-roots activity, including via a charitable foundation or other income-generating mechanisms.

We need to ensure we capture all elements and levers available to us to enable widespread mobilisation to tackle the challenges we face. As such, I am keen for this work to be reported to both the ICB and the ICP (and our four Area ICPs) to emphasise what a cross-cutting and system-wide challenge this is. I will bring some final proposals on this work to the November ICB meeting for the Board's consideration.

3.4 EFRA Committee Inquiry on Rural Mental Health

I was pleased to be invited to give evidence to this Committee on some of the mental health challenges faced by our rural communities alongside NHS England's National Mental Health Director, Claire Murdoch. The Committee's key areas of focus were on NHS England's commitment to work with Department for Environment, Food and Rural Affairs; the specific needs of agricultural and veterinary workers; data on suicides in rural areas; key metrics of success and the breakdown of ICB funding formulas and weightings to reflect rurality.

As the largest ICS area in the country, with a large rural population spread across Northumberland, Durham and North Cumbria I was able to update the Committee on the challenges of service delivery in rural areas with their hidden pockets of deprivation, relatively high rates of suicide (especially among men in the agriculture sector), patchy digital infrastructure and the challenges of attracting and retaining a workforce to work in rural settings. I also highlighted the barriers to accessing specialist services at some distance from rural communities.

We explored some of the innovative solutions that we have pioneered so far including the ICB-led initiatives on recruitment and retention – e.g., the successful "find your place" campaign, and engaging communities and the voluntary, community and social enterprise sector (VSCE) to develop co-produced plans for good mental health and suicide prevention. We also looked at the opportunities as well as challenges in whatever replaces the Common Agricultural Policy which provided financial support to farmers pre-Brexit (in 2019-20 farmers in England received over £1.8 billion in direct payment subsidies), and how the UK government might balance effective land management, and a sustainable and productive farming sector, alongside mental wellbeing for rural communities and benefits for the environment.

As an ICS that covers an area of 5,500 square miles – which is over half the size of Wales – with some of the most remote and rural communities in England, I was clear that adequately weighted funding for ICBs is a matter for government and it needs to take into account the unavoidable cost of providing services across the large rural areas that make up the North East and North Cumbria.

3.5 New Local Authorities of Cumberland and Westmorland and Furness

Board members will be aware that Cumbria County Council and its six constituent district councils are being abolished and replaced by two new unitary authorities from 1 April 2023:

- Cumberland Council – comprising the former districts of Carlisle, Allerdale and Copeland
- Westmorland and Furness Council – comprising the former districts of Eden, South Lakeland and Barrow-in-Furness.

Our current ICB footprint is based on the old North Cumbria CCG boundary, which covers Carlisle, Allerdale and almost all of Copeland (except the town of Millom,

which was previously in Morecambe Bay CCG due to hospital flows to Furness General Hospital in Barrow).

Therefore, our ICB area covers (a) almost all of the new Cumberland Council footprint (except Millom which will be in Lancashire and South Cumbria ICB), as well as (b) approximately 50% of the new Westmorland and Furness Council area due to our retention of the Eden district.

ICB footprints have been largely determined based on historic patient flows, and from as early as the foundation of the NHS in the 1940s, patient flows from North Cumbria/Cumberland across the Pennines for specialist treatment were recognised in the drawing of the NHS's regional boundaries – indeed, our current ICB footprint matches almost exactly the 'Newcastle Regional Hospital Authority' (RHA) boundary established by the first NHS Act in 1946.

However, both myself and NHS and local authority colleagues in Cumbria recognise that system boundaries should always be managed carefully and kept under review, so I have had early discussions with my counterpart in Lancashire and South Cumbria ICB, Kevin Lavery. I was also very pleased to be invited to participate in the recruitment of both Andrew Seekings as Chief Executive of Cumberland Council, and Sam Plum as Chief Executive of Westmorland and Furness Council and have met with both since their appointments. These will be key relationships for us going forward and I look forward to supporting our North Cumbria Place Team to work closely with Andrew and Sam.

3.6 Surge Management Workshop

It was great to see over 140 delegates at our session on the 17 August where we came together as a system to test our winter plans. The event was chaired by Helen Ray, Chief Executive, North East Ambulance Service, and the opening address was given by Jacqueline Myers, the ICB's Executive Director of Strategy and System Oversight.

The event gave us all the time out to consider how we best pool our vast skills, experience and knowledge from across the spectrum of our system to develop a shared action plan that balances our urgent operational challenges whilst planning for the future in a strategic way. The stakes have never felt higher and this was expressed by many who participated: the surge we are seeing all year round, the backlog created by the Covid pandemic, the cost of living crisis and the tightening economic outlook in the health and social care sectors (and the pressure on the workforce) all create a multi-faceted challenge that we must respond to as a system.

We were pleased to welcome Matthew Taylor, Chief Executive of the NHS Confederation, to give a keynote address, and his emphasis on 'split screen thinking' (considering our immediate and longer term priorities) alongside empowering our staff, overcoming boundaries and freeing up capacity - and how we communicate clearly to the public - was extremely helpful. He also spoke eloquently about our how we have tended to invest in bricks but not the mortar, in pistons but not the oil, and was referring to us all in our system as the mortar that binds us together and the oil

that enables the parts to work in congruence, to deliver high quality urgent and emergency care in the most challenging of circumstances.

I was inspired by all the speakers, and it is clear that we need to take the best learning from the Covid period, where whole communities and voluntary services were activated, where organisations shared and re-deployed staff in agile and flexible ways, where we all rallied around a compelling need. Such an approach should be a guiding principle for ICSs, but the event also helped us to identify some key emerging areas of focus:

System focus on managing inflow - right care, right time, right place

- How we manage the 'front end' including call handling, clinical advice, alternative dispositions
- The role of anticipatory care in unblocking pressure points at handover and discharge
- How this approach is integrated into primary, community, and mental health services.

Making the best use of all of our resources especially our staff –

- Exploring options for flexible staffing and the freedoms that worked during Covid
- Redeployment opportunities, careers and working across health and care
- Integrated neighbourhood team developments, and how we implement the Fuller Report.

Call to Action

- As the country faces a humanitarian crisis, a call to action across our system and communities
- Creating integrated lists of vulnerable people, mobilise VCSE and community support, proactively support those in fuel, energy and food poverty, and those socially isolated
- Lobbying nationally and to businesses and regulators about support packages, and sensitive policy changes that anticipate the looming cost of energy crisis.

A follow up event is planned for the 28 September where we will build on these discussions and agree a programme of action, and I will update the Board at our meeting in November.

3.7 Cyber Security Incident

Strengthening our cyber resilience is a crucially important responsibility, and that was a key driver for the appointment of Graham Evans to be the ICB's Executive Chief Digital Officer. Our cyber security arrangements ensure that we comply with relevant standards, protect patient data and can respond effectively in the event of a cyber incident.

We recently experienced a cyber security incident, which Graham will outline in more detail at our Board meeting. 'Advanced', a key NHS clinical and line-of business technology service provider, was impacted by a Ransomware attack on 4 August 2022. A national Level 3 incident, coordinated by ICB emergency preparedness,

resilience and response (EPRR) teams – including ours – was initiated and business continuity arrangements mobilised, and the current position is now moving into a phase of recovery and restoration.

Cyber security threats of this nature are an on-going and present risk for us as an ICB, and something that can have far reaching adverse impacts to the health and care system – not least as our health and care system is increasingly digitally dependent on some common/shared digital systems and services as well as common vendors within the health and care supply chain.

I would like to commend the prompt action and thorough follow up to this led by Graham's team, and this will remain an area of focus for us and a key risk that we will formally register once formal after-action reviews have concluded, and appropriate lessons learned.

3.8 Reducing the use of Agency Staff Across our System

NHS England (NHSE) is introducing a new ceiling on the amount spent within each integrated care system on agency staff as part of a drive to find further savings across the health service. Agency spending caps were first applied to trusts from 2015 but agency spending has grown due to the operational challenges faced during the pandemic.

The move is part of a wider efficiency programme from NHSE, with further national control measures to be introduced over the next 18 months, and system spending will be assessed under NHSE's oversight framework. NHS England has set a 2022/23 agency spend cap for each Integrated Care Board. This is based on an aggregate of plans submitted by provider organisations. The cap for the North East and North Cumbria is £74.6m, which is a relatively low target, but one that is based on an ambitious plan to reduce the level of 2021/22 spend by almost 30%. This will be challenging to deliver so to support our system in managing spend on agency staff we are working closely with our Foundation Trust Provider Collaborative, providing analysis of the position and helping to identify good practice in the management of agency spend.

3.9 North East and North Cumbria Learning and Improvement Community

Central to our improvement approach, on 21 September the ICB will be hosting a special event to bring together diverse teams from across the region so we can start to create a learning and improvement community for the North East and North Cumbria.

A learning community is a group of peers who come together in a safe space to share their judgements and uncertainties about their current practice and to share ideas or experiences to collectively improve. A shared understanding of what excellence looks like is co-created. This peer – or horizontal – accountability is core to the learning community purpose: the approach has its roots in complexity theory and the benefits arising from adopting a 'positive error culture'.

The event will be held at St James' Park in Newcastle. It will be an interactive day, designed so that everyone can contribute. The aims of the day are to:

- Mobilise people from across North East and North Cumbria (NENC) who can contribute to achieving our system goals for health improvement
- Create the founding membership of our NENC learning and improvement network.
- Enable 'boundaryless' learning across the NENC, making connections and sharing data and learning - across geographical, system, organisational and sector boundaries
- Acknowledge and celebrate the existing strengths and assets of our system for learning and improvement.
- Agree actions to co-create the network and the outcomes we want it to help improve.

3.10 Workshop with the Association of Directors of Adult Social Services (ADASS)

The ICB Executive Team members held a constructive workshop with our ADASS colleagues from across our local authorities on 2 August where we explored principles of future working, shared priority areas and focussed action, and how ADASS can be supported to work across the system.

As the North East branch of ADASS is almost coterminous with the ICS (with colleagues from Cumbria unofficially attending their branch meetings), this offers us a real opportunity to work smarter and make the best use of capacity and skills. We explored how the ICB has taken over the eight CCGs' budgets and responsibilities (but delegating much of these powers back to ‘place level’). Several budget lines including continuing health care, and funded nursing care are interdependent with social care budgets, and new social care funding is being allocated to ICBs. We have the potential for greater alignment and pooling of budgets to promote the key determinants of good health, and we will work with ADASS on shaping our approach to integrated commissioning at place and system level. We also considered a range of important areas of mutual interest, including how we have approached the commissioning of learning disability and autism services, the emerging work on 'fare cost of care' (FCOC) and our joint approach to strategic housing.

The North East ADASS representative on the ICB Board - Ann Workman, Director of Adult Social Services (DASS) for Stockton – will be the overall ADASS lead for the ICB, and we also committed to looking at DASS representation in each of our ICP a We also committed to aligning DASS leads to the ICS priority areas – making better use of the North East ADASS governance structure, avoiding duplication of effort and allowing the best person/organisation to lead.

The creation of a statutory Integrated Care Partnership of the ICB and our 13 local authorities setting joint system priorities in an integrated care strategy, and it has been extremely helpful to have DASS involvement in the working group looking at the formulation of this strategy, and we will also need to engage with the Adult Social Care Lead Member Network.

Much of our collaborative work is already in train and focused on the day-to-day operational challenges of delayed discharge, market frailty, sustainable funding flows and more importantly driving quality and improvement for service users and carers. However, we also considered a range of other strategic areas where we share priorities, including workforce planning, market shaping and longer-term commissioning and understanding our shared financial position and future pressures for the ICB and local authorities.

There are a number of key enablers which will support these shared priorities, including housing (where each local authority is responsible for a refresh of their housing needs assessment, and ADASS have established a housing board which we will participate in), technology, and joint work on the Great North Care Record and electronic care records and sensory equipment is already in train, and quality and safeguarding – as ICBs and local authorities are statutory partners for children's and adult's boards – and preparation for inspections given that both the ICB and local authorities will be inspected next year.

In terms of next steps, we committed to building relationships via informal workshops between the North East ADASS and the ICB senior leadership team, meeting at least three times per year, where we will focus on a small number of joint priority areas to add value and pace for the system. We also agreed to take forward a range of practical next steps which will further strengthen our joint-working arrangements:

- Joint project roles, integrated posts and secondments
- Developing joint communication messages and campaigns
- Scoping an service level agreement regarding analysis of data/information as happens in other ICS areas
- Agreeing a protocol of how the system/ICB engages with the independent social care sector, building on existing local authority-led local provider forums).
- Supporting user and carer involvement arrangements to better understand lived experience
- Supporting each other with the new assurance frameworks for social care and ICSs
- Coordinating interactions with Department of Health and Social Care and NHS England regional teams
- Involving ADASS colleagues in key ICB workshops, e.g., those on winter planning and assurance

3.11 <u>First Meeting of the Integrated Care Partnership</u>

The inaugural meeting of our Integrated Care Partnership (ICP) was held on the 20 September. The ICP is a statutory joint committee of the ICB and the 13 local authorities in the North East and North Cumbria and responsible for setting the priorities for our system through the development and approval of an integrated care strategy for our ICS. Sir Liam Donaldson helpfully agreed to chair the meeting in the interim, although we agreed that we will appoint a substantive chair at our second meeting in December.

The meeting was very well attended, and we were able to consider national guidance on the establishment of ICPs, as well as it's chairing and membership arrangements. We also considered recommendations on ways of working between the strategic ICS-wide ICP and our four locally-focused 'area ICPs' and how they in turn will develop a picture of need from each of their constituent health and wellbeing boards. These arrangements were agreed by the strategic ICP and our executive directors of place-based delivery will now begin to convene the first meetings of their area ICPs in November.

We were also able to consider presentations on the economic outlook for the North East and North Cumbria, delivered by Rob Hamilton, the Chief Economist at the North of Tyne Combined Authority, alongside a presentation that I gave on our current health and care challenges and opportunities. We then considered the recommendations of a working group jointly convened by Jacqueline Myers and Jane Robinson (Corporate Director of Adult's and Health Services at Durham County Council and ADASS Chair for the North East) on the formulation of our integrated care strategy, and the drafts of this strategy are now being consulted on, ahead of formal approval the next meeting of the strategic ICP in December.

4. Recommendations

The Board is asked to receive the report for assurance and information.

Name of Author: Samantha Allen, NENC ICB Chief Executive

Name of Sponsoring Director: N/A

Date: 20/09/2022

Item: 9
Enclosure: 3

NHS
North East and North Cumbria

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	✓
Official: Sensitive Commercial		Provides assurance	
Official: Sensitive Personal		For information only	

BOARD MEETING

27 September 2022

Report Title:	**Amendments to the Executive Committee Terms of Reference**

Purpose of report

To seek approval from the Board to update the terms of reference for the Executive Committee.

Key points

NHS North East and North Cumbria Integrated Care Board (the ICB) is responsible for the commissioning of health services and the effective stewardship of NHS spending for all the people who live in the North East and North Cumbria.

As set out in the Constitution, the ICB Board (the Board) may appoint committees to exercise functions on its behalf. All committees and sub-committees are listed in the ICB's Scheme of Reservation and Delegation.

The Board agreed the establishment of the Executive Committee at its meeting on 1 July 2022, along with an agreed set of terms of reference.

The Committee held its first meeting on 12th July 2022 and reviewed the terms of reference to ensure they were fit for purpose and would enable the Committee to deliver its delegated responsibilities effectively, along with providing assurance to the Board on the delivery of these.

The review highlighted that the quoracy arrangements for the Committee were restrictive and presented a possible in risk in the Committee's ability to maintain quoracy as it required single individuals to be present for every meeting. Therefore, the Committee recommended an amendment to the terms of reference to allow for nominated deputies to attend on behalf of the named individuals to ensure quoracy could be always maintained and enable effective decision making to continue in accordance with the ICB's internal control mechanisms.

The terms of reference are attached at appendix 1 and the relevant updated section (5.1) is highlighted for ease of reference.

Risks and issues
It is a risk if the Committee does not have clear terms of reference as it would not be able to effectively exercise its delegated functions on behalf of the Board.
Assurances
The Committee's terms of reference have been developed by the relevant subject experts and in line with all mandated guidance and best practice.
Recommendation/Action Required
The Board is asked to approve the updated terms of reference for Executive Committee.

Sponsor/approving director	C Riley, Executive Director of Corporate Governance, Communications and Involvement
Report author	D Cornell, Board Secretary

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues
Health and Social Care Act 2022

Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**		**N/A**	✓
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	None noted.
Has there been/does there need to be appropriate clinical involvement?	Yes, as part of developing the terms of reference.
Has there been/does there need to be any patient and public involvement?	Not applicable as terms of reference only.

Has there been/does there need to be partner and/or other stakeholder engagement?	Yes, as part of developing the terms of reference.

APPENDIX 1

North East & North Cumbria

Integrated Care Board

EXECUTIVE COMMITTEE - TERMS of REFERENCE

1. Constitution

The North East and North Cumbria Integrated Care Board (NENC ICB) was established by statute on 1st July 2022.

The Board of the NENC ICB has resolved to establish the Executive Committee (the Committee) as a committee of the Board.

These Terms of Reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

2. Authority

The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference
- Commission any reports it deems necessary to help fulfil its obligations
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any

decisions to such groups

For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions, and the SoRD other than the Committee being permitted to meet in private.

The Committee may not establish any subcommittees without prior Board approval as stated in the Constitution and SoRD.

3. Purpose

The principal purpose of the Committee is to support the Board by:

- Overseeing the day-to-day operational management and performance of the ICB in support of the Chief Executive in the delivery of his/her duties and responsibilities to the Board

- Providing a forum to inform ICB's strategies and plans and in particular the committee will undertake any commissioning and planning activity on behalf of the Board, helping to secure continuous improvement of the quality of services

- Implementation of the approved ICB strategies and plans.

The Committee will contribute to the overall delivery of the ICB objectives by delivering its remit as set out in these Terms of Reference.

The Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4. Membership and attendance

All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Board Chair. The Board Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.1 Chair and Vice Chair

- Chief Executive (Chair)
- Executive Medical Director (Vice Chair)

4.2 Membership (subject to Chair's approval as above)

- Chief Executive (Chair)
- Executive Director of Finance (or nominated deputy)
- Executive Medical Director (or nominated deputy)
- Executive Chief Nurse (or nominated deputy)
- Executive Director of Place Based Delivery - North (or nominated deputy)
- Executive Director of Place Based Delivery – South and Central (or nominated deputy)
- Executive Chief Digital and Information Officer (or nominated deputy)
- Executive Director of Innovation (or nominated deputy)
- Executive Chief People Officer (or nominated deputy)
- Executive Director of Strategy and System Oversight (or nominated deputy)
- Executive Director of Corporate Governance, Communications and Involvement (or nominated deputy)
- The Vice Chair will be agreed by the Committee members in the absence of the Chair.

Nominated deputies must be agreed with the Chair. Nominated deputies will have the same rights and responsibilities as members, and where applicable will form part of the quoracy.

4.3 Attendees

Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee may also be attended by the appropriately nominated individuals who are not members of the Committee.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter.

4.4 Attendance

Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Chair. Once agreed, that person will have the same voting rights and responsibilities as the member.

Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair (or Vice Chair in his/her absence).

5. Meetings Quoracy and Decisions

The Committee will meet in private, however any aspects relating to the commissioning of delegated primary care services from NHSEI that may have a requirement for public visibility will be managed in a public facing meeting.

The Committee will meet at least 10 times a year and arrangements and notice for calling meetings are as set out in the Standing Orders. Additional meetings may take place as agreed by the Chair (or Vice Chair in his/her absence).

The Board or ICB Chair may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.1 Quorum

For a meeting to be quorate a minimum of 50% (six) members is required, must include the following:

- Chair or Vice Chair
- Executive Director of Finance (or their nominated deputy)
- At least one of the Executive Directors of Place Based Delivery (or their nominated deputies), and
- Executive Medical Director or Executive Chief Nurse (or their nominated deputies).

5.2 Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. If a decision is needed which cannot wait for the next scheduled meeting, the chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. Responsibilities of the Committee

The Committees responsibilities are as follows:

6.1 Commissioning

- Commissioning of Acute services for the NENC ICB population, including core contracts and other independent sector (private) provision across the Board's commissioning portfolio

- Commissioning primary care services (consistent with delegation from NHS England)

- Commissioning any specialised services not commissioned by NHS England (NHSE) but recognising the need to work with NHSEI in relation to the commissioning of specialised services

- Overseeing significant service reconfiguration to meet the needs of the population and providing assurance to the Board on the proposals.

- The Committee will work in conjunction with the Executive Directors of Place Based Delivery to ensure any delegated commissioning arrangements at place (or a wider geographical area) are consistent with the ICB strategies and plans

- Monitoring provider performance to ensure outcomes are met and report material exceptions (to the Board)

- Overseeing the rigorous and ongoing analytical review of the drivers of system pressures, so that solutions to these pressures may be developed with a collaborative approach

- Developing and monitoring a Board approved performance and outcomes framework that will provide assurance to the Board on delivery

- Under the arrangements agreed by the Committee, reviewing ICB performance against the NHS System Oversight Framework

- Ensuring the ICB's response to the ongoing recovery of services as a result of Covid-19 pandemic

- Recommends the ICB's programme budgets to the Board for approval

- Approves ICB programme costs subject to the SoRD and financial delegations and financial limits

- In conjunction with the Finance, Performance, and Investment Committee, overseeing the development of an annual system plan [with partner trusts] to meet the health and healthcare needs of the population within the NE&NC having regard to the Integrated Care Partnership Integrated Care Strategy and place health and wellbeing strategies

- Overseeing the ICB's process for provider contract development

- Ensuring that commissioning activities promote the health and wellbeing of communities across the NE&NC as well as addressing health inequalities, and commissioning activities to ensure cost effective care is delivered

- Promoting collaborative working across all providers in the NE&NC provider landscape

- Approve arrangements for complying with the NHS Provider Selection Regime

- Ensuring that commissioning activities are underpinned and informed through communications and involvement with partners across the ICS and at place to ensure the voice of local populations is heard and understood

- Align public and key stakeholder engagement in the development and implementation of ICB strategies and plans as set out in the ICB's statutory duties for patient and public involvement, including the duty to consult where required

- Adhering to ICB's process for quality assurance, linking with the ICB Quality and Safety Committee to escalate any areas of concern, to ensure the quality and safety of commissioned services and that quality and safety are central to all of the Committee’s functions

- Ensuring that commissioning activities promote the health and wellbeing of communities across the NE&NC as well as addressing health inequalities, and to ensure cost effective care is delivered

- Taking account of collaborative commissioning activities, including those of clinical networks, to consider and make recommendations to the Board as to whether they will have wider contracting/financial across the NE&NC system.

6.2 Corporate

6.2.1 System Control

- Support the Chief Executive to prepare the SoRD, Operating Framework and Operating Structure

- To ensure the ICB fulfils the functions, duties and responsibilities set out in the ICB's Constitution

- Establish a comprehensive system of internal control across the ICB

- To ensure the effective operational management of the ICB in accordance with organisational policies and procedures

- To advise the Board of urgent or emerging strategic issues and risks and recommend an ICB response to the Board

- To ensure adequate arrangements are established in relation to the System Oversight Framework.

- Develops the Organisational Development (OD) Plan and oversees the delivery of the OD Plan

- Managing the ICB's own performance and associated risks (noting that Finance, Performance and Investment Committee monitors financial performance).

6.2.2 People

- Implementation of the people priorities including delivery of the People Plan and People Promise

- Workforce planning and sustainability

- To approve arrangements for staff recruitment, retention, and development

- To advise the Board on compliance with its statutory duties relating to people and employment legislation and to provide the Board performance reports of KPIs relating to people and employment

- WRES disclosure

- Prepare a Code of Conduct for staff for approval by the Board.

6.2.3 Research

- To advise the Board on compliance with its statutory duties relating to section 14Z40 (duty in respect of research).

6.2.4 Policies

- Recommend human resources policies to the Board for approval

- Approve and implement the ICB's complaints policy

- Approve arrangements and for ensuring the ICB has an integrated approach to the management standards of health and safety and has appropriate strategy and policies in place

- Approve and implement the ICB's health and safety policies

- Approve and implement the ICB's information governance policies including handling Freedom of Information requests, ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data

- Approve corporate policies not specifically stated elsewhere (excludes HR or clinical polices)

- Approve ICB Standard Operating Procedures (SOPs).

6.2.5 Strategy

- Development, and implementation, of a system-wide strategy and action on data and digital, subject to approval of the strategy by the Board

- Development, and implementation, of a Communications and Engagement Strategy for approval by the Board

- Development, and implementation, of the Equalities and Diversity Strategy for approval by the Board

- Develop and implement an Equality, Diversity ad inclusion Action Plan

- Development of other ICB strategies, not specifically delegated to other committees, for approval by the Board

6.2.6 Governance Assurance Reports

- Receive and monitor Governance Assurance Reports (GAR)

6.2.7 Litigation

- Approve and implement the arrangements for action on litigation against or on behalf of the ICB.

6.2.8 Legal

- Determine arrangements for securing legal advice, where necessary.

6.2.9 Emergency Planning Resilience and Response (EPRR)

- Approve and implement the ICB's arrangements for planning, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.

6.2.10 Conflicts of Interest

- Oversee the ICB's compliance with the management of conflicts of interest as stated in the Constitution and the Standards of Business Conduct Policy/Conflicts of interest policy and procedures.

6.2.11 Risk Management

- Approve and implement the ICB's risk management policy.

- Escalate any issues or risks for inclusion on the corporate risk register as necessary.

Any other operational matter as determined by the Chief Executive, and subject to the SoRD, approved budgets and the Financial Delegations and Limits.

7. Behaviours and Conduct

7.1 ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

7.2 Conflicts of interest

In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to the NHS guidance on managing conflicts of interest.

Conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If a conflict of interest arises, the Chair may require the affected member to withdraw at the relevant point.

7.3 Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

8. Accountability and Reporting

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The Committee will submit to the ICB Board a decision and assurance report following each Committee meeting, summarising key decisions.

The Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded and submitted to the ICB Board, in private or public as appropriate.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

9. Secretariat and Administration

The Committee shall be supported with a secretariat function which will ensure that:

i) The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.

ii) Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.

iii) Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.

iv) Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

v) The Chair is supported to prepare and deliver reports to the Board.

vi) The Committee is updated on pertinent issues/ areas of interest/ policy developments.

vii) Action points are taken forward between meetings and progress against those actions is monitored.

10. Review

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Version: **v1-1**

Date of approval: **TBC**

Date of review: **1 July 2023**

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REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official		Proposes specific action	
Official: Sensitive Commercial		Provides assurance	✓
Official: Sensitive Personal		For information only	

BOARD 27 September 2022	
Report Title:	**Highlight report and minutes from the Executive Committee meeting held on 12 July 2022**

Purpose of report

To provide the Board with an overview of the discissions and decisions at the Executive Committee meeting in July 2022.

Key points

The key points include:

- Overview of community diagnostic programme and the need for the business case to be approved
- Approval of NICE Type 2 Guidelines and the commissioning of an audit to review implementation of NICE Guidance across the ICB
- Approval of all Policies and agreement they will all be reviewed over the next 12 months.

Risks and issues

The Committee identified the following risks and issues:

- The risk of duplication across integrated care system workstreams and has commissioned a review of these
- The need to ensure the business case for the community diagnostic programme is approved.
- The risk that NICE guidance has been implemented differently across the North East and North Cumbria and commissioned a review of this via an audit to identify the key risks.

Assurances

- Community diagnostic programme and development
- Establishing a system of risk management, which will be subject to internal audit review for further assurance.

Recommendation/Action Required

The Board is asked to receive the highlight report and confirmed minutes for the Executive Committee meeting held on 12 July 2022.

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Sponsor/approving director	Samantha Allen, Chief Executive
Report author	Deborah Cornell, Board Secretary

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues
Health and Care Act 2022

Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**		**N/A**	✓
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	

Key implications	
Are additional resources required?	Identified as part of the committee minutes.
Has there been/does there need to be appropriate clinical involvement?	Yes as part of the Executive Committee membership.
Has there been/does there need to be any patient and public involvement?	Not applicable as highlight report only.
Has there been/does there need to be partner and/or other stakeholder engagement?	Not applicable as highlight report only.

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Executive Committee Highlight Report

Introduction

The principal purpose of the Executive Committee is to support the Board by:

- Overseeing the day-to-day operational management and performance of the Integrated Care Board (ICB) in support of the Chief Executive in the delivery of her duties and responsibilities to the Board
- Provide a forum to inform ICB strategies and plans and in particular, the committee will undertake any commissioning and planning activity on behalf of the Board, helping to secure continuous improvement of the quality of services
- Implementation of the approved ICB strategies and plans.

The Committee will contribute to the overall delivery of the ICB objectives by delivering its remit as set out in its terms of reference.

Summary report

The Executive Committee, chaired by Samantha Allen, Chief Executive, met on 12 July 2022 and a summary of the meeting is included below.

Overview from the Chair

The Chair introduced everyone to the first meeting of the Executive Committee since its establishment by the Board on 1 July 2022. The Chair set out the main purpose and principles of the Committee to ensure all members were aware of the Committee's duties and responsibilities as set out in its terms of reference, and in particular, how the Committee related to the role of the Finance, Performance and Investment Committee.

The Committee will be meeting on a monthly basis to focus on business delivery on behalf the North East and North Cumbria Integrated Care Board (the ICB). It was noted however that, due to the being the first meeting of the Committee, there were a number of items of business on the agenda that were necessary as part of the establishment of the ICB (such as a significant number of corporate and human resources policies) and required approval. The Chair explained this was an exception and agendas would be more focussed on essential items of business and assurance going forward as well as new developments and key innovations that the ICB would be progressing to help address the number of key issues for the population we serve.

Key developments to bring to the attention of the Board

Some key areas to bring to the Board's attention following a discussion at the Committee include:

- **Children's immunisations Quality Outcomes Framework for Newcastle and Gateshead** - a discussion took place regarding a proposal the former Clinical Commissioning Group was considering as part of this work and what further support could be offered to practices. It was noted that the ICB needed to be cognisant of all the areas it covered regarding health inequalities and alternative ways to support this work will be explored further.
- **Updated NICE guidelines for Type 2 Diabetes** – a discussion took place in relation to health inequalities as it was again highlighted that the ICB needed to ensure coverage for all in terms of GP access, good guidelines and educating prescribers. The guideline was approved and it was agreed a comprehensive audit would be carried out to understand the position with regards to NICE Compliance across the ICB and bring this back to the Committee for further discussion to identify what needed to be prioritised.
- **Community diagnostics** –an overview of the background, current position and work ongoing in relation to community diagnostics were discussed. With regards to inequalities, the work

undertaken around the patient experience part of the process was discussed and noted, along with the role of community diagnostic hubs in supporting the establishment of new ways of testing, such as home testing and use of digital. It was noted that digital connectivity was critical in delivering better care and should be encouraged.

- **Priority areas** – work was underway to review the current workstreams across the integrated care system to understand priorities, ways of working and membership and a development plan would be a standing agenda item going forward to ensure the Committee remained sighted on the priority areas. There were some concerns noted that there may be duplication across the workstreams and this needed to be addressed.
- **Virtual wards funding –** It was agreed this initiative would be funded by the ICB for this financial year but further clarity was needed for the funding position for next year. There were no details as yet but this presented a potential risk for next year as additional capacity would be needed to deliver virtual wards. There is currently a huge variation of costs for beds across the providers within the ICB area and a mapping exercise was underway around this.

Governance and assurance

The Committee also received a number of items for assurance and these included:

- An integrated delivery report – a high level overview of the key metrics across the system and internal to the ICB, covering access, experience, outcomes, people and finance
- A finance update report – an overview of the current financial position
- A governance and assurance report – an end of year position from the former clinical commissioning groups across the North East and North Cumbria
- A risk management report – a position statement on the ICB's current risks
- The committee cycle of business for 2022/23

Recommendations

The Board is asked to:

- Note the contents of the committee highlight report;
- Received the approved minutes attached at appendix 1 for assurance.

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Appendix 1

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North East and North Cumbria

North East and North Cumbria Integrated Care Board

EXECUTIVE COMMITTEE

Minutes of the meeting held on Tuesday 12 July 2022, 9.30-12.30 at Riverside House, Board Room, Newburn Riverside

Present:

Samantha Allen, Chief Executive (Chair)
Dr Neil O'Brien, Medical Director
Claire Riley, Executive Director of Corporate Governance, Communications and Involvement
Jon Connolly, Executive Director of Finance
Jacqueline Myers, Executive Director of Strategy and System Oversight
Prof Graham Evans, Executive Chief Information and Digital Officer
David Gallagher, Executive Director of Place Based Delivery
Annie Laverty, Executive Chief People Officer
Aejaz Zahid, Executive Director of Innovation

In attendance:

Nicola Bailey, ICB Director of Transition
Ewan Maule, Interim ICS Pharmacist Lead (agenda item 12)
Ruth James, ICS Diagnostic Programme Director (agenda item 13)

EC/2022/01 Welcome and introductions

The Chair welcome everyone to the first meeting of the Integrated Care Board Executive Committee.

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EC/2022/02 Apologies for absence

Mark Adams, Executive Director of Place Based Delivery
David Purdue, Executive Chief Nurse

EC/2022/03 Declarations of interest

There were no declarations of interest on this occasion.

EC/2022/04 Committee Terms of Reference

The Chair presented the Committee with its terms of reference for consideration and review.

It was noted that the Committee had been established by the Board at its first meeting on 1 July 2022 and a set of terms of reference agreed as part of the establishment process. These had been included for review by the Committee members to ensure they would enable it to discharge its delegated duties effectively on behalf of the Board.

The need for a reference to developing a learning and improving system was highlighted and agreed this would be added to the terms of reference.

A further query was raised regarding the minimum quoracy needed for the Committee. The terms of reference currently specified that one of the required members needed as part of the 50% minimum quoracy was the Executive Director of Finance only with no alternative or nominated deputy possible. It was agreed this would be amended to include a reference to a nominated deputy to ensure quoracy could be maintained.

The Chair requested all members prioritised attendance at Committee wherever possible. If an absence could not be avoided, for example, annual leave, it was agreed that nominated deputies could attend but must be fully briefed beforehand by the relevant executive. It was agreed regular observers could also attend where appropriate.

Action:
The Executive Director of Corporate Governance, Communications and Involvement to amend the terms of reference to include a reference to the learning and improvement system and amend the minimum quoracy requirements.

RESOLVED:
The Executive Committee **AGREED** to amend the terms of reference as set out above and **RECOMMENDED** submission of the revised terms of reference to the Board for formal ratification.

EC/2022/05 Integrated Delivery Report

The Executive Director of Strategy and System Oversight presented the report and explained to members this would be a monthly report and a standing agenda item.

It was noted there was further work needed to continue developing and enhancing the report to ensure information was presented in an appropriate and meaningful way. A report had been taken to the Board at its first meeting on 1 July 2022 and work would continue to develop the cycle of reporting.

The report was intended to be a high-level report against key metrics across the system and internally within the ICB. It would cover access, experience, outcomes, people and finance.

Members discussed the role of this Committee and how it related to the role of the Finance, Performance and Investment Committee. The need for an independent appointed person to undertake Individual Funding Requests was also discussed and it was agreed this needed to be reviewed and expectations clarified as to what was needed.

Actions:
The Executive Director of Corporate Governance, Communications and Involvement to review the expectations and requirements of independent members to support the individual funding request process.

The Executive Director of Strategy and System Oversight to ensure the integrated delivery report included relevant internal and external metrics to provide a high-level overview of performance across the system.

RESOLVED:
The Committee **RECEIVED** the integrated delivery report for assurance.

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EC/2022/06 Finance Report

The Executive Director of Finance gave a verbal update on current financial issues and confirmed there would be set of slides going forward that would highlight the main issues and areas to note for members.

Work was ongoing with regards to developing an aligned continuing healthcare (CHC) policy. There were currently some variations in how CHC was being managed across the former clinical commissioning group (CCG) areas that needed to be addressed. A discussion took place in relation to the risks associated with consolidating the processes for CHC and it was noted these would be considered as part of the policy development.

Work had also been initiated to set internal budgets for the ICB now that senior leaders were in post. The output from this work would be brought back to the Committee in October for approval. In the interim, the ICB would be using the systems inherited from the former CCGs across the North East and North Cumbria.

It was clarified that the finance report would be both from a system wide and an ICB perspective and sit as part of the integrated delivery report.

The need for training and development budgets to be considered as part of this was also highlighted.

It was confirmed that the transferring of payroll was on track.

Actions:
The Executive Director of Finance to bring the internal budgets back to Committee for approval in October 2022.

RESOLVED:
The Committee **RECEIVED** the verbal update on financial issues for assurance.

EC/2022/07 Governance Assurance Report

The Executive Director of Corporate Governance, Communications and Involvement presented the end of year governance assurance report for 2021/22 from the former CCGs. The report outlined the governance assurance reporting profiles.

It was recognised that NECS had provided the governance assurance support

service for the former CCGs of County Durham, Newcastle Gateshead, Northumberland, Sunderland, South Tyneside, and Tees Valley. The former CCGs of North Tyneside and North Cumbria CCG had managed their own internal arrangements for governance assurance reporting.

The NECS process had transferred into the ICB as part of the CCG closedown and transition process. It was recommended that this process continued in its current form as an interim measure until a review could be undertaken to standardise the governance arrangements during the ICB's first year of transition. Further consideration would need to be given to the incorporation of the North Tyneside and North Cumbria governance assurance processes and this would be resolved during September.

A suggestion was made as to the addition of supporting narrative to the report going forward as it would be helpful to provide more context. For example, the Data Security and Protection (DSP) Toolkit included a required compliance level of at least 95% of all staff completing information governance training and this needed to be reflected more clearly in the report. The governance leads would be asked to work with executives to review the report to ensure it contained the right parameters.

There also needed to be real time information on compliance that was tracked all year round as the report was looking backwards.

It was noted that compliance with statutory and mandatory training needed to be consistent and standardised across all the ICB places. This would be part of the ICB development plan.

It was queried whether there needed to be a clear ICB executive lead for each area and where assurance would come from, i.e., either place or wider ICB level. There needed be control mechanisms in place around reporting and it was agreed this would be looked at.

A query was raised in relation to accessing legal advice and it was confirmed there was a legal services framework in place that could be accessed. An audit was underway of costs across each of the former CCGs which would be used in a procurement document for ICB legal support going forward.

<u>Actions</u>:
The Executive Director of Corporate Governance, Communications and Involvement to:

- **Work with governance leads to review and revise the governance assurance report format as appropriate**

- **Review what control mechanisms needed to be in place around reporting.**

RESOLVED:
The Committee **RECEIVED** the report for assurance.

EC/2022/08 Corporate Policies

The Executive Director of Corporate Governance, Communications and Involvement presented a suite of corporate policies for review and approval as part of ICB establishment.

It was noted that several key policies had been approved by the Board at its meeting on 1 July 2022 however the Board had delegated authority to the Executive Committee to approve the remaining high risk and substantive policies on its behalf.

The Committee approved all policies as set out in the report.

It was noted that a further review of all policies would need be undertaken over the following six-month period to ensure all policies fully reflected the ICB ways of working. A degree of consistency was to be applied to the policies, along with any errors corrected, e.g., references to CCGs in the policies.

A review list of all policies would be produced to ensure an executive lead had been identified for each policy, along with a date for review. The policies would need be prioritised due to the large number needing to be reviewed.

A query was raised as to whether a policy for policies needed to be developed. It was noted that other policies may be missing and the list would need to be reviewed to identify these.

There also needed to be a clear mechanism in place to ensure ICB staff could access the policies.

Actions
The Executive Director of Corporate Governance, Communications and Involvement to:

- **Produce a prioritised policy review list, with identified executive leads and clear timescales for review**
- **Check if a policy on policies had been prepared.**

RESOLVED:
The Committee **APPROVED** the corporate and human resource policies set out in the report and **AGREED** for a further review of all policies to be undertaken over the following six-month period.

EC/2022/09 Human Resources Policies

The Executive Chief People Officer presented a suite of human resources policies (42 in total) for review and approval.

It was agreed these could be approved and follow the same review process as set out for the corporate policies in the previous item.

RESOLVED:
The Committee **APPROVED** the human resource policies set out in the report and **AGREED** for a further review of all policies to be undertaken over the following six-month period.

EC/2022/10 Risk Management Report

The Executive Director of Corporate Governance, Communications and Involvement presented the report which provided an initial overview of the ICB's current risk management position.

The report included a preliminary risk register and summary of risks specific to each place-based delivery areas within the ICB. The register had been developed using the former CCG risk registers, along with specific risks relating the ICB as organisation.

Work was continuing to refine the risk management process, linking it back to the risk management strategy. Comments and feedback on the report and register were requested.

It was noted that information from the risk register needed to be an integral part of this report and it was agreed a governance lead would be asked to look into this.

Confirmation was received that an electronic risk management system was in place (SIRMS) and a board assurance framework was being developed. The electronic system had not been used by all former CCGs and this was

currently being addressed to ensure a consistency of approach across the ICB to ensure there was a single reporting system for risk.

It was confirmed that there would be separate sections which will show the local place level risks for review and mitigation at place with agreed tolerance for escalation to the Committee. This process would also apply for corporate risks.

It was noted that general practice also fed into SIRMS, using the incident reporting module.

Actions:
The Executive Director of Corporate Governance, Communications and Involvement to work with the governance leads to continue refining the risk management process and ensure information from the risk register fed into to the risk management report.

RESOLVED:
The Committee **RECEIVED** the report for assurance.

EC/2022/11 Children's' Immunisations QOF

The Executive Medical Director presented the report which had been agreed at the Primary Care Commissioning Committee of the former Newcastle Gateshead CCG but not yet implemented.

Advice received from NHS England was that local QOF schemes could not be changed, therefore the Committee was being asked to review the proposal again and take a view on its implementation.

Given the demographics in Newcastle Gateshead, a discussion took place in relation to any specific health inequalities and particular challenges that needed to be considered. Whilst a Local Enhanced Scheme may seek to address this, consideration needed to be given to further ways in which practices could be supported.

It was noted that the ICB needed to be cognisant of all the areas it covered regarding health inequalities.

It was confirmed that a register of place-based decisions would come to the Committee for regular review.

The Director of Transformation for Primary Care was to be asked to review this and make a recommendation to the Executive Medical Director in relation to the support packages available to practices across Newcastle Gateshead.

Actions:
The Executive Medical Director to ask the Director of Primary Care Transformation to review the support packages in place for the Newcastle Gateshead practices for a recommendation.

RESOLVED:
The Committee **RECEIVED** the report and requested further information to be submitted to the Executive Medical Director to enable a recommendation to be made.

EC/2022/12 Updated NICE Guidelines for Type 2 Diabetes

The Interim ICS Lead Pharmacist joined the meeting for this item and presented the paper which described the implications of the updated NICE guidelines for type 2 diabetes. The paper requested approval of the recommendation from the Northern Treatment Advisory Group (NTAG).

This issue had been identified as a significant financial risk in the prescribing agenda and would be a financial pressure that the ICB would need to address over the coming years.

It was confirmed that the recommendation had been discussed and approved by NTAG as a principle but due to the size of the financial impact it had been brought to the Committee for formal ratification.

A discussion took place in relation to health inequalities as it was again highlighted that the ICB needed to ensure coverage for all in terms of GP access, good guidelines and educating prescribers. The latter would ensure the identification of the appropriate patients.

The report highlighted other NICE recommended treatments that the ICB was not currently in a position to support, for example Tier 3 obesity services were not currently available across the ICB area. It was agreed that an audit would be carried out to understand the position with regards to NICE Compliance across the ICB and bring this back to the Committee in November.

Consideration needed to be given to evaluation and health inequalities to ensure those populations that would benefit the most would be able to access the drug. There was also the wider piece of work needed regarding NICE compliance to identify where there were gaps and what needed to be prioritised.

Actions:

The Executive Medical Director was asked to:

- **Ensure an audit was carried out to understand the position with regards to NICE Compliance across the ICB and bring this back to the Committee in November**
- **A wider piece of work to be undertaken regarding NICE compliance to identify where there were gaps and what needed to be prioritised.**

RESOLVED:

The Committee formally **RATIFIED** the recommendation in the paper, with further work needed around identifying NICE compliance across the ICB area.

EC/2022/13 Community Diagnostics

The ICS Diagnostic Programme Director presented the Committee with an overview of the background, current position and work going on in relation to community diagnostics and what, as an ICS, would need to be considered going forward.

The Chair thanked the ICS Diagnostic Programme Director for the comprehensive update and thanked the team for their work and all they have achieved thus far. The positive impact of the programme was also noted.

An invitation was extended to members of the team to share their views on the presentation and a request made to receive a further update before the end of the year.

With regards to inequalities, the work undertaken around the patient experience part of the process was discussed and noted, along with the role of community diagnostic hubs in supporting the establishment of new ways of testing, such as home testing, use of digital.

There were several business cases that need to be mapped and the process for approval from a funding point of view clearly understood to ensure the Executive Team had oversight of these.

It was noted that digital connectivity was critical in delivering better care and should be encouraged. The funding processes needed to be considered and clarity sort around capital monies, for example in Tees, but the people aspect was just as important and it all needed to be joined up.

The presentation was a good start in discussing this issue as capital management was difficult and more time would be needed to discuss it.

It was noted that doing nothing was not an option, but the appropriate approval processes needed to be in place and the Chair asked those concerned to take away the questions raised and produce a high-level strategy which sets out the ambition and it needs to include the whole system not just ICB.

Actions:
The Committee Secretary to schedule a further update for the Committee on community diagnostics for the end of the year

The Executive Director of Finance to discuss the production of a high-level strategy and bring this back to the Committee at a future meeting.

RESOLVED:
The Committee **RECEIVED** the presentation update for information.

EC/2022/14 Priority Areas

The Chair presented this item and noted was a supporting development plan which would be a standing agenda item, supported led by the Executive Director of Corporate Governance, Communications and Involvement.

Work was underway to review the current workstreams to understand priorities, ways of working and membership. A suggestion was made for session to be held at the end of July to start this review, but it was acknowledged that due to the timescales for completion, this would be difficult as this work needed to be undertaken quickly.

A concern was raised that there was a lot of duplication across the workstreams and resources and capacity were needed to work on new projects.

A discussion took place around the need to standardise reporting and the Executive Director of Strategy and System Oversight advised she would draft a template to enable this and would share it with members for comment.

It was noted there was a real opportunity for standardisation to ensure the work of the ICB was having the right impact and delivering against the organisational agreed priorities.

Actions:
The Executive Director of Strategy and System Oversight to produce a template to standardise reporting and share with the Executive Team for comments.

RESOLVED:
The Committee **RECEIVED** the update for assurance.

EC/2022/15 Cycle of Business

A cycle of business was being developed for the Committee to ensure all essential items of business were scheduled as appropriate. This would ensure the Committee met its responsibilities and delegated duties on behalf of the Board.

The cycle of business would be reviewed to ensure it was synchronised with the Board.

All members were asked to review the document to check it included what it needed to and ensure there was no duplication. Comments were asked for within two weeks of this meeting.

Action:
All members to review the cycle of business and provide feedback to the Chief executive within two weeks of the meeting.

RESOLVED:
The Committee **RECEIVED** the cycle of business for information.

EC/2022/16 Any Other Business

The issue of director vacancies was raised and a concern noted regarding the filling of these as there was the need to understand the alignment of

posts. This would be discussed in more detail at the Executive Team meeting the following week.

The issue of funding for virtual wards was also raised. This initiative was being funded centrally for this financial year but further clarity was needed for the funding position for next year as it was likely to be matched funding.

There were no details yet, but this presented a potential risk for next year as additional capacity was needed to deliver virtual wards and providers were asking for assurances in relation to recurrent funding, i.e., recruitment of staff.

There was a huge variation of costs for beds across the providers within the ICB area and a comprehensive financial strategy was needed. More information would be available in the coming weeks as a mapping exercise was underway around this.

A query was raised as to whether this work linked with the priorities of the workstreams; whether it needed to sit under the Urgent and Emergency Care Network; or be a standalone piece of work. A review would be undertaken as to who was currently involved in this work to utilise and coordinate this resource across the patch.

With regards to flu vaccination programme, it was queried when this would start and how quickly the programme could be rolled out. Assurance was given that there was a well- established Vaccination Board in place to manage this, along with a good process across the region to deliver the programme.

The double vaccination approach was being taken nationally this year and so the programme needed to start as early as possible to address this challenge.

It was noted there was a robust communications strategy to join up the flu and Covid vaccination campaigns to support this.

Action:
Director vacancies to be discussed at the Executive Team meeting

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The Executive Medical Director and ICB Director of Transition to review who was currently involved in the virtual wards work to utilise and coordinate this resource across the patch.

RESOLVED:
The Committee **RECEIVED** the items of other business for information.

Meeting closed at 12.25 pm

Signed: 

Position: Chief Executive (Chair)

Date: 13 September 2022

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REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	✓
Official: Sensitive Commercial		Provides assurance	
Official: Sensitive Personal		For information only	

BOARD 27 September 2022	
Report Title:	**Highlight report from the Finance, Performance and Investment Committee held on 1 September 2022**
Purpose of report	
To provide Board members with an overview of items considered and discussed at the inaugural meeting of the Finance, Performance and Investment Committee.	
Key points	
A short summary of the inaugural Committee meeting held on 1 September 2022 is included in the report below.	
Risks and issues	
The terms of reference for the Committee are under review and any recommended changes will be submitted to the Board for consideration and approval.	
Assurances	
A highlight report and confirmed minutes will be submitted to the Board after each meeting.	
Recommendation/Action Required	
The Board is asked to: • Note the highlight report; • Note an amended version of the Committee terms of reference will be submitted to the Board in November for consideration and formal approval	
Sponsor/approving director	David Chandler, Director of Finance
Report author	Jen Lawson, General Manager
Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	

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CA2: tackle inequalities in outcomes, experience and access	
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	None identified.
Has there been/does there need to be appropriate clinical involvement?	Not applicable as highlight report only.
Has there been/does there need to be any patient and public involvement?	Not applicable as highlight report only.
Has there been/does there need to be partner and/or other stakeholder engagement?	Not applicable as highlight report only.

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Finance, Performance and Investment (FPI) Committee Highlight Report

Introduction

The purpose of the FPI Committee is to provide oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable, system financial plan. The Committee reviews and scrutinises the financial performance of both the ICB and NHS organisations within the ICB footprint.

Summary report

The FPI Committee, chaired by Jon Rush, Non-Executive Director, met on 1 September 2022 and a summary of the meeting is included below.

Overview from the Chair

The inaugural FPI committee met face to face at Pemberton House, Sunderland on 1 September. The Executive Director of Finance presented a high level financial update, which included: the Integrated Care Board (ICB) financial framework; ICB interim budget delegation position; finance staff development; capita; communication; month four overview; ICB financial efficiency targets; risk and mitigation; Integrated Care System (ICS) provider position.

The terms of reference were also discussed by members and the following changes are being considered:

- Part 1 and part 2 of the meeting be combined into one and include the ICB Board foundation trust partner members
- Conflicts of interest to be managed appropriately by the Chair
- ICB provider sector finance director representatives to be removed, as this is a duplication of meetings already taking place between the ICB executive director of finance and ICS directors of finance.
- The inclusion of the Audit Chair as a regular, non-voting attendee to the Committee under section 4.3.

Governance and assurance

Reports received at the committee were:

- ICB Finance Update
- Terms of Reference
- Future meeting cycle

Recommendation

The Board is asked to:

- Note the contents of the committee highlight report;
- Note an amended version of the Committee terms of reference will be submitted to the Board in November for consideration and formal approval.

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REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	
Official: Sensitive Commercial		Provides assurance	✓
Official: Sensitive Personal		For information only	

BOARD MEETING 27 September 2022	
Report Title:	**Ockenden Report - Immediate Actions Review**

Purpose of report

- To provide a thematic review following insight visits of all maternity services in North East and North Cumbria (NENC)
- To review good practice and areas for improvement in maternity services
- To enable targeted support from the Integrated Care System (ICS), Local Maternity Neonatal System (LMNS) and regional team.

Key points

In 2017, the former Secretary of State for Health and Social Care instructed NHS England and Improvement (NHSE/I) to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at the Shrewsbury and Telford Hospitals NHS Trust. This was undertaken by Donna Ockenden and known as the Ockenden report.

The initial report was published December 2020, the final report was published March 2022. All Trusts undertaking maternity care were required to submit evidence for all of the 49 questions within the 7 Immediate Essential Actions, Workforce and Guidelines. This was analysed and reports released December 2021. Unfortunately, many of the findings in the report are not new and can be found in previous reports and publications.

The regional maternity teams have conducted Ockenden Insight Visits to review the current position against self-assessments undertaken by each provider, based on the initial report of December 2020.

This paper focuses on the main themes from recommendations and the support from the ICB and the LMNS to improve the current position.

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Risks and issues
• Compliance with the seven initial immediate and essential actions are improving across the NENC Integrated Care Board (ICB) with no red actions for any provider • The final report with the 16 immediate and essential actions have not been reviewed and will be assessed after the publication of the East Kent report • Maternity services remain a high risk for providers.
Assurances
• The external review has seen an improving compliance against the Ockenden review. All providers report the position to their public boards • The LMNS, maternity network is working with the regional team to identify the key areas of improvement for the next six months.
Recommendation/Action Required
To note the paper.

Sponsor/approving director	David Purdue, Executive Chief Nurse
Report author	David Purdue, Executive Chief Nurse

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**		**N/A**	✓
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

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Key implications	
Are additional resources required?	No.
Has there been/does there need to be appropriate clinical involvement?	Clinical involvement critical.
Has there been/does there need to be any patient and public involvement?	Maternity Voices Partnership.
Has there been/does there need to be partner and/or other stakeholder engagement?	Regional Maternity Team, Maternity Network and Neonatal Operational Delivery Networks.

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Ockenden Immediate Essential Actions Current Position

1. Introduction

The regional maternity team have undertaken a review of all eight of the ICB maternity units' self-assessment against the seven immediate and essential actions identified in the initial Ockenden Report. This paper identifies the current position of our maternity units, highlighting the key areas for support by the ICB, LMNS and regional maternity team.

2. Background

The former Secretary of State for Health and Social Care instructed NHS Improvement in 2017 to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust. This report was conducted by Donna Ockenden and the initial report was published December 2020, with the final report published in March 2022.

All Trusts, with maternity services, were required to submit evidence for all of the 49 questions within the 7 Immediate Essential Actions, Workforce and Guidelines. This was analysed initially by the regional maternity team and reports released December in 2021. Provider Trusts were mandated to publish a standard maternity dashboard at each of their public Board meetings to highlight the progress against the seven actions.

Many of the findings in the report are not new and can be found in previous reports and publications.

3. Main Issue

The following table identifies the current overall position of the eight Trusts providing maternity services within NENC ICB from the initial assessment in December 2021 to the reassessment in August 2022.

Ockenden Interim report Immediate & Essential Actions	Evidence submitted			North East & North Cumbria Themes for improvement	Evidence rating (overall for IEA)			North East & North Cumbria Themes for improvement
	Met	Partial	Not met	December 2021	Met	Partial	Not met	August 2022
1: Enhanced Safety		8		**Qu 2** external opinion for intra uterine death (IUD),maternal death (MD) Neonatal brain injury & neonatal death (NND). **Qu 4** audit 100% perinatal	6	2		**Qu 1** the triumvirate meeting as a team with minutes and action logs. **Qu 2** external opinion for intra uterine death (IUD),maternal death

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				mortality review tool (PMRT) cases were reviewed to standard and had an external review.				(MD) Neonatal brain injury & neonatal death (NND). **Qu 4** Embedded audit of PMRT **Qu 5** Maternity Services Dataset is not always to the required standard.
2: Listening to Women & Families	**1**	**7**		**Qu 11** Non executive director (NED) requirements **Qu 14** Safety Champions requirements.	**5**	**3**		**Qu 11** Non executive director (NED) staff did not know them or their roles* **Qu 14** Safety Champions staff did not know them or their roles. **Qu 43** Embedding of coproduction *many organisations had challenges during the pandemic which impacted the ability of the NED to engage with maternity services
3: Staff training & working together	**1**	**7**		**Qu 17** where not meeting targets mitigations are in place. **Qu 19** no ring fenced monies for maternity; budget statements; evidence of spending and spend reports to LMNS	**7**	**1**		**Qu 17** Live drills including baby abduction drills **Qu 18** there was not consistent evidence of a day & night ward round, with MDT presence. **Qu 19** no ring fenced monies for maternity; budget statements; evidence of spending and spend reports to LMNS.
4: Managing complex pregnancies		**8**		**Qu 25** audit of complex needs and referral; no referral to maternal medicine centre. **Qu 26** SOP for named consultant and an audit plan	**4**	**4**		**Qu 25 & 26** audits of compliance are not being completed with an agreed timetable to repeat in line with the results.
5: Risk assessment throughout pregnancy	**1**	**7**		**Qu 30** how women are risk assessed for place of birth at every antenatal contact. **Qu 31** risk assessment for referral birth options clinics, personalised care and support plan (PCSP) and audit. **Qu 32** Risk Assessment undertaken at every visit and PCSPs and audit	**5**	**3**		**Qu 30** & **Qu 31** audits of compliance are not being completed with an agreed timetable to repeat in line with the results.
6: Monitoring fetal wellbeing		**8**		**Qu 34** leads completing incident reviews and investigations. **Qu 35** sufficient expertise, clinical supervision, interface with other units, lead reviews of adverse outcomes.	**7**	**1**		**Qu 35** Evidence of job descriptions or role expectations of consultant leads were not always available / shared
7: Informed consent		**8**		**Qu 39** information on choice and Maternity voice partnership (MVP) rag rating of website **Qu 41** pregnant women/people being part of decision making, the CQC survey action plan **Qu 44** the Trust website gap analysis and quality of information	**4**	**4**		**Qu 39 & Qu 40** information available and language used around choice including maternal choice for caesarean section; Maternity voice partnership (MVP) review of website and other resources. **Qu 41** & **Qu 42** audit of pregnant women participating equally and feeling that their choices were respected in all decision making processes about their care
Workforce		**8**		**Qu 45** six monthly review of clinical workforce.		**8**		**Qu 45** six monthly review of clinical workforce at Trust & LMNS Board. **Qu 49** Strengthening of midwifery leadership teams
Guidelines	**1**	**7**		**Qu 49** audit that guidelines are in date.	**6**	**2**		Qu 49 audit that guidelines are in date

3.1 The table identifies the significant improvement in the compliance against the seven immediate and essential standards. Three of the Trusts are fully compliant against all seven standards. The key standards which the need additional support are; informed consent and risk assessment through pregnancy.

3.2 Workforce remains at amber for all providers, which is a national issue. Work is being undertaken with the regional workforce team to review training numbers with our Higher Educational Institutions. A shortened post graduate midwifery

course is also being discussed with Health Education England. The recruitment of international midwives is underway in a number of Trusts but the pipeline for international midwives is not as strong as other registrants due to the training undertaken outside of the United Kingdom.

4. Key Themes

Following the reviews, a number of recommendations have been made. The strengthening of coproduction with the Maternity Voices Partnerships (MVP) and improving service user involvement. Improving audit compliance especially in relation to informed choice. Improving training compliance including live drills and baby abduction. The improvement of Board oversight of maternity services including the governance of Board to Ward visibility. A review of governance processes for closing the loop and identifying learning and how this is shared across the providers. Positively all of the eight providers have signed up to the use of a single digital end to end maternity system. This will assist in improving compliance against the audit and documentation requirements for the Ockenden actions.

Strong effective leadership, respectful culture and teamwork**:** NHSE have commissioned a leadership programme for the quadrumvirates and triumvirates to provide training for the most senior leaders in maternity. The six-month programme, open to all Trusts over the next two years, will support tools for effective leadership. In addition, work is being undertaken nationally around improving culture.

Adequately resourced governance teams and training facilitators to provide good governance: all providers have been signposted to the reinvigorated maternity self-assessment tool Version 6 2021, to benchmark against a nationally recommended adequately resourced governance structure.

The ICB will support the governance processes to ensure maternity services are ready for the introduction of the Patient Safety Incident Response Framework.

Optimal place of birth for extremely pre-term babies**:** continued collaboration with clinical networks, LMNS's, providers and service users to improve the proportion of babies under 27/40 born in NICU.

Provide a positive working environment for staff and promote supportive, open cultures that help staff do their job to the best of their ability: the region have a successful Professional Midwifery Advocate (PMA) forum. There is ongoing commitment from the regional team to support succession planning in this area.

Continue to learn from women/birthing people who use services: MVP involvement, adequate resource, and true co-production: the development of a Strategic MVP Group. Nationally agreed renumeration will enable our MVPs to support underserved communities most affected by inequity across our services. The NENC LNMS have prioritised awareness of informed consent and choice, following high level feedback from an MVP survey.

When deviation from safety standards are identified there needs to be prompt action to meet the standards to prevent poor outcomes and/or regulatory enforcement: the national team are establishing an independent advisory board for the final Ockenden report. A revised national delivery plan will be prepared autumn 2022 with a long-term plan refresh.

Celebrating success: Celebrating and Sharing Good Practice event planned Spring 2023.

The ICB has reviewed the current structures in place to support maternity services. The proposed plan is to realign the three main networks with the ICB executive chief nurse becoming the senior responsible officer for the LMNS and working jointly with the Maternity Network and Neonatal Operational Delivery Network. Bringing the three teams together to focus on improving outcomes.

5. Recommendations

The Board/Committee is asked to note the improvement in compliance against the seven Ockenden standards.

Name of Author: David Purdue, Executive Chief Nurse
Name of Sponsoring Director: David Purdue
Date: 09.09.2022

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REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	
Official: Sensitive Commercial		Provides assurance	✓
Official: Sensitive Personal		For information only	

BOARD MEETING 27 September 2022	
Report Title:	**Safeguarding and Learning from Life and Death Reviews of People with Learning Disabilities and Autistic People Position Paper**

Purpose of report

To provide the Board with the current status of the North East and North Cumbria Integrated Care Board (the ICB) safeguarding function and the priorities for completion of the strategy due in December 2022 and to receive the Learning from Lives and Deaths of People with Learning Disabilities and Autistic People annual report for 2021/22.

Key points

The ICB has undertaken a review of the current position of safeguarding against the national framework and has rag-rated itself as amber. A report on the self -assessment is attached at appendix 1.

The aim is to achieve a green rating by October 2022 and have an approved safeguarding strategy in place for December 2022.

The statutory responsibility for effective safeguarding and Learning from Lives and Deaths of People with Learning Disability and Autistic People (LeDer) transferred from CCGs to the ICB on 1 July 2022.

The LeDer annual review is attached at appendix 2 and is an amalgamation of the former individual North East and North Cumbria CCG annual reports and identifies the ICB approach as well as the key learning to be shared across the ICB.

Risks and issues

Ensuring a robust safeguarding function is essential for the ICB. The place-based structures remain insitu during the period of transition and gives assurance that processes remain in place. The size of the ICB does mean that oversight needs to be transparent and governance processes robust to ensure statutory accountability.

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Assurances
Assurance in place for both processes as existing structures have not altered during the transition period.

Recommendation/Action Required
The Board is asked to: • Receive the report for assurance, noting the transitional arrangements in place remain robust and continue to meet our statutory responsibilities for safeguarding adults and children • Receive the LeDer annual report 2021/22 for assurance.

Sponsor/approving director	David Purdue, Executive Chief Nurse
Report author	Louise Mason Lodge, Director of Nursing and Strategic Safeguarding lead Judith Thompson, Network Manager and Assurance lead

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues
The Childrens Act 2004, amended by the Children and Social Work Act 2017 The Care Act 2014

Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**		**N/A**	✓
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	None identified
Has there been/does there need to be appropriate clinical involvement?	Full clinical engagement in both reviews

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Has there been/does there need to be any patient and public involvement?	Service User involvement in the LeDer review and policy
Has there been/does there need to be partner and/or other stakeholder engagement?	Local authorities, police services, local voluntary groups

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Appendix 1

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Safeguarding Self- Assessment

1. Introduction and Background

Safeguarding is firmly embedded within the core duties of all organisations and all staff across the health system. However, there is a distinction between providers' responsibilities to provide safe and high-quality care, and commissioners' responsibilities to assure themselves of the safety and effectiveness of the services they have commissioned.

The context of safeguarding continues to change in line with societal risks both locally and nationally, large scale inquiries and legislative reforms.

Fundamentally, it remains the responsibility of every NHS-funded organisation and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied; the well-being of those children and adults is at the heart of what we do.

Every NHS funded organisation needs to ensure that sufficient capacity is in place for them to fulfil their statutory duties. They should regularly review their arrangements to assure themselves that they are working effectively. Organisations need to co-operate and work together within new demographic footprints to seek common solutions to the changing context of safeguarding and developing structural landscape needed to deliver the NHS Long Term Plan.

2. Main Issue

The North East and North Cumbria Integrated Care System (the ICS) has the statutory responsibility in health to be assured those processes and procedures for safeguarding are robust and keep people safe. The existing safeguarding services remain at place whilst the North East and North Cumbria Integrated Care Board's (the ICB) strategy for safeguarding is developed. The final structure is required in the first week of December 2022.

As part of the initial process a self-assessment and heat map was submitted for review by NHS England (NHSE) on the 9 September 2022.

3. Current Position

The ICB's current rag rating is amber, noting the Multi-Agency Safeguarding Hub (Mash) rag rating is green.

The assessment has been completed by the ICB directors of nursing responsible for safeguarding in the four ICB areas.

Within the ICS there are 13 community safety partnerships, 10 adult safeguarding boards, 11 childrens' safeguarding boards, 13 multi-agency safeguarding hubs and one violence reduction unit.

Name	Rag Rating	Mitigation plans, update, next steps, work shops, partnership structures etc
System Leadership and accountability for action on health inequalities		An ICS SRO in place and Health inequalities workstream is in situ across the ICS. ICB Quality and Safety Governance now incorporates an ICB wide Safeguarding Committee as reflected in the ICB Quality and Safety Committees ToR.. The influence of safeguarding needs to be firmly established and work is ongoing to support greater connectivity at a strategic level and across the ICS. One of the NENC 22/23 planning priorities is to develop an approach to population health management, prevent ill-health and address inequalities as tackling inequalities in outcomes, experience and access is one of ICB key aims
Structures and matrix working agreed with key roles		An ICS safeguarding transitional plan is in place for 22/23. The ICB Executive Chief Nurse and an ICB DoN have defined strategic leadership roles for oversight of the safeguarding elements of the ICB Operational Model and the development of ICB Safeguarding strategy. The ICB DoNs continue to provide leadership and oversight in the established partnership arrangements at place and in the discharge of the ICB safeguarding statutory duties.
Interim CN or substantive CN with accountability		The ICB Executive Chief Nurse is in post and formally approved as ICB Executive Safeguarding Lead. The ICB Directors of Nursing continue to provide leadership and oversight at place supported by Designated Professional teams
Priorities and work plan agreed		Transition Plan in place, with ongoing review and refresh. Q3/4 plan to finalise the operating model and ICB strategy
Partnership Arrangements and understanding		Robust place based partnership arrangements in place in all LA/CCG areas.
Supervision of Mash teams and data arrangements in place		Safeguarding supervision is undertaken by relevant employing organisations in accordance with Safeguarding policy & procedures. Annual self assessment (Health) is undertaken to understand/check compliance, and information is utilised/ informs Safeguarding Partnerships dashboards reporting (* this is at place across the ICS footprint). This is for all MASH's (Children) . Data /information sharing agreements are in place via Safeguarding Partnerships but there are also MASH IG agreements and individual Primary care (GP) arrangements in some places.

Q2 Questions

Name	Rag Rating	Mitigation plans, update, next steps, work shops, partnership structures etc
Which safeguarding programmes are profiled within the ICB to ICP joint forward plan		ICB Operating Model clearly outlines the accountabilities, functions and decision making at system/ICB and place for safeguarding Joint Management Executive Group – task and finish group made up of NHS and Local Authority Leaders set up to help with the development of the ICS and ICB. The four 'sub-ICPs' will develop a strategic view of shared challenges and opportunities from each of their HWBBs, which will then feed into Integrated Care Strategy development
How is the SAAF being used within the ICB with escalation to regional quality groups via the Regional Safeguarding Leads		Routes of escalation for safeguarding are outlined as an example in the ICB Operating Framework. For serious/high profile cases routes of escalation are in place to ICB DoNs at place, to the ICB Chief Nurse, communications and NHSE. Formal reporting routes are in place via QRGs. Designated Professionals membership of provider safeguarding committees as well as Safeguarding Boards Partnership Groups and then to the System Quality Group. The ICB Quality Committee will receive a Safeguarding Exception Report, exceptions would be included in the ICB Integrated Delivery Report

The table above outlines the two areas for further work. There are actions in place to address these, with a final ICB safeguarding strategy due for completion at the end of November.

4. Recommendations

The Board is asked to receive the report for assurance, noting the transitional arrangements in place remain robust and continue to meet our statutory responsibilities for safeguarding adults and children.

Report author: **Louise Mason-Lodge, Director of Nursing and Strategic Safeguarding Lead**

Sponsoring Director: **David Purdue, Executive Chief Nurse**

Date: **16 September 2022**

Item: 15
Enclosure: 7i

Appendix 2

Learning from Lives and Deaths of People with Learning Disabilities and Autistic People Position Paper

1. Background

The North East and North Cumbria were the first region in England to implement the Learning from Lives and Deaths of People with Learning Disabilities and Autistic People (LeDer) policy in 2016. Much has improved as a result of the learning from the LeDeR reviews however the national annual report published earlier this year continues to report that men with learning disability die, on average 22 years sooner than men without learning disability and women with learning disability, die on average 26 years soon that women without learning disability of preventable and avoidable causes. This huge inequality cannot continue to happen.

The ICB structure presents the opportunity to transform not only how LeDeR is delivered across NENC but also to tackle the health inequalities clearly continuing to be faced by people with learning disability and autistic people.

2. Learning from the Lives and Deaths of People with Learning Disability and Autistic People – LeDeR policy

LeDeR is a national service improvement programme aimed at improving local services for people with learning disability and autistic people reducing premature mortality.

The on-going contribution of people with learning disability and autistic people must inform all aspects of the programme and be central to development and delivery.

LeDeR reviews need to be conducted by multi-agency reviewing teams, including experts with lived experience, and carried out in a timely way with appropriate supervision and administrative support.

The review will take a holistic view of a person's life as well as their death. Key principles of transparency, independence, cooperation, and communication will be upheld working alongside other review or investigation processes. The programme overall strives to ensure reviews lead to reflective learning and improved health and social care delivery is made.

Every person age four and over with learning disability and every adult age 18 and over with a diagnosis held on a clinical system of autism are entitled to a LeDeR review. A person doesn't necessarily need to be on local GP QOF learning disability register to be entitled to a LeDeR review.

The ICS is expected to measure the impact of its work to demonstrate improvement.
The ICS is expected to complete all reviews within 6 months of the death being notified on the LeDeR platform except where other statutory processes are taking place, or the bereaved family have asked for a delay.

The ICS must establish local governance panels to sign off reviews and in addition agree SMART objectives and improvement activity that feeds into local and ICS wide strategic plans. LeDeR quality assurance must be part of ICS governance and not sat separately.

Governance panels/groups must consist of people who have responsibility for improving services and must take action to improve services. The panels/groups must also include experts with lived experience.

NHS England region teams will hold the ICS to account to ensure robust review and assurance processes are in place and will monitor quarterly against actions for all reviews completed.

3. North East and North Cumbria LeDeR system

The ICS will fulfil its LeDeR responsibilities ensuring the core values and principles as set out in the policy, as well as those developed by the North East North Cumbria Stop People Dying Too Soon Confirm and Challenge Group are central to delivery.

There is considerable under reporting of deaths from black and minority ethnic communities therefore the ICS will need appoint a named individual who will be responsible for ensuring the challenges faced by people from these communities are well understood, considered and addressed as part of the LeDeR programme.

NENC have a history of meaningful engagement and coproduction with people with lived experience and established the Stop People with Learning Disability Dying Too Soon Confirm and Challenge Group.

Feedback from the Group about being part of the future Governance arrangements is as follows:

- '*We felt very respected being at the heart of the plans'*
- *'We love the jobs in the area teams for Experts'*
- *'We feel like it brings people together to all work together'*
- *'It focuses on making changes to make things better'*

LeDeR is the responsibility of the ICB Executive Chief Nurse. Regional oversight arrangements will include NHSE/I sampling to assure quality of reviews. Local governance arrangements will feed into local quality surveillance groups and for local authorities, health and wellbeing boards, to ensure that the people who can affect the necessary improvements understand the issues that need to be addressed.

ICSs are responsible for ensuring that:

- LeDeR reviews are completed for their local area
- Actions are implemented to improve the quality of all mainstream services for people with a learning disability to reduce health inequalities and premature mortality
- Local actions are taken to address the issues identified in reviews
- Recurrent themes and significant issues are identified and addressed at a more systematic level.

4. Governance

The ICS LeDeR Governance Board is established and chaired by the ICB Executive Chief Nurse. Terms of reference are developed setting out membership, responsibility, and accountability. The previous LeDeR Steering Group will be disbanded although some of its members will transfer to the Governance Board.

The ICB directors of nursing will be responsible for LeDeR for each area within the ICB (North Cumbria, North, Central and Tees Valley) and will continue to carry out their duties as local area contacts.

The LeDeR Governance Board will be directly accountable to the ICB Executive Committee and will report six-monthly to the Executive Committee. The ICB Executive Committee will be responsible for producing an annual report that is published on the website.

People with lived experience will be represented at the LeDeR Governance Board by members of the Stop People with Learning Disability Dying Too Soon Confirm and Challenge Group. The Learning Disability Network will continue to provide strategic leadership and co-ordination for the LeDeR programme at a system level.

LeDeR will be a standing item at the ICB Quality Assurance Group to ensure shared learning, oversight of improvement activity and performance management.

LeDeR panels will be established in each ICB area, chaired by the directors of nursing/local area contacts. Panels will receive completed reviews including reviewers sharing areas of learning, good practice, and areas of concern. Reviewers will no longer be responsible for making recommendations. The ICB area LeDeR panels will sign off reviews and make any recommendations. An agreed percentage amount will be forwarded to the ICS Governance Board for oversight and assurance.

The ICB Governance Board and ICB area LeDeR panels will be established and functioning by December 2022.

A copy of the NENC LeDer governance arrangements, implementation and three year strategy plan, September 2021 is attached at Appendix 3.

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5. Learning into Action

The fundamental purpose of LeDeR is to learn from the lives and deaths of people with learning disability and autistic people. Learning from reviews needs to be widely understood at place level (all 13), ICB area and ICB/S levels.

The ICS learning into action should be led and overseen by the ICB Executive Director of Nursing and co-ordinated by the ICS LeDeR Governance Board through the Learning Disability Network.

Each place, ICB area panel and ICS Governance Board will have its own learning into action plan comprising of a description of the improvement action needed, who will carry it out, how and when it will be done and monitoring/assurance arrangements that demonstrate successful completion. Co-ordination, oversight and reporting of the learning into action plans will be carried out by the Learning Disability Network.

A summary of all learning into action will be published within the NENC annual report.

Learning into Action plans will be established at place, ICB area and ICS levels by January 2023.

Name of Author: **Judith Thompson, Network and Assurance Lead, Learning Disability Clinical Network, NHS England**

Sponsoring Director: **David Purdue, Executive Chief Nurse**

Date: **9 September 2022**

North East & North Cumbria Integrated Care System

LeDeR
Learning from Life and Death Reviews

Revised Governance Arrangements, Implementation Plan and 3 Year Strategic Plan

September 2021

Author Trish Churchill
Contributors Amy Hocking and Julie Tucker
on behalf of the NENC Learning Disability Network

Contents

Background and context

LeDeR; Learning from Life and Death Reviews is a service improvement programme to improve services for people with a learning disability and autistic people.

Responsibility for ensuring the delivery of LeDeR currently (2021/22) lies with CCGs and as the systems evolve over the next year, responsibility and accountability for LeDeR will change to rest with Integrated Care Systems (ICS). North East and North Cumbria (NENC) is already working together as one ICS and will become a statutory organisation, subject to approvals by Parliament, from 1 April 2022. NCNE ICS have named Learning Disability and Autism as one of their six priority workstreams under the leadership of Nicola Bailey who is currently Accountable Officer at County Durham CCG.

This report provides the LeDeR draft implementation plan and new governance arrangements required to be in place by 1 April 2022.

- A full version of the new policy can be found here.
- An easy read version of the policy can be found here.
- Find out more about the North East & North Cumbria Integrated Care System here.

Local delivery expectations

NENC have a history of meaningful engagement and coproduction with people with lived experience and established the Stop People with Learning Disability Dying Too Soon Confirm and Challenge Group. Feedback from the Group about being part of the future Governance arrangements is as follows:

> *'We felt very respected being at the heart of the plans'*
> *'We love the jobs in the area teams for Experts'*
> *'We feel like it brings people together to all work together'*
> *'It focuses on making changes to make things better'*

The NENC ICS has already made some progress in relation to the delivery expectations of the new LeDeR policy including having a named lead for Black, Asian and Minority Ethnic Inequalities. Annie Topping is Executive Director of Nursing, Quality and Patient Safety at Northumberland CCG. NENC also demonstrated its commitment to narrowing the gap in health inequalities and premature mortality during (2020/21) when 74% of people on the learning disability register received an annual health check.

At present there are robust plans in place within CCGs to ensure that reviews are completed within 6 months of notification of death. It is anticipated that delivery of reviews will remain at 'place'.

Reviewers at Place will systematically capture evidence where recommendations are being made, that they are being acted upon or that changes are having the desired impact. Through the Local Area Contacts (LAC), reviewers will feed into the Steering Group any action from learning required and any areas for escalation. The NENC Learning Disability Network will continue to be the mechanism for using the learning from Leder reviews to improve services.

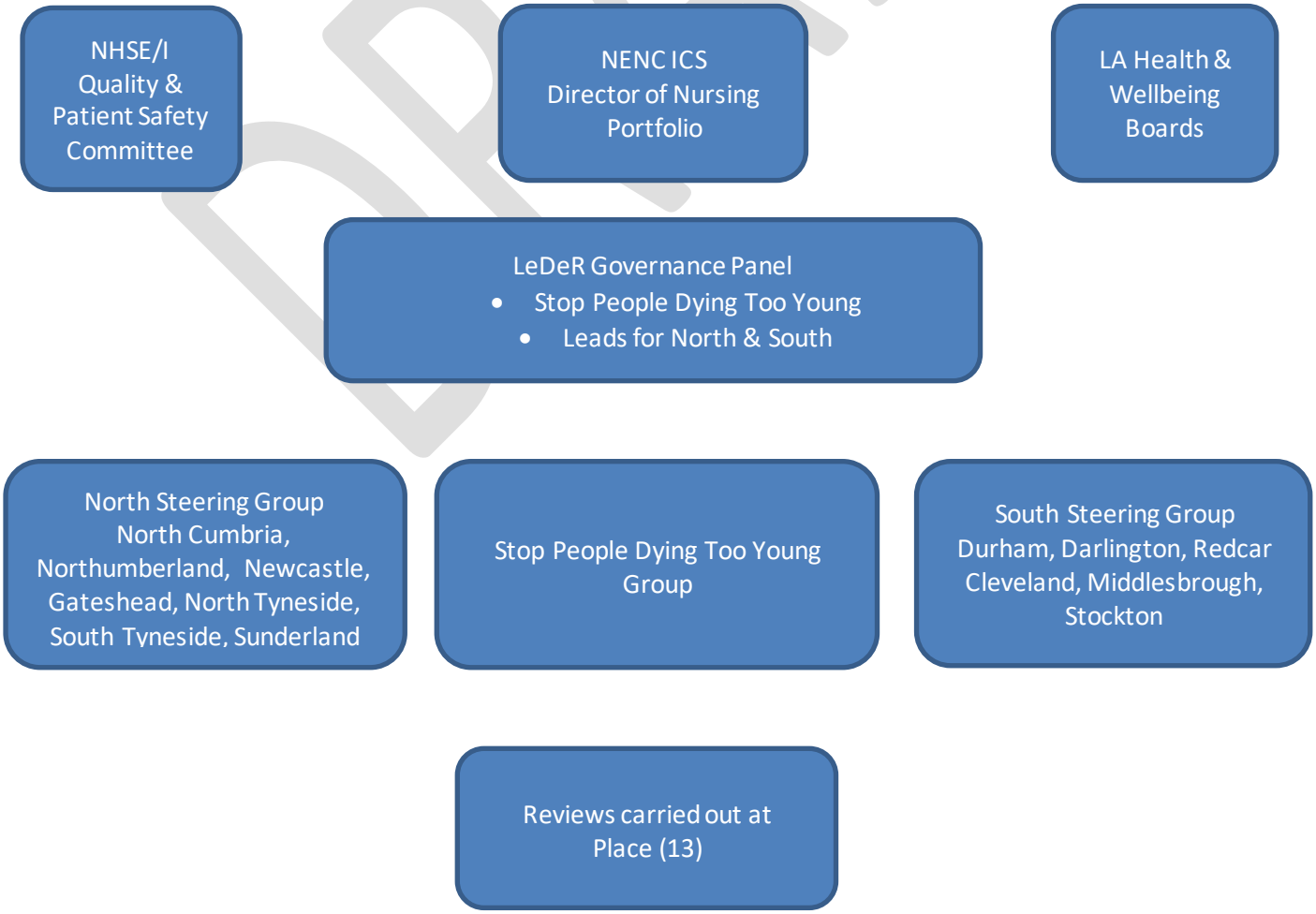
Governance and Assurance

It is the responsibility of individual ICSs to determine how LeDeR is best governed within its own quality and governance arrangements, Regional oversight arrangements will include NHSE/I sampling to assure quality of reviews.

Local governance arrangements will feed into local Quality Surveillance Groups and, for Local Authorities, Health and Wellbeing Boards, to ensure that the people who can affect the necessary improvements understand the issues that need to be addressed.

ICSs will become responsible for ensuring:

- that LeDeR reviews are completed for their local area
- that actions are implemented to improve the quality of all mainstream services for people with a learning disability to reduce health inequalities and premature mortality.
- that local actions are taken to address the issues identified in reviews.
- that recurrent themes and significant issues are identified and addressed at a more systematic level.



The ICS Governance Panel membership will include representation from:

- → Stop People with Learning Disability Dying Too Young Confirm & Challenge Group
- → ICS senior leaders
- → The Learning Disability Network
- → NHS England
- → Local Area Contacts leads from the North and South
- → Local Authorities
- → Acute Hospitals
- → Specialist Learning Disability Hospitals
- → Primary Care Networks
- → Coroner's Office
- → Care Quality Commission

The Role of the ICS Governance Panel:

- → signing off the quality of focused reviews
- → oversight on quality of reviews
- → areas of learning
- → good practice
- → areas of concern
- → feed into strategic plan for NENC
- → Inc people with lived experience
- → NHSE/I Quality surveillance
- → ICS quality governance

Workforce Planning

The role(s) expected of the LAC will sit within the ICS. This is a different role to the current LAC role and there will be greater independence between the reviewing team and the LAC in future. The LAC(s) will chair the Governance Panel and be responsible for reporting into NHSE/I, the ICS and LAs through the agreed mechanisms (see Governance diagram above).

The Senior Reviewer is a new role which will lead a multidisciplinary team of reviewers providing professional and line management support and professional/clinical supervision and ensuring that the team works cooperatively together to deliver all the reviews within their remit. The Senior Reviewer(s) will chair the North and South Steering Groups and be responsible for reporting into the LeDeR Governance Panel.

Reviewers will work in teams (one North and one South) to allow peer support and to ensure improved quality and consistency. Reviewers should be using NHS or LA IT equipment that is compliant with Information Governance rules.

The revised workforce model will also need to include time to gather and present the learning and recommendations that come from reviews at the various forums as described in the Governance Diagram.

Dedicated Business Support will be employed as part of the ICS Workforce Model to support the ICS Governance Panel, the North and South Review Teams and to provide support to the ICS LeDeR review process generally. The Business Support Role will coordinate production of the ICS LeDeR Annual Report as well as preparation of reports into NHSE/I Quality and Patient Safety Committee and Local Authority Health and Wellbeing Boards. The business support role will also lead on performance reporting which is critical to ensure that NENC is aware of its ability to reach the KPIs and can take appropriate action to address any under/over resourcing.

Autistic people due in average 16 year younger than the general population and in 2021, the LeDeR process will include the deaths of autistic people.
Personal-tragedies-public-crisis-ONLINE.pdf (autistica.org.uk)

Since we have yet to begin reviewing the deaths of autistic people, it is difficult to predict the demand and the associated workforce resource required and this remains an estimate.

Calculating the number of reviews – assumptions used

The following workforce model is based on a number of assumptions in the total number of reviews which can be tested and revised during October 2021 to March 2022, including:

- 6.52% of the NENC population is from Black, Asian and Minority Ethnic groups
- 2.16% of the NENC population has a learning disability (they may also be autistic)
- 1% of the NENC population is autistic
- The baseline used for notifications is 20-21 and the estimated conversation rate on these reviews is 50%
- 0.01% of families/carers etc will request a review; these will be additional to the baseline notifications and there will be a 50% conversion rate from initial to focussed reviews
- There will be half as many deaths of autistic people reported through the LeDeR platform as learning disabled people

More detail can be found in Appendix 2.

Workforce Modelling

NENC LeDeR Workforce Model			
Time to complete reviews		**Initial**	**Focussed**
Hours to complete reviews (ref NECS modelling)		12	45
Number of reviews		154	243
Hours to complete reviews		4764	10935
Total time needed (hours)			15699
Workforce needed to complete reviews			
Reviewer FT 220 days per year	1650		
Reviewers needed	9.5		
Reviewer - learning into action	1		
Total reviewers needed B7	10.5		
LAC B8c	0.2		
Senior Reviewer B8a 2 x 0.5	1		
Project Support B6	0.5		
Costs based on 20-21	**WTEs**		**£**
Total reviewers needed B7	10.51		614,846
LAC B8c	0.2		19,539
Senior Reviewer B8a	1		68,131
Project Support B6	0.5		24,867
Total cost to ICS			**727,382**

Risks and Mitigation

There are a number of risks in transition to new LeDeR workforce model:

- Future ICS governance arrangements have not been confirmed, this model assumes that LeDeR will be within the Director of Nursing Portfolio who will sit on the ICS Board
- CCG reviewers are currently working at place and will be required to transition to one ICS, in addition there are few WTEs who are solely employed to carry out LeDeR reviews; this results in the inability to accurately measure time spent to date on reviews and therefore to accurately monitor/predict exact resource required; this risk can be mitigated through the consideration of a blended delivery model with North of England Commissioning Support Unit partners
- Monitoring and reporting needs to be set up to ensure that the ICS is meeting the KPIs; systems and processes will need to be established by April 2022

- Deaths of autistic people will not be able to be notified to the system until later in 2021 there for it is difficult to plan effectively
- The workforce model assumes that the ICS will continue to receive the annual LeDeR funding from NSHE/I.

Implementation Plan and 3 Year Strategic Planning; Key areas for Improvement; Themes and Priorities

CCGs across NENC ICS have completed their Local Area LeDeR Annual Reports for deaths reported 1st April 2020 – 31st March 2021. The reports offer opportunities to highlight areas of best practice, note where improvements are required and share the learning and recommendations from LeDeR reviews. The information contained in these reports will influence the strategic priorities of the NENC ICS Learning Disability and Autism Workstream and directly impact the implementation of the new LeDeR policy for the region. The following plan should be viewed as the first draft and will be a live document owned by the LeDeR Governance Panel and LeDeR Steering Groups.

Development Area	Objective	Progress to date	Timeline for completion
1. Governance	Have a named lead with responsibility for Black, Minority Ethnic inequalities	In place; Annie Topping Executive Director of Nursing, Quality and Patient Safety, NHS Northumberland CCG and NHSE/I (North East and Yorkshire) Strategic Lead for Chief Nursing Officer (England) BAME SAG Action Plan	Complete
	Identify a named executive lead as SRO for LeDeR within the ICS	Nicola Bailey is SRO for the Learning Disability and Autism Workstream	Complete
	A robust plan in place to ensure that reviews are completed within 6 months of the notification of death	NCNE completed 100% of cases within the 6 month KPI prior to the new operating system. Future workforce plan in development.	See Workforce Plan
	Evidence of meaningful engagement of people with lived experience in governance group	The Stop People Dying too Young Confirm and Challenge Group are part of the current and future governance arrangements and produce a Newsletter which is disseminated.	Draft Plan in place by 30th September 2021 Delivery from April 2022

	Quarterly report demonstrating progress against delivery of LeDeR actions RAG rated	Monthly progress reports into Executive Strategy Group; broken down by CCG, provides opportunity to escalate via CCG Accountable Officers (and ICS equivalent once confirmed). Quarterly reports will be accompanied by a Newsletter for Acute Trusts, LA Commissioners and ADASS colleagues. The ICS Website will also be a repository for LeDeR information.	Draft Plan in place by 30th September 2021 Delivery from April 2022
	Clear Governance in place which includes LeDeR governance in mainstream ICS quality surveillance and governance arrangements	Development of process for reporting areas of concern and sharing learning/action from learning required via regional Quality Surveillance Groups. See Governance diagram NCNE will work with the ICSs in Y&H to provide a quarterly report to the NEY Quality and Patient Safety Committee to highlight any learning. Escalation process will be via the NCNE Executive Strategy Group and the LACs in the first instance.	Draft Plan in place by 30th September 2021 Delivery from April 2022
	Development of 3 year strategy shared with NHSE/I's Regional Team	See below	Draft Plan in place by 30th September 2021
	Sustainable workforce model in place	See Workforce Planning	Draft Plan in place by 30th September 2021 Delivery from April 2022
	Local Governance Panel in place	See Governance and Assurance	Draft Plan in place by 30th September 2021 Delivery from April 2022
3 Year Strategic Plan to deliver a reduction in the gap in health inequalities and premature mortality			

2. Reducing Health inequalities	To drive improvement in the quality of health and social care service delivery for people with learning disabilities	The current LeDeR work programme is directly linked to the broader tackling health inequalities work programme of the North East and Cumbria Learning Disability Network. The priorities which have been set for 2021/24 are: Pneumonia Aspiration pneumonia Cancer Wider health promotion End of life Flagging Sepsis Constipation Epilepsy Mental Capacity Act AAA Screening Programme Dementia Oral care NHS 111 and Urgent Care Data dashboard in development with NECS will provide live monitoring information on Primary Care Registers to enable targeted approaches based on that data.	NB each one of the areas has its own activity, action plan and timeline managed through and by the Learning Disability Network which would provide too greater detail for the Strategic Plan. Ongoing with review against baseline at April 2022

3. Annual Health Checks	Improve how the Annual Health Checks and Health Action Plans work. This will include: Use of Easy Read for more effective AHCs A training support programme for staff Updates to Health Action Plans to show support for healthy lifestyle	Good Access to Primary Care Services Network (GAPS) The North East and Cumbria GAPS Network is a regional network made up of the learning disability primary care facilitators from across the region. The network is facilitated and supported by the North East and Cumbria Learning Disability Network. The GAPS network has been established since 2018 and has led on a range of initiatives to improve the care and experiences of people with a learning disability in primary care services. The network meets 6 weekly with their current 2021 focus on: • Facilitating reasonable adjustments in general practice and primary care • Improving the quality and uptake of learning disability Annual Health Checks • Improving GP learning disability registers • Provide learning disability awareness training to GP Practices • Improving access, health and health outcomes and experiences of primary care service for people with a learning disability and their families reducing premature mortality • Peer review • Covid19 vaccination roll out • Improving uptake of flu immunisation in people with a learning	Ongoing with review against baseline at April 2022
	Continue to raise awareness across the ICS of the importance of the AHC, including with families and carers and PCNs.		
	Respond to performance rates of AHC to provide support to the ICS to ensure the national target is met year on year		

	Review AHC resources and coproduce for autistic people in line with national roll out of AHCs	disability and their carers • Development and implementation of the Learning Disability Diamond Standard Primary Care Pathways and Workforce Education Package • Working in partnership with the A2A and Learning Disability CCG Clinical Leads networks. During the Covid19 pandemic the North East and Cumbria Learning Disability Network will continue to support our network members to improve the uptake and quality of Annual Health Checks through: • Learning disability Annual Health Check pre-questionnaire • Annual Health Check risk stratification tool to support GP practices whilst managing the pandemic • Primary care resource pack for GP practices • Support General Practice and CCGs to design and deliver 'reasonably adjusted' Annual Health Check models • Resources: https://www.youtube.com/watch?v=e3ZSPDyBAVA&t=27s https://necldnetwork.co.uk/wp-content/uploads/2021/01/What-is-AHC-Flu-Registers.docx Current work focusing on AHCs for children and young people, awareness and access to AHCs with aim of developing sustainable health behaviours and access to primary care. Funding application in with national team to develop resources specifically for this age group.	

4. Reasonable Adjustments	Raising awareness of Reasonable Adjustments within all action areas. For example: Providing Easy Read leaflets/resources Longer appointments Helping people with their choices and how they can have reasonable adjustments made	Learning Disability Acute Diamond Pathways In 2020 The Learning Disability Diamond Standards have been developed by the North East and Cumbria Learning Disability Network and Access to Acute (A2A) Network to support NHS Acute Trusts to deliver high quality, reasonably adjusted care to people with learning disability. Resources: A4_Learning_Pack.pdf (necldnetwork.co.uk) PowerPoint Presentation (necldnetwork.co.uk) Currently developing diamond pathways for primary care with support from Clinical leads network and GAPs network.	Ongoing with review against baseline at April 2022
5. Screening programmes	Supporting people to take part in screening programmes	Long established cancer project with focus on screening, resources available at: https://necldnetwork.co.uk/work-programmes/health-inequalities/cancer/cancer-screening/ Currently developing new peer education programme Be Screening Aware in partnership with National PHE screening team and Northern Cancer Alliance. Work in partnership with Screening and immunisation team and local screening centres. Currently piloting health quality checks in breast and bowel screening in partnership with Skills for People and Sunderland People First.	Ongoing with review against baseline at April 2022

6. Hospital passport	Increase use of across Secondary Care	Every Acute Trust in our region offers a paper Hospital Passport to people with a learning disability. Through the Covid19 pandemic we have developed a regional Covid19 Hospital Passport which can be accessed here: https://necldnetwork.co.uk/wp-content/uploads/2021/01/Word-Hospital-Passport.pdf Current project developing/creating a digital hospital passport which will standardize hospital passport for the whole region. Supported by Health call, Great North Care Record and Skills for People.	Ongoing with review against baseline at April 2022
7. Workforce, Training, Information and Awareness	Making sure professionals have safeguarding and equality training Sharing information on early warnings of illness	The Acute diamond standards include an e-learning and face to face delivery resource. This has been adopted by all trusts across the ICS. To be a diamond standard ward/organisation 70% of staff need to have completed the training. Due to a lack of guidance about how best to support people with learning disability to learn about the PBS approach and no nationally-agreed standards about the training requirements or qualifications and experience individuals or services need to have, the North East and Cumbria PBS Steering Group worked collaboratively with a number of partners from across the health and care sector and with Northumbria University to co-develop, validate, co-deliver and evaluate a range of accredited learning programmes in Positive Behavioural Support for the North East and North Cumbria. As such, the PBS approach is becoming a way of life across health, social and education care in the North East and North	Ongoing with review against baseline at April 2022

	More training for hospital staff around Learning Disabilities and the Mental Capacity Act	Cumbria. The North East and North Cumbria PBS work programme has its own website which was launched in January 2021 and can be found here www.pbsnec.co.uk Early warning resources • Developed resources include Stop and Watch. • Ongoing commitment to Confirm and Challenge group – Inclusion North • Continued promotion of AHC/Health Action Plans • Promotion of covid vaccination and flu vaccination • Work with Northern Cancer Alliance on awareness campaigns Be Cancer Aware « Learning Disability Network (necldnetwork.co.uk) Workforce Our collective vision is that the North East and Cumbria will be the best place in England for a person with learning disability and/or autism and their family to live. In a rapidly-changing political, economic and social environment it is of paramount importance to have a robust workforce transformation and delivery plan in place to support the multi-disciplinary workforce and family carers We are doing this by transforming the workforce to support people to live better, more fulfilling lives and to enable better care and support to be delivered closer to home, with earlier and more appropriate intervention when necessary. The updated NCNE Learning Disability and Autism Workforce Strategy is in draft with the Workforce Plan to follow in early 2022.	
8. Choice and control	Comprehensive End of Life Planning	To improve recognition of people (and their families) who are nearing the end of their lives, to develop education and training materials and increase awareness of appropriate responses across health and social care. Currently working with Palliative care and End of Life Network to	Ongoing with review against baseline at April 2022

		develop easy read resources in partnership with experts by experience from Inclusion North.	
	Improved completion of assessments and forms inc. • Medication reviews • Discharge information	STOMP and STAMP project - to promote alternatives to medication. Dave Gerard and Ruth Lee – PBS Workforce Development Manager leading discussions on project.	
	How to work with people if they say no to treatment/ Follow up on missed appointments/no show	Current work looking at 'Adult not brought' flagging and processes led by clinical leads network with partners from across primary and acute services.	
9.Communication	Improved communication between health, social care and families	Appointment of Workforce Development Manager for Families PBS website aims to: Have a shared vision that brings families and professionals together with the aim to improve the quality of life of children, young people and adults with a learning disability and or autism. Have a shared understanding that PBS can be hugely effective in helping a group of people to best understand a person with a learning disability and or autism to support them to have the best life possible Share resources the website is a platform to reach out to families, carers and services sharing useful and practical information as well as celebrating the quality of PBS work in the North East and North Cumbria and the lives of people with a learning disability • Primary care bulletin • NECLDnetwork.co.uk website • Learning disability matters to families website	Ongoing with review against baseline at April 2022

Appendix 1 LeDeR Policy Changes - Easy Read

NENC LeDeR model v2 ER.pdf

Appendix 2

Estimating the total number of Leder Review over a twelve month period			
	Total Population in NENC		3315740
	BAME Population	6.52%	216340
	% BAME and learning disability (est)	2.16%	4673
	% BAME who are autistic (est)	1%	2163
	% of popn with a Learning disability	2.16%	71620
	% of popn who are autistic	1%	33157
	Notifications 20-21		298
	as a % of popn:- people with a learning disability	0.42%	
	Estimated additional reviews		
Initial	Requested by families (est)	0.01%	5
Focussed	Requested by families (est)	0.01%	5
Focussed	Autistic people (including BAME popn)	0.21%	70
Focussed	BAME who have a learning disability and are autistic	0.42%	20
	Notifications 20-21 est 50% conversation rate		
Initial			149
Focussed			149
	Total initial reviews		154
	Total focussed reviews		243

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REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	
Official: Sensitive Commercial		Provides assurance	✓
Official: Sensitive Personal		For information only	

BOARD 27 September 2022	
Report Title:	**Vaccination Plan**

Purpose of report

To update the Integrated Care Board (ICB) on current status and future delivery strategy for all vaccination activities with a particular focus on Flu, COVID and Monkeypox.

Key points

- Vaccination background
- Flu vaccination autumn plan
- COVID vaccination autumn plan
- Monkeypox status update
- Future vaccination delivery plan
- All providing the ICB with the necessary assurance regarding our vaccination plan

Risks and issues

- Risk of low vaccination uptake
- Risk posed by complex vaccine supply chains
- Risk of limited capacity/workforce to deliver

Assurances

- Historic good performance with respect to flu uptake
- Excellent COVID uptake enabled by multiple delivery models, strong system leadership, effective engagement and communications; including population insights and a focus on inequalities
- System Vaccination Operations Centre (SVOC) coordination working closely with place leads on vaccine logistics

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- Excellent system engagement to deliver across the complex North East and North Cumbria (NENC) geography, using multiple delivery models to meet the needs of the population.

Recommendation/Action Required	
Receive the report for assurance; we will update regularly on vaccine performance at future board meetings.	
Sponsor/approving director	Dr Neil O'Brien, Executive Medical Director
Report authors	Stephanie Klein, COVID Programme Director, NuTH Neil Watson, COVID Programme COO, NuTH Rachel Chapman, Head of Commissioning & Contracting (Public Health & Secondary Dental),NHS England and NHS Improvement – North East & Yorkshire Region

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	
CA4: Help the NHS support broader social and economic development	

Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**			
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**			
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**			

Key implications	
Are additional resources required?	Current delivery to 31 December 2022 is fully funded. Future delivery will require a fully costed business case.
Has there been/does there need to be appropriate clinical involvement?	On-going proactive clinical involvement through regular engagement sessions across NENC.
Has there been/does there need to be any patient and public involvement?	Communications and campaign development based on insight and involvement with target communities.

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Has there been/does there need to be partner and/or other stakeholder engagement?	Vaccination programme engages with key partners including local authorities, public health teams, primary care networks and community pharmacy representatives.

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Vaccination Plan

1. Introduction

This report updates the ICB on our vaccination plan and future delivery strategy for all vaccination activities with a particular focus on Flu, COVID and Monkeypox.

2. Background

For the last two years during the coronavirus (COVID-19) pandemic we have had the largest NHS influenza vaccination programmes ever. We have also seen some of the best influenza vaccine uptake levels ever achieved in many of the cohorts, with more people vaccinated than ever before. This has been delivered alongside an extremely successful COVID vaccination programme which has seen an average spring booster uptake of 84% of the eligible population across the North East and North Cumbria Integrated Care System.

As a result of non-pharmaceutical interventions in place for COVID-19 (such as mask-wearing, reduced social interactions and international travel) influenza activity levels were extremely low globally in 2020 to 2021. As social contact returns to pre-pandemic norms there is likely to be a resurgence in influenza activity in winter 2022 to 2023 to levels similar to or higher than before the pandemic. This has been the reality in southern hemisphere countries such as Australia where, in their winter season (July 2022), a large wave of flu cases eclipsed pre-pandemic levels. The potential for co-circulation of influenza, COVID-19 and other respiratory viruses could add substantially to pressures in the NHS in 2022 to 2023. Consequently, in the North East and North Cumbria Integrated Care System there is an immediate focus on the delivery of an effective Autumn Vaccination campaign for both flu and COVID vaccination, utilising the learning, operations centre approach and engagement platforms built for the deployment of the COVID vaccine.

3. Flu Vaccination – Summary of 2021/22 Delivery and 2022/23 Delivery Plan

The 2021/22 flu season saw improved uptake of the flu vaccine for clinical at-risk groups and those aged 50 years and over, with uptake for the 65 years and over cohort at the highest level ever, achieving the ambition target of 85%. Insights projects were subsequently completed with the intention of supporting increased uptake for the 2022/23 flu season for those in clinical at-risk groups, pregnant women, care home staff and 2+3 year olds. In addition, service improvement initiatives were conducted with school-age immunisation services to support and enhance flu and other school vaccination uptake.

Uptake figures for 2021/22 can be found in appendix I and II.

The expanded flu programme is now aligned with COVID vaccination (50 to 65y and some secondary school year groups) to allow for co-administration, where possible, the eligibility groups and aspirational targets are detailed in the table below. Flu vaccination is delivered across general practice and through community pharmacy. Across the North East and North Cumbria Integrated Care System community pharmacy, last season, delivered over 270,000 flu vaccines. This was an increase of over 60% compared to 2020/21 when 160,000 flu vaccines were delivered. There is a potential for the system to see a further increase in 22/23, we are promoting collaboration across general practice and community pharmacy to improve access and therefore uptake of the vaccine.

3.1 Flu Vaccination Uptake Ambition for Autumn 2022

Eligible Cohort	Ambition Uptake
65 yrs and over	85%
6 months - <65 yrs in Clinical Risk Groups	75%
Children age 2–10 years on 31st August 2022 (up to primary school year 6) Secondary School Years 7,8 & 9, delivery from 5th December 2022	70%
Pregnant Women	75%
50 – 64 year olds (NOT in a Clinical risk group) from 15th October 2022	75%
Long-Stay Residential Care Homes	> previous years uptake
Frontline HCW (by employer) – all to be offered	70 – 90%

Preparatory work for the Autumn Flu campaign has included a test and challenge session held in August 2022 to give assurances that plans are aligned to this year's anticipated delivery requirements. Workstreams have been established and engagement work undertaken with target groups (incl. Maternity, Data/Digital, School Age Immunisation Services, Inequalities, Learning Disabilities & Autism Network, Social Care Workers) to address lessons learnt, problem solve and forecast 22/23 issues. There has been a particular focus on clinically at risk, pregnant women and 2-3 year olds.

Communication and engagement plans are aligned to include both flu and COVID-19 which has streamlined planning and stakeholder management at

locality level. This also ensures a clear and cohesive public messaging and media campaign can be developed regarding the importance of vaccination.

Operational support regarding flu vaccine supply and system coordination, including opportunities for co-administration where feasible, is being provided. All GP practices have been surveyed to establish supply status and to ensure that mitigations are in place to manage any risk to delivery. Provider plans are in place to deliver the School-Age Immunisation Flu Programme. As an ICB we have agreed a mechanism to redistribute vaccines across the North East and North Cumbria to areas of greatest need but we are confident we have enough vaccine to offer the eligible population.

4. COVID Vaccination Autumn Plan

COVID-19 is more serious in older people and in some groups with underlying health conditions. This winter it is expected that many respiratory infections, including COVID-19 and flu may be circulating at high levels, putting increasing pressure on hospitals and other health care services. For these reasons, people aged 50 years and over, those in care homes, and those aged 5 years and over in clinical risk groups are being offered an autumn booster of Bivalent COVID-19 vaccine. A booster will also be offered to front-line health and social care staff, those who care for vulnerable individuals and families of individuals with weakened immune systems. The eligibility for a COVID autumn booster vaccination has been aligned with flu to support co-administration where possible. The key message being to have both and ‘double your defence’.

The COVID vaccination programme continues to be managed through the Lead Provider Model with Newcastle Hospitals having a Management and Coordination Organisation (MCO) role, with oversight by the ICB. It provides senior leadership expertise, stakeholder management and system coordination through System Vaccination Operations Centre (SVOC). This MCO lead provider functions ceases at the end of the autumn programme (31 December 2022).

To date over 6.9 million COVID vaccinations have been delivered by the NENC providers, which includes 255,000 spring booster doses. See Appendix III for cohort uptake data.

There has been extensive planning with 71 PCN’s, 130 community pharmacies, 19 hospital hubs and 15 roving services engaged to provide COVID vaccinations between September and December 2022. The campaign commenced on the 5 September with care homes and housebound first. The target being to complete care home visits by mid October. There is a national incentive payment scheme to support this work.

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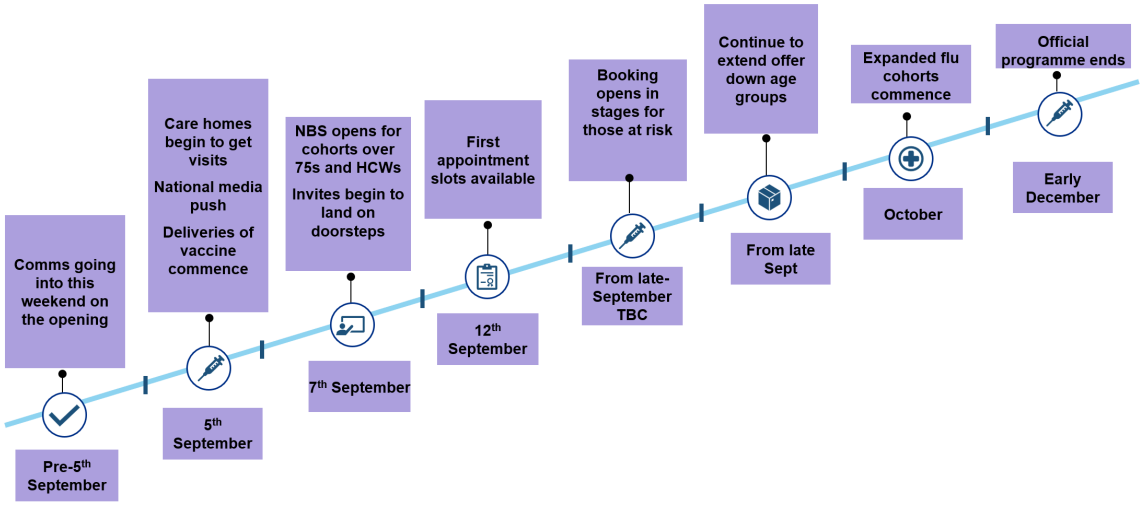
Key milestones in campaign launch



From 12 September bookings for over 75's and self-declaring H&SC (health and social care) workers will commence and vaccination can be accessed via both local booking systems and the national booking system (NBS). Thereafter, activity will be stepped up and open to the over 65's and then over 50's by mid October 2022. The whole campaign will be complimented by strong communications and engagement plan encompassing both the public and providers.

Key public messages

- ✓ Importance of having both flu and COVID vaccination – 'Double your Defence'
- ✓ Don't contact your GP you will be invited through local booking systems.
- ✓ Letters will also be sent out which will invite people to book on the national booking system

Key provider messages

- ✓ Co-promote and co-administer vaccinations where possible to improve patient experience and uptake
- ✓ Deliver opportunistically in a permissive way whenever we can (incl. hospital inpatients)
- ✓ Regions/systems and sites to maximise uptake amongst eligible populations with focus on underserved communities
- ✓ Flexibility for ICSs to go at their own pace

In addition to the Autumn campaign plan, we also have a system wide surge plan, which will allow for rapid increase in capacity, should it be required.

New bivalent vaccines will be used in the autumn campaign which provide protection against the both the original and the new Omicron version of COVID-19. These give dual protection. All patients will be provided with an information leaflet when they attend a vaccination clinic.

4.1. COVID Autumn Booster Eligibility

JCVI advises that for the 2022 autumn booster programme, the following groups should be offered a COVID-19 booster vaccine:

- residents in a care home for older adults and staff working in care homes for older adults
- frontline health and social care workers
- all adults aged 50 years and over
- persons aged 5 to 49 years in a clinical risk group,
- persons aged 5 to 49 years who are household contacts of people with immunosuppression
- persons aged 16 to 49 years who are carers.

5. Monkeypox

Monkeypox infection is caused by the monkeypox virus and is endemic in some countries in West Africa. There has been a recent increase in cases of monkeypox in the UK as well as other parts of the world where it has not been seen before; unrelated to travel to endemic areas. The symptoms of monkey pox begin from 5 to 21 days (average 6 to 16 days) after exposure. Treatment for monkeypox is mainly supportive. The illness is usually mild and most of those infected will recover within a few weeks without treatment. The virus can spread if there is close contact between people and the risk to the UK population is low. Recent cases are predominantly in gay, bisexual and other men who have sex with men (GBMSM), most commonly aged 31 to 44 years. These groups are being advised to be alert to any unusual rashes or lesions on any part of their body, especially their genitalia, and to contact a sexual health service if they have concerns. The majority of cases have been seen in London with 47 cases in the North East of England. There have been a number of hospital admissions in our region.

Vaccination is available with the smallpox vaccine (modified Vaccinia Akara (MVA) vaccine). This is authorised for protection against monkeypox and is likely to be effective at preventing around 85% of infections. MVA is stored between 2-8C and given by sub-cutaneous route at a dose of 0.5ml; JCVI have recently suggested a lower ‘fractional’ dose of 0.1ml could be given intradermally. This would require further training of vaccinators but would mean more doses can be administered per vial.

Pre-exposure vaccination is recommended for healthcare workers who are due to care for patients with confirmed monkeypox (these people are identified within the health care setting and vaccination is being delivered by occupational health), gay, bisexual and other men who have sex with men at high risk of exposure. It

may be that these vaccines could be delivered in services such as sexual health services who see people in these risk groups, however it is important that other models are looked at to ensure efficient delivery of vaccine and that those who are high risk who do not attend sexual health services have the opportunity to be vaccinated when it becomes available.

The vaccine is also given as post exposure for people who have had close contact with a patient who is confirmed to have monkeypox. It needs to be given within four days but can be given up to 14 days after exposure in those considered at high risk of further exposure.

So far, over 25,000 people have been vaccinated in the UK. Additional stocks of vaccine will be arriving for use in the UK across September 2022.

There is an opportunity to utilise the Systems Vaccination Operations Centre (SVOC) and the COVID vaccination leadership approach to support and co-ordinate monkeypox vaccination, alongside NENC UKHSA team.

6. Other vaccinations

The system continues to deliver a range of other public health vaccinations to protect against infectious disease. Childhood immunisation has continued as usual, and delivery has remained a priority. Adolescent booster programmes commence early 2023, this includes catch-up for 2022 cohorts where uptake is low.

An immunisation toolkit has been developed to support improvement in uptake across childhood immunisations and reduce inequalities, through local Immunisation working groups and working with GP practices. There has been low uptake (<95%) for the 5-year-old pre-school boosters (Dtap/IPV and dose 2 MMR) seen across most localities. Plans have been put in place to improve uptake which include the development of a MMR Elimination Focus Strategy and focused work with GP practices and Child Health Information Services.

Adult immunisations such as pneumococcal and shingles continue to be delivered through primary care.

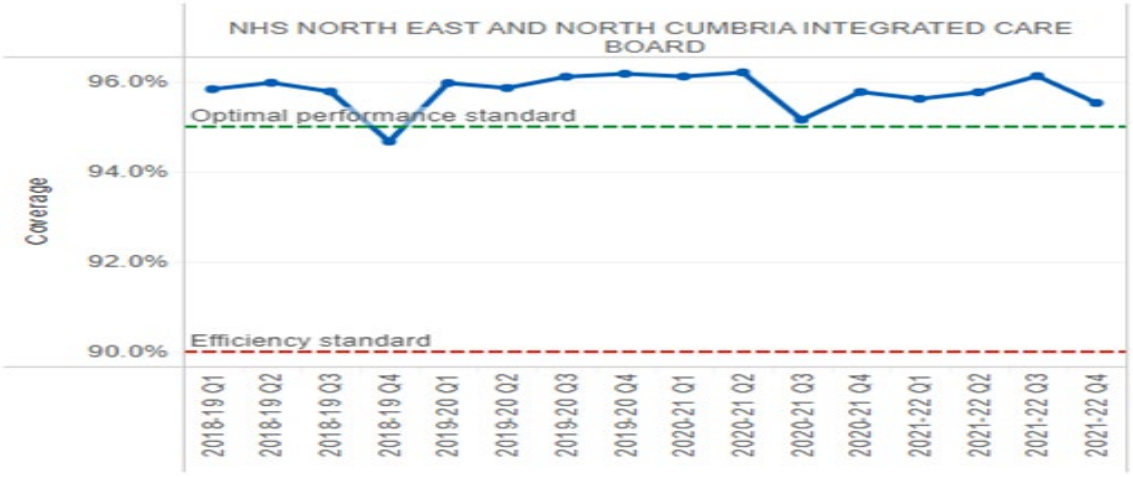
We have access to data on childhood immunisations, 0-5 yrs, ICS, local authority and GP practice level, which is used to assess uptake and generate work for improvement working with local partners and practices. For the purposes of this paper for the ICB, the following data is illustrative of the main issues for uptake across the ICB area.

The North East and North Cumbria consistently achieves the overall highest rates in England across all the 0-5 vaccinations and has done for several years. However, we are aware of significant variation at practice and local authority levels and are seeking to improve this.

The chart illustrates “primary” childhood vaccinations and the rates are good and generally above 95% for herd immunity. However, underlying this is local authority level and GP practice variation which we seek to address.

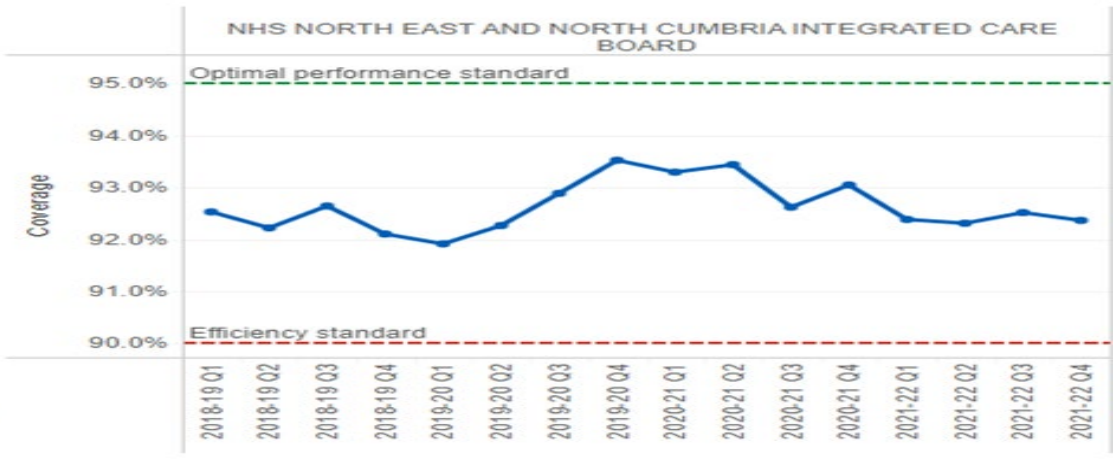
Source: [Cover of vaccination evaluated rapidly (COVER) programme: annual data - GOV.UK (www.gov.uk)]

12m DTaP/IPV/Hib3 coverage time series against **England** coverage:



The chart below shows that the ICB does not achieve 95% for the second MMR and, for information, this is in line with the pre-school boosters which are administered at the same time age 3 years and 4 months. Again, underlying this statistic is local authority and GP practice variation.

5yr MMR2 coverage time series against **England** coverage:



Through the North East and North Cumbria Vaccination Board the following is recommended on childhood vaccinations 0-5 years:

- GP practices supported by local partners should actively review vaccination status for completeness and catchup
- GP practices supported by local partners be aware of their rates and seek to achieve 95%.

The current priorities are:

- MMR and pre-school boosters – in light of concern about increasing incidence of measles and nationally declining MMR rates
- Polio containing vaccinations – in light of the current National Incident for polio, where, while there are no cases in the UK, there are sewage samples in London indicating possible presence of the virus in the population
- We have identified local authority areas in which enhanced work to address uptake is needed and we are working with local partners to do this.

7. Communications & Engagement

The North East and North Cumbria ICB are working with NHSE, local authorities and a wider range of other partners to run a region wide campaign to promote up take of COVID and flu vaccine this autumn. This will help the public understand what vaccinations they are eligible for and how to access them.

The ICB are in the process of commissioning a new campaign building on the previous #DoYourBit campaign. The primary objective is to enhance immunity in those at higher risk of COVID and therefore optimise protection against, hospitalization and death over winter 22/23. Campaign strap line ‘Double your Defense, Get Vaccinated” - get protected, protect yourself, protect your family. A toolkit and social media will begin from 12 September.

8. Risks and issues

8.1. Risks

- Risk of low vaccination uptake
- Risk posed by Complex Vaccine supply chains
- Risk of limited capacity/workforce to deliver.

8.2. Mitigations of risks

- Historic good performance with respect to flu uptake. Excellent COVID uptake enabled by multiple delivery models, strong system leadership, effective engagement and communications; including population insights and a focus on inequalities
- SVOC coordination working closely with place leads on vaccine logistics
- For COVID there is a successful lead provider/employer model – support and sign posting of volunteers. Excellent system engagement to deliver across the

complex NENC geography, using multiple delivery models to meet the needs of the population.

9. Future Delivery

A cohesive and well organised vaccination and immunisation programme is fundamental to health protection and there is a real opportunity to use the learning from the successful deployment and management of the COVID vaccination programme brought together with the knowledge and established processes for flu, childhood immunisation and other schemes.

Structured management and coordination of services should be sponsored at an executive level by the ICB with oversight and performance management through the ICS Vaccination Board, which is inclusive of all commissioners and providers. Strong delivery at an operational level should be led by a Senior Responsible Officer (SRO) for vaccination, who can work with operational leads and place based leads to support implementation across the whole ICS. Each place has its own vaccination board to enable local delivery – with each place having representation at the ICS Vaccination Board.

A key success of the COVID vaccination programme was the establishment of a System Vaccination Operations Centre (SVOC). The SVOC team deliver seamless working between organisations and place leads, are a conduit for national policy and guidance, manage and monitor vaccination uptake data, ensure coordination of processes around site assurance and vaccine supply chain to support the deployment of vaccine to the right place at the right time to minimse cold chain incidents and waste. Working with the COVID senior leadership team and a dedicated communications team, the SVOC have been able to deliver effective vaccine deployment for all phases of the COVID vaccination programme. It is recommended that this functionally be retained to support delivery of the whole vaccination programme and has the potential to support a broader range of population health challenges.

There is an opportunity for the ICS to build upon the lessons learnt from the system leadership approach adopted to deliver the COVID vaccination programme and to build a “business as usual” plan to deliver routine vaccination to its population, whilst retaining the ability to respond to any future pandemic.

10. Recommendations

The Board is asked to note the assurance provided in this report for autumn vaccination delivery.

Additionally, it is recommended that a full review of vaccination and immunisation is undertaken following an initial scoping exercise, to build a business as usual ICS plan for vaccination. This includes consideration to utilise SVOC and the system leadership approach for all vaccination and immunisation co-ordination. Furthermore, to consider the opportunity presented by using this approach for other population health challenges.

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Name of Sponsoring Director:
Dr Neil O'Brien, Executive Medical Director

Date: 9th September 2022

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Appendix I

2021-22 flu uptake data for eligible cohorts
Data source: Seasonal flu vaccine uptake in GP patients: monthly data, 2021 to 2022 - GOV.UK (www.gov.uk)

CCG	65 and over	Under 65 (at-risk only)	Pregnant	All aged 50 to under 65 years	Age 2	Age 3
	% Uptake	% Uptake	% Uptake	% Uptake	% Uptake	% Uptake
North East and Yorkshire Commissioning Region	**84.8**	**56.0**	**41.0**	**57.2**	**48.6**	**51.5**
NENC Average Uptake	85.5	57.9	43.3	59.2	**52.6**	**55.6**
NHS Northumberland CCG	87.6	63.4	41.2	64.4	60.4	62.8
NHS South Tyneside CCG	83.6	55.4	38.0	53.2	48.6	51.3
NHS Sunderland CCG	83.5	53.3	38.5	52.7	50.6	52.7
NHS North Cumbria CCG	86.9	64.8	44.7	65.3	50.8	56.0
NHS Newcastle Gateshead CCG	84.8	56.5	43.9	57.5	50.6	54.9
NHS Tees Valley CCG	84.2	53.6	44.1	55.8	47.8	49.2
NHS County Durham CCG	86.0	59.9	45.2	60.8	57.8	61.8
NHS North Tyneside CCG	86.5	58.8	44.7	61.4	57.5	60.1
England Average Uptake	82.3	52.9	37.9	52.5	48.7	51.4

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Appendix II

School aged flu uptake data 2021-22
Data Reference: Seasonal flu vaccine uptake in children of school age: monthly data, 2021 to 2022 - GOV.UK (www.gov.uk)

Local Authority	4 - 11 years	11 - 16 years	All years
	% Uptake	% Uptake	% Uptake
Hartlepool	43.8	32.8	39.1
Middlesbrough	41.6	25.8	35.5
Redcar and Cleveland	45.1	32.3	39.5
Stockton-On-Tees	52.2	27.3	42.3
Darlington	47.6	35.7	42.5
County Durham	52.4	35.7	45.3
Northumberland	69.3	43.8	58.8
Gateshead	69.2	58.0	64.6
Newcastle Upon Tyne	58.4	23.1	43.6
North Tyneside	63.4	34.8	51.6
South Tyneside	62.3	56.7	60.0
Sunderland	68.8	50.4	60.9
Cumbria	74.9	60.1	68.6
England Average	**57.2**	**43.3**	**51.5**

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Appendix III

North East and North Cumbria: COVID-19 Vaccination Uptake by JCVI Cohort as at 4th September 2022

JCVI Group	Popn	1st Uptake	2nd Uptake	Booster Popn (All)	Booster Uptake (All)	Booster Popn (Eligible)	Booster Uptake (Eligible)	Spring Booster Popn *	Spring Booster Uptake
1 - Care Home	15,716	97%	96%	15,126	97%	15,106	97%	14,695	81%
2 - Aged 80+ & Frontline	362,355	97%	96%	347,815	92%	347,689	92%	142,553	88%
3 - Aged 75 - 79	127,927	97%	96%	123,446	98%	123,434	98%	121,198	87%
4 - Aged 70 - 74 & High-Risk	157,660	96%	96%	150,800	97%	150,841	97%	4,076	81%
5 - Aged 65 - 69	170,126	95%	94%	160,290	96%	160,341	96%		
6 - Mod Risk Aged 16 - 64	483,441	88%	85%	413,032	84%	412,462	84%		
7 - Aged 60 -64	103,536	92%	91%	94,683	94%	94,698	94%		
8 - Aged 55 - 59	120,898	90%	89%	107,851	91%	107,876	91%		
9 - Aged 50 - 54	123,015	87%	86%	105,716	88%	105,732	88%		

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NHS
North East and North Cumbria

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	
Official: Sensitive Commercial		Provides assurance	✓
Official: Sensitive Personal		For information only	

BOARD MEETING 27 September 2022	
Report Title:	**Integrated Delivery Update Report**

Purpose of report

To provide the Board with an integrated delivery report providing a high-level and parallel overview of quality, performance and outcomes, and finance for the North East and North Cumbria Integrated Care System (NENC ICS).

Key points

The integrated delivery report is structured around the 2022/23 planning priorities and linked to the system oversight framework (SOF) which applies to all integrated care systems (ICSs), NHS trusts and foundation trusts to provide oversight of our delivery of the NHS Long Term Plan (LTP) commitments.

This report provides the NENC position in relation to the 2022/23 planning priorities and the themes set out in the 2022/23 SOF.

Key themes of the report and areas of focus:

- Health inequalities are increasing in some areas across NENC and work continues to understand variation at local level
- Increased and continued patient demand for all primary care services with a total of 1.4m appointments during July 22 with 4.75% DNAs. 70.37% of all appointments were delivered face to face
- Plans are underway to transform and build community services capacity to deliver more care at home and improve hospital discharge across NENC ICS which remains a challenge
- A&E four hour wait performance continues to be a pressure due to volatile activity levels in the urgent care system with Type 1 performance still under significant pressure. August performance against the four hour standard (95%) is at 76.5% which compares favourably to the national performance of 71.4%
- The ambulance sector is under significant and sustained pressure. Increasing demand and fundamental changes to the nature of heath economy are adversely affecting performance. The North East Ambulance Service NHS Foundation Trust (NEAS) is

meeting the category 1 ambulance response times standard in August, however category 2 response times are not being met
- There was an average of 70.81 hours lost per day due to ambulance handover delays in NENC (August 2022)
- Referral to treatment standards (RTT) have been impacted by recent waves of Covid-19 and associated workforce pressures. The NENC ICS is within its plan to have no more than 55 104+ week waiters remaining at the end of August. Both 52 and 78 week waiters are increasing at a level above plan with associated increases in waiting lists
- The NENC ICS is not currently achieving the faster diagnosis standard with significant challenges at some Trusts in relation to 62 day backlogs
- The NENC ICS is performing well in its increased delivery of SMI health checks
- The 21/22 LTP learning disability health checks target has been delivered by the NENC ICS and work is progressing in 22/23 to increase the number of checks.

Risks and issues

- Growing Health Inequalities
- Systemwide workforce pressures
- Spinal 104+ waiters
- Urgent care and discharges remain pressured across the NENC ICS
- Ambulance response times and handover delays
- Cancer 62 day backlogs

Assurances

- Actions being undertaken as highlighted in body of report
- Further detailed actions available through local assurance processes

Recommendation/Action Required

The Board is asked to receive the report for information and assurance.

Sponsor/approving director	Jacqueline Myers Executive Director of Strategy and System Oversight
Report author	Claire Dovell, Performance Manager

Link to ICB corporate aims (please tick all that apply)

CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues

Health and Care Act 2022

Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**		**N/A**	✓
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓

If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	N/A
Has there been/does there need to be appropriate clinical involvement?	N/A
Has there been/does there need to be any patient and public involvement?	N/A
Has there been/does there need to be partner and/or other stakeholder engagement?	N/A

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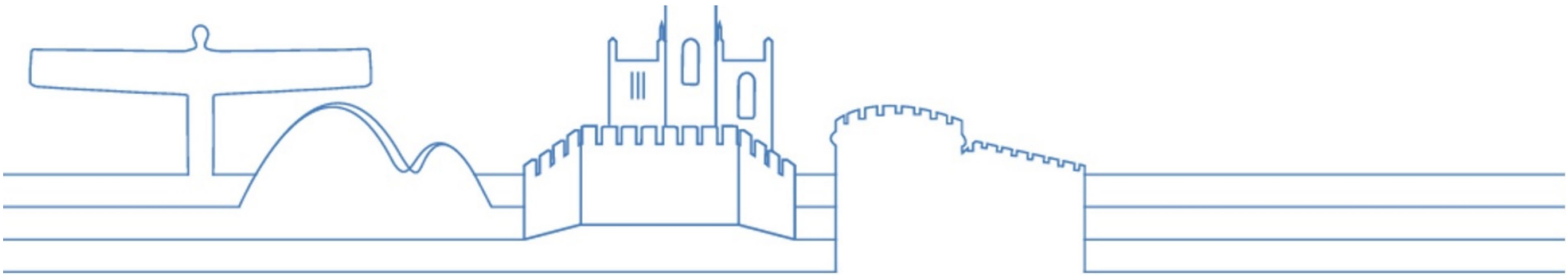
North East & North Cumbria ICB:

Board Meeting

27th September 2022
Integrated Delivery Report



North East & North Cumbria Performance Report

NHS
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Introduction

This report encompasses the recommendations of the Francis review so that quality and safety are reviewed alongside performance and finance to ensure a parallel view of quality performance, finance and leadership. Published data is at July 2022 where possible, unless otherwise specified.

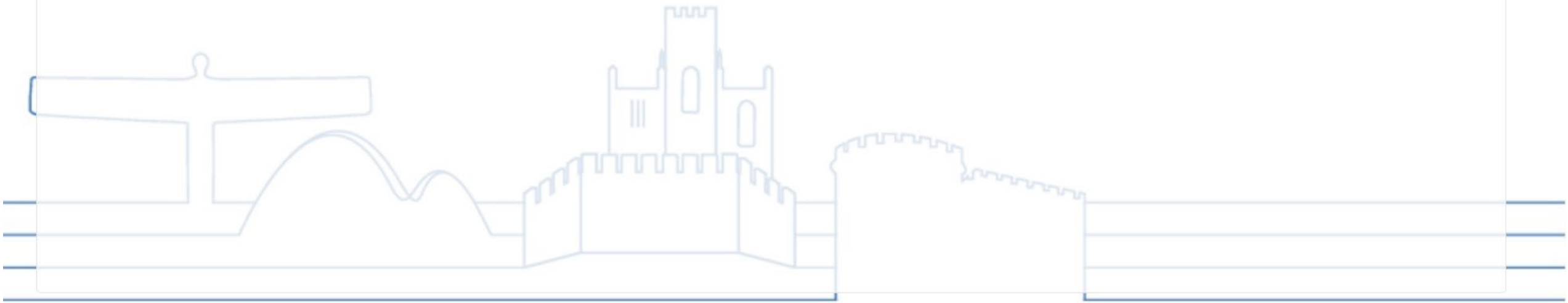
System Oversight Framework (SOF)
The SOF delivers oversight to ensure delivery of the planning priorities and monitoring of the Long Term plan (LTP) commitments and encompasses quality, access and outcomes. This report provides the North East and North Cumbria (NENC) position in relation to the NHS planning priorities and is aligned to the SOF.

Outcomes and Health Inequalities– A key focus in NENC is to address the health inequalities gap and improve outcomes for our populations through prevention, engagement with our communities and population health management.

Quality
Quality Dashboard for FTs set out by Area with Quality Exceptions narrative for the ICS. Workforce and patient experience is included within this section.

Exception Reporting
This report highlights key performance priority areas linked to the delivery of the Long Term Plan and any associated risks, achievements and mitigations.

Finance Overview – A finance summary will be included in the report for the board.



NENC Oversight report: Executive Summary September 2022

NHS North East and North Cumbria

STRATEGIC UPDATE PLANNING PRIORITIES

	North	North Cumbria	Central	Tees Valley
Workforce				
Covid				
RTT				
Cancer				
Maternity				
UEC				
Community				
Primary care				
Mental health				
Learning disability / autism				
Health inequalities				
Digital				

PROGRESS UPDATE:

This report gives assurance of local progress against the 2022/23 priority areas within NHS Long Term plan (LTP) as detailed in the 2022/23 Operational Planning Guidance.

ICP Areas have reviewed their Q1 position against the 2022/23 planning priorities. The review/rating is self-assessed and subjective. ICPs and places have local arrangement in place to monitor detailed risks and mitigating actions for all planning commitments within each of the over-arching categories.

Key points worthy of note include:

- UEC continues to be a significant pressure and NENC is working hard to increase capacity and operational resilience in urgent and emergency care ahead of winter
- Continued focus on ambulance performance and the roll out of virtual wards to support patients at home
- Ongoing work with social care partners to improve LoS and discharges
- Restoration of cancer services – increasing pressures, mitigations required, working closely with NCA.
- Digital - Managed convergence is happening across the NENC ICS, at strategic programme level, with system-wide collaboration in the delivery of regional interoperability programmes and innovations eg: Great North Care Record (GNCR) - Comprising of a regional Health Information Exchange (HIE) and Patient Engagement Platform (PEP – 'MyGNCR').

PEOPLE LEADERSHIP AND WORKFORCE

Effective staff engagement is the measure of success of an organisation and demonstrates strong leadership.
Work is ongoing on the development of the care workforce plan incorporating domiciliary care and care home objectives. This is to be developed to be reported towards the end of the year.

People Promise
A suite of metrics within the "People Promise" domain have been illustrated for regular peer comparison and review. Key highlights include:

Staff engagement score: Northumbria HC staff engagement theme score was 9.69% higher than the NENC median value and 7.83% higher than the national median. Conversely North Cumbria IC NHS FT staff engagement theme score was 6.83% lower than the national median.

We are always learning People Promise score: was 9.75% higher at Northumbria HC NHS FT in comparison to North Cumbria ICNHS FT which was 9.24% lower than the national median and CDDFT which was 6.34% lower than the national average for this theme.

PREVENTION, HEALTH INEQUALITIES AND OUTCOMES

	ICB/Or highest & lowest place	NATIO-NAL
Inequality in life expectancy male	8.5 Cumbria 14.3 Stockton	9.4 (years)
Inequality in life expectancy female	6.9 S Tyne 13.3 Stockton	7.6 (years)
Childhood obesity	40.3 Hartlepool 33% Northumberland	35.2%
Smoking at time of delivery	15%	10.4%
People with LD in suitable accommodation and supported into paid employment	4.1%	5.1%
<75 mortality rate for cancers (persons)	152.5	129.2
<75 mortality rate for respiratory disease	44	34.2
Children living in poverty	15.6 Cumbria 42.4 Middlesbrough	18.5%

NB: North Cumbria data unavailable – Cumbria data used as a proxy

FINANCE

Month 4 Position	YTD Plan Surplus / (Deficit) £m	YTD Actual Surplus / (Deficit) £m
NENC Commissioner		
Financial position	(0.895)	20.651
Efficiency / CIP	Not Reported	Not Reported
NENC Provider		
Financial position	(9.870)	(8.636)
Efficiency / CIP	Not Reported	Not Reported

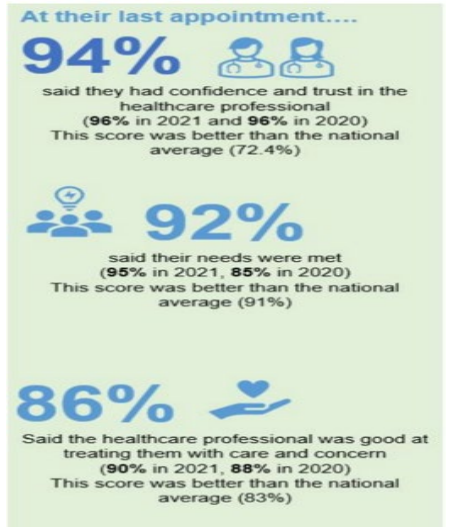
Nb: YTD surplus for the ICB is technical in nature and due to the transfer of balances from CCGs to ICB.

SYSTEM OVERSIGHT AND SEGMENTATION

In 2021/22 NENC ICS has been allocated segment 2, as have the providers within NENC ICB, with the exception of Newcastle upon Tyne Hospitals NHS FT, Cumbria, Northumberland, Tyne and Wear NHS FT (CNTW FT) and Northumbria Healthcare NHS FT who have been allocated segment 1 and South Tees NHS FT, North Cumbria Integrated Care NHS FT (NCIC FT) and Tees, Esk and Wear Valleys NHS FT (TEWV) segment 3.

PATIENT EXPERIENCE

GP Patient experience Survey 2022



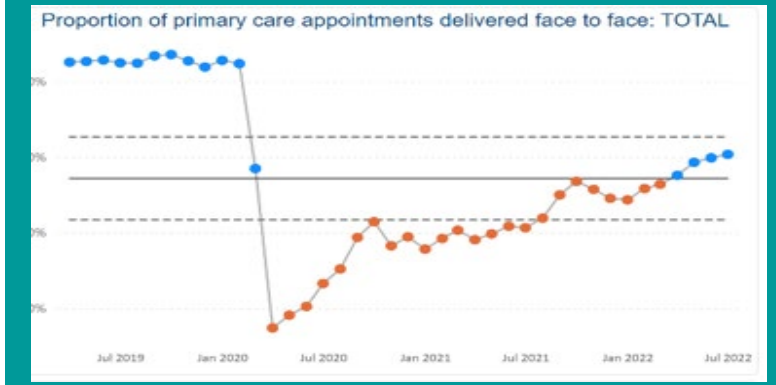
NENC Quality, Access & Outcomes

OPERATIONAL PERFORMANCE

= Standard met
= Standard partially met
= Standard not met

Indicator (and target)		Actual
A&E 4hr wait (95%)		**76.48%**
12 hour breaches (2%)		**2.3%**
Ambulance handovers		
Average Hours lost per day (4 Sept)		**70.81**
30+ mins delays (5%) Aug		**40.62%**
111 call abandonment (<3%) July		**0.72%**
999 Mean Response		**33.48 s**
% Patients not meeting criteria to reside (Aug)		**23.53%**
Ambulance response	NEAS	NWAS
C1 Mean (7 mins)	6:56	**9:04**
C2 Mean (18 mins)	**37:31**	**50:29**
Bed occupancy (85%)		**88.03%**
104+ waiters (0 March 23; 55 end Aug 22)		**34** (Aug)
78+ waiters (0 by April 2023; 574 Aug plan)		**940** (Aug)
52+ waiters (0 by 2025; 5549 Aug)		**9220** (Aug)
Diagnostics 6 week wait (1%) July		**17.65%**
Cancer FDS (75%) June		**73.5%**
Cancer 62 Days (85%) June		**61%**

PRIMARY CARE ACTIVITY



- Increased and continued patient demand for all primary care services
- GP appointment levels at pre-pandemic levels with a total of 1.4m during July 22
- Increasing % of DNAs (4.75% July 22).
- Practices routinely offering face to face appointments where clinically necessary and they continue to increase, 70.4% of total appointments delivered in July 2022
- Practices and PCNs supported to review their Health Inequalities

MENTAL HEALTH

= Standard met
= Standard partially met
= Standard not met

Indicator (and target)		Actual
IAPT Access		
Patients accessing treatment within 6 weeks (75%)		**95.29%**
Patients accessing treatment within 18 weeks (95%)		**98.65%**
IAPT Moving to recovery (50%)		**50.09%**
Proportion of patients waiting for treatment from first to second treatment >90 days (10%)		**35.95%**
SMI Health checks (16,260)		**13,335**
Children and Young People Eating Disorders (95%)		
Urgent patients seen in 1 week NENC		**82.14%**
Routine patients seen in 4 weeks NENC		**67.2%**
Dementia (67%)		**65.08%**

LEARNING DISABILITY & AUTISM

= Standard met
= Standard partially met
= Standard not met

Indicator (and target)		Actual
Learning Disability health checks (73% 22/23)		**13%** YTD
Reduction in CCG IP beds (69 beds)		**75** (Aug)
Reduction in Secure Services IP beds (76 beds)		**76** (Aug)

QUALITY

Indicator (and target)		Actual
Never events (zero tolerance)		**11** to date
MRSA (zero tolerance)		**0**
Serious incidents 2 day reporting (95% target)	5 trusts outside the target in month	
Patient safety alerts	1 open past deadline	

NENC ICS: Planning Priorities 2022/23

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Planning Priorities

Operational planning commitments Q1 overview

This report gives assurance of local progress against the 2022/23 priority areas within NHS Long Term plan (LTP) as detailed in the 2022/23 Operational Planning Guidance.

ICP Areas have reviewed their Q1 position against the 2022/23 planning commitments demonstrated with the summary position shown in the table. The review/rating is self-assessed and based on plan development, and ICP Areas have worked together to facilitate consistency in assessment as far as possible.

ICP Areas and places have local arrangement in place to monitor detailed risks and mitigating actions for all planning commitments within each of the over-arching categories.

The narrative and detail within the integrated delivery report provides detail on current performance against the key commitments within the table. Key points worthy of note include:

• Urgent and Emergency Care (UEC) continues to be a significant pressure and NENC is working hard to increase capacity and operational resilience ahead of winter

• Continued focus on ambulance performance and the roll out of virtual wards to support patients at home

• Ongoing work with social care partners to improve Lenght of Stay (LoS) and discharges

• PLans continue for the restoration of cancer services – increasing pressures, mitigations required, working closely with NCA.

• Digital - Managed convergence is happening across the NENC ICS, at strategic programme level, with system-wide collaboration in the delivery of regional interoperability programmes and innovations eg: Great North Care Record (GNCR) - Comprising of a regional Health Information Exchange (HIE) and Patient Engagement Platform (PEP – 'MyGNCR').

Strategic Priorities 2022/23 - August 2022 Position

Domain	North	North Cumbria	Central	Tees Valley
Workforce				
UEC				
RTT				
Primary Care				
Mental Health				
Maternity				
Learning Disability / Autism				
Health Inequalities				
Digital				
Covid				
Community				
Cancer				

System Oversight Framework

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System Oversight Framework

The System Oversight Framework (SOF) applies to all Integrated Care Systems (ICSs), NHS Trusts and Foundation Trusts and is aligned to the NHS planning priorities to provide oversight of our delivery of the NHS Long Term Plan (LTP) commitments.

Following publication of the SOF for 2022/23 in July 2022, the published framework of metrics which measures our progress against the LTP through assessment against the following domains has been delayed due to data coverage and will therefore be reported at the November Board.

- Quality of care, Outcomes and access
- Preventing ill health and reducing inequalities
- People
- Leadership and capability
- Finance and use of resources
- Local Strategic Priorities

Segmentation

To provide an overview of the level and nature of support required across systems, inform oversight arrangements and target support capacity as effectively as possible, ICSs and trusts have been allocated to one of four 'segments' in 2021/22. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4).

In 2021/22 NENC ICS has been allocated segment 2, as have the providers within NENC ICB, with the exception of Newcastle upon Tyne Hospitals NHS FT, Cumbria, Northumberland, Tyne and Wear NHS FT (CNTW FT) and Northumbria Healthcare NHS FT who have been allocated segment 1 and South Tees NHS FT, North Cumbria Integrated Care NHS FT (NCIC FT) and Tees, Esk and Wear Valleys NHS FT (TEWV) segment 3.

System Outcomes Framework - Summary

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Summary of System outcomes framework

System outcome frameworks are being developed with health and Local Authority (LA) partners at place, requiring partners to work together to deliver the prevention agenda and address health inequalities.
Metrics within an agreed framework (Gateshead System Partnership) linked to the Health and Wellbeing priorities have been pulled into Power BI and illustrated at ICS level and place where available (North Cumbria is not available currently therefore Cumbria has been utilised as a proxy measure).
Summary of key themes against the health and wellbeing domains:

Reduction in Health inequalities
- Inequality in life expectancy at birth (Female) is widest in Stockton on Tees at 13.3 years (although an improving picture) compared to South Tyneside (6.9 years) and the national (7.6 years).
- Inequality in life expectancy at birth (Males) is widest in Stockton (14.3 years) compared to 8.5 years in Cumbria and 9.5 national.

Every child has the best start in life
- The number of mothers still breast feeding at 6-8 weeks is highest in Newcastle (50.9%) and lowest in Sunderland at 25.7%. NB this data is not available for 4 of our LAs. The national value is 48% compared to NENC 34.6%.
- Inequality in attainment between children eligible and not eligible for school meals is highest in Northumberland (26%) compared to 17% in Darlington. The national value is 21%.
- The number of children living in poverty is lowest in Cumbria (15.6% improving) and highest in Newcastle upon Tyne (32.2% worsening) and South Tyneside (31.1% worsening). Nationally this is 18.5%.
- % children with free school meals achieving a good level of attainment at the end of reception is highest in Sunderland (63% improving) and lowest in Cumbria (50%), Gateshead (53%) and Redcar and Cleveland (53% worsening). Nationally this is 57%.
- % of mothers smoking at the time of delivery is lowest in Gateshead and Newcastle (12.8% and improving) and highest in Sunderland (18.3% - worsening). The national value is 10.4% compared to NENC 15%.

Families and communities
- Unemployment rate is highest in Newcastle (7.6 and worsening) and Hartlepool 6.8% and lowest in Cumbria 3.1%

Prevention and Early help
- Deaths from drug misuse is highest in Middlesborough (16.3 per 100,000 population) and Hartlepool (15.5 per 100,000 population) and lowest in Northumberland (6.1 per 100,000). Nationally this is 4.1 per 100,000.
- Prevalence of children in year 6 of excess weight is highest in Hartlepool 40.3% and Middlesbrough 40.2% and lowest in Northumberland (33%) . Nationally this is 35.2%.

Supporting people and families to be independent
- People with LD in suitable accommodation and supported into paid employment is lowest in Durham (0.7%) and highest in Hartlepool (22.3%)
- % of adult social care users who have as much social contact as they would like is highest in Sunderland (55%) and lowest in Newcastle (46.5%)
- Proportion of adults with a learning disability who live in their own home or with family is highest in Darlington (95.8%) and lowest in Stockton (72%)

Coordinated care
- Self reported survey scores for users of adult social care were highest in Sunderland 72.2 and lowest in Newcastle 62.7 . Nationally this was 64.2.

Reduce Avoidable disease/death
- Under 75 mortality rate for cancer highest in Middlesborough (175.1 per 100,000) and lowest in Cumbria (122.8) and Northumberland (125). Nationally this was 129.2 compared to NENC overall 152.5.
- Under 75 mortality for circulatory disease is highest in Middlesborough (100.8 per 100,000) and lowest in Northumberland (69.9 per 100,000) . The national value is 70.4 compared to NENC overall 85..
- Under 75 mortality rate for respiratory disease is highest in Middlesborough (69.3 per 100,000) and lowest in Cumbria (27.8 per 100,000). The nationall value was 34.2 compared to NENC overall 44.

System Outcomes Framework - Summary

Domain	Indicator	Metric Period	Northumberland	Newcastle upon Tyne	Gateshead	North Tyneside	Cumbria	South Tyneside	Sunderland	County Durham	Darlington	Stockton-on-Tees	Hartlepool	Middlesbrough	Redcar and Cleveland	NE&C	England
A reduction in health inequalities and an increase in healthy life years	Inequality in life expectancy at birth (Female) (PHOF A02a)	3 Years - 2017-19	▲ 9.9	▼ 8.4	▲ 9.6	▼ 10.6	▲ 8	▼ 6.9	▲ 8.7	▲ 7.9	▲ 9.7	▼ 13.3	– 10.4	▼ 11	▲ 8.6	N/A	▲ 7.6
	Inequality in life expectancy at birth (Male) (PHOF A02a)	3 Years - 2017-19	▲ 11.2	▼ 12.6	▲ 10.7	▲ 11.7	▼ 8.5	▲ 10.3	▼ 11	▲ 9.8	▼ 11.9	▼ 14.3	▲ 13.1	▲ 12.9	▲ 13.6	N/A	▼ 9.4
Every child has the best start in life	6-8 week breast feeding rate (PHOF 2.02ii)	Annual - 2019/20	▲ 38.8%	▲ 50.9%	38.7%	42.2 %	N/A	N/A	▼ 25.7%	▼ 27.8%	▼ 33.5%	N/A	N/A	▲ 32.6%	▲ 27.6%	▲ 34.6%	▲ 48%
	Inequality in attainment between children eligible and not eligible for free school meals	Annual - 2019	▼ 26%	▲ 19%	▲ 22%	▲ 24%	▲ 25%	▼ 21%	▲ 20%	– 22%	▼ 17%	N/A	▲ 29%	▲ 22%	▼ 19%	N/A	▼ 21%
	Inequality in attainment between children eligible and not eligible for free school meals (Achievement of KS2 (RWM) pupils eligible for free school meals (Expected Level))	Annual - 2019	▲ 45%	▼ 53%	▼ 51%	▼ 47%	▼ 44%	▲ 50%	▼ 52%	▼ 48%	▲ 53%	N/A	▼ 48%	▼ 49%	▲ 56%	N/A	▲ 47%
	Inequality in attainment between children eligible and not eligible for free school meals (Achievement of KS2 (RWM) pupils not eligible for free school meals (Expected Level))	Annual - 2019	▲ 71%	▼ 72%	▼ 73%	– 71%	▲ 69%	▼ 71%	▼ 72%	▼ 70%	▲ 70%	N/A	▲ 77%	▲ 71%	– 75%	N/A	– 68%
	Number of children living in poverty (PHOF B05)	Annual - 2021	▲ 25.6%	▲ 32.2%	▲ 28.9%	▲ 23.9 %	▼ 15.6%	▲ 31.1 %	▲ 30.8%	▲ 28.8%	▲ 28.5%	N/A	▲ 30.1%	▲ 42.4%	▲ 30.7%	N/A	▼ 18.5%
	School readiness % children with free school meals achieving a good level of development at the end of reception (PHOF B02a - free school meals)	Annual - 2019	▲ 61%	– 61%	– 53%	▼ 54%	▼ 50%	▼ 60%	▲ 63%	▼ 55%	▲ 61%	N/A	▲ 62%	▲ 55%	▼ 53%	N/A	– 57%
	Smoking at time of delivery (PHOF C06)	Annual - 2019/20	▲ 13.8%	▼ 12.8%	▼ 12.8%	▲ 11.7 %	▲ 13.6%	▼ 13.9 %	▲ 18.3%	▼ 16.8%	▲ 16.4%	▼ 16.5%	▼ 16.5%	▼ 16.5%	▼ 16.5%	▼ 15%	▼ 10.4%
Health and care offer built around people families and communities	Unemployment rate	Annual - 2022	▲ 5.2%	▲ 7.6%	– 5.9%	▲ 5.6%	▲ 3.1%	▼ 6.3%	▼ 5.9%	▲ 5.3%	– 5.3%	– 5.6%	– 6.8%	▼ 7.3%	▲ 5.9%	N/A	N/A
Increased focus across the system on prevention and early help	Deaths from drug misuse (PHOF C19d)	Annual - 2017-19	▲ 6.1	▲ 10.3	▼ 9.8	▼ 7.4	▲ 6.8	▲ 8.2	▲ 9.5	▼ 7.4	▲ 8.8	▲ 10.1	▲ 15.5	▲ 16.3	▲ 11	▲ 8.1	▲ 4.7
	Prevalence of children in year 6 of excess weight (PHOF C09a)	Annual - 2020	▲ 33%	▼ 40.2%	▲ 38.7%	▲ 35.7 %	▲ 34.3%	▲ 40%	▼ 36.7%	▼ 37.6%	▼ 37.6%	N/A	▼ 40.3%	▲ 40.2%	▲ 39.3%	N/A	▲ 35.2%
People and families are supported to live in their communities and to be as independent as possible	People with LD in suitable accommodation and supported into paid employment (ASCOF 1E)	Annual - 2020/21	▼ 4.1%	▼ 3.4%	▼ 8.9%	▼ 3.9%	▼ 2.7%	▲ 5.1%	▼ 3.3%	▼ 0.7%	▼ 5.3%	▼ 4.7%	▼ 22.3%	▲ 1.7%	▼ 7.2%	▼ 4.1%	▼ 5.1%
	Percentage of adult social care users who have as much social contact as they would like (ASCOF 1I)	Annual - 2019/20	▲ 49.7%	▼ 46.5%	▲ 52.3%	▲ 47.3 %	▼ 51.6%	▲ 47.9 %	▲ 55%	▼ 51%	▼ 46.7%	▲ 48.7%	▼ 53.6%	▼ 47.1%	▼ 49.6%	▲ 50.1%	▼ 45.9%
	The proportion of adults with a learning disability who l ive in their own home or with their family (ASCOF 1G)	Annual - 2020/21	▼ 86.1%	▲ 85.9%	▲ 82.9%	▲ 93.2 %	▼ 73.5%	▼ 81.5 %	▼ 92.9%	▼ 82.3%	▲ 95.8%	▼ 72%	▼ 89.7%	▼ 82.4%	▼ 84.5%	▼ 83.8%	▲ 78.3%
People experience excellent co-ordinated care with dignity and respect	Self-reported user experience (ADSC users survey)	Annual - 2019/20	▲ 64.7	▼ 62.7	▲ 64.2	▲ 66.4	▲ 74.4	▲ 65.9	▲ 72.2	▲ 69.6	N/A	▲ 70.2	▲ 69.3	▼ 70.2	▼ 68	N/A	▼ 64.2
Reduce avoidable disease/death	Under 75 mortality rate for cancers (persons) (PHOF E05a)	3 Years - 2017-19	▼ 125	▼ 157.9	▼ 157.2	▼ 147. 3	▼ 122.8	▼ 155.5	▲ 165.1	▼ 145.5	▲ 137.4	▼ 146.8	▼ 160.1	▼ 175.1	▼ 150.8	▼ 152.5	▼ 129.2
	Under 75 mortality rate for circulatory disease (persons) (PHOF E04a)	3 Years - 2017-19	▼ 69.9	▲ 87.9	▼ 86	▼ 77.7	▲ 75.5	▲ 90.3	▲ 89	▲ 78.9	▼ 74.3	▼ 73.1	▲ 99.1	▼ 100.8	▼ 88	▲ 85	▼ 70.4
	Under 75 mortality rate for respiratory disease (persons) (PHOF E07a)	3 Years - 2017-19	▲ 31.3	▼ 46.3	▲ 48.2	▲ 40	▼ 27.8	▼ 54.3	▲ 45.3	▲ 43	▲ 47.3	▼ 42	▲ 49.4	▲ 69.3	▲ 49	▲ 44	▼ 34.2

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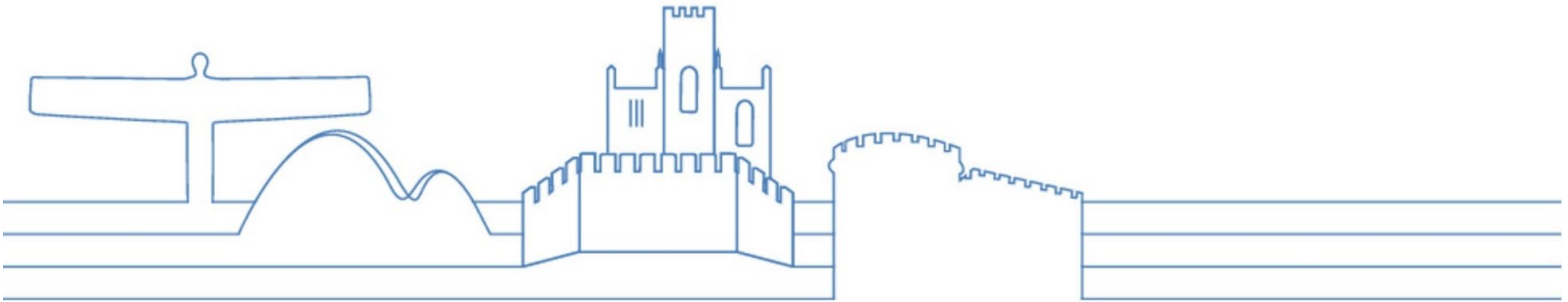
Quality



Variation and Assurance Icons

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Are we improving declining or staying the same?

Orange = significant concern or high pressure

Blue = significant improvement or low pressure

Grey – no significant change

Can we reliably hit the target?

Orange = system change required to hit target

Hit and miss the target

Blue = will reliably hit the target

Variation	Assurance	Description
H	F	Special cause of a concerning nature where the measure is significantly HIGHER. This occurs where there is higher pressure in the process or deteriorating performance. This process is not capable. It will FAIL the target without process redesign.
H	P	Special cause of a concerning nature where the measure is significantly HIGHER. This occurs where there is higher pressure in the process or worse performance. However despite deterioration the process is capable and will consistently PASS the target.
H	?	Special cause of a concerning nature where the measure is significantly HIGHER. This occurs where there is higher pressure in the process or worse performance. This process will not consistently hit or miss the target. This occurs when target lies between process limits.
L	F	Special cause of a concerning nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.
L	P	Special cause of a concerning nature where the measure is significantly LOWER. However the process is capable and will consistently PASS the target.
L	?	Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
	F	Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.
	P	Common cause variation, no significant change. This process is capable and will consistently PASS the target.
	?	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Variation	Assurance	Description
H	F	Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.
H	P	Special cause of an improving nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target.
H	?	Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
L	F	Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.
L	P	Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.
L	?	Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
↗		Special cause variation where UP is neither improvement or concern
↘		Special cause variation where DOWN is neither improvement or concern

Quality - North and North Cumbria

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-	-	NCIC				Northumbria				NuTH				Gateshead FT			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Serious Incidents	Proportion of incidents reported within 60 days - August 2022	100%				100%				100%				100%			
	Proportion of incidents reported within 2 days - August 2022	0%				83.33%				81.82%				100%			
	Number of Serious Incidents reported - August 2022	2				6				22				6			
	Number of Serious Incident Never Events reported - August 2022	0				0				0				0			
Quality - Mortality	Summary Hospital-level Mortality Indicator (SHMI) value - March 2022	111.54				98.9				91.9				101.15			
Quality - HCAI	Incidence of MSSA - July 2022	2				4				16				0			
	Incidence of MRSA - July 2022	0	0			2	0			0	0			0	0		
	Incidence of E Coli - July 2022	8	8			4	11			42	17			6	6		
	Incidence of C Difficile - July 2022	2	4			6	4			7	14			1	3		

-	-	NCIC				Northumbria				NuTH				Gateshead FT			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Staff	Staff Absence Rate - April 2022	6.15%				7.08%				6.99%				6.14%			
	Staff Turnover Rate - May 2022	1.29%				1.16%				4.18%				1.16%			
Quality - Friends and Family	Proportion of service users that would recommend Community Health Services - June 2022	89.8%				88.83%				72.73%				90%			
	Proportion of service users that would recommend Emergency Department - June 2022	73.05%				77.84%				0%				73.97%			
	Proportion of service users that would recommend Inpatient Services - June 2022	81.75%				82.3%				89.16%				85.63%			
	Proportion of service users that would recommend Maternity Services - June 2022	100%				96.97%				81.63%				100%			
	Proportion of service users that would recommend Mental Health Services - June 2022					75%								0%			
	Proportion of service users that would recommend Outpatient Services - June 2022	89.45%				84.39%				84.21%				85.88%			

Quality - Central and South

NHS North East & North Cumbria

-	-	STSFT				CDDFT				NTHFT				STHFT			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Serious Incidents	Proportion of incidents reported within 60 days - August 2022	100%		H		100%				100%				100 %		H	
	Proportion of incidents reported within 2 days - August 2022	100%				75%				0%				50%			
	Number of Serious Incidents reported - August 2022	4				4				1				4			
	Number of Serious Incident Never Events reported - August 2022	0				0		L		0				0			
Quality - Mortality	Summary Hospital-level Mortality Indicator (SHMI) value - March 2022	114.63		H		108.87				95.95		L		111.34		H	
Quality - HCAI	Incidence of MSSA - July 2022	10				6				4				8			
	Incidence of MRSA - July 2022	0	0		?	0	0	L	?	0	0	L	?	0	0	L	?
	Incidence of E Coli - July 2022	14	10		?	22	9		?	8	6		?	22	12		?
	Incidence of C Difficile - July 2022	7	5		?	3	5		?	3	5		?	7	9		?

-	-	STSFT				CDDFT				NTHFT				STHFT			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Staff	Staff Absence Rate - April 2022	5.84%		H		7.02%		H		6.51%		H		6.98%		H	
	Staff Turnover Rate - May 2022	1.01%				1.15%		H		0.97%				0.95%			
Quality - Friends and Family	Proportion of service users that would recommend Community Health Services - June 2022	67.74%				85.19%				86.04%				85.71%		H	
	Proportion of service users that would recommend Emergency Department - June 2022	58.33%				0%				70.21%				67.4%			
	Proportion of service users that would recommend Inpatient Services - June 2022	88.28%				85.85%				82.46%		H		81.17%			
	Proportion of service users that would recommend Maternity Services - June 2022	100%				87.91%		H		90.63%				60%			
	Proportion of service users that would recommend Mental Health Services - June 2022	78.05%															
	Proportion of service users that would recommend Outpatient Services - June 2022	0%				0%				84.52%		H		87.35%		H	

Quality - Mental Health and Ambulance

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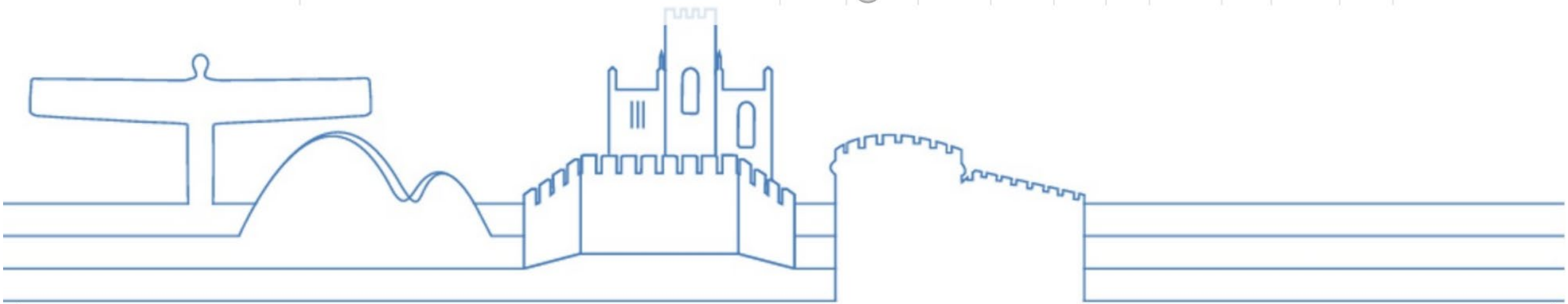
-	-	NEAS				TEWV				CNTW			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Serious Incidents	Proportion of incidents reported within 60 days - August 2022	100%				100%				100%			
	Proportion of incidents reported within 2 days - August 2022	100%				57.14 %				100%			
	Number of Serious Incidents reported - August 2022	1				8				5			
	Number of Serious Incident Never Events reported - August 2022	0				0				0			

-	-	NEAS				TEWV				CNTW			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Staff	Staff Absence Rate - April 2022	9.77%				6.88%				8.06 %			
	Staff Turnover Rate - May 2022	0.79%				1.32%				1.05 %			
Quality - Friends and Family	Proportion of service users that would recommend Mental Health Services - June 2022					73.57%				68.6 %			
	Proportion of service users that would recommend Patient Transport Services - June 2022	78.57%											



Quality - Exceptions - Safe

NHS
North East &
North Cumbria

Risks and Mitigations

Healthcare Acquired Infections (HCAI)
MRSA: no cases reported in June 2022.

C Difficile Infection: Three Trusts (NHCFT, CDDFT and STHFT) were above their monthly trajectories for June 2022. All cases continue to have root case analysis investigations carried out and findings shared at HCAI meetings. Findings are also summarised in the quarterly IPC reports which are fed back to the Infection Control Committee.

E. Coli: Two Trusts (NuTHFT and CDDFT) were above their monthly trajectories for June 2022.

NuTHFT - the Gram-Negative Bacteraemia Blood Stream Infections (GNBSI) Steering Group continues to monitor and review ongoing Quality Improvement (QI) projects. The IPC Team has commenced the "Gloves off" education campaign, which will promote best practice, improve hand hygiene compliance thereby resulting in a general HCAI reduction for all mandatory reporting organisms.
CDDFT as part of their overall HCAI reduction plans for C-Difficile and Carbapenamase-Producing Enterobacteriaceae a full mattress and pillow audit is to be completed in September/October 2022 due to concerns of potential contamination.

Never Events – NENC ICS year to date (YTD) total (n=11)
NuTHFT reported 1 never event in June (retained vaginal swab). YTD n=3.
NHCFT reported 1 never event in July (administration of medication via wrong route) – oral morphine given intravenously in error. YTD n=1.
STSFT reported 1 never event in June 2022 (wrong implant/prosthesis used in total hip replacement procedure). YTD n=2.
STFT reported 2 never events in July 2022. Maternity (retained foreign object – vaginal tampon) and medication (overdose of insulin due to incorrect device). YTD n=4.
Nuffield Health Tees reported 1 never event in August (wrong implant/prosthesis used in total knee replacement procedure). YTD n=1

Serious Incident (SI) reporting
2 day reporting (Q1 2022/23) : Six trusts were outside the 95% threshold for the reporting of serious incidents within two days of identification.
60 day reporting: The 60 day deadline for the submission of reports was paused nationally during the pandemic. Regular discussion on serious incident performance takes place at all Trust Quality Review Group (QRG) meetings and commissioner serious incident panels to gain assurance there are processes in place to manage the backlog of any cases.
NuTHFT Ophthalmology Lost to Follow-Up (LTFU) Theme: Transformation workstream and a comprehensive improvement plan in place following a number of serious incidents.
STHFT LTFU Theme: Programme of improvement work to address themes including staffing pressures, diagnostic reporting processes, incident identification and reporting. These will be reviewed by ICB Director of Nursing/Quality team.
NTHFT: Concerns in relation to diagnostic delays. A review group was established with regular review by commissioners. The themes around the deteriorating patient work were showcased at the last CQRG. Action plan closed.
TEWVFT Serious Incidents and DATIX: The Trust has worked on reducing its backlog in this area. They were giving regular updates on their position at each CQRG meeting with NECS but following discussion with ICB Chief Nurse, these are now stood down as the Quality Board continues. These will be chaired by ICB Chief Nurse with NECS support.
TEWVFT Affective Disorders Team - A 'deep dive' into the caseload of around 800 patients was undertaken in 2021 following several serious incidents. The Trust report was shared with Tees Valley ICB, confirmed in the May 2022 CQRG meeting. Assurance given and action closed.
TEWVFT Peri-Natal & Sexual Safety – a thematic review of incidents undertaken, and learning identified in relation to the referral process and education, safeguarding, collaborative working and information sharing. Trust shared and presented this report in April 2022 and work is ongoing.
TEWVFT Durham Crisis Team – The Trust commissioned an internal thematic review of cases. Report directly shared with ICB and NECS, assurance was given, and action closed.

Quality Exceptions - Safe and Caring

NHS
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Risks and Mitigations

Staffing and workforce

• NHS Sickness Absence Rates: Ten trusts were above the England average for March 2022 (6.02%). Continued workforce pressures due to sickness absence and vacancies; although some improvement has been seen. A range of measures are in place to ensure operational challenges are managed, safe staffing levels are in place and support is being offered to staff to maintain their health and wellbeing. Regular safe staffing updates are provided at QRG.

Patient Safety Alerts

• GHFT has one outstanding alert. Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators during surgical and invasive procedures' (deadline 25/11/21). Trust contacted to seek assurance so this alert can be closed. The Trust continues to provide assurance on their compliance with patient safety alerts at the QRG meetings via their integrated oversight report.

• NEAS has one outstanding alert NatPSA/2022/005/UKHSA - Contamination of hygiene products with Pseudomonas aeruginosa (deadline 01/07/22). This will be discussed with NEAS at October's QRG .

Mortality – Summary Hospital-level Mortality Indicator (SHMI

• STSFT and STHFT continue to be negative outliers, reporting more deaths than expected.

• STSFT site ratios show the number of deaths at St Benedict's Hospice is impacting on overall organisational SHMI value/banding position. An independent opinion from NEQOS on the impact of removal of COVID-19 deaths and the reduction in activity concluded this had negatively impacted on the SHMI. Alternative assurance is gained by the Trust through all other sources of mortality data, including the Mortality Review process, using Hogan, NCEPOD preventability scores and Fisher Exact testing. Learning is shared at clinical governance and mortality & morbidity meetings and incorporated into Patient Safety Bulletins for organisational learning. An independent review commissioned December 2021 of a random sample of Stage 2 reviews showed widespread agreement with the initial scoring and the Lead Medical Examiner (ME) concluded no cause for concern. Additional MEs have been recruited to expand the team to 5 with the move towards scrutinising community deaths. Roll-out of the Community ME programme is progressing, and a pilot commenced across a small number of practices in July 2022. STSFT is assured that palliative care coding is correct but are aware that there may be variation of use of end-of-life supportive care specialist codes with some Trusts which impacts on the mortality metric.

• STHFT: Although SHMI remains higher than expected it is trending in the right direction. Trust has embarked on clinical coding improvement programme to improve the quality of clinical coding and mortality KPIs. The ME team coverage of mortality continues to be in excess of 95% of all deaths with around 10% referred for further review. Learning is cascaded through governance structures. New reviewers have been recruited to address the backlog of reviews and the impact of this is being monitored over the coming months.

Friends and Family Test (FFT)

• NHCFT: A drop in FFT recommendation score for mental health has been noted. Trust wide patient perspective results continued to be positive in Q1 with 63% of inpatients, 67% of outpatients and 82% of day case, giving the highest scores of rating their experience as excellent. The Trust has demonstrated a strong overall performance and remained within the top 20% when benchmarked against national performance data. A New Real time survey is being implemented and the patient experience team is interviewing patients across the Trust. The outcomes will be shared with individual clinical/management teams. A yearly review of feedback gathered from the Attend Anywhere virtual outpatient clinics demonstrated a comparable outcome compared with previous year's result with an overall rating of 94%.

• GHFT: A drop in FFT recommendation score for outpatients was noted in June 2022. As part of their Human Rights Equality Diversity and Inclusion Objectives and Action Plan 2020-2024, the Trust is undertaking an assessment of how to triangulate Patient Experience data (e.g., PALS, formal complaints, FFT) with patient safety data (e.g., incidents, staffing data). The Patient Experience team are working collaboratively with both the Community Business Unit and Maternity and are looking to implement a digital FFT option in 2022/23. This is currently in the development stage.

• NTHFT: A drop in FFT recommendation score for inpatient and outpatients has been noted this month. The Trust continuously monitors the positive and negative comments on a weekly basis to ensure that any similar issues or concerns can be acted upon by the ward matrons. This helps in reducing the reoccurrence of similar issues in the future.

• CNTWFT: recommendation rate was slightly below average this month. Feedback through the Points of You (PoY) survey increased in Q1 2022/23 by 109% on the previous quarter. The CYPS mailshot of PoY has been reinstated and has generated an increased level of feedback. The online version of PoY is being made more accessible to encourage greater feedback levels and localities will be encouraged to promote this.

Quality exceptions and concerns including CQC visits

NHS
North East &
North Cumbria

Risks and Mitigations

NuTHFT
IT error recently occurred which prevented approx. 7200 discharge letters being sent to GP practices. On identifying and rectifying the error this triggered a mass sending of delayed letters in bulk which created additional workload for GP practices plus a risk of missed medications or urgent actions. Issue was flagged to the Trust by NECS in August following contact from practices who had received batches of discharge letters. Trust pharmacy hub has been working alongside practices to review all delayed discharge letters for actions and medication changes. Trust digital team has provided assurance the issue is now resolved. Practices to report any individual cases of patient harm on SIRMS, which will be shared with the Trust for review. This has been reported as a SI and a full investigation has commenced.

STSFT
CQC undertook an unannounced inspection visit to the Trust in June 2022 and a well-led assessment in August 2022. Report will be published in due course.

NEAS
In response to the adverse media coverage in May 2022, an enhanced surveillance programme was put in place, which involved a series of face-to-face visits to NEAS by commissioners, walking through systems and processes as well as observing quality-related Trust committees. A report has been prepared which will feed into the national independent enquiry. The benefits of enhanced surveillance, particularly the joint learning, were acknowledged by QRG members at the meeting in August 2022 and the Trust was thanked for their support regarding this.
Handover delays and pressures are leading to an increase in patient safety incidents and serious incidents. NWAS has produced a handover data quality pack which has been adopted by NEAS and will be trialled at JCUH. It is possible that the Urgent and Emergency Care Network may wish to have this in place for every Trust. NEAS is anticipating an early wave of flu as seen in Australia and recognises that pressures associated with this, coupled with Covid, will be a challenge for all providers. Winter plans were to be tested on 17 August 2022. QRG acknowledged the importance of working as a system rather than separate components.
Regulation 28 Learning from Deaths notice was issued to Tees Valley CCG about the commissioning of transport for patients with mental health patients and NEAS is supporting the response. Although capital funding for such transport was made available in 2019, there is an issue with revenue funding for staffing. NEAS senior team believes that funding could be better utilised in providing mental health advisors as opposed to a vehicle. Further discussion is required via the NEAS contract meetings and assurance will be fed back via the QRG.
An unannounced CQC visit took place to the Emergency Operations Centre. Three areas of concern were identified relating to incident reporting and feedback processes, safeguarding reporting and feedback processes and medicines management processes. The Trust has provided a response to the CQC and an action plan is being developed.

CNTWFT
Regulation 28 was issued from the Sunderland Coroner in May 2022. The matters of concern were that the family were not as engaged by the Trust as they could have been with regards to sharing of information and acting on information provided to them. Trust has responded the coroner setting out the improvement work to proactively engage with family members and a copy of this was shared/discussed at the QRG meeting in August 2022.
Rose Lodge (learning disability specialist assessment inpatient unit) – improvement plan is in place as a result of an unannounced CQC visit in March 2022. Six areas required immediate review and action, which are currently being addressed.

CNTWFT CQC Inspection to wards for people with a learning disability and autism: Report was published in August 2022 and overall was rated as 'requires improvement'. All domains were rated as 'requiring improvement' with the exception of the care domain which was rated as 'good'. Trust has nine wards and the CQC visits took place across all of these apart from one (Wansbeck) which was closed at the time of the inspection although data about this service was reviewed and reflected in report. The findings of the CQC inspection were discussed at QRG in August 2022. The Trust was in the process of responding to the inspection findings and regular updates on their improvement plan will be shared via the QRG.
Low compliance with Safeguarding Level 3 Adults Training. An improvement plan is in place, staff are to be released to attend training and regular communications are being sent out to staff to increase training compliance. This continues to be monitored via the QRG.

Quality exceptions and concerns including CQC visits

NHS
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Risks and Mitigations

Maternity Safety and Ockenden Update

All Trusts continue to offer progress updates in relation to the recommendations of the Immediate Essential Actions (IEAs) following the Ockendon review at QRG meetings and report progress within their board meetings. All Trusts continue to offer progress updates in relation to the recommendations of the Immediate Essential Actions (IEAs) following the Ockendon review at QRG meetings and report progress within their board meetings.

• CDDFT has completed quality improvement work of training, documentation, audit and internal governance meetings. A maternity commissioner clinical assurance visit has been completed, which was undertaken by a MDT team from Durham and Tees Valley ICB/NECS. The report has been sent to the Trust for comments.

• STSFT Maternity Services – due to the ongoing temporary closure of the Midwifery-Led Birthing Centre (MLBC) in South Tyneside and performance concerns with CNST and compliance with the Ockenden actions the Trust was placed in enhanced surveillance. This process is being managed by ICB nursing and quality colleagues at place. Monthly meetings are in place with the second meeting held in July 2022 where the Trust were able to report progress against their improvement plan. A third meeting is scheduled for end of August 2022. A number of target dates for the CNST and Ockenden actions are for September and therefore it has been proposed that a further enhanced surveillance meeting takes place in October 2022 to enable the Trust to report on milestones and to determine future arrangements based on the level of progress. A new Head of Midwifery appointed. MLBC status remains under weekly review by the Trust Executive team and a formal consultation process is ongoing with the community midwifery teams to support an enhanced workforce model for when it re-opens. A proposal paper has been submitted to the Executive team for a Director of Midwifery role. Progress is being made with the CNST actions and the Ockenden immediate and essential actions (IEAs) but IT related issues may impact on full compliance by September 2022. Work is ongoing with the action plan in place for the emerging themes from HSIB investigations around CTGs and culture.

Independent Providers

• Butterwick Hospices – Both sites remain under CQC review. Continue to work on an agreed action plan as of August 2022.

People Promise

NHS
North East &
North Cumbria

Risks and Mitigations

Effective staff engagement is the measure of success of an organisation and demonstrates strong leadership.

Social Care Workforce survey:
A voluntary national Social Care Workforce experience survey for CQC-registered care homes and domiciliary care providers via the Capacity Tracker ran for a month from 13 September 2021 to 14 October 2021 and aimed to gain insight into the scale of workforce challenges and specific areas of concern. Response rates represented 27% of all CQC-registered care homes and 44% of all CQC-registered domiciliary care providers and therefore data is not available at a NENC level.

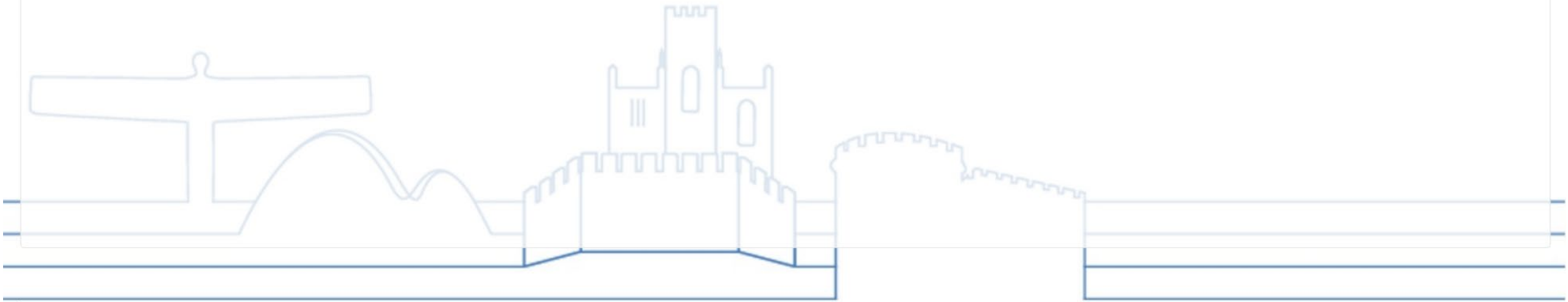
Work is ongoing on the development of the care workforce plan incorporating domiciliary care and care home objectives. This is to be developed to be reported towards the end of the year.

People Promise
A suite of metrics within the "People Promise" domain have been illustrated for regular peer comparison and review. The following table gives a summary by provider in relation to the key 9 People Promise themes in comparison to the national median and the peer median. Key highlights include:

Morale theme score: Northumbria HC NHS FT and Cumbria Northumberland Tyne and Wear (CNTW) NHS FT scored most favourably across the NENC with a score 11.22% higher than the ICS median, and 9,99% higher than the national median (Northumbria) and 7.47% higher than the ICS median and 6.77% higher than the national (CNTW). Conversely NEAS scored 15.6% lower than the national, and CDDFT 5.09% less than the national for this theme.

Staff engagement score: Northumbria HC staff engagement theme score was 9.69% higher than the NENC median value and 7.83% higher than the national median. Conversely North Cumbria IC NHS FT staff engagement theme score was 6.83% lower than the national median.

We are always learning People Promise score: was 9.75% higher than the national at Northumbria HC NHS FT and 9.85% higher than the national median at CNTW, in comparison to North Cumbria ICNHS FT which was 9.24% lower than the national median and CDDFT which was 6.34% lower than the national average for this theme.



People Promise

Collected Annually - Showing results from 2021

Indicator	South Tyneside and Sunderland NHS Foundation Trust			Northumbria Healthcare NHS Foundation Trust			Newcastle Upon Tyne Hospitals NHS Foundation Trust			Gateshead Health NHS Foundation Trust			North Tees and Hartlepool NHS Foundation Trust			South Tees Hospitals NHS Foundation Trust		
	Value	% Difference to Peer Median	% Difference to National Median	Value	% Difference to Peer Median	% Difference to National Median	Value	% Difference to Peer Median	% Difference to National Median	Value	% Difference to Peer Median	% Difference to National Median	Value	% Difference to Peer Median	% Difference to National Median	Value	% Difference to Peer Median	% Difference to National Median
We work flexibly People Promise element score	5.85	0.00%	-4.30%	6.12	4.48%	0.18%	5.64	-3.72%	-8.02%	5.96	1.82%	-2.48%	5.92	1.09%	-3.20%	5.81	-0.73%	-5.02%
We each have a voice that counts People Promise element score	6.66	-0.32%	-2.02%	7.31	8.93%	7.23%	6.76	1.15%	-0.56%	6.86	2.64%	0.94%	6.86	2.61%	0.91%	6.84	2.31%	0.61%
We are safe and healthy People Promise element score	5.94	0.26%	-0.98%	6.48	8.81%	7.57%	5.96	0.56%	-0.68%	6.00	1.28%	0.04%	6.14	3.54%	2.30%	5.89	-0.61%	-1.85%
We are recognised and rewarded People Promise element score	5.66	-3.03%	-4.94%	6.38	9.00%	7.09%	5.77	-1.05%	-2.96%	5.95	1.96%	0.05%	6.04	3.51%	1.59%	5.89	0.94%	-0.97%
We are compassionate and inclusive People Promise element score	7.12	-1.50%	-2.61%	7.77	7.34%	6.22%	7.32	1.29%	0.18%	7.37	2.06%	0.94%	7.40	2.48%	1.37%	7.31	1.19%	0.08%
We are always learning People Promise element score	5.13	-2.04%	-4.21%	5.90	11.91%	9.75%	5.21	-0.48%	-2.65%	5.13	-2.05%	-4.21%	5.30	1.18%	-0.98%	5.11	-2.33%	-4.50%
We are a team People Promise element score	6.36	-2.79%	-5.07%	6.96	6.23%	3.95%	6.45	-1.37%	-3.66%	6.60	0.93%	-1.36%	6.75	3.18%	0.89%	6.69	2.29%	0.00%
Staff engagement theme score	6.68	-1.03%	-3.90%	7.43	9.69%	6.83%	6.95	2.91%	0.05%	6.92	2.52%	-0.35%	6.95	2.93%	0.07%	6.92	2.54%	-0.32%
Morale theme score	5.71	-1.10%	-2.33%	6.46	11.22%	9.99%	5.85	1.31%	0.07%	5.86	1.41%	0.18%	5.94	2.70%	1.47%	5.77	-0.08%	-1.32%

Indicator	North Cumbria Integrated Care NHS Foundation Trust			County Durham and Darlington NHS Foundation Trust			North East Ambulance Service NHS Foundation Trust			Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust			Tees, Esk and Wear Valleys NHS Foundation Trust		
	Value	% Difference to Peer Median	% Difference to National Median	Value	% Difference to Peer Median	% Difference to National Median	Value	% Difference to Peer Median	% Difference to National Median	Value	% Difference to Peer Median	% Difference to National Median	Value	% Difference to Peer Median	% Difference to National Median
We work flexibly People Promise element score	5.66	-3.37%	-7.66%	5.69	-2.81%	-7.11%	4.40	-8.91%	-32.49%	6.76	11.75%	10.14%	6.33	5.19%	3.59%
We each have a voice that counts People Promise element score	6.40	-4.27%	-5.98%	6.58	-1.58%	-3.28%	5.74	-1.01%	-16.90%	7.12	4.11%	4.63%	6.85	0.34%	0.86%
We are safe and healthy People Promise element score	5.89	-0.71%	-1.95%	5.76	-2.94%	-4.17%	5.24	-0.77%	-13.51%	6.38	6.73%	6.04%	6.16	3.29%	2.61%
We are recognised and rewarded People Promise element score	5.70	-2.31%	-4.22%	5.69	-2.42%	-4.33%	4.82	-0.61%	-20.89%	6.48	8.98%	8.58%	6.18	4.27%	3.87%
We are compassionate and inclusive People Promise element score	6.93	-4.12%	-5.24%	7.17	-0.80%	-1.91%	6.59	0.38%	-10.27%	7.66	4.53%	4.70%	7.37	0.72%	0.90%
We are always learning People Promise element score	4.88	-7.08%	-9.24%	5.02	-4.17%	-6.34%	4.41	3.41%	-19.28%	5.90	10.33%	9.85%	5.37	0.80%	0.31%
We are a team People Promise element score	6.43	-1.64%	-3.92%	6.54	0.00%	-2.29%	5.79	1.44%	-14.47%	7.17	7.13%	6.91%	6.86	2.78%	2.55%
Staff engagement theme score	6.48	-3.97%	-6.83%	6.64	-1.61%	-4.48%	5.68	-2.04%	-20.08%	7.11	2.68%	2.33%	6.79	-1.93%	-2.27%
Morale theme score	5.59	-3.29%	-4.53%	5.56	-3.86%	-5.09%	5.00	-2.80%	-15.60%	6.26	7.47%	6.77%	5.90	1.65%	0.94%

GP Patient Experience Survey 2022 - Headline Findings - NENC ICS

NHS North East & Cumbria

76%

reported a good overall experience of their GP practice (**85%** in 2021, **83%** in 2020). This score was better than the national average (72%)

75%

Said they were satisfied with the appointment they were offered the last time they tried to book one. This score was better than the national average (72%)

57%

Said they were satisfied with the appointment times available (**69%** in 2021, **65%** in 2020) This score was better than the national average (55%)

At their last appointment....

94%

said they had confidence and trust in the healthcare professional (**96%** in 2021 and **96%** in 2020) This score was better than the national average (72.4%)

92%

said their needs were met (**95%** in 2021, **85%** in 2020) This score was better than the national average (91%)

86%

Said the healthcare professional was good at treating them with care and concern (**90%** in 2021, **88%** in 2020) This score was better than the national average (83%)

59%

Reported a good overall experience of making an appointment (**73%** in 2021 and **68%** in 2020). This score was better than the national average (56%)

55%

said they found it easy to get through to their practice by phone (**70%** in 2021, **69%** in 2020) This score was better than the national average (52.7%)

52%

used an online general practice service in the past 12 months. This score was below national average (55%)

53.7%

of patients who needed an appointment said they had avoided making one in the last 12 months for any reason. This score was better than the national average (55.4%)

23.5%

of patients who needed an appointment said they had avoided making one in the last 12 months as they found it too difficult. This score was better than the national average (25.6%)

52%

reported a good overall experience of NHS services when their GP practice was closed (**69%** in 2021, **72%** in 2020). This score was better than the national average (50%)

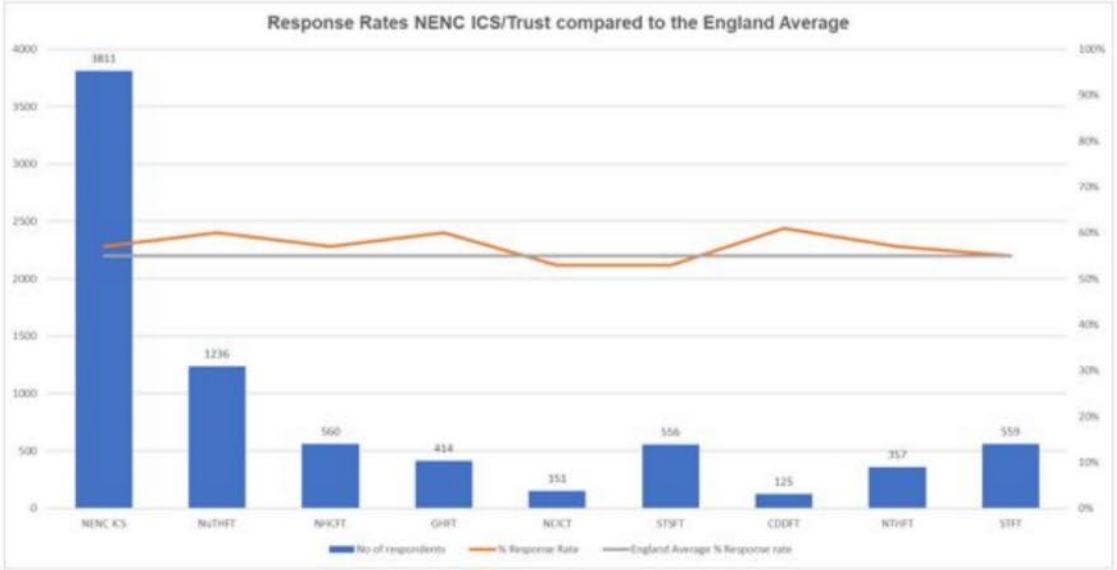
National Cancer Patient Experience Survey 2021 - NENC ICS & Trust Results

NHS North East & North Cumbria

The sample for the survey included all adult NHS patients (aged 16+) with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May, June 2021. Fieldwork was undertaken between Oct 2021 and Feb 2022. Questionnaire was redeveloped in the 2021 survey and due to the significant changes made there is no trend data or year on year comparisons. Sixty-one questions from the questionnaire were scored as these questions relate directly to patient experience. For all but one question (Q59), the score shows the percentage of respondents who gave the most favourable response to a question. For Q59, respondents rate their overall care on a scale of 0 to 10.

Overall response rate

NENC ICS and 6 Trusts were above the England average response rate (55%). NCICT and STSFT were slightly below this with a response rate of 53%. The overall England response rate has slightly declined in comparison to previous reiterations of the survey (61% in 2019, 64% in 2018, 64% in 2017). NuTHFT had the highest number of respondents (n= 1236) and CDDFT the lowest (n=125)



Question Scoring by NENC/Trust

Above Expected Range – are where a Trust/ICS is a positive outlier, with a score statistically significantly higher than the national mean. This indicates that the ICS/Trust performs better that what ICS/Trusts of the same size and demographics are expected to perform.
Expected Range – are where scores are where they would be expected to be given the size and demographics of the ICS/Trust.
Below Expected Range – are where a Trust/ICS is a negative outlier, with a score statistically significantly lower than the national mean.

The table below shows the range of scores across the questions asked:

	Above Expected Range	Within Expected Range	Below Expected Range
NENC ICS	15	46	Nil
NuTHFT	10	50	1
NHCFT	17	43	1
GHFT	12	48	1
NCICFT	5	55	1
STSFT	3	57	1
CDDFT	7	53	1
NTHFT	1	54	6
STFT	5	56	Nil

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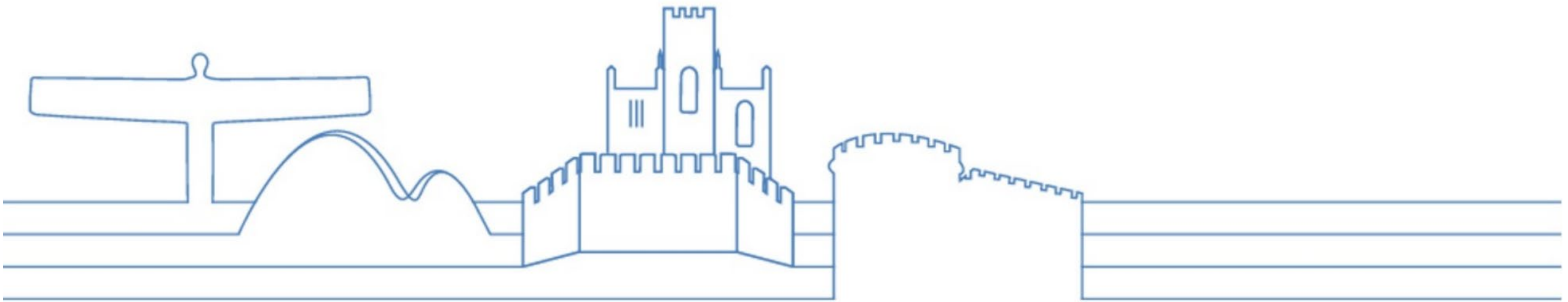
Performance



Primary care

NHS
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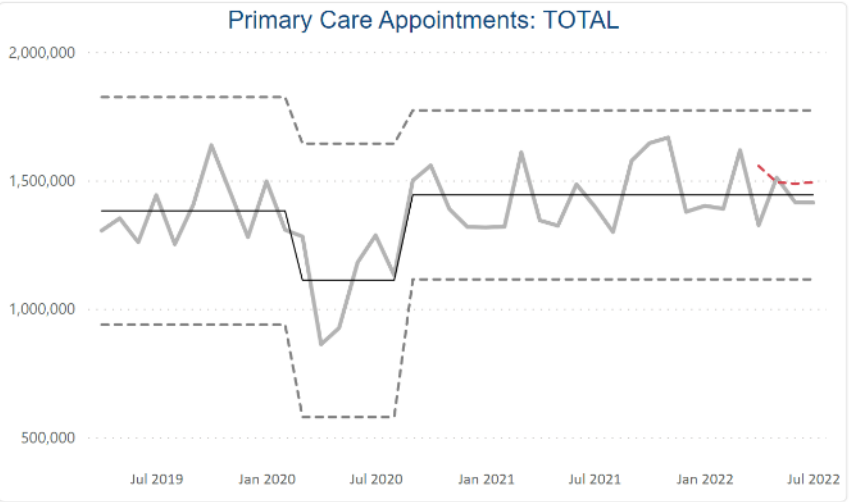
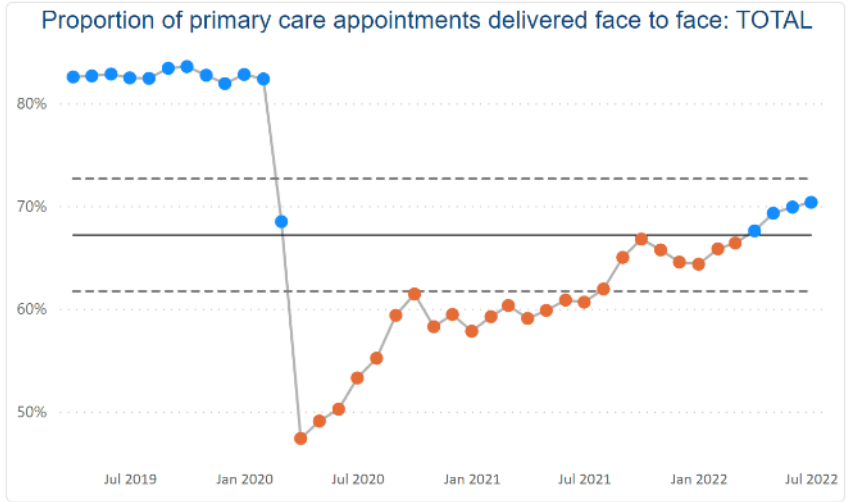
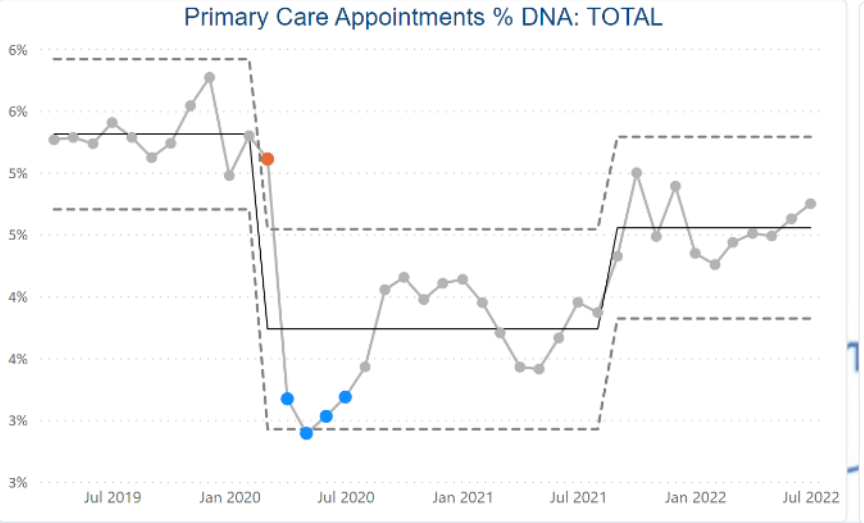
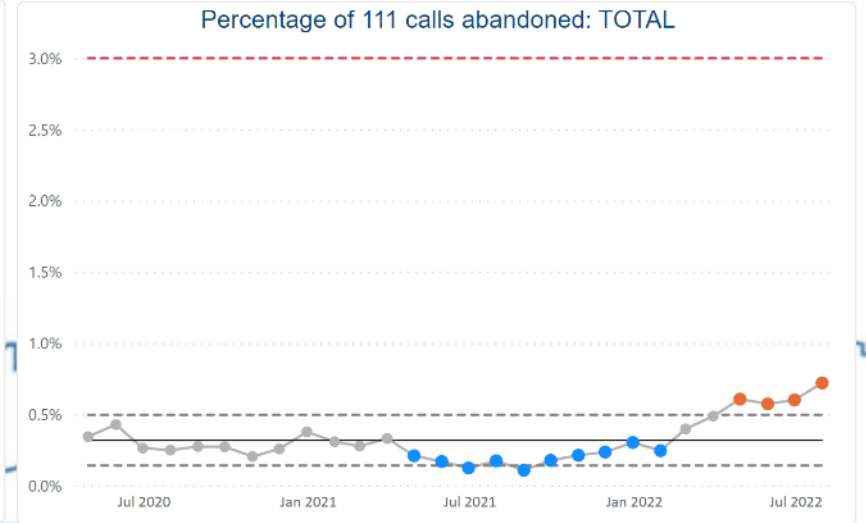
Metric	Latest date	Value	Target	Variation	Assurance
Primary Care Attends	Jul-22	1346530			
Primary Care Appointments	Jul-22	1413666	1492685		
Primary Care Appointments % DNA	Jul-22	4.75%			
Proportion of primary care appointments delivered face to face	Jul-22	70.37%			
Percentage of 111 calls abandoned	Jul-22	0.72%	3%		

Target









Risks and Mitigations

Increased and continued patient demand for all primary care services

GP appointment levels at pre-pandemic levels with a total of 1.4m during July 22 which is slightly below planned trajectory for July.

Increasing % of DNAs (4.75% of all appointments July 22).

Practices routinely offering face to face appointments where clinically necessary and they continue to increase, 70.4% of total appointments delivered in July 2022

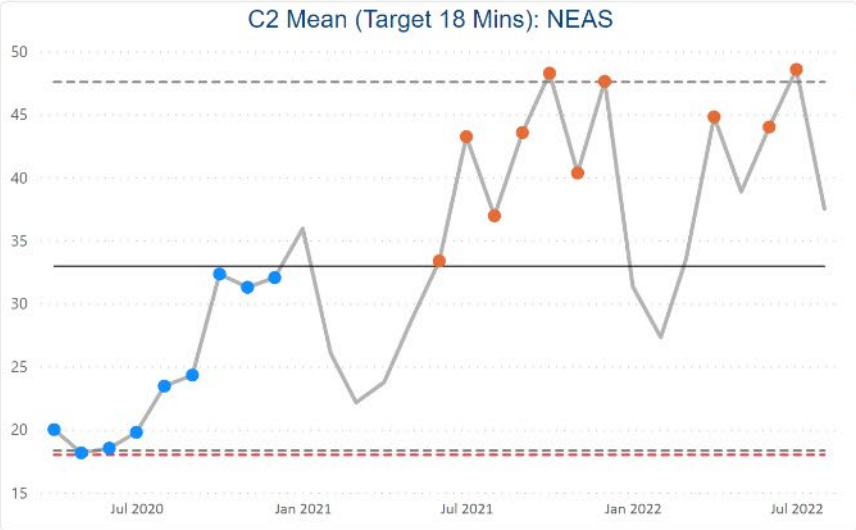
Practices and PCNs supported to review their Health Inequalities

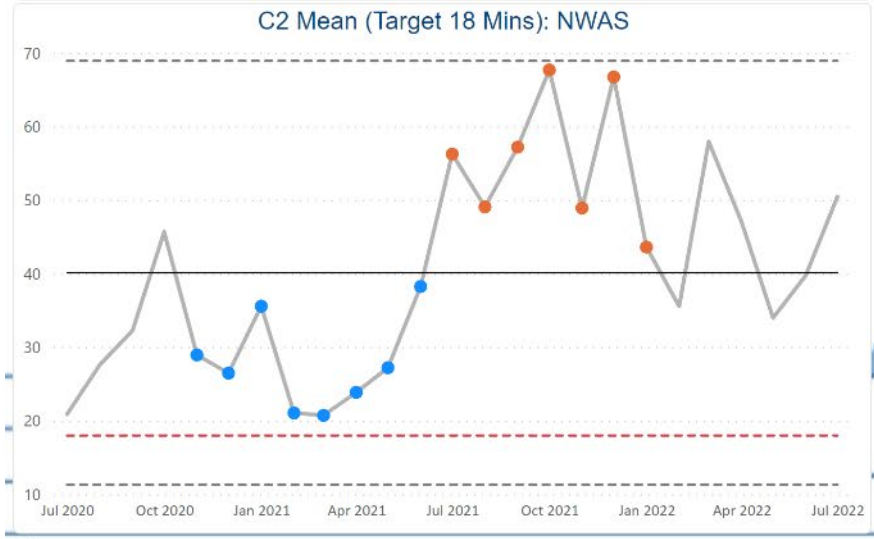
The percentage of 111 calls abandonned (NEAS only) icontinues to increase in July, at 0.72% but below the national threshold of 3%.

Ambulance Response Times

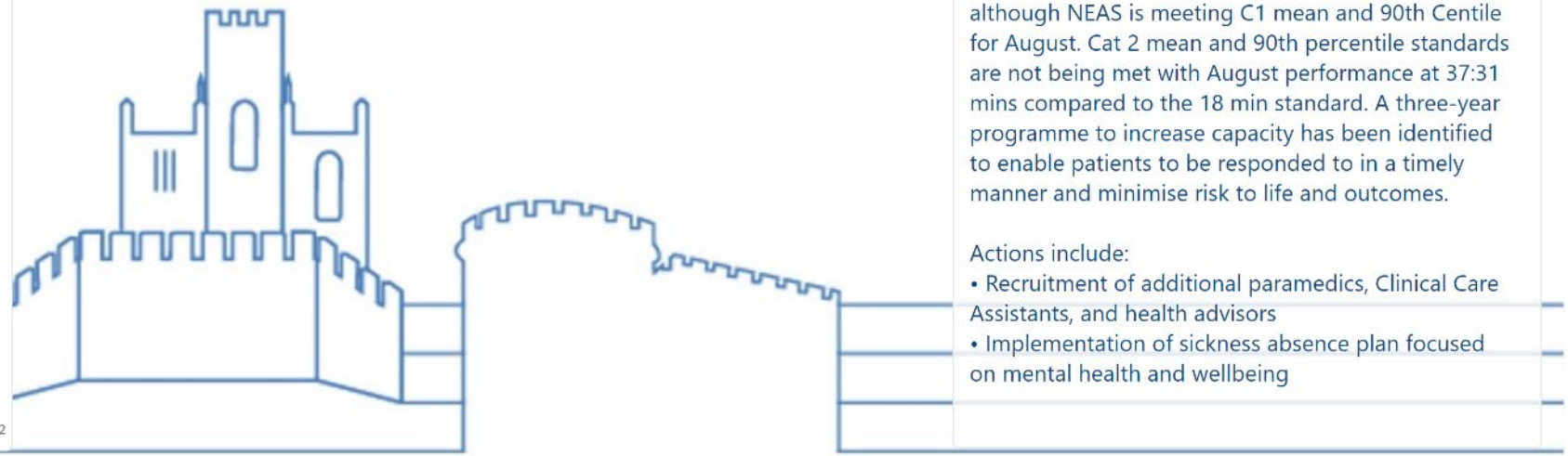
Metric		Latest date	Value	Target	Variation	Assurance
C2 Mean (Target 18 Mins):	NWAS	Jul-22	00:50:29	00:18:00		
C2 Mean (Target 18 Mins):	NEAS	Aug-22	00:37:31	00:18:00		

NHS
North East & North Cumbria





		NEAS			NWAS		
Metric	Target	Value	Variation	Assur.	Value	Variation	Assur.
C1 Mean (Target 7 Mins)	00:07:00	00:06:56			00:09:04	H	F
C1 90th Centile	00:15:00	00:13:48	H	P	00:14:38		
C2 Mean (Target 18 Mins)	00:18:00	00:37:31		F	00:50:29		
C2 90th centile	00:40:00	01:18:11			01:52:36		
C3 90th centile	02:00:00	05:05:05			09:45:09		
C4 90th centile	03:00:00	04:54:52			13:32:59		



Risks and Mitigations

Urgent and Emergency Care (UEC) continues to be a significant pressure and NENC is working hard to increase capacity and operational resilience ahead of winter with a continued focus on ambulance performance and response.

NWAS - Response times for North Cumbria CCG remain challenged in August and below standard. C1 mean has been flagged a high concern and consistently failing the target. However, NWAS performance in North Cumbria continues to be notably better than other areas of the North West. C2 performance is at 50:29 for August compared to the 18 minute standard.

NEAS – Response times continue to be a pressure although NEAS is meeting C1 mean and 90th Centile for August. Cat 2 mean and 90th percentile standards are not being met with August performance at 37:31 mins compared to the 18 min standard. A three-year programme to increase capacity has been identified to enable patients to be responded to in a timely manner and minimise risk to life and outcomes.

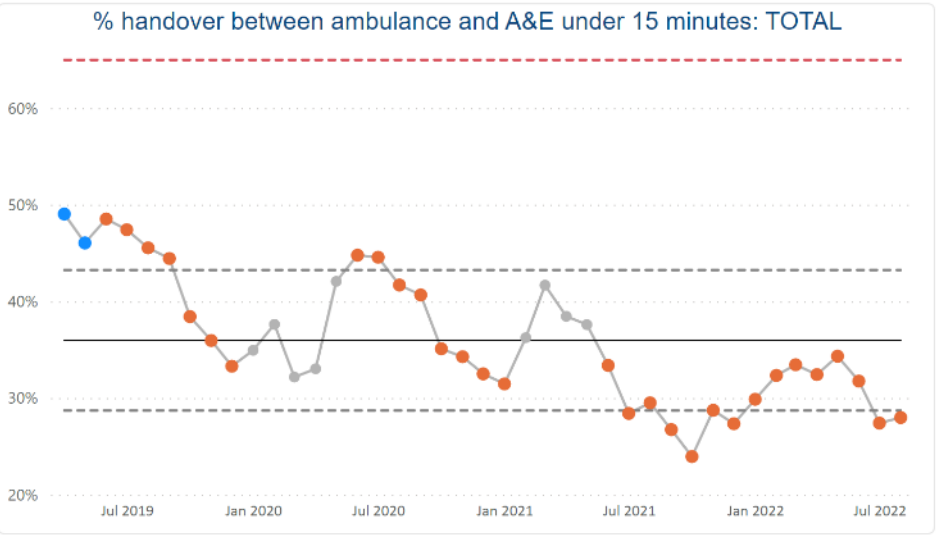
Actions include:
- Recruitment of additional paramedics, Clinical Care Assistants, and health advisors
- Implementation of sickness absence plan focused on mental health and wellbeing

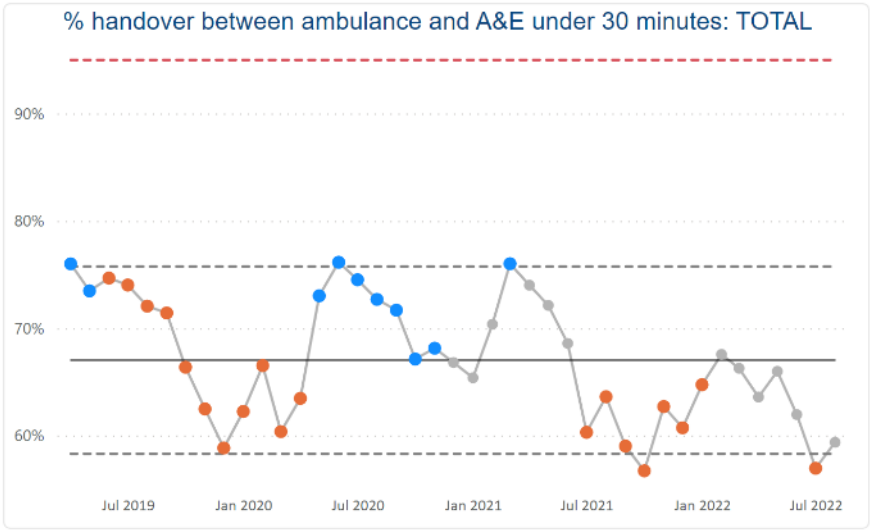
Ambulance Handover

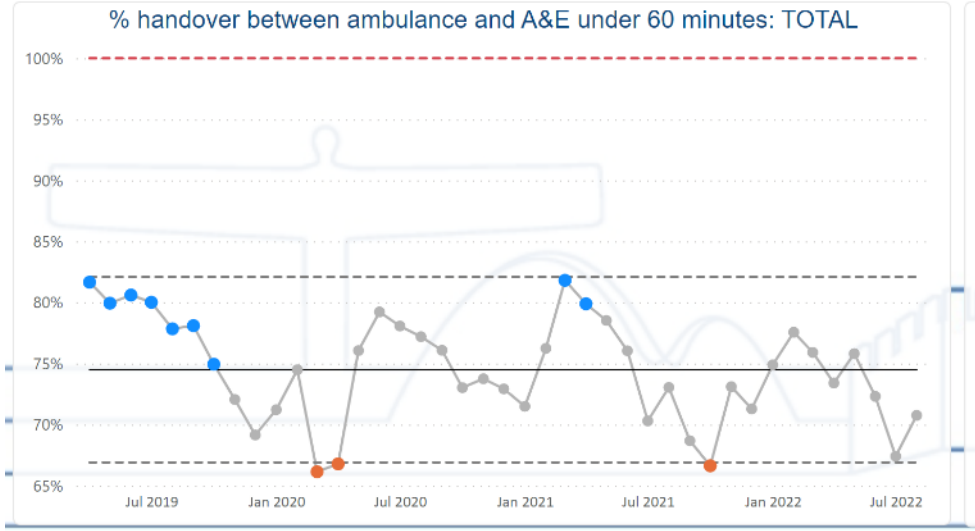
NHS North East & North Cumbria

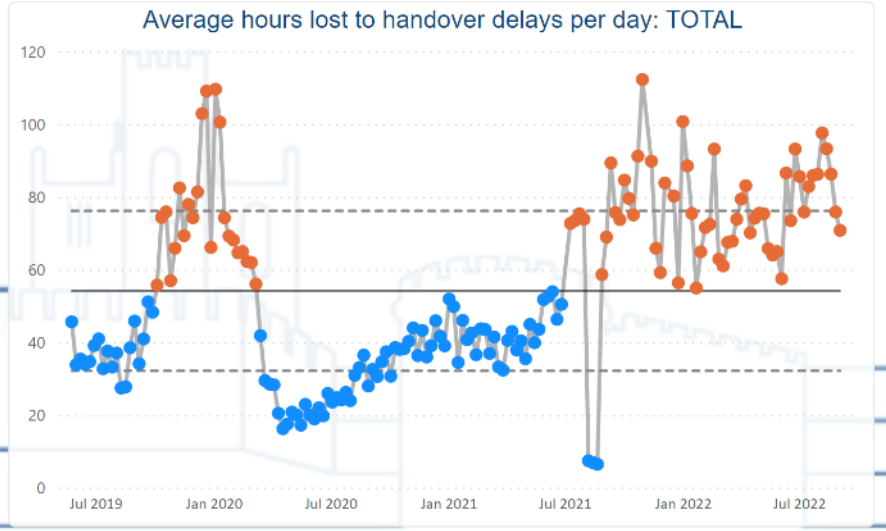
Metric	Latest date	Value	Target	Variation	Assurance
Average hours lost to handover delays per day	Sep-22	70.81			
% handover between ambulance and A&E under 60 minutes	Aug-22	70.76%	100%		
% handover between ambulance and A&E under 30 minutes	Aug-22	59.38%	95%		
% handover between ambulance and A&E under 15 minutes	Aug-22	27.98%	65%		

Target









Risks and Mitigations

NENC are working towards the following standards for ambulance handovers at our FTs: eliminating handover delays of over 60 minutes; ensuring 95% of handovers take place within 30 minutes; ensuring 65% of handovers take place within 15 minutes. Delays however do continue- resulting in 70.81 average hours lost per day across NENC as at w/e 4 September 2022.

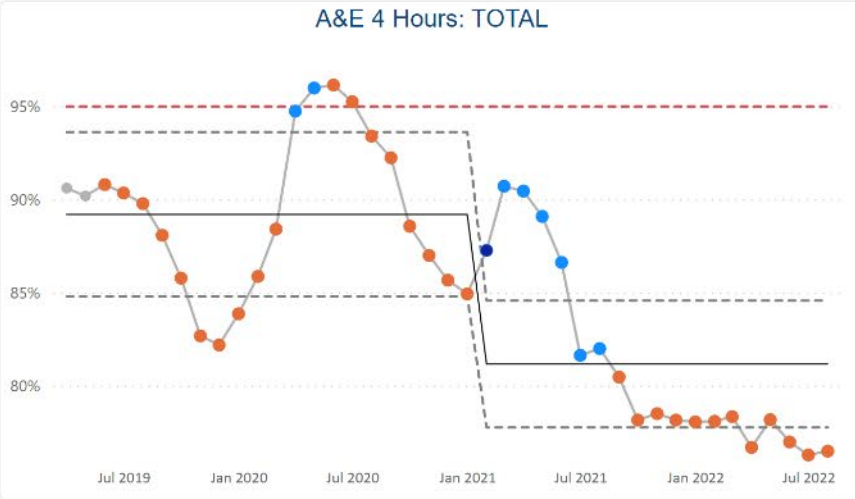
NWAS Area - Although there continues to be significant numbers of handover delays, NCIC is working collaboratively with NWAS to implement fit to sit, conveyance direct to SDEC and cohorting to reduce ambulance delays to get crews back on the road quickly.

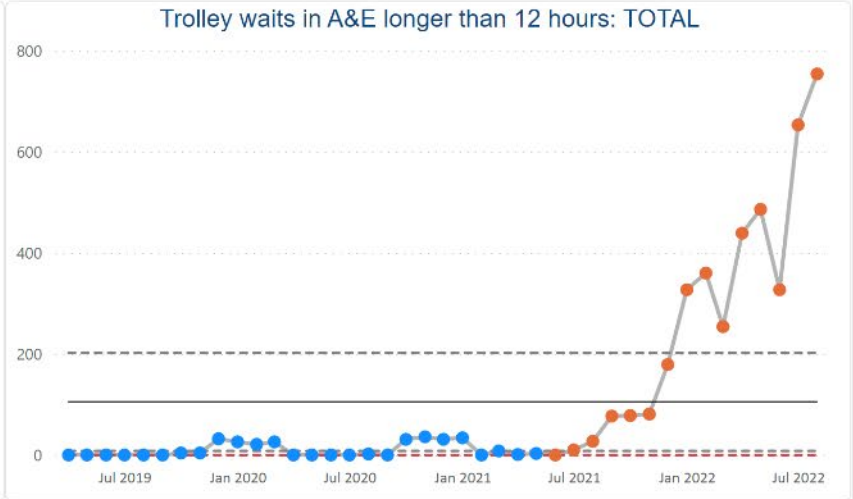
NEAS area- Regional Acute trust visits have taken place. The visits have informed a set of recommendations to be implemented. Local improvement plans will now be developed reflective of the recommendations and other local issues. Delivery of these plans will be governed by the Urgent Emergency Care Network Board. Recommendations include developing Consistent data flows to UEC RAIDR app. An engagement exercise has commenced to seek patient public views on the implementation of an intergated Urgent Care model at the James Cook site. STFT are a regional outlier and delays impact both NWAS and NEAS providers.

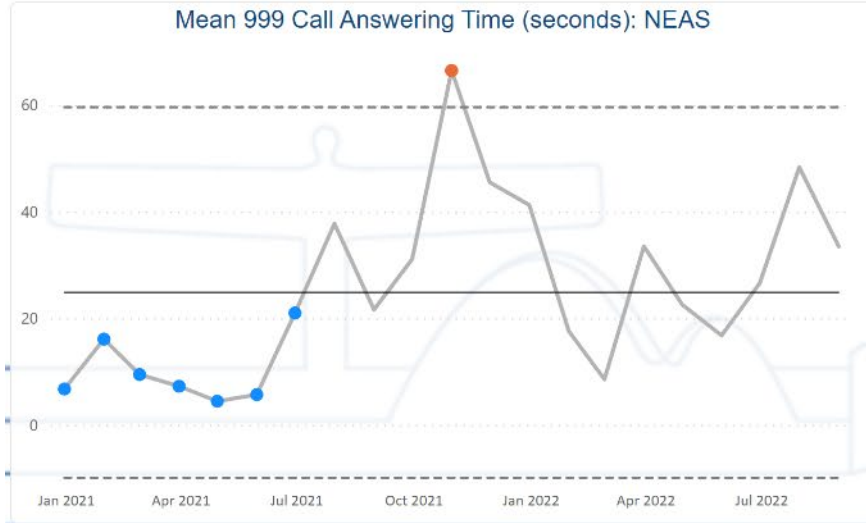
Accident and Emergency

Metric	Latest date	Value	Target	Variation	Assurance
Mean 999 Call Answering Time (seconds)	Aug-22	33.48			
% Patients spending 4 Hours or less in A&E	Aug-22	76.48%	95%		
A&E 4 Hours (T1 only)	Aug-22	61.16%	95%		
Trolley waits (from DTA) in A&E longer than 12 hours	Aug-22	754	0		
% A&E waits from arrival to discharge, admission or transfer longer than 12 hours	Jul-22	2.32%	2%		

Target







Risks and Mitigations

A&E four hour wait performance continues to be a pressure due to volatile activity levels in the urgent care system with Type 1 performance still under significant pressure (61.16% NENC compared to 58% nationally). Ongoing pressures result from increased attendance and admission rates together with persistently high levels of medically optimised patients persists across the system. Although not meeting the 95% standard, NENC performance is performing favourably compared to the national for August for all providers which stood at 76.48% (all types) for NENC compared to 71.4% nationally. Patients waiting in A&E more than 12 hours following decision to treat has increased to 754 in August in NENC. The % of patients waiting longer than 12 hours from arrival to discharge is above the 2% standard for August at 2.32% in NENC.

Central - Performance for providers in the ICP continues to deteriorate and local A&E Delivery Boards continue to focus on actions to improve flow and performance which includes reducing ambulance handovers and long stay patients. Winter planning sessions have taken place to prepare for the seasonal pressures later in the year, but workforce challenges continue to be a concern as does the acuity of patients and the impact of mental health presentations which is impacting 12-hour trolley waits.

Tees Valley - STHFT 4-hour standard performance remains below average. The impact of COVID-19 on staffing levels in this staff group and patient flow (segregation of pathways) continues to be observed. Increased levels of urgent and emergency care activity continue. NTHFT do not report against the 4 hour standard due to participation in the National CRS pilot. Actions include:

- ECIST improvement project
- Patient first document
- Estate expansion and reconfiguration to create additional cubicle capacity
- Development of full capacity protocol, which is now in place
- Collaborative development of surge and escalation plans

North Cumbria - NCIC is working with the national Emergency Care Improvement Support Team (ECIST) to expand the use of SDEC and implement the 'perfect day' improvement tools. Rapid Access and Treatment at West Cumberland Hospital went live in June and site co-ordination and internal escalation policies are being reviewed.

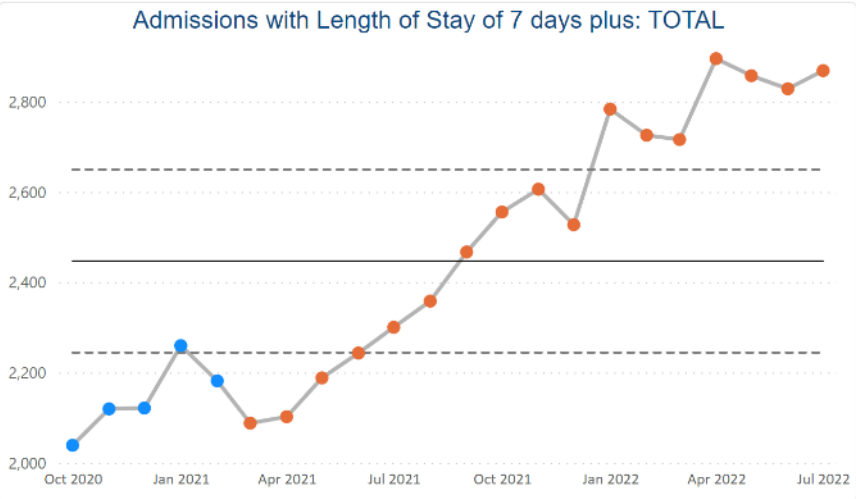
North – Trust wide urgent and Emergency Care (UEC) action plans are in place corresponding to the national UEC 10 point plan. Key focuses include increasing staffing in both the short term and long term. Through the North ICP Strategic A&E Board and NEAS transformation board we will continue to work with each Trust to refine and develop their SDEC model to provide consultant assessment and diagnosis, rapid treatment and early facilitated discharge.

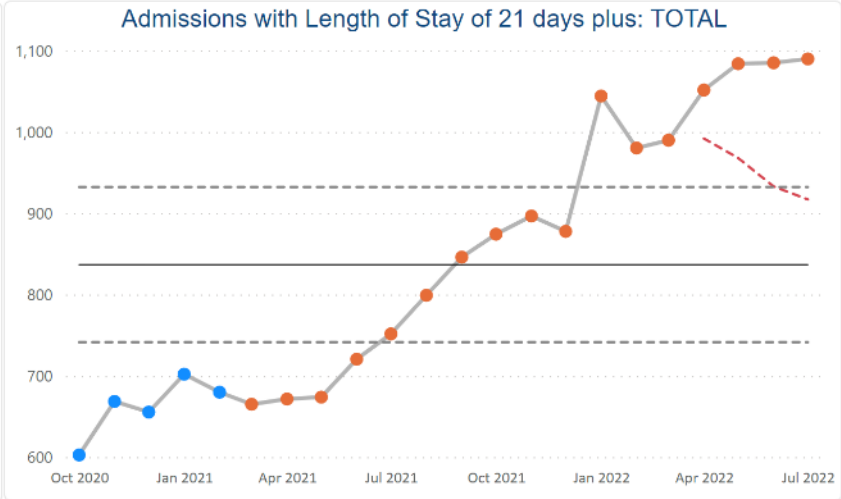
Patient Flow & Discharge

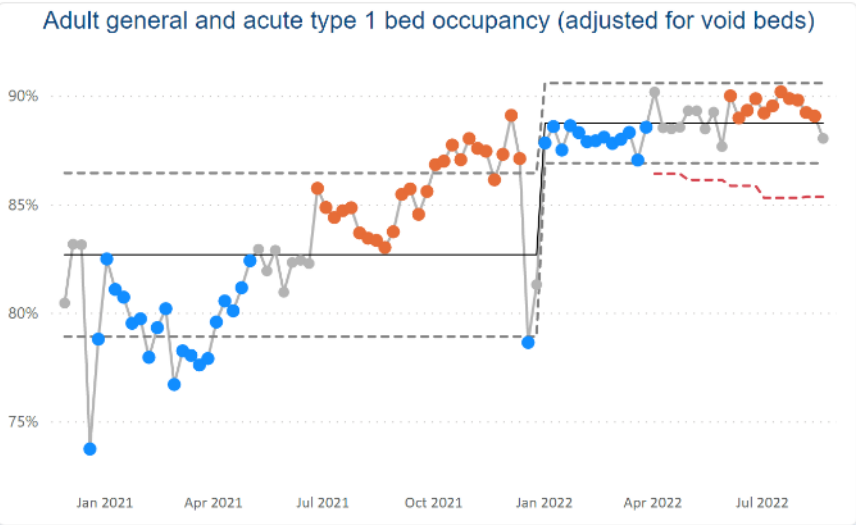
NHS North East & North Cumbria

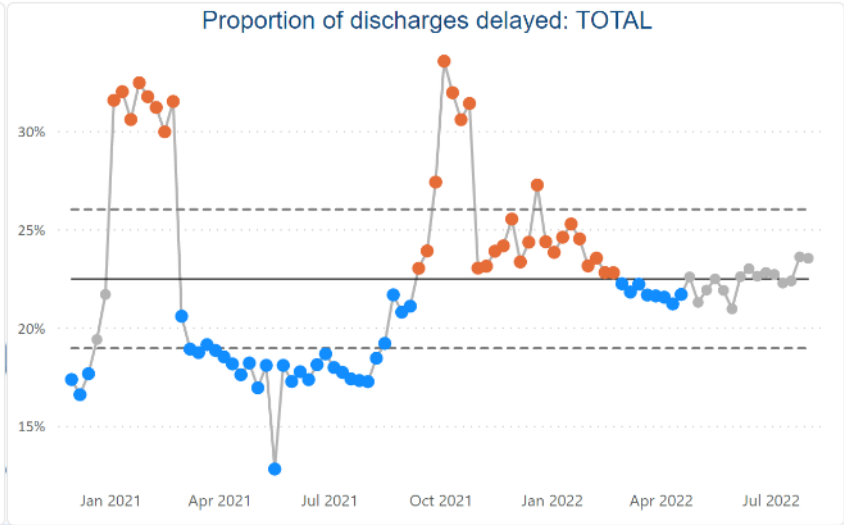
Metric	Latest date	Value	Target	Variation	Assurance
Admissions with Length of Stay of 21 days plus	Jul-22	1089.94	917		
Admissions with Length of Stay of 7 days plus	Jul-22	2868.71			
Adult general and acute type 1 bed occupancy (adjusted for void beds)	Aug-22	88.03%	85.34%		
Proportion of discharges delayed	Aug-22	23.53%			

Target









Risks and Mitigations

Length of stay for patients residing in hospital over 7 and 21 days has continued to increase and is above trajectory.

Patients who no longer meet the criteria to reside and whose discharge is delayed has remained relatively stable since April.

Bed occupancy remains high and is above the 85% required standard in NENC at 88.03% for August 22.

Plans are underway to transform and build community services capacity to deliver more care at home and improve hospital discharge across NENC ICS.

The ICS is committed to implementing new and enhancement of current virtual wards to support plans for elective recovery and improvement of UEC pathways.

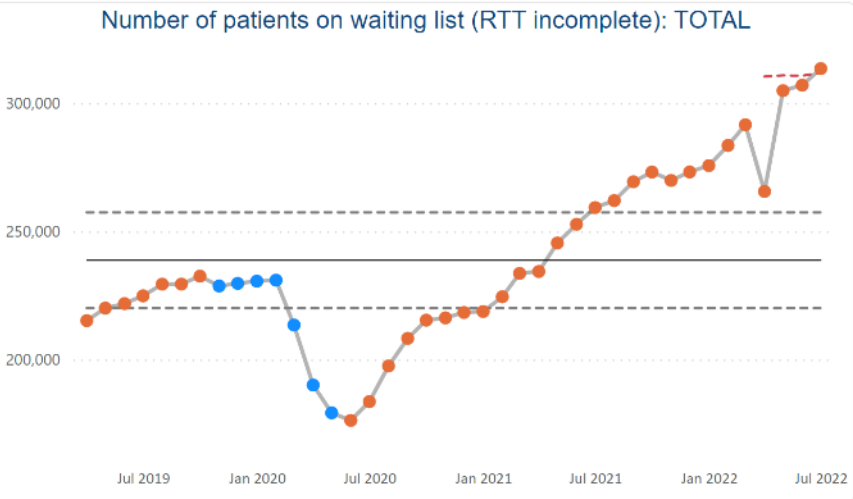
Local systems with their partners are making sure that their Urgent Crisis Response (UCR) models are part of the wider local health and care integration redesign. UCR data is being standardised across the ICS and will be included in future reports to ensure delivery of the 2 hour standard across the ICS.

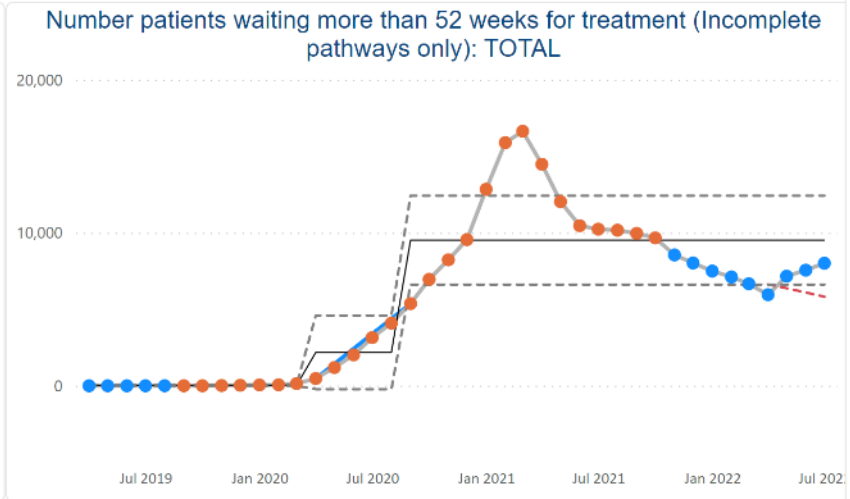
Both Virtual wards and Urgent crisis response wok plan has been established together with ICS wide working groups to explore and share pathway models to standardise across the ICS.

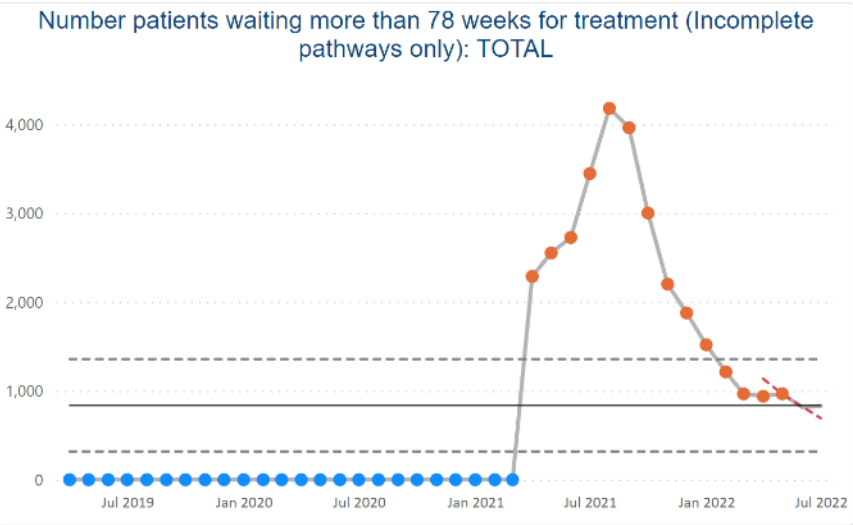
Referral to Treatment and Long Waiters

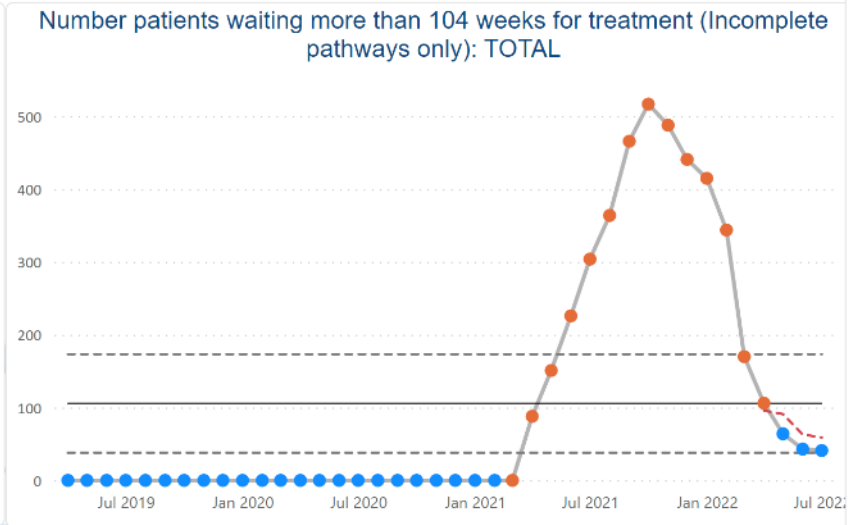
Metric	Latest date	Value	Target	Variation	Assurance
Number patients waiting more than 52 weeks for treatment (Incomplete pathways only)	Jul-22	8011	5819		
Number patients waiting more than 78 weeks for treatment (Incomplete pathways only)	Jul-22	830	693		
Number patients waiting more than 104 weeks for treatment (Incomplete pathways on...	Jul-22	41	59		
Number of patients on waiting list (RTT incomplete)	Jul-22	313541	312029		

Target









Risks and Mitigations

The total number of patients on the waiting list continues to grow and has exceeded operational plan trajectory for July 22. Through a national weekly data collection (unvalidated) more current data demonstrates:

There were 34 104+ week waiters as at 28/8/22 all spinal patients at Newcastle upon Tyne Hospitals NHS FT . This is within the planned level. The Trust continues to seek additional capacity through local and Independent sector (IS) providers.

78+ waiters are increasing after a continual reduction over recent months and are now above planned levels. Of the 940 78+ waiters in total as at 28/8/22, 708 were at NUTH, 109 at S. Tees, and 90 at CDDFT.

52+ week waiters continue to increase and are above planned levels. Of the 9220 in total as at 28/8, 4919 were at NUTH, 1745 at South Tees, and 1441 at CDD. Pressures exist across high volume specialties at NUTH including T&O, Dermatology, Ophthalmology and Plastic Surgery.

Mitigations

North - Additional sessions, implementation of digital pathways in Dermatology, continued use of the Newcastle Westgate Cataract Centre and subcontracting with the IS has helped reduce long waiters. The Newcastle elective treatment centre is likely to open mid-September

Tees Valley - STHFT has now appointed a vacant post within the RTT validation team and are developing focus reports in line with recent planning & priorities guidance. The trust has agreed an SLA with source group and work is underway and performance is expected to continue to improve in 2022/23. NTHFT waiting lists have continued to increase and Covid related absences are still impacting on performance. Conversations continue with IS providers regarding what capacity is available should any Trusts need to utilise.

Central - RTT performance continues to be strong in the Central patch with low levels of over 52 week waiters and a continued decrease in 104 week waiters. Pressures in the urgent care system however is beginning to impact on performance and elective care recovery. Additional resources have been committed via the ERF to increase elective capacity at Trusts and the Area continues to focus on maximising elective capacity through use of the I.S.

Cumbria - NCIC successfully eliminated 104 week waits in 2021/22 and the focus has moved to the elimination of 78 week waits by the end of the current financial year. Waiting list continues to grow, The theatre improvement programme remains a key priority and the NECS review of selected outpatient specialties has been used in the development of a transformation and improvement plan. In addition, the modular endoscopy unit is still on site, additional elective capacity has been secured from BMI and Nuffield and a sub-contract is in place for Ophthalmology.

Diagnostic Waiting List

NHS North East & North Cumbria

Metric	Latest date	Value	Target	Variation	Assurance
Number of patients waiting more than 6 weeks from referral for a diagnostic test	Jul-22	13275			
% Patients waiting more than 6 weeks from referral for a diagnostic test	Jul-22	17.65%	1%		

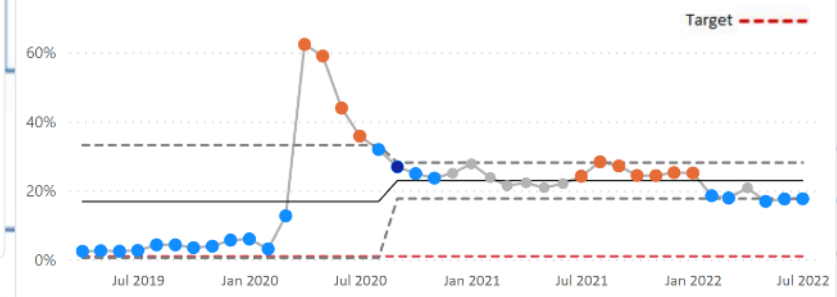
% Patients Waiting more than 6 weeks for a diagnostic test - by Modality

Metric	% Patients waiting more than 6 weeks from referral for a diagnostic test			Number of patients waiting more than 6 weeks from referral for a diagnostic test		
	Value	Variation	Assur.	Value	Variation	Assur.
AUDIOLOGY_ASSESSMENTS	37.72%			1606		
BARIUM_ENEMA	6.04%			9		
COLONOSCOPY	28.36%			948		
CT	6.79%			680		
CYSTOSCOPY	21.26%			250		
DEXA_SCAN	8.5%			248		
ECHOCARDIOGRAPHY	34.3%			2773		
ELECTROPHYSIOLOGY	0%			0		
FLEXI_SIGMOIDOSCOPY	28.17%			342		
GASTROSCOPY	31.68%			1223		
MRI	12.6%			1571		
NON_OBSTETRIC_ULTRASOUND	10.7%			2683		
PERIPHERAL_NEUROPHYS	41.3%			532		
SLEEP_STUDIES	24.09%			244		
URODYNAMICS	46.37%			166		

% Patients Waiting more than 6 weeks for a diagnostic test - by provider

Metric	% Patients waiting more than 6 weeks from referral for a diagnostic test			Number of patients waiting more than 6 weeks from referral for a diagnostic test		
	Value	Variation	Assur.	Value	Variation	Assur.
TOTAL	17.65%			13275		
CDDFT	8.66%			888		
Gateshead FT	23.37%			1452		
NCIC	21.09%			1653		
Northumbria	5.66%			626		
NTHFT	21.23%			1661		
NuTH	14.12%			1744		
STHFT	31.39%			3385		
STSFT	19.52%			1380		

% Patients waiting more than 6 weeks from referral for a diagnostic test: TOTAL



Risks and Mitigations

Diagnostics >6 week performance is relatively stable across NENC and continues below 1% target at 17.65% for July 2022. Key pressure areas include Echo-cardiography, Endoscopy and Audiology.

Diagnostics Mitigations

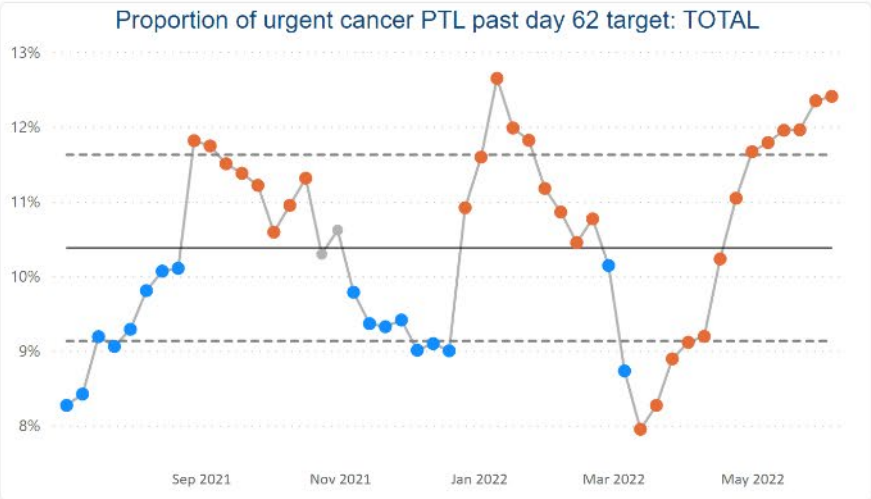
Significant echo backlogs have been cleared at NUTH through additional capacity, Gateshead continue with insourcing to clear echo backlog and central area has secured additional capacity through 22/23. An additional cardio-echo machine at West Cumberland Hospital, provides a further 30% capacity in Cumbria.
Community diagnostics funded schemes are increasing capacity in Radiology and endoscopy across NENC as well as additional capacity sought through the Independent sector.
Audiology workforce pressures remain a risk across NENC

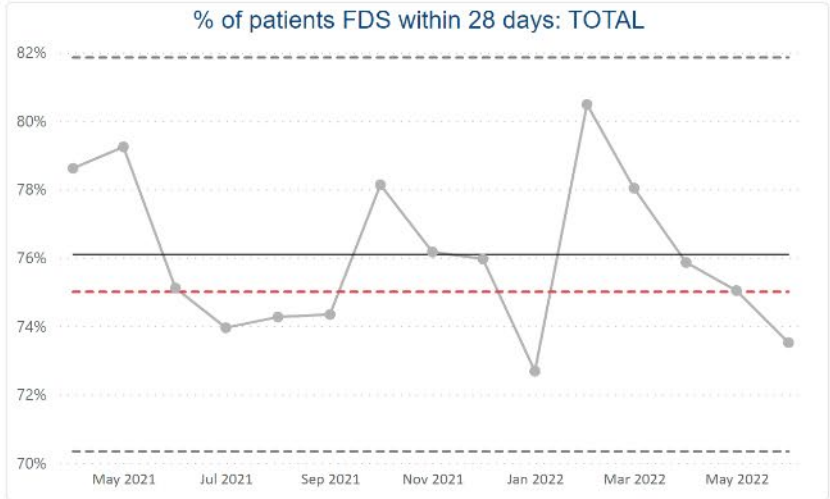
Cancer

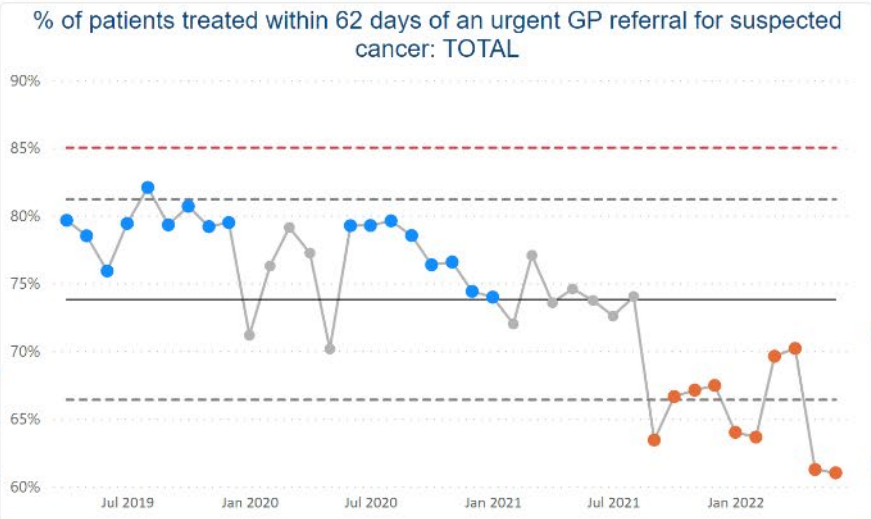
NHS
North East & North Cumbria

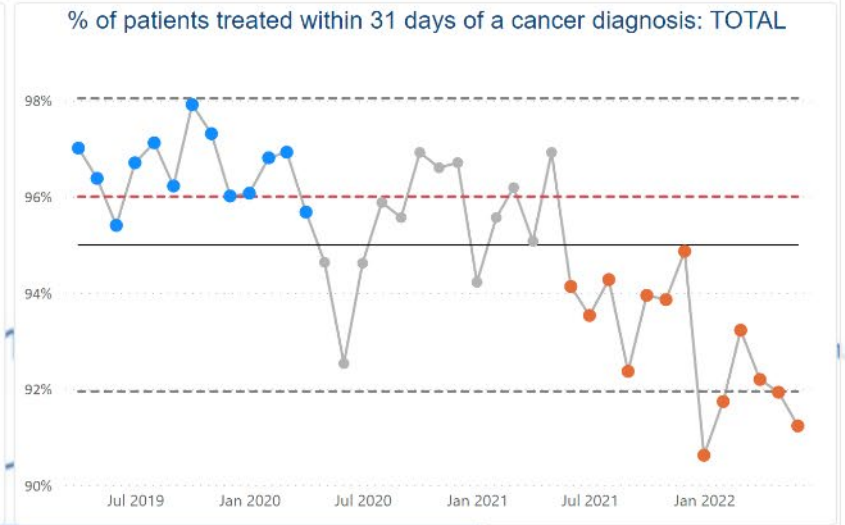
Metric	Latest date	Value	Target	Variation	Assurance
Proportion of urgent cancer PTL past day 62 target	Jun-22	12.41%			
% of patients FDS within 28 days	Jun-22	73.52%	75%		
% of patients treated within 62 days of an urgent GP referral for suspected cancer	Jun-22	61%	85%		
% of patients treated within 31 days of a cancer diagnosis	Jun-22	91.23%	96%		

Target









Risks and Mitigations

NB Due to changes in national reporting of cancer data at ICB level, July data has been delayed and will be updated as soon as this becomes available.

NENC are not currently achieving the faster diagnosis standard for June at 73.5% v the 75% target. Variation between Trusts exists with highest performance at CDD FT,(92.32%) Gateshead and North Tees.

31 day treatment standard and the 62 days referral to treatment standards are not currently being met.

Variation in 62 day performance ranges from S. Tees 48.3%, and 49% at NUTH to 79.6% at CDDFT. The proportion of patients on the waiting list (PTL) who have been waiting longer than 62 days is a particular pressure at NCIC FT which has been identified as a national outlier and the trust is receiving support from NHSE/I including mutal aid, access to regional clincial leads for pathologst and improvement support from ECIST.

NCA continue to roll out optimal pathways but pressures remain in skin, lung, colorectal and breast, impacted by workforce and capacity pressures. Cancer care coordinators and navigators support rapid diagnostics initiatives as well as enhanced cancer tracking capacity.

Urology is a particular pressure across North Area footprint and a working group is being established to review optimal pathways.

Skin Successful roll out of tele-dermatology pathway at NUTH has eased pressures in skin although seasonal referrals are creating additional pressure.

NCA non surgical oncology should improve the equitable and timely delivery of chemotherapy and radiotherapy across the ICS.

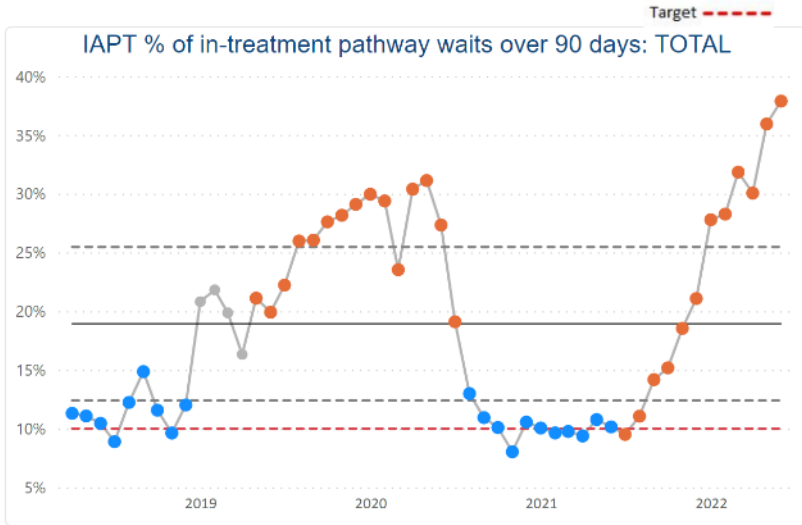
Improving Access to Psychological Therapies (IAPT)

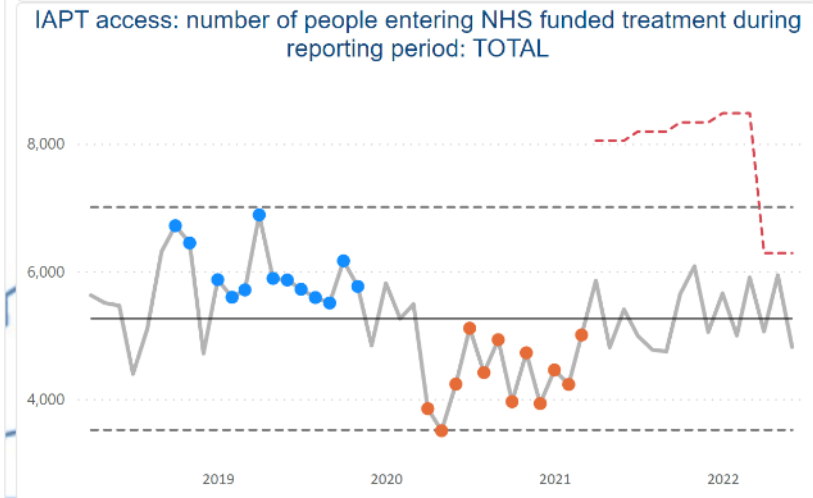
NHS North East & North Cumbria

Metric	Latest date	Value	Target	Variation	Assurance
IAPT access: number of people entering NHS funded treatment during reporting period	Jun-22	4815	6286		
IAPT recovery rate for Black, Asian or Minority Ethnic groups	Jun-22	42.62%	50%		
IAPT % of in-treatment pathway waits over 90 days	Jun-22	37.89%	10%		
IAPT recovery rate: % of people that attended at least 2 treatment contacts and are m...	Jun-22	53.18%	50%		
IAPT % of people receiving first treatment appointment within 6 weeks of referral	Jun-22	97.82%	75%		
IAPT % of people receiving first treatment appointment within 18 weeks of referral	Jun-22	99.07%	95%		

IAPT Recovery by Sub ICB location

Metric	IAPT recovery rate for Black, Asian or Minority Ethnic groups			IAPT recovery rate: % of people that attended at least 2 treatment contacts and are moving to recovery		
	Value	Variation	Assur.	Value	Variation	Assur.
TOTAL	42.62%			53.18%		
Co Durham	45.45%			52.17%	H	
N Cumbria	37.5%			53.85%	H	
N Tyneside	50%			55.88%	H	
Ncl-Gateshead	38.3%			52.34%		
Northumberland	40%			53.7%	L	
S Tyneside	60%			51.22%		
Sunderland	40%			55%		
Tees Valley	42.11%			53.85%		





Risks and Mitigations

Access rates continue to be sporadic and have been below plan and target. Over more recent months the IAPT access numbers have started to increase and more in line with pre-pandemic numbers. Contributing factors impacting IAPT delivery include workforce, and demand.

Moving to recovery rates are above the 50% expectation in NENC for all patients, however the recovery rate for black, asian or minority groups is slightly lower.

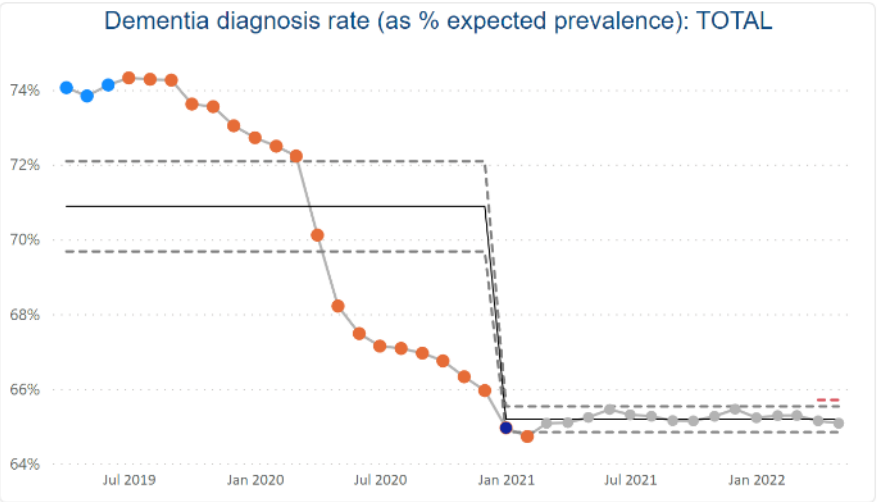
IAPT providers in the NENC are working to recovery plans to achieve national standard access rates and improve waiting times from first to second treatment which have remained static and are significantly above the national expectation of 10% at 37.89% for June. North Cumbria are currently within this standard at 5% Actions across the ICS include: mobilisation of the NENC ICS IAPT Delivery & Oversight Group, as well as pulicity, targeting pathways such as older persons, DNA initiatives as well as recruitment drives, and subcontracting.

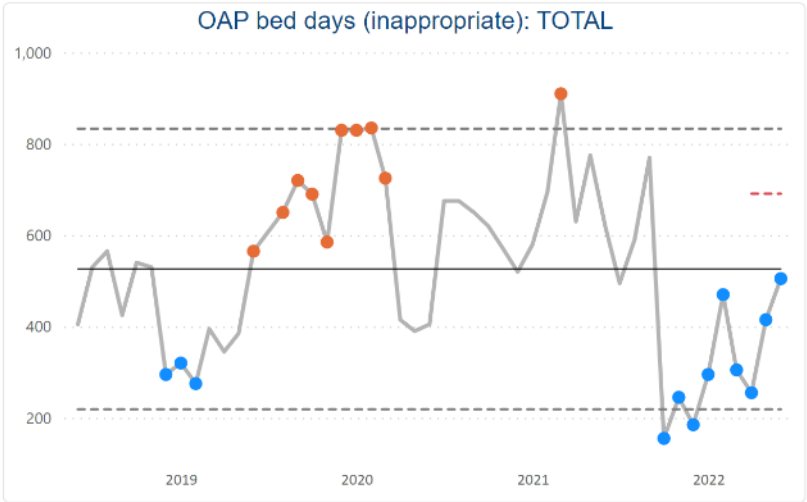
Mental Health (Adult)

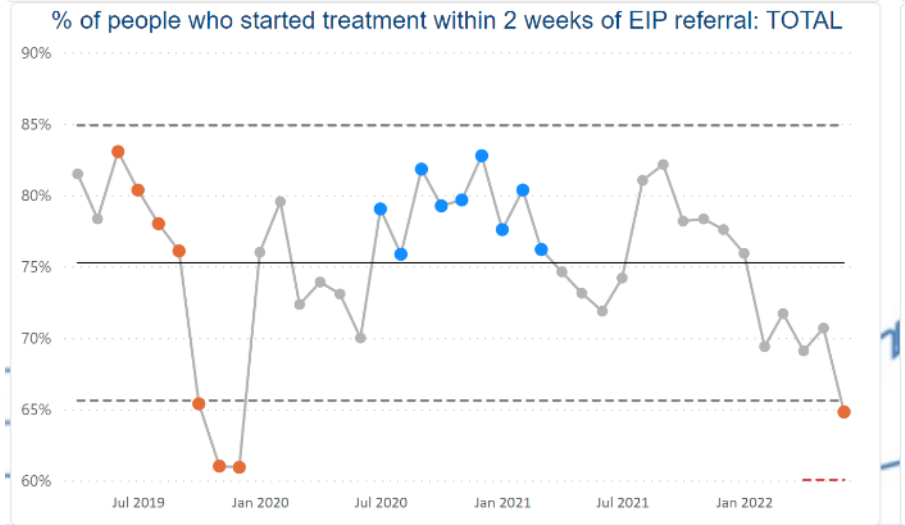
NHS North East & North Cumbria

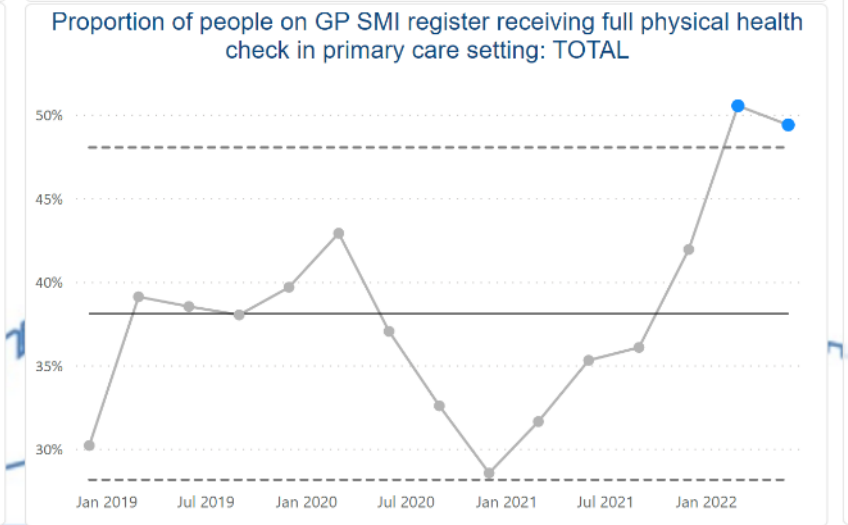
Metric	Latest date	Value	Target	Variation	Assurance
Total number of inappropriate Out of Area bed days	Jun-22	505	691		
EIP % of people who started treatment within 2 weeks of referral - All ages	Jun-22	64.81%	60.07%		
Number of people on GP SMI register receiving full physical health check in primary ca...	Jun-22	13110	13056		
Dementia diagnosis rate (as % expected prevalence)	May-22	65.08%	65.7%		

Target









Risks and Mitigations

64.81% people in NENC started treatment within 2 weeks for Early intervention in Psychosis compared to the 60% standard.

Dementia diagnosis is at just below the 67% standard for NENC at 66.4% for Q4 and continues to increase for Q1. THere was a dip in performance throughout the pandemic and teams are working to recover.

The Number of SMI Health checks completed has started to increase throughout 21/22 and into 22/23 and although below the 22/23 standard it is progressing above plan in NENC. Actions include: deployment of portable testing equipmnet, continued mobiisation of community mental health transformation models at place and local support to PCNs and clinical teams to ensure continued focus.

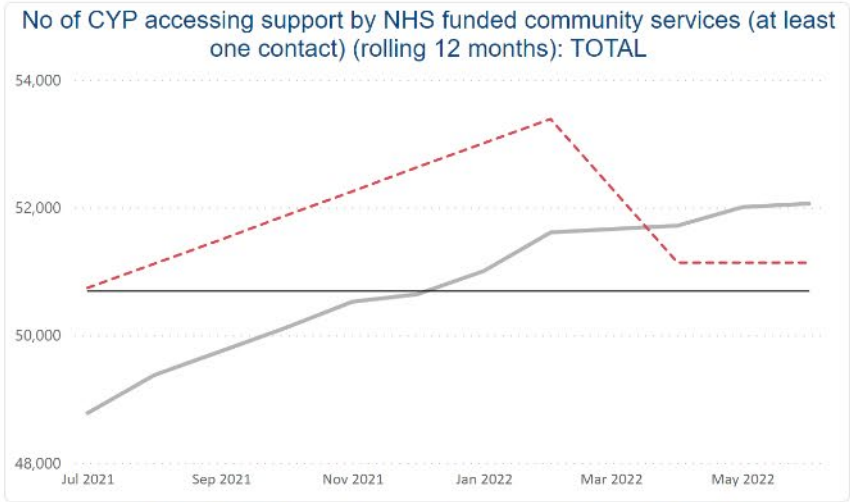
The number of Out of Area Placement bed days for NENC decreased throughout the pandemic and has been decreasing throughout 21/22 to Dec 21 where we have seen an increase. April and May 22 to date has seen inapproporate bed days decreasing and wihtin local plan although the numbers remain above the target of 0.

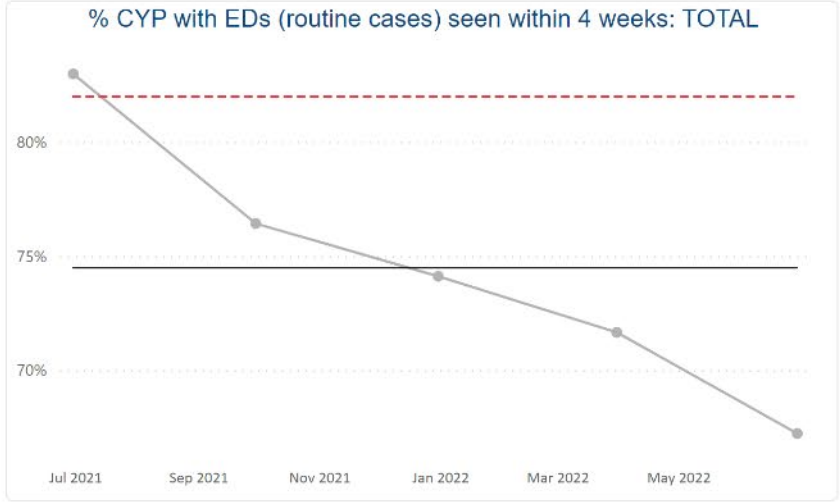
Children and Young People Mental Health

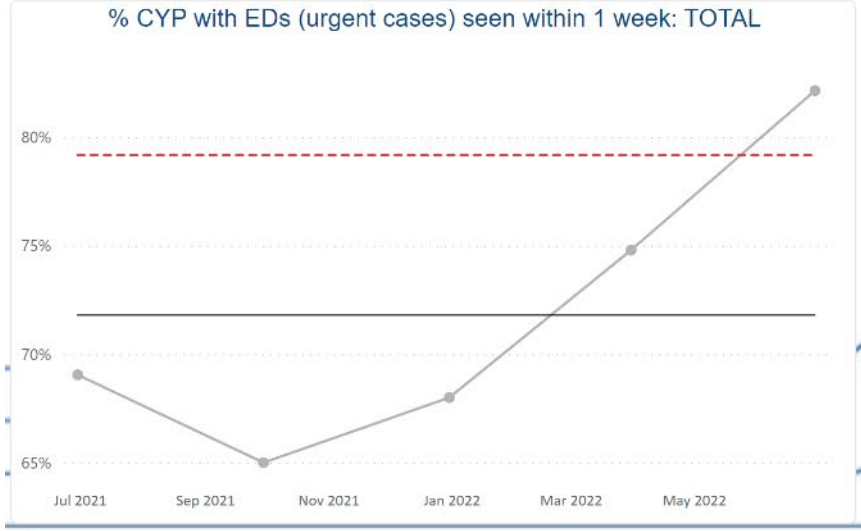
NHS
North East & North Cumbria

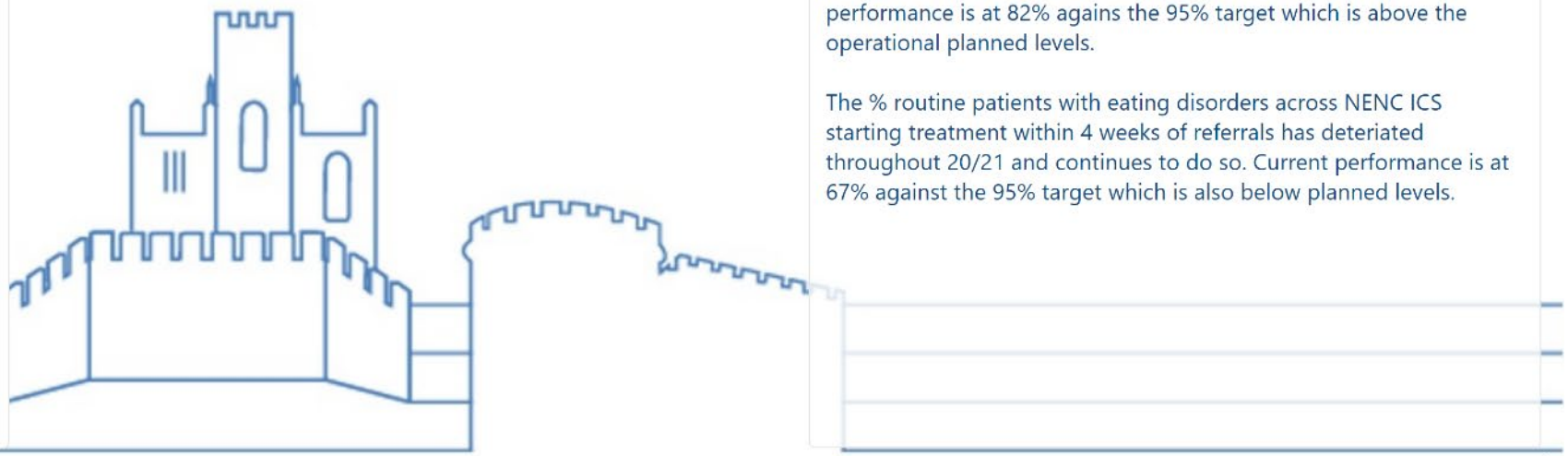
Metric	Latest date	Value	Target	Variation	Assurance
No of CYP accessing support by NHS funded community services (at least one contact...	Jun-22	52060	51136		
% of CYP with eating disorders (routine cases) seen within 4 weeks of referral for NICE ...	Jun-22	67.23%	81.99%		
% of CYP with eating disorders (urgent cases) seen within 1 week of referral for NICE a...	Jun-22	82.14%	79.17%		

Target









Risks and Mitigations

The number of CYP aged under 18 supported through NHS funded mental health services receving at least one contact is showing some improvement in NENC throughout 21/22, although this is not the same rate of growth as the target. May 22 shows the CYP access above plan but below target. Place based actions to review pressure points and determine need include waiting list recover plans, alternative model implementation and pathway design. Workfroce initiaitives including recruitment and retention projecys are also underway as well as system level digital action plans in place to support interoperability.

The % of urgent patients with Eating disorders across NENC ICS starting treatment within 1 week of referral has deteriorated throughout 20/21 and into 21/22. However from September 21 onwards there has been continual improvements. Current performance is at 82% agains the 95% target which is above the operational planned levels.

The % routine patients with eating disorders across NENC ICS starting treatment within 4 weeks of referrals has deteriated throughout 20/21 and continues to do so. Current performance is at 67% against the 95% target which is also below planned levels.

Learning Disability and Autism LTP Deliverables RAG Rating

NHS
North East & North Cumbria

Long Term Plan commitment or mandate	Current RAG Rating
Reducing reliance on inpatient care • By 2023/24 there will be reduction in reliance on inpatient care for people with a learning disability, autism or both to 30 inpatients per million adult population • By 2023/24 no more than 12 to 15 children or young people with a learning disability, autism or both per million, will be cared for in an inpatient facility.	**Total adult inpatient in NCNE as of 5th August 2022 = 151** CCG: **75** (6 over trajectory) Secure Services: **76** (at trajectory) NCNE CAMHS Total: **9**
Care (Education) and Treatment Reviews CETRs; compliance with national policy	**2 areas non-compliant as of 30 June 2022** Under 18's: Pre or Post admission CETRs = 0% (0 of 4 completed) Adults: Pre or Post admission CTR = 70% (7 of 10 completed) Compliant for adults = 75% Compliant for U18s = 90%
Learning Disability Mortality Reviews (LeDeR); compliance with national policy	**As of 18 June 2022 98% of reviews after June 2020 are complete of which 19% are focussed reviews.** LeDeR Implementation Plan and Revised Governance Arrangements submitted based on new ICS working arrangement. A new ICS reporting system is being explored.
Annual health checks **• By 2023/24 - 75% of people on the learning disability register will have had an annual health check.**	**22-23 Long Term Plan Target 70% (achieved 77% in 20-21)** Reported data via NECS from April 22 to May 2022: 2648 reviews completed – which is 13% of the register for 22/23. Plans in place to offer annual health checks to all people who did not receive one in 21/22 by Sept 22. 22-23 Target 73% 23-24 Target 75%

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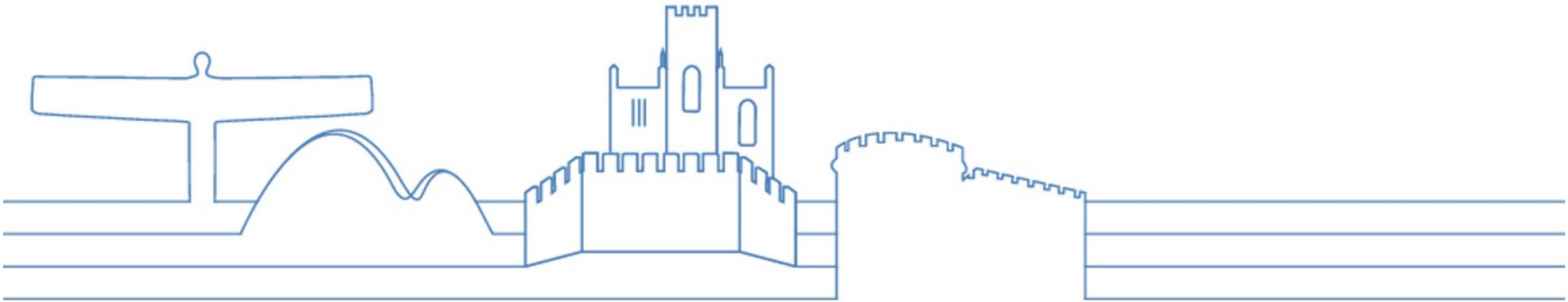
Finance



Executive Summary

NHS North East & North Cumbria

	M04 - July 2022		YTD	Forecast
Income & Expenditure	**Overall 2022/23 Financial Position - (Surplus) / Deficit** For the financial year 2022/23 the ICB combined with the Q1 position of the NENC CCG is on track to deliver the planned surplus position of £2.6m *Nb: The YTD surplus for the ICB is technical in nature and due to the transfer of balances from CCGs to ICB.	Plan Actual	£0.895 m * (£20.651) m	(£2.633) m (£2.633) m
	July 2022 - March 2023 Financial Position - (Surplus) / Deficit ICB is reporting a year to date and forecast outturn in line with the submitted financial plan for the period July 2022 - March 2023 - (£0.441m) YTD and (£3.970m) Forecast	Plan Actual	(£0.441) m (£0.441) m	(£3.970) m (£3.970) m
	July 2022 - March 2023 Programme Spend ICB is reporting a year to date variance of (£0.441m) an outturn variance of (£3.970m) in line with the submitted financial plan for the period July 2022 - March 2023 (Surplus) / Deficit	Plan Actual	£539.1 m £538.7 m	£4,852.1 m £4,848.1 m
	July 2022 - March 2023 Running cost ICB is reporting a year to date variance of £0m against a YTD budget of £4.784m and an outturn variance of £0m against a budget of £43.055m for the period July 2022 - March 2023	Plan Actual	£4.8 m £4.8 m	£43.1 m £43.1 m
	Overall 2022/23 QIPP/Efficiency ICB is reporting a year to date variance of £0m and an outturn variance of £0m against the annual efficiency plan of £48.4m.	Plan Actual	£15.56 m £15.56 m	£48.433 m £48.433 m
	Overall 2022/23 Mental Health Investment Standard (MHIS) The ICB is on track to achieve the MHIS target for 2022/23.		5.26%	5.26%

ICP Financial Position - Overview

NHS North East & North Cumbria

Month 4 - July 2022	YTD Plan	Revised YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Revenue Resource Limit	(542,765)	(542,765)	0	(4,884,887)	(4,884,887)	0
Programme						
Acute Services	272,353	273,358	1,006	2,451,173	2,458,967	7,793
Mental Health Services	59,606	61,000	1,394	536,457	536,537	80
Community Health Services	37,480	41,258	3,778	337,316	337,504	189
BCF	27,614	25,445	(2,168)	248,522	249,238	716
Continuing Care	30,462	30,164	(298)	274,158	277,153	2,996
Prescribing	47,196	47,410	214	424,763	422,328	(2,435)
Primary Care	10,247	10,655	408	92,219	93,469	1,250
Primary Care Co-Commissioning	44,284	44,284	0	398,555	398,555	(0)
Other Programme Services	2,526	4,078	1,553	22,733	22,934	201
Other Commissioned Services	2,113	2,075	(38)	19,015	19,215	199
Programme Reserves	3,448	(2,234)	(5,681)	31,029	20,177	(10,852)
Contingency	214	47	(167)	1,922	1,785	(137)
Total ICB Programme Costs	**537,540**	**537,540**	**0**	**4,837,862**	**4,837,862**	**(0)**
Admin						
Running Costs	4,784	4,784	0	43,055	43,055	0
Total ICB Admin Costs	**4,784**	**4,784**	**0**	**43,055**	**43,055**	**0**
ICB planned (Surplus) / Deficit	441	0	(441)	3,970	0	(3,970)
CCG Q1 b/f position & rephased expenditure	1,586,976	1,566,767	(20,210)	1,585,787	1,587,125	1,338
New unallocated allocations	1,138	1,138	0	10,239	10,239	0
Total 22/23 Financial Position	**2,130,879**	**2,110,228**	**(20,651)**	**6,480,913**	**6,478,281**	**(2,632)**

Overview of the Financial Position

As at 31st July 2022 the ICB is reporting financial performance in line with the financial plan submitted 20th June 2022.

The financial plan of the ICB required an overall efficiency target of £48.4m and the ICB is on track to deliver this.

The ICB is on track to deliver the Mental Health Investment Standard. Potential risk on prescribing and continuing healthcare are expected to be managed via non recurrent measures.

An unmitigated risk remains. This is mostly associated with elective recovery independent sector activity, where costs have been incurred but availability of funding to cover these costs is not yet certain.

ICP Financial Position - Place

NHS
North East &
North Cumbria

Financial Position at 'Place'	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
M4 - M12	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
North Cumbria Place	**56,757**	**56,757**	**(0)**	**510,815**	**510,815**	**0**
Newcastle Place	61,117	61,117	(0)	550,055	550,055	(0)
Gateshead Place	49,744	49,744	0	447,697	447,697	(0)
North Tyneside Place	33,678	33,678	0	303,100	303,100	0
Northumberland Place	51,739	51,739	0	465,645	465,645	0
North Area	**196,278**	**196,278**	**0**	**1,766,497**	**1,766,497**	**(0)**
County Durham Place	94,195	94,195	0	847,759	847,758	(0)
South Tyneside Place	27,459	27,459	(0)	247,132	247,132	0
Sunderland Place	48,398	48,398	(0)	435,582	435,582	(0)
Central Area	**170,053**	**170,053**	**0**	**1,530,473**	**1,530,473**	**(0)**
Tees Valley Place	**114,453**	**114,453**	**0**	**1,030,078**	**1,030,078**	**0**
Total ICB Programme Costs	**537,540**	**537,540**	**0**	**4,837,862**	**4,837,862**	**(0)**

Overall (Surplus)/Deficit

NHS North East & North Cumbria

Month 4 - July 2022	YTD Plan (Surplus) / Deficit	YTD Actual (Surplus) / Deficit	YTD Variance (Surplus) / Deficit	Annual Plan (Surplus) / Deficit	Forecast (Surplus) / Deficit	Forecast Variance (Surplus) / Deficit
	£000s	£000s	£000s	£000s	£000s	£000s
NENC Commissioner (ICB)						
Q1 CCG	1,336	(20,210)	(21,546)	1,336	(20,209)	(21,546)
Q2-Q4 ICB	(441)	(441)	0	(3,970)	17,576	21,546
Total Commissioner Position	**895**	**(20,651)**	**(21,546)**	**(2,633)**	**(2,633)**	**(0)**
NENC Providers	9,870	8,636	(1,234)	2,633	2,607	(26)
Total Provider Position	**9,870**	**8,636**	**(1,234)**	**2,633**	**2,607**	**(26)**
Total 22/23 Financial Position	**10,765**	**(12,015)**	**(22,780)**	**(0)**	**(26)**	**(26)**

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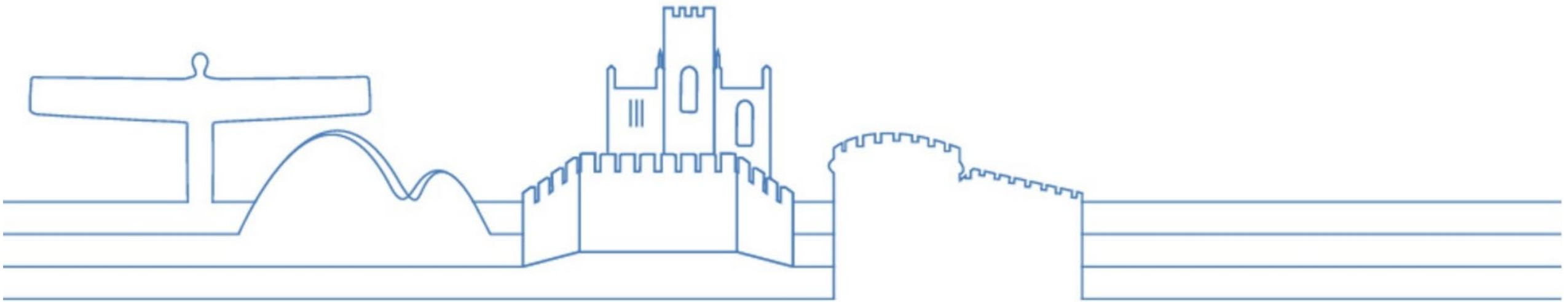
Appendices



Mental Health Core Data Monitoring Summary

NHS
North East & North Cumbria

Locality	CYP Access (1+ Contact)	A&E Waits of 12+ Hours (CYP)	CYP Eating Disorder Waiting Time - Urgent	CYP Eating Disorder Waiting Time - Routine	IAPT Access - All (Monthly)	IAPT Access - All (Rolling Quarter)	IAPT Recovery Rate	IAPT 6 Week Wait	IAPT 18 Week Wait	IAPT 1st to 2nd Treatment > 90 Days	IAPT Access: Older Persons	IAPT Recovery: White British	IAPT Recovery: BAME	Dementia Diagnosis Rate
County Durham	10,460	0	77.8%	35.5%	1,065	2,995	54.0%	100.0%	100.0%	26.0%	165	54.0%	53.0%	65.8%
Newcastle Gateshead	6,555	0	100.0%	58.1%	930	2,555	43.0%	97.0%	99.0%	21.0%	115	53.0%	43.0%	73.3%
North Cumbria	3,590	0	100.0%	53.2%	445	1,280	53.0%	100.0%	100.0%	5.0%	100	54.0%	54.0%	55.7%
North Tyneside	2,980	0	100.0%	89.6%	305	890	57.0%	95.0%	99.0%	66.0%	60	62.0%	54.0%	65.3%
Northumberland	4,740	0	87.5%	81.3%	775	1,455	53.0%	55.0%	99.0%	61.0%	120	51.0%	58.0%	58.5%
South Tyneside	3,875	0	100.0%	88.9%	380	1,035	50.0%	93.0%	100.0%	35.0%	85	57.0%	48.0%	68.1%
Sunderland	5,060	0	75.0%	88.1%	730	1,745	50.0%	99.0%	100.0%	63.0%	120	63.0%	67.0%	59.6%
Tees Valley	14,745	0	66.7%	77.3%	1,310	4,005	50.0%	59.0%	77.0%	46.0%	260	51.0%	49.0%	69.9%
NENC ICS	51,740	5	82.1%	67.2%	5,945	15,960	50.0%	87.0%	95.0%	36.0%	1,025	54.0%	49.0%	65.0%
North East & Yorkshire	118,229	0	71.0%	76.0%	16,287	47,852	51.0%	90.0%	98.0%	29.0%	3,024	53.0%	47.0%	64.0%
England	689,380	355	68.1%	68.9%	110,327	311,673	50.1%	88.8%	98.5%	23.6%	19,427	51.5%	47.9%	62.0%

Locality	Discharges Followed Up within 72 Hours	EIP Waiting Times - MHSDS	SMI Physical Health Checks	OAP Bed Days (Inappropriate)	OAP % External (Inappropriate)	Community MH Access (2+ Contacts)	Admissions with No Prior Contacts (All Patients)	Admissions with No Prior Contacts (White British)	Admissions with No Prior Contacts (BAME)	Adult Acute LOS (60+ Days)	Older Adult Acute LOS (90+ Days)	Individual Placement and Support	A&E waits 12+ Hours (Adults)	Perinatal Access (No. of Women)	Perinatal Access YTD
County Durham	93.0%	58.6%	2,391	155	100.0%	7,140	6.0%	5.0%	0.0%	6.3%	12.7%	105	40	445	205
Newcastle Gateshead	87.0%	75.0%	2,456	170	100.0%	4,820	19.0%	13.0%	41.0%	6.8%	14.4%	110	20	350	145
North Cumbria	89.0%	61.9%	1,242	225	100.0%	5,175	9.0%	8.0%	0.0%	9.8%	13.2%	55	15	205	65
North Tyneside	68.0%	64.7%	778	5	100.0%	1,495	20.0%	15.0%	0.0%	5.6%	11.9%	25	0	140	55
Northumberland	86.0%	50.0%	1,196	50	100.0%	3,470	12.0%	13.0%	0.0%	4.9%	0.0%	30	0	220	85
South Tyneside	83.0%	100.0%	1,022	45	100.0%	2,495	0.0%	0.0%	0.0%	6.7%	0.0%	40	0	90	45
Sunderland	92.0%	92.0%	1,332	185	100.0%	4,700	20.0%	20.0%	0.0%	3.6%	21.9%	40	10	160	65
Tees Valley	85.0%	70.4%	2,693	130	100.0%	5,825	13.0%	12.0%	0.0%	6.3%	13.8%	105	60	460	195
NENC ICS	87.0%	69.4%	13,110	960	100.0%	35,015	12.0%	10.0%	22.0%	6.2%	12.7%	500	145	2,045	860
North East & Yorkshire	80.0%	71.0%	36,213	7,875	100.0%	85,316	15.0%	13.0%	21.0%	7.0%	11.0%	1,065	500	5,637	1,971
England	75.0%	68.8%	227,076	54,090	99.5%	507,925	14.0%	12.0%	16.0%	8.7%	11.1%	7,970	4,360	44,967	16,555

Constitutional Standards – Sub ICB

NHS North East & North Cumbria

Constitutional Indicators - Sub ICB	Target	Period	NHS Newcastle Gateshead	NHS North Tyneside	NHS Northumberland	NHS South Tyneside	NHS Sunderland	NHS County Durham	NHS North Cumbria	NHS Tees Valley	National
Cancer Indicators											
% of patients seen within 2 weeks of an urgent GP referral for suspected cancer	93%	Jun-22	80.5%	85.3%	89.5%	85.3%	85.8%	79.3%	81.8%	66.4%	77.7%
		YTD	81.4%	86.4%	89.8%	86.4%	87.7%	81.8%	81.1%	70.6%	78.2%
% of patients seen within 2 weeks of an urgent referral for breast symptoms	93%	Jun-22	59.8%	81.8%	84.2%	81.8%	92.5%	89.8%	76.6%	82.3%	66.1%
		YTD	61.6%	86.1%	86.2%	86.1%	89.1%	86.7%	76.3%	86.4%	68.2%
% of patients treated within 62 days of an urgent GP referral for suspected cancer	85%	Jun-22	48.6%	78.4%	71.1%	78.4%	72.5%	70.3%	50.5%	51.9%	59.9%
		YTD	55.9%	76.1%	67.9%	76.1%	73.2%	65.5%	48.5%	63.2%	60.5%
% of patients treated within 62 days of an urgent GP referral from an NHS Cancer Screening Service	90%	Jun-22	50.0%	100.0%	50.0%	100.0%	87.5%	85.2%	41.7%	81.5%	67.1%
		YTD	66.7%	100.0%	58.1%	100.0%	92.0%	82.9%	46.7%	77.6%	68.1%
% of patients treated for cancer within 62 days of consultant decision to upgrade status	N/A	Jun-22	52.9%	85.7%	33.3%	85.7%	76.5%	86.7%	90.9%	79.2%	74.9%
		YTD	51.2%	88.0%	60.0%	88.0%	88.6%	83.3%	76.3%	82.4%	74.9%
% patients treated within 31 days of a cancer diagnosis	96%	Jun-22	86.7%	100.0%	84.0%	100.0%	98.2%	94.6%	86.1%	96.8%	91.8%
		YTD	87.7%	97.0%	86.8%	97.0%	96.7%	94.0%	89.0%	95.2%	91.8%
RTT											
% patients waiting for initial treatment on incomplete pathways within 18 weeks	92%	Jul-22	61.9%	67.5%	66.3%	67.5%	70.2%	64.1%	56.4%	62.8%	53.8%
		YTD	68.2%	76.0%	73.7%	76.0%	79.4%	71.6%	62.5%	70.3%	58.6%
Number of patients waiting more than 52 weeks for treatment	0	Jul-22	2,250	195	838	195	245	1,402	940	1,363	380,187
		YTD	2,250	195	838	195	245	1,402	940	1,363	380,187
Mixed Sex accomodation - number of unjustified breaches	0	Jul-22	0	0	1	0	1	8	13	6	3,088
		YTD	0	0	1	0	2	24	50	29	10,552
Diagnostics											
% patients waiting less than 6 weeks for the 15 diagnostic tests (including audiology)	99%	Jul-22	82.3%	88.8%	90.3%	88.8%	75.5%	85.7%	79.1%	75.6%	72.1%
Dementia											
Improve diagnosis rate for people with dementia	70%	Jul-22	73.4%	68.1%	58.6%	68.1%	60.1%	66.3%	55.7%	69.9%	62.0%
A&E											
% patients spending 4 hours or less in A&E or minor injury unit	95%	Jul-22	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Constitutional Standards - Provider

NHS North East & North Cumbria

Constitutional Indicators - Provider	Target	Period	Gateshead Health NHS Foundation Trust	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Northumbria Healthcare NHS Foundation Trust	South Tyneside & Sunderland NHS Foundation Trust	County Durham And Darlington NHS Foundation Trust	North Cumbria Integrated Care NHS Trust	South Tees Hospitals NHS Foundation Trust	North Tees and Hartlepool NHS Foundation Trust	National
Cancer Indicators											
% of patients seen within 2 weeks of an urgent GP referral for suspected cancer	93%	Jun-22	88.8%	75.6%	95.6%	88.2%	78.0%	81.6%	53.1%	81.6%	77.7%
		YTD	88.3%	77.9%	95.1%	90.3%	80.2%	80.9%	60.0%	82.9%	78.2%
% of patients seen within 2 weeks of an urgent referral for breast symptoms	93%	Jun-22	93.6%	57.3%	88.2%	n/a	79.7%	78.3%	72.7%	88.9%	66.1%
		YTD	95.9%	60.2%	89.6%	n/a	82.5%	77.7%	76.5%	90.0%	68.2%
% of patients treated within 62 days of an urgent GP referral for suspected cancer	85%	Jun-22	52.5%	49.1%	78.6%	74.8%	79.6%	55.1%	48.3%	56.9%	59.9%
		YTD	55.3%	56.6%	74.5%	74.9%	73.7%	49.1%	65.1%	60.8%	60.5%
% of patients treated within 62 days of an urgent GP referral from an NHS Cancer Screening Service	90%	Jun-22	93.1%	40.6%	77.8%	80.0%	66.7%	33.3%	86.7%	86.1%	67.1%
		YTD	94.2%	50.9%	56.4%	95.7%	69.2%	35.7%	58.6%	86.0%	68.1%
% of patients treated for cancer within 62 days of consultant decision to upgrade status	N/A	Jun-22	n/a	49.3%	54.5%	89.1%	75.0%	94.1%	74.4%	100.0%	74.9%
		YTD	88.9%	53.7%	69.2%	91.0%	70.1%	82.5%	84.0%	90.4%	74.9%
RTT											
% patients waiting for initial treatment on incomplete pathways within 18 weeks	92%	Jul-22	66.4%	61.7%	73.3%	70.3%	62.2%	54.8%	57.4%	70.6%	53.8%
		YTD	73.1%	68.3%	82.0%	79.6%	69.1%	60.8%	63.1%	78.3%	58.6%
Number of patients waiting more than 52 weeks for treatment	0	Jul-22	77	4,443	7	107	1,302	783	1,408	73	380,187
		YTD	77	4,443	7	107	1,302	783	1,408	73	380,187
Mixed Sex accomodation - number of unjustified breaches	0	Jul-22	0	0	0	0	4	13	17	0	3,088
		YTD	0	0	0	0	16	50	44	0	10,552
Diagnostics											
% patients waiting less than 6 weeks for the 15 diagnostic tests (including audiology)	99%	Jul-22	76.6%	85.8%	94.3%	80.5%	91.4%	79.0%	67.0%	78.8%	72.1%
Dementia											
Improve diagnosis rate for people with dementia	70%	Jul-22	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
A&E											
% patients spending 4 hours or less in A&E or minor injury unit	95%	Jul-22	77.5%	79.0%	89.5%	75.5%	69.4%	72.2%	68.1%	50.0%	63.7%

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REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	✓
Official: Sensitive Commercial		Provides assurance	
Official: Sensitive Personal		For information only	

BOARD 27 September 2022	
Report Title:	**Roadmap to place based working**

Purpose of report

This report sets out a roadmap for the development and agreement of place based working with local partners.

Key points

The government's Integration White Paper 'Joining Up Care for People, Places and Populations' has set out further expectations for place-based working by 2023. This includes strengthening local joint governance arrangements between Integrated Care Boards (ICBs) and local authorities, and the accountability for delivering of local shared plans. Formal place-based governance structures will need to enable agreement of shared outcomes, manage risk, and resolve disagreements – and how better use is made of existing structures and processes, including Health & Wellbeing Boards, the Better Care Fund, and pooled budgets.

In each of our fourteen places in North East and North Cumbria (NENC) we have begun to explore the governance options for place-based working set out in national guidance with our local government partners, with the aim of developing a mutually agreed governance roadmap with local partners to include the powers and resources delegated from the ICB (and local authority in the case of a joint committee).

The aim is to develop early proposals for consideration by the ICB and local authorities by November, with the option for shadow-running the proposed arrangements from January onwards, followed by a review in March ahead of formal adoption of local governance arrangements by April 2023.

Risks and issues

- The integration white paper 'Joining Up Care for People, Places and Populations' sets the expectations for place based working arrangements between partners to be in place in some form by April 2023. In order to achieve that ambition a roadmap to explore governance arrangements needs to be put in place.

Assurances

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- The Board will, through the Executive Directors of Place Based Delivery, be appraised of progress as partnerships develop.

Recommendation/Action Required	
The Board is asked to note the proposals below and the plans for place governance models roadmap to April 2023.	
Sponsor/approving director	David Gallagher, Executive Director of Place Based Delivery (Central and South) Nicola Bailey, Interim Executive Director of Place Based Delivery (North and North Cumbria)
Report author	Neil Hawkins, Head of Corporate Affairs

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues
Health and Care Act 2022 Integration White Paper 'Joining Up Care for People, Places and Populations'

Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	Additional resources may be required to support the placed based models to ensure new governance arrangements are established and supported. To be agreed as part of partnership discussions.
Has there been/does there need to be appropriate clinical involvement?	Clinicians involved locally in established partnerships.
Has there been/does there need to be any patient and public involvement?	Not at this stage.
Has there been/does there need to be partner and/or other stakeholder engagement?	Place stakeholders and statutory bodies concerned are engaged in the process.

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Roadmap to place based working

1. Introduction

The government's Integration White Paper 'Joining Up Care for People, Places and Populations' has set out further expectations for place-based working by 2023. This includes strengthening local joint governance arrangements between ICBs and local authorities, and the accountability for delivering of local shared plans. Formal place-based governance structures will need to enable agreement of shared outcomes, manage risk and resolve disagreements – and how to make use of existing structures and processes, including Health and Wellbeing Boards, the Better Care Fund and pooled budgets.

2. Background

Each place, or upper tier local authority footprint, has begun to explore the governance options for place-based working set out in national guidance, with the aim of developing a mutually agreed governance roadmap with local partners to include the powers and resources delegated from the ICB (and local authority in the case of a joint committee).

Discussions with partners were launched at an ICB event 24 June 2022, where partners from all of the local authority footprints came together with the ICB senior team at an event in Gateshead to discuss local priorities and to begin thinking about the approach they wanted to take.

Following this session, the key points of discussion, next steps and the timeline included in this paper were shared with participants (included in appendix 1).

3. Main Issue

The aim is to develop early proposals for consideration by the ICB and local authorities by November, with the option for shadow-running the proposed arrangements from January onwards, followed by a review in March ahead of formal adoption of local governance arrangements by April 2023.

Elected members as democratically elected representatives will hold a key role in setting local and region-wide priorities and leading how health and care will work together going forward, through their role on both the Integrated Care Board and the Integrated Care Partnerships, alongside their ongoing role on Health and Wellbeing Boards and local scrutiny committees.

Many of our places already have established some form of placed based partnership that can evolve over time to take on more decision making responsibility as the partnership arrangements develop.

The government's 'Thriving Places' guidance illustrates some potential governance models that places can consider. For example:

- A place-based **Consultative Forum**, with a broad membership, which would act in an advisory capacity to the Executive Directors of Place-Based Delivery but could not make binding decisions

- A formal **Place Committee of the ICB**, coterminous with a single local authority (or group of neighbouring local authorities), with formal delegation of NHS resources and a direct line of reporting and assurance to the ICB. The chair and members of such a committee could include ICB staff and a range of partners but they would be accountable to the ICB. Such a committee could not make decisions on behalf of other bodies.

- A **Joint Committee**, coterminous with a single local authority (or group of neighbouring local authorities), allowing collective decisions to be made within its scope of authority on behalf of a number of organisations – for example, the ICB and one or more local authorities. Such a committee would have a direct line of reporting and assurance to both the ICB and the other constituent statutory bodies, requiring agreement by all parties to the level of delegated authority or statutory decisions set out in a formally approved MOU. Such a joint committee would allow for multi-agency decision-making and delegation of resources, which could more effectively address the wider determinants of health and wellbeing.

  Whichever of these or other governance models are chosen, one key task is to be clear on the remit of these committees (for example, would they include children's services alongside adult social care), as well as their relationship to their local Health and Wellbeing Boards and other relevant local multi-agency forums, including Safeguarding Boards.

  For all of these options a minimum core membership is proposed to include:

  - A jointly appointed chair
  - Senior ICB officers
  - Local Authority senior officers, covering the disciplines of public health and adults' and children's social care
  - Local clinicians, covering primary, community and secondary care
  - Senior officers from local Foundation Trusts
  - The voluntary sector
  - Patient, service user and public voice

4. Next steps

As mentioned above, many of the fourteen places in NENC have established partnerships to build upon, with strong working relationships developed and working well.

ICB place based teams are working with local partners to develop a plan for the further development of these forums or committees, including the approvals required from statutory decision-makers prior to their establishment, the emerging shared local priorities for each committee, and any resourcing requirements to ensure these committees have the necessary capacity to deliver their objectives.

Each place has been asked to consider these issues and to develop an outline plan for the development of their preferred local governance arrangement by early October to enable the ICB and local authorities to consider how to move forward together on implementation ahead of January 2023.

These governance arrangements can and will develop as the partnership arrangements mature and the model chosen for April 2023 will mark the beginning of those formal governance arrangements that may evolve over time.

Name of Author: Neil Hawkins, Head of Corporate Affairs

Name of Sponsoring Director: **David Gallagher, Executive Director of Place Based Delivery (Central & South)**
Nicola Bailey, Interim Executive Director of Place Based Delivery (North & North Cumbria)

Date: 07 September 2022

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North East and North Cumbria joint NHS and LA workshop event
Working together for healthier and happier lives - 24 June 2022
Feedback and Next Steps

1. Executive Summary

Over 180 people attended a half-day workshop with representatives from Local Authorities, the NHS, Voluntary and Community Sector, Healthwatch and universities from across the North East and North Cumbria. Alongside a keynote from our chair, Professor Sir Liam Donaldson on the opportunities of working together as an Integrated Care System (ICS), presentations were given on the Integrated Care Board (ICB) and its operating model, the completion of the work PWC started with the ICS before the pandemic on our ICS vision and strategy, the role of the Integrated Care Partnership in identifying our shared priorities and developing our integrated health and care strategy, and how our ICB teams in each place will be working with you during this transition year.

This was followed by table-based discussions on key questions, including what should be included in the strategic priorities of the ICS, through to what does 'place-based working' mean and what principles should drive the development of our joint working arrangements.

Following the work of the Joint Management Executive Group (JMEG), where senior leaders from across the NHS and local authorities came together to oversee key objectives in the formation of the ICB as a statutory body – including the ICB's constitution, the composition of the board and delegation of key ICB's functions to each of the thirteen local authority 'places' – we are now focused on working with our partners on the next set of key deliverables for our ICS.

These are:

- The formation and membership of our strategic **Integrated Care Partnership** (ICP), and its relationships with our four locally-focussed ICPs
- The joint development of our **Integrated Care Strategy** through the ICP, which the ICB and all of the local authorities in our ICS area must have regard to in making decisions.
- The development of formal **place-based governance arrangements** between the ICB and local authorities
- Take forward the 8 actions PWC shared with us (see Appendix 1)

We will be working closely with your teams on these over the coming months, with the first meeting of the ICP meeting scheduled for 20 September, which will receive recommendations from a multi-agency working group on the formulation of our Integrated Care Strategy.

We have also a proposed programme of work for developing place-based governance which are set out in detail from page 5 of this paper, but the key next steps here will be contact from our Executive Directors of Place-Based Delivery to arrange local discussions on your preferred model of place governance, with a view to agreeing outline proposals with you by October 2022 and these discussions have already commenced.

2. Key feedback themes from the 24 June workshop

Grouped into place-based teams, each coterminous with our thirteen Local Authority areas, attendees engaged in a range of discussions from the strategic intent of the ICS through to what does 'place-based working' mean and what principles should drive the development of our joint working arrangements. A rich discussion followed, and we have captured the key themes in the following 'word clouds' for each of the questions we asked. This feedback has been incredibly important in the

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ongoing development of our Integrated Care Strategy, ICS operating model, and place-based working arrangements.

The top priorities from this discussion included:

- Population health, prevention and tackling health inequalities
- A shared workforce plan
- Managing access and demand
- Managing our collective resources
- Developing a culture of working together

Top priorities from this discussion included:

- Sharing best practice
- Reducing variation
- Freedom to act locally
- Agility in decision making

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Top priorities from this discussion included:

- Having a clear purpose
- Ensuring patient voice is front and centre in our developing plans
- Being clear on what is delegated
- Autonomy to act
- Flexibility within the system

Top priorities from this discussion included:

- Transparency and accountability
- Ensuring plans are needs based
- Ensuring the voice of the communities we serve are referenced within the plans
- Ensuring we have robust governance arrangements in place

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Top priorities from this discussion included:

- Ensuring teams have the resources to deliver what is required
- Ensuring the system works flexibly and teams have the space and time to do what is required
- Sharing agreements and joint appointments
- Using data intelligently

3. How we are using this feedback

This feedback has been useful to support the ongoing development of our ICS. This has included our emerging shared strategic priorities and how the role of the locally focussed ICPs can add value to place and system working (which will be considered at the first meeting of the ICP), and how we can further clarify our place-based governance arrangements to ensure they are fit for purpose.

Since the workshop we have met a series of important milestones, and have scheduled a series of further meetings through which we will take these key themes forward:

- The first board meeting of the **Integrated Care Board** took place on 1 July at Sunderland City Hall – you can watch this meeting here Board meeting held in public: Friday 1 July 2022 | North East and North Cumbria NHS (northeastnorthcumbria.nhs.uk)
- All of the ICB executive directors are now in place, as well as the appointment of place directors aligned to each of our local authority areas. There are two vacancies for place directors and these are being recruited to with input from our partners.
- The first meeting of our strategic **Integrated Care Partnership** has been scheduled for the 20 September and invitations have now gone out to all thirteen of our local authorities, who, with the ICB itself, form the statutory membership of the ICP. At this first meeting partners will decide chairing and governance arrangements for the ICP, and how we best develop an Integrated Care Strategy built up from our existing Joint Strategic Needs Analyses in each of our places, and the work of colleagues including the North East and North Cumbria Directors of Public Health network.
- Work is ongoing with regards to the formulation of the **Integrated Care Strategy** and a regional oversight group has been set up with representatives from across the health and care sector. Leading this work is Jacqueline Myers, Executive Director of Strategy and System Oversight. Over the coming months there will be opportunities for all partners to influence this developing strategy.
- We are also taking steps to coproduce our collective approach to **Building a Learning and Improvement System**. An event is planned for 21 September to start this work and invitations to participate in this session have gone out to all partners.

4. The governance of place-based working

Formalising the governance of our place-based working arrangements is a key task for us to work on with you during this important transition year. The ICB has delegated responsibility for the delivery of its place-based functions and relevant budgets through two Executive Directors of Place Based Delivery whose roles are described in our ICB Operating Model.

These functions are set out in the 'Functions and Decisions Map' which forms part of the ICB's Constitution and set out how our ICB place-based teams will:

- Develop and agree a plan to meet the health and healthcare needs of the local population
- Plan and commission services (to include developing business cases and procurement strategies), in line with the ICB's scheme of delegation and delegated financial limits.
- Commission local primary care services (excluding nationally negotiated GP contracts)
- Develop local clinical leadership, including clinical pathway redesign and helping to shape the commissioning of acute services.
- Build strong relationships with communities, the wider local system including Healthwatch, the Voluntary Sector, and other local public services.
- Foster service development and delivery with a focus on neighbourhoods and communities, ensuring local engagement and consultations are undertaken as necessary.
- Monitor local service quality and the place-based delivery of key enabling strategies as agreed by the ICB Board or Executive Committee.
- Monitor and deliver target outcomes and outputs set by the Secretary of State, NHS England, NICE, CQC and other authorised bodies and providing assurance to the ICB on progress.

In addition, ICB place-based teams will play a key role in the formal place-based joint working arrangements between the NHS and Local Authorities, and they will continue to:

- Coordinate NHS input into local partnership initiatives to improve public health, prevent disease and reduce inequalities.
- Fulfill the NHS's statutory health advisory role in adults' and children's safeguarding.
- Jointly commission local integrated community-based services for children and adults (including care homes and domiciliary care), including:
  - Continuing health care
  - Personal health budgets
  - Community mental health, learning disability and autism
  - Children and young people's services (including transitions, Special Educational Needs and Disabilities, Looked After children)
  - Service integration initiatives and jointly funded work through, e.g. the Better Care Fund and Section 75 agreements.

Our two Executive Directors and their place-based ICB teams will manage the operational delivery of the ICB's functions, and the ongoing joint work we need to carry on in each of our local authority areas. Business continuity during this transition period is vital and our teams are working closely with our partners to avoid disruption and maintain business as usual.

5. Place governance options

The government's Integration White Paper 'Joining Up Care for People, Places and Populations' has set out further expectations for place-based working by 2023. This includes strengthening local joint governance arrangements between ICBs and local authorities, and the accountability for delivering of local shared plans. Formal place-based governance structures will need to enable how we agree shared outcomes, manage risk and resolve disagreements – and how we make use of existing structures and processes, including Health & Wellbeing Boards, the Better Care Fund and pooled budgets.

Our Executive Directors of Place-based Delivery will work with each place to explore the governance options for place-based working set out in national guidance, then develop a mutually agreed governance roadmap with you to include the powers and resources delegated from the ICB (and local authority in the case of a joint committee). Our aim is to develop early proposals for consideration by the ICB and local authorities by November, with the option for shadow-running the proposed

arrangements from January onwards, followed by a review in March ahead of formal adoption of local governance arrangements by April 2023.

Elected members as democratically elected representatives will hold a key role in setting local and region-wide priorities and leading how health and care will work together going forward, through their role on both the Integrated Care Board and the Integrated Care Partnerships, alongside their ongoing role on Health and Wellbeing Boards and local scrutiny committees.

We have identified some key questions that each of our thirteen places need to consider, and our Executive Directors and their teams will be in touch as soon as possible to arrange facilitated discussions on the following issues:

Of the governance models set out in the government's 'Thriving Places' guidance, and building on what you may already have in place, which is the preferred option for your place-based partnership?

For example:

- A place-based **Consultative Forum**, with a broad membership, which would act in an advisory capacity to the Executive Directors of Place-Based Delivery but could not make binding decisions.

- A formal **Place Committee of the ICB**, coterminous with a single local authority (or group of neighbouring local authorities), with formal delegation of NHS resources and a direct line of reporting and assurance to the ICB. The chair and members of such a committee could include ICB staff and a range of partners but they would be accountable to the ICB. Such a committee could not make decisions on behalf of other bodies

- A **Joint Committee**, coterminous with a single local authority (or group of neighbouring local authorities), allowing collective decisions to be made within its scope of authority on behalf of a number of organisations – for example, the ICB and one or more local authorities. Such a committee would have a direct line of reporting and assurance to both the ICB and the other constituent statutory bodies, requiring agreement by all parties to the level of delegated authority or statutory decisions set out in a formally approved MOU. Such a Joint Committee would allow for Multi-agency decision-making and delegation of resources, which could more effectively address the wider determinants of health and wellbeing.

Whichever of these or other governance models are chosen, we would ask each place to consider the remit of these committees (for example, would they include children's services alongside adult social care), as well as their relationship to their local Health and Wellbeing Boards and other relevant local multi-agency forums, including Safeguarding Boards.

For all of these options we would look for a minimum core membership to include:
- A jointly appointed chair
- Senior ICB officers
- Local Authority senior officers, covering the disciplines of public health and adults' and children's social care
- Local clinicians, covering primary, community and secondary care
- Senior officers from local Foundation Trusts
- The voluntary sector, especially local infrastructure bodies
- Patient, service user and public voice

6. Next steps

Our Executive Directors of Place-Based Delivery will work with you and other key partners to develop a plan for the development of these Committees, including the approvals required from statutory decision-makers prior to their establishment, the emerging shared local priorities for each committee, and any resourcing requirements to ensure these committees have the necessary capacity to deliver their objectives.

We would like each place to consider these issues and to develop an outline plan for the development of your preferred local governance arrangement by the early October to enable the ICB and local

authorities to consider how we move forward together on implementation ahead of January 2023.

Implement the eight actions PWC recommended be taken forward by the ICS.

19 August 2022

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REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	✓
Official: Sensitive Commercial		Provides assurance	
Official: Sensitive Personal		For information only	

BOARD 27 September 2022	
Report Title:	Risk Management Strategy

Purpose of report

To seek approval of the risk management strategy for the North East and North Cumbria Integrated Care Board (the ICB).

Key points

The attached strategy sets out the ICB's approach to risk and the management of risk in fulfilment of its overall objectives. The principles are consistent with those within the NHS England's (NHSE) risk management framework and risk management policy issued in 2019.

The strategy sets out the ICB's risk management framework for how risk management will be implemented throughout the organisation to support the realisation of its strategic objectives. This includes the processes and procedures adopted by the ICB to identify, assess and appropriately manage risks and detailed roles and responsibilities for risk management.

The adoption and embedding within the organisation of an effective risk management framework and processes will ensure that the reputation of the ICB is enhanced and maintained, and its resources are used effectively to ensure business success, continuing financial strength and continuous quality improvement in its operating model.Through this strategy, the ICB is keen to ensure that risk management is not seen as an end in itself, but rather a part of an overall management approach that supports the organisation in developing achievable management action.

The strategy reflects the key points from the risk management policies used by the former CCGs, current national NHS guidance and has been updated to reflect best practice. It is supported by a standard operating procedure.

The Executive Committee reviewed the strategy at its meeting on 12 July and recommended its approval.

Risks and issues

No risks or issues identified in relation to the strategy.

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Assurances
The strategy has been developed in line with national guidance and best practice.

Recommendation/Action Required
The Board is asked to: • Note the Executive Committee recommendation for approval; • Formally ratify the risk management strategy.

Sponsor/approving director	Claire Riley, Director of Corporate Governance, Communications and Involvement
Report author	D Cornell, Board Secretary W Marley, Governance and Assurance Manager, North of England Commissioning Support

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues
Health and Care Act 2022

Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**	✓	**No**		**N/A**	
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	None identified.
Has there been/does there need to be appropriate clinical involvement?	None identified.
Has there been/does there need to be any patient and public involvement?	None identified.

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Has there been/does there need to be partner and/or other stakeholder engagement?	None identified.

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North East and North Cumbria

Corporate	ICBP037 Risk Management Strategy

Version Number	Date Issued	Review Date
V1.4	July 2022	July 2024

Prepared By:	Governance Manager, North of England Commissioning Support Unit.
Consultation Process:	ICS Integrated Governance Workstream
Formally Approved:	July 2022
Approved By:	Executive Committee

EQUALITY IMPACT ASSESSMENT

Date	Issues
June 2022	None

STRATEGY/POLICY VALIDITY STATEMENT

Strategy/policy users should ensure that they are consulting the currently valid version of the documentation. The strategy/policy will remain valid, including during its period of review. However, the strategy/policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net

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Version Control

Version	Release Date	Author	Update comments
1.4	July 2022	Governance Manager, NECS	Not Applicable

Approval

Role	Name	Date
Reviewed by	ICB Executive Committee	12 July 2022
Approved by	ICB Board	tbc

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Contents

1. Introduction

For the purposes of this strategy, NHS North East and North Cumbria Integrated Care Board will be referred to as "the ICB".

The strategy sets out the ICB approach to risk and the management of risk in fulfilment of its overall objectives. The principles are consistent with those within the NHS England's (NHSE) risk management framework and NHSE's risk management policy issued in 2019. The adoption and embedding within the organisation of an effective risk management framework and processes will ensure that the reputation of the ICB is enhanced and maintained, and its resources are used effectively to ensure business success, continuing financial strength and continuous quality improvement in its operating model.

As part of this strategy, it is also acknowledged that not all risks can be eliminated. Ultimately it is for the organisation to decide which risks it is prepared to accept based on the knowledge that an effective risk assessment has been carried out and the risk has been reduced to an acceptable level as a consequence of effective controls.

At its simplest, risk management is good management practice and risk assessment provides an effective management technique for managing the organisation (through the identification of risks and the development of mitigating action). Through this strategy the ICB is keen to ensure that risk management is not seen as an end in itself, but rather a part of an overall management approach that supports the organisation in developing achievable management action.

1.1 Status

This strategy is a corporate strategy.

1.2 Purpose and scope

The purpose of this strategy is to provide a support document to enable staff to undertake effective identification, assessment, control and action to mitigate or manage the risks affecting the normal business.

The strategy sets out an organisation wide approach to managing risk, in a simple, straightforward, clear manner and the intentions of the ICB for timely, efficient and cost-effective management of risk at all levels within the organisation.

The strategy aims to:

- Ensure that risks to the achievement of the ICB'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 ICB is committed to managing risk appropriately

- Protect the services, staff, reputation and finances of the ICB through the process of early identification of risk, risk assessment, risk control and elimination.

This strategy applies to all employees and contractors of the ICB.

Managers at every level have an objective to ensure that risk management is a fundamental part of the approach to integrated governance. All staff at every level of the organisation is required to recognise that risk management is their personal responsibility.

NHS providers and independent contractors are responsible for ensuring compliance with relevant legislation and best practice guidelines and for the development and management of their own procedural documents.

Independent contractors are also required to demonstrate compliance with risk management processes which are compatible with this strategy.

2. Definitions of risk

The strategy is based on the following definitions:

- **Risk** is the chance that something will happen that will have an impact on the achievement of the ICB objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and consequence (impact or magnitude of the effect of the risk occurring)

- **Risk appetite** is the organisation's unique attitude towards risk taking that in turn dictates the amount of risk that it considers acceptable

- **Risk management** is the systematic application of management policies, procedures and practices to the tasks of identifying, analysing, assessing, treating and monitoring risk

- **Risk assessment** is the process used to evaluate the risk and to determine whether precautions are adequate or more should be done. The risk is compared against predetermined acceptable levels of risk

- **Risk response** is the process of doing everything possible to reduce the likelihood and/or impact of a risk towards zero. This process involves minimising the likelihood, eliminate completely, transferring the risk or partially treating the risk by mitigating actions to reduce the harm should it materialise

- **Residual risk** is the risk remining after the risk response has been applied

- **Target risk** is an indication of whether following existing or planned mitigating actions will result in the risk falling within acceptable levels for the organisation or

if there is a desire to reduce the risk further and that additional work will likely be required beyond that already in place or planned.

2.1 Examples of risk

Examples of the types of risk that the ICB might encounter and need to mitigate against include:

- **Corporate risks** – operating within powers, fulfilling responsibilities, ensuring accountability to the public, governance issues.

- **Clinical risks** – associated with our commissioning responsibilities and including service standards, competencies, complications, equipment, medicines, staffing, patient information.

- **Reputational risks** – associated with quality of services, communication with public and staff, patient experience.

- **Financial** – associated with achievement of financial targets, commissioning decisions, statutory issues and delivery of the QIPP programme.

- **Environmental including health and safety** – ensuring the well-being of staff and visitors whilst using our premises.

3. Approaches to risk management: principles, aims and objectives

The strategy sets out the ICB's approach to the way in which, in general terms, risks are managed. This will be achieved by having a thorough process of risk assessment in place. It will provide a useful tool for the systematic and effective management of risk and will inform and guide staff as to the way in which all significant risks are to be controlled.

The strategy will:

- Ensure that risks to the achievement of ICB's objectives are understood and effectively managed

- Maintain a risk management framework to assure the ICB that strategic and operational risks are being effectively managed

- Ensure that risk management is a cohesive element of the internal control systems within the ICB's corporate governance framework

- Ensure that risk management is an integral part of the ICB culture and its operating systems

- Ensure that the ICB meets its statutory obligations including those relating to health and safety and data protection

- Assure all stakeholders, staff, and partner organisations that the ICB is committed to managing risk appropriately.

To achieve this, the ICB is committed to ensuring that:

- Risk management is embedded as an integral part of the management approach to the achievement of objectives

- The management of risk is seen as a collective and individual responsibility, managed through the agreed committee and management structures

- Patient feedback, complaints and staff feedback are used as an integral part of the approach to risk management

- Risk management support, training and development will be provided by the Commissioning Support Unit Governance Team.

4. Risk management framework

This strategy sets out the ICB's risk management framework for how risk management will be implemented throughout the organisation to support the realisation of the strategic objectives. This includes the processes and procedures adopted by the ICB to identify, assess and appropriately manage risks and detailed roles and responsibilities for risk management.

4.1 Risk assessment

Whenever risks to the achievement of ICB's objectives have been identified, it is important to assess the risk so that appropriate controls are put in place to eliminate the risk or mitigate its effect. To do this, a standard risk assessment matrix is used, details of which are provided in appendix 2 of this strategy.

This risk matrix is based on current national guidance which has been adapted to suit the ICB's agreed risk appetite. Using this standardised tool will ensure that risk assessments are undertaken in a consistent manner using agreed definitions and evaluation criteria. This will allow for comparisons to be made between different risk types and for decisions to be made on the resources needed to mitigate the risk.

Risks are assessed in terms of the likelihood of occurrence/re-occurrence and the consequences of impact. An initial risk rating is applied to the risk based on current controls. An action plan should be developed based on any gaps identified in putting control measures in place.

The risk action plan will identify further mitigating action to ensure adequate controls are in place. Risks are reassessed to take account of the effectiveness of the controls i.e. whether they are considered to be satisfactory, have some weaknesses or to be weak. Reassessment will determine a residual risk rating.

4.2 Categories of risk**:**

- Very high – the consequence of these risks could seriously impact upon the achievement of the organisations' objectives, its financial stability and its reputation. Examples include loss of life, extended cessation or closure of a service, significant harm to a patient(s), loss of stakeholder confidence, failure to meet national targets and loss of financial stability

- High – these are significant risks that require prompt action. With a concerted effort and a challenging action plan, the risks could be reduced within a realistic timescale

- Moderate – these risks can be reduced within a realistic timescale through reasonably practical measures, such as reviewing working arrangements, purchase of small pieces of new equipment, raising staff/patient awareness etc. These risks should be managed through the existing line management arrangements

- Low – these risks are deemed to be low level or minor risks which can be managed and monitored within the individual department

- Negligible (very low) – these risks cause minimal or limited harm or concern.

Once the category of risk has been identified, this will be entered onto the ICB's risk register. Please refer to 'section 7' below for further guidance on risk registers.

Any risk identified through the risk assessment process (or the incident reporting process), which the ICB is required legally to report, will be reported accordingly to the appropriate statutory body, e.g. Health and Safety Executive or Information Commissioner.

4.3 Degrees of control

The ICB can exert different levels of control or influence over risks depending on their source and type. Some risks can be largely mitigated or eliminated, however not all types of risk can be adequately or effectively dealt with in this manner. The risk management process will therefore be tailored to different risks depending on the perceived level of control and to some degree the risk appetite (how much more control to exert).

The ICB predominantly focuses on risks that are fully or partially within its sphere of control or influence (financial, operational, regulatory, compliance and strategic risks). However, there may be occasion where the source of a risk event threatening objectives is external. The ICB cannot prevent such external events from occurring and therefore management efforts will focus on the identification and mitigation of their impact, for example by putting contingency plans in place where significant external risks are identified.

The categories of control are as follows:

Risk category	Description
Category A: Full control	Preventable internal risks that can be controlled by the ICB (e.g. Health and Safety or payment processing)
Category B: Partial control	Strategic risks taken on by the organisation to achieve its corporate objectives. These risks may be partially within the control of the ICB (e.g. the risk associated with transformational change, or from investment in new sector improvement initiatives).
Category C: Limited or no control	External risk events and/or system-wide risks largely beyond the sole control or influence of the ICB. Examples may be the increasing risk of political uncertainty (i.e. EU Exit), a terrorist event or natural disaster; or from risk interdependencies across the wider health and social care system.

4.4 Fraud, bribery and corruption risks

The ICB recognises the risk that fraud, bribery and corruption pose to its resources. This risk is included in the corporate (strategic) risk register with an appropriate internal risk owner identified. Operational management and recording of detailed fraud, bribery and corruption risks will be carried out by the ICB's counter fraud provider and as agreed in the counter fraud workplan and using a fraud risk planning tool. Regular meetings will be held between key ICB staff and the counter fraud specialist to review existing and emerging risks. Regular reports will be provided to the Audit Committee or equivalent to ensure effective executive and non-executive level monitoring of fraud, bribery and corruption risks.

4.5 Risk management process as a commissioner

As the ICB focuses on its role as a commissioner of safe and high-quality services, it seeks to embed the principles and practice of risk management into its commissioning function. As a commissioner, the ICB seeks to ensure that all services commissioned meet nationally identified standards which are managed through the contracting process. Risk management within commissioning is regularly reported through the quality processes on behalf of the ICB.

4.6 Partnership working

The ICB may establish partnership working relationships with other agencies, including but not limited to other NHS organisations, local authorities, the voluntary sector, patient representatives and other ICBs.

In some cases, these arrangements will be intended to manage and reduce risk across the wider health and social care economy, for example arrangements around safeguarding. However, in other cases the existence of joint working

arrangements may pose challenges that need to be managed to ensure that objectives can be delivered.

Where such partnership arrangements exist, the ICB will ensure that they work closely and collaboratively with partners to ensure that risk management is fully integrated into joint working arrangements and to identify any risks that need to be captured and reported within the ICB's internal processes.

5. Risk appetite

The ICB aims to reduce risks to the lowest possible level reasonably practicable. Where risks cannot reasonably be avoided, every effort will be made to mitigate the remaining risk. However, there is the recognition that understanding the organisation's 'risk appetite' will ensure the ICB supports a varied and diverse approach to commissioning.

Risk appetite is the amount of risk that the organisation is prepared to accept, tolerate, or be exposed to at any point in time. It can be influenced by personal experience, political factors, and external events. Risks need to be considered in terms of both opportunities and threats and the consequent impact on the capability of the ICB, its performance, and its reputation.

6. Risk tolerance

Risk tolerance is the threshold level of risk exposure which, when exceeded, will trigger an escalation to bring the situation to the attention of a senior manager.

Any risks with a residual score of 12 or above (i.e. high or very high risk) should be escalated to the responsible ICB Executive Lead and immediately added to the ICB corporate risk register in order for the Audit Committee or equivalent to review and monitor the risk.

Moderate risks with a score between 8 and 10 will be managed and monitored at a directorate or place-based level.

Low risks with a score of 6 or lower will be managed and monitored at team level.

Any risks of concern even if not scoring as a high risk can be highlighted to the Audit Committee or for escalation to the ICB.

7. Risk register

Current and potential risks are captured in the ICB's risk register and include actions and timescales identified to minimise such risks. The risk register is a log of risks that threaten the organisation's success in achieving its aims and objectives and is populated through the risk assessment and evaluation process.

The register contains a record of current and potential risks to the achievement of the corporate objectives as identified. The register is updated and reviewed on a quarterly basis at a minimum as requested by the ICB.

7.1 Corporate risk register

The ICB maintains a corporate risk register, which is a management tool to provide it with an overview of all significant 'live' risks facing the organisation and the action being taken to reduce them. The corporate risk register is underpinned by place-based risk registers, used to monitor and manage risks at a place-based level within the organisation.

The risks included within the corporate risk register are varied and cover the entirety of the ICB's activities, from health and safety risks to risks around the delivery of services and achieving financial balance. The corporate risk register is therefore populated from a number of different sources, including:

- Principal risks identified in the assurance framework in relation to corporate objectives where action needs to be taken to close an identified gap in control measures
- Risks identified by the ICB and via committee risk registers as being high or very high and requiring escalation to the Audit Committee
- Risks that have been identified at a place-based level that require escalation to the ICB
- Any risks arising out of the annual operating framework and the development of related action plans
- Risks identified through evaluation of incident and complaints reporting
- Risks identified through the evaluation of national incident reports.

The corporate risk register is a live document, maintained on an on-going basis by the governance lead and regular reports are provided to the ICB and relevant committees. The risk register is reviewed by the Audit Committee at least quarterly, or more frequently as required, with issues escalated to the governing body as appropriate.

Each place is responsible for maintaining its own place-based risk registers, ensuring monthly updating and reports to relevant committee as outlined in the ICB constitution. Each place-based risk register underpins the corporate risk register and records all relevant risks facing each place, along with supporting action plans to mitigate these as far as possible.

Risks within the place-based risk registers that have been assessed as being high or extreme and meet the criteria for escalation will be escalated to the corporate risk register and included for review as part of this are cascaded to the Audit Committee monthly (or more frequently if it is required) for consideration around inclusion within the corporate risk register.

8. Risk Materialisation

If a risk materialises whilst being managed through the risk register, it should be recorded as an incident as per the agreed ICB process. Management of risks and incidents is interdependent since risks can be identified through the monitoring of incident themes and trends. If a particular type of incident continues to occur, this is an indication that there is a risk that requires management through the risk register.

If a risk materialises whilst being managed through the risk register, it should be considered whether it needs removing from the risk register. Reasons for occurrence should be analysed and evidence established as to whether a trend of similar incidents exists, that need to be managed through the risk register. If the risk is certain to materialise again or has the potential to re-occur, the risk should remain open on the risk register for on-going management in order to ensure that underlying causes are addressed. If there is no chance it could happen again, the risk should be closed with an explanation that the incident management process is being followed in order to invoke actions to deal with consequences.

The risk that has materialised should be recorded as an incident as per the ICB's incident reporting and management policy.

9. Assurance framework

All government departments, including NHS organisations, are required to provide an annual assurance statement that they have robust systems in place across their organisation to manage risk. This assurance forms part of the organisation's statutory accounts and annual report.

In order to produce an annual assurance statement as part of the annual report, the Board must be able to demonstrate that they have been kept properly informed about the risks facing the organisation and has received assurances that these risks are being managed in practice, including that any gaps in controls intended to manage risks have been identified and action taken to address them. The Board will be able to demonstrate that it has met this requirement through the establishment of a robust and formal assurance framework.

Together with this strategy and the risk register, the assurance framework is the key document used by the Board to monitor the position in relation to risk management, providing it with a sound understanding of not only the key risks facing the organisation but also the action being taken to manage and reduce them.

The assurance framework is firmly connected to the organisation's principal objectives as set by the Board, and is a live document, maintained on an on-going basis by the governance lead. The assurance framework is monitored by the Audit Committee and Board on a six monthly basis.

The assurance framework sets out:

- the organisation's principal objectives
- any significant risks that may threaten the achievement of those objectives (detailed in the supporting strategic risk register)
- the key controls intended to manage these risks
- the assurance available to demonstrate that controls are working effectively in practice to manage risks together with the source of that assurance. any areas where there are gaps in controls and/or assurances; and how the organisation plans to take corrective action where gaps have been identified in either controls or the assurances available.

10. Implementation

This strategy will be available to all staff to use through the public website for the ICB. It will also be available from the Executive Director of Corporate Governance, Communications and Involvement. All directors and managers are responsible for ensuring that relevant staff within their own directorates and teams have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

11. Training Implications

The Chief Executive (supported by the Executive Director of Corporate Governance, Communications and Involvement) will ensure that the necessary training or education needs and methods needed to implement this strategy and supporting procedure(s)are identified and resourced as required. This may include identification of external training providers or development of an internal training process.

Regular training is key to the successful implementation of this strategy and embedding a culture of risk management in the organisation. Through a robust training and education programme staff will have the opportunity to develop more detailed knowledge and appreciation of the role of risk management.

Staff are expected to undertake training every two years as a minimum requirement. Training and education in risk management will be offered through regular staff induction programmes and a rolling programme of risk management and training programmes.

12. Documentation

Other related policy documents:

- Incident reporting and management policy

Legislation and statutory requirements:

- NHS England Risk Management Policy 2017
- NHS England Risk Management Framework 2019
- Health & Safety: Policy & Corporate Procedures NHS England 2015
- NHS England Business Continuity Management Framework 2016
- Data Protection Act 2018
- Data Security and Protection toolkit
- General Data Protection Regulation (GDPR) 2016.

Best practice guidance:

- NHS Audit Committee Handbook, 4th edition (2018)
- The Healthy NHS Board: Principles for Good Governance (2013)
- Building the Assurance Framework: A practical guide for NHS Boards March 2003. Gate log Reference1054

13. Monitoring, review and archiving

13.1 Monitoring

The ICB will review the strategy in accordance with the specified review date, unless legislation or new guidance to ensure it continues to be compliant with good practice.

Risk management assurance will be reported to the appropriate ICB committee via the governance assurance report. Senior leads will ensure that teams review their risk registers on a quarterly basis (or within individually agreed review times).

The ICB's internal auditors carry out an annual audit of governance and risk management. The effectiveness of the ICB's controls in relation to risk is considered as part of this audit, the outcome of which is reported to Audit Committee. .

13.2 Review

The ICB will ensure that this strategy document is reviewed in accordance with the specified review date. No strategy will remain operational for a period exceeding two years without a review taking place.

Staff who become aware of any change which may affect the strategy should advise the Executive Director of Corporate Governance, Communications and Involvement who will then consider the need to review the strategy or procedure outside of the agreed timescale for revision. For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the strategy must always follow the original approval process.

13.3 Archiving

The ICB will ensure that archived copies of superseded strategy documents are retained in accordance with Records Management: A guide to the management of health and care records 2021.

Appendix 1: Schedule of Duties and Responsibilities

ICB	The ICB is responsible for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Chief Executive	The Chief Executive has overall responsibility for the strategic direction and operational management, including ensuring that ICB process documents comply with all legal, statutory and good practice guidance requirements • ensuring the implementation of an effective risk management framework, supporting risk management systems and internal control • continually promote risk management and demonstrate leadership, involvement and support • ensuring an appropriate committee structure is in place and developing the corporate governance and assurance framework ensuring all directors and senior leads are appointed with managerial responsibility for risk management.
Executive Director of Finance	The Executive Director of finance has a responsibility for: • providing expert professional advice to the ICB on the effective, efficient and economic use of the ICB's allocation to remain within that allocation and identify risks to the delivery of required financial targets and duties • ensuring robust risk management and audit arrangements are in place to make appropriate use of the ICB's financial resources • ensuring appropriate arrangements are in identify risks and mitigating actions to the delivery of QIPP and resource releasing initiatives incorporating risk management as a management technique within the financial performance management arrangements for the organisation.
Executive Director of Corporate Governance, Communications and Involvement	The Executive Director of Corporate Governance, Communications and Involvement is the lead for risk management and has a responsibility for: • ensuring risk management systems are in place throughout the ICB, co-ordinating risk management in accordance with this strategy • ensuring the assurance framework is regularly reviewed and updated • ensuring that there is an appropriate external review of the ICB's risk management systems and that these are reported to the governing body • overseeing the management of risks as identified by the quality, safety and risk committee, ensuring risk action plans are put in place, regularly monitored and implemented • incorporating risk management as a management technique within the performance management arrangements for the organisation • ensuring that systems are place for assuring the commissioning of high quality and safe services, and the on-going monitoring of the same ensure incidents, claims and complaints are and managed used the appropriate procedures.
Executive Leadership Team	Members of the Executive Leadership Team will: • Maintain awareness of the main risks facing the organisation • Take ownership where relevant of principal (strategic) risks that pose a threat to the achievement of strategic objectives and ensure appropriate action is taken to mitigate and manage risks ensuring regular updates to the ICB • Take or delegate ownership, where relevant, of risks that pose a threat to the achievement of objectives or the business of the ICB and ensure appropriate action is taken to mitigate and manage risks ensuring regular updates are added to the risk register • Ensure the processes for managing risk within the ICB are clearly understood, appropriately delegated and effective.

Audit Committee	The Audit Committee has overall responsibility for overseeing the implementation of this strategy and will: • Review all risks on the corporate risk register and monitor progression of stated action on a quarterly basis. Ensure the established processes to manage risk is in place and provide support for action where necessary • Ensure the processes for managing risk within the ICB are clearly understood, appropriately delegated and effective. Escalate issues to the governing body as appropriate, in particular the identification of new, significant risk or areas of concern of risks graded very high or high to the ICB.
Senior Leads	All senior leads have a responsibility to incorporate risk management within all aspects of their work and are responsible for ensuring the implementation of this strategy by: • demonstrating personal involvement and support for the promotion of risk management • ensuring staff under their management are aware of their risk management responsibilities in relation to this framework • setting personal objectives for risk management and monitoring their achievement • ensuring risk are identified, managed and mitigating actions are implemented in functions for which they are accountable • ensuring a risk register is established and maintained that relates to their area of responsibility, ensuring risks are escalated where they are of a strategic in nature.
Risk owners	Responsible for managing individual risks and providing updates on the management of those risks and identifying and carrying out action plans to mitigate risks.
All Staff	Risk management is everybody's responsibility and all staff must be familiar with the main risks in their area of activity
CSU Staff	Whilst working on behalf of the ICB, CSU staff will be expected to comply with all policies, procedures and expected standards of behaviour within the ICB, however they will continue to be governed by all policies and procedures of their employing organisation.
Counter Fraud Specialist	Manages counter fraud activities on behalf of the ICB.

Appendix 2: Risk Assessment

To manage risks effectively, it is crucial to ensure that both the initial (inherent) and residual risk is assessed.

The initial (inherent) risk assessment gives an indication of the impact of the risk should controls fail. The residual risk assessment shows the current level of the risk remaining after mitigating controls are applied.

A standardised approach is taken across the ICB to analyse and measure risk, this is detailed below. Managers must ensure that, for their area, risk assessments are carried out and documented, and that the necessary control measures are implemented in order to reduce risks. The level of detail in the risk assessments and any subsequent action taken should be proportional to the risk.

Step 1: Determine the consequence score

This is offered as guidance when completing a risk assessment, either when an incident has occurred or if the consequence of potential risks is being considered.

Choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. Note consequence will either be negligible, minor, moderate, major or catastrophic.

Table 1: Consequence score

Impact	1. Very Low	2. Low	3. Moderate	4. High	5. Very High
A. Injury	Minor injury not requiring first aid.	Minor injury or illness, first aid treatment needed.	RIDDOR / Agency reportable.	Major injuries or long-term incapacity / disability.	Death or major permanent incapacity.
B. Patient experience	Unsatisfactory patient experience not directly related to patient care.	Unsatisfactory patient experience – readily resolvable.	Mismanagement of patient care.	Serious mismanagement of patient care.	Totally unsatisfactory patient outcome or experience.
C. Service / business interruption	Loss / interruption>1 hour.	Loss / interruption>8 hours.	Loss / interruption>1 day.	Loss / interruption>1 week.	Prolonged loss of service or facility.
D. Staffing and skill mix	Short term low staffing level temporarily reducing service quality	Ongoing low staffing level reducing service quality.	Late delivery of key objective / service due to lack of staff. Ongoing unsafe staffing	Uncertain delivery of key objective / service due to lack of staff.	Non-delivery of key objective / service due of lack of staff.
E. Financial / asset	Funded/partially funded between £0 and £10k. Unfunded between £0 and £10k	Funded/partially funded between £10k and £50k. Unfunded between £10k and £25k	Funded/partially funded between £50k and £100k. Unfunded between £25k and £50k	Funded/partially funded between £100k and £1m. Unfunded between £50k and £500k	Funded/partially funded over £1m. Unfunded over £500k
F. Inspection / audit	Minor recommendations. Minor noncompliance with standards and/or policies.	Recommendations given. Non-compliance with standards and/or policies.	Reduced rating. Challenging recommendations. Non-compliance with core standards and/or policies.	Enforcement action. Critical report and Low rating. Major noncompliance with core standards and/or policies.	Prosecution. Zero rating Severely critical report.
G. Adverse publicity / reputation	Rumours.	Short term damage with stakeholders Minor effect on staff morale.	Longer term damage with individual stakeholders Significant effect on staff morale.	Widespread stakeholder damage Local media > 3 days	Sustained and widespread stakeholder damage National media > 3 days
H. Data Security and Protection	There is absolute certainty that no adverse effect can arise from the breach	A minor adverse effect must be selected where there is no absolute certainty. A minor adverse effect may be: The cancellation of a procedure but does not involve any additional suffering. Disruption to those who need the data to do their job.	An adverse effect may be: Release of confidential information into the public domain leading to embarrassment. Unavailability of information leading to the cancellation of a procedure that has the potential of prolonging suffering but does not lead to a decline in health. Prevention of someone doing their job such as cancelling a procedure that has the potential of prolonging suffering but does not lead to a decline in health.	Potential pain and suffering / financial loss: Reported suffering and decline in health arising from the breach. Some financial detriment occurred. Loss of bank details leading to loss of funds. Loss of employment.	Death / catastrophic event: A person dies or suffers a catastrophic occurrence.

Step 2: Determine the likelihood score

Now determine what is the likelihood of the impact occurring. The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency. The frequency-based score will either be classed as rare, unlikely, possible, likely or almost certain.

Table 2: Likelihood score

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	Only occurs in exceptional circumstances, > 5-year period	Could occur at sometime within 1 to 5 years	Could occur in the next 12 months	Will probably occur in the next 6 months	Expected to occur in the next 3 – 6 months

Step 3: Assigning a risk rating

Now apply the consequence and likelihood ratings to give you a risk rating for each of the risks you have identified. Calculate the risk rating by multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

Table 3: Risk rating = consequence x likelihood (C x L)

	Likelihood				
	1	**2**	**3**	**4**	**5**
Consequence	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	**5**	**10**	**15**	**20**	**25**
4 Major	**4**	**8**	**12**	**16**	**20**
3 Moderate	**3**	**6**	**9**	**12**	**15**
2 Minor	**2**	**4**	**6**	**8**	**10**
1 Low	**1**	**2**	**3**	**4**	**5**

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

	1 - 6	Low risk
	8 - 10	Moderate risk
	12 - 16	High risk
	20 - 25	Extreme risk

Appendix 3: Equality Impact Assessment Screening

Step 1

As a public body organisation we need to ensure that all our strategies, policies, services and functions, both current and proposed have given proper consideration to equality and diversity, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership, Carers and Health Inequalities).

A screening process can help judge relevance and provides a record of both the process and decisions made.

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Julie Rutherford
Role: Senior Governance Officer NECS

Title of the service/project or policy:

Risk Management Strategy

Is this a:

☑ Strategy / Policy ☐ Service Review ☐ Project

If other, please specify:

What are the aim(s) and objectives of the service, project or policy:

This strategy aims to set out the ICB's approach to risk and the management of risk in fulfilment of its overall objective to commission high quality and safe services. In addition, the adoption and embedding within the organisation of an effective risk management strategy and processes will ensure that the reputation of the ICB is enhanced and maintained, and its resources are used effectively to reform services through innovation, large- scale prevention, improved quality and greater productivity.

Who will the project/service /policy / decision impact?

Consider the actual and potential impacts:

- [✓] Staff
- [✓] service users/patients
- [✓] other public sector organisations
- [ ] voluntary / community groups / trade unions
- [ ] others, please specify:

Questions	Yes	No
Could there be an existing or potential impact on any of the protected characteristic groups?	Yes	
Has there been or likely to be any staff/patient/public concerns?	Yes	
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	Yes	
Could this piece of work affect the workforce or employment practices?	Yes	
Does the piece of work involve or have an impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing equality of opportunity • Fostering good relations	Yes	

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document.

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Executive Committee	Approver	July 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

Equality Impact Assessment

This EIA should be undertaken at the start of development of a new project, proposed service review, policy or process guidance to assess likely impacts and provide further insight to reduce potential barriers/discrimination. The scope/document content should be adjusted as required due to findings of this assessment. This assessment should then be updated throughout the course of development and continuously updated as the piece of work progresses.

Once the project, service review, or policy has been approved and implemented, it should be monitored regularly to ensure the intended outcomes are achieved.

This EIA will help you deliver excellent services that are accessible and meet the needs of staff, patients and service users.

This document is to be completed following the STEP 1 – Initial Screening Assessment

Step 2 Evidence Gathering

Name of person completing EIA:
Title of policy/strategy/guidance: Risk Management Strategy
Existing: ☐ New/proposed: ☑ Changed: ☐
What are the intended outcomes of this policy/service/process? **Include outline of objectives and aims.** The purpose of this strategy is to provide a support document to enable staff to undertake effective identification, assessment, control and action to mitigate or manage the risks affecting the normal business. The Strategy sets out an organisation wide approach to managing risk, in a simple, straightforward and clear manner the intentions of the ICB for timely, efficient and cost-effective management of risk at all levels within the organisation. The Strategy aims to: • To ensure that risks to the achievement of the ICB's objectives are understood and effectively managed • To ensure that the risks to the quality of services that the organisation commissions from healthcare providers are understood and effectively managed • To assure the public, patients, staff and partner organisations that the ICB is committed to managing risk appropriately.
Who will be affected by this policy/strategy /guidance? (please tick) ☐ Consultants ☐ Nurses ☐ Doctors ☑ Staff members ☐ Patients ☐ Public ☐ Other If other please state:

Current Evidence/Information held	Outline what current data/information is held about the users of the service / patients / staff / policy / guidance? Why are the changes being made?
(Census Data, Local Health Profile data, Demographic reports, workforce reports, staff metrics, patient/service users/data, national reports, guidance ,legislation changes, surveys, complaints, consultations/patient/staff feedback, other)	Workforce data

Step 3 Full Equality Impact Assessment

The Equality Act 2010 covers nine 'protected characteristics' on the grounds upon which discrimination and barriers to access is unlawful. Outline what impact (or potential impact) the new policy/strategy/guidance will have on the following protected groups:
Age *A person belonging to a particular age*
There is no impact on any staff member belonging to a particular age group. Should risk training be required for this strategy there are accessible venues across the ICB footprint with good IT facilities for presentations with several screens placed within each room and training can also be delivered remotely over Microsoft Teams.
Disability *A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities*
Positive impact, risks will be reviewed and actions will be put in place to mitigate any further risk. Staff can get assistance to report and manage a risk from the NECS Governance Team if required. The strategy will be made available via the ICB's intranet and can be made available in other formats where required, such as Braille, Audio, easy read etc. Should risk training be required for this strategy there are accessible venues across the ICB footprint with good IT facilities for presentations with several screens placed within each room and training can also be delivered remotely over Microsoft Teams.
Gender reassignment (including transgender) and Gender Identity *Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self perception.*
Positive impact, staff can get assistance to report and manage a risk from the NECS Governance Team if required. The content of the strategy does not include vocabulary that should cause offense.
Marriage and civil partnership *Marriage is defined as a union of a man and a woman or two people of the same sex as partners in a relationship. Civil partners must be treated the same as married couples on a wide range of legal matters*
Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required. The content of this strategy does not negatively impact on marriage and civil partnership.
Pregnancy and Maternity *Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.*
Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The content of this strategy does not negatively impact on pregnancy and maternity.

Should risk training be required consideration will be made to those on maternity/paternity leave to ensure they are included when they return to work.

Race
It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The content of the strategy does not include vocabulary that should cause offense.

The strategy can be made available in other languages, interpreters can also be made available if applicable.

Religion or Belief
Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The content of this strategy does not negatively impact on religion or belief and does not include vocabulary that should cause offense.

Sex/Gender
A man or a woman.

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The strategy has no impact on sex/gender and does not discriminate between males and females.

Sexual orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The strategy uses appropriate language and does not negatively impact on sexual orientation.

Carers
A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the CSU Governance Team if required.

Should risk training need to be provided consideration will need to be made to those with carer responsibilities to ensure that consideration is given to part time working as well as caring responsibilities.

Other identified groups relating to Health Inequalities
such as deprived socio-economic groups, rural areas, armed forces, people with substance/alcohol abuse and sex workers.
(Health inequalities have been defined as "Differences in health status or in the distribution of health determinants between different population groups."
Health inequalities can therefore occur across a range of social and demographic indicators, including socio-economic status, occupation, geographical locations.)

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the CSU Governance Team if required.

Step 4 Engagement and Involvement

Have you engaged stakeholders in testing the policy/guidance or process proposals including the impact on protected characteristics?
SIRMS users and ICB Committee Members - via bulletins, communications, training sessions and contact with members of the CSU Governance Team who are always contactable for help and assistance.
If no engagement has taken place, please state why:

Step 5 Methods of Communication

What methods of communication do you plan to use to inform service users/staff about the policy/strategy/guidance?
☑ Verbal – through focus groups and/or meetings ☑ Verbal - Telephone ☐ Written – Letter ☑ Written – Leaflets/guidance booklets ☑ Email ☑ Internet ☑ Other
If other please state: Via SIRMS (Safeguard Incident and Risk Management System)

Step 6 Potential Impacts Identified – Action Plan

Ref no.	Potential/actual Impact identified	Protected Group Impacted	Action(s) required	Expected Outcome	Action Owner	Timescale/ Completion date
NA		All	Risk Management Training to staff and incident managers to promote quality of risk reporting & data.	Positive - increased awareness of process and support on offer.	**WM**	**Ongoing**

Sign off

Completed by:	Wendy Marley Senior Governance Officer
Date:	07 June 2022
Presented to: (appropriate committee)	
Publication date:	

Item: 20
Enclosure: 12i

NHS
North East and North Cumbria

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	
Official: Sensitive Commercial		Provides assurance	✓
Official: Sensitive Personal		For information only	

BOARD MEETING 27 September 2022	
Report Title:	**Finance Update and Overview Report**

Purpose of report

To provide the Board with an update on the financial performance of the North East and North Cumbria Integrated Care Board (NENC ICB) in the financial year 2022-23 for the period to 31 July 2022.

Key points

As at 31st July 2022 the ICB is reporting financial performance in line with the overall financial plan approved by Board on 1st July 2022, reflecting a forecast surplus of £2.6m. This offsets a forecast deficit across relevant NHS providers, resulting in a balanced financial position across the ICS.

The ICB Finance, Investment and Performance Committee plays an important role in reviewing the financial performance of the ICB and providing oversight and assurance to the Board. The financial position shown here was discussed in detail at the Committee meeting on 1st September 2022.

The financial plan of the ICB required an overall efficiency target of £48.4m and the ICB is on track to deliver this.

The ICB is also currently on track to deliver the Mental Health Investment Standard.

At this stage of the year there is always limited data available for the majority of commissioned services. This year following the transition from CCGs to the ICB, the financial position shown here is effectively the month 1 position for the ICB. Future reports will include further analysis of the position on individual budget areas as further information becomes available.

NHS Providers remain on block contracts for 2022/23, this arrangement gives the ICB certainty over the expenditure associated with these contracts for the year and reduces the level of risk in the financial position. NHS expenditure accounts for approximately 65% of total ICB expenditure.

NHS Provider block contract values were agreed within financial plans approved earlier in the year. A summary of relevant contract values is included within table 5 of the report with contracts subsequently being agreed in accordance with approved budget values.

Financial pressures are being reported on acute services budgets, this relates to independent sector activity linked to elective recovery plans, as well as on continuining healthcare budgets. These are currently being offset through underspends on prescribing budgets and use of programme reserves.

Table 6 within the report summarises the ICB Better Care Fund (BCF) contributions with each relevant local authority for the financial year, in accordance with national requirements. The BCF represents pooled budget arrangements with local authorities supporting integration of health and social care, with minimum contributions agreed by NHS England. These values were previously agreed within budgets by the predecessor clinical commissioning groups and within the financial plan approved by Board in July 2022. Following publication of final BCF guidance, relevant section 75 agreements are now being approved through Health and Wellbeing Boards in line with national timescales and approval processes.

Further information on the objectives and requirements of the BCF, along with details of the outcomes delivered from the current year BCF agreements will be presented to a future Board meeting.

Risks and issues

Whilst the ICB has reported a forecast in line with plan, a number of potential financial risks have been identified, totalling £29m.

Key risks identified at this stage include:

- Risk that the growth in both prescribing and continuing healthcare (CHC) expenditure is above planned levels, and
- Risk that the growth in independent sector activity and therefore cost is unfunded through the Elective Servcies Recovery Fund due to missed system targets.

Mitigations have been identified to manage the majority of potential ICB risks, leaving an unmitigated potential risk of almost £9m linked to elective recovery fund activity. Additional elective recovery funding to cover these costs is subject to overall system performance which presents a significant risk. The unmitigated risk amounts to less than 0.2% of total ICB funding. This will continue to be reviewed over the year along with system partners.

In addition to ICB specific financial risks there are a number of potential risks to the wider ICS financial position. This includes uncertainty around performance against elective recovery targets and related funding implications, and potential pressure on both pay and non-pay costs. Work is continuing across the system to review potential pressures and identify appropriate mitigations where possible.

There is a potential forecast pressure of £32m on capital spending plans across the ICS in comparison to the confirmed ICS capital departmental expenditure limit (CDEL) allocation. Work continues to review relevant capital plans with individual provider trusts and discussions continue with NHS England in respect of the capital funding allocation for the year.

Assurances

ICB finance teams will monitor and report monthly on the risks noted above. This will include actions being taken to mitigate these risks.

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The financial position will continue to be reviewed in detail on a monthly basis by the Finance, Investment and Performance Committee.

Recommendation/Action Required
The Board is asked to: • note the latest year to date and forecast financial position for 2022/23 and take assurance that overall performance is in line with plan, • note there are a number of potential financial risks across the system to be managed, • note that BCF agreements are being approved through Health and Wellbeing Boards in line with approved budgets.

Sponsor/approving director	D Chandler, Interim Executive Director of Finance
Report author	R Henderson, Director of Finance (Corporate) E Forster, Head of Finance (North Tyneside)

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	
CA2: tackle inequalities in outcomes, experience, and access	
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	

Relevant legal/statutory issues
Health and Care Act 2022

Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**	✓	**N/A**	

Key implications	
Are additional resources required?	n/a
Has there been/does there need to be appropriate clinical involvement?	n/a
Has there been/does there need to be any patient and public involvement?	n/a
Has there been/does there need to be partner and/or other stakeholder engagement?	Yes, engagement within the ICB and the wider ICS.

Executive Summary

	M04 - July 2022			YTD	Forecast
Income & Expenditure	**Overall 2022/23 Financial Position - (Surplus) / Deficit** For the financial year 2022/23 the ICB combined with the Q1 position of the NENC CCG is on track to deliver the planned surplus position of £2.6m *Nb: The YTD surplus for the ICB is technical in nature and due to the transfer of balances from CCGs to ICB.	Plan Actual	*	£0.895 m (£20.651) m	(£2.633) m (£2.633) m
	July 2022 - March 2023 Financial Position - (Surplus) / Deficit ICB is reporting a year to date and forecast outturn in line with the submitted financial plan for the period July 2022 - March 2023 - (£0.441m) YTD and (£3.970m) Forecast	Plan Actual		(£0.441) m (£0.441) m	(£3.970) m (£3.970) m
	July 2022 - March 2023 Programme Spend ICB is reporting a year to date variance of (£0.441m) an outturn variance of (£3.970m) in line with the submitted financial plan for the period July 2022 - March 2023 (Surplus) / Deficit	Plan Actual		£539.1 m £538.7 m	£4,852.1 m £4,848.1 m
	July 2022 - March 2023 Running cost ICB is reporting a year to date variance of £0m against a YTD budget of £4.784m and an outturn variance of £0m against a budget of £43.055m for the period July 2022 - March 2023	Plan Actual		£4.8 m £4.8 m	£43.1 m £43.1 m
	Overall 2022/23 QIPP/Efficiency ICB is reporting a year to date variance of £0m and an outturn variance of £0m against the annual efficiency plan of £48.4m.	Plan Actual		£15.56 m £15.56 m	£48.433 m £48.433 m
	Overall 2022/23 Mental Health Investment Standard (MHIS) The ICB is on track to achieve the MHIS target for 2022/23.			5.26%	5.26%
Statement of Financial Position	**July BPPC** The BBPC target is for 95% of NHS and Non NHS invoices to be paid within 30 days			by volume NHS 100.00% Non NHS 99.97%	by value 100.00% 99.80%

Overview of the Financial Position

This report provides an update on the financial performance of ICB in the financial year 2022/23 for the period to 31st July 2022.

As at 31st July 2022 the ICB is reporting financial performance in line with the financial plan submitted 20th June 2022, reflecting a forecast surplus of £2.6m. This offsets a forecast deficit across relevant NHS providers, resulting in a balanced financial position across the ICS.

The financial plan of the ICB required an overall efficiency target of £48.4m and the ICB is on track to deliver this.

The ICB is on track to deliver the Mental Health Investment Standard.

NHS Providers remain on block contracts for 2022/23, this arrangement gives the ICB certainty over the expenditure associated with these contracts for the year. NHS expenditure accounts for approximately 65% of total ICB expenditure.

The main areas of risk and uncertainty for the ICB arises from non nhs activity, including in particular prescribing and continuing healthcare costs.

At this stage of the year there is always limited data available for the majority of commissioned services, with a time lag of two months in respect of prescribing data and other activity based contract information. This adds a level of risk and uncertainty to the reported forecast outturn position.

Whilst the ICB has reported a forecast in line with plan, a number of potential financial risks have been identified, totalling £29m. This includes in particular potential risks around prescribing, continuing healthcare and independent sector acute activity, linked to the elective recovery programme.

Mitigations have been identified to manage the majority of potential risks, leaving an unmitigated potential risk of almost £9m linked to elective recovery fund activity. Additional elective recovery funding to cover these costs is subject to overall system performance which presents a significant risk. The unmitigated risk amounts to less than 0.2% of total ICB funding. This will continue to be reviewed over the year along with system partners.

Table 1: ICB Financial Position - Overview

Month 4 - July 2022	YTD Plan	Revised YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Revenue Resource Limit	(542,765)	(542,765)	0	(4,884,887)	(4,884,887)	0
Programme						
Acute Services	272,353	273,358	1,006	2,451,173	2,458,967	7,793
Mental Health Services	59,606	61,000	1,394	536,457	536,537	80
Community Health Services	37,480	41,258	3,778	337,316	337,504	189
BCF	27,614	25,445	(2,168)	248,522	249,238	716
Continuing Care	30,462	30,164	(298)	274,158	277,153	2,996
Prescribing	47,196	47,410	214	424,763	422,328	(2,435)
Primary Care	10,247	10,655	408	92,219	93,469	1,250
Primary Care Co-Commissioning	44,284	44,284	0	398,555	398,555	(0)
Other Programme Services	2,526	4,078	1,553	22,733	22,934	201
Other Commissioned Services	2,113	2,075	(38)	19,015	19,215	199
Programme Reserves	3,448	(2,234)	(5,681)	31,029	20,177	(10,852)
Contingency	214	47	(167)	1,922	1,785	(137)
Total ICB Programme Costs	**537,540**	**537,540**	**0**	**4,837,862**	**4,837,862**	**(0)**
Admin						
Running Costs	4,784	4,784	0	43,055	43,055	0
Total ICB Admin Costs	**4,784**	**4,784**	**0**	**43,055**	**43,055**	**0**
ICB planned (Surplus) / Deficit	441	0	(441)	3,970	0	(3,970)
CCG Q1 b/f position & rephased expenditure	1,586,976	1,566,767	(20,210)	1,585,787	1,587,125	1,338
New unallocated allocations	1,138	1,138	0	10,239	10,239	0
Total 22/23 Financial Position	**2,130,879**	**2,110,228**	**(20,651)**	**6,480,913**	**6,478,281**	**(2,632)**

Table 1.1: Financial Position at 'Place'

Financial Position at 'Place'	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
M4 - M12	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
North Cumbria Place	**56,757**	**56,757**	**(0)**	**510,815**	**510,815**	**0**
Newcastle Place	61,117	61,117	(0)	550,055	550,055	(0)
Gateshead Place	49,744	49,744	0	447,697	447,697	(0)
North Tyneside Place	33,678	33,678	0	303,100	303,100	0
Northumberland Place	51,739	51,739	0	465,645	465,645	0
North Area	**196,278**	**196,278**	**0**	**1,766,497**	**1,766,497**	**(0)**
County Durham Place	94,195	94,195	0	847,759	847,758	(0)
South Tyneside Place	27,459	27,459	(0)	247,132	247,132	0
Sunderland Place	48,398	48,398	(0)	435,582	435,582	(0)
Central Area	**170,053**	**170,053**	**0**	**1,530,473**	**1,530,473**	**(0)**
Tees Valley Place	**114,453**	**114,453**	**0**	**1,030,078**	**1,030,078**	**0**
Total ICB Programme Costs	**537,540**	**537,540**	**0**	**4,837,862**	**4,837,862**	**(0)**

Note: The above numbers at 'place' exclude CCG Outturn in M1-3

Table 2: Overall ICS (Surplus) / Deficit

Month 4 - July 2022	YTD Plan (Surplus) / Deficit	YTD Actual (Surplus) / Deficit	YTD Variance (Surplus) / Deficit	Annual Plan (Surplus) / Deficit	Forecast (Surplus) / Deficit	Forecast Variance (Surplus) / Deficit
	£000s	£000s	£000s	£000s	£000s	£000s
NENC Commissioner (ICB)						
Q1 CCG	1,336	(20,210)	(21,546)	1,336	(20,209)	(21,546)
Q2-Q4 ICB	(441)	(441)	0	(3,970)	17,576	21,546
Total ICB Position	**895**	**(20,651)**	**(21,546)**	**(2,633)**	**(2,633)**	**(0)**
NENC Providers	9,870	8,636	(1,234)	2,633	2,607	(26)
Total Provider Position	**9,870**	**8,636**	**(1,234)**	**2,633**	**2,607**	**(26)**
Total ICS Financial Position 22/23	**10,765**	**(12,015)**	**(22,780)**	**(0)**	**(26)**	**(26)**

Table 3: Efficiencies

	M4 YTD Budget	M4 YTD Actual	M4 YTD Variance	2022/23 Plan	2022/23 Forecast	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Acute	294	294	0	2,650	2,650	0
Community Healthcare	2,712	2,712	0	8,144	8,144	0
Primary Care (inc. Primary Co-Commissioning)	5,535	5,535	0	16,592	16,592	0
Continuing Healthcare	6,744	6,744	0	20,229	20,229	0
Other Programme Services	270	270	0	818	818	0
Overall Financial Position	**15,555**	**15,555**	**0**	**48,433**	**48,433**	**0**
Of Which:						
Recurrent	5,765	5,765	0	17,280	17,280	0
Non Recurrent	9,790	9,790	0	31,153	31,153	0
Overall Financial Position	**15,555**	**15,555**	**0**	**48,433**	**48,433**	**0**

	M4 YTD Budget	M4 YTD Actual	M4 YTD Variance	2022/23 Plan	2022/23 Forecast	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Demand Management (referrals)	164	164	0	500	500	0
Evidence based interventions	294	294	0	2,650	2,650	0
Pathway transformation	1,780	1,780	0	5,346	5,346	0
Continuing Healthcare - cost per case review	6,744	6,744	0	20,225	20,225	0
Primary Care Prescribing	4,498	4,498	0	13,480	13,480	0
Tranforming community-based primary care	932	932	0	2,796	2,796	0
Non-NHS Procurement	489	489	0	1,462	1,462	0
Estates / NHS property rationalisation	152	152	0	456	456	0
Other	502	502	0	1,518	1,518	0
Overall Financial Position	**15,555**	**15,555**	**0**	**48,433**	**48,433**	**0**

Table 3: Efficiencies key points

The tables across show the efficiency targets set out in the ICB plan by ISFE category and programme area. At Month 4 the ICB is forecasting that it will achieve the overall planned position and the efficiencies embedded within it.

Table 4: Better Payment Practice Code

For the month to 31st July 2022		
Better Payment Practice Code - 30 Days	**NUMBER**	**£000's**
Non-NHS		
Total Non-NHS Trade Invoices Paid in the Year	9,551	105,855
Total Non-NHS Trade Invoices Paid Within 30 Day Target	9,548	105,641
Percentage of Non-NHS Trade Invoices Paid Within 30 Day Target	**99.97%**	**99.80%**
NHS		
Total NHS Trade Invoices Paid in the Year	273	358,218
Total NHS Trade Invoices Paid Within 30 Day Target	273	358,218
Percentage of NHS Trade Invoices Paid Within 30 Day Target	**100.00%**	**100.00%**

Table 5: NHS Provider Contract Annual Value 2022-23

NHS Provider Organisation	2022-23 Annual Contract Value
	£000s
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	502,737
CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	313,509
GATESHEAD HEALTH NHS FOUNDATION TRUST	248,758
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	369,981
NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST	168,290
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	305,972
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	476,531
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	382,045
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	546,855
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	225,107
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	600,704
Total NHS Provider Contracts	**4,140,487**

Table 6: Better Care Fund (BCF) Annual Contract Value 2022-23

Local Authority	2022-23 Annual Contract Value
	£000s
NEWCASTLE CITY COUNCIL	26,870
GATESHEAD COUNCIL	18,716
NORTH TYNESIDE COUNCIL	12,311
NORTHUMBERLAND COUNTY COUNCIL	28,220
CUMBRIA COUNTY COUNCIL	28,077
SUNDERLAND CITY COUNCIL	164,930
SOUTH TYNESIDE COUNCIL	28,091
DURHAM COUNTY COUNCIL	50,241
STOCKTON-ON-TEES BOROUGH COUNCIL	16,638
MIDDLESBROUGH BOROUGH COUNCIL	13,448
REDCAR AND CLEVELAND BOROUGH COUNCIL	12,980
HARTLEPOOL BOROUGH COUNCIL	8,493
DARLINGTON BOROUGH COUNCIL	9,135
Total Better Care Find (BCF) Contracts	**418,150**

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NHS
North East and North Cumbria

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	
Official: Sensitive Commercial		Provides assurance	
Official: Sensitive Personal		For information only	✓

BOARD MEETING

27 September 2022

Report Title:	**Presentation of the 2021/22 Annual Reports of the former Clinical Commissioning Groups of County Durham, North Cumbria and Northumberland**

Purpose of report

To present to the Board with the annual reports of the former clinical commissioning groups detailed above, including the governance statements for 2021/22.

Key points

The former CCG annual reports for 2021/22 were developed in line with the Department of Health's Manual for Accounts and are structured as follows:

- Performance report
- Accountability report
- Financial statements

The performance reports include several key areas including:

- An overview from the Accountable Officer's perspective
- Performance analysis (including key performance measures, the organisation's development and performance, performance on other matters including sustainable development)

The accountability reports include:

- A corporate governance report, including the statement of Accountable Officer's responsibilities and governance statement
- A remuneration and staff report
- A parliamentary and audit report

The governance statement is a key requirement within the annual reports and the statement included within the attached documents have been prepared in accordance with the Department of Health Manual for Accounts and NHS England governance statement template. The statement covers CCG key governance and risk management areas as follows:

- Governance framework

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- Risk management framework
- Internal control framework
- Review of effectiveness of the above frameworks
- Head of internal audit opinion and report from external auditor

Due to the timing of the former CCGs' governing bodies of Durham, North Cumbria and Northumberland, the reports were not able to be presented at a meeting held in public before the dissolution of CCGs on 30 June 2022. As per NHS England guidance, the responsibility to receive the reports in a meeting held in public transferred to the ICB.

The annual reports are attached as follows:
- NHS County Durham CCG – Appendix 1
- NHS North Cumbria CCG – Appendix 2
- NHS Northumberland CCG – Appendix 3

Risks and issues

The key issues and risks are highlighted in the attached reports.

Assurances

The attached reports were prepared in accordance with the guidance issued by NHS England. The reports were reviewed in detail and approved by the relevant CCG Committee, Accountable Officer, external auditors and NHS England.

Recommendation/Action Required

The Board is asked to receive the annual reports for information.

Sponsor/approving director	D Gallagher, Executive director of place based delivery (Central and Tees Valley) N Bailey, Acting Executive director of place based delivery (North and North Cumbria)
Report author	R Long, Corporate Affairs Manager

Link to ICB corporate aims (please tick all that apply)

CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues

Note any relevant Acts, regulations, national guidelines etc

Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**		**N/A**	✓

If yes, please specify

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Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	None noted
Has there been/does there need to be appropriate clinical involvement?	Not applicable – for information only
Not applicable – for information only	Not applicable – for information only
Has there been/does there need to be partner and/or other stakeholder engagement?	Not applicable – for information only

NHS
County Durham
Clinical Commissioning Group

Annual report and accounts 2021/22

County Durham
Care Partnership

Contents

Statement from our Clinical Chair and Accountable Officer

Welcome to the NHS County Durham Clinical Commissioning Group's (CCG) Annual Report and Accounts for the 2021/22 financial year which provides an insight into our work during our final full year as a Clinical Commissioning Group ahead of the planned transition to an Integrated Care Board (ICB). This report is our second as NHS County Durham CCG, following the merger of NHS Durham Dales, Easington and Sedgefield (DDES) CCG and NHS North Durham CCG in 2020.

The Covid-19 pandemic has continued to impact health services throughout the year and we continued to collaborate closely with our partners to ensure we provided maximum response to these unprecedented challenges. We have once again seen incredible efforts from staff, partners and volunteers, working together to ensure services have been delivered and maintained despite the increased pressure of Covid-19, whilst keeping everyone as safe as possible. We are proud of the shared determination of everyone involved, supporting local our communities. We also want to thank members of the public who have played such a key part in slowing the spread of the virus and have used services appropriately. Your support is greatly appreciated by everyone who delivers our local services.

This report provides an overview of our role and responsibilities as a CCG, planning and purchasing health care services on behalf of our population of around 520,000 people.

The report is split into a number of sections; the performance section provides an overview of who we are and how we have performed against national standards. The accountability report provides detail about our committees and governance structures as well as information about our member GP practices. The last section of the report is our annual accounts and provides detail about how we have spent the budget allocated to us to plan and purchase health care services on behalf of our local population.

Integration remains very much at the heart of what we do in County Durham and drives our ambition to further develop system-wide integrated models of care by working closely with our partners as part of the County Durham Care Partnership.

Our work has continued to be led by local clinicians working within our member practices and local health systems, working closely with Durham County Council and local NHS providers, to ensure a continued focus on the specific health needs of our local populations.

As we reflect on 2021/22, with the continued rollout of the Covid-19 vaccination programme, we continued our focus on providing services that meet the needs of our local communities, and to address inequalities in health across our area. It has been important for us to work in partnership to support recovery work across County Durham.

At the same time, we have worked closely with partners on system development of the North East and North Cumbria Integrated Care System looking at arrangements for Place Based Partnerships, commissioning plans and provider collaboratives. We will build on what is already working well at place and engage closely with wider stakeholders as Integrated Care System plans develop and to collectively explore the best way to deliver Integrated Care Board priorities across County Durham.

We are proud of our legacy since the formation of Durham Dales, Easington and Sedgefield CCG and North Durham CCG in 2013, and the subsequent merger to NHS County Durham CCG in 2020. There have been significant achievements which have brought positive impact to patients across our area. We would like to thank our member practices and our staff for their support and contributions over the years. We would also want to put on record our thanks to the local people we serve, especially those who have generously given their time through our engagement activities.

Looking forward, we will continue to play a key role in the establishment and transition to the Integrated Care Board.

Dr Jonathan Smith
Clinical Chair

Dr Neil O'Brien
Accountable Officer

PERFORMANCE REPORT

Performance Overview

This section of the Annual Report looks at how our system has performed over the last financial year, the purpose and activities of the CCG, its organisational structure, objectives and strategies for achieving these in the context of its local population. The issues and risks associated with achieving these objectives are explained.

The content that follows contains further detail including that about accountability and decision-making. The sections being:

- a performance analysis,
- a Corporate Governance Report,
- a Remuneration and Staff Report,
- a Parliamentary Accountability and Audit Report,
- the CCG's Financial Statements.

In this overview, we start with information specific to our CCG, our population, our geographical area and how our member practices work together locally to help to address health inequalities.

We then explain our role in regional collaborative working across the health and social care system across the North East and North Cumbria which is the NHS England / NHS Improvement geographical area within which we operate.

Focusing on local arrangements, we turn to the integrated approach we take with our local partners as part of the County Durham Care Partnership. Our key partners include Durham County Council, County Durham and Darlington NHS Foundation Trust which is our main acute and community trust, and Tees, Esk and Wear Valleys NHS Foundation Trust our main provider of mental health services and services for those with learning disabilities. We reference our Health and Social Care Plan, our Joint Health and Wellbeing Board Strategy and our County Durham Place Based Commissioning and Delivery Plan for 2020-25.

There are also a range of other areas that are essential to the successful delivery of our ambitions that we try never lose sight of. These include improving quality, engaging with our patients and the public, tackling our performance challenges, financial stability and the management of risk.

We outline the priorities we focused on in 2021/22, highlighting some examples of specific pieces of work and our achievements. Finally, we have a brief look ahead at the priorities for 2022/23.

About NHS County Durham Clinical Commissioning Group

We are a group of 61 general practices which have come together to commission (or buy) local health services for people who live within County Durham. This is the second year of the existence of the NHS County Durham Clinical Commissioning Group (CCG) following the merger of Durham Dales, Easington and Sedgefield CCG and North Durham CCG in April 2020.

The services we commission include:

- urgent care services from hospitals, NHS 111 and local 'out of hours' services
- planned inpatient and day-case hospital services
- diagnostic and treatment services, such as x-ray or hearing aid services
- community services
- mental health services
- learning disability services
- maternity and children's services
- medicines prescribed by the GP practices within the CCG boundary
- continuing health care and free nursing care services
- delegated authority from NHS England to commission primary care services delivered in GP practices

All GP practices in County Durham have a hand in shaping how the CCG works by developing, and signing up to, a Constitution. The constitution sets out the arrangements to ensure the CCG meets its responsibilities for commissioning high quality health care for the people of County Durham. It describes the governing principles, rules and procedures that will ensure integrity, honesty and accountability in our day-to-day activities. It commits the CCG to making decisions in an open and transparent way and places the interests of patients, carers and public at its heart.

Our Vision, Objectives and Values

Our vision, objectives and values were determined with input from our member practices and staff and agreed by our Governing Body to align with those of our partners in the County Durham Care Partnership.

Our ambition is to improve the health of our population and to address health inequalities that exist across our different local areas. We want to close the health and wellbeing gap and drive transformation to improve the quality of services that we commission. We manage our local health system with our social care partners, and actively enable our clinical leaders to develop alternate pathways of care to maintain financial stability, ensure effective corporate governance and risk management.

We put people at the centre of everything we do, working closely with our partners to seek to understand the impact of our decisions, plans and work on others, actively engaging with local people, including groups that can seldom be heard. We aspire to find better and different ways of working whilst valuing everyone's views to understand their priorities, needs, abilities and limits.

We get the best value from all that we do and are honest and open about what we can and cannot do. At NHS County Durham CCG we use our collective resources as partners to deliver the best possible health and wellbeing outcomes for population of County Durham.

Vision

- Working together in County Durham for healthier lives.

Objectives

- Work with partners to ensure a planned and effective recovery from the impact of the Covid-19 pandemic.

- Be an effective partner, aligning strategies, policies and activities to reduce duplication and ensure greater impact on the population's health and wellbeing.
- Develop and deliver high quality services with co-design and co-production with those who use services and those who provide support as the norm.
- Maximise opportunities to work with local communities to reduce health inequalities and improve health and wellbeing.
- Use our collective resources as partners to deliver the best possible health and wellbeing outcomes for population of county Durham.
- Make the best use of public funds to ensure health care meets the needs of patients and is safe and effective.
- Ensure the CCG demonstrates effective corporate governance and risk management in everything it does.

Values

- We put people at the centre of everything we do
- We achieve more by working with others
- We aspire to find better and different ways of doing things
- We value people's differences
- We get the best value from all that we do
- We are honest and open about what we can and cannot do
- We ensure safe care and positive experiences.

Our People

We encourage 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.

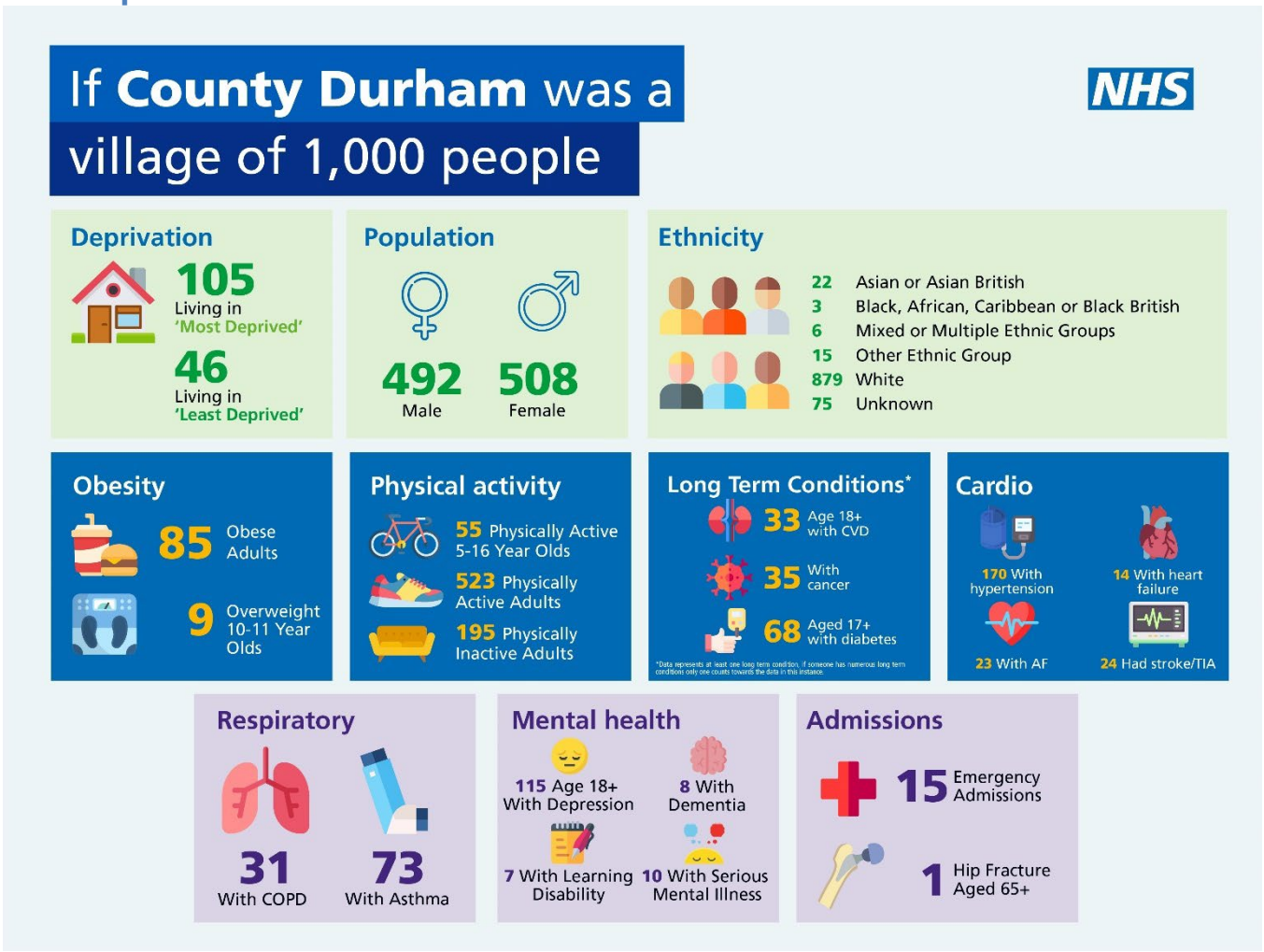
We continue to offer guaranteed interviews to applicants with a disability who are identified as meeting the essential criteria for any advertised roles; and reasonable adjustments under the Equality Act 2010 are considered and implemented during the recruitment process and during employment.

By working closely with DWP, we have maintained our 'Level 2 Disability Employer' status for 2021- 2022 by demonstrating our commitment to employing the right people for our business and continually developing our people. During 21/22 many of our staff have continued to work from home due to the continued impact of the COVD-19 pandemic.

Our Constitution

Our Constitution sets out our duties and how we make decisions. It sets out our responsibilities as commissioners of care for people in County Durham. It describes our governing principles, rules and procedures that we adopt for the day to day running of our CCG and so enables us to achieve our vision.

Our Population



Our health challenges

People who live in County Durham area have significant health challenges and problems. They are also more likely to die sooner than those living in other parts of the country. The main causes of early death include high levels of cancer and diseases of the heart or blood vessels. With an ageing population, we also experience greater demand for hospital services and an increase in illnesses related to older people such as stroke, long-term conditions, and dementia.

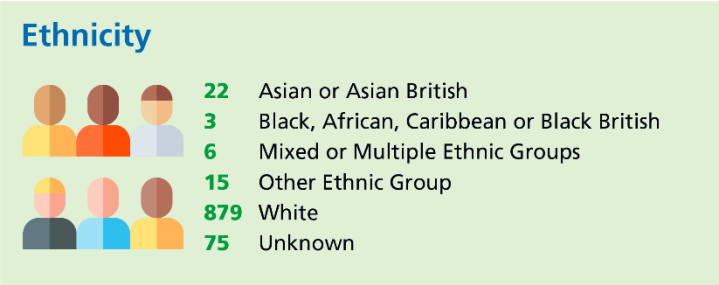
The large student population in Durham City results in a demand for sexual health, alcohol, and harm reduction services. Other key challenges facing County Durham CCG include:

- health problems caused by unemployment and low incomes,
- many local people are still smoking, drinking too much alcohol and are overweight,
- people with disabilities have worse health than those without,
- local children's health and lifestyles are poorer than elsewhere in the country,
- the environment can have an effect on health, for example changes in the weather or lots of traffic in some areas,
- social isolation.

Reducing health inequalities

Over the next five to ten years the NHS will increase its focus on prevention and closing the gap in inequalities in health. Work continues with our Governing Body to ensure that addressing health inequalities is at the heart of everything we do. Unnecessary variations in care are at the centre of all our plans.

In County Durham we are developing tools and approaches that use data to identify health inequalities and differences in health outcomes across the whole of the County, and within Primary Care Networks. We understand our local population and local health needs, through the use of the Joint Strategic Needs Assessment (JSNA) 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 know that both the older population and BAME (black and minority ethnic) population have been affected disproportionately by the Covid-19 pandemic. Governing Body members continue to consider strategic issues and proactive learning from the JSNA to place greater focus on health inequalities going forward to make a difference across the range of vulnerabilities.

As the local commissioners of health services, we seek to ensure that the services that are purchased on behalf of our local population reflect their needs. We work 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 health care for the local population. More detailed information is provided in the Performance Analysis section from page 29.

Our area

Our 61 member practices serve very different patient lists with significant variations in health, covering a mixture of rural and urban areas and a large and internationally diverse student population at Durham University. The CCG is coterminous with Durham County Council and about 97% of our population live within the council boundaries. The remainder live in the Gateshead and Sunderland Local Authority areas.

Clinical Leadership

We have continued to ensure strong clinical leadership throughout 2021/22. Our Clinical Chair, Clinical Accountable Officer and Medical Directors are all GPs who work within the CCG's area. In addition, we have a several Executive GPs and GP Clinical Leads who provide clinical advice and local knowledge across the range of our clinical priorities. They take part in our governance arrangements as appropriate to ensure clinical challenge. The leadership they provide has been particularly important in our response to the Covid-19 pandemic not just within the CCG but across the wider system. Our GP Clinical Leads have supported both the Influenza Vaccination Programme and the Covid-19 Vaccination Programmes, with sessions being used to ensure the most vulnerable in our communities, such as the homeless receive their vaccinations.

Our approach

Led by our member general practices NHS County Durham CCG exists to secure high quality services for our local population. We are committed to ensuring that people get the same quality and access to health services, wherever they live. We aim to ensure that health services meet the needs of patients, that the health of the community is improved, health inequalities are reduced, and that the CCG obtains value for money and efficiency from available resources.

In doing this we follow national guidance and work collaboratively with our partners both regionally and locally.

As outlined earlier, the Covid-19 pandemic has further highlighted the need to focus on inequalities across our population and we have worked from Governing Body level with colleagues in public health in particular to ensure that tackling inequalities is central to our work.

Our Primary Care Networks (PCNs)

Primary Care Networks (PCNs) bring together local GPs and health and social care practitioners to proactively care for populations of around 30,000 to 50,000 people. The 13 PCNs in Durham are:

Bishop Auckland PCN	Chester-le-Street PCN	Claypath and University PCN
Derwentside PCN	Durham East PCN	Durham West PCN
Easington Central PCN	Durham Coast PCN	North Easington PCN
Sedgefield PCN	Sedgefield North PCN	Teesdale PCN
Wear Valley PCN		

The PCNs are developing to deliver nationally defined service areas and locally agreed action to tackle inequalities that exist in our communities:

- structured medication reviews,
- enhanced health in care homes
- supporting early cancer diagnosis,
- cardiovascular disease,
- anticipatory (community) care.

This requires a wider range of primary care services available to patients, involving new staff roles such pharmacists, pharmacy technicians, nursing associates, physiotherapists, paramedics, mental health workers and social prescribers. The PCNs are taking a proactive approach to health and wellbeing including assessing the needs of the PCN population to identify people who would benefit from targeted support. They are working with a range of partner agencies to improve health and care and developing activities which help to reduce ill-health and supports people self-care. In addition, the PCNs promote shared decision making with patients about their care.

PCNs have continued to support the County Durham response to the pandemic not least the Covid-19 vaccination programme.

In response to the Improving Access to Primary Care initiative, PCNs have increased County service capacity to improve patient access to urgent, same day care, outside of hospital.

Regional Collaboration

Local Resilience Forum (LRF)

The Local Resilience Forum (LRF) has continued to undertake a significant role this year in co-ordinating the response to the Covid-19 pandemic. The LRF is a multi-agency partnership made up of representatives from local public services, including emergency services, the NHS, local authorities and others when necessary such as the military, voluntary organisations, the Highways Agency and public utility companies. We have been an active member of the LRF across the year with a nominated Executive Director attending all meetings to ensure consistency throughout the pandemic.

The North East and North Cumbria Integrated Care System (ICS) and Integrated Care Partnerships (ICPs)

NHS County Durham CCG is part of the North East and North Cumbria (NENC) Integrated Care System (ICS) which is a regional partnership between the organisations that meet health and care needs across the area, to coordinate services and to plan in a way that improves the health of the 3 million people it serves and reduces inequalities between different groups. The North East and North Cumbria Integrated Care System (NENC ICS) is the largest in England and is responsible for the health services of more than three million people across 5,313 square miles. It is one of the most geographically diverse areas from the Lake District in the west to large urban areas in the north east and more rural areas.

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

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

We have high levels of unemployment, low levels of decent housing, and significant areas of deprivation. These contribute to some of the starkest health inequalities, early death rates and highest sickness levels in England, driving much of the pressure that health and social care struggle to manage. You can find out more about our ICS, population, demographics and challenges at www.northeastandnorthcumbriaics.nhs.uk

North East and North Cumbria transition and development

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

- place and neighbourhood,
- four Integrated Care Partnership areas,
- Integrated Care System.

During 2021/22 we developed our System Development Plan which sets out our approach, governance, workstreams and plans to transition to the North East and North Cumbria ICS

(NENC) by July 2022. It covers areas such as outcomes and priorities, establishing the Integrated Care Board (ICB) and Integrated Care Partnership (ICP), arrangements for Place Based Partnerships, commissioning arrangements, provider collaboratives, data and digital transformation and engagement with system partners.

The North East and North Cumbria ICS established an ICS Development and Transition Programme Board with a series of workstreams to manage this transition. CCG staff were involved in these workstreams, providing valuable expertise in planning for the transition and looking at opportunities for improving ways of working in the future. Partners were also linked in where appropriate. All workstreams shared the approach of building on what is already working well at place and will be sharing this with wider stakeholders.

We have worked with partners to collectively explore the best way to deliver ICB priorities across the ICS, ensuring we retain and strengthen the very best local, placed based working. The Integrated Care Partnership (ICP) at NENC level will operate as a statutory committee, bringing together the NHS and local authorities as partners to focus more widely on health, public health and social care. It will include representatives from the ICB, local authorities and other partners such as NHS providers, public health, social care, and voluntary, community and social enterprise (VCSE) organisations.

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

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

North East and North Cumbria Urgent and Emergency Care Network

The North East and North Cumbria Urgent and Emergency Care (UEC) Network brings together organisations across the Integrated Care System (ICS), including NHS County Durham CCG, to ensure the quality, safety and equity of urgent and emergency care services in the region.

The network entered 2021/22 with clear aims aligned to the national Long Term Plan, designed to reduce pressure on emergency hospital services, provide alternative pathways to ambulance services, continue to enhance integrated urgent care services and reduce length of stay in hospital and delayed discharges.

The UEC Delivery Plan has been centrally coordinated at ICS level for progression and implementation. The UEC network in preparation for winter 2021/22 undertook an ICS system balance review identifying current pressures and challenges within the system with a final report making final recommendations to support the winter plan.

The health intelligence tool, RAIDR supports our Population Health Management work, using advanced analytical techniques to link and aggregate data. The RAIDR App has continued to be developed throughout the year enhancing the way we manage pressures across the system including the addition of additional Care Home metrics, Critical Care data automated from the national Directory of Services (DoS) and ongoing revisions of historical metrics to aid with the increasing pressure noted by our system.

Our look for the year ahead is to focus on other services such as Mental Health to get a better picture of their pressures and also working with our ambulance colleagues to improve their data input.

More information is available on page 37.

Partnership working locally – County Durham Care Partnership

'Place-based' arrangements for the CCG is County Durham. The CCG is coterminous with our Local Authority, Durham County Council.

In County Durham, we have a strong and long-standing track record of effective partnerships and integrated working in the County Durham Care Partnership.

Locally we worked closely and in collaboration with our partners which include:

- Durham County Council including Public Health and social care,
- our 13 Primary Care Networks (PCNs),
- County Durham and Darlington Local Medical Committee (LMC),
- County Durham and Darlington NHS Foundation Trust (CDDFT) our local provider of acute and community care,
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) our local provider of mental health and learning disabilities services, and
- other providers such as the North East Ambulance Service NHS Foundation Trust which provides services to a larger geographical area.

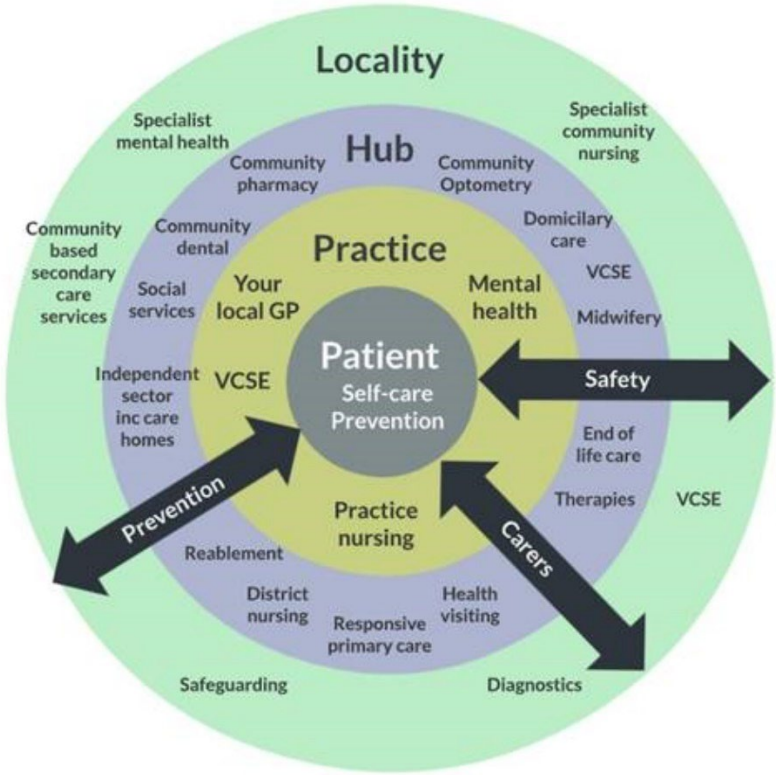
We have a Director of Integrated Community Services working jointly across the CCG, Durham County Council and CDDFT as well as a Head of Integrated Strategic Commissioning who is employed jointly by the CCG and Durham County Council.

Our vision is *'To bring together health and social care and voluntary organisations to achieve improved health and wellbeing for the people of County Durham'* which aligns with the Health and Wellbeing Board's vision '*County Durham is a healthy place, where people live well for longer*'.

Our commitment to the people of County Durham is to:

- deliver the right care to you by teams working together,
- help you and those in your community lead a healthy life,
- build on existing teams already working together to help you stay well and remain independent,
- provide improved services closer to your home,
- offer a range of services working alongside GP practices which meet your needs.

Across County Durham health, social care and voluntary organisations have already come together to agree a model of integrated care, as represented in the figure below.



Our collaborative approach across the County Durham has enabled:

- faster improvements in care,
- improved health outcomes across whole populations,
- an improved approach to prevention with a focus on joined up solutions,
- less duplication across the system, making it easier to navigate for the public and staff,
- maximising the impact of the Durham pound by using collective resources more efficiently.

The positive relationships and integrated approach that we had already developed proved to be significantly beneficial in enabling us to work together effectively and speedily in our joint response to the Covid-19 pandemic.

The Partnership Forum brings together, in an informal setting, CCG Governing Body Lay Members, Councillors and Trust Non-Executive Directors to focus on shared issues. These range from health inequalities, the needs of particular groups, developments in national or regional policies and their impact locally and to foster a better understanding of each organisation.

In March 2021 County Durham Care Partnership decided to strengthen its partnership structures through the formation of the ‘County Durham Care Partnership Executive’ to support the delivery of shared aspects of the statutory functions of Durham County Council and the CCG.

This was to bring more opportunities for collaborative working and to help focus on population health and inequalities. The governance arrangements bring together a broad partnership of individuals and organisations, working together to promote health and social care integration in the county, with the Health and Wellbeing Board at its centre.

The new arrangements saw the creation of Partnership Boards that sit underneath the County Durham Partnership Executive that will build on existing joint working groups and partnerships for:

- acute services,
- children's and young people's services,
- mental health, learning disabilities and autism,
- primary care, community services and social care.

The Partnership Forum encourages the County Durham Partnership Executive and Partnership Boards to integrate services and highlight areas where the system is working well or may need to re-consider our approach.

In the Performance Analysis section, we look in more detail at the integration work outlined in the themes of our four partnership boards described above.

Local priorities are set out in strategies such as our Joint Health and Wellbeing Strategy. We also have Health and Social Care Plan for County Durham agreed with partners which describes three key elements:

- an Integrated Governance Framework,
- an Integrated provider model for community services,
- a Joint Strategic Commissioning Function.

The CCG is supported by North of England Commissioning Support (NECS) in commissioning services. We contract with NECS to provide a range of support services including provider management, finance and data analysis.

Health and Social Care Plan for County Durham

As already outlined above County Durham, there is a strong and long-standing track record of effective partnerships and integrated working. Health and Local Authority organisations (provider and commissioner) work in line with the following principles for health and care delivery.

- A whole system approach, moving from fragmented to integrated care, with a willingness to put the needs of the public before the needs of individual organisations.
- Person-focused to promote wellbeing, prevention and independence.
- Providing the right care and support, in the right place, at the right time, by the right person.
- Delivering a sustainable health and social care system within existing resources, using a multidisciplinary team approach.
- A system built on trust, not only between leaders and organisations but also with local people and communities.
- Supporting and developing staff to develop a shared culture, behaviours and ownership.
- Everyone's contribution matters – from local people, frontline teams, healthcare practitioners, providers, voluntary and community sector leaders and board members.
- The integrated model will be developed to link with the wider system including housing,
- employment, the environment, voluntary and community facilities, in order to align
- priorities for the benefit of local communities. This evolving partnership approach will
- involve primary care being at the centre of patient activity and taking a proactive role in

- the commissioning of both NHS and integrated service provision.

The Joint Health and Wellbeing Strategy

The CCG continues to be an active member of the County Durham Health and Wellbeing Board, with our Chief Officer holding the role of Vice-Chair. As a member of the Board the CCG has helped to shape the local priorities for County Durham as influenced by the Joint Strategic Needs Assessment. The *Health and Social Care Act 2012* places clear duties on local authorities and CCGs to prepare a Joint Health and Wellbeing Strategy (JHWS).

We have chosen six objectives across our three strategic priorities that are of importance given the impact they have on people's health and of where we want to be in 2025. We recognise these are challenging but by working together across our partnerships and local communities we can make a difference:

- improve healthy life expectancy and reduce the gap within County Durham and between County Durham and England;
- we will have a smoke free environment with over 95% of our residents not smoking and an ambition that pregnant women and mothers will not smoke
- decrease overall levels of unemployment and specifically close the employment gap between the general population and those living with a long term physical or mental health condition, or with a learning disability
- over 90% of our children aged 4-5 years, and 79% of children aged 10-11 years are of a healthy weight;
- improved mental health and wellbeing evidenced by increased self-reported wellbeing scores and reduced suicide rates
- increase the number of organisations involved in Better Health at Work Award (to improve health and wellbeing interventions at work).

The reviewed Joint Health and Wellbeing Strategy 2021-25 was signed off by the Board in March 2021.

The County Durham Place Based Commissioning and Delivery Plan for 2020-2025

Our County Durham Place Based Commissioning and Delivery Plan for 2020-25 is in its third iteration following a further update in September 2021. The latest iteration of the plan reflects the progress made against actions detailed within each chapter, and to reflect the work being undertaken to restore services as a result of the pandemic. The plan continues to reflect both The County Durham Partnership Vision for 2035 and the Joint Health and Wellbeing Strategy 2021-25. Developments within the plan include explicit steps to identify and reduce health inequalities and support people and communities to understand and change health behaviours associated with smoking, alcohol, physical activity and diet across all chapters. An associated outcomes framework has been developed that supports a whole-system understanding of the health and wellbeing of our communities across the Triple Aim of improving outcomes and patient experience, and ensuring the system has a sustainable health and care workforce. Work is also being progressed on engaging partners within the Voluntary and Community Sector in the development of the next iteration as we move toward co-producing our future plans with our partners, people, and communities. This in part is being facilitated by the content of the plan being available via the County Durham Partnership website, where

interested partners will be able to provide comment and support the plan as it continues to evolve.

Area Action Partnerships (AAPs)

The CCG remains an active partner in each of the fourteen Action Area Partnerships (AAPs) within its geography. The partnerships also consist of members of the public, representatives for Durham County Council, town and parish councils, police, fire, health, housing, business, the University and voluntary organisations. Together we:

- work with communities and organisations to meet the needs of the communities, through identifying local priorities and actions required to tackle them,
- allocate funding to local organisations and support their development,
- monitor the difference that funding and support is making to communities,
- ensure that residents can get involved with consultation activities and are aware of what is going on in their community.

Our other priority areas that we never lose sight of:

Improving Quality

A variety of tools and processes are used when reviewing the quality of our commissioned services. This work is undertaken with a wide range of partners and assists us in obtaining the appropriate levels of evidence-based assurance and understanding how these services feel for patients, families, and carers. These activities inform and shape our quality and safeguarding annual work programme. For more information please see page 60.

Supporting our Staff

The NHS People Plan for 2020/21 was published on 31 July 2020 and set out guidelines for employers and systems within the NHS, as well as actions for NHS England and NHS Improvement and Health Education England. The plan also included 'Our People Promise', which outlines behaviours and actions that staff can expect from NHS leaders and colleagues, to improve the experience of working in the NHS for everyone.

As a CCG, ensuring our staff feel supported has always been important to us. Throughout the continued Covid-19 response, individuals and teams have supported each other. Individual risk assessments encouraged a health and wellbeing conversation. The individual risk assessments were designed to allow safe space conversations for staff to discuss any concerns they have regarding Covid-19 and an opportunity to request further support if needed via a comprehensive Occupation Health service available to all staff. Following approval by the Governing Body an additional day's annual leave was awarded to staff. This was in recognition of the collective and individual commitment given by staff in response to the immense challenge during the Covid-19 pandemic.

In addition to completing the National Staff Survey, we also undertook regular short surveys to understand how staff were feeling and to provide an additional opportunity to raise issues with management and allowing us to listen and respond constructively to concerns and suggestions raised.

The initial challenge of Covid-19 compelled us to work differently and to make the best use of our people's skills and experience, to provide the best possible patient care. Building on this a 'Hybrid Working' approach has been implemented for all staff in the organisation, embracing the principles of the NHS People Plan and allowing staff to benefit from increased flexibility. This enabled staff to select the most suitable location for them, to maximise productivity.

Engaging with our patients and the public

Throughout 2021/22 the CCG has continued to develop and strengthen the integrated approaches in relation to engaging with our patients and the public for the future.

Working jointly with colleagues from Durham County Council a collective approach to co-production across our integrated commissioning has taken significant steps forward. By working alongside a public partners it has been possible to develop a programme of training for staff about the use of co-production, as well as materials to support them when implementing this in their own work programmes.

Since the announcement of the national implementation of Integrated Care Systems, there has been close work between engagement teams in the region. This has enabled us to take a strategic approach for the North East and North Cumbria ICS in developing a regional strategy/framework for involvement.

To support the regional developments, local efforts have concentrated on the necessary mechanisms across County Durham that help ensure the voice of our residents will be able to effectively be heard as part of future conversations.
This has included dedicated support for staff in our Primary Care teams to look at what happens in the future to support conversations within each of our individual practices, but also as part of each Primary Care Network in the future too.

Alongside all of these conversation, subject specific areas of work have also been undertaken. These include conversation in relation to subjects such as Primary Care services around Wingate, Community Equipment services, Home Oxygen Assessment services, Maternity services as well as the continuing work in relation to Shotley Bridge Community Hospital.

Our Performance Challenges

Information about the CCG's performance against the requirements under the NHS Constitution and the health outcome measures, against which the CCG is assessed, is included from page 29. It includes information about plans that have been put in place to address those areas where performance has been below expectations.

The Covid-19 pandemic has continued to have a significant impact on performance against these standards, with significant capacity constraints being experienced throughout the whole year as resources were necessarily diverted to the pandemic response. This is reflected in the performance against the standards shown in this year's Annual Report.

The information below includes data up to and including Quarter 4 2021/22. Due to pressures arising from Covid-19 pandemic, some of the information has not been collected through 2021/22 in accordance with guidance from NHS England / NHS Improvement (NHSE/I).

Recovery plans have been developed with our local providers, utilising both capacity within our NHS hospitals and local Independent Sector providers, however these have continued to be impacted by Covid-19 restrictions, enhanced Infection Prevention and Control measures and the impact of staff being redeployed to directly support the Covid-19 response and staff absences.

Financial Statements

Also included in this report are the CCG's financial statements for 2021/22 (pages 125 to 147). One of the CCG's objectives is to make the best use of public funds to ensure health care meets the needs of patients and is safe and effective. The financial review section includes information about the systems and processes in place to achieve this – see page 56 onwards.

Temporary financial arrangements continued to apply during 2021/22, similar to those implemented during the second half of 2020/21. These were based upon the principles of system allocations, system performance and risk management, centrally set block payment values for all NHS providers, funding to support relevant Covid-19 costs and additional funding to support recovery of elective activity.

All key statutory financial duties and targets have been delivered by the CCG during the year, with an additional in-year surplus of £4.62 million delivered, reflecting the successful management of cost pressures within available funding envelopes.

The principles of system financial envelopes will continue during 2022/23 with system allocations set at Integrated Care Board level and CCG performance considered in aggregate at system level.

Anti-fraud, Bribery and Corruption

The CCG will not accept any level of fraud, bribery or corruption. We have continued to be committed to protecting our assets and are committed to promoting honesty and integrity in all our activities. We remain determined to prevent, deter and detect all forms of fraud, bribery and corruption committed against, whether by internal or external parties.

Management of Risk

The CCG has an effective risk management strategy, systems and controls in place. Risk is identified and embedded in the organisation via a number of mechanisms including a comprehensive risk register which identifies current and prospective risks to the CCG. The risk register incorporates the full comprehensive list of all risks facing the CCG at an operational and strategic level.

All risks are reviewed on a regular basis and reported to respective committees and Governing Body at least quarterly. All corporate 'red' risks, identified as having the potential to have a significant impact on the CCG corporate objectives are escalated and specifically reviewed by Governing Body. During 2021/22 our two most significant 'red' risks related to the Covid-19 pandemic and the delivery of NHS Constitutional Standards. Both represent a significant continued challenge for the CCG and the health and social care system in general.

More detail about the management of the risks to the CCG is included in the Governance Statement (page 96).

Equality and Diversity

County Durham CCG complies with the *Equality Act 2010* and the *Public Sector Equality Duty* and we have demonstrated our commitment to taking equality, diversity and human rights into account in everything we do, whether that is commissioning services, employing people, developing policies, communicating, consulting or involving people in our work. More detail is available from page 63.

Emergency Preparedness

Both our emergency preparedness arrangements and our BCP have been tested throughout the year and as referenced earlier the CCG has been an active member of the Local Resilience Forum. We will continue to review our plans to ensure that any lessons learned are incorporated.

Similarly, our member practices have appropriate business continuity plans in place which have been tested due to the pandemic.

Key priorities achieved or progressed during 2021/22

Towards the end of last year, the CCG prioritised a number of projects and work to progress during 2021/22 across a full range of areas. The Covid-19 pandemic continued to impact on plans. Priorities were reviewed on an on-going basis and work continued to focus on supporting our member practices and our partners within the County Durham Care Partnership and wider, in response to the pandemic.

In the Performance Analysis section that follows we outline in detail our performance in 2021/22. We start by looking at the CCG Performance against Constitutional Standards which details referral to treatment and over 52 week waits, A&E four hour waits and 12 Hour Trolley waits and ambulance wait times.

As supporting the response to the Covid pandemic has continued to be a priority throughout 2021/22 we have provided detail of some of the work that we have undertaken and supported (page 33).

The report then looks in more detail at the integration work set out in the themes of our four partnership boards

- acute services including the work of the urgent and emergency care network (page 37),
- children's and young people's services (page 38),
- mental health, learning disabilities and autism (page 41),
- primary care, community services and social care (page 44).

We also provide details about work undertaken in specific areas which help reduce health inequalities. These include:

- infection prevention and control (page 52),
- our Learning Disabilities Mortality Review (LeDeR) programme (page 52), and
- medicines optimisation (page 53).

Finally in the performance analysis section we provide information about the overarching priorities and enabling functions of the CCG which include:

- engaging with people and our communities (page 53),
- a financial review (page 56),
- detail about how we improve quality (page 60),
- information about reducing health inequalities (page 63).

Key pieces of work

Some specific pieces of work that we are particularly proud of are highlighted below with more detail about these and some others areas being outlined in the performance analysis section as outlined above.

Response to Covid

Reference to the response to Covid-19 including the vaccination programme is made throughout this report as it remained a national priority throughout the year. Our Medicines Optimisation, Infection Prevention and Control, and Primary Care Teams in particular have continued to support the roll out of the vaccination programme across County Durham.

This support has been multi-faceted, and complex, requiring joined up working across various aspects of the health economy; within the CCG with the primary care team, the dedicated Covid-19 e-mail inbox, the Infection Prevention and Control Team and the Executive and Medical Directors; locally with Trusts, the Local Pharmaceutical Committee and the Local Authority; regionally within the Integrated Care System and with the System Vaccination Operation Centre and also; nationally, requiring attendance at national webinars and communication with national bodies such as Specialist Pharmacy Service.

The primary care team continued to work closely with our 13 Primary Care Networks (PCNs) in County Durham to support the on-going implementation of the COVID-19 vaccination programme. This has ensured that vaccine supply, and timely delivery has been maintained throughout the pandemic to our 15, PCN managed, Local Vaccination Sites (LVS). The team have supported our PCNs and ensured that they are kept informed of any changes in national NHS England policy and the impact of these changes on the delivery of the vaccination programme.

Due to the fast-moving nature of the vaccination programme, with rapidly changing recommendations and guidance, the teams have worked hard to ensure that all Primary Care Networks (PCNs) were kept up-to-date and aware of any changes and the impact of these on the delivery of the vaccination programme.

In a collaboration between health and care systems across the whole of County Durham the CCG worked with the Local Authority to ensure that vaccine was offered to all patients in hard-to-reach groups, for example patients with Learning Disabilities, Black and Minority Ethnic groups, Refugees, Gypsy Romany Travellers, homeless people, and those from disadvantaged areas within the County.

County Durham and Darlington NHS Foundation Trust also provided significant support with regard to the vaccination programme; their community nurses continued to vaccinate the majority of housebound patients and supported the PCNs in the vaccination of care home residents and staff. The Trust also facilitated a walk-in vaccination clinic open to all adults, aged 18 and over at Durham County Council's County Hall, demonstrating the strength of mutual support and integration of organisations across County Durham.

Prehabilitation - Wellbeing for the Time Being

Wellbeing for the Time Being supports patients to prepare well, both physically and emotionally, before treatment or surgery. Those taking part in the programme, which includes cancer patients, attend an initial assessment and risk factors are discussed. A personal health and well-being plan is developed and where appropriate patients are referred to allied Health Professionals for specialist support.

The programme aims to contact 800 patients per month and feedback to date has been mixed with some patients feeling the service should have been implemented sooner, whilst others expressing their thanks for the service and requesting post-surgery support.

For more information on Wellbeing for the Time Being please see page 35.

Cancer

Cancer Services have continued to be heavily impacted by Covid-19 in 2021/22, both in terms of staffing resource impacts but also the ongoing restoration of patients presenting to their GP with suspected cancer symptoms. Where demand has recovered, diagnostic and treatment clinics are straining to meet higher than average volumes as well as clear backlogs. Performance against urgent referral and treatment targets are struggling in almost all tumour groups, not just in Durham but regionally and nationally. Progress against closing gaps in health inequalities in cancer has been impacted.

However great the challenges, there are many achievements to be acknowledged. National, regional and local public awareness media campaigns such as the #HelpUsHelpYou and #WhyWaitCancerDoesn't continue to be part of the recovery in Durham, in collaboration with the Norther Cancer Alliance (NCA) and local stakeholders. Furthermore, a social marketing campaign aimed at pushing tumour specific cancer awareness messages deeper into hard-to-reach communities began in late 2021.

For more information on Cancer work please refer to the Performance Analysis section on page 50.

Learning Disabilities / Autism

The CCG has an on-going commitment to the Learning Disabilities Mortality Review (LeDeR) programme which examines learning from the premature deaths of people with a learning disability, and temporary reviewers for the programme have now been made permanent. The focus remains on service improvement with recommendations being made at board level and a new LeDeR portal which went live in 2021 for the completion of leder reviews. Learning and recommendations taken directly from completed reviews are detailed within the LeDeR Local Area Annual Report available to the public on the CCG's website. LeDeR reviews now to include people who died with a diagnosis of Autism.

Palliative and End of Life Care

A new commissioning lead was appointed in Autumn 2021 to provide dedicated resource to developing and delivering a new County Durham strategy for Palliative and End of Life (PEoL) Care. A short-term immediate priority plan has since been developed for 2022/23, covering key topics such as admissions/discharge processes to and from hospices, taking forward recommendations from the Learning Disabilities Mortality Review (LeDeR) programme.

Longer-term planning will involve bench-marking against the six national ambitions from the National Framework to focus on seeing the patient as an individual, with individual needs as well as fair access to well co-ordinated care within care settings and communities that are sufficiently trained and resourced to provide care.

For more information on Palliative care please refer to the Performance Analysis section on page 51.

Heart Failure @ Home Project

Patients with heart failure have been identified as a priority for the NHS @home programme. Heart Failure (HF) affects 332 per 100,000 population and is higher in deprived areas with socioeconomic deprivation.

In County Durham NHSE funding was secured to run a project that supported people under the care of the CDDFT Community Heart Failure Team to self-monitor their condition using pulse oximeters, blood pressure machines, and scales. The patient's condition is flagged to the community team who are able to respond immediately, rather than wait for a deterioration in symptoms. Initial results from the project have been very encouraging, with some patients reporting an increased confidence in managing their condition without the need for multiple home visits.

More detail can be found in the Performance Analysis section of the report on page 36.

Great North Care Record

The Great North Care Record is a way of sharing patient information with health and care staff. It operates in the North East of England and North Cumbria and covers the 3.2m people living in our region. The project, which was highly commended at the at the HSJ Awards 2021, involves electronically connecting patient information from GPs, local hospitals, social care and community and mental health teams together across the system, helping to make care better and safer.

Great North® Care Record

My Great North Care Record will start being rolled out in 2022. It will mean patients can interact with their local hospitals from the ease of their smartphones or tablets. Eventually patients will be able to digitally access all their information from all NHS organisations in the North East and North Cumbria ICS.

Shotley Bridge Hospital

County Durham CCG submitted an application to redevelop the Shotley Bridge Community Hospital (SBCH) site in 2017. The original bid highlighted the failing infrastructure and unsuitability of current estate and the need to develop a modern, fit for purpose building. Work has been ongoing since this date to seek a funding source and develop a business case to design and build a more appropriate healthcare facility.

In Autumn 2020 it was confirmed that the SBCH project would form part of the New Hospitals Programme, one of 48 new hospitals to be developed nationally. Since this time work to date has been co-produced with clinicians and members of the public. Building on public engagement in 2019 and subsequently in 2021 a model of care was developed, and a proposed site chosen for future development.

In early 2022 the project was handed over to our system partners, County Durham and Darlington NHS Foundation Trust (CDDFT). Currently the Outline Business Case is being developed and assurance being sought with a planned date for completion of the project for 2025.

Working with and Supporting the Voluntary and Community Sector

The CCG had previously funded Durham Community Action (DCA) to undertake engagement between the voluntary and community sector (VCS) and the NHS within our area. The sector provided vital support both prior to and during the Covid pandemic. We were aware of the

impact of increasing numbers of people accessing support from VCS organisations and decreases in charitable donations that help our VCS organisations to continue to operate.

The development of Social Prescribing Link Workers has increased the opportunities for referral to VCS organisations for support where appropriate, instead of a referral to health and care services. Volunteering England report that every £1 spent on volunteering returns £4-£8 or more in direct economic value.

We recognised the need for longer-term funding for a VCS Local Infrastructure Organisation (LIO) and worked with Durham County Council to develop a joint agreement. With Governing Body support we increased annual funding for VCS organisations, via Durham Community Action as the LIO, to £100k per year for three years from April 2021.

Our legacy since 2013

Clinical Commissioning Groups were established with effect from April 2013. The predecessor CCGs to NHS County Durham CCG were NHS Durham Dales, Easington and Sedgefield (DDES) CCG and NHS North Durham CCG, which merged to form NHS County Durham CCG on 1 April 2020.

From the outset the CCGs had a significant level of engagement with local member GP practices and met regularly with all the local Foundation Trusts, Healthwatch and our Local Authority. This laid the foundations of the significant integration that is now seen across all organisations in the County. The success of which is reflected throughout this report.

A selection of some of the accomplishments achieved together are listed below.

Primary Care

- We introduced regular time out educational events with each practice closing for an afternoon to take part in practice wide education
- The development of the Primary Care Home concept - a forerunner of Primary Care Networks (PCNs)
- The development of GP Federations with the ability to work on behalf of PCNs to deliver services at scale on their behalf
- The establishment of incentive schemes to encourage practices to undertake more work in Primary Care. These were very successful and developed into our current Local Improvement and Integration Scheme (LIAISE) which is implemented across the whole of County Durham.
- Recommissioning of our main community contract and GP Federation employed community nurses - VAWAS Service (Vulnerable Adults Wrap Around Service)
- The development of a community-based diabetes model
- The development of community based mental health nurses wrapped around groups of general practices
- We established a GP Career Start Scheme that has been very successful in attracting and retaining GPs to County Durham

Community Services

- We commissioned a new community services contract to ensure equitable standardised pathways of care which were person-centred, value for money and improved patient experience

- We established a new community paediatric continence service pathway based on a multidisciplinary team led by a paediatric continence nurse specialist which ensures clear and effective referrals
- We invested in community stroke rehabilitation services to ensure that when people are discharged from hospital, they receive the best possible care at home from a range of professionals including physiotherapists, occupational therapists, speech and language therapists and specialist assistants
- Nationally, ophthalmology is recognised as a high-volume specialty due to a combination of an ageing population, new treatment availability and NICE guidelines, in response we established a full range of community optometry services delivered by local optometrists
- From July 2017 we commissioned Supportive - Volunteer Driver Service which offers eligible patients, often our must vulnerable patients, transport to and from their appointments

Secondary Care

- We agreed block contract arrangements with our main community and acute service provider County Durham and Darlington NHS Foundation Trust (CDDFT) which enabled us to focus resources on innovation
- We led the development of a very successful Urgent and Emergency Care Network
- Recommissioned urgent care contracts and the established enhanced access hubs for primary care

Mental Health and Learning Disabilities/Autism

Through the creation of a Mental Health and Learning Disability/Autism partnership across County Durham and Tees Valley we developed:

- Shared oversight of quality, performance and financial position, including the wider system through the Partnership Board
- Joint processes (commissioner/ provider) for agreeing investment across the whole mental health and learning disabilities / autism health system
- Shared ownership of system risk and shared solutions and mitigation planning
- A system focused upon early intervention and prevention this enabling a more equitable distribution of resources (health performing as one voice)
- Greater transparency/understanding and appreciation of financial pressures/complexities within commissioning and providers
- Increased expertise and capacity to support clinical delivery/patient pathways around complex cases across all specialties and across functions
- Strong provider forum with 70+ providers involved (from the independent sector and the voluntary and community sector). Consistent bi-monthly attendance of 15 or so different providers - giving good feedback on engagement

We have developed workstreams dedicated to promoting transformation across County Durham to support:

- Starting Well – Children and Young People
- Community Transformation
- Parity of Esteem - for mental health and physical health
- Health Inequalities
- Suicide Prevention

Through local Investment and prioritisation we have developed key initiatives including:

- Alignment of mental health resources with PCNs
- Significant investment in the voluntary sector as partners
- Investment in reducing avoidable admissions for children and young people
- The development of 'United Voices', a children's, carers' and families' co-creation group
- Investment into online counselling for young people – through Kooth
- Investment into a street triage model to support people in crisis
- Funded a number of alternatives to crisis initiatives
- Funded the If You Care Share Foundation to provide postvention suicide support

Quality

- We developed Cancer Champions within each GP Practice across County Durham
- Implemented Cancer Navigators within acute hospital settings to act as a conduit between primary and secondary care services
- Implemented the Capacity Tracker system across all care homes in County Durham to monitor bed vacancies and business continuity data
- Within Adult Safeguarding secured funding from the Academic Health Sciences Network and led a care home workforce project between commissioners, local authorities, the acute trust and providers of services to up-skill registered nurses and carers employed by care homes and ultimately improve the quality of care of residents
- Led the co-design of new suspected cancer pathway educational materials for primary and secondary care
- Developed a robust, local tool for use across the CCG; to identify the sustainability and quality of general practices
- Assisted the North Durham Palliative and End of Life Clinical Lead in supporting general practice with maintaining and updating their palliative care registers
- Established a Career Start Practice Nurse Programme
- Commissioned and developed of training programmes specifically for the nursing workforce in Primary Care

Infection Prevention Control

- Unique among CCGs in the North East we directly employ a community infection prevention and control team of nurses
- The team supports healthcare and social care workers help protect the safety of County Durham residents from healthcare associated infections, through direct education and expert advice
- They developed an infection control care champion network, held regular meetings and an annual conference that 100 care staff attended
- They have provided quality assurance in various formats to the CCG and Local Authority while maintaining strong links with County Durham and Darlington NHS Foundation Trust (CDDFT) colleagues
- We are proud to reflect that a strong infection prevention and control ethos has been embedded within County Durham provider organisations which will continue into the future health and social care structure of commissioning and provision.

Digital Innovations

- We established electronic medication ordering available for staff in nursing, care, learning disability and children's homes
- Sharing of GP patient records with clinicians in nursing homes and management staff in care home
- Set up remote consultations between care home residents and clinicians on a 1-2-1 basis or as part of a multi-disciplinary meeting using video software and tablets or mobile phones
- We procured and delivered hardware and online software to enable video consultations, vaccination bookings and remote access for staff for all GP practices / PCNs
- Secured considerable funding to support telephone system upgrades and website improvements in order to improve patient access
- Implemented patient online access to medical records
- Connected all GP practice staff to the Health Information Exchange
- Developed and supported regional clinical system resources which support pathways and referrals such as tele-dermatology
- Improved electronic transfer of care communication and referrals between primary care, secondary care and the Local Authority

Looking forward to 2022/23

This continues to be a particularly challenging time for both the NHS and wider health and care system. In addition to the pressures placed on the system by the Covid pandemic we are going through a significant period of change. Once legally established, Clinical Commissioning Groups (CCGs) will be replaced by Integrated Care Boards. Working through a due diligence process we have been preparing to ensure the safe transfer of the CCG's functions to our future Integrated Care Board for the North East and North Cumbria.

Health and Care Act

The Health and Care Act received royal assent in April 2022, with Clinical Commissioning Groups being replaced by Integrated Care Boards (ICBs) in July 2022. ICBs will take on the NHS commissioning functions of CCGs as well as some of NHS England's commissioning functions and will be accountable for NHS spend and performance within the system.

The Act makes the previously informal roles of Integrated Care Systems (ICSs) formal, to help ensure they can be held accountable and empower them to govern NHS finances at a local level. Each ICS will be led by an ICB, with responsibility for NHS functions and budgets, as well as an Integrated Care Partnership (ICP), a statutory committee bringing together all system partners to produce a health and care strategy. In July 2022 the legal establishment of the ICB will see Clinical Commissioning Groups (CCGs) abolished.

It was originally expected that these changes would come in to effect in April 2022. However, to allow sufficient time for the remaining parliamentary stages, a new date of 1 July 2022 was agreed for new statutory arrangements to take effect and Integrated Care Boards (ICBs) to be legally and operationally established.

Each ICS will have an ICP* (the Integrated Care Partnership) which will be established jointly by the ICB and local authorities, but which will be a widely inclusive arrangement of small and large organisations locally that are stakeholders in health and social care.

*Please note – the ICP referred to here is a system-wide committee that will span the NENC ICS and not the four sub-geographies across the current ICS.

Our future in 2022/23 and beyond

NHS County Durham staff will continue to work for the benefit of the population we serve be that at scale working across the Integrated Care Board for the North East and North Cumbria or locally within future place-based arrangements for County Durham. We will ensure that we build on the great work done to date in collaboration with our partners and will strive to improve the health and wellbeing of our population further.

Dr Neil O'Brien
Accountable Officer
17 June 2022

Performance analysis

In this Performance Analysis section, we start by looking at the CCG Performance against Constitutional Standards which details referral to treatment and over 52 week waits, A&E four hour waits and 12 Hour Trolley waits and ambulance wait times.

As supporting the response to the Covid pandemic has continued to be a priority throughout 2021/22 we have provided detail of some of the work that we have undertaken and supported.

The report then looks in more detail at the integration work set out in the themes of our four partnership boards

- acute services including the work of the urgent and emergency care network,
- children's and young people's services,
- mental health, learning disabilities and autism,
- primary care, community services and social care.

We also provide more details about work undertaken in specific areas which help reduce health inequalities. These include:

- infection prevention and control,
- our Learning Disabilities Mortality Review (LeDeR) programme, and
- medicines optimisation.

Finally in this section, we provide information about the overarching priorities and enabling functions of the CCG which include:

- engaging with people and our communities
- a financial review,
- detail about how we improve quality,
- information about reducing health inequalities.

Performance against Constitutional Standards

This section provides a summary of the CCG's performance against key standards. The information below includes data up to and including Quarter 4 2021/22. Due to pressures arising from Covid-19 pandemic, some of the information has not been collected through 2021/22 in accordance with guidance from NHS England / NHS Improvement (NHSE/I).

The Covid-19 pandemic has had a significant impact on performance against these standards, with significant capacity constraints being experienced throughout the whole year as resources were necessarily diverted to the pandemic response.

Performance is reviewed by NHSE/I to ensure that CCGs are delivering quality outcomes for patients both locally, and as part of the national standards.

Indicators described below include:

- referral to treatment times,
- diagnostic waiting times,
- cancer waiting times,
- Accident and Emergency (A&E) four hour waits,
- ambulance response times,
- healthcare associated infections (MRSA and Clostridium difficile).

Further information on performance against Constitutional Standards is reported to each of our Governing Body meetings. This can be found in the performance report within Governing Body papers is available on the CCG's website.

	Monthy/ YTD	Reporting Period	Operational Standard	County Durham CCG
Referral to treatment access times				
% patients waiting for initial treatment on incomplete pathways within 18 weeks	Monthly	Mar-22	92.0%	74.8%
Number patients waiting more than 52 weeks for treatment			0	997
Diagnostic waits				
% patients waiting less than 6 weeks for the 15 diagnostics tests (including audiology)	Monthly	Mar-22	1.00%	8.8%
A&E waits				
% patients spending 4 hrs. or less in A&E or minor injury unit	YTD	Mar-22	95.0%	73.9%
Handover between ambulance and A&E over 30 minutes			0	7637
Handover between ambulance and A&E over 60 minutes			0	2957
Trolley waits in A&E not longer than 12 hours			0	238
Ambulance response times				
C1 Mean (Target 7 Mins)	YTD	Mar-22	100%	00:08:05
C1 90th Centile (Target 15 Mins)			100%	00:17:04
C2 Mean (Target 18 Mins			100%	00:42:22
C2 90th Centile (Target 40 Mins)			100%	01:27:20
C3 Mean (Target 2 hrs)				01:54:22
C3 90th Centile (Target 2 hrs)		Mar-22	100%	04:51:04
C4 Mean (Target 3hr)				01:37:09
C4 90th Centile (Target 3hr hrs)			100%	04:16:54
HCAI				
Incidence of MRSA	YTD	Mar-22	0	4
Incidence of C Diff			Various	98
Incidence of GNBSI		Mar-22		604
Cancer				
% of patients seen within 2 weeks of an urgent GP referral for suspected cancer	YTD	Mar-22	93.0%	79.7%
% of patients seen within 2 weeks of an urgent referral for breast symptoms			93.0%	74.2%
% of patients treated within 31 days of a cancer diagnosis			96.0%	93.6%
% of patients receiving subsequent treatment for cancer within 31 days - drugs			98.0%	98.8%
% of patients receiving subsequent treatment for cancer within 31 days - surgery			94.0%	83.5%
% of patients receiving subsequent treatment for cancer within 31 days - radiotherapy			94.0%	97.6%
% of patients treated within 62 days of an urgent GP referral for suspected cancer			85.0%	70.6%
% of patients treated within 62 days of an urgent GP referral from an NHS Cancer Screening Service			90.0%	80.7%
% of patients treated for cancer within 62 days of consultant decision to upgrade status			N/A	82.4%

Referral to Treatment and Over 52 Week Waits

Throughout 2021/22, our Provider Trusts have formulated Elective Recovery Plans to ensure patients that have been waiting for treatment are seen. However due to continued Covid-19 restrictions including Infection Prevention and Control (IPC) measures, staff being redeployed

to directly support the Covid-19 response and staff having to isolate due to Covid, activity levels have been significantly reduced causing patients to have to wait longer to be treated.

All cases of patients waiting longer than 52 weeks have a harm review. As part of the triage of waiting lists, where treatment for patients is being delayed, these are all risk assessed for potential harm (this is also the case when the patient has chosen to delay treatment).

Acute providers have implemented robust measures to ensure that a clinical triage of all referrals is made by an appropriately qualified clinician. This can lead to the referrals being sent back to Primary Care with specialist advice for ongoing management. In addition to this, Clinicians are able to place patients in the most appropriate clinics to ensure that outpatient appointments are maximised – e.g. telephone appointment, virtual appointment or face to face appointment.

Hospitals have had to review the way they work and have adapted a number of initiatives, including Patient Initiated Follow Ups, Advice and Guidance to GPs for the management of patient care, this has had a positive impact in reducing unnecessary demand into Secondary care. They are also reviewing the clinical priority of patients to ensure all patients waiting for treatment are appropriate and are prioritised for treatment accordingly.

As part of the recovery work, additional capacity has been secured at our local Independent hospitals, to assist in reducing the backlog of patients waiting to be treated and to also support our NHS hospitals to continue to deliver urgent work, including cancer treatment. The additional Independent Sector activity is for Outpatients, non-urgent elective surgery and diagnostics.

A Waiting Well service has also been implemented across the NENC region to support patients on the waiting list and provide pre-habilitation support to prepare patients for their procedure, aiming to minimise recovery time and maximise surgical outcome.

By the end of March 2022 no patient should be waiting over 104 weeks for elective surgery, unless it is patient choice. Unfortunately, there were 12 patients still waiting for surgery at the end of March 2022, this was largely due to the complexity of the procedures involved.

Robust recovery plans that will provide a standardised approach to delivery across the ICB footprint are being developed. All NHS Provider Trusts across the NENC have committed to work closely as partners, with the support of commissioners, on targeted plans that will enable the NENC system to recover elective activity systems in a swift and equitable approach.

Diagnostics

Our Provider Trusts are continuing to work through the backlog of activity due to non urgent diagnostic work being stood down during 2020/21 and this has resulted in the target being breached. The main area of backlog has been endoscopy. As part of the agreed recovery plan, additional capacity was sought at Independent Providers which has supported in reducing the backlog. An additional CT scanner is now in place at our main Provider Trust which has supported in reducing the backlog. Work is ongoing to implement community diagnostic hubs across the region.

Cancer

Although Cancer performance has worsened throughout the Covid-19 pandemic, it has always remained a priority to ensure that there is a continuation of services. There has been pressure

in diagnostics due to strict infection control processes, however additional capacity was sought at Independent Hospitals and an additional CT scanner has helped reduced the backlog. The average waiting time for patients to be seen has significantly reduced compared to last year and the CCG and our main providers continue to implement initiatives to further reduce the cancer backlog.

Cancer hubs have been established within the North and South of the North East Region, with representatives from the Acute hospitals and Northern Cancer Alliance to review the capacity within the system to ensure that patients with a high priority are seen appropriately.

A&E four hour waits and 12 Hour Trolley waits

Throughout the year, A&E attendances have increased causing performance against the four hour wait and 12 hour standard to deteriorate. The Local A&E Delivery Board (LADB) continue to review pressures in the system and agree plans to reduce risks.

The following initiatives have been implemented to reduce patient waits in an A&E setting.

- Same Day Emergency care (SDEC) – ensuring that those patients who require longer than 4 hours but not an overnight admission are catered for in a timely and effective way.
- Emergency Department Staffing Model – ensuring a workforce fit for the future.
- Care of the Elderly and Frailty – ensuring that frail patients have their very specific needs met in the best way possible and avoiding admission to acute sites wherever appropriate.
- Expansion of Virtual Wards
- Primary Care service at University Hospital North Durham to appropriately stream patients away from A&E who should be seen by a Primary Care clinician

Ambulance response times

Our ambulance provider, the North East Ambulance Services NHS Foundation Trust (NEAS), performed well against the life-threatening response time target (C1) in 2021/22 and was one of the best performing Trusts nationally against this standard. However, the Trust has struggled with all other response times, with significantly longer wait times recorded against the Category 3 (C3) standard (for urgent problems requiring response to 90% of patients within 2 hours).

An increase in call numbers and patient acuity has impacted on performance across the standards, as well as staff sickness rates and covid isolation requirements. Ambulance handover delays at the Acute Trusts have continued to be a cause for concern, both locally and at a national level. Third party provision was procured to support the service and a 'no send' policy was implemented for those lower acuity patients, where appropriate. Additional funding was agreed to support NEAS to improve response times. This funding was used to recruit additional call handlers/health advisors, to recruit additional clinical staff - to focus on the dispatch queue ensuring clinical safety during times of surge. It was also used to increase signposting to alternative options to ambulance services, to procure third party vehicles and the development of a quality and performance deck, which has oversight of all vehicles and reviews crew movements and will liaise with hospitals in relation to handover delays / pressures to improve ambulance turn-around times.

Healthcare Acquired Infections (HCAI)

Root cause analyses are completed when these occur to determine cause and action plans are produced and followed.

Covid-19 Response

Our Medicines Optimisation and primary care teams focused on providing clinical support and advice to colleagues across the local health and social care system in support of the response to the Covid-19 vaccination campaign.

The vaccination campaign was led by the pharmacists within the medicines optimisation team which involved working with our PCNs to initially set up 14 local vaccination sites across County Durham. Through the year this has been complimented by community pharmacy sites and also widening the delivery model to GP practices where possible.

Keeping up to date for all of our clinicians on the vaccination programme as it changed throughout the pandemic and this was delivered via education sessions on the new vaccines as well as fortnightly clinical updates that were recorded and cascaded to all clinicians working in GP practices, community teams and community pharmacies across County Durham. The Medicines optimisation team provide daily advice on vaccination queries to all clinicians via a manned phone line and email box.

The work has involved addressing inequalities in covid vaccine uptake across County Durham by working with our health and social care partners. Different delivery models were explored for vaccination such as mobile buses, pop up clinics within student marquees and church halls. By the end of January 2021, the total number of COVID-19 vaccinations delivered across 23 mobile pop-up clinics was 7,988.

The team have also continued with patient safety workstreams across county Durham to address high levels of pain medication prescribing, antibiotics prescribing and continually working with our prescribers to review their prescribing to optimise treatment for our patients.

The focus of the Infection Prevention and Control Team this year has again been to provide clinical support and advice to staff in primary care, secondary care, adult social care providers and special needs schools and education in response to Covid-19. The team has continued to work closely with partners throughout the system to ensure that safe, effective care is provided and preventative measures are in place to reduce the transmission of avoidable healthcare associated infections (HCAI).

The work involved in the Covid response has included ensuring providers are aware of new guidance and how this is reflected in their practice, a point of contact to providers to answer their infection control queries. The team has worked in conjunction with Durham County Council and Darlington Borough Council and UKHSA to identify which Care homes, SEND schools that required the most support. We visited SEND schools and care homes including those with an outbreak of Covid 19 cases to provide targeted advice and support.

PCNs continue to support the COVID-19 Vaccination Programme from 15 Local Vaccination Sites and up to 40 General Practice Sites across County Durham, ensuring that all eligible individuals are offered the chance to be vaccinated. PCNs have worked with the CCG to tackle Health Inequalities by providing targeted clinics in areas of high deprivation/low uptake, out of the MELISSA vaccination bus and other community venues. In addition, PCNs in

County Durham have signed up to provide an enhanced 'out of school' offer, providing school aged children access to local vaccinations, where the opportunity for 'in school' vaccination was missed.

Most recently, PCNs have supported delivery of the accelerated Booster Covid-19 Programme as well as ensuring our most vulnerable populations are able to access 3rd and 4th doses, where appropriate.

The Covid Oximetry @ Home service improves detection of (silent) hypoxia to help reduce mortality and morbidity. The purpose of our Covid Oximetry @ Home service is to enable patients discharged from hospital to self-manage their condition where appropriate.

Over the last year the pathway has expanded to include a wide range of services, including Ambulance Services, pregnancy, learning difficulties, caring responsibilities and/or deprivation. A lighter touch pathway was also made available to any adult aged 18 – 64, that has tested positive and has not been double vaccinated. This pathway is fully self-managed and escalated

A further entry point also included a step down approach from the COVID Virtual Ward implemented in County Durham and Darlington NHS Foundation Trust hospital sites.

More details on Covid Oximetry @ Home can be found in the Performance Analysis section of the report on page 49.

In November 2020 the Government set out details for a new national requirement to establish post-Covid syndrome assessment clinics across the country. In response to this we established a multidisciplinary team (MDT) with colleagues from primary and secondary care, and community and mental health services, enabling a personalised approach to patients suffering from Long Covid.

A Long Covid pathway was developed to provide integrated, holistic, person-centred care for patients across County Durham and Darlington who are experiencing ongoing symptoms. A real benefit of the MDT clinic model is that the service is a ‘one stop shop’ for people's Long Covid support, rather than more referrals across the system to address the range of symptoms. Once linked into the Long COVID clinic, patients can continue to access the range of support within the service without having to go back to their GP.

More information on Long Covid can be found in the Performance Analysis section on page 49.

Covid Vaccination Programme

Over the past 18 months health and care organisations across the North East and North Cumbria, including NHS County Durham CCG have come together to urge the public to #DoYourBit to help protect themselves, each other, and their communities by having a free flu vaccination during winter.

With more people eligible for the free vaccine this year additional efforts have been made to encourage update amid concerns around the risk of catching flu during the pandemic.

The #DoYourBit communications campaign aimed to reassure the public that it’s safe to have the vaccine – with robust infection control and social distancing measures in place across the region. As a result, significantly more flu vaccines were given in County Durham than in previous years.

The Covid-19 vaccination programme across County Durham was rolled-out through appointment based and walk-in vaccinations from local GP led clinics, community pharmacies, Durham County Hall and The Arnison Centre mass vaccination hub.

The CCG and the Primary Care Networks (PCNs) worked collaboratively with the Local Authority and County Durham and Darlington NHS Foundation Trust to offer vaccinations to housebound patients, patients in hard-to-reach groups and those from disadvantaged areas within the County. Partnership working demonstrated the strength of mutual support and integration of organisations across County Durham.

Mobile walk-in clinics operated at numerous venues across the county, via the MELISSA bus (Mobile Educational Learning, Improving Simulation and Safety Activities), provided by Health Education England North East, and the mobile vaccination clinic provided by the System *Vaccination* Operations Centre (SVOC) at The Newcastle Upon Tyne Hospitals NHS Foundation Trust. Sites for mobile clinics were determined by national guidance and the monitoring of low vaccination uptake areas as identified by Durham County Council Public Health and the CCG vaccine inequalities teams.

Integration Work: County Durham Care Partnership

The Partnership Forum brings together, in an informal setting, CCG Governing Body Lay Members, Councillors and Trust Non-Executive Directors to focus on shared issues. These range from health inequalities, the needs of particular groups, developments in national or regional policies and their impact locally and to foster a better understanding of each organisation. The forum encourages the County Durham Partnership Executive and Partnership Boards to integrate services and highlight areas where the system is working well or may need to re-consider our approach. Underneath the Executive there are four Partnership Boards what follows is some detail of our achievements under the four themes of those partnership arrangements:

- acute care,
- children and young people's care,
- mental health learning disabilities and autism,
- primary, community and social care.

Below is a summary of work that has taken place during 2021/22 set out by these themes.

Integration Work: Acute Care including an update about the North East and North Cumbria Urgent and Emergency Care Network

Prehabilitation - Wellbeing for the Time Being

Wellbeing for the Time being is a prehabilitation programme which started in November 2021, supporting patients to prepare well, both physically and emotionally, before treatment or surgery. Those taking part in Wellbeing for the Time Being receive a letter first from the consultant that explains we will be in touch, then a phone call from the team, explaining the programmes on offer, followed by an invitation to attend an initial assessment either by telephone, virtually or in person. Risk factors and support interventions can then be discussed with the patient. A personal health and well-being plan is then developed which might include exercise and lifestyle changes. In some cases, patients can be referred to allied Health Professionals for specialist support.

In County Durham a total of 763 surgical and newly diagnosed cancer patients have been identified by the programme and are now receiving the universal offer, with around 40% proceeding to holistic assessment. The aim is to contact 800 patients per month. In addition, there have been 63 referrals into the service. Goals have been set for patients to support them while they await treatment, and these include alcohol reduction, increasing exercise, support to stop smoking, weight management and emotional and wellbeing support.

Feedback has been mixed with some patients feeling the service should have been implemented sooner, whilst others expressing their thanks for the service and requesting post-surgery support. Some patients expressed gratitude fearing they had been forgotten about.

The service is now exploring options after surgery, and patients during their cancer treatment, further exercise referral opportunities and additional staff training including Level 3 and Level 4 enhanced exercise qualifications.

Heart Failure @ Home Project

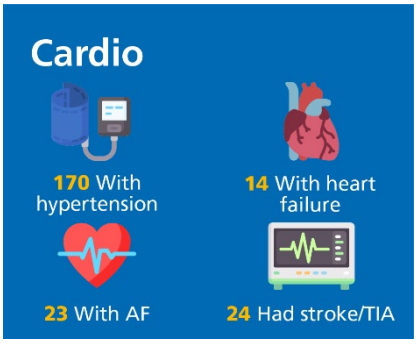
Patients with heart failure have been identified as a priority for the NHS @home programme. Heart Failure (HF) affects 332 per 100,000 population and is higher in deprived areas with socioeconomic deprivation, and accounts for 5% of emergency admissions and 2% of NHS bed days. COVID-19 has had a significant impact on outcomes and on care; in July 21 national mortality rates from HF was up by 23% since April 2020, whilst admissions for HF fell in March/April and have not recovered to pre COVID-19 levels.

In County Durham NHSE funding was secured to run a project that supported people under the care of the CDDFT Community Heart Failure Team to self-monitor their condition using pulse oximeters, blood pressure machines, and scales. The measurements taken were entered into an app designed by HealthCall that linked to the community team and with their GP records. If a patient's measurements indicated a change in the patient's condition this would be flagged to the community team who are then able to respond immediately, rather than wait for a deterioration in symptoms. Initial results from the project have been very encouraging, with some patients reporting an increased confidence in managing their condition without the need for multiple home visits, and staff have reported more targeted use of their time supporting patients that need intervention rather than routine visits where no intervention may have been necessary. The project has secured additional funding into 22-23 that will double the number of patients that can safely self-monitor at home from 50 to 100.

Research and Evidence - Evidence Synthesis Project

County Durham CCG and the NECS Research and Evidence Team are working together on a new pilot service providing high quality evidence syntheses to help inform commissioning decisions.

Evidence is clearly valued by CCGs, but studies suggest it is typically used in an ad-hoc manner with a major factor in the use of evidence being the scarcity of time to search databases and evaluate the relevant studies. Interventions focused on providing a bespoke service to assist with evidence searching and synthesis has shown tangible benefits. The aim of the project is to provide an organically developed bespoke service, to make sure the needs of the CCG are met in the best way possible.



The topics for the evidence syntheses are identified by the CCG, and the questions are clarified by the Research and Evidence Team ensure the CCG are provided with the most

relevant evidence in the shortest timeframe. Local data is provided to contextualize the evidence, aiding the ease of application of scientific evidence for best practice to the CCGs unique local population.

So far topics for County Durham CCG have focused around extra care, looking at the impact of different residential mixes in terms of need, extending stays in extra care and specific adaptations for dementia. We have also shared a report looking at Long Covid and are now looking at paediatric community nursing.

The pilot service is currently running until June 2022. An evaluation of the new service is running alongside, to see if this is something which would be good to provide on an ongoing basis.

North East and North Cumbria Urgent and Emergency Care Network

The CCG is an active member of the North East and North Cumbria Urgent and Emergency Care Network (UEC), which brings together organisations across the Integrated Care System (ICS) to ensure the quality, safety and equity of urgent and emergency care services in the region.

The network provides a delivery team (based at North of England Commissioning Support), Directory of Services (DoS) function and real time information through the UEC-RAIDR urgent care app, allowing providers to focus on operational delivery whilst the network provides operational and programme management support.

The network entered 2021/22 with clear aims aligned to the national Long Term Plan, designed to reduce pressure on emergency hospital services, provide alternative pathways to ambulance services, continue to enhance integrated urgent care services and reduce length of stay in hospital and delayed discharges.

UEC Network

The UEC network undertook an extensive horizon scanning exercise reviewing planning guidance, recommendations and good effective practice developed during the 20/21 COVID challenges at a National Regional and local level to develop the UEC Operational Delivery Plan. The UEC Delivery Plan has been centrally coordinated at ICS level for progression and implementation. The UEC network in preparation for winter 21/22 undertook an ICS system balance review identifying current pressures and challenges within the system with a final report making final recommendations to support the winter plan.

The Surge Management Team have continued to provide a coordinated approach in communicating system pressures across the ICS as well as progressing a number of targeted pieces of work such as the work with North Tees and Hartlepool in the reviewing and revision of the OPEL triggers.

UEC RAIDR App

The UEC RAIDR App has continued to be developed throughout the year enhancing the way we manage pressures across the system including the addition of additional Care Home metrics, Critical Care data automated from the national Directory of Services (DoS) and ongoing revisions of historical metrics to aid with the increasing pressure noted by our system We have worked with our Cumbria colleagues to increase the amount of data we now hold for them and are leading the way for other areas to increase their data input too.

The network has also continued to promote the smart alerts from the mobile application to allow users to be notified when there are increasing pressures, and we are continuing to develop these notifications inline with customer needs.

Our look for the year ahead is to focus on other services such as Mental Health to get a better picture of their pressures and also working with our ambulance colleagues to improve their data input.

Directory of Services

This year continued to see advances in the Directory of Services (DoS), the central directory that is used by 111 and 999 staff if the patient does not require an ambulance, and by clinicians in urgent and emergency care to identify the most appropriate referral for the patient. The DoS can now be used by a wider audience within the health care professional setting through the use of Service Finder meaning more access to service provision that is timely and up to date.

Further developments across the system rely heavily on the DoS including the new Streaming and Redirection product that has been in use in Newcastle RVI Emergency Department as well as being set up in the Queen Elizabeth, Gateshead and Northumberland Emergency Specialist Hospital and the Urgent Treatment Centres in that area. This allows patients to be directed to the most appropriate place in the hospital grounds itself, or when appropriate sign posted to a more suitable place for their healthcare needs to enable a more timely support.

The directory continues to be used in 111 Online and development is now underway to allow even more referrals for patients to more suitable settings through the tool including to registered pharmacies that can support with minor ailments which previously patients may have been redirected back to their own GP where services are very busy. The pandemic has saw an increase in the use of 111 Online and therefore the focus for the DoS team will be to ensure the services reflected in the toll are accurate, up to date and appropriate for the needs of the patients.

Integration Work: Children and Young People

Within County Durham CCG, the children's team have responsibility for CCG commissioned services for children and young people aged 0-18 and, as the statutory requirements relating to Special Educational Needs and Disabilities (SEND) falls within our remit, we are also responsible for young people aged 18-25 where they have an Education, Health and Care Plan (EHCP).

As part of the County Durham Care Partnership plans around the integration of health and social care, the team work very closely with colleagues in Durham County Council children's commissioning team. We meet regularly as a team to help with pressures and challenges across the system. As an integrated team, we prioritise service transformation projects for delivery regardless of where project management staff are employed within the system. Consequently, staff have been looking at, amongst others, the following areas of transformation:

- sufficiency of appropriate places for children coming into care,
- school equipment, aids and adaptations,
- neurodevelopmental support and diagnostic services,
- personal budgets,
- paediatric therapies,
- short breaks.

The team have continued to respond to pressures and demands relating to the COVID pandemic across the system. For example, supporting the system to prepare for the anticipated increase in very young children with respiratory disease.

Safeguarding Children

The Covid-19 pandemic has resulted in significant changes to the way the CCG and partners work to carry out their statutory functions. The Designated Nurses have linked into the National Network for Designated Professionals to understand the national safeguarding context during the pandemic. Business continuity plans were shared with the Durham Safeguarding Children Partnership (DSCP) and regularly updated with the Designated Professionals retaining oversight and feeding back via the Embedded Learning Group.

The need to reduce face to face contact resulted in the development of virtual learning opportunities with the Designated Leads providing online sessions for Practice Safeguarding Leads as well as developing sessions for Primary Care to meet level 3 competencies.

The CCG continues to be represented on Durham Safeguarding Children's Partnership by the Director of Nursing and Quality
with support provided by the Designated Doctor for Safeguarding Children who provides independent safeguarding expertise. The Safeguarding Team have continued to lead and influence the DSCP Partnership Improvement plans with impacts monitored via the Embedded Learning Group.

The successful roll out of ICON (Preventing Injuries in Children Under 12 months) has continued and an impact evaluation is to be conducted prior to the roll out of Phase 2 this year.

The Designated Nurses attend the Tees, Esk and Wear Valleys Safeguarding Public Protection Steering Group and Quality Review Group and will have oversight of the mental health needs of children and young people in county Durham.

The safeguarding Team have also engaged in quality workstreams using the RACI (Responsible, Accountable, Consulted and Informed) model to ensure that safeguarding children remains a priority across the new ICS arrangements.

Safeguarding Team roles have been reviewed to ensure they are in line with the requirements of the Intercollegiate Document and relevant changes have been made to ensure the CCG provide the right resources to support the provision of services for safeguarding children and for looked after children.

The Safeguarding Team's contribution to the DSCP Multi agency audit program has remained strong and they are leading on the next audit session which will review the compliance and effectiveness of the Bruising in Non-mobile Children Policy. The policy was introduced due to concerns that nationally and locally bruising was not always responded to appropriately by Health Visitors, Doctors, GPs and other health professionals. There have been 6 Serious Case reviews previously published in Durham that involved injuries to very young children. No Safeguarding Practice Reviews were commissioned last year in Durham.

Future Work for Children and Young People

The Board is currently reviewing the chapters of the County Durham System plan which they are responsible for as well as co-producing a new strategy for children, young people and families to ensure that the priorities included reflect experiences and changes as they stand today. The structure of the governance will be reviewed to ensure that all relevant work can be heard by members of the Partnership Board to enable issues and challenges to be resolved by the system rather than being the responsibility of one partner organisation in isolation. The focus of the sub-groups may change, depending on the direction required by the new strategy and to reflect that the Partnership Board can now oversee some service transformation work.

Maternity Services

County Durham CCG has supported the maternity services delivered by our local Trusts over the course of this year to deliver on the national maternity transformation programme as well as with implementation of the recommendations in the December 2020 Donna Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust. A brief overview of achievements in this area include:

- Project management support to get a pilot model of continuity of care up and running in Stanley Primary Care centre in November 2020. The excellent outcome data from this project supported the second phase and highlighted what was important to tweak for patients and staff. Breastfeeding rates increased and smoking at time of delivery decreased.
- Non recurrent funding to support estate solutions for co-location of midwives and health visitors in Bishop Auckland as part of maternity transformation
- Support was also put in place to offer vaccines to pregnant people and to highlight the importance of getting a covid vaccine when pregnant
- The CCG also worked with system partners to map out the pre birth pathways and offer solutions to areas for improvement such as standardisation of the public health advice, extending the mental health offer and further work on qualitative feedback from patients and partners.
- The Quality Team have also offered their support to ensuring the Ockenden recommendations are put in place and this assurance has been welcomed by NHS E
- County Durham CCG is also a part of the County Durham Care Partnership and through this is supporting the Best Start in Life agenda which is around giving 0-5 year olds the best possible beginning in life. There is a sub group which focuses on projects such as perinatal mental health, speech and language and school readiness and links up different parts of the system including maternity, health visitors and primary care.

Eating disorders work

The service has seen considerable increase in demand and more than trebled the size of the team in an attempt to meet this. We have developed partnership roles with paediatrics and work closer with paediatric wards than ever before, needing their support and expertise to manage the most at risk young people needing urgent physical health assessments.

Rapid Response Service for Young People

The Rapid Response Service for Young People (RRS) has recently been established in partnership with Durham County Council and Child Adolescent Mental Health Services (CAHMS) provided by Tees, Esk and Wear Valleys NHS Foundation Trust, and with support from Rollercoaster and Investors in Children.

The service aims to enable young people to feel safe, secure and have stability following a mental health crisis, and has been developed in response to an identified need for

additional services to support young people and their families where there is a high level of risk and need, and particularly where there has been previous or there is a current risk of admission to hospital under the Mental Health Act.

The service, staffed by one Team Manager and four RRS workers, provides intensive support and intervention packages tailored to the particular needs of a young person and their families and carers. Referrals come directly for young people on the MACC/Dynamic Support Register and from the Crisis CAMHS Team. Comprehensive risk assessments are completed for young people and reviewed monthly.

Positive feedback has been received regarding the packages of support, which aim to build resilience and coping strategies are which are tailored to each young person and can range from supporting a young person with CAHMS appointments, to support around arranging a permanent home. Rapid Response is currently working with 12 young people and this will increase over time to 20-25 with an overall plan to allocate 4/5 young people to each worker in post.

United Voice

United Voice, funded by the CCG and coordinated by Investing in Children (IIC) and Rollercoaster Family Support, is a place for Children and Young People (CYP) up to the age of 25 and their families to have their voices heard and to help shape CYPs mental health services across County Durham. Members of United Voice play a key role in evaluating the effectiveness of current emotional and mental health provision in County Durham.

The programme gives members an equal voice in the design and development of any new locally delivered CYP mental health services, with an opportunity to co-design, scope new opportunities challenge decisions and recognise good practice.

Online meetings are held bi-monthly, with sub-groups able to respond to specific issues. Examples of sub-groups include one which links in with the Rapid Response Services for Young People aged 18- to 25-year-olds, as already described in this report, and another sub-group which meets to discuss waiting lists.

United Voice isn't the only forum for young people and families to have a voice however it is recognised as a forum for young people and families within the governance of the CYP Mental Health Partnership.

Integration Work: Mental Health, Learning Disabilities and Autism

Engaging people with Learning Disability and Autism

During 2021-22, investment has been made in how health and care services are able to support local organisations as they work in partnership to engage our residents on topics that matter to them.

This includes dedicated partnerships with a range of local service providers to enable individuals who have a Learning Disability or Autism (as well as their families) to be at the heart of conversations about services for them.

By co-designing this work with community partners, their extensive knowledge and experience directly led to creative methods used for the conversations. A key element to this approach was ensuring there was recognition for the time that staff from our partners gave as part of this work.

The County Durham and Tees Valley Mental Health and Learning Disabilities Partnership

In the 2021-22 financial year, County Durham CCG, in partnership with Tees Esk and Wear Valleys NHS Trust, ran a number of programmes to better provide community mental health services. This included putting mental health workers into primary care to work alongside general practitioners to ensure mental health support was widely available. Additional investment also supported those in hospital to gain additional support ensuring they were able to leave hospital quicker and with increased support once they returned home supporting them to reengage with the community. This work has also scoped several new areas of work including a new offer for 14- to 25-year-olds as we know these transitional years are some of the most challenging. We have made new investment to support a new 'Rapid Response Service' for children, young people and families in County Durham ensuring that families are supported; this offer staffs the local authority, Tees Esk Wear Valley NHS Trust and several voluntary sector organisations to offer quick and intense mental health support during a crisis.

We continue to support the voluntary sector and have made new investment into the Community Connector Grant. £740,000 was made available to Voluntary Sector Organisations to support a mental health offer, these grants funded a range of projects from suicide prevention crisis call lines, arts projects to support older and vulnerable members of our community and support for new mums to name a few. This work has been supported and administered by County Durham Community Foundation with support from many organisations across County Durham supporting the application process.

A new vision for community mental health teams work and integrate within each place based system to provide person centred care has been created and work has been ongoing to deliver physical health care teams to ensure those with a severe mental illness receive their annual physical health care checks, ahead of national targets.

To better support people with learning disabilities, County Durham CCG piloted a change in how annual health checks and medication reviews are delivered which has made patients feel they have been listened to and feel included. Outcomes have shown quality of life improvements, lifestyle changes, medication reduction and the identification of physical health needs. Outcomes will be used across the CCG to build upon the programme success

During winter County Durham CCG invested over £450,000 to support winter pressures. This funding was used to expand hospital discharge programmes, increase social worker numbers within the local authority to ensure a quicker response during a crisis and to support County Durham and Darlington Foundation Trust. This support was to staff paediatrics with mental health staff to ensure young people who have dual needs of physical and mental health were best supported; this is an approach we will continue during 2022/23.

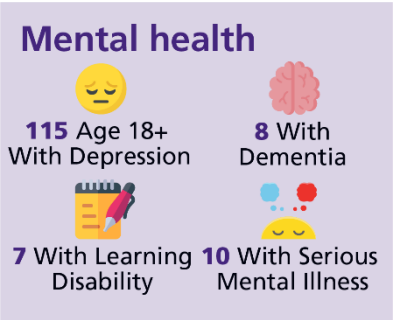
Community Mental Health Transformation

The NHS Long Term Plan described an ambitious transformation of community mental health services for adults and older people with severe mental illness (SMI). In summary, the CMHF describes a new, place-based, integrated core model for community mental health provision across all sectors. It also places specific requirements on systems to ensure there is a dedicated focus for people with a diagnosis of personality disorder, those with more chronic needs who need specialist community rehabilitation, young people's transition, adults with an eating disorder, and improving the physical health of all adults with SMI. This is a 3-5 year programme of transformation which, ultimately, will mean support looks very different for local people and will deliver place-based, integrated care (aligned to Primary Care

Networks). Implementation will be supported by 3 years of transformation money from NHSE, of which at least 20-30% is expected to be invested into VCSE provision.

The transformation is about:

- delivering flexible interventions that are needs-led, not diagnosis led,
- genuine system partnerships and shared accountability/responsibility for getting it right, and embracing the concept of "no wrong door",
- radically re-thinking how we, together, best support the needs of local populations and align services across the system with Primary Care Networks as the "place" (effectively creating community mental health hubs aligned to PCNs as far as possible),
- centred on co-production and choice/building on people's strengths,
- providing the opportunity to focus more on early intervention and prevention, making community based support more sustainable (eg voluntary sector) and, for those with the most complex needs, making sure they all have easy access to the right evidence based therapies and interventions.



Across County Durham, we have put partnership governance structures in place and have, through 2021/22, co-produced with partners, users/carers and communities a local vision of what the core model might look like. We have agreed a number of areas to be "early adopters" of this model, and through 2022 will be working with local partners within each place to operationalise the new approach. Joint working with Public Health colleagues has led to the development of a 'Population Health Management' programme, which is producing important data to help use really understand local need, and make sure the configuration of our new models is flexed to meet these needs. To support this, we have supported a range of initiatives through 2021/22 to better understand what might be helpful, including specific support relating to medication and physical health, different approaches to supporting young people through transition and opportunities to better support carers and families. We have also invested significant time and energy through 2021/22 in developing the 3 'dedicated focus areas' in the framework, ie support for people with complex emotional needs, support for people who need more specialist mental health rehabilitation, and support for adults with an eating disorder. Examples of the work we have done include:

- embedding a structured approach to better support people aged 16-25 with a first presentation of eating disorder,
- embedding a more comprehensive approach using structured clinical management for people with complex emotional needs, and testing peer mentor roles in partnership with the Police and Crime Commissioners Office,
- significant development and expansion of our community rehabilitation team, including partnerships with housing (DCC and VCSE) and VCSE providers.

NHS Community Mental Health and Learning Disability Connector Fund

The Community Mental Health and Learning Disability Fund, supported by the Durham and Tees Valley Mental Health and Learning Disability Partnership, awards grants to locally based community organisations which provide mental health and emotional wellbeing support, testing new or different ways of working to enable larger scale projects to be developed with greater reach and impact. Established in June 2021, the fund has so far awarded 34 grants with a total value of £649,096. The fund is managed by County Durham Community Foundation, an independent grant-making foundation.

Grant applications are reviewed by a panel of representatives from the NHS, local authority and community sector, with progress reports required from each organisation/group after six months. Groups receiving funding have demonstrated a determination to improve participants' mental health and wellbeing, reducing social isolation, promoting greater capacity to cope with challenging situations, where possible through increased face to face support.

Examples of organisations benefitting from the Community Mental Health and Learning Disability Fund include Durham City Youth Project, offering a holistic psychological package of support for young people, If U Care Share Foundation, supporting a suicide prevention service and Real Lives Real Choices, hosting network and membership based project to support positive mental health.

Integration Work: Primary, Community and Social Care

Continuing to support the Covid-19 Vaccination Programme

The primary care team have continued to work closely with our 13 Primary Care Networks (PCNs) in County Durham to support the on-going implementation of the COVID-19 vaccination programme. This has ensured that vaccine supply, and timely delivery has been maintained throughout the pandemic to our 14, PCN managed, Local Vaccination Sites (LVS). The team have supported our PCNs and ensured that they are kept informed of any changes in national NHS England policy and the impact of these changes on the delivery of the vaccination programme.

The CCG responded to the Government's accelerated vaccination booster campaign in December 2021 by offering the PCNs additional staffing support from the CCG and NECs staffing teams, if required, to increase vaccination provision.

The CCG also supported general practice in maintaining access to Covid-19 testing for staff during the national shortage of test availability in early 2022. This support helped ensure that our general practices were able to respond to staff isolating at home, but who were testing negative, and therefore able to return to work and ensure their general practice remained open.

Work continued throughout 2021-22 to mitigate vaccine inequalities and ensure underserved populations in County Durham had access to the COVID-19 vaccine.

The CCG and local authority have supported our PCNs and community pharmacies to deliver pop-up vaccination clinics from the MELISSA Training Bus, at Stanley, Consett, Murton and Wingate, all areas with lower vaccine uptake. To date, approximately 8,000 COVID vaccines have been administered on the bus.

A pilot, Homeless Vaccine Service was also commissioned by the CCG providing an outreach vaccination service offering both COVID-19 vaccinations and influenza immunisation to clinically eligible people, in temporary accommodation.

To support our most vulnerable patients (those aged 70+) in accessing their Covid-19 vaccination appointments, the CCG introduced a non-emergency patient transport service to local, Primary Care Networks operating Covid vaccination clinics.

An in-house transport booking system was established, and our member general practices were able to make referrals to the hub with patients then contacted directly. To date, over 1,700 transport requests have been organised.

Publication of the Primary Care Commissioning and Investment Strategy for County Durham

Our Primary Care Commissioning and Investment Strategy was launched in 2021-22. The document outlines our CCG's vision and priorities for primary care development in County Durham in the coming years.

The strategy aims to increase the scale and integration of ‘out of hospital’ services, based around local communities and improve population health outcomes, through the ongoing development of our Primary Care Networks (PCNs). Our ambition is to deliver more personalised, proactive, and co-ordinated care to improve health outcomes; we also want to ensure the future sustainability of primary care in County Durham. Our strategy outlines our plans for commissioning activity and where we will target increased investment over the next two years to support the delivery.

The strategy is multi-faceted and covers themes including addressing health inequalities and working with our partners at “place” to redesign and improve services whilst enabling proactive, personalised, and coordinated care for the residents of County Durham.

Enhanced Health in Care Homes (EHiCH)

People living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through collaborative working between health, social care, Voluntary, Community, and Social Enterprise (VCSE) sector and care home partners.

The NHS Long Term Plan (2019) contained a commitment as part of the Ageing Well Programme to roll out EHiCH across England by 2024. The project commenced in 2020 and became a key strategic priority for the CCG; with the Primary care team working with our partners in Durham County Council and County Durham and Darlington NHS Foundation Trust, on the system-wide implementation across County Durham.

The EHiCHEnhanced Health in Care Homes (EHiCH) model moves away from traditional reactive models of care delivery, and towards proactive care that is centred on the needs of individual residents, their families and care home staff. Such care can only be achieved through a whole-system, collaborative approach.

A key objective from the primary care team during the year was to gain a clear understanding of how well EHiCH is embedded across our PCNs; how well it is integrated, and how effective the associated wrap-around care being provided into care homes is currently.

Going forwards, the aim is to provide clear recommendations about what needs to be done in County Durham to extend levels of integrated working; improve workforce skills, whilst also improving the standards of care being provided to people living in our care homes.

Anticipatory Care

Anticipatory Care is a national programme of work that features as a key priority of the NHS operational plan. The initiative considers proactive care and support, targeted at people living with frailty, multi-morbidity and / or complex needs, that helps them to stay independent and healthy for as long as possible at home.

An Anticipatory Care Plan is bespoke and developed in consultation with the individual concerned, their carers, and their GP, and also with input from other health and social care services. Its sets out exactly what is to happen in the event of a ‘crisis’ in and out of hours. This

way those who are meeting the person for the first time will know exactly what the patient's circumstances are and can follow the care plan which has already been agreed. Central to this plan is the aspiration for the patient to be supported locally at home or in the community and not admitted to hospital inappropriately.

In October 2021, the primary care team began work to develop and co-produce with key local partners, a comprehensive primary care model of Anticipatory Care. As there are already several services which contribute towards Anticipatory Care in County Durham, the first stage of activity is looking at identifying what is already in place and where best practice exists. It is anticipated that this information can then be used as a baseline position for improvement.

Local Improvement and Integration Scheme (LIAISE)

In 2021-22, we continued to develop our local primary care incentive scheme LIAISE. The scheme builds on the areas of enhanced primary care services, by applying local additions that closely match the needs of the residents of County Durham, in line with local and national health care priorities.

We use our LIAISE scheme as a vehicle to bring together all elements of the Primary Care Strategy. Through financial rewards, the scheme encourages our primary care services to meet additional targets that seek to reduce inequality of services and encourage prevention, integration, and the future development of our individual practices and Primary Care Networks as the building blocks of place-based services across County Durham.

GP Career Start Scheme

The County Durham GP Career Start scheme has been running successfully since 2015 with almost 50 GPs accessing the programme to date.

The GP Career Start initiative is aimed at attracting GPs who are looking for the opportunity to take up a post in general practice. The programme offers GPs the chance for ‘added value’ personal development. For example, medical student teaching and minor surgery, as well as benefitting from a mentorship programme whilst, at the same time, trying to expand the role of primary care within the local health economy.

It is envisaged that after completing the first two years of these salaried posts (hosted by individual practices) that GPs will be ready to take the next step to partnership in a practice within our County Durham area. Our practices are keen to ensure that GPs flourish, rather than be flattened by an immense workload, hence the emphasis on development. GPs have regular contact with a GP trainer who ensures that they are managing well, and they are getting the best possible experience.

In 2021-22, work began on a proposal to increase capacity in the current GP Career Start scheme. It is anticipated that an 'enhanced offer', and a so-called 'GP Career Start Plus' scheme, will attract more GPs to work in the 'place' of County Durham, contributing to general practice resilience.

Practice Nurse Career Start Scheme

The Career Start Practice Nurse (CSPN) programme was originally identified following discussions around developing a service to offer clinical sessional cover to enable the existing Practice Nursing teams to be released to undertake professional development. However, it was recognised that this also presented an opportunity to introduce and train nurses new to Primary Care and so provide an opportunity to address future workforce succession planning.

The innovative Career Start Practice Nurse programme offers nurses the opportunity to gain knowledge and skills whilst working alongside experienced nurses and teams in a base practice and the locality.

Established in Derwentside in 2001 it now covers all 5 areas of County Durham. Since 2001 there have been 68 nurses through the CSPN programme and over 88% have remained in Primary Care. There are 8 CSPNs currently in post. One will leave in May 2022 and we have recruited 3 who will start over the next few months. We also placed one nurse in Darlington and she is now working in a practice in County Durham.

Each CSPN is employed on an Agenda for Change Band 5, 30 month fixed term contract working 18.75hrs (0.5WTE) per week. Each CSPN has a base practice and nurse mentor who works collaboratively with the Practice Nurse Link to promote effective communication, encourage development and ensure access to training opportunities. This in turn ensures the delivery of safe, appropriate and cost effective care for patients

Protected Learning Time (PLT) is incorporated into their working week to ensure time for training, reflection and consolidation of learning and development of clinical competence. In their first year they will have 7.5hrs per week PLT. This reduces to 3.75hrs per week for the remainder of their post. This allows them to access opportunities to help them develop a portfolio of skills and knowledge required in Primary Care.

They offer clinical sessional cover to encourage the existing locality nursing workforce to access training and professional development.

The programme:

- offers structured recruitment for Practice Nurses in response to the workforce needs for the future planning,
- enables existing nurses to access professional development without clinic interruption and so minimise any disruption to patients,
- helps to address workforce progression by developing nurses who have enhanced and appropriate knowledge and skills,
- encourages collaborative working across localities between CCGs, GP Federations, PCNS, General Practice and the wider healthcare providers,
- it promotes delivery of safe, effective patient care.

Improving access for patients to Primary Care and supporting General Practice

In preparation for what was expected to be a very demanding winter period NHS England issued a 'Plan' in October 2021, which set out actions designed to support improved patient access to general practice including access to face to face appointments with GPs.

Actions contained in the Plan were aimed at:

- addressing variation in access to primary care and encouraging good practice
- increasing and optimising primary care capacity and
- improving communication with the public about primary care, including tackling abuse and violence against NHS staff.

A £250 million Winter Access Fund (WAF) was established to enable implementation of the Plan and specifically, to improve patient access to urgent, same day care, outside of hospital. Our PCNs were invited to submit bids for access to the money with the aim of increasing staffing levels across County Durham and therefore increasing the capacity and speed at

which our residents can access their surgeries. A total of £1.1 million of the Winter Access Fund was received in County Durham.

Admissions Avoidance Review Launched

The CCG commenced a review in early 2022 to look at admissions into primary care services that could potentially be avoided. The review is looking at service provision across County Durham with an aim to integrate the new national Urgent Care Response Standards.

The ambition of the new standards is to improve the offer for patients and deliver improved access and outcomes providing an overall better experience of care. The proposals set out how changing the measures for urgent and emergency care would not only reflect the change in how people expect to access care, but also enable the ongoing improvements in how that care is received. The intention is to enable a new national focus on measuring what is both important to the public, but also clinically meaningful.

The services under review include the Vulnerable Adult Wrap around Service (VAWAS) in south Durham, pro-active home visiting service, also in south Durham. The weekend home visiting service for elderly patients in north Durham, and our PCN Home visiting service.

The review aims to streamline these services, identify where improvements can be made to ensure better integrated working across the system and how these services can work with system partners to deliver the nationally mandated Urgent Community Response.

Extended Access: County Durham Overflow Hub

In November 2021, the CCG commissioned a pilot to provide an overflow appointments hub to Primary Care in County Durham. The pilot also aims to identify where improvements can be made to ensure the appropriate filtering of patients between primary and secondary care, whilst looking to ease the pressure on County Durham and Darlington's NHS Foundation Trust's Accident and Emergency Department.

The pilot reviews the type of condition of patients presenting into the Accident and Emergency department. The aim is to identity, at front of house, which is the most appropriate service for patients, and redirect them accordingly based on their individual need.

These patients are either streamed to various options such as A&E, Same Day Emergency Care (SDEC), Urgent Care, X-Ray facilities, or if the presentation is suitable for management in primary care.

This has been a key project in terms of demonstrating the success of integrated working across partners in County Durham, the initial pilot for General Practice streaming gathered valuable data which can inform service design and decision making into 2022-23 and beyond.

Supporting our Primary Care Networks (PCNs) in their development

Through the ongoing development of our Primary Care Networks (PCNs), our aspiration is to improve the quality of primary care delivery, improve health outcomes and ensure the future sustainability of primary care in County Durham.

Our PCNs successfully completed their workforce plans for 2021/22 and are currently recruiting well to a range of additional roles. If the plans are achieved in full, we anticipate approximately 80% utilisation of the total Additional Roles Reimbursement Scheme (ARRS) fund allocation, which will be an improvement on 2020-21.

The recruitment of the mental health practitioner roles to work in primary care settings continued. These are jointly funded between Tees, Esk and Wear Valley NHS Foundation Trust and our PCNs. The recruitment of community paramedics working in general practice also got underway in 2021-22.

Two new service specifications within the Network Contract DES have commenced with effect from 1 October 2021. The specifications focus on improving cardiovascular disease prevention, through improving diagnosis of patients with hypertension and improving access to blood pressure testing.

The second specification focuses on tackling Neighbourhood Health Inequalities and has initially focused on people with learning difficulties, and severe mental illness. PCNs have started work to identify a population within their PCN experiencing inequality in health provision and / or outcomes and will develop improvement plans by the end of March 2022 to tackle their unmet needs.

Long Covid Services

For some people, COVID-19 can cause symptoms that last weeks or months after the infection has gone. This is known as post-Covid syndrome, or Long Covid. In November 2020 the government set out details for a new national requirement to establish post-COVID syndrome assessment clinics across the country. In response to this we established a multidisciplinary team (MDT) in December 2020 with colleagues from primary and secondary care, and community and mental health services, enabling a personalised approach to patients suffering from Long COVID.

A Long COVID pathway was developed to provide integrated, holistic, person-centred care for patients experiencing ongoing symptoms. The service is a 'one stop shop' for Long COVID support enabling patients to continue to access a range of support without having to go back to their GP.

The overall Long COVID pathway includes 3 tiers:

- Tier 1: Self care
- Tier 2: Primary care assessment and management by GP, promoting self-care and linking with the COVID resilience team and Wellbeing for Life team for support, and referral to Tier 3 if appropriate
- Tier 3: Long COVID service – assessment and intervention
  - Initial assessment with a GP and Medical consultant; access to therapy and mental health advice
  - Combined clinic appointment with access to clinicians, therapists, mental health practitioners depending on the personalised patient plan
  - Follow-up reviews
  - Long COVID specialist support e.g., rehabilitation
  - Targeted group or individual intervention to support self-management

Clinics are currently held at Shotley Bridge Hospital and Sedgefield Community Hospital. All referrals into the service are made by a patient's GP after they have carried out a series of initial investigations. The Long COVID service is for those who are experiencing prolonged symptoms 12 weeks or more after their initial COVID-19 illness.

Covid Oximetry @ Home

Covid Oximetry @ Home As treatment of Covid-19 can help further reduce mortality and morbidity, to enable enhanced self-management by patients. Patients who are clinically stable

but are at risk of deterioration because of factors such as age or co-morbidities can access the service when discharged from a hospital setting, or when presenting at a practice or through '111'.

Enhanced self-management support, including the use of oximetry, enables early identification of deterioration, in particular silent hypoxia, so that appropriate action can be initiated as quickly as possible. Patients are offered an enhanced support package which includes a pulse oximeter and instructions on how to use it, and remote contact from practice staff at agreed times if required, for a maximum of 14 days. A clinician provides an assessment where their baseline data is collected and patients then record their clinical information (including oxygen saturations) three times a day.

The Service went live in December 2020 and over the last year the pathway has expanded to include a wide range of services, including Ambulance Services, pregnancy, learning difficulties, caring responsibilities and/or deprivation. A lighter touch pathway was also made available to any adult aged 18 – 64, that has tested positive and has not been double vaccinated. Data is now being automatically extracted from practices showing County Durham with high referring, onboarding and off boarding patients onto the pathway since go live.

A further entry point also included a step down approach from the Covid Virtual Ward implemented in County Durham and Darlington NHS Foundation Trust hospital sites, which allowed patients who could be managed at home to be referred into the pathway through the GP and discharged from Hospital. These patients again would be triaged and would only be requiring a lower level of support of monitoring.

Cancer

Cancer Services have continued to be heavily impacted by Covid-19 in 2021/22, both in terms of staffing resource impacts but also the ongoing restoration of patients presenting to their GP with suspected cancer symptoms. Where demand has recovered, diagnostic and treatment clinics are straining to meet higher than average volumes as well as clear backlogs. Performance against urgent referral and treatment targets are struggling in almost all tumour groups, not just in Durham but regionally and nationally. Progress against closing gaps in health inequalities in cancer has been impacted.

However great the challenges, there are many achievements to be acknowledged. National, regional and local public awareness media campaigns such as the **#HelpUsHelpYou** and **#WhyWaitCancerDoesn't** continue to be part of the recovery in Durham, in collaboration with the Norther Cancer Alliance (NCA) and local stakeholders. Furthermore, a social marketing campaign aimed at pushing tumour specific cancer awareness messages deeper into hard-to-reach communities began in late 2021. A much-anticipated lung cancer case-finding pilot secured funding in 2021 and plans are in development to roll-out the pilot in areas with some of the highest levels of deprivation, smoking and COPD prevalence in the county. This pilot will see high-risk patients being supported and offered a low-dose CT scan in order to detect lung cancer as early as possible as well as provide further training and awareness within clinical teams. The national Galleri Trial, a blood test that picks up multiple cancers, arrived in the North East in 2021, with a planned Durham roll-out in Spring – again targeting areas of high deprivation and health inequalities first. Further development of stratified follow-up has continued for prostate and colorectal, with gynae, thyroid and haematology tumour groups to follow in 2022/23. Patient experience surveys carried out by CDDFT have shown encouraging results in terms of quality in patient care, despite the pressures and challenges. A new Macmillan Programme is under development to build upon previous and existing clinical and non-clinical support services. The Cancer Awareness Team, commissioned by Public Health and delivered by the Pioneering Care Partnership, continue to demonstrate great results in

reaching out to vulnerable and at-risk communities around screening uptake and symptom awareness. Finally, work began in 2021 to work closer with Primary Care to support their objectives around early diagnosis. The next twelve months will continue to challenge, particularly around workforce pressures and diagnostic capacity, but the achievements and progress made in 2021/22 are a significant step forward.

Palliative and End of Life Care

A new commissioning lead was appointed in Autumn 2021 to provide dedicated resource to developing and delivering a new County Durham strategy for Palliative and End of Life (PEoL) Care. A short-term immediate priority plan has since been developed for 2022/23, covering key topics such as admissions/discharge processes to and from hospices, taking forward recommendations from the LeDeR programme, a review of KPIs and data to baseline current performance, refreshing links with Primary Care Networks around Palliative Care Registers and collaboration with NEAS on accessing crucial patient details in emergency calls, developing a staff training and awareness programme and developing specialist services both in hospices and the wider community such as paracentesis and dementia support.

Longer-term planning will involve benchmarking against the six national ambitions from the National Framework (2021/26) as well as specific PEoL-related Personalised Care goals from the NHS Long Term Plan. Both of these frameworks focus on seeing the patient as an individual, with individual needs as well as fair access to well co-ordinated care within care settings and communities that are sufficiently trained and resourced to provide care. County Durham patients have historically been hindered with fair access issues arising from rural vs urban geographies but staffing and specialist skill shortages add to the challenge. In early 2022, key stakeholders will be involved in identifying gaps in service provision as well as benchmarking and mapping exercises to build a long-term strategy in order to meet the six national ambitions by 2026. PEoL Care does not follow a traditional linear pathway like many other clinical pathways, such as cancer, rather the care needs and choices of the individual and their families/carers are placed at the centre of the care model. Collaboration, innovation and learning between commissioners, acute and community hospitals, hospices, care homes and domiciliary care providers will be essential to longer-term transformation.

'Do It For Yourself' Lung Cancer Campaign

Covid-19 caused confusion over lung cancer symptoms and hesitancy of GP visitation by patients. The diagnosis is associated with fear and stigma, and disproportionately impacts the vulnerable and those living in deprived regions who are less likely to access healthcare services. As a result Covid-19 was seen as partly responsible for a decline in Lung cancer referrals across the country, impacting rates of early diagnosis.

The ‘Do It For Yourself’ campaign sought to raise awareness of symptoms and the fact that not every cough is Covid-19, whilst reassuring people that their GP practices are open and ready to see them safely. Do It For Yourself, rolled out across our region by North Cancer Alliance, brought together a broad coalition of organisations to create an insight-led, integrated, regional lung cancer awareness campaign.

The campaign focussed on men as the primary audience for the campaign. Research was undertaken to identify key barriers across the audience demographic. Messaging frameworks were developed, with online focus groups to identify the most impactful execution of the campaign.

Initial results indicate that the campaign was successful in creating a message which resonated with the target audience, gaining significant reach through an effective multi-channel

approach. Partner feedback confirmed that the campaign helped fill a gap, helping the Northern Cancer Alliance to build further visibility and credibility within local communities, as well as enhancing connectivity between national and regional organisations.

Additional achievements of dedicated teams within the CCG

Infection Prevention and Control

April 2021/March 22 the Infection Prevention and Control Team continued to work closely with partners throughout the system to ensure that safe, effective care is provided to the people of County Durham and Darlington and preventative measures are in place to reduce the transmission of avoidable healthcare associated infections (HCAI). Our focus this year has again been to provide clinical support and advice to staff in primary care, secondary care, adult social care providers and special needs schools, education in response to Covid-19.

The work involved in the Covid response has been challenging to the team and we have undertaken a significant amount of work. This has included ensuring providers are aware of new guidance and how this is reflected in their practice, a point of contact to providers to answer their infection control queries. The team has worked in conjunction with Durham County Council and Darlington Borough Council and UKHSA to identify which Care homes, SEND schools that required the most support. We visited SEND schools and care homes including those with an outbreak of Covid 19 cases to provide targeted advice and support.

The team continued with non-Covid 19 work, completing assurance visits to primary care and care homes. Continued to monitor and investigate CCG assigned Clostridium difficile and Methicillin-resistant staphylococcus aureus bacterium cases. Visited and gave advice to care home staff when a resident has tested positive to an alert organism.

Learning Disabilities Mortality Review (LeDeR) programme

The CCG remains fully committed to learning from the premature deaths of people with a learning disability in order to influence change and implement service improvements across health and social care where necessary. Temporary reviewers have now been made permanent. Learning and recommendations taken directly from completed reviews are detailed within the LeDeR Local Area Annual Report available to the public on the CCG's website. Notable achievements to date from the learning from LeDeR reviews include the following:

- On-going governance arrangements and multiagency working through the service improvement group
- The service improvement group meet bi-monthly with a range of health and social care professionals with a focus upon service improvement for people in County Durham with a learning disability. We now including patient representation to ensure the needs of those with a learning disability are being heard.
- Learning Disability Link Nurses working collaboratively with Care Providers to complete Annual Health Checks.
- Feedback from Care Providers have identified the benefit of link nurses working directly with care home in completing annual health checks. Since the alignment of GP practices with individual Care Homes, one practice has started monthly ward rounds with multi agency partners which has led to better understanding of learning disabilities and sharing of knowledge (reasonable adjustments, referral routes)
- Quality Checkers pilot extended to GP practices, to assess quality of service from the view-point of people with a learning disability

- Skills for People have recruitments and supported people with a learning disability to assess three GP practices in relation to their support of people with a learning disability and reports of their finding submitted. The pilot also aimed to look at social service provision and TEWV
- TEWV staff in post to support Annual Health Check's, referral form available on GPTN
- A learning Disability Nurse has been employed by TEWV to support GP Practices to increase the annual health check compliance.
- Health Call digital rolled out to specialist learning disability residential providers
- A pilot of five residential care homes with learning disabilities has commenced in Durham Dales with the support of DDHF. The Care Home are provided with medical equipment and an electronic tablet to record and upload observations to the GP. This has been successfully rolled out to older persons care homes

Medicines Optimisation

Our Medicines Optimisation team focused on providing clinical support and advice to colleagues across the local health and social care system in support of the response to the Covid-19 vaccination campaign.

The vaccination campaign was led by the pharmacists within the medicines optimisation team which involved working with our PCNs to initially set up 14 local vaccination sites across County Durham. Through the year this has been complimented by community pharmacy sites and also widening the delivery model to GP practices where possible.

Keeping up to date for all of our clinicians on the vaccination programme as it changed throughout the pandemic and this was delivered via education sessions on the new vaccines as well as fortnightly clinical updates that were recorded and cascaded to all clinicians working in GP practices, community teams and community pharmacies across County Durham. The Medicines optimisation team provide daily advice on vaccination queries to all clinicians via a manned phone line and email box.

The work has involved addressing inequalities in Covid vaccine uptake across County Durham by working with our health and social care partners. Different delivery models were explored for vaccination such as mobile buses, pop up clinics within student marquees and church halls. By the end of January 2021, the total number of Covid-19 vaccinations delivered across 23 mobile pop-up clinics was 7,988.

The team have also continued with patient safety workstreams across county Durham to address high levels of pain medication prescribing, antibiotics prescribing and continually working with our prescribers to review their prescribing to optimise treatment for our patients.

Engaging people and communities

Integrated Care System Engagement Strategy

The County Durham CCG Engagement team have been working with colleagues across the North East and North Cumbria ICS. Together they have been exploring what is important to our local stakeholders/members of the public by asking for feedback and thoughts on topics such as:

- *What they think currently works well about how local NHS organisations involve people and what they think could be improved*
- *Listening to any concerns they may have about involvement at a regional level*

- *As well as trying to understand what the term 'place' means to you (for example, County Durham, or a smaller neighbourhood or community)*

A series of local conversations took place in each part of the ICS. In County Durham this included audiences such as our Patient, Public and Carer Engagement Committee, Durham Youth Council, the Better Together Forum and Healthwatch County Durham.

The feedback received was collated together with that from across the North East and North Cumbria and has been used to further develop a strategic approach to involvement for the region.

Developing Integrated approaches to Engagement

Across County Durham, working has continued to develop our local arrangements and structures that support public engagement within integrated commissioning.
This work is a continuation of the integrated commissioning arrangements between health and care services in County Durham. It also has focused on how the collective County Durham voice connects into the emerging ICS arrangements.

A core principle for this development work was a co-produced approach. Connecting with our network of volunteers, such as PRG members, GP and PCN leads as well as our voluntary and community sector organisations to start to develop our thinking on how engagement could work across County Durham in the future.

From this work, proposals built on the benefits already demonstrated from having engagement as part of the commissioning organisation's governance (through our PPCE Committee) arrangements, which can be of significant benefit to the wider system.

Wingate GP practice patient survey

All of the registered patients at this practice were written to directly, providing them with information about the conversations that were needed to help inform future planning of their Primary Care services.

A copy of a the visual summary and Frequently Asked Questions documents were made available on the CCG website, as well as a stakeholder briefing being sent out directly to local Councillors in the surrounding areas.

The period of engagement for all patients registered at the Wingate GP practice closed towards the end of July 2021. The survey had a great response with over 800 individual surveys completed and returned in relation to the views of patients, the total responses representing 26% of the registered patient population who were contacted.

The information captured through this patient engagement was written up and the report from the feedback has been published on the CCG website and shared with the Primary Care team at the CCG to include as part of their future planning and provision of this contract.

Community Equipment

Following on from the Community equipment services engagement in the previous year, further engagement in relation to Community Equipment Services took place.
A co-production approach was used with people who have used the service, carers and staff which included representation from the Gypsy, Roma and Traveller community, faith communities and Veterans. A series of sessions focussed on how to increase the items that are returned once they are no longer needed. Members of the co-production group developed plans for an amnesty style "returns roadshow" in 2022.

In addition to this, the Community Equipment co-production group have been developing the concept of community champions and a long-term plan to improve the returns rate of un-used equipment.

Home Oxygen Assessment service

Patients who have used oxygen from the Home Oxygen Assessment Service and live in; Middlesbrough, Redcar and Cleveland, Darlington, County Durham, South Tyneside or Gateshead were asked for their views about the service.

The CCGs were keen to understand the views and experience of patients who have used the Oxygen at Home Service, how they access it, any barriers to service and what a 'good' service looks like to them.

The survey questions were posted out to a sample of the existing service users, as well as an online version of the questions being available more broadly.
The analysis of the patient feedback was undertaken by staff from the Tees Valleys CCG engagement team on behalf of the partners involved. You can find the full engagement report from this work on the CCG website using the link included.

Little Orange Book

The Little Orange Book is a great resource and covers everything from common minor ailments like teething, constipation and colds, through to more serious conditions like urinary tract infections and wheezy chests.

Support was provided to the commissioning team working across County Durham and Tees Valley CCGs as part of the promotion of the 'Little Orange Book'. This specifically related to the production of the animation about this resource for parents to help them find out about it through social media information. Further information is available on the CCG website - https://countydurhamccg.nhs.uk/little-orange-book-lends-new-parents-a-helping-hand/

Shotley Bridge Community Hospital services

Following the previous period of public engagement in February and March 2021, the CCG published the report with this feedback on their website. This period of engagement was focused on further public dialogue regarding the proposed clinical model in relation to Shotley Bridge Community Hospital services.

The information obtained during the public engagement was then able to be taken into the initial development of designs for the new building. To support this work further, participants from the engagement work were invited to join a series of discussion groups which looked at the design elements in more detail.

The Shotley Bridge Community Hospital project transferred to County Durham and Darlington NHS Foundation Trust (CDDFT) in Spring 2022. The project will benefit from dedicated engagement resource led by the Trust during a period of handover.

Financial Review

Overview

Temporary financial arrangements continued to apply during 2021/22, similar to those implemented during the second half of 2020/21. These were based upon the principles of system allocations, system performance and risk management, centrally set block payment values for all NHS providers, funding to support relevant Covid-19 costs and additional funding to support recovery of elective activity.

For County Durham CCG, the system funding was allocated at an Integrated Care Partnership (ICP) level.

County Durham CCG is part of the 'Central ICP', alongside the following constituent organisations:

- NHS South Tyneside CCG
- NHS Sunderland CCG
- County Durham and Darlington NHS Foundation Trust
- South Tyneside and Sunderland NHS Foundation Trust

Constituent organisations may achieve a surplus or deficit but as long as the ICP in total achieved at least a break-even position, the system and the member organisations will have been deemed to have achieved financial targets.

The maintenance of financial control and stewardship of public funds has remained critical during the NHS response to Covid-19. All financial controls have continued to operate as normal and the robust systems of financial governance and financial management processes have allowed all financial risks to be appropriately managed during the year enabling the delivery of financial targets.

Further details on the CCG's financial position can be found in the Governing Body (GB) finance reports published on the CCG's website.

This continues to be a challenging time for the NHS with significant pressures from managing the impact of the pandemic and recovery of activity backlogs. The financial performance outlined in the CCG's annual accounts is pleasing to see, reflecting the strong financial management within the organisation.

Financial targets and performance for the year

CCG surplus position

In addition to the requirement to fulfil its statutory duties, the CCG is expected by NHSE/I to deliver a cumulative surplus of at least 1% of its funding allocation. This surplus is carried forward from one year to the next.

For County Durham CCG, NHSE/I confirmed the CCG's historical brought forward surplus for 2021/22 of £22.28 million. This excludes the surplus delivered in 2020/21 of £2.35 million and NHSE/I have confirmed this will not be returned to CCGs.

During 2021/22, County Durham CCG improved their performance against plan. This resulted in the CCG delivering an in-year surplus of £4.62 million in total.

A summary of the CCG's final surplus position at the end of the year is as follows:

	£ million	% of total funding
Surplus brought forward from prior year	22.28	1.9%
Total funding allocation received for the year	1,179.05	100%
Total spent by the CCG	1,174.43	99.6%
Additional surplus delivered in year	4.62	0.4%
Final surplus carried forward to 2022/23	26.9	2.3%

It is important to note that this final surplus balance of £26.9 million is not a 'profit' or surplus generated during the financial year. The majority of it reflects a historical balance carried forward from previous years, with an additional £4.62 million of surplus generated during 2021/22 as a result of improved CCG performance and the impact of the temporary financial regime implemented for the year.

The CCG's successful results in 2021/22 are set out in the table below, with further detail included in note 17 of the full annual accounts published alongside this Annual Report.

Target	Outcome	Target Met?
Maintain expenditure within 'in-year' funding allocation	In-year surplus of £4.62 million against an in-year funding allocation of £1,179.05 million	✓
Maintain running costs within separate running cost allowance	Surplus of £1.16 million delivered on running cost budgets	✓
Maintain capital spending within capital resource limit	No capital resource required and no capital spend in year	N/A
Ensure cash spending is within the cash limit set	Cash managed within available resources	✓

Expenditure not to exceed resource limits

Unlike commercial companies which make a profit or loss, CCGs are set resource limits within which they must contain net expenditure for the year. There are separate resource limits set for revenue and capital expenditure, with revenue expenditure limits further split between programme spend and running costs.

The CCG financial performance is reported on an in-year basis.

The CCG's final in-year programme budget allocation for 2021/22 was £1,168.6 million.

As highlighted above, a separate running cost allowance is provided to all CCGs, to cover the administrative costs of running the CCG. There is a requirement to manage administrative costs within this allowance.

Total running costs for the year amounted to £9.3 million, compared to a running cost allowance of £10.5 million. That underspend on running costs was used during the year to increase spend on direct healthcare.

Capital resource limit

The CCG had no capital expenditure in 2021/22 and therefore did not require any capital resource, hence this target is not applicable in the current year. In future the capital requirements of the CCG, and any related capital resource received, are expected to be minimal.

Other financial targets and disclosures

In addition to the above statutory duties, CCGs have similar responsibilities to other NHS organisations to record performance against the Better Payment Practice Code (BPPC) published by the Department of Health.

Compliance with Better Payment Practice Code

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

The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms.

Details of compliance with the code are given in note 5 to the financial statements.

Performance against the target is monitored by the CCG on a monthly basis with performance maintained at over 95% of invoices paid within 30 days of receipt, measured against both total invoice value and overall volume of invoices.

Prompt payments Code

In addition to compliance against the BPPC, on 11 February 2014 the CCG became an approved signatory of The Prompt Payment Code. This initiative was devised by the government with The Institute of Credit Management (ICM) to tackle the crucial issue of late payment and to help small businesses. Suppliers can have confidence in any company that signs up to the code that they will be paid within clearly defined terms, and that there is a proper process for dealing with any payments that are in dispute.

Approved signatories undertake to:

- pay suppliers on time,
- give clear guidance to suppliers and resolve disputes as quickly as possible,
- encourage suppliers and customers to sign up to the code.

Setting of charges for information

The CCG has complied with HM Treasury's guidance on setting charges for information.

Pensions

Details of the accounting for pension liabilities can be found in the accounting policies and pension costs notes in the CCG's financial statements (notes 1.7.2 and 3.3 respectively). Further details of senior managers' pension benefits can be found in the Remuneration and Staff Report.

Audit and Assurance Committee

An Audit and Assurance Committee has operated throughout the year, chaired by the Lay Member for Governance and Audit. Details of other members of the committee can be found within the Members Report.

External auditors

Ernst & Young continued to be the appointed auditors to the CCG for 2021/22.

The cost of audit services can be found in note 4 of the CCG's financial statements.

The auditors bring an annual work plan to the Audit and Assurance Committee for approval. This states that the audit team are independent of the CCG and also would include any details of non-audit work if applicable. When considering whether the level of any non-audit work is appropriate the CCG would consider the composition of the team (and whether any audit team members are involved) and the level of fees.

Looking forward

This continues to be a particularly challenging time for both the NHS and wider health and care system. The principles of system financial envelopes will continue during 2022/23 with system allocations set at Integrated Care Board level and CCG performance considered in aggregate at system level.

The arrangements for 2022/23 have seen a reset to move allocations back towards a fair distribution of resource, leading to an additional efficiency ask across the North East and North Cumbria ICB.

County Durham CCG is committed to working with its partners in the Central ICP and wider Integrated Care System (ICS) to collectively manage the system financial position and any financial risk.

Sustainable Development

As an NHS organisation, responsible for public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. We have an identified lead for sustainability who is a member of our Governing Body. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition of reducing the carbon footprint of the NHS, public health and social care system. We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the *Public Services (Social Value) Act (2012)* are met. While we are committed to this, we have not yet issued a statement on meeting the requirements of the Public Services (Social Value) Act.

In order to embed sustainability it is important to explain where in our process and procedures sustainability features. One of the ways in which we can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP) and this will be considered for the future as part of our commitment to achieving a carbon net zero NHS in the North East and North Cumbria.

We did not use the Sustainable Development Assessment Tool (SDAT) tool in 2021/22 or develop a Sustainable Development Management Plan as a result of staff working from home for the majority of the year; however going forward we will work with our staff to ensure we have a focus and programme of work to ensure we develop more sustainable ways of working as a commissioner, local employer and member of the County Durham community.

The continuation of the Covid pandemic has resulted in staff working from home this year, and this has provided us with an opportunity to reflect on our ways of working with less time in the office base, making more use of teleconferencing technology to support virtual meetings and reducing non-essential travel. We developed 'hybrid working' principles which will encourage us to consider when office work is best suited and when it could be more beneficial and conducive to a better work-life balance to reduce travel and work from other sites and sometimes from home.

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

Improving quality

Quality is defined as care that is safe, effective and provides as positive an experience as possible for patients. Commissioning high-quality, person centred healthcare is at the heart of everything the CCG strives to achieve for people across County Durham.

To assist in the delivery of this we use a variety of tools, processes and mechanisms when reviewing our commissioned services. This work is undertaken in a collaborative manner with a wide range of partners and stakeholders from the health and social care economy including patient representatives and their carers. This approach assists us in obtaining the appropriate levels of evidence-based assurance as well as an understanding of the reality of how these services feel for patients, families and carers. These activities inform and shape our quality and safeguarding annual work programme.

This section of the report describes the work we have undertaken to assess and improve quality in the services we commission.

Clinical Quality Assurance Framework

Clinical quality is fundamental to the commissioning process and the quality team within the CCG and North of England Commissioning Support (NECS) continue to input into the process at various stages in the pathway.

The clinically led Quality Committee and Primary Care Quality Assurance Sub-Committee remains a well-established forum the CCG uses to review the effectiveness, safety and patient experience of services.

There has been significant work to improve the information available to primary care and the CCG about the quality of services and this has allowed the CCG to identify and support vulnerable practices. The CCG also continues to work with neighbouring CCGs to ensure a consistent approach to quality standards in all our providers.

There has been further improvement work undertaken in collaboration with Durham County Council commissioners to align quality standards, service quality monitoring and integrate processes. Phase two of this work is scheduled to continue in 2022/23.

Serious incident monitoring

NHS staff report incidents when aspects of care and treatment go wrong, or when care could have gone wrong. It is important the NHS system responds appropriately to ensure services and processes continue to improve.

We are responsible for ensuring there is an effective governance process in place to manage incidents that occur within providers or within the CCG. Incident investigations are undertaken to identify a root cause and timeline of events. We ensure that the governance process is followed to manage the incident and highlight lessons learnt and ensure improvements are embedded into practice.

The governance process is managed through the Safeguard, Incident and Risk Management System (SIRMS) supported by the North of England Commissioning Support Unit (NECS) and CCG staff. This has been a very different year for the NHS as a result of the Covid-19 pandemic. We have continued to work with providers throughout 2021/22 to maintain the quality of care provided.

Complaints

Complaints are a valuable source of information and they are monitored for themes and trends. Complaints that are investigated by the CCG, rather than the organisation providing the care, are reviewed by the Quality Committee.

108 complaints/concerns were received from County Durham residents. 18 related directly to NHS County Durham CCG, the remaining cases were about other organisations, including NHS trusts.

Of the 18 CCG cases, 5 were managed under the formal complaints procedure and 13 were addressed as informal concerns or enquiries.

The subjects raised most frequently in complaints/concerns relating to the CCG were:

- Covid 19 issues (3)
- Primary care commissioning (3)
- Continuing Healthcare eligibility decisions/appeals (3)
- Patient transport commissioning (3)

4 formal complaints relating to the CCG were closed during the year. The remaining 2 complaints were withdrawn.

NICE guidance compliance

The CCG seeks assurance from the services it commissions that national guidance issued by the National Institute for Health and Care Excellence (NICE) guidance is being complied with.

Committees and Groups

We continued to operate the following groups that play different roles in the quality assurance process:

Quality Committee

The role of the Quality Committee is to examine and make recommendations with regard to the quality standards of commissioned services, pathway developments and quality indicators of new services against the clinical priority areas of the national Improvement and Assessment Framework (IAF). It supports the delivery of the CCG's statutory duties to reduce inequalities in the health of the local population and to ensure equity of health and access to services. It also ensures that innovative ways of working are considered and tested by using safe and measured approaches. It approves and ratifies any necessary quality related documents prior to submission to the Governing Body of each CCG.

Membership of the committee is clinically focused. As part of our response to the pandemic Quality Committee meetings were stood down for a number of months allowing our clinicians to focus on frontline services. Views of members were still sought via e-mail, with any required business being taken through our Executive Committee for decision.

Primary Care Quality Assurance Sub-Committee

The role of the Primary Care Quality Assurance Sub-committee is to support delivery of the '*Primary Medical Services Assurance Framework'* (NHS England, April 2013) and implement local process as defined by NHS England (NHSE), Cumbria and the North East. The primary objectives of the Sub-Committee are to:

- safeguard our patients from harm,
- ensure continued development of appropriate high-quality provision of primary,
- medical care services to the population,
- secure rapid improvements to the quality of care in failing practices,
- drive up quality and foster a culture of safety across primary medical care.

Clinical Quality Review Groups / Quality Assurance Committee

We work with local providers to monitor, evaluate and drive forward quality standards, and we have held or contributed to regular Clinical Quality Review Group (CQRG) / Quality Assurance Committee meetings. These meetings include clinicians from NHS Foundation Trusts and the CCG. This enables productive dialogue and provides an opportunity for the Trusts to identify innovation; best practice; areas for improvement; and increasingly, evidence patient outcomes. It also enables us, through analysis of specific quality indicators, to gain an insight into the

quality of care delivered to local people as well as share and promote lessons learned. We use the CQRGs to continuously monitor areas that require improvement with our local providers, detailed action plans are submitted and we gain assurance that providers are taking action to improve the quality of care provided to patients.

Quality Surveillance Groups

Local Quality Surveillance Groups are led by NHS England / NHS Improvement. They bring together regulators, commissioners and providers of services to explore quality by sharing intelligence, particularly that which could help identify early signs of service failure or poor quality. They also include primary care services such as GP practices, dentists, pharmacists and optometrists.

Reducing health inequality

Our commitment to equality and diversity is driven by the principles of the *NHS Constitution*, the *Equality Act 2010* and the *Human Rights Act 1998*, and also 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.

Public Sector Equality Duty (PSED)

We understand that we are required under the Public Sector Equality Duty (PSED) which is set out in s149 of the Equality Act 2010, to have due regard to:

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

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

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

Governance

Equality, Diversity and Health Inequalities is governed and reports into the Governing Body. The committee ensures we are compliant with legislative, mandatory and regulatory requirements regarding equality and diversity, develops and delivers national and regional diversity-related initiatives within the CCG, provides a forum for sharing issues and opportunities, functions as a two-way conduit for information dissemination and escalation, monitors progress against the equality strategy and supports us in the achievement of key equality and diversity objectives.

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

Equality Strategy

Our Equality Strategy for 2020-2023 has been developed. 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.

The Equality Delivery System 2 - Our Equality Objectives

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

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

Objective 1 – Continuously improve engagement and ensure that services are commissioned and designed to meet the needs of patients in at least 6 protected characteristics.

Objective 2 – Ensure processes are in place to provide information in a variety of communication methods to meet the needs of patients, in particular the ageing population and those with a disability.

Objective 3 – Monitor and review staff satisfaction to ensure they are engaged, supported and represent the population they serve.

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

Our Staff - Encouraging Diversity

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

By working closely with DWP, we have maintained our 'Level 2 Disability Employer' status for 2021 – 2022 by demonstrating our commitment to employing the right people for our business and continually developing our people.

Workforce Race Equality Standard

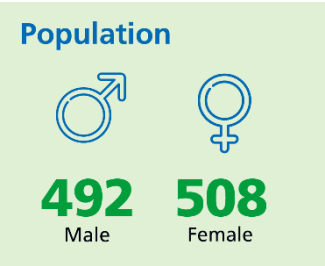
In accordance with the Public Sector Equality Duty and the NHS Equality and Diversity Council's agreed measures to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace, the CCG has shown due regard to the Workforce Race Equality Standard (WRES).

We have due regard to the standard by seeking assurance of compliance from trusts and aim to improve workplace experiences and representation at all levels for black and minority ethnic staff.

Equality Impact Assessments

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

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



The EIA is embedded into our governance process and sign off from the Governing Body 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 has due regard to the standard by obtaining feedback from Patient Reference Groups (PRG's) 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/

Health Inequalities

We have regard to the need to reduce inequalities between patients in accessing health services for our local population.

We understand our local population and local health needs, through the use of 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 work 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.

We seek 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 Healthwatch.

As the local commissioners of health services, we seek to ensure that the services that are purchased on behalf of our local population reflect their needs. We appreciate that to deliver this requires meaningful consultation and involvement of all our stakeholders. We aim 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.

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 were awarded E&D Partner status for 2016/17 and have continued to work closely with partners as part of the alumni programme.

We continue 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: Local Authority Health Profiles
Public Health England – Local Health: http://www.localhealth.org.uk

North Durham JSNA: County Durham Joint Strategic Needs Assessment - Durham County Council

North Durham CCG Health Inequalities Right Care Pack: https://www.england.nhs.uk/wp-content/uploads/2018/12/ehircp-ney-north_durham-ccg-dec-18.pdf

Durham, Dales and Easington JSNA: http://www.durham.gov.uk/JSNA

Durham, Dales and Easington CCG Health Inequalities Right Care Pack: https://www.england.nhs.uk/wp-content/uploads/2018/12/ehircp-ney-durham_dales_easington_and_sedgefield-ccg-dec-18.pdf

ACCOUNTABILITY REPORT

Corporate Governance Report

Members' Report

Council of Members

The CCG is a membership organisation. The Council of Members comprises of an individual selected by each member practice belonging to one of the CCG's three constituencies. The individual selected has authority to represent the practice's views and to act on its behalf in its dealings between the practice and the CCG.

The Council of Members has one representative that sits on the Governing Body, representing the views of member practices.

The Council of Members:

- contributes to, changes and approves the CCG's Constitution and any amendments thereafter,
- elects relevant members of the Governing Body,
- reviews and agrees the annual delivery plan,
- contributes to and agrees the commissioning intentions,
- reviews year end performance of the Governing Body,
- holds an Annual General Meeting open to the public.

Member Practices

Below are hyperlinks to the websites of each of our 61 member practices (as at the end of 2021/22).

A map showing the location of each of our practices is available via our website.
NHS County Durham CCG Member Practices

Chester-le-Street

1. Bridge End Surgery
2. Cestria Health Centre
3. Great Lumley Surgery
4. Middle Chare Medical Group
5. Pelton and Fellrose Medical Group
6. Sacriston Surgery
7. The Villages Medical Centre

Derwentside

8. Annfield Plain Surgery
9. Browney House Surgery
10. Cedars Medical Group
11. Consett Medical Centre
12. Leadgate Surgery
13. Oakfields Health Centre
14. Lanchester Medical Centre
15. Queens Road Surgery
16. Stanley Medical Group
17. Tanfield View Medical Group
18. The Haven Surgery
19. West Road Surgery

Durham

20. Belmont and Sherburn Medical Group
21. Bowburn Medical Centre
22. Chastleton Medical Group
23. Claypath and University Medical Group
24. Coxhoe Medical Practice
25. Cheveley Park Medical Centre
26. Dunelm Medical Practice
27. The Medical Group
28. West Rainton Surgery

Durham Dales

29. Auckland Medical Group
30. Barnard Castle Surgery
31. Bishopgate Medical Centre
32. Evenwood Surgery
33. Gainford Surgery
34. North House Surgery
35. Old Forge Surgery
36. Pinfold Medical Practice
37. Station View Medical Centre
38. Weardale Practice
39. Willington Medical Group
40. Woodview Medical Practice

Easington

41. Bevan Medical Group
42. Blackhall and Peterlee Practice
43. Byron Medical Group
44. East Durham Medical Group
45. Horden Group Practice
46. Marlborough Practice
47. Murton Medical Group
48. New Seaham Medical Group
49. Silverdale Family Practice
50. Southdene Medical Centre
51. William Brown Medical Centre
52. Wingate Medical Centre

Sedgefield

53. Bewick Crescent Surgery
54. Bishops Close Medical Practice
55. Ferryhill and Chilton Medical Practice
56. Hallgarth Surgery
57. Jubilee Medical Group
58. Peaseway Medical Centre
59. Skerne Medical Practice
60. St Andrews Medical Practice
61. West Cornforth Medical Centre

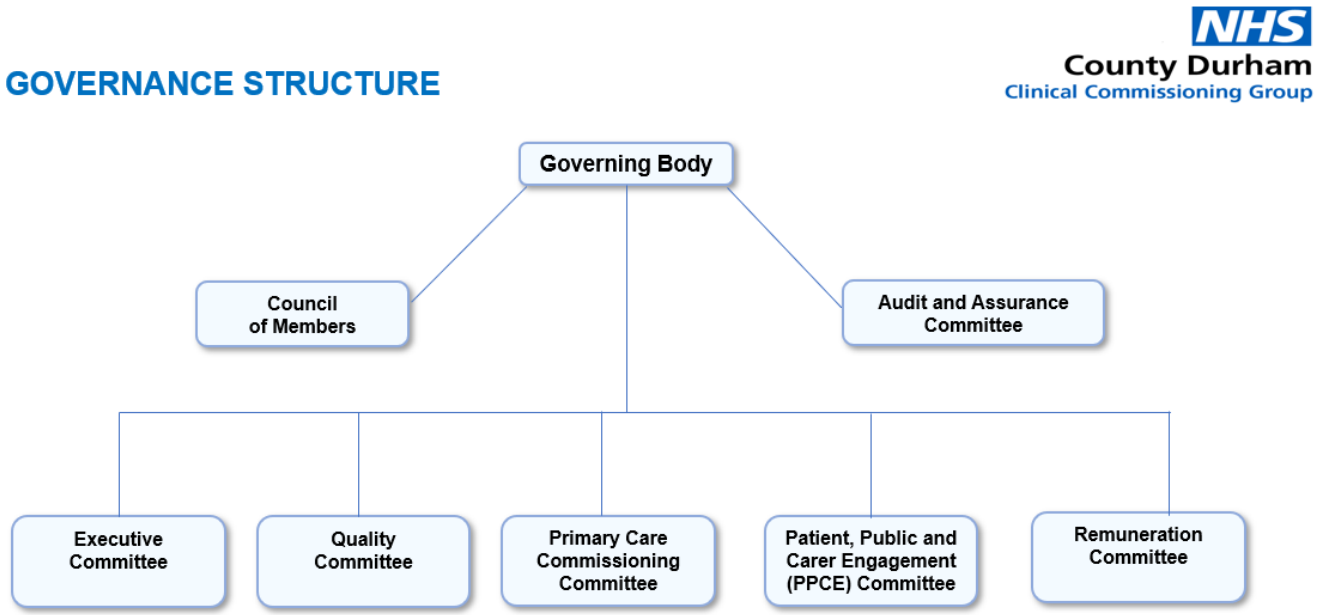
Governing Body

The Governing Body is responsible for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance.

The Governing Body is also responsible for the CCG's budget of over £1 billion ensuring this is spent as efficiently as possible to provide high quality healthcare for the local population.

Further details of the governance framework and organisational structure operating within the CCG, including the role of the Governing Body and related committees can be found in the Governance Statement.

The CCG's Governance Structure is outlined below:



Members who have left or joined the CCG Governing Body during 2021/22

There have been no changes to the membership of the Governing Body in 2021/22. The Director of Nursing left the CCG with effect from 15 August 2021. Prior to that she had been on secondment with cover arrangements in place, so this did not impact membership of the Governing Body.

There has been one addition to the list of those people in attendance that being Michael Laing, Director of Integrated Community Services for the County Durham Care Partnership. This reflected the continued progress in relation to partnership working in County Durham.

Membership of the Governing Body and CCG Committees is shown in the table below, along with the membership of all other committees and details of attendance at relevant meetings throughout the year.

County Durham CCG Corporate meeting attendance summary for April 2021 – March 2022

County Durham CCG April 2021 – March 2022 **M = Member** **IA= In attendance** **NVM= non-voting member**	**Title / Name**	**Governing Body / GBDS/ GB in Common**	**Audit and Assurance Committee**	**Primary Care Commissioning Committee**	**Remuneration Committee**	**CCG Executive Committee / CD Care Partnership and CCG Executives in Common**	**Patient, Public and Carer Engagement Committee**	**Quality Committee**	**Northern CCGs Joint Committee**	**Research and Innovation Sub Committee**	**Primary Care Quality Assurance Sub Committee**
	Total number of meetings to attend:	**12**	**5**	**5**	**0**	**24**	**6**	**10**	**8**	**3**	**3**
Andrew Atkin	Lay Member	**M 12**	**M 5**	**M 4**	**M 0**						
Nicola Bailey	Chief Officer	**M 10**	**IA 2**	**M 3**	**IA 0**	**M 18**			**NVM 1**		
Mike Brierley	Director of Commissioning Strategy and Delivery (MH, LD, Autism and Digital)	**NVM 9**		**M 2**		**M 20**					
Sarah Burns	Joint Head of Integrated Commissioning	**NVM 10**		**M 4**		**M 20**					
Dr James Carlton	Medical Director	**M 6**		**NVM 0**		**M 17**		**M 9**			**M 3**

County Durham CCG April 2021 – March 2022 **M = Member** **IA= In attendance** **NVM= non-voting member**	**Title / Name**	**Governing Body / GBDS/ GB in Common**	**Audit and Assurance Committee**	**Primary Care Commissioning Committee**	**Remuneration Committee**	**CCG Executive Committee / CD Care Partnership and CCG Executives in Common**	**Patient, Public and Carer Engagement Committee**	**Quality Committee**	**Northern CCGs Joint Committee**	**Research and Innovation Sub Committee**	**Primary Care Quality Assurance Sub Committee**
Joseph Chandy	Director of Commissioning Strategy and Delivery (Primary Care)	**NVM 7**		**NVM 3**		**M 18**				**M 0**	**M 1**
Dr Ian Davidson	Medical Director	**M 1**		**NVM 3**		**M 17**		**M 8**			**M 3**
Dr Stewart Findlay	Chief Officer	**M 4**		**M 3**	**IA 0**	**M 15**			**M 0**		
Anne Greenley	Account Director NECS/Interim Director of Nursing and Quality (*interim arrangements 13/7/2020 to date*)	**M 9**		**M 3**		**M 21**		**M 9**			**M 3**
Amanda Healy	Director of Public Health, Durham County Council / Health and Wellbeing Board representative for GB	**NVM 6**		**NVM 0**							
Richard Henderson	Chief Finance Officer	**M 12**	**IA 5**	**M 5**	**IA 0**	**M 23**					

County Durham CCG April 2021 – March 2022 **M = Member** **IA= In attendance** **NVM= non-voting member**	**Title / Name**	**Governing Body / GBDS/ GB in Common**	**Audit and Assurance Committee**	**Primary Care Commissioning Committee**	**Remuneration Committee**	**CCG Executive Committee / CD Care Partnership and CCG Executives in Common**	**Patient, Public and Carer Engagement Committee**	**Quality Committee**	**Northern CCGs Joint Committee**	**Research and Innovation Sub Committee**	**Primary Care Quality Assurance Sub Committee**
Feisal Jassat	Lay Member, Patient and Public Involvement	**M 12**	**M 4**	**M 5**	**M 0**		**M 6**				**M 3**
Michael Laing	Director of Integrated Community Services (*from 1.7.2020*) *Joined GB from October 2021*	**NVM 2**				**IA 21**					
Diane Murphy	Director of Commissioning and Delivery (Continuing Health Care)	**NVM 1**				**M 13**					
Dr Neil O'Brien	Accountable Officer / Clinical Chief Officer	**M 10**	**IA 0**		**IA 0**	**M 15**			**M 7**		
Jane Robinson	Corporate Director of Adult and Health Services, Durham County Council	**NVM 5**									
Dr Jonathan Smith	Clinical Chair	**M 10**	**IA 0**	**NVM 3**	**M 0**	**IA 14**	**M 1**		**M 2**		
Dr Ian Spencer	Secondary Care Clinician	**M 8**			**M 0**			**IA 10**			
John Whitehouse	Lay Member, Audit and Governance	**M 10**	**M 5**								

County Durham CCG April 2021 – March 2022 **M = Member** **IA= In attendance** **NVM= non-voting member**	**Title / Name**	**Governing Body / GBDS/ GB in Common**	**Audit and Assurance Committee**	**Primary Care Commissioning Committee**	**Remuneration Committee**	**CCG Executive Committee / CD Care Partnership and CCG Executives in Common**	**Patient, Public and Carer Engagement Committee**	**Quality Committee**	**Northern CCGs Joint Committee**	**Research and Innovation Sub Committee**	**Primary Care Quality Assurance Sub Committee**
Elected Healthcare Professional	Dr Chris Marwick	**M 5**									
GP Clinical Lead representative / Executive GP	Dr Dilys Waller Dr Rushi Mudalagiri Dr Winny Jose Dr Ellen Osborne Dr Jan Panke Dr Pat Wright Dr Mike Smith	**NVM 4**		**NVM 0**		**M 23**		**M 10**			**M 2**
Quality and Development Manager	Kim Lawther Rob Milner Susan Hepburn							**M 9**		**M 2**	**M 3**
Research and Innovation Lead	Dr James Larcombe Helen Riding							**IA 2**		**M 3**	
Patient Reference Group Representative Chester-le-Street	Ian Doyle Keith Holyman						**M 3**				
Patient Reference Group Representative Derwentside	Marian Morrison Nancy Carr						**M 6**				

County Durham CCG April 2021 – March 2022 **M = Member** **IA= In attendance** **NVM= non-voting member**	**Title / Name**	**Governing Body / GBDS/ GB in Common**	**Audit and Assurance Committee**	**Primary Care Commissioning Committee**	**Remuneration Committee**	**CCG Executive Committee / CD Care Partnership and CCG Executives in Common**	**Patient, Public and Carer Engagement Committee**	**Quality Committee**	**Northern CCGs Joint Committee**	**Research and Innovation Sub Committee**	**Primary Care Quality Assurance Sub Committee**
Patient Reference Group Representative Durham	Pat Rafferty Jen Mole						**M 5**				
Patient Reference Group Representation North Durham PRG	Keith Holyman Jennifer Mole	**NVM 8**									
Patient Reference Group Representative Durham Dales	Angela Seward Brewis Henderson	**NVM 10**					**M 6**				
Patient Reference Group Representative Easington	Linda Allison	**NVM 0**					**M 5**				
Patient Reference Group Representative Sedgefield	Chris Cunnington-Shore Hilary Stoker	**NVM 7**					**M 6**				
Public Member	Stephen Hann						**M 3**				

County Durham CCG April 2021 – March 2022 **M = Member** **IA= In attendance** **NVM= non-voting member**	**Title / Name**	**Governing Body / GBDS/ GB in Common**	**Audit and Assurance Committee**	**Primary Care Commissioning Committee**	**Remuneration Committee**	**CCG Executive Committee / CD Care Partnership and CCG Executives in Common**	**Patient, Public and Carer Engagement Committee**	**Quality Committee**	**Northern CCGs Joint Committee**	**Research and Innovation Sub Committee**	**Primary Care Quality Assurance Sub Committee**
Public Member	Helen Embleton						**M 3**				
Public Member	Julie Cairns						**M 6**				
Public Member	Sarah Cotes						**M 5**				
Public Health representative / Health and Wellbeing representative at GB, Durham County Council	Gill O'Neill Chris Allan Glenn Wilson Amanda Healy			**NVM 1**		**IA 20**		**M 9**		**M 1**	
Practice Nurse Links representative	Caryl Bowie							**M 0**			**M 1**
Commissioning Team representative	Lou Stainer / David Hand / Joanna Dunbar / Cresta Crawley / Marta Lowell							**M 7**			

County Durham CCG April 2021 – March 2022 **M = Member** **IA= In attendance** **NVM= non-voting member**	**Title / Name**	**Governing Body / GBDS/ GB in Common**	**Audit and Assurance Committee**	**Primary Care Commissioning Committee**	**Remuneration Committee**	**CCG Executive Committee / CD Care Partnership and CCG Executives in Common**	**Patient, Public and Carer Engagement Committee**	**Quality Committee**	**Northern CCGs Joint Committee**	**Research and Innovation Sub Committee**	**Primary Care Quality Assurance Sub Committee**
Medicines Optimisation Team representative	Kate Huddart / Alda Hummerlinck / Michelle Chapman / Rachel Berry							**M 10**		**M 2**	
Voluntary Community Sector representative – AAP	Michael Wilkes Paul Goodwin						**M 1**				
NECS Clinical Quality Team representative	Lorraine Legg Claire Richardson							**M 4**			**M 0**
Voluntary Community Sector representative – Durham Community Action representative	Kate Burrows Susan Garratt						**M 5**				
Safeguarding Lead representative	Melanie Hesketh / Linda Haines / Heather McFarlane / Karen Watson / Rachel Upton							**M 10**			**M 2**
Infection Control Team representative	Gail Watkin / Jane Lawson							**M 10**			**M 3**

County Durham CCG April 2021 – March 2022 **M = Member** **IA= In attendance** **NVM= non-voting member**	**Title / Name**	**Governing Body / GBDS/ GB in Common**	**Audit and Assurance Committee**	**Primary Care Commissioning Committee**	**Remuneration Committee**	**CCG Executive Committee / CD Care Partnership and CCG Executives in Common**	**Patient, Public and Carer Engagement Committee**	**Quality Committee**	**Northern CCGs Joint Committee**	**Research and Innovation Sub Committee**	**Primary Care Quality Assurance Sub Committee**
Durham County Council Communication representative							**M 0**				
Healthwatch representative	Denise Rudkin Julia Catherall			**NVM 5**			**M 6**				
NHS England representative	David Steel Christopher Black Jennifer Long			**NVM 5**							
Commissioning Manager Primary Care										**M 0**	
3 x clinical members of the CCG	Laura Coulthard / Dr Rajiv Mansing / Sue Shine / Paul Dodds / Jane Lawson									**M 3**	
Patient representative	John Hannon									**M 2**	
NENC Local Clinical Research Network Engagement Lead	Dean Phillips Beth Pickering									**M 2**	

Governing Body Member Profiles

Statutory Roles – Voting members

Andrew Atkin, Lay Member on the Governing Body
Andrew worked in local government for over 25 years. For 14 years he was Assistant Chief Executive for Hartlepool Borough Council with a focus on performance management, effective governance and leading major change programmes in the Council. Andrew is committed to making all services to the public the best they can be.

Andrew is our Freedom to Speak Up Guardian in accordance with our CCG's Raising Concerns (formerly whistle-blowing) Policy.

Anne Greenley, Interim Director of Nursing and Quality
Anne Greenley has been assigned to the CCG as interim Director of Nursing and Quality taking over from Gill Findley. Anne has held various posts in senior leadership positions in commissioning including Assistant Director of system development in a Primary Care Trust (PCT). She headed up the Clinical Quality service in the North of England Commissioning Support Unit (NECS) before becoming Account Director and head of provider management which is her substantive post in NECS. Anne qualified as a Registered General Nurse in 1983. She has led on a range of quality initiatives working across systems with primary, secondary and social care partners and service users. Anne has always lived in the North East and is passionate about service improvement, patient safety and reducing health inequalities.

Richard Henderson, Chief Finance Officer
Richard is a qualified accountant (ACA) and brings significant financial experience to the CCG from a broad range of private and public sector organisations. Richard trained as an auditor with Deloitte LLP, working with a variety of organisations, before joining the NHS in County Durham. Richard was previously the Chief Finance Officer of North Durham CCG.

Feisal Jassat, Lay Member, Patient and Public Involvement
Feisal has worked in both the NHS and Local Government for over 30 years. His NHS career began in operating theatres where he worked as a paramedic supporting both anaesthetists and surgeons in theatre procedures. He moved into public health and developed his public health career by working in local government pursuing healthy public policy. He moved to work for Durham County Council in 2006 where he led and managed the Overview and Scrutiny process. Feisal is committed to reducing health inequalities and improving the health and health care services for local communities. He is passionate about involving people in decisions about their health.

Dr Neil O'Brien, Chief Clinical Officer and Accountable Officer
Dr O'Brien has been a local GP in Chester-le-Street for over 20 years. He has developed a special interest in cardiology and has previously worked as a GP with special interest in this area. Neil is a practicing clinician, which strengthens his influence with local practices and other clinicians.

Dr O'Brien is also the Clinical Accountable Officer for two other CCGs - NHS Sunderland CCG and NHS South Tyneside CCG. Neil is a member of the Integrated Care System (ICS) Management Group representing the needs of local populations at the North East and North Cumbria ICS.

During the last year Neil has chaired the ICS vaccination board overseeing the roll out of the flu vaccination programme and the Covid-19 vaccination programme, Neil is also a member of the national clinical advisory group advising the national roll out of the Covid-19 vaccination.

Neil has recently been appointed as the North East and North Cumbria Integrated Care System (ICS) Executive Medical Director designate. He is very excited about this new role and the opportunities and improvements that integrated care will provide across the region.

Dr Jonathan Smith, Clinical Chair
Living in the North East all his life and originally from Stockton-on-Tees, Jonathan went to Medical School in Newcastle, and qualified in 2003. During his work as a hospital doctor and GP trainee he has spent time in most of the hospitals in our region. As a GP trainee Jonathan worked in practices in Gateshead, Derwentside, Sunderland and Durham Dales. He has been a full time GP Partner in South Hetton since 2008 and has been involved in medical student teaching and research as well as clinical work during this time. He has been involved in several roles in the CCGs over the years, including Chair of DDES CCG 2015-2020, and then Chair of the merged County Durham CCGs since 2020. Outside of work Jonathan enjoys spending time with his young family, as well as running and cycling whenever possible.

Dr Ian Spencer, Secondary Care Clinician
Ian Spencer was a Consultant Anaesthetist for almost 30 years before retiring in 2011. Initially his medical career was in the Royal Air Force, where he was promoted to Group Captain and was made the RAF Consultant Adviser for his specialty. Following the closure of military hospitals, he became an NHS Consultant in 1995 and worked thereafter at CDDFT (formerly Dryburn Hospital) in Durham. Additionally, he was an Examiner for the Royal College of Anaesthetists for 13 years, Chairman of his hospital's Medical Advisory Committee and its BMA Representative. After retiring, he worked as a Volunteer for the CAB, dealing with clients who wish to claim medically related benefits, before joining the CCG Board. In this role he believes his wide experience in Secondary Care, as well as risk management, quality assessment and audit, has been of benefit to the Board.

John Whitehouse, Lay Member Governance and Audit
John is a qualified public finance accountant. In a career spanning 37 years he has worked in local government, the private sector and the NHS. Within the NHS he held a number of senior roles in finance but most significantly in internal audit. He lives in Hartlepool with his wife. He has two daughters and growing grandchildren with whom he spends a great deal of his time.

In addition to chairing the Audit and Assurance Committee, John is our Conflicts of Interest Guardian in accordance with our Standards of Business Conduct Policy.

John is also a Governing Body member at North Cumbria CCG and South Tyneside CCG

Other Governing Body Roles – Voting members

Nicola Bailey, Chief Officer
Prior to joining the CCG Nicola had worked in Local Government at an Executive level including as interim Chief Executive for Hartlepool Borough Council and as Director of Child and Adult Services. Nicola began her early career by training and working as a nurse in the NHS before working in integrated services between the NHS and the Local Government in Cheshire. With over 25 years of working in a managerial and leadership capacity within health and Local Government she has had extensive experience of managing and leading organisations through change, developing integrated services and solutions and working at a senior board level. Nicola previously held roles as shared Chief Operating Officer between North Durham CCG and DDES CCG and Chief Officer in the Southern CCG Collaborative. As County Durham CCG was formed Nicola remained with County Durham CCG as a Chief Officer.

She is the Cumbria and North East Senior Responsible Officer (SRO) for Learning Disabilities Transforming Care (LDTC) Programme and Chair of the Mental Health and Learning Disabilities Partnership Board covering Tees Valley and County Durham, with Tees, Esk and Wear Valleys NHS Foundation Trust.

Nicola is our Senior Information Risk Officer (SIRO).

Dr James Carlton, Medical Director
James works as a Salaried GP three days a week in Bishop Auckland and Evenwood. He has been a GP in County Durham and Darlington since 2002; prior to this he was a Doctor in the Army. He is the Medical Director to County Durham CCG supporting clinical input to the CCG on the wide range of responsibilities in the CCG remit, with particular emphasis on clinical quality and clinical leadership.

Dr Ian Davidson, Medical Director
Dr Davidson has been a GP Principal at Lanchester Medical Centre since 2003. He currently chairs the Northern Treatment Advisory Group and County Durham and Tees Valley Area Prescribing Committee. He is also a member of the Regional Medicine Optimisation Committee. Dr Davidson was awarded a fellowship of the Royal College of General Practitioners in 2011.

Dr Davidson is our Caldicott Guardian.

Dr Stewart Findlay, Chief Officer
Stewart was a GP Partner at Bishopgate Medical Centre in Bishop Auckland from 1983 and retired from clinical practice in August 2015. He has been involved in commissioning health care services for the local population for over 30 years. In addition to his current role as Chief Officer he is also Vice Chair of the County

Durham Health and Wellbeing Board, Co-Chair of the County Durham and Darlington Local Accident and Emergency (A&E) Delivery Board. He is currently focused on integrating health and social care in County Durham and has been seconded to CDDFT for 2 days per week. He is also responsible for developing Primary Care Networks and their integration with community and mental health services.

For the last 18 months he has also been the clinical director for the Covid-19 Vaccination programme across the North East and North Cumbria, responsible in particular for the delivery of the vaccine programme from Primary Care Networks.

Dr Chris Markwick, Elected Health Care Professional
Chris is a GP working in Middleton-in-Teesdale. He joined the Governing Body of the newly established NHS County Durham CCG in April 2021 as an elected Health Care Professional representing our practice members.

Non-voting attendees

Linda Allison, Patient Reference Group Interim Chair for Easington Locality
Following retirement from a career in Nursing within the NHS and as a Lecturer in Higher Education, Linda helped set up a Patient Participation Group at her GP Practice in 2017, taking on the role of Chair. This is now East Durham Medical Group. She then became an active member of the Easington Patient Reference Group, with a role of Vice Chair and since December 2020, Interim Chair. She is committed to encouraging local patient involvement in providing feedback on experiences of health care and service provision.

Linda is also a member of the Patient, Public and Carer Engagement Committee and a non-voting member of the Governing Body.

Mike Brierley, Director of Commissioning Strategy and Delivery
At a strategic level Mike has worked with both the public and private sector and assignments have ranged from leading a large Informatics service to implementing strategic planning frameworks and the development of organisation wide strategic plans. Mike is an experienced senior programme manager and has strong leadership skills and stakeholder and relationship management experience; with an ability to achieve results in complex environments. He has led numerous large-scale change and redesign programmes, as well as short high intensity projects. Mike holds an MBA and has extensive experience in change management, supporting teams and individuals to implement whole system redesign programmes. Mike enjoys various sports and lives with his wife and family in Escomb outside of Bishop Auckland.

Sarah Burns – Joint Head of Integrated Commissioning
Sarah has worked in the public sector for over 25 years, with the past 19 years in the NHS. During her time in the NHS, Sarah has worked in a range of roles including performance management, intelligence, contract management and commissioning. She has led a number of complex service changes programmes. In March 2020 Sarah took up a role focussed on commissioning across Health and Social Care

appointed jointly by County Durham CCG and Durham County Council. Sarah lives in Durham with her husband and two young sons.

Joseph Chandy, Director of Commissioning Strategy and Delivery
Joseph joined the NHS in 1996 as a Practice Manager in Easington. He led on GP Fundholding within his practice and developed his local GP Out-of-Hours co-operative from 1998-2004. He was elected Chair of Easington Practice Based Commissioning Group from 2005-2012. In 2011 he was appointed Director of Practice Based Commissioning for Durham Primary Care Trust (PCT). In 2012 Joseph founded Easington South Federation CIC which later evolved to South Durham Federation CIC. In 2013 he was appointed as Director of Performance for DDES CCG before being appointed as Director of Primary Care in 2014. Joseph also took up the role of Director of Primary Care for North Durham CCG in April 2016 and since the merger of the CCGs his role transferred to County Durham CCG. Joseph remains Managing Partner in his GP Practice and is also a GP surgery premises owner/developer.

Chris Cunnington-Shore, Patient Reference Group (PRG) Chair, Sedgefield Locality
This is Chris's sixth year as the Chair of the Sedgefield Locality Patient Reference Group and his fourth year as an invited member of the Clinical Commissioning Group's Governing Body. Having retired from a career in health, he wanted to support the local healthcare delivery within the locality and joined his local Practice Patient Group nine years ago.

Amanda Healy, Director of Public Health, Durham County Council
Amanda has been a Director of Public Health for five years and previously worked across Gateshead, South Tyneside and Sunderland as a consultant in public health. She has worked on reducing health inequalities using an assets approach for over twenty years and plays a key role in understanding both the health challenges and the positive aspects of health and wellbeing locally. Amanda works in collaboration with a range of partners to develop plans e.g., Joint Health and Wellbeing Strategy and has a pivotal part in communicating and co-ordinating key health messages and campaigns.

The key aspects of work over her career include teenage pregnancy, long term conditions, Health and Social Care integration and she has a long-standing commitment to reduce smoking levels.

Amanda took up the role of Director of Public Health in County Durham in May 2017 and is committed to improving and protecting the health of local residents. She is Chair of the Association of Directors of Public Health for the North East and involved in public health at a local, North East and national level. Amanda is the Senior Responsible Officer for the Prevention Board of the Integrated Care System, Cumbria and North East.

Keith Holyman, Patient Reference Group Chair for North Durham
As a member of Chastleton Patient Participation Group (Forum), he joined the North Durham Patient Reference Group in August 2012, taking over as its Chair in April 2016. Keith’s early working life was spent in Engineering, leaving his position as a

Design Engineer with Timex behind and re-training in 1981/82 to teach Design Technology to 11 to16 year olds in secondary education in Darlington before retiring in July 2007.

Angela Seward, Patient Reference Group Chair for Durham Dales Locality
Angela joined Durham Dales PRG in February 2015 and became Chair in 2018. She is also Chair of Barnard Castle Surgery Patient Participation Group (PPG). Angela is in her 3rd and final three-year term as an Elected governor at South Tees Hospitals NHS Foundation Trust. In March 2017 she was elected Lead Governor for the 30 Governors on the Trust's Governing Body, and again re-elected Lead Governor in February 2021.

During her working life, Angela has held a number of posts, the most rewarding of which was teaching adults with mental and learning difficulties, demanding a high degree of patience, empathy, effective team-working and good communication.

Jane Robinson, Corporate Director of Adult and Health Services – Durham County Council
Jane Robinson qualified as an Occupational Therapist in 1991 and worked during the 1990's in a range of Services in Newcastle, with a focus on Orthopaedic rehabilitation and community-based services, establishing Occupational Therapy services with GP practices.

In 2000 Jane led the development of intermediate care services in Newcastle. Leaving Newcastle in 2003 to join Darlington Borough Council as a Commissioning Manager, Jane led services for older and disabled people. Jane completed an Executive MBA at Newcastle Business School in 2006 and became Assistant Director for Adults and Health in Darlington.

In July 2009 Jane joined South Tyneside as Head of Adult Social Care leading on Service Improvement and Quality across a broad range of Services.

In September 2014 Jane was appointed as Head of Commissioning for Durham County Council during which time she led on the Commissioning of services for Adults, Children and Public Health.

In July 2016 Jane became the Interim Director for Adult and Health Services and was subsequently then appointed to Corporate Director for Adult and Health Services in October 2016.

Jane's areas of responsibility in this role include:

- Social Care for Adults
- Public Health
- Commissioning Health and Social Care Services

Disclosure of information to auditors

Each individual who is a member of the Governing Body at the time the Members' Report is approved confirms:

- so far as the member is aware, that there is no relevant audit information of which the CCG's external auditor is unaware; and,

- that the member has taken all the steps that they ought to have taken as a member in order to make themselves aware of any relevant audit information and to establish that the CCG's auditor is aware of that information.

Register of Interests

All members of the Governing Body and its committees are required to declare any interests that they have in accordance with the CCG's Standards of Business Conduct and Declarations of Interest Policy. They are required to review and update their declarations of interest on a bi-monthly basis. The registers of declarations of interest are maintained throughout the year and include details of when declarations were added or removed. The registers are made available to the public via the CCG's website:

Register of Interests

Where any interests are identified within meetings, these are declared by the relevant individual and appropriate action is agreed, including whether the individual concerned should withdraw from discussions if appropriate.

In order to further support CCGs to manage conflicts of interest, CCG staff are required to complete Conflict of Interest online training on an annual basis.

Personal data related incidents

There have been no personal data related incidents or data security breaches during 2021/22 that required disclosure to the Information Commissioner.

Modern Slavery Act

County Durham CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement is published on our website:
Modern Slavery Statement.

Statement of Accountable Officer's Responsibilities

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the CCG and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

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

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;

- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- prepare the accounts on a going concern basis; and
- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

Dr Neil O'Brien
Accountable Officer
17 June 2022

Governance Statement

Governance Statement by Dr Neil O'Brien as the Accountable Officer of NHS County Durham Clinical Commissioning Group

Introduction and Context

County Durham Clinical Commissioning Group (CCG) is a body corporate established by NHS England on 1 April 2020 under the *National Health Service Act 2006* (as amended). The CCG was formed from the merger of Durham Dales, Easington and Sedgefield CCG and North Durham CCG.

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

As at 1 April 2022 and throughout the year, the CCG was not subject to any directions from NHS England issued under Section 14Z21 of the *National Health Service Act 2006*.

Scope of Responsibility

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

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

Governance Arrangements and Effectiveness

The main function of the governing body is to ensure that the CCG 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.

The CCG has a Constitution based on NHS England's original model template. The Constitution was developed for the establishment of the merged CCG on 1 April 2020 and has been reviewed against NHS England's revised Model Template, released in 2019/20.

Review of the CCG's Constitution confirms that it complies with the elements of the self-certification checklist, including:

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

Throughout 2021/22 the CCG has continued to operate with a governance structure that reflects guidance and best practice. This is largely consistent with the governance arrangements that operated during the previous year.

Terms of reference have been agreed for all committees, which support the organisation in the delivery of effective governance. The terms of reference are included as appendices to the CCG's Constitution which can be found on the CCG's website.

The Members' Report provides further detail relating to the membership practices, the role of the Council of Members, Governing Body and other committees, including membership and meeting attendance records.

The governance arrangements in place meet the requirements of best practice guidance in respect of risk management and ensure that a strong accountability framework has been established. They reflect the public service values of accountability, probity and openness and specify as Accountable Officer my responsibility for ensuring that these values are met within the CCG.

The Governing Body has an ongoing role in reviewing the CCG's governance arrangements to ensure that these continue to reflect the principles of good governance. The Audit and Assurance Committee plays a key role in supporting this by providing assurance to the Governing Body around the risk and governance processes within the CCG.

During the year 2021/22 the CCG's Governing Body met formally on 8 occasions with non-confidential meetings being live streamed on the CCG's Facebook page. An annual business cycle is in place, with agendas structured to deal with items for decision, discussion and information covering strategic, performance, quality assurance, risk and governance issues. Highlights of the work performed during the year by the Governing Body within this business cycle include:

- approval of the CCG's financial plan and budgets,
- approval of the CCG's Involvement Strategy 2021/22
- approval of the Choice and Equity Policy
- review of Integrated Care System and Integrated Care Board plans throughout the year,
- review of the draft Integrated Care Board Constitution
- review and agreement of Shotley Bridge Hospital programme

- regular review of progress against plans, financial targets, performance measures, clinical quality standards and significant risks to the CCG.

The Governing Body also met on 4 occasions during 2021/22 as part of a programme of development sessions covering a range of areas including; the impact of the Covid-19 pandemic, Covid-19 recovery plans, Covid-19 vaccination arrangements, strategic and financial planning, Integrated Care System (ICS) and Integrated Care Partnership (ICP) working, health and social care integration across County Durham, Shotley Bridge Community Hospital and Safeguarding updates.

Description of the Established Governing Body Committees

The roles of each of the Governing Body committees are set out broadly below. The Governing Body committees have authority under the Scheme of Delegation to establish sub committees or sub-groups to enable them to fulfil their role. Each of the Governing Body Committees has detailed terms of reference. Each committee is authorised by the Governing Body to pursue any activity within their terms of reference which are subsequently approved by the CCG's Council of Members.

Each committee is authorised by the Governing Body to operate within the scheme of reservation and delegation. The Governing Body receives the confirmed minutes of its Committees to enable it to consider the work and effectiveness of the respective Committee and to receive assurance relating to the delivery of their terms of reference.

Executive Committee

The Executive Committee is a committee of the Governing Body that operates as a forum for discussion, decision and assurance of the operational management of the CCG in support of the Governing Body and its committees in:

- ensuring the continued development of the CCG;
- overseeing and accounting for delivery of the CCG's strategic objectives and their supporting plans;
- supporting the development of effective collaboration across the local health economy, and
- managing and monitoring clinical quality, financial performance and activity.

The Governing Body has delegated the day to day operational management of the CCG to the Executive Committee. As with all other committees, the Executive Committee has an agreed business cycle. It usually meets formally twice per month and has met 24 times during 2021/22. Highlights of the work performed during the year by the Executive Committee include:

- detailed discussions and decision making around plans to address the impact of the Covid-19 pandemic and subsequent vaccination programmes,
- detailed review of the County Durham Place Based Commissioning and Delivery Plan,
- review of clinical quality indicators and concerns,
- detailed review of financial performance as well as delivery against NHS Constitutional Standards and other performance metrics,

- review of financial plans and investment priorities,
- quarterly review of CCG risk register and detailed review of the assurance framework,
- review and approval of CCG policies and procedures,
- monitoring of the development of local Primary Care Networks (PCNs),
- updates and review of the Shotley Bridge Hospital programme,
- evaluation of Integrated Diabetes Model,
- review of County Durham Care Partnership arrangements and proposals for a Joint Committee for health and social care in Count Durham

County Durham Care Partnership Executive Committee

The County Durham Care Partnership Executive was established to progress and embed the County Durham Care Partnership arrangements, which have been in place since April 2017. The partnership arrangements are in line with the proposals in the NHS White Paper, *'Integration and Innovation: working together to improve health and social care for all'*, published in February 2021. The Executive was established as a result of the Memorandum of Understanding (MoU), between the organisations set out below, being agreed in December 2020. The Executive is responsible for monitoring the shared ambitions set out in the MoU:

- To be responsible for the strategic planning, delivery and oversight of health and social care in Durham.
- To ensure the delivery of the County Durham Place Based Commissioning and Delivery Plan 2020-2025.
- To have oversight of:
    - strategic planning,
    - performance and delivery,
    - integration across the County Durham health and social care system,
    - financial performance,
    - quality,
    - using the resources available to reduce health inequalities in County Durham.
- To ensure effective corporate governance in line with the Constitutions of each of the Care Partnership organisations.
- To monitor the progress of work within the thematic partnership, acting as an escalation point where necessary.

The Executive, as an entity, does not have delegated authority as yet from any of the County Durham Care Partnership organisations, however, decisions may be made in line with the delegated authority conferred on individual members in line with each organisation's Constitution and Scheme of Delegation.

The Executive met in common with the CCG's Executive Committee on 11 occasions during 2021/22 to further improvement integrated working ahead of the establishment of the Integrated Care Board (ICB).

Quality Committee

The role of the Quality Committee is to examine and make recommendations with regard to the quality standards of commissioned services, pathway developments and quality indicators of new services. It supports the delivery of the CCG's statutory duties to reduce inequalities in the health of the local population and to ensure equity of health and access to services. It also ensures that innovative ways of working are considered and tested by using safe and measured approaches. It approves and ratifies any necessary quality related documents prior to submission to the Governing Body.

The primary objectives of the committee are to safeguard patients from harm, develop high quality services and foster a culture of safety.

The Quality Committee met 10 times during 2021/22. Highlights of the work performed by the Committee during the year are:

- received regular verbal updates with regard to the position of Covid-19 in the County Durham area,
- review of the clinical quality standards of our health care providers,
- review of the work of the CCG's Medicines Optimisation team,
- monthly review of safeguarding adults and safeguarding children concerns,
- development of a quality improvement scheme to drive up quality in primary care,
- clinical agreement and assurance with regard to the CCG's clinical support information,
- clinical agreement of new service specifications and expected clinical outcomes for patients,
- clinical review of the CCG's Primary Care Commissioning and Investment Strategy,
- regular review and management of clinical quality risks,
- oversight of the programme of clinical research and implications for practices,
- quarterly assurance that we meet statutory safeguarding requirements,
- compliance with the safe management and storage of controlled drugs.

Patient, Public and Carer Engagement (PPCE) Committee

The PPCE Committee was established to provide assurance to the CCG's Governing Body in relation to patient, public and carer engagement. The committee is responsible for developing the communications and engagement strategy of the CCG, reviewing, challenging and evaluating CCG engagement processes and providing a two-way communication channel between the CCG and patients, public and carers.

The Committee meets formally on a bi-monthly basis, meeting 6 times during the year, and its work included:

- review of future engagement strategy development in County Durham,
- reviewing of the CCG's engagement work plan and delivery against these objectives,
- receiving regular quarterly engagement reports and feedback from the Patient Reference Group and Voluntary and Community Sector representatives,
- having a key role in relation to the continued work to review healthcare across County Durham, including plans for the use of Shotley Bridge Hospital,

- considering the Covid-19 system recovery plan – communication and engagement plan,
- considering the Primary Care Commissioning and Investment Strategy.

Audit and Assurance Committee

The Audit and Assurance Committee supports the Governing Body in its main function of ensuring the CCG has made appropriate arrangements to ensure functions are exercised effectively, efficiently and economically and that all relevant principles of good governance are adhered to.

In line with the requirements of the NHS Audit Committee Handbook and NHS Codes of Conduct and Accountability, the committee provides the CCG with an independent and objective review of systems of internal control, risk and governance processes and arrangements, and compliance with laws, guidance, and regulations governing the NHS. The committee is a non-executive committee of the Governing Body and has no executive powers. Its work aligns with that of the Quality Committee to seek assurance that robust clinical quality systems are in place.

The committee's business cycle includes review of the CCG's risk management processes, including the Assurance Framework and corporate risk register. The committee considers the work of both internal and external audit, together with other assurance functions including in particular those relating to North of England Commissioning Support (NECS), upon which the CCG is dependent for the majority of commissioning support, to fulfil its role of providing assurance to the Governing Body.

The Audit and Assurance Committee, as part of its terms of reference, provides regular updates to the Governing Body together with an Annual Report of its work. The draft report covering the financial year 2021/22 was made available alongside the final Annual Report and Accounts in June 2022 to support the final Governance Statement. The principal purpose of the report is to provide assurance to the Governing Body and to support the Accountable Officer's review of the internal control arrangements. The Audit and Assurance Committee has a business cycle which enables the committee to carry out its key objectives necessary to support its assurances regarding the effectiveness of the CCG's internal controls.

The Audit and Assurance Committee met 5 times during the financial year 2021/22, and highlights from the year's work include:

- agreement of the internal audit plan and review of progress against that plan,
- agreement of annual counter fraud plan and review of progress against that plan,
- review of risk management processes, including assurance framework and corporate risk register,
- consideration of cyber security arrangements and potential risks and assurances,
- review of assurance processes and reports in respect of outsourced functions,
- review of the output of external audit work,
- review and approval of the Annual Report and Accounts of the CCG under delegated authority from the Governing Body.

The requirements of the Audit Committee Handbook and the committee's terms of reference are used to develop the committee's annual work plan.

Remuneration Committee

The Committee is established to make recommendations to the Governing Body on remuneration, fees, pensions, allowances and conditions for senior employees of the CCG and people who provide services to the CCG. This includes remuneration for executive officers as well as the Chair and independent Lay Members and other Governing Body members. The committee also considers any business cases for early retirement and redundancy. The committee reviews the performance of the Accountable Officer and other senior team members and determines annual salary awards as necessary. It is also responsible for considering the severance payments of the Accountable Officer and of other senior staff.

It has not been necessary for the Committee meet during 2021/22.

Primary Care Commissioning Committee

The Primary Care Commissioning Committee has been established in accordance with the statutory provisions enabling NHS England to delegate to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act. The Committee makes collective decisions on the review, planning and procurement of primary care services in County Durham under delegated authority from NHS England. The role of the Committee is to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, including:

- GMS, PMS and APMS contracts,
- Newly designed enhanced services,
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF),
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers,
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

In addition, the Committee carries out the following activities:

- Planning, including needs assessment, primary medical care services in County Durham.
- Undertaking reviews of primary medical care services in County Durham.
- Co-ordinating a common approach to the commissioning of primary care services generally.
- Managing the budget for commissioning of primary medical care services in County Durham.

The terms of reference of the Committee reflect relevant national guidance, with the committee made up of a majority of non-conflicted members. The committee met 5 times during 2021/22.

Key areas that the Committee have focused on during the year include:

- GP preparedness for supporting Covid-19 arrangements,
- Primary Care and Primary Care Network development updates,
- regular review of primary care financial arrangements, primary care quality and primary care risks on the Corporate risk register,
- consideration of the GP practice staff and patient survey results,
- consideration of a Healthwatch review on access to GP services in County Durham,
- Improving access for patients to primary care and supporting general practice,
- review and recommissioning of Wingate APMS contract,
- commissioning of Special Allocation Scheme in County Durham,
- review of Primary Medical Care Quality Assurance Framework.

Joint Committees

Northern CCGs Joint Committee (Cumbria and the North East)

In common with all of the other seven CCGs in the North East and North Cumbria, we play an active role in the Northern CCG Joint Committee.

During 2021/22 the Joint Committee considered the following:

- Developing an Integrated Care System (ICS) in the North East and North Cumbria
- Research and evidence annual update
- Update on the use of Avastin for the treatment of wet AMD (age-related macular degeneration)
- Academic Health Science Network (AHSN) and its role with the National Lipid Management Pathway including inclisiran
- Northern Joint Committee Annual Report 2020/21
- Northern Treatment Advisory Group (NTAG) Annual Report 2020/21
- Learning Disabilities Treatment and Assessment Review
- North of England Commissioning Support (NECS) customer board reports.
- Gender Dysphoria
- System approach to preparing well for surgery in North East North Cumbria (NENC)
- Acute pressures
- Pre-Term Birth Clinics - commissioning for safety, quality and equity: request to combine allocations
- Value Based Clinical Commissioning Policy

Due to Covid-19, it was not possible to hold meetings of the Committee in public and it met in private virtually. Relevant extracts from these minutes were approved for publication on CCG websites.

Joint Committee of County Durham CCG, Tees Valley CCG and North Yorkshire CCG

As a result of CCG mergers and changed emphasis relating to ICP working, this Joint Committee was established to replace the previous Joint Committee of the Southern Collaborative of CCGs. The review of the previous Committee and the formation of the new Committee aims to provide an effective mechanism for the purpose of making decisions

normally delegated to the Governing Bodies, where those decisions must be made together to ensure a consistent and efficient approach to the commissioning and reconfiguration of services that meet the needs of the populations served by the member CCGs.

There was no requirement for either the Southern Collaborative Joint Committee or the Joint Committee of County Durham CCG, Tees Valley CCG and North Yorkshire CCG to meet during 2021/22.

Joint Committee of Durham CCG, South Tyneside and Sunderland CCGs for the Path to Excellence Transformation Programme

This Joint Committee was established in 2021/22 and is responsible for the delivery and management of the overall Path to Excellence transformation programme and supports the member CCGs to work efficiently, effectively and economically, ensuring effective clinical engagement and patient and public involvement, as well as promoting the involvement of all member CCGs and their practices in the work of the CCGs in securing improvements in applicable services through the Path to Excellence programme. The Joint Committee met on 2 occasions in 2021/22.

Other committees on which the CCG is a partner

Health and Wellbeing Board – Durham County Council
The CCG is a member of the County Durham Health and Wellbeing Board and membership is in accordance with the Council's governance arrangements.

Durham Local Safeguarding Children Board and Durham County Council Safeguarding Adults Board
The CCG is also a statutory member on the County Durham Local Safeguarding Children Board, County Durham Safeguarding Adults Board, and the County Durham-wide Safeguarding Vulnerable Adults Board. These bodies are led by our Local Authority partners.

Mental Health and Learning Disabilities Partnership Board
The CCG is a key partner of the Durham, Darlington and Tees Valley NHS Mental Health and Learning Disability Partnership. The aim of the partnership is to enable the three local CCGs of the Southern Collaborative to work together with our main provider Tees, Esk and Wear Valleys NHS Foundation Trust, to improve the quality of care across the system.

UK Corporate Governance Code

Although NHS Bodies are not required to comply with the UK Code of Corporate Governance, the CCG takes a robust approach to its application of good governance principles and continuous improvement. Throughout 2021/22, this has included holding dedicated development sessions held with the Governing Body as well as regular staff meetings that have also incorporated elements of governance to ensure an embedded approach.

The guidance contained within the Code enables assessment of Governing Body effectiveness against the criteria of leadership, effectiveness, accountability, remuneration and relations with stakeholders. There are numerous arrangements in place within the

CCG's assurance processes that capture performance and progress against these, for example the NHS Oversight Framework.

Discharge of Statutory Functions

During establishment of the CCG (and its predecessor CCGs), the arrangements put in place to govern the organisation were developed with extensive expert, external legal input to ensure compliance with all relevant legislation. That legal advice also informed the matters reserved for the Council of Members and Governing Body decisions and scheme of delegation. All subsequent changes to the Constitution or Scheme of Delegation have been confirmed as appropriate by NHS England.

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

Responsibility for each duty and power has been clearly allocated to a lead Director.

Risk management arrangements and effectiveness

Our comprehensive approach to risk management employs best practice in compliance with accepted standards. A Risk Management Policy is in place which takes into account current guidance on risk management best practice and incorporates guidance provided by ISO 31000:2009 (formerly AZ/NZ Standard 4360:2004) and the former National Patient Safety Agency in its approach to assessing risk. It is also consistent with NHS England's Risk Management Policy and Process guidance.

The Risk Management Policy sets out the CCG's approach to the assessment and management of clinical and non-clinical risk in fulfilment of our overall objective to commission high quality and safe services. This includes clear CCG processes and procedures to identify, evaluate and control risks. The Risk Management Policy provides guidance for the systematic and effective management of risk to prevent risk, to deter risks from arising and to manage current risks. Key elements of the Risk Management Policy include:

- a clear statement of Governing Body and individual accountability for delivery of the policy,
- clear principles, aims and objectives of the risk management process,
- a clearly defined process for delivering the framework including an implementation plan to ensure that the framework and risk management awareness is communicated to all staff,
- details of the approach to be undertaken to assess and report risk,
- an agreed process for reporting, managing, analysing and learning from adverse events supported by a "fair blame" culture and approach,
- confirmation of the arrangements for reporting risk through the risk register.

Our risk management framework is the systematic application of management policies, procedures and practices to the tasks of identifying, monitoring, mitigating and managing risk. All CCG risks are, once identified, recorded and managed in the electronic Safeguard Incident Risk Management System (SIRMS). Additionally, the CCG assurance framework enables the Executive Committee, Audit and Assurance Committee and the Governing Body to ensure effective arrangements are in place for the management of risks to principal strategic objectives and for the sound governance of the organisation.

Our approach to risk management ensures:

- risk management is a cohesive element of the internal control systems within the corporate governance framework supported by robust risk management systems and processes,
- the organisation meets statutory obligations including those relating to health and safety and data protection,
- all stakeholders, staff and partner organisations are assured that the CCG is committed to managing risk appropriately,
- staff can access support and risk management training and development is provided across the organisation by the NECS Governance team,
- updates and guidance reviews are communicated to all staff.

The Risk Management Policy sets out the CCG's position in respect of risk appetite, being the amount of risk that the organisation is prepared to accept, tolerate or be exposed to at any point in time. The CCG endeavours to reduce risks to the lowest possible level reasonably practicable. Where risks cannot reasonably be avoided, every effort will be made to mitigate the remaining risk.

All our policies are assessed utilising a nationally recognised Equality Impact Assessment (EIA) tool. This process of analysing a new or existing service, policy or process enables us to identify what is the (likely) effect of implementation for different groups within the community (including patients, public and staff), allowing risks to be identified and managed appropriately.

The CCG has a well-established and transparent incident reporting and management system which is embedded across the organisation and used to identify any related risks. The CCG openly encourages and supports incident reporting by ensuring that there a robust Incident Reporting and Management Policy and Standard Operating Procedure (SOP) in place which is reviewed annually and that the appropriate training is provided in a timely manner.

Capacity to Handle Risk

Strong leadership and an effective governance structure are vital elements of the CCG's capacity to handling risk. The governance arrangements as outlined above meet the requirements of best practice guidance in respect of risk management and ensure that a strong accountability framework has been established and is maintained.

The CCG has clear lines of accountability with defined responsibilities and objectives relating to all aspects of risk reporting and management. The Accountable Officer has overall responsibility for ensuring the implementation of an effective risk management

strategy, systems and controls. Each of the directors of the CCG is responsible for the management of strategic and operational risk in their specific areas, including ensuring that all areas of risk are assessed appropriately, in a timely manner and action taken to implement improvements.

The Governing Body has overall responsibility for governance, assurance and management of risk and therefore a clear oversight of the CCG's performance. The Governing Body has a duty to assure itself that the CCG has properly identified the risks it faces and that it has processes and controls in place to mitigate those risks and the impact they have. The Governing Body monitors the key risks relating to the achievement of the strategic objectives through the Governing Body Assurance Framework.

The Audit and Assurance Committee is responsible for reviewing and providing assurance to the Governing Body on the systems in place across the CCG for governance and risk management including internal control.

The Executive Committee, Quality Committee and the Primary Care Commissioning Committee are responsible for ensuring that all risks relevant to their respective areas of responsibility are identified, addressed and reported to the Governing Body as appropriate.

Identifying, reporting and management of risk is 'everybody's' responsibility within the CCG and all staff are familiar with the main risks in their area of activity which ensures the submission of timely and accurate information to support the assessment of CCG risks to ensure compliance with statutory obligations.

Risk management training is provided to all executive members and risk leads/risk coordinators where requested. An annual training requirements discussion is undertaken by the CCG risk lead and NECS Senior Governance Officer. Staff at present have a good working knowledge and understanding of the risk management framework and the risk/incident module of SIRMS and generally refer to the "Risk Management Standard Operating Procedure" (SOP) instruction guide for the information they need. However, if staff require refresher risk management training or if there is a new starter to the organisation, modules of risk management training are provided on request.

Risk Assessment

Whenever risks have been identified it is important to assess and record the risk so that appropriate controls are put in place to eliminate the risk or mitigate its effect. To do this, a standard risk matrix is used, as outlined in the CCG Risk Management Policy, the matrix in our risk assessment guidance is based on current national guidance and also adapted to suit the CCG risk appetite.

Risk is identified and embedded in the organisation via a number of mechanisms including a comprehensive risk register which identifies current and prospective risks to the organisation. The risk register incorporates the full comprehensive list of all risks facing the organisation at an operational and strategic level, across the five areas of delivery, development and transition, finance, performance and quality.

The risk register captures details of the assessment of each risk in terms of consequence and likelihood to produce an overall risk score, together with the mitigating action then being taken to manage those risks.

Each risk is assigned to a responsible director/senior manager, who maintains overall responsibility for the risk, with each risk also aligned to a Governing Body committee based on the respective delivery area. Finance, performance, delivery and development risks are aligned to the Executive Committee and quality risks aligned to the Quality Committee. Risks relating to primary care commissioning are aligned to the Primary Care Commissioning Committee.

All risks are reviewed on a regular basis by risk owners and by the respective aligned committee at each committee meeting to ensure that risks are appropriately assessed and that where required action is being taken, with the Executive Committee and Governing Body performing an overall review of all risks.

All corporate red risks identified as having the potential to have a significant impact on the CCG corporate objectives are then escalated and specifically reviewed by Governing Body.

The Audit and Assurance Committee ensures the CCG works within and adheres to robust risk reporting and management processes and systems. An annual review and update of the CCG's Risk Management Policy ensures that risk management processes and systems are updated in line with current best practice guidance. In addition, the CCG Risk Management Standard Operating Procedure (SOP) provides clear instructions on how to identify risks and the process for the reporting and management of risks within all employees' areas of responsibility.

The CCG Risk Management SOP was updated in June 2021 in line with NHSE/I Risk Management Policy and good practice to include an updated risk assessment matrix (see diagram 1 below), added guidance on functionality to link actions to controls and consequence descriptors updated to include data security risk assessment criteria.

Diagram 1: Risk assessment matrix 2021 (full risk rating = consequence x likelihood details described in SOP)

	Likelihood				
	1	2	3	4	5
Consequence	Rare	Unlikely	Possible	Likely	Almost certain
5 Very high	5	10	15	20	25
4 High	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Low	2	4	6	8	10
1 Very low	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

	1 - 6	Low risk
	8 - 10	Moderate risk
	12 - 16	High risk
	20 - 25	Very high risk

Current major risks to governance, risk management and internal control

A summary of the significant corporate risks which the CCG has faced during the year and which continue to be the most significant risks to the CCG currently is set out below:

Risk Ref	Description	Controls	Assurances	Score
0010	**Delivery of NHS Constitutional Standards** There is a risk of failure to achieve NHS Constitutional Standards for our patients. Significant pressures are evident in certain standards, particularly in respect of A&E 4 hour waits, cancer waiting times, HCAI targets and ambulance response times. Any failure to deliver the standards has the potential to adversely impact on patient care, as well as posing a reputational risk for the CCG.	Performance is monitored in detail by the Executive Committee, as well as via contract meetings with providers Same Day Emergency Care (SDEC) has been implemented, along with the implementation of the Clinical Advice Line (CAL) Elective recovery plans have been developed with main providers. Weekly meetings in place to review activity across all surgical specialities and theatre list allocation weighted towards specialties with highest number of long waiters (once cancer and urgent cases accommodated) Weekly meetings in place at CDDFT to review the Cancer Patient Tracker List Dedicated elective wards at CDDFT to protect elective surgery and additional capacity agreed at Independent Sector providers Action plans in place with providers to manage relevant pressure areas	Performance monitored quarterly by Governing Body and monthly by Executive Committee Director leads established Performance reviewed by Local A&E Delivery Board. Several initiatives implemented and monitored by Local A&E Delivery Board Root cause analysis undertaken on HCAI and cancer breaches Quarterly review against NHS Assurance Framework indicators	20
0002	**Coronavirus (Covid-19)** There is a risk around the ability of the local health system to manage increased demand, whilst maintaining quality and safe services for patients. There is potential for the coronavirus outbreak to interrupt the business of the CCG, either due to increased staff sickness or potential disruption to supply chain	The CCGs have tested business continuity plans in operation, which will be invoked should the situation arise Covid-19 Tactical Command Cell (TCC) implemented to manage CCG response Weekly CCG directors call to review progress and actions Working with providers to agree re-prioritisation of clinical services, following NHSE guidance, as appropriate Review and monitoring of quality of services continues as normal Identified lead Director to support enquiries and national mandates.	Business continuity plans have been tested and enacted Action log and updates provided to directors call Action/decisions log in place, reported to formal Executive Committee meetings Well established quality review arrangements Provide senior decision maker in the process. Point of contact for major concerns	20

The outcomes and assessment of all risks reported and managed across the organisation are firmly aligned to good management practice and ensures that effective processes and responsibilities for managing the risks are clear within the organisation. All risks are managed and aligned actions assessed on an individual risk by risk basis. The CCG is keen to ensure that risk management is not seen as an end in itself, but rather a part of an overall management approach that supports the organisation in developing achievable management action plans.

Potential future risks

The current pressures on the health service as a result of Covid-19 are substantial and well documented. The challenge of meeting the current additional demands on services arising from Covid-19, whilst continuing to maintain quality and ensure services are safe for all patients will continue to be a significant risk in the short term.

In addition to the immediate pressure and demand on the health economy, the longer-term recovery of services to meet the demands of less urgent treatment for patients will represent a potential risk and challenge through 2022/23.

The proposed legislative changes to Integrated Care Systems (ICS), which have been recommended by NHS England and NHS Improvement and form part of the Government Whitepaper, would essentially result in CCG functions and responsibilities transferring to the ICS from July 2022. Whilst there are a number of potential benefits and opportunities from these proposals, there are clearly significant implications for the CCG and its staff, and a potential risk of destabilising existing local place-based arrangements that have developed in County Durham. The delay in target implementation date for the Integrated Care Board to 1 July 2022 also presents additional complexities and potential risks relating to a transition part-way through the financial year. These potential risks will need to be carefully managed over the coming year.

Other Sources of Assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the CCG to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control was in place in the CCG for the year ended 31 March 2022 and is consistent with the controls that operated during the previous year.

The CCG's system of internal control includes the governance framework and arrangements highlighted in the governance arrangements and effectiveness section above, with the Scheme of Reservation and Delegation, Standing Financial Instructions and supporting financial and operational policies. The Audit and Assurance Committee plays a key role in reviewing the adequacy of the internal control framework and providing assurance to the Governing Body on the effectiveness of internal control arrangements.

This includes, but is not limited to, reviewing the work of internal audit who evaluate the effectiveness of the design and operation of the CCG's system of internal control.

Annual audit of conflicts of interest management

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

An internal audit was undertaken during quarter four of 2021/22. The objective of this audit is to review the arrangements that the CCGs have in place to manage conflicts of interest and gifts and hospitality, including compliance with NHS England's statutory guidance on managing conflicts of interest for CCGs.

The scope of the audit included:

- governance arrangements, including that: policies/procedures comply with legal requirements and statutory guidance; appropriate number of Lay Members and a conflict of interest guardian is/are appointed; and required training has been provided;
- declarations of interests and gifts and hospitality, including that: declarations are being made and recorded in accordance with legal requirements and statutory guidance;
- registers of interests, gifts and hospitality and procurement decisions, including that: each of these registers are maintained and published in accordance with legal requirements and statutory guidance;
- decision making processes and contract monitoring, including that: there are mechanisms for the management of conflicts within meetings, when making procurement decisions and in relation to contract management; and
- reporting concerns and identifying and managing breaches/ non-compliance, including that: processes are in place for managing breaches and for the publications of anonymised details of breaches on the CCGs' websites.

The CCG received good assurance with two medium priority and two low priority recommendations which are being implemented.

Data Quality

The NECS Data Management service has processes and systems in place to assess the quality and completeness of commissioning data managed on behalf of the CCG. Data is checked at all stages of processing through CSU systems and finally on publication of reports/analysis. Data is compared against historic and planned levels to provide assurance on completeness as well as with peer organisations in the form of benchmarking analysis.

Processes are in place to raise any data quality issues with providers on a monthly basis, feedback from these challenges is utilised to alter any processing routines as required. The CCG utilises contract levers where necessary to ensure high quality data is captured at source and to minimise any updating of data once received by commissioners.

Reconciliation accounts for each contract highlight any discrepancies between provider and commissioner data that are then investigated and resolved.

Significant validation steps are in place in all routine data processing tasks to ensure poor quality data is not made available for analysis and then subsequently used as the basis for commissioning decisions.

The CCG relies on NECS to process other types of personal data, for example Human Resources or some patient data in order to fulfil its functions. NECS complies with the data quality requirements of the Data Security and Protection Toolkit and has procedures in place to ensure the quality of the data.

Data Security and Protection / 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 a Data Security and Protection Toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework comprising an approved strategy, a suite of approved policies and procedures, a programme of mandatory training, an Information Governance Handbook for staff, information risk management and incident management. We have also adopted and implemented NHS Digital's (HSCIC) Guide to the Notification of Data Security and Protection Incidents.

We have in place an incident reporting and management framework for the reporting of data security and protection incidents to the Information Commissioner. This framework outlines the scope of responsibilities and details the reporting procedures to be used in the event of a data security breach. There have been no Information Governance 'reportable' breaches during 2021/22.

The Information Governance agenda is heard at the Executive Committee which also oversees the day-to-day management of Information Governance systems and processes. The CCG has also appointed a Caldicott Guardian (Dr Ian Davison, Medical Director) and Senior Information Risk Owner (Nicola Bailey, Chief Officer).

The Data Security and Protection Toolkit has been provided by NHS Digital to support performance monitoring of progress on Information Governance in the NHS. The CCG intends to publish the Data Security and Protection Toolkit Version for 2021/22 by 30 June 2022 and has answered all mandatory requirements.

The CCG complies with its statutory duty to respond to requests for information. During the year, the CCG received 161 requests under the Freedom of Information Act 2000 and 64 subject access requests under the Data Protection Act 2018. All the requests were responded to within the statutory timescales.

Business Critical Models

The CCG is aware of the quality assurance requirements in respect of business critical models contained within the recommendations in the Macpherson report and it is considered that appropriate arrangements are in place to provide sufficient quality assurance.

Third Party Assurances

The majority of commissioning support services are procured from our CSU, NECS, including risk and governance expertise, together with the management of the majority of internal control systems and processes, for example in relation to finance systems and controls.

A service auditor reporting process has continued to provide assurance over the effectiveness of controls and processes within NECS. A report has been received to cover the year to 31 March 2022. The detailed findings of the report and in particular those control objectives which were not achieved for the full period have been reviewed and are not considered to significantly impact on the CCG. Additional controls are in place within the CCG in terms of the review of transactions processed by NECS which mitigate any risk arising from deficiencies in these control objectives.

The CCG also has additional systems of control and review mechanisms internally over the work performed by the CSU which provide additional assurance that there have been no significant internal control issues which have impacted on the CCG.

In addition to the majority of commissioning support services which are provided by the CSU, the CCG has also outsourced certain other systems and services to third party providers. The national Integrated Single Financial Environment (ISFE) and procurement systems are provided by NHS Shared Business Services and the national Electronic Staff Records (ESR) system is operated by NHS Business Services Authority. There are also various other outsourced services and systems relating to primary care services, including the Exeter System provided by NHS Digital and systems operated by Capita which provides the services of all primary care support teams.

Assurance over the relevant control environments in place for these systems has been gained from independent auditor reports for the year ended 31 March 2022, in accordance with ISAE 3000 or 3402 (International Standard on Assurance Engagements). No significant control deficiencies have been identified from these auditor reports which cause a concern for the CCG.

Payroll services are also received from a third party provider in Northumbria Healthcare NHS Foundation Trust. The CCG's own system of internal controls provides assurance over the operation of payroll, this includes the Scheme of Reservation and Delegation and prime financial policies which govern and set levels of authorisation, together with subsequent monthly payroll reviews. Again, no significant issues have been identified from the review of payroll information during the year, with substantial assurance being provided from internal audit review of the payroll services.

Control Issues

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

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

The CCG has well developed systems and processes in place for managing its resources. Robust financial governance arrangements have been maintained throughout the year, including the Standing Orders, Scheme of Reservation and Delegation, and Prime Financial Policies incorporated within the CCG Constitution, supplemented by the CCG's Standing Financial Instructions and detailed financial limits, all of which provide the framework through which the CCG discharges its business. This is supported by comprehensive and well established systems of internal control which help to govern the effective use of resources.

Budgets were set by the CCG in line with the temporary financial arrangements implemented by NHS England and Improvement, covering two six month periods.

Similar to the previous year, the impact of the Covid-19 pandemic and the revised NHS financial regime significantly altered the usual planning and investment prioritisation process during the year. The CCG reviewed financial governance arrangements during 2020/21 in light of the revised financial regime and related guidance, to ensure arrangements were fit for purpose to efficiently and effectively manage the response to the pandemic, with no changes required. The CCG implemented appropriate arrangements for managing additional Covid-19 costs and has continued to follow relevant NHS England and improvement guidance in managing the response to the pandemic, including relevant Hospital Discharge arrangements.

The Executive Committee plays a key role in managing performance and delivery against financial plans, ensuring appropriate action is taken to address any issues as required and providing assurance to the Governing Body that resources are being utilised in line with plans, and that expected outcomes are being delivered. In addition, reports are also reviewed at each Governing Body meeting, showing performance against budgets and financial targets.

The Audit and Assurance Committee also plays a key role in providing assurance to the Governing Body in relation to financial governance arrangements and the effectiveness of systems and processes of internal control. A significant component of this assurance is the work of the CCG's internal and external auditors.

Specifically, as part of their annual audit, the CCG's external auditors are required to satisfy themselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources. They do this by examining documentary evidence and through discussions with senior managers. Their audit work is made available to and reviewed by the Audit and Assurance Committee. Although the work of the external auditors does not form part of the CCG's internal control environment, their conclusions in respect of this use of resources work provides further assurance that the processes implemented by the CCG are robust.

The CCG's internal control framework comprises several elements including the CCG Constitution, assurance framework, risk management, incident management, financial management, policy management, audit and governance assurance reporting, which work in harmony to complement each other. Controls and assurances are monitored through the Governing Body and committee structure as described above.

Delegation of Functions

Delegation arrangements exist through the CCG's governance process and committee structures, as set out in the role and remit of each committee. The systems and processes to ensure resources are used economically, efficiently and effectively, together with the related assurance mechanisms highlighted above, apply throughout the organisation, covering all relevant committees and delegations.

This includes the governing body which oversees the work of all committees, with formal reporting arrangements, together with the other assurance processes summarised above.

Specifically, in respect of primary care delegated arrangements with effect from 1 April 2020, the Primary Care Commissioning Committee was established to carry out the relevant functions relating to that delegation, with relevant reporting and assurance arrangements summarised above. This follows on from the primary care delegated arrangements within the two predecessor CCGs from 1 April 2015.

Counter Fraud Arrangements

The CCG has adhered to the NHS CFA requirements which were released in January 2021. A comprehensive counter fraud service, including an accredited Counter Fraud Specialist is commissioned through our internal auditors to undertake counter fraud work proportionate to identified risks.

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 and Assurance Committee which focuses on the deterrence, prevention, detection and investigation of fraud. Progress against this plan is regularly monitored by the Audit and Assurance Committee with an annual counter fraud report also received.

The Audit and Assurance Committee also receives a report against the Standards for Commissioners at least annually and considers the relevant actions being implemented to address any identified deficiencies. There is executive support and direction for a proportionate work plan to address identified risks.

The Chief Finance Officer is proactively responsible for tackling fraud, bribery and corruption. Counter-fraud requirements and regulations have been discussed with both the Governing Body and wider CCG employees during the year to cement their knowledge and understanding of counter-fraud arrangements. In addition, notifications and briefings regarding actual and potential fraud are circulated to key staff to ensure counter-fraud vigilance is maintained and enable payment systems to be reviewed for emerging risks.

Head of Internal Audit Opinion

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

Final Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpins the organisation's own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist in the completion of the Annual Governance Statement.

My opinion is set out as follows:

- Overall opinion;
- Basis of the opinion;

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.

Basis of the Opinion

The basis for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes for governance and the management of risk;

2. An assessment of the range of individual opinions arising from audit assignments, contained within risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses;

3. Brought forward Internal Audit assurances;

4. An assessment of the organisation's response to Internal Audit recommendations, and

5. Consideration of significant factors outside the work of Internal Audit.

In providing this opinion, it is important to recognise the additional limitations on our work caused by the Covid-19 pandemic. These limitations include access to CCG personnel and the timely supply of information that would be available to us under normal circumstances.

However, as your Head of Internal Audit I am satisfied that we have sufficient evidence, to provide the CCG with a robust Head of Internal Audit Opinion.

I would like to take this opportunity to thank the staff at County Durham CCG for the co-operation and assistance provided to my team during the year.

Carl Best
Associate Director of Audit
AuditOne

8 June 2022

Audit area	Assurance Level
Core Assurance	
Governance Structures and Risk Management Arrangements [Draft]	Substantial
Conflicts of Interest [Final]	Good
Data Security and Protection Toolkit Follow-up [Final]	Substantial
PCN Development [Final] – advisory audit with no assurance level	N/A
Contract and Performance Management [Final]	Substantial
Key Financial Controls [Final]	Substantial
Continuing Healthcare – Contract Management [Final]	Substantial

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 and the executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports. I have been advised on the implications of the result of this review by the Governing Body, Executive Committee, the Audit and Assurance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

As part of the CCG's risk management processes, an Assurance Framework has been in place throughout the year which provides a simple yet comprehensive method for the effective and focused management of the principal risks and assurances to meeting and delivering the CCG's objectives. The Assurance Framework reflects the principal risks associated with the delivery of the CCG's strategic objectives. This includes risks around the delivery of the CCG's strategic aims, financial stability including QIPP delivery, and development of effective corporate governance and risk management.

The Assurance Framework details with the key controls and assurances in place against each risk, together with any relevant action being taken to address gaps in controls and assurances where required. This is supplemented by detailed risk registers that record the full comprehensive list of all risks facing the CCG at an operational and strategic level across the five areas of delivery, development and transition, finance, performance and quality.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principal objectives have been reviewed.

As highlighted above, the Audit and Assurance Committee plays a key role in providing assurance to the Governing Body on the effectiveness of the systems of internal control and governance arrangements operated by the CCG. As part of this the work of both internal and external audit and other sources of assurance are considered. No significant internal control issues have been identified from the work of the Audit and Assurance Committee.

Similarly, no significant governance or internal control issues have been identified through Governing Body, Executive Committee or any other assurance process which impact upon my review of the effectiveness of the system of internal control.

As described within the third party assurances section above, external assurances have been obtained over all significant outsourced services, including commissioning support services from NECS. No significant issues have been identified which impact upon the CCG or this review.

The Head of Internal Audit opinion is set out above. This contributes to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the CCG's system of internal control. The Head of Internal Audit opinion provides substantial assurance that there is a generally sound system of internal control.

Conclusion

No significant internal control issues have been identified.

Dr Neil O'Brien
Accountable Officer

17 June 2022

Remuneration and Staff Report

Remuneration report

Remuneration Committee

The Remuneration Committee was established to advise the Governing Body about pay, other benefits and terms of employment for senior employees of the CCG and people who provide services to the CCG. This includes any potential severance payments for relevant senior staff.

The Committee is established in accordance with the CCG's constitution, standing orders and scheme of delegation. The Committee was made up as follows for the year ended 31 March 2022:

Andrew Atkin	Lay Member and Chair of Remuneration Committee
Feisal Jassat	Lay Member, Patient and Public Involvement
Dr Jonathan Smith	CCG Chair
Ian Spencer	Secondary Care Clinician

The terms of reference and membership of the Remuneration Committee have remained unchanged from the previous year.

The Remuneration Committee provides recommendations to the Governing Body on pay and remuneration for senior employees of the CCG and people who provide services to the CCG.

The Accountable Officer, Chief Officers, Chief Financial Officer and HR advisor have provided advice and guidance to the Committee in relation to pay rates and terms and conditions for relevant staff, although they were specifically excluded from any discussions in relation to their own pay rates and terms and conditions.

Policy on the remuneration of senior managers

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

Continuation of employment for all senior managers is subject to satisfactory performance. Performance in post and progress in achieving set objectives is reviewed annually. There were no individual performance review payments made to any senior managers during the year and there are no plans to make such payments in future years. This is in accordance with standard NHS terms and conditions of service and guidance issued by the Department of Health and Social Care.

Contracts of employment in relation to the majority of senior managers employed by the CCG are permanent in nature and subject to between three and six months' notice of termination by either party. The Elected Health Care Professionals are usually employed on

a fixed term of three years. From 1 April 2020, lay members and the Secondary Care Doctor have been appointed for a period of three years for County Durham CCG.

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 Senior Managers

For the purpose of this remuneration report, the CCG has considered the definition of 'senior managers' within the 2021/22 CCG Annual Reporting Guidance and the Department of Health and Social Care Group Accounting Manual and considers that the regular attendees of the Governing Body represent the senior managers of the CCG.

Details of the relevant salaries and allowances for all of the senior managers of the CCG can be found in the tables below, both for 2021/22 and also relevant comparative figures for 2020/21.

The following disclosures within the Remuneration and Staff Report are subject to audit by the CCG's external auditors:

- the table of salaries and allowances of senior officers on pages 113 to 114 and related narrative notes on pages 115 to 116;
- the table of pension benefits of senior managers on pages 118 to 119;
- the analysis of staff numbers and costs on page 121; and
- the table of pay multiples and related narrative notes on pages 116 to 117.

Important Note regarding 'All Pension Related Benefits' stated in the tables below:

Please note the amount included here is the annual increase in pension entitlement accrued during the current year multiplied by 20 (as an estimate of the benefit that being a member of the pension scheme may provide). This value has been determined in accordance with the HMRC method of calculation, in accordance with guidance from NHS England. Employee pension contributions made in 2021/22 have been deducted from the total. Pension related benefits shown in the table above relate to the NHS pension scheme members only. **The figure shown is not intended to reflect annual remuneration received by the individual during the financial year.**

NHS County Durham CCG senior officers' salaries and allowances - 2021/22:

Name	Title	2021/22					
		Salary (Bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100)	Performance pay and bonuses (Bands of £5,000)	Long-term performance pay and bonuses (Bands of £5,000)	All Pension related benefits (Bands of £2,500)	Total (Bands of £5,000)
		£000	£	£000	£000	£000	£000
Dr N O'Brien	Accountable Officer	50 - 55	1,700	-	-	12.5 - 15	70 - 75
N Bailey	Chief Officer	150 - 155	7,300	-	-	47.5 - 50	205 - 210
S Findlay	Chief Officer	160 - 165	5,900	-	-	-	165 - 170
Dr J Carlton	Medical Director	80 - 85	7,000	-	-	20 - 22.5	105 - 110
Dr I Davidson	Medical Director	45 - 50	-	-	-	-	45 - 50
R Henderson	Chief Finance Officer	105 - 110	-	-	-	32.5 - 35	140 - 145
A Greenley	Director of Nursing and Quality	125 - 130	-	-	-	40 - 42.5	165 - 170
M Brierley	Director of Commissioning, Strategy and Delivery	50 - 55	300	-	-	12.5 - 15	65 - 70
J Chandy	Director of Commissioning, Strategy and Delivery	120 - 125	-	-	-	25 - 27.5	145 - 150
S Burns	Joint Head of Integrated Strategic Commissioning	55 - 60	1,600	-	-	15 - 17.5	75 - 80
Dr J Smith	Chair	55 - 60	-	-	-	2.5 - 5	60 - 65
F Jassat	Lay Member, Patient and Public Involvement	15 - 20	-	-	-	-	15 - 20
J Whitehouse	Lay Member, Governance and Audit	15 - 20	-	-	-	-	15 - 20
A Atkin	Lay Member	15 - 20	-	-	-	-	15 - 20
Dr I Spencer	Secondary Care Clinician	10 - 15	-	-	-	-	10 - 15
Dr C Markwick	Elected Health Care Professional (GP)	5 - 10	-	-	-	-	5 - 10

The value in the table above for A Greenley reflects the recharge to the CCG from NECS for her secondment.

NHS County Durham CCG senior officers' salaries and allowances - 2020/21 (comparative figures):

Name	Title	2020/21					
		Salary (Bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100)	Performance pay and bonuses (Bands of £5,000)	Long-term performance pay and bonuses (Bands of £5,000)	All Pension related benefits (Bands of £2,500)	Total (Bands of £5,000)
		£000	£	£000	£000	£000	£000
Dr N O'Brien	Accountable Officer	50 - 55	1,700	-	-	12.5 - 15	65 - 70
N Bailey	Chief Officer	150 - 155	7,200	-	-	2.5 - 5	160 - 165
S Findlay	Chief Officer	160 - 165	5,900	-	-	-	165 - 170
Dr J Carlton	Medical Director	80 - 85	7,000	-	-	32.5 - 35	120 - 125
Dr I Davidson	Medical Director	45 - 50	-	-	-	-	45 - 50
R Henderson	Chief Finance Officer	105 - 110	-	-	-	27.5 - 30	135 - 140
G Findley	Director of Nursing and Quality (until 13 July 2020, then from 4 December 2020 to 31 January 2021)	40 - 45	-	-	-	20 - 22.5	65 - 70
J Cram	Director of Nursing (from 13 July 2020 to 4 December 2020)	15 - 20	-	-	-	-	15 - 20
A Greenley	Director of Nursing and Quality (from 1 February 2021)	15 - 20	-	-	-	5 - 7.5	20 - 25
M Brierley	Director of Commissioning, Strategy and Delivery	50 - 55	-	-	-	-	50 - 55
J Chandy	Director of Commissioning, Strategy and Delivery	120 - 125	-	-	-	57.5 - 60	180 - 185
S Burns	Director of Commissioning, Strategy and Delivery	55 - 60	2,700	-	-	45 - 47.5	105 - 110
Dr J Smith	Chair	60 - 65	-	-	-	25 - 27.5	85 - 90
F Jassat	Lay Member, Patient and Public Involvement	15 - 20	-	-	-	-	15 - 20
J Whitehouse	Lay Member, Governance and Audit	15 - 20	-	-	-	-	15 - 20
A Atkin	Lay Member	15 - 20	-	-	-	-	15 - 20
Dr I Spencer	Secondary Care Clinician	10 - 15	-	-	-	-	10 - 15
Dr C Markwick	Elected Health Care Professional (GP)	5 - 10	-	-	-	-	5 - 10

The values in the table above show the remuneration for J Cram for the period 1 October to 4 December 2020. For the period 13 July to 30 September this was paid by County Durham and Darlington NHSFT as part of the block contract arrangements. Total remuneration for the period of this role is £35-£40k.

Notes:

The taxable benefits included in the tables above all relate to car allowance and lease car benefits.

No performance related benefits have been agreed for any senior officers.

All pension related benefits disclosed in this report relate to 'officer employment' only, i.e. for any general practitioners, the figures exclude any benefits derived from practitioner employment.

All senior officer remuneration is processed through the CCG's payroll.

Shared Management Arrangements

Throughout 2021/22 (and 2020/21), the Accountable Officer has operated in a shared role across the following three CCGs; County Durham CCG, South Tyneside CCG and Sunderland CCG. The costs of this role are split equally across the three CCGs.

In addition, the following senior officer operated in a shared management role across both County Durham CCG and Tees Valley CCG throughout 2021/22 (and 2020/21), with costs split equally across the two CCGs:

M Brierley Director of Commissioning, Strategy and Delivery

The following senior officer operated in a shared management role across both County Durham CCG and Durham County Council throughout 2021/22 (and 2020/21), with costs split equally across the two organisations:

S Burns Joint Head of Integrated Strategic Commissioning

The remuneration shown above for these three posts represents only the share that relates to the County Durham CCG role. The total remuneration earned by each individual for all work across the relevant CCGs in 2021/22 is shown below:

Name	Title	2021/22		
		Salary (Bands of £5,000) £000	Expense payments (taxable) (Rounded to the nearest £100) £	Total (Bands of £5,000) £000
Dr N O'Brien	Accountable Officer	165 - 170	5,100	170 - 175
M Brierley	Director of Commissioning, Strategy and Delivery	105 - 110	700	105 - 110
S Burns	Joint Head of Integrated Strategic Commissioning	120 - 125	3,300	120 - 125

The level of total annual remuneration for the Accountable Officer reflects that the role is being performed across multiple CCGs, together with the clinical nature of the role, and has been benchmarked against other Clinical Chief Officer roles and equivalent general practice earnings.

The remuneration of the two Chief Officer roles reflects historical arrangements in place with the former CCGs, with relevant pay protection arrangements applying based on former roles. The Chief Officer remuneration has previously been benchmarked against equivalent roles during appointment of the posts with the Chief Officer salary initially agreed within the £145-150k salary band.

There were three other senior officers who received a salary in excess of the prime minister's salary of £150,000 in 2021/22 on a pro rata basis. The pro rata basis represents the full time salary for individuals who work part time. The salary reflects the clinical nature of the role, and has been benchmarked against other equivalent general practice earnings.

The following senior officers are not employed by the CCG and receive no remuneration from the CCG for their role as Governing Body members:

A Healy	Director of Public Health
J Robinson	Durham County Council Representative
C Cunnington-Shore	Patient Reference Group Chair (Sedgefield)
K Holyman	Patient Reference Group Chair (North Durham)
L Allison	Patient Reference Group Chair (Easington)
A Seward	Patient Reference Group Chair (Durham Dales)

Pay multiples

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 of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director in the CCG in the financial year 2021/22 was £165-170k (2020/21: £165-170k). The relationship to the remuneration of the organisation's workforce is disclosed in the table below:

	25th percentile Total remuneration ratio		Median Total remuneration ratio		75th percentile Total remuneration ratio	
	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21
Band of Highest Paid Director's Total Remuneration (£'000)	165 -170	165 -170	165 -170	165 -170	165 -170	165 -170
Total remuneration £	31,534	30,615	47,126	44,503	108,075	104,927
Ratio	5.31	5.47	3.55	3.76	1.55	1.60

No performance related pay or bonuses have been paid to senior officers or employees during 2021/22 (2020/21: none).

In 2021/22, no employees (2020/21: none) received remuneration in excess of that of the highest paid director. Full time equivalent banded remuneration for employees ranged from £15-20k up to £165-170k (2020/21: £15-20k up to £165-170k).

For the purposes of identifying the highest paid director for this disclosure, it is the cost to the CCG of an individual that is considered, rather than the total of that individual's remuneration.

The banded remuneration of £15-20k relates to the CCG's lay members who receive an annual remuneration for a time-commitment below the CCG's normal contractual hours. As this represents the annual remuneration for the full required time-commitment, this is considered to represent the full time equivalent remuneration for that role although it relates to a time-commitment significantly below the CCG's normal contractual hours.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Accordingly, the total remuneration figures reflected here exclude the pension related benefits shown in the salaries and allowances table on page 113.

There has been a slight reduction in the ratio from previous year when comparing the total remuneration of the highest paid director to the organisations workforce as a result of the pay award to employees and reflecting the relatively stable structure in place within the CCG.

There has been no percentage change from the previous financial year in respect of the highest paid director and the average percentage change from the previous financial year in respect of employees of the entity is 1.48% which includes the impact of the pay award.

NHS County Durham CCG senior officers' pension benefits 2021/22:

Name and Title	Real increase / (reduction) in pension at age 60 (bands of £2,500)	Real increase / (reduction) in Pension Lump Sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2022 (bands of £5,000)	Lump Sum at aged 60 related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021	Real increase in cash equivalent transfer value	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr N O'Brien Clinical Chief Officer	2.5 – 5	0 – 2.5	25 – 30	15 – 20	303	28	356	-
N Bailey Chief Officer	2.5 – 5	-	100 – 105	-	1,486	61	1,577	-
Dr I Davidson Medical Director	-	-	-	-	-	-	-	1
Dr J Carlton Medical Director	0 – 2.5	0 – 2.5	10 – 15	0 – 5	148	12	171	-
R Henderson Chief Finance Officer	0 – 2.5	-	20 – 25	-	227	15	257	-
A Greenley Director of Nursing and Quality	2.5 – 5	2.5 - 5	40 - 45	115 – 120	905	64	989	-
M Brierley Director of Commissioning, Strategy and Delivery	0 – 2.5	0 – 2.5	30 – 35	50 – 55	524	27	567	-
J Chandy Director of Commissioning, Strategy and Delivery	0 – 2.5	-	30 – 35	75 – 80	565	24	609	-
S Burns Director of Commissioning, Strategy and Delivery	0 – 2.5	0 – 2.5	25 – 30	50 – 55	417	20	456	-
Dr J Smith Chair	0 – 2.5	-	15 - 20	30 - 35	264	2	278	-

NHS County Durham CCG senior officers' pension benefits 2020/21 (comparative figures):

Name and Title	Real increase / (reduction) in pension at age 60 (bands of £2,500)	Real increase / (reduction) in Pension Lump Sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2021 (bands of £5,000)	Lump Sum at aged 60 related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2020	Real increase in cash equivalent transfer value	Cash Equivalent Transfer Value at 31 March 2021	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr N O'Brien Clinical Chief Officer	2.5 - 5	-	20 - 25	15 - 20	257	18	303	-
N Bailey Chief Officer	0 - 2.5	-	95 - 100	-	1,410	30	1,486	-
Dr I Davidson Medical Director	-	-	-	-	-	-	-	1
Dr J Carlton Medical Director	0 - 2.5	-	10 - 15	0 - 5	117	18	148	-
R Henderson Chief Finance Officer	0 - 2.5	-	20 - 25	-	198	11	227	-
G Findley Director of Nursing and Quality	0 - 2.5	0 - 2.5	55 - 60	80 - 85	791	20	882	-
A Greenley Director of Nursing and Quality	0 - 2.5	0 - 2.5	35 - 40	110 - 115	813	10	905	-
M Brierley Director of Commissioning, Strategy and Delivery	0 - 2.5	-	25 - 30	50 - 55	503	-	524	-
J Chandy Director of Commissioning, Strategy and Delivery	2.5 - 5	2.5 - 5	25 - 30	75 - 80	489	50	565	-
S Burns Director of Commissioning, Strategy and Delivery	2.5 - 5	7.5 - 10	25 - 30	50 - 55	330	66	417	-
Dr J Smith Chair	0 - 2.5	0 - 2.5	15 - 20	35 - 40	235	15	264	-

The tables above include only those senior managers who are members of the NHS pension scheme where the CCG made contributions to the scheme as an employer during the year.

The figures included above reflect total pension benefits accrued within the NHS Pension Scheme, not just those accrued from employment within the CCG. No lump sum is shown for employees who only have membership in the 2008 section of the NHS Pension Scheme.

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

The real increase figures shown above relate only to the period each individual was in post as a senior officer.

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 membership of the pension scheme, not just their service in a senior capacity to which the 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 Cash Equivalent Transfer Values

This reflects the increase in CETV effectively 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).

Staff report

Staff Numbers

Details of staffing costs for the year and the average number of employees can be found in notes 3.1 and 3.2 of the financial statements respectively.

The CCG's senior officers are listed in the remuneration report. Four of the senior officers are on very senior manager (VSM) bandings, four of the senior officers are on agenda for change band 9 and the remaining senior officers are either paid on a sessional basis or are non-executive members and hence have no agenda for change banding.

Staff Composition

The CCG employs 115 people, 83.45 whole time equivalents. The staff gender profile is given in the table below. This reflects our gender representation on the Governing Body and other CCG staff.

	Female	Male
Governing Body	35%	65%
Employees	73.9%	26.1%

These figures are as at 31 March 2022 and reflect the number of employees rather than full time equivalent figures.

Gender by Employee Category (Measure = Headcount)

The CCG can demonstrate fair and equitable recruitment, workforce engagement and employment terms and conditions to ensure levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work, and work rated as of equal value, and being entitled to equal pay.

Staff Turnover Rate

The staff turnover rate for 2021/22 was 19.74% (2020/21: 13.7%) with the majority of those leavers moving to other roles within the NHS.

Staff Sickness Absence

The table below provides staff sickness absence data for the 12 months ended 31 December 2021, showing the total number of full time equivalent (FTE) staff days lost to sickness absence and the total number of FTE years available, based on the total number of FTE staff members within the CCG. This equates to an average number of days' sickness per FTE member of staff of 3.77:

	2021 Number of days	2020 Number of days
Total number of days lost to sickness absence	311.93	359.3
Total staff years	82.85	84.2
Average number of working days lost to sickness absence	**3.77**	**4.3**

Diversity

The CCG's workforce is predominantly female, predominantly white British with a broad spread of ages. Other ethnic groups are represented (five individuals) although it should be noted that a number of staff have chosen not to declare or specify their ethnic origin.

Trade Union Representation

None of the CCG's employees had a role as a Trade Union Official during 2021/22. We would provide appropriate support for any individual who wished to undertake such a role.

Staff Policies

The CCG is committed to giving full and fair consideration to all applications for employment received including those received from disabled persons, having regard to their particular aptitudes and abilities.

To support the human resource function the CCG has a suite of HR policies, implementation of which is supported by Human Resource Team within North of England Commissioning Support. They cover the full range of HR issues including recruitment, training and career development.

All appropriate support would be provided to any employee who might become a disabled person during the period when they were employed by the CCG.

The NHS People Plan: Supporting our Staff

The NHS People Plan for 2020/21 was published on 31 July 2020 and set out guidelines for employers and systems within the NHS, as well as actions for NHS England and NHS Improvement and Health Education England. The plan also included 'Our People Promise', which outlined behaviours and actions that staff can expect from NHS leaders and colleagues, to improve the experience of working in the NHS for everyone. Work has continued with HR colleagues to develop a more structured approach for 2021/22 as life returns to normal to address the nine areas identified:

- health and wellbeing,
- flexible working,

- equality and diversity,
- culture and leadership,
- new ways of delivering care,
- growing the workforce,
- recruitment,
- retaining staff,
- recruitment and deployment across systems.

Expenditure on Consultancy

Details of expenditure on consultancy services can be found in note 4 of the financial statements, with expenditure on agency staff shown in note 3.1 of the financial statements. For 2021/22, the value of consultancy services expenditure is £9k and for agency staff £85k.

Off-Payroll Engagements

There have been no off-payroll engagements during the year of greater than £245 per day and lasting longer than 6 months.

Exit Packages

No exit packages have been agreed in the financial year.

Dr Neil O'Brien
Accountable Officer
17 June 2022

Parliamentary Accountability and Audit Report

County Durham CCG is not required to produce a Parliamentary Accountability and Audit Report. Where relevant, disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report in pages 125 to 147.

An audit report is also included in this Annual Report at page 148.

Dr Neil O'Brien
Accountable Officer
17 June 2022

Financial statements

NHS County Durham CCG Financial Statements for the year ended 31 March 2022

CONTENTS **Page Number**

The Primary Statements:

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

	Note	2021/22 £000	2020/21 £000
Administration costs and programme expenditure			
Other operating income	2	-	(154)
Total operating income		-	**(154)**
Gross employee benefits	3.1	4,975	4,662
Purchase of goods and services	4	1,169,313	1,051,922
Other operating costs	4	145	375
Total operating expenditure		**1,174,433**	**1,056,959**
Net operating costs for the financial year		**1,174,433**	**1,056,805**
Net loss on transfer by absorption	6	-	70,186
Total net expenditure for the year		**1,174,433**	**1,126,991**
Total comprehensive net expenditure for the year		**1,174,433**	**1,126,991**

Statement of Financial Position as at 31 March 2022

	Note	31 March 2022 £000	31 March 2021 £000
Current assets			
Trade and other receivables	8	2,240	1,962
Cash and cash equivalents	9	132	45
Total current assets		**2,372**	**2,007**
Total assets		**2,372**	**2,007**
Current liabilities			
Trade and other payables	10	(63,082)	(69,550)
Total current liabilities		**(63,082)**	**(69,550)**
Total assets less current liabilities		**(60,710)**	**(67,543)**
Financed by taxpayers' equity			
General fund		(60,710)	(67,543)
Total taxpayers' equity		**(60,710)**	**(67,543)**

The notes on pages 130 to 147 of the Annual Report form part of this statement.

The financial statements on pages 126 to 147 were approved and authorised for issue by the Audit and Assurance Committee on 13 June 2022 and signed on its behalf by:

Dr Neil O'Brien
Accountable Officer
17 June 2022

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2022

	General fund £000	Total reserves £000
Changes in taxpayers' equity for 2021/22:		
Balance at 1 April 2021	(67,543)	(67,543)
Changes in CCG taxpayers' equity for 2020/21		
Net operating costs for the financial year	(1,174,433)	(1,174,433)
Net recognised CCG expenditure for the financial year	**(1,174,433)**	**(1,174,433)**
Net funding	1,181,266	1,181,266
Balance at 31 March 2022	**(60,710)**	**(60,710)**

	General fund £000	Total reserves £000
Changes in taxpayers' equity for 2020/21:		
Balance at 1 April 2020	-	-
Changes in CCG taxpayers' equity for 2020/21		
Net operating costs for the financial year	(1,056,805)	(1,056,805)
Transfers by absorption to (from) other bodies	(70,186)	(70,186)
Net recognised CCG expenditure for the financial year	**(1,126,991)**	**(1,126,991)**
Net funding	1,059,448	1,059,448
Balance at 31 March 2021	**(67,543)**	**(67,543)**

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Net operating costs for the financial year		(1,174,433)	(1,056,805)
(Increase) / decrease in trade and other receivables	8	(278)	409
(Decrease) in trade and other payables	10	(6,468)	(2,771)
Net cash outflow from operating activities		**(1,181,179)**	**(1,059,167)**
Net cash outflow before financing		**(1,181,179)**	**(1,059,167)**
Cash flows from financing activities			
Net funding received		1,181,266	1,059,448
Net cash inflow from financing activities		**1,181,266**	**1,059,448**
Net increase in cash and cash equivalents	9	**87**	**281**
Cash and cash equivalents at the beginning of the financial year		45	(236)
Cash and cash equivalents (including bank overdrafts) at the end of the financial year		**132**	**45**

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of CCGs shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to CCGs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

On 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, CCGs will be abolished and the functions, assets and liabilities of NHS County Durham CCG will transfer to the North East and North Cumbria Integrated Care Board (NENC ICB) from the 1 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. Although the CCG will cease to exist with effect from 1 July 2022, its functions will continue to be provided by the NENC ICB.

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

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

1.2 Accounting Convention

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

Notes to the financial statements (continued)

1. Accounting Policies (continued)

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

As public sector bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 business combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care Group Accounting Manual requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

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

1.4 Pooled Budgets

Where the CCG has entered into a pooled budget arrangement 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.

1.5 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the CCG's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 *Critical Judgements in Applying Accounting Policies*

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

- determining whether a substantial transfer of risks and rewards has occurred in relation to leased assets; and
- determining whether a provision or contingent liability should be recognised in respect of certain potential future obligations, particularly in respect of continuing healthcare.

1.5.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the CCG's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- the assumptions applied in the estimation of activity not yet invoiced as at the Statement of Financial Position date;
- the estimate of potential future liabilities in respect of continuing healthcare services; and
- the estimate of prescribing expenditure for the final two months of the year based on the ten months of actual charges received from the Prescription Pricing Division.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the standard have been employed. These are as follows:

• as per paragraph 121 of the standard the CCG will not disclose information regarding the performance obligations part of a contract that has an original expected duration of one year or less;

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

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

Revenue in respect of services provided is recognised when, 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.

1.7 Employee Benefits

1.7.1 *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.

1.7.2 *Retirement Benefit Costs*

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the CCG of participating in the 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.

1.8 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.

Expenses and liabilities in respect of grants are recognised when the CCG has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.9 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.9.1 The CCG as Lessee

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

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

1.10 Cash & Cash Equivalents

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

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

1.11 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.

1.12 Non-clinical Risk Pooling

The CCG participates in the Liabilities to Third Parties Scheme. This is a risk pooling scheme under which the CCG pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses as and when they become due.

1.13 Contingent liabilities and contingent assets

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

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

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

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.14 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.

Financial assets are classified into the following categories:

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

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

All CCG assets have been classified as financial assets at amortised cost.

1.14.1 *Financial Assets at Amortised cost*

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.14.2 *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 the Department of Health and Social Care 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.

1.15 Financial Liabilities

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

1.15.1 *Other Financial Liabilities*

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

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.16 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.

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

The Department of Health and Social Care Group Accounting Manual does not require the following Standards and Interpretations to be applied in 2021/22. These standards are still subject to HM Treasury FREM adoption, with IFRS 16 being for implementation to 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16: Leases (application from 1 April 2022), as adapted and interpreted by the FREM;

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the Statement of Financial Position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the Statement of Financial Position, the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The CCG will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the CCG will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the general fund at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the rate implicit in the lease. Where the implicit rate cannot be determined the CCG will use the incremental borrowing rate. The CCGs incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the CCG will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

- IFRS 17: Insurance Contracts (application from 1 January 2021) but not yet adopted by the FREM which is expected to be April 2023: early adoption is not therefore permitted.

The application of the Standards as revised would not have a material impact on the accounts for 2021/22, were they applied in that year.

2. Other Operating Revenue

	2021/22 Total £000	2020/21 Total £000
Other non contract revenue	-	154
Total other operating revenue	-	**154**

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

Revenue is totally from the supply of services. The CCG receives no revenue from the sale of goods.

Notes to the financial statements (continued)

3. Employee benefits and staff numbers

3.1 Employee benefits

2021/22	Total	Permanent Employees	Other
	£000	£000	£000
Employee benefits:			
Salaries and wages	3,937	3,852	85
Social security costs	388	388	-
Employer contributions to NHS Pension scheme	642	642	-
Apprenticeship levy	8	8	-
Gross employee benefits expenditure	**4,975**	**4,890**	**85**

No amounts were recovered in respect of employee benefits and no employee benefits were capitalised during the year (2020/21: none).

2020/21 Comparative figures

3.1.1 Employee benefits

2020/21	Total	Permanent Employees	Other
	£000	£000	£000
Employee benefits:			
Salaries and wages	3,635	3,635	-
Social security costs	381	381	-
Employer contributions to NHS Pension scheme	630	630	-
Apprenticeship levy	8	8	-
Termination benefits	8	8	-
Gross employee benefits expenditure	**4,662**	**4,662**	-

A contribution to 3 shared posts was made for exit packages agreed in 2019/20, the costs shown within termination benefits in 2020/21 relate to an additional charge for class 1As payable from 1st April 2020 on those exit packages.

3.2 Average number of people employed

	2021/22 Total Number	2021/22 Permanently employed Number	2021/22 Other Number	2020/21 Total Number
Total	**69**	**67**	**2**	67

None of the above people were engaged on capital projects (2020/21: none).

Notes to the financial statements (continued)

3. Employee benefits and staff numbers (continued)

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 Schemes 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. The Schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each Scheme is accounted for as if it were a defined contribution scheme: the cost to the CCG of participating in the 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 2022, is based on valuation data at 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FREM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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 Scheme was completed for the year ending 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

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

The employer contribution rate for NHS Pension Schemes increased from 14.3% to 20.6% from 1st April 2019. For 2021/22, the CCG continued to pay over contributions at the former rate with the additional amount being paid by NHS England on behalf of the CCG. The full cost and related funding has been recognised in these accounts.

Notes to the financial statements (continued)

4. Operating expenses

	2021/22 £000	2020/21 £000
Other costs		
Services from other CCGs and NHS England	9,079	8,306
Services from foundation trusts	778,070	681,761
Services from other NHS trusts	3	14
Purchase of healthcare from non-NHS bodies	179,543	165,142
Prescribing costs	105,051	105,478
Pharmaceutical services	215	195
Primary Medical Services Costs (GPMS/APMS and PCTMS)	93,161	84,679
Supplies and services – clinical	1	1
Supplies and services – general	86	43
Consultancy services	9	40
Establishment	82	344
Transport	-	1
Premises	3,274	5,249
Audit fees	115	71
Other non statutory audit expenditure		
· Other services	1	1
Other professional fees	539	471
Legal fees	35	78
Education and training	49	48
Total Purchase of goods and services	**1,169,313**	**1,051,922**
Other Operating Expenditure		
Chair and Non Executive Members	144	145
Clinical negligence	4	6
Expected credit loss on receivables	(3)	215
Other expenditure	-	9
Total other costs	**145**	**375**
Total operating expenses	**1,169,458**	**1,052,297**

Included within Other professional fees is £44,338 paid for Internal Audit Services (2020/21: £31,781).

Limitation of auditor's liability:

The CCG's contract for external audit services provides for a limitation of the auditor's liability of £2,000,000 (2020/21: £2,000,000).

Notes to the financial statements (continued)

5. Better Payment Practice Code

Measure of compliance	2021/22 Number	2021/22 £000	2020/21 Number	2020/21 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the year	43,058	295,415	41,105	270,059
Total Non-NHS Trade invoices paid within target	42,896	294,537	41,015	269,001
Percentage of Non-NHS Trade invoices paid within target	**99.62%**	**99.70%**	**99.78%**	**99.61%**
NHS Payables				
Total NHS Trade invoices paid in the year	687	789,129	1,677	696,632
Total NHS Trade invoices paid within target	687	789,129	1,667	696,470
Percentage of NHS Trade invoices paid within target	**100.00%**	**100.00%**	**99.40%**	**99.98%**

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

6. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

	2021/22 £000	2020/21 £000
Transfer of receivables	-	2,371
Transfer of payables	-	(72,321)
Transfer of borrowings	-	(236)
Net loss on transfer by absorption	**-**	**(70,186)**

Notes to the financial statements (continued)

7. Operating Leases

7.1 As lessee

The CCG has entered into a small number of formal operating lease arrangements, relating to leased cars and the lease of photocopying equipment, none of which are individually significant. Specific lease terms vary by individual arrangement but are based upon standard practice for the type of arrangement involved.

The CCG occupies property owned and managed by NHS Property Services Limited and Community Health Partnerships Limited. The charges shown in note 7.1.1 from NHS Property Services Limited are intended to reflect the cost of occupancy, calculated based on market rents by NHS Property Services Limited.

The CCG has a lease with NHS Property Services Limited for the occupation of premises at the Lavender Centre and Wheatley Hill. This note includes future minimum lease payments for the Lavender Centre and Wheatley Hill only.

7.1.1 Payments recognised as an expense

	2021/22 Buildings £000	2021/22 Other £000	2021/22 Total £000	2020/21 Total £000
Payments recognised as an expense				
Minimum lease payments	106	2	**108**	**409**
Total	**106**	**2**	**108**	**409**

7.1.2 Future minimum lease payments

	2021/22 Buildings £000	2021/22 Other £000	2021/22 Total £000	2020/21 Total £000
Payable:				
No later than one year	91	-	**91**	**55**
Between one and five years	456	-	**456**	**-**
After five years	1,115	-	**1,115**	**-**
Total	**1,662**	**-**	**1,662**	**55**

8. Trade and other receivables

	Current 31 March 2022 £000	Non-current 31 March 2022 £000	Current 31 March 2021 £000	Non-current 31 March 2021 £000
NHS receivables: Revenue	1,611	-	647	-
NHS accrued income	7	-	102	-
Non-NHS and Other WGA receivables: Revenue	355	-	670	-
Non-NHS and Other WGA prepayments	329	-	617	-
Non-NHS and Other WGA accrued income	-	-	74	-
Expected credit loss allowance - receivables	(212)	-	(215)	-
VAT	149	-	66	-
Other receivables	1	-	1	-
Total trade and other receivables	**2,240**	**-**	**1,962**	**-**
Total current and non current	**2,240**		**1,962**	

The great majority of trade is with other NHS bodies, including other CCGs as commissioners for NHS patient care services. As CCGs are funded by Government to commission NHS patient care services, no credit scoring of them is considered necessary.

8.1 Receivables past their due date but not impaired

	31 March 2022 £000	31 March 2021 £000
By up to three months	1,414	115
By three to six months	-	32
By more than six months	-	86
Total	**1,414**	**233**

£1,358k of the amount above has subsequently been recovered post the Statement of Financial Position date.

The CCG did not hold any collateral against receivables outstanding at 31 March 2022 (31 March 2021: none).

8.2 Expected credit losses on financial assets

The CCG has expected credit losses on trade and other receivables of £212k in 2021/22 (2020/21 £215k).

The CCG has reviewed all receivables to determine whether an impairment value is required. In determining the recoverability of a receivable, the CCG considers any change in credit quality of the receivable from the date credit was initially granted up to the reporting date. The overall level of credit risk is considered to be relatively low due to the proportion of the customer base which is comprised of NHS bodies.

Notes to the financial statements (continued)

9. Cash and cash equivalents

	2021/22 £000	2020/21 £000
Balance at 1 April	45	(236)
Net change in year	87	281
Balance at 31 March	**132**	**45**
Made up of:		
Cash with the Government Banking Service	132	45
Cash and cash equivalents as in Statement of Financial Position	**132**	**45**
Balance at 31 March	**132**	**45**

The CCG held £nil cash and cash equivalents at 31 March 2022 on behalf of patients (31 March 2021: £nil).

10. Trade and other payables

	Current 31 March 2022 £000	Non-current 31 March 2022 £000	Current 31 March 2021 £000	Non-current 31 March 2021 £000
NHS payables: revenue	1,886	-	1,607	-
NHS accruals	17	-	1,017	-
Non-NHS and Other WGA payables: Revenue	5,671	-	6,118	-
Non-NHS and Other WGA accruals	54,214	-	59,145	-
Social security costs	68	-	67	-
Tax	68	-	68	-
Other payables	1,158	-	1,528	-
Total trade and other payables	**63,082**	**-**	**69,550**	**-**
Total current and non-current	**63,082**		**69,550**	

At 31 March 2022, the CCG had no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2021:none).

Other payables include £746k in respect of outstanding pension contributions at 31 March 2022 (31 March 2021: £786k).

Notes to the financial statements (continued)

11. Commitments

There were no contracted or non-cancellable contracts entered into by the CCG at 31 March 2022 (31 March 2021: none) which are not otherwise included in these financial statements.

12. Financial instruments

12.1 Financial risk management

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

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the CCG's standing financial instructions and policies agreed by the Governing Body. Any treasury activity would be subject to review by the CCG's internal auditors.

12.1.1 Currency risk

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

12.1.2 Interest rate risk

The CCG has no borrowings and has only limited powers to borrow funds from government for capital expenditure, subject to affordability as confirmed by NHS England. The CCG therefore has low exposure to interest rate fluctuations.

12.1.3 Credit risk

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

12.1.4 Liquidity risk

The CCG is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The CCG draws down cash to cover expenditure, as the need arises. The CCG is not, therefore, exposed to significant liquidity risks.

12.1.5 Financial Instruments

As the cash requirements of the CCG 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 the CCG's expected purchase and usage requirements and the CCG is therefore exposed to little credit, liquidity or market risk.

Notes to the financial statements (continued)

12. Financial instruments (continued)

12.2 Financial assets

	Financial Assets measured at amortised cost 31 March 2022 £000	Total 31 March 2022 £000	Financial Assets measured at amortised cost 31 March 2021 £000	Total 31 March 2021 £000
Trade and other receivables:				
· NHSE bodies	1,615	1,615	712	712
· Other DHSC group bodies	3	3	240	240
· External bodies	356	356	542	542
Cash and cash equivalents	132	132	45	45
Total at 31 March	**2,106**	**2,106**	**1,539**	**1,539**

12.3 Financial liabilities

	Other 31 March 2022 £000	Total 31 March 2022 £000	Other 31 March 2021 £000	Total 31 March 2021 £000
Trade and other payables:				
· NHSE bodies	1,099	1,099	1,586	1,586
· Other DHSC group bodies	1,644	1,644	27,968	27,968
· External bodies	60,203	60,203	39,861	39,861
Total at 31 March	**62,946**	**62,946**	**69,415**	**69,415**

13. Operating segments

The CCG has considered the definition of an operating segment contained within IFRS 8 in determining its operating segments, in particular considering the internal reporting to the CCG's Governing Body, considered to be the 'chief operating decision maker' of the CCG, which was used for the purpose of resource allocation and assessment of performance.

All activity performed by the CCG relates to its role as a commissioner of healthcare for its relevant population. As a result, the CCG considers that it has only one operating segment, being the commissioning of healthcare services.

The CCG received delegated responsibility for the commissioning of certain primary medical care services from NHS England with effect from 1 April 2015. The CCG has reviewed this against the definition of an operating segment but does not consider it to be a separate operating segment as the value of the delegated budgets amount to less than 10% of the total CCG budget and the performance of those budgets are reported and managed as part of the CCGs overall commissioning budgets.

An analysis of both the income and expenditure and net assets relating to the segment can be found in the Statement of Comprehensive Net Expenditure and Statement of Financial Position respectively.

14. Pooled budgets

A pooled budget arrangement exists between Durham County Council and NHS County Durham CCG in respect of the Better Care Fund, through a section 75 agreement. The BCF operates under a lead commissioner arrangement, with services being commissioned by a lead organisation on behalf of the pooled budget, rather than being a jointly controlled operation or jointly controlled asset arrangement.

The CCG contribution to the pooled budget in 2021/22 was £47,632k (2020/21: £45,235k) which was used to commission a range of health and social care services in line with the agreed objectives of the Better Care Fund. This contribution to the Better Care Fund is recognised within the financial statements as CCG expenditure.

No other pooled budget arrangements are in place.

Notes to the financial statements (continued)

15. Related party transactions

During the year the CCG has undertaken transactions with the following CCG Governing Body members or members of the key management staff, or parties related to any of them:

CCG Governing Body member	Related Party	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
	NHS Sunderland CCG	852	(73)	-	-
	NHS South Tyneside CCG	1	(136)	-	-
	Cestria Health Centre	2,003	-	146	(26)
	Coxhoe Medical Practice	1,035	-	47	-
Dr N O'Brien	Central Durham GP Providers	2,326	(54)	6	-
Accountable Officer	Chester le Street Health Federation	1,541	-	4	-
S Findlay	County Durham & Darlington NHS Foundation Trust	407,667	-	318	-
Chief Officer	Bishopgate Medical Centre	2,077	-	79	-
	Evenwood Medical Practice	669	-	174	-
	Bishopgate Medical Centre	2,077	-	79	-
Dr J Carlton	Durham Dales Health Federation	4,823	-	223	-
Medical Director	NHS Tees Valley CCG	60	(946)	-	(176)
Dr I Davidson	Lanchester Medical Centre	742	-	32	(28)
Medical Director	Derwentside Healthcare Limited	2,810	-	146	-
M Brierley					
Director of Commissioning, Strategy and Delivery	NHS Tees Valley CCG	60	(946)	-	(176)
J Chandy	South Durham Health CIC	9,636	(28)	113	-
Director of Commissioning, Strategy and Delivery	East Durham Medical Group	3,556	-	134	-
S Burns					
Joint Head of Integrated Strategic Commissioning	Durham County Council	79,308	(16,323)	11,749	(52)
Dr J Smith	GP Partner Silverdale Family Practice	853	-	40	-
Chair	South Durham Health CIC	9,636	(28)	113	-
J Whitehouse	NHS North Cumbria CCG	56	-	15	-
Lay Member, Governance and Audit	NHS South Tyneside CCG	1	(136)	-	-
	Vocare Ltd	1	-	-	(8)
Dr C Markwick	Old Forge Surgery	658	-	26	-
Elected Healthcare Professional (GP)	Durham Dales Health Federation	4,823	-	223	-
A Greenley					
Director of Nursing and Quality	North of England Commissioning Support Unit	9,327	(12)	1,057	-
A Healy					
Director of Public Health (DCC)	Durham County Council	79,308	(16,323)	11,749	(52)
J Robinson					
Durham County Council	Durham County Council	79,308	(16,323)	11,749	(52)

All of these transactions were undertaken under standard terms and conditions in the normal course of business.

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

- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Resolution; and,
- NHS Business Services Authority.

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Durham County Council.

Notes to the financial statements (continued)

15. Related party transactions (continued)

2020/21 comparative figures:

During 2020/21 the CCG undertook transactions with the following CCG Governing Body members or members of the key management staff, or parties related to any of them:

CCG Governing Body member	Related Party	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
	NHS Sunderland CCG	521	(71)	162	-
	NHS South Tyneside CCG	131	(71)	-	-
Dr N O'Brien	Cestria Health Centre	1,943	-	180	-
Accountable Officer	Chester le Street Health Federation	952	-	19	-
S Findlay	Bishopgate Medical Centre	2,047	-	92	-
Chief Officer	North of England Commissioning Support Unit	8,025	(749)	1,182	(9)
	Evenwood Medical Practice	646	-	157	-
	Bishopgate Medical Centre	2,047	-	92	-
Dr J Carlton	Durham Dales Health Federation	3,522	(5)	138	-
Medical Director	NHS Tees Valley CCG	384	(640)	25	(184)
Dr I Davidson	Lanchester Medical Centre	752	-	25	(28)
Medical Director	Derwentside Healthcare Limited	1,945	-	299	(9)
M Brierley					
Director of Commissioning, Strategy and Delivery	NHS Tees Valley CCG	384	(640)	25	(184)
J Chandy	South Durham Health CIC	5,199	(14)	194	-
Director of Commissioning, Strategy and Delivery	East Durham Medical Group	3,231	(2)	98	-
S Burns					
Joint Head of Integrated Strategic Commissioning	Durham County Council	82,113	(15,141)	10,815	(133)
Dr J Smith	GP Partner Silverdale Family Practice	830	-	35	-
Chair	South Durham Health CIC	5,199	(14)	194	-
J Whitehouse					
Lay Member, Governance and Audit	NHS South Tyneside CCG	131	(71)	-	-
Dr C Markwick	Old Forge Surgery	690	-	23	-
Elected Healthcare Professional (GP)	Durham Dales Health Federation	3,522	(5)	138	-
A Greenley					
Director of Nursing and Quality	North of England Commissioning Support Unit	8,025	(749)	1,182	(9)
J Cram					
Director of Nursing and Quality	County Durham and Darlington NHS FT	369,735	(1)	762	-
A Healy					
Director of Public Health (DCC)	Durham County Council	82,113	(15,141)	10,815	(133)
J Robinson					
Durham County Council	Durham County Council	82,113	(15,141)	10,815	(133)

All of these transactions were undertaken under standard terms and conditions in the normal course of business.

Notes to the financial statements (continued)

16. 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 County Durham 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.

17. Financial performance targets

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

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

	2021/22 Target £000	2021/22 Performance £000	2020/21 Target £000	2020/21 Performance £000
Expenditure not to exceed income	1,179,049	1,174,433	1,059,307	1,056,959
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	1,179,049	1,174,433	1,059,153	1,056,805
Revenue administration resource use does not exceed the amount specified in Directions	10,487	9,331	10,487	9,538

CCG financial performance is reported on an in-year basis. The figures within this note reflect only the in-year position, being the difference between the in-year allocation (plus any pre-approved surplus drawdown) and total expenditure.

The CCG received no capital resource during 2020/21 and incurred no capital expenditure.

Performance against the revenue expenditure duties is further analysed below:

	2021/22 Programme Resource £000	2021/22 Administration Resource £000	2021/22 Total £000
Revenue resource	1,168,562	10,487	**1,179,049**
Net operating cost for the financial year	1,165,102	9,331	**1,174,433**
Underspend against revenue resource	**3,460**	**1,156**	**4,616**

The CCG has delivered an in-year surplus of £4.6m in 2021/22, in line with plans agreed with NHS England and NHS Improvement.

	2020/21 Programme Resource £000	2020/21 Administration Resource £000	2020/21 Total £000
Revenue resource	1,048,666	10,487	**1,059,153**
Net operating cost for the financial year	1,047,267	9,538	**1,056,805**
Underspend against revenue resource	**1,399**	**949**	**2,348**

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS COUNTY DURHAM CLINICAL COMMISSIONING GROUP

Opinion

We have audited the financial statements of NHS County Durham Clinical Commissioning Group ("the CCG") for the year ended 31 March 2022 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 17, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the 2021/22 HM Treasury's Financial Reporting Manual (the 2021/22 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2021/22 and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England.

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS County Durham Clinical Commissioning Group as at 31 March 2022 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22; and
- have been properly prepared in accordance with the National Health Service Act 2006 (as amended).

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 for the audit of the financial statements section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01 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 – Transition to an Integrated Care Board

We draw attention to Note 16 - Events after the end of the reporting period, which describes the Clinical Commissioning Group's transition into the North East and North Cumbria Integrated Care Board from the 1 July 2022. 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, or the successor body's, ability to continue as a going concern for a period to 30 June 2023.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or

conditions can be predicted, this statement is not a guarantee as to the CCG's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on the Remuneration and Staff Report

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued in the Department of Health and Social Care Group Accounting Manual 2021/22; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 (as amended) because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we make a written recommendation to the CCG under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have nothing to report in these respects.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities in respect of the Accounts, set out on pages 85 and 86, 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.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or has no realistic alternative but to do so.

As explained in the Annual Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

• We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant are the Health and Social Care Act 2012 and other legislation governing NHS CCGs, as well as relevant employment laws of the United Kingdom. In addition, the CCG has to comply with laws and regulations in the areas of anti-bribery and corruption and data protection.

• We understood how NHS County Durham Clinical Commissioning Group is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, the head of internal audit and those charged with governance, and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our reading of the CCG's minutes, review of the CCG's Constitution and Governance Handbook and enquiry of employees to confirm the CCG's policies. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.

• We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy, testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the CCG is engaging in any transactions outside the usual course of business. Based on our risk assessment procedures, we identified manipulation of reported financial performance through improper recognition of year end accruals and management override of controls to be our fraud risks.

• Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures involved enquiry of management, the Head of Internal Audit and those charged with governance, reading and reviewing relevant meeting minutes of those charged with governance and the Governing Body and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations.

• We addressed our fraud risk related to improper recognition of year end accruals by substantively testing all material accrual balances and a sample of other accrual balances, considering the appropriateness of management judgements and assumptions and the relevance and reliability of information used to inform each accrual.

• We addressed our fraud risk related to management override through implementation of a journal entry testing strategy,, assessing accounting estimates for evidence of management bias and evaluating the business rationale for significant unusual transactions.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2020, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in December 2021 as to whether the CCG had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 (as amended) to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 (as amended) requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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.

Report on Other Legal and Regulatory Requirements

Regularity opinion

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (as amended) (the "Code of Audit Practice").

We are required to obtain evidence sufficient to give an opinion on whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have issued our Auditor's Annual Report for the year ended 31 March 2022. We have completed our work on the value for money arrangements and will report the outcome of our work in our commentary on those arrangements within the Auditor's Annual Report.

Until we have completed these procedures, we are unable to certify that we have completed the audit of the accounts in accordance with the requirements of the Local Audit and Accountability Act 2014 (as amended) and the Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the members of the Governing Body of NHS County Durham Clinical Commissioning Group in accordance with Part 5 of the Local Audit and Accountability Act 2014 (as amended) and for no other purpose. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the members as a body, for our audit work, for this report, or for the opinions we have formed.

Maria Grindley (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Reading
17 June 2022

NHS

North Cumbria

Clinical Commissioning Group

Annual Report and Annual Accounts 2021/22

Contents

INTRODUCTION

This year has continued to challenge health and care services with the unprecedented demand created by the Covid-19 pandemic.

We are proud to have supported one of the largest vaccination rollouts in modern history and throughout 2021-2022, we have continued to see incredible work from our primary care teams, community pharmacies, hospital Trusts and a veritable army of volunteers and support from our other partners to ensure that communities in north Cumbria are protected. Teams adapted and mobilised quickly with a unique flexibility and resilience under extreme pressures; to deliver exactly what was asked of them. We are deeply proud of our record in north Cumbria and once again thank communities for their patience, understanding and support through what have been incredibly challenging times.

Despite significant pressures – local NHS teams have continued to work throughout the pandemic with regular 'day to day' appointments, adapting services where necessary to ensure that medical care continued for all our communities, with the most vulnerable patients prioritised. As we all get used to living with Covid-19, it has also proved particularly challenging for our CCG Staff whom, over recent months and like all organisations, have experienced the impact on staff absences from positive Covid tests. Teams have worked tirelessness to provide patients with the best service possible with the resources available and we are very thankful to communities and patients for their compassion, understanding and patience.

During the pandemic we have seen the advancement of technology really come to the forefront with new ways of working for both front line and back office staff. Although remote technology and video appointments have been around for some time, there continues to be some focused work in north Cumbria to increase these opportunities, thus reducing travel for patients and clinicians in our large rural areas. We appreciate that every patient and situation is different – with some understandably still preferring face to face contact – but the availability of these other options is still an achievement not to be overlooked and opens up lots of potential for the future.

System working has again played an absolute crucial role in how we deliver care to communities and this will continue to be the case as we work through the recovery phase. Much of our work has focused on the enormous task of supporting the system to treat those who have seen their operations delayed, and ensuring that those may have been put their health concerns on hold, can access the help they need. The health of our communities is massively improved when we adopt a partnership approach and ensure that the patient is at the heart of everything we do. We are very aware that this includes not just the physical health of our communities but also mental health. The events we have all lived through over the last year will have certainly raised anxiety and uncertainty among many, and we must ensure that this is an integral part of our system approach.

General Practice also continues to develop how they work, with more varied teams looking after communities, for example, if it is more appropriate, you may see a practice nurse or a social prescriber to provide treatment, guidance or advice. Integrated Care Communities and our Primary Care Networks will continue to develop ensuring our collaborative approach in bringing together primary care, community care, adult social care and our vibrant third sector organisations.

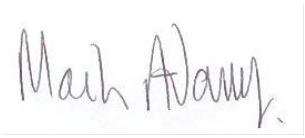
As we look ahead, we reflect too upon the final chapter of NHS Clinical Commissioning Groups as we move towards the implementation of the North East and North Cumbria Integrated Care Board. Although things will change in the commissioning structures behind the scenes, please be assured that keeping patients safe and working for the best health outcomes for our population in north Cumbria, will continue to be our top priority. We know that new structures can be confusing and often challenging to understand, but the key thing to take away is that the local relationships that have been built in our communities will continue on the journey of engagement, tackling inequalities and ensuring the best patient care. Change can bring new opportunities especially for collaboration and potentially innovative new ways of working to deliver better outcomes and improvements. As we emphasised last year, throughout this period of change we will remain a strong voice for our community.

Finally a huge heartfelt thank you to all the colleagues, communities and organisations who have been a part of the CCG's journey over the last 9 years. Especially for all those involved in our co-production work and those who offered feedback, enthusiasm and provided inventive solutions. There have been difficult moments and challenges but also innovative solutions, new ways of working, important relationships and valuable discussions that will continue as north Cumbria moves into the new world of Integrated Care Boards.

Jon Rush
Chair

Mark Adams
Accountable Officer

PERFORMANCE REPORT



Mark Adams
Accountable Officer
17 June 2022

Overview

NHS North Cumbria Clinical Commissioning Group (CCG) has a registered population of **329,110 (at 1 February 2022)**.

The CCG is characterised by a higher than average proportion of the population living in rural communities. Population density is therefore very low. Our west coast communities are geographically relatively isolated, and there are significant pockets of economic deprivation especially in the urban areas. These issues present major challenges for our health services in terms of delivery and recruitment/retention of staff.

The CCG has a total of 35 member Practices (as of April 2022), serving populations between just 908, to over 36,979 registered patients.

Out of hours primary care is provided by Cumbria Health on Call (CHoC).

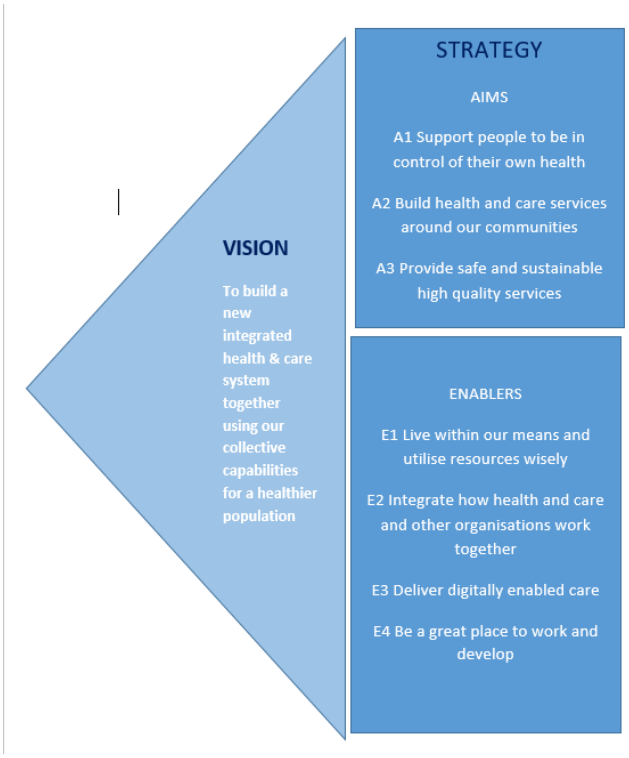
North Cumbria is served by three main NHS Trusts:

- **North Cumbria Integrated Care NHS Foundation Trust (NCIC)** is responsible for providing healthcare services in North Cumbria.
- **Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)** provides mental health services in North Cumbria
- **North West Ambulance Service NHS Trust (NWAS)** delivers Paramedic Emergency Services, Patient Transport Services and NHS 111.

For the North Cumbria population there are significant patient flows to a number of Trusts in the North East, particularly Newcastle Hospitals NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust, Gateshead Health NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust.

What we want to achieve and the risks that could affect it

The CCG's vision and purpose are shown below and continue to reflect the continuing significant change and challenge the CCG faces in line with other CCGs and NHS bodies.



CCG HIGH LEVEL OBJECTIVES

1. Work with partners to build and improve integrated health services and pathways
2. Commission and improve the quality , safety and sustainability of health and care services
3. Deliver on our annual and long term plans
4. Ensure financial sustainability of our organisation and North Cumbria
5. Develop services that prevent ill health and reduce inequalities
6. Become a great place to work
7. Enable a positive transition to ICS
8. Promote recovery from Covid 19

During 2021 and 2022 our NHS North Cumbria CCG has supported our health and care partners on our collective priorities:

- **Health Inequalities and Population Health**
- **Developing our workforce**
- **Recovery from Covid**
- **Finance**
- **Patient flow**
- **Continuing development of our Integrated Care Communities**

There are a number of inherent risks identified to delivery of these priorities that have a significant impact, notably:

The impact of COVID, both on the population health but also the impact on capacity, productivity and associated patient flow through our services. This has had a direct impact on both unscheduled and planned care in all sectors, including acute hospital care, mental health services, emergency ambulances and all aspects of out of hospital care.

As previously noted the staffing challenge is also a significant problem for all providers, both directly within the NHS and particularly in the care sector. There are risks in terms of key clinical staff in all NHS sectors but also particular pockets in the care sector where a combination of rurality and wider economic factors (e.g. employment levels) create a particular challenge. Nevertheless, the CCG has worked with NHS and local authority partners to provide further stability in the care market over winter to improve staff retention and also look at other opportunities to minimise the impact on the ability of the system to discharge patients from secondary care.

The underlying financial challenge for both the CCG and wider NHS system in North Cumbria is very significant, although to some extent the short-term risk has been mitigated by the NHS COVID financial regime in place since 2019/20. However, this issue and consequential service impact has been recognised by the system, with collective endeavours being applied to develop a financial recovery process while acknowledging the short-term operational risk presented by COVID. It is important to recognise a key driver of the risk is the challenge of providing accessible and safe services across a geographically remote area, both within North Cumbria itself (e.g. two acute hospital sites for a population of 329,110) **a**nd the ability to mitigate risk given the distance from "nearest neighbour" services.

More detail on the CCG's approach to assessing and managing risk is covered on pages 83 to 86 of this report.

Values and Behaviours

As part of our organisation's commitment to continuous improvement we have agreed values and behaviours across the organisations covering how we act towards each other, our colleagues and the wider community. The values continue to be embedded as part of our organisational behaviours.

The CCG worked with our provider colleagues to develop the values so they reflect the ambition and behaviours across all NHS organisations in North Cumbria. These updated values were initially rolled out in 2019 and are shared with North Cumbria Integrated Care NHS Foundation Trust.

Kindness -
Kindness and compassion cost nothing, yet accomplish a great deal.
Respect -
We're respectful to everyone and are open, honest and fair.
Ambition -
We set goals to achieve the best for our patients, teams, organisation and partners.
Collaboration -
We're stronger and better working together with and for our patients.

The end of CCGs and the path to an ICB (Integrated Care Board)

All CCGs will be changing from 1 July 2022. The CCGs in our areas will become the North East and North Cumbria Integrated Care Board (NENC ICB).

From a patient perspective you will still continue to have the same NHS services. The new organisation will take on the roles of the current CCGs and these changes are all part of the behind the scenes organisation in the region's focus on improving patient care across the North East and North Cumbria area ensuring:

- Secure, effective structures that ensure accountability, oversight and stewardship of resources.
- High quality planning arrangements to address population health needs, reduce health inequalities and improve care.
- Ensure the continuity of effective place-based working between the NHS, local authorities and partners.

As part of these changes the following **key terminology** should be a useful guide in these new structures and help to understand the new emerging organisational NHS commissioning landscape.

- **Integrated Care System (ICS)** – the geographical area – in our case the North East and North Cumbria - in which health and care organisations (including third sector, public health and community groups) work together through the following bodies

- **Integrated Care Board (ICB)** – the statutory NHS organisation that replaces the 8 CCGs currently in the North East and North Cumbria area. They will take on the CCG's previous responsibilities to plan and deliver healthcare across the 13 upper tier local authorities (our 'places') in the ICS area. The ICB will delegate many of its functions to this 'place' level.

- **Integrated Care Partnership (ICP)** – a joint committee of the ICB and the 13 local authorities responsible for developing an Integrated Care Strategy built up from the needs assessments from each of our 13 places that the ICB and the local authorities must 'have regard to' in planning and delivering services.

  There will be four 'sub regional ICPs' underneath this larger board. In North Cumbria this will be the North Cumbria Health and Care Partnership which you may be familiar with and is detailed in the next section.

  Health and Wellbeing Board (HWBBs) – a statutory sub-committee of each local authority responsible for developing a Joint Strategic Needs Assessment (JSNA) for their local area, and a Joint Health Wellbeing Strategy. The ICB and its place-based teams will work with HWBBs as CCGs currently do.

More on the North East and North Cumbria Integrated Care System (NENC ICS) can be found at: https://www.NortheastandNorthcumbriaics.nhs.uk. We work collaboratively across the region to ensure the best outcomes for our patients and tackle some of our shared challenges together. ICSs are systems in which NHS commissioners and providers, working closely with GP networks,

local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they use their collective resources to improve quality of care and health outcomes.

The new ICB organisation will continue to put the voices of people and communities at the centre of decision making and governance. This will also be the case at every level of the ICS.

The CCG's co-production work and approach will continue in the ICB, starting engagement early when plans are developing, ensuring feedback to people and communities about how their engagement has influenced activities and decisions.

We will also continue to build on our understanding of communities in North Cumbria including their needs, experience and aspirations. Our local relationships with key partners will also continue to build on the work that the CCG has supported, ensuring clarity to accessible public information about our vision, plans and progress to continue building understanding and trust.

Our North Cumbria Health and Care Partnership

The North Cumbria Health and Care Strategy, published in 2020, continues to guide the collaborative approach taken by our health and care partners.

The North Cumbria Integrated Care Partnership Leadership Board has continued to meet and develop more strategic links into our wider community, involving new partners including our universities, the county's Local Economic Partnership (LEP) and Active Cumbria. It is made up of health and care commissioners and providers which include NHS North Cumbria Clinical Commissioning Group, North Cumbria Integrated Care NHS Foundation Trust, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, NHS England, NHS Improvement, North West Ambulance Service and Primary Care, working in partnership with Cumbria County Council, third sector organisations and our community.

More information can be found here: https://Northcumbriaccg.nhs.uk/about-us/North-cumbria-health-and-care-partnership/North-cumbria-integrated-care-partnership-leaders-board

These priorities are closely connected with the **North Cumbria Health and Care Strategy:**

3 Strategic Aims: We will

1) *improve the health and care outcomes of our local communities and support people of all ages to be in control of their own health*

2) *build health and care services around our local communities*

3) *provide safe and sustainable high quality services.*

To help us achieve this we will focus on key areas – **our strategic enablers: we will**

A) *be a great place to work and develop*

B) *integrate how health and care and other organisations work together*

C) *live within our means and spend resources wisely*

D) *deliver digitally enabled care*

Performance Analysis

Measuring our performance against national and local priorities helps ensure our services are being delivered to a high quality standard and provide value for money. NHS North Cumbria CCG works within the wider health and care system to oversee and monitor the performance of its local healthcare providers to ensure that:

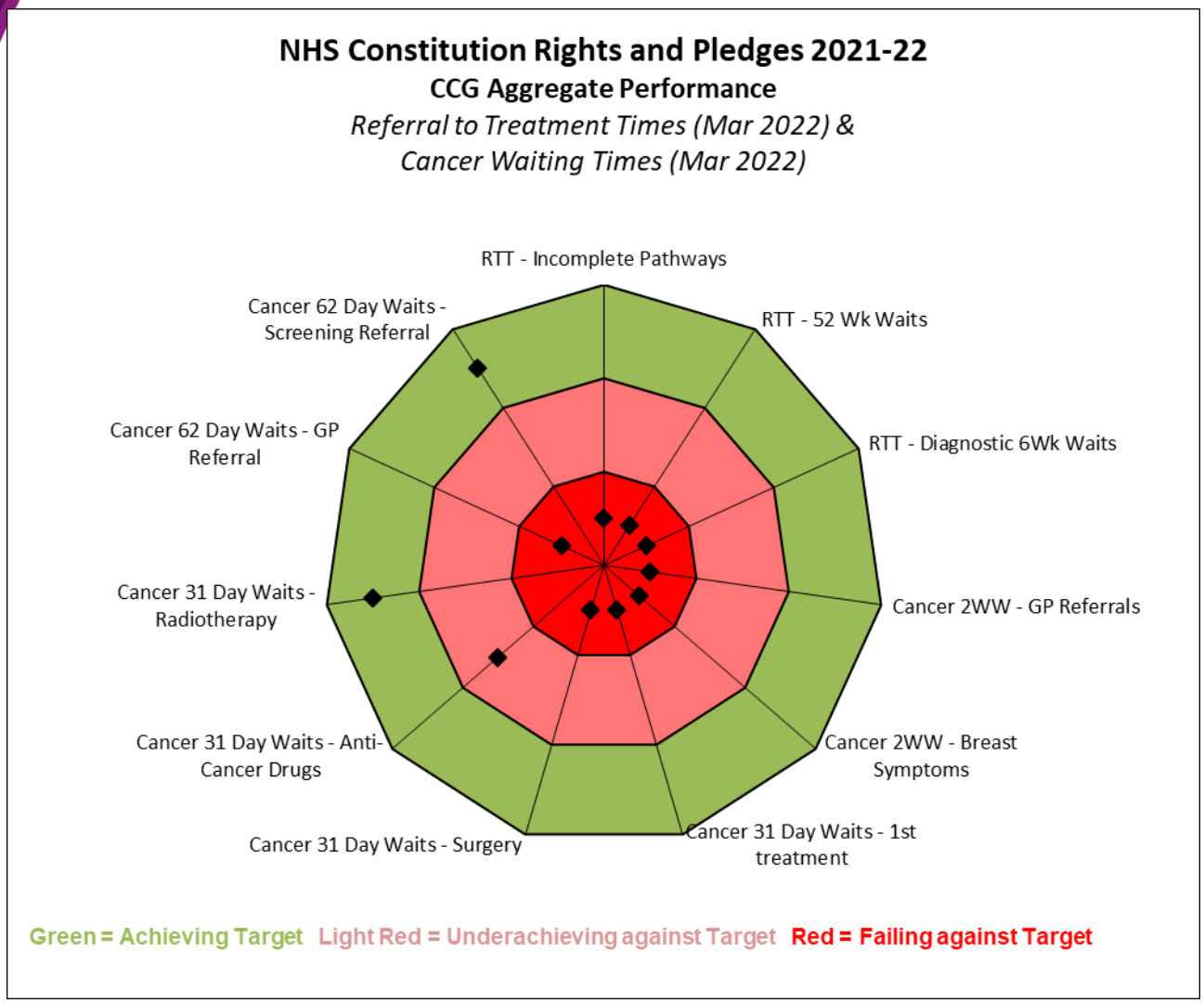
- Local people receive good quality care. There are processes in place to measure quality of care under three domains: Patient Safety (including infection prevention and control and clinical incident reporting), Patient Experience and Clinical Effectiveness (including how providers of care ensure they are providing the most clinically effective care).
- Patient rights under the NHS constitution are being promoted. These include: waiting times for A&E, cancer treatment, elective surgery and ambulance calls; mixed-sex accommodation breaches and the mental health care programme approach.

As services have sought to recover during the later stages of the Covid-19 Pandemic, North Cumbria has continued to see challenges in many areas. Notable successes have been the reductions in those waiting over 2 years for elective procedures and an overall improvement in waiting times for diagnostic services, though further progress is needed.

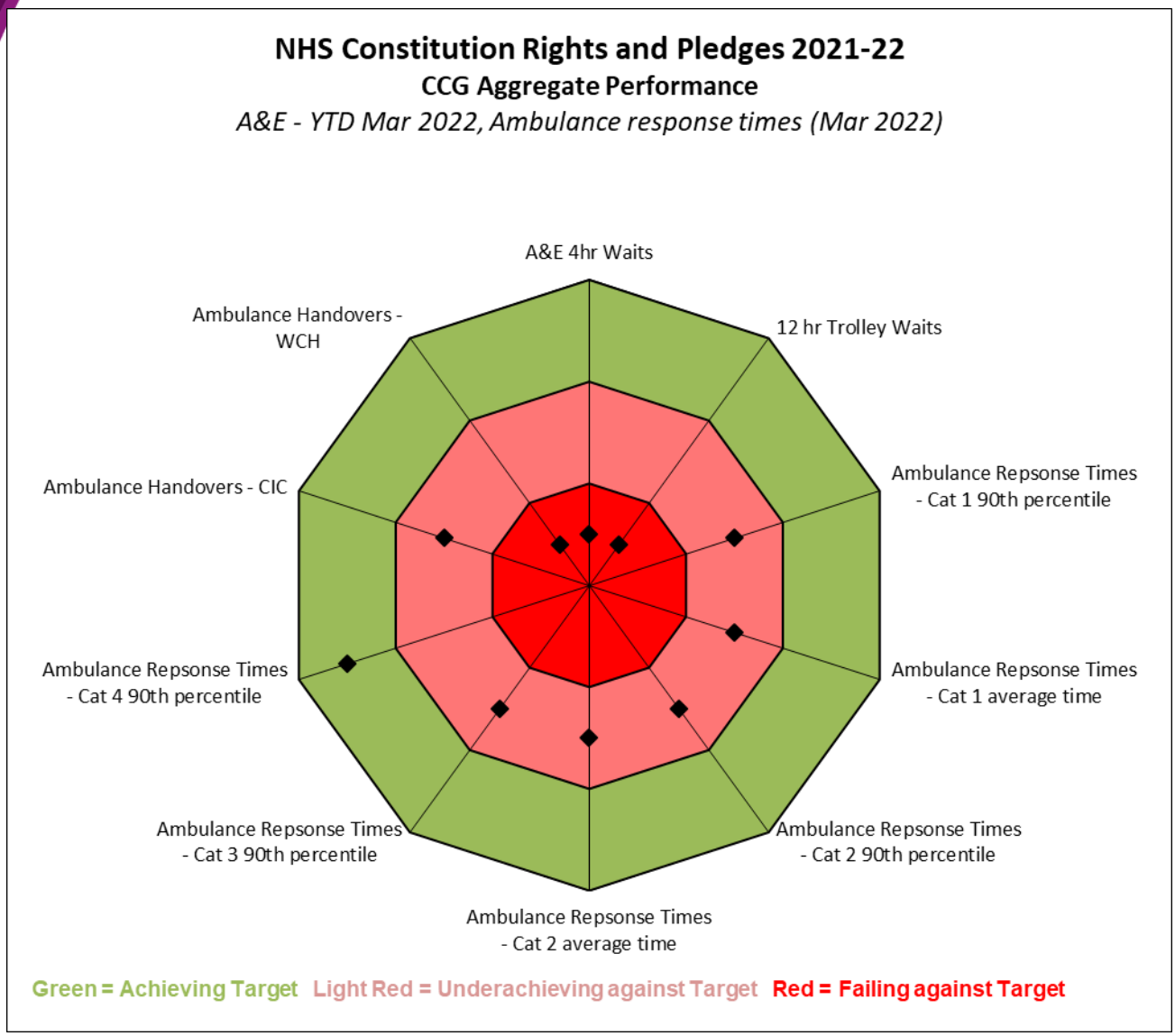
Performance Measures

One of the primary aims of the NHS Constitution, and the associated service standards, is to set out clearly what patients, the public and staff can expect from the NHS. The CCG aims to ensure compliance with the constitution and its standards in the services it commissions from providers such as hospitals, community services and ambulance services.

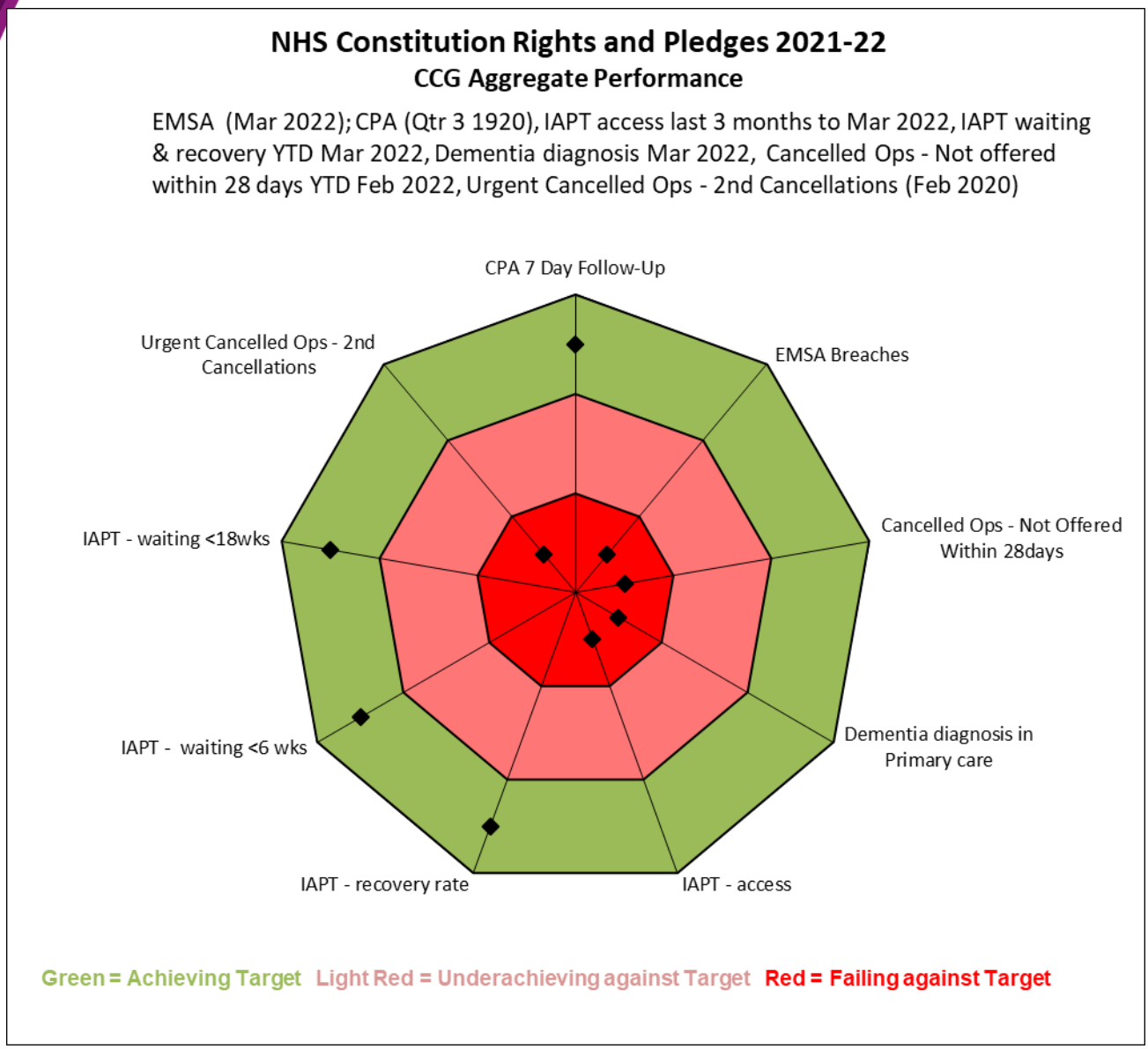
At the end of March 2022 the CCG had achieved the standards in six of the key national measures. Many of the pressures which were experienced across the NHS nationally as a result of the Covid-19 Pandemics have impacted in North Cumbria, with specific challenges for patient access times for cancer and routine elective care. In a number of instances, the CCG and its care providers have been unable to fully deliver the constitutional standards but are working hard to secure improvements. Where necessary, specific recovery plans have been agreed with providers.



Acronyms: RTT – Referral to Treatment, 2WW – two week wait, 52 Wk – 52 week wait, 6Wk – six week wait



Acronyms: A&E – Accident and Emergency, CIC - Cumberland Infirmary Carlisle, WCH West Cumberland Hospital



Acronyms: CPA – Care Programme Approach, EMSA – Eliminating Mixed Sex Accommodation, IAPT - Improving Access to Psychological Therapies

Key areas for improvement and what the CCG is doing about them:

Cancer – the pandemic placed significant pressure on cancer services at North Cumbria Integrated Care NHS Foundation Trust (NCIC). Staff sickness, radiology challenges and a significant increase in referrals all had an impact on the Trust's ability to diagnose and treat patients within the standards. None of the waiting time targets was achieved, with the 62-day standard continuing to be very challenging. However, the Trust has made improvements in a number of areas including using innovative tests like colon capsule endoscopy and Cytosponge, introducing Teledermatology and opening a modular endoscopy unit. Looking forward, NCIC has developed a Cancer Delivery Plan with a focus on tackling the backlog, improving pathways and streamlining steps to reduce how long North Cumbria patients have to wait for diagnosis and treatment.

Urgent and Emergency Care - both Emergency Departments have faced ongoing pressures from increased attendances, high admission rates and the impact of Covid absences on staffing levels. As

a result, performance against the A&E four hour waiting time target has remained consistently below standard. A further issue at both sites is persistently high numbers of medically optimised patients awaiting discharge. This has created challenges for patient flow through the hospitals, leading in turn to significantly high numbers of 12-hour trolley waits. The CCG has made assurance visits to both Emergency Departments and is working with the Trust and wider partners to make continual improvements to discharge arrangements and community provision.

There has been significant challenges to ambulance response times throughout the pandemic but North West Ambulance Service's performance in North Cumbria continues to be notably better than other areas of the North West. Work continues at both hospital sites to improve ambulance handovers.

Elective Care Waiting Times - the pandemic placed significant strain on the delivery of elective services leading to longer waits for many patients and an increasing waiting list. NCIC has a plan in place to tackle the backlog of elective care and return to delivering constitutional standards in full over the medium term. The Trust has successfully removed waits in excess of 104 weeks and is focussed on reducing 78 week waits to zero in the coming year. The Trust's theatre improvement plan is a key priority and work is underway on a plan to transform and improve outpatient services.

Diagnostic Waiting Times – the position deteriorated significantly during the Covid peaks as activity reduced and social distancing requirements led to ongoing capacity issues. Performance against the 6 week waiting time standard is improving and the total waiting list has reduced considerably following around 18 months at roughly double the pre-Covid volume. Additional capacity is in place in cardiology and echocardiography and FIT testing of colonoscopy patients has started. £5.7 million awarded to NCIC as part of the community diagnostic centre bid will be used to bolster capacity.

Improved Access to Psychological Services (IAPT) – performance against the access standard has been below target throughout the year reflecting the impact of the pandemic. The recovery rate however has been close to or above target and waiting times for the service have been consistently better than the minimum standard.

Dementia Diagnosis is an area where the CCG has been working hard to improve its standard. An improvement action plan is in place, a Health Pathway for the assessment and management of cognitive impairment has been developed, and recruitment is underway for Memory Link Workers. Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust (CNTW) have improved the referral triage process to reduce time from referral to diagnosis and have been developing rapid diagnosis clinics.

Cancelled Operations under the 28 day rule are those cancelled by the hospital at the last minute for non-clinical reasons and where the patient has not been offered another binding date within 28 days. These have been notably high at NCIC throughout the pandemic reflecting the pressures on staffing and bed capacity.

Eliminating Mixed Sex Accommodation – reporting was paused for most of the year but the most recent position shows a relatively high number of breaches. Most of these are at NCIC and reflect the ongoing pressures on capacity within the Trust.

Sustainable development

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services.

Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. Meeting the diverse needs of people in existing and future communities, promoting personal wellbeing, social cohesion and inclusion, and creating equal opportunity is all at the heart of both our engagement and co-production work.

During this year our commitment in North Cumbria has continued to develop. Our carbon footprint continued to be reduced considerably with CCG staff working predominately from home, meaning less traffic on roads and also reduced printing. This also extends to miles travelled to meetings, with the majority taking place 'online' using virtual tools. These virtual technologies were initially used out of business necessity, linked to the Covid-19 pandemic, but it has also created new ways of working providing structures, ideas and has expanded the CCG's options to support our sustainable development with a hybrid approach to work currently taking place.

The offices at our 'Parkhouse' location in Carlisle are more economic and environmentally sustainable than our previous offices and should again help to continue to lower our carbon footprint with reduced energy costs.

By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources.

We acknowledge this responsibility to our patients, local communities and the environment as we continue to work at minimising our footprint with our staff newsletters also running articles that provide ideas to encourage people to 'go green'.

Local developments

In this section of the Annual Report we describe some of the service developments that have taken place in North Cumbria during April 2021-March 2022.

Commissioning

Weight Management Service

2021/22 has seen the successful development and implementation of a Tier 3 Weight Management Service for the population of North Cumbria. The service has been commissioned in pilot phase from North Cumbria Integrated Care NHS Foundation Trust (NCIC) during the last quarter of the year and will be opened up fully to GP referrals from 1 April 2022. This is a full multi-disciplinary team, patient focused service for individuals who meet the relevant criteria for access to the service. It has been a gap in local service provision for a number of years and will mean that patients who would benefit from this intensive weight management programme will no longer have to travel to providers out of county.

Ageing Well

There has been significant work undertaken under the umbrella of Ageing Well. The priority focus for 2021/22 was the development and implementation of Urgent Community Response. Urgent Community Response Teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours, between 8-8pm every day. In North Cumbria, planning for this project began in June 2021, with the first ICC areas going live in October 2021, with full coverage across North Cumbria in March 2022.

The service is available for all statutory partners to refer patients into and plans are in place for patients to be able to self-refer into the service via 111 in 2022/23. In North Cumbria we are already achieving the national target of 70% of referrals receiving a service within 2 hours. This initiative has been an excellent example of integrated working between local providers, out of hours providers, the Local Authority, CCG and Primary Care colleagues.

Also under the Ageing Well banner, work has been undertaken to enhance healthcare in care-homes. A care-home digital pack has been purchased for care homes to enable care home staff to make digital referrals to Out of Hours Services and Community Teams and additional Speech & Language Therapy staff are being recruited to increase the therapy support to care homes.

Community Urgent Eye Care Service

2021/22 has also seen the successful implementation of a Covid (now called Community) Urgent Eye Care Service which has been commissioned to allow local optometry practices to see urgent eye

care conditions either remotely or in person referred to them by GP practices, hospital eye service, 111 and self-referrals. This service ensures that patients are directed to the most appropriate setting for any appropriate urgent eye conditions and has the added benefit of freeing up capacity in GP surgeries and hospital eye services for other patients who require these services. Patient and GP feedback has been extremely positive.

Voluntary Sector

North Cumbria health and care system have developed a close working relationship with third sector partners during the last 18 months to two years, and in particular over the 2021/22 winter period, providing financial support to the charitable and community sector to help people regain and maintain their independence at home and in the community once they are discharged from hospital.

The CCG funded Cumbria Voluntary Services (CVS) to provide a Health & Welfare Telephone Support Service which would assess patients referred to them at discharge and ensure that the correct voluntary sector support was provided to meet their needs. CVS now incorporates a Third Sector Referral Coordination service to support the increase in activity into voluntary sector support at discharge.

During the winter of 2021/22 the increasing challenges experienced in enabling patients to be discharged led to a further exploration of what additional support the voluntary sector might be able to offer to enable patients to be discharged home from hospital. Cumbria Community Foundation received a grant from the CCG from which to allocate funds in response to proposals from voluntary sector organisations.

As a result, the following initiatives commenced:

- Age UK provided a flexible service to prepare a patients home for their return. Support included, for example, one off tasks such as reconnecting utilities, one off initial light housework, moving furniture, prescription collection or equipment prescriptions. In the west this also included delivery of meals from Wiltshire Farm foods for those that had difficulty catering for themselves initially
- In the Carlisle area, Meals on Wheels provided a service of 3 hot meals and a tea-time sandwich per week for 4 weeks after discharge to patients that needed this support
- The British Red Cross provided an equipment provision service
- Working in partnership, Citizens Advice Allerdale, Copeland and Carlisle & Eden provided advice and support with benefits applications, housing issues and other similar challenges
- Eden Carers, Carlisle Carers and West Cumbria Carers worked in partnership to assess and administer £500 carers grants and provide support to those families. This was to enable carers to put in place initial arrangements needed to take the patient home safely.

This support has been really valuable providing support to vulnerable people to meet a range of needs. The CCG aims to continue to support the voluntary sector with grant funding in 2022/23 to enable this work to continue and develop and to focus not just on patient discharge but also to explore how voluntary sector support might prevent admissions happening.

Learning disabilities and/or autism

The Enhanced Community Model (ECM) is now active and links to the Dynamic Support Register (DSR) - a register which highlights an individual with a learning disability or disabilities and/or autism who is at risk of hospital admission. This is updated weekly with actions to prevent admission and enables enhanced community support to those in crisis, thus preventing unnecessary admissions and supporting with timely discharges. Additionally we have recruited four independent clinical reviewers for Care (Education) and Treatment (CETR) reviews.

'Experts by Experience' are now supporting with regular oversight visits for those in in-patient facilities to ensure that they are receiving high-quality and safe care that is appropriate to their needs and aspirations, and that discharge planning commences from the point of admission. Despite the pandemic our host commissioner visits have continued appropriately, regularly and in a COVID-secure manner: we review the care and treatment of all patients who have been admitted and provide feedback to other commissioners who may have patients in North Cumbria.

Other proactive work includes: quarterly reporting of DSR/CETR processes to inform commissioning/planning including identifying service issues and gaps; commissioning post-diagnostic-support via third-sector partners to relieve pressures on autism waiting lists; developing and facilitating a 6-week course for individuals and their families/supporters to help understand their autism; and the continuation of weekly 'lunch clubs' for people with autism to establish peer-support networks to assist in reducing isolation and loneliness.

Community Mental Health Transformation

Community mental health services play a crucial role in delivering mental health care for adults and older adults with severe mental health needs as close to home as possible. As part of the commitment to the NHS long term plan, the CCG was awarded £4.6million, over the next 3 years to invest in community mental health services for service users who have severe mental illness (SMI).

In 2021/22 the CCG launched this program of work and has worked alongside the Third Sector in order to fund a volunteer and work placement scheme especially for people with SMI, as we know that this can be an important step to recovery, improving self-esteem, confidence and reducing psychological distress.

We have also partnered with Cumbria Community Foundation to offer grants to the Third Sector in order to help deliver some of the transformation objectives such as working with service users from disadvantaged backgrounds in order to support them to engage with statutory and community services, as well as support physical health needs of people with SMI.

The CCG is currently working on expanding the eating disorders pathway, specifically focusing on early intervention. We are introducing a physical health team who will work with GP's to perform physical health checks with people who have SMI as we know the physical health of people with SMI is poorer and many of these service users are dealing with multiple co-existing conditions. We are investing in a mental health rehabilitation hub and bespoke model to provide SMI service users

who have co-existing substance abuse issues with support and recovery services within their communities.

We are also delivering bespoke training for staff who work in social prescribing and connecting roles.

Mental health Support Teams in Schools (MHSTs)

The CCG has continued to make progress with the development of the Mental Health Support Teams (MHSTs) that are working with designated schools in Carlisle and Allerdale.

The practitioners working in the Carlisle team have completed their training year, passing their qualification with distinction and are now working full time in schools meeting the needs of children and young people and helping to establish the team.

The Allerdale team practitioners have all started their formal training and the team is getting to know their schools and communities.

Recruitment has been challenging. However both teams are now fully recruited.

The next significant challenge is resolving the decision on where the third team will be working. To assist in this process an Engagement Officer has been appointed by the provider, Barnardo's, to ensure that the voices of children, young people and their families are heard throughout the decision making process.

Primary Care

Vaccination programme

Covid-19 continued to be the biggest challenge our NHS has faced in 2021/22. The role of the Primary Care team has been to continue to support our providers and ensure that our communities were able to receive services, support and information throughout 2021-2022.

Our focus on dealing with the pandemic in 2021/22 was the continued support to deliver two main priorities. Firstly, to coordinate and support how Health and Care services continued to deliver services and secondly, to promote and support the delivery of the effective flu vaccine and Covid-19 vaccine programmes in order to protect our communities.

Through the continued support from Primary Care Networks, General Practices, Community Pharmacies, NCIC, CNTW, Local Authorities and the incredible support from the Third Sector, by the end of March 2022 there had been over 263,000 first vaccinations administered (85% of those eligible), 252,000 seconds (80% of those eligible) and 208,000 Boosters (85% of those eligible), bringing a total of 723,000.

The flu vaccination campaign achieved a final uptake of 169,000 (72.5% of those eligible) which was the best performance from any CCG within the Northern and Yorkshire Region.

Development of PCN structures

The 8 Primary Care Networks (PCNs) continued to develop throughout the year with the Clinical Directors, Operational Leads and Practice Managers all working closely with the CCG's Primary Care Team to deliver services as the Covid pandemic and vaccination programme continued to dominate. General practice responded to help to protect patients so 'Covid Pathways' continued within PCNs, along with the use of PPE and increased offer of telephone appointments and video consultations to support patients remotely.

Recruitment to key roles within PCNs including GPs and nursing roles continued to be a significant challenge. The CCG supported PCNs to introduce new roles via the Additional Roles Reimbursement Scheme (ARRS). This included the development of associated service specifications, ARRS induction programmes and introducing peer support networks. The aim of the scheme is to build and utilise the additional roles to help the workforce shortage in general practice including, First Contact Practitioners (Physiotherapists), Clinical Pharmacists, Social Prescribing Link Workers, Physician Associates, Community Paramedics, Care Coordinators, Health and Wellbeing Coaches, Mental Health Practitioners and other Allied Health Professionals.

Dr Niall McGreevy stood down as the Chair of The General Practice Provider Collaborative (GPPC) and Dr. Robert Westgate from Carlisle Healthcare took over this position.

Integrated Care Communities

The Integrated Care Communities (ICCs) worked hard to prevent people being admitted to hospital as well as offering support to enable patients to be discharged as early as possible. The Covid pandemic caused major difficulties with ongoing infections and staff absences. The North Cumbria System Executive commissioned a paper to consider the Value for Money offered by ICCs and this was presented and discussed in the Autumn with all recommendations being agreed. These included appointing a Senior Responsible Officer to take forward a 'diagnostic and review' of the ICCs and renewing the business case, including the vision, objectives, measures and involvement of all stakeholders.

Supporting primary care element of new pathways

The CCG introduced a number of new clinical pathways in 2021/22 including Long COVID, a Covid Medicine Delivery Unit, Blood Pressure at home monitoring and Oximetry at home monitoring. These new services supported patients in their own homes and those patients who are vulnerable to infection.

A Winter Access Fund (WAF) was delivered across all PCNs and practices, bringing new funding to the area, overseen by the CCG's Primary Care Team.

Digital

In year, there were a number of 'behind the scenes' key structural projects being implemented. These included the active mail directory migration, moving mail from servers in Morecambe Bay to North Cumbria, converting e-mail addresses to nhs.net, the setting up of a virtual desktop infrastructure to support remote working for clinicians, setting up a remote and locum hub for GPs and other clinical roles to ensure that all possible clinical capacity is utilised within the CCG area.

Professional Development

A GP and GP Nurse Fellowship programme was established and a Practice Nurse Leadership structure was agreed, with posts to be recruited to.

An Intermediary Group was created to address clinical issues arising through organisational interfaces e.g. primary and secondary care, ensuring that people are treated and supported at the right time and in the most appropriate settings.

Improve Quality

The CCG Nursing & Quality Team has maintained a focus on Quality and Safety in the services provided to the population served during 2021/22. The Covid-19 pandemic made this another challenging year with a continued need to be innovative, creative and flexible in the way that the CCG has fulfilled its responsibilities for quality assurance of the services. The most significant impact of the Covid-19 pandemic this last year has been on staff sickness across the whole health and social care economy and this has had direct consequences on the fragility and sustainability of services, independent agencies and individual packages of care.

The demand on health and social care services has remained high and with additional winter pressures has resulted in large number of medically optimised patients in hospital for long periods, significant waits for discharge from mental health and learning disability beds and long waits in Accident and Emergency Departments. The CCG has worked closely in partnership with statutory and Third Sector agencies as well as in its assurance role to support improvements in these areas.

The CCG Outcomes & Quality Assurance Committee (OQAC) continued throughout the year. This group reports to the CCG Governing Body on quality matters in the services the CCG commissions. This Committee, chaired by a Governing Body Lay Member (Quality & Performance), has provided appropriate challenge to ensure the most robust approaches to improving quality were being considered and implemented, and gave collective oversight of the progress towards safer patient care. The group has a focus on 'making a difference' and on what is being achieved in improving quality.

The OQAC had these general functions:

- To facilitate joint working within and across the system to address specific quality issues affecting service delivery
- To provide a mechanism for facilitating direct assurance of the quality in the health care system across North Cumbria
- To monitor and be assured around both Adult and Children Safeguarding across the system
- To share good progress and practice and build upon positive improvements in quality of care

The OQAC included in its oversight assurance reports on quality of care to the Governing Body updates from the Ambulance Service, the Drug and Alcohol service provider, Cumbria Health on Call (CHOC) the Out of Hours GP service and the Hospice services in addition to our larger Foundation Trusts. We have also worked closely in partnership with North East CCG colleagues in the quality oversight of CNTW across North East and North Cumbria.

CCG Nursing and Quality leads through formal quality review meetings, NCIC Quality Board and regular assurance meetings have had oversight of progress against CQC actions plans

NHS Continuing Health Care

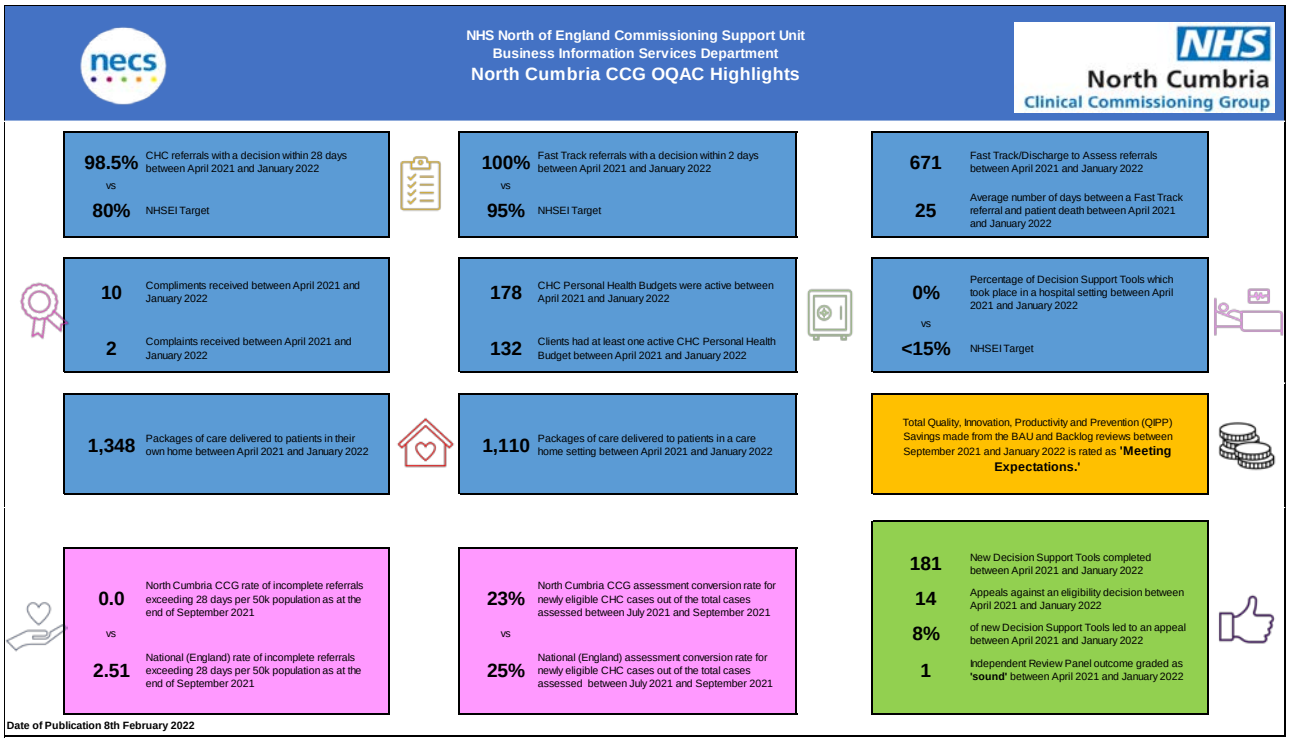
NHS Continuing Healthcare (CHC) is a package of ongoing care that is arranged and funded solely by the National Health Service (NHS) where the individual has been assessed and found to have a

'primary health need'. Such care is provided to an individual aged 18 or over, to meet health and associated social care needs that have arisen as a result of disability, accident or illness.

Continuing Health Care processes have continued despite the pressures from new waves of Covid-19. The team has continued to work with hospital staff to support the work on hospital discharges and to work with local providers who have also suffered major workforce pressures as a result of the pandemic.

The CHC team has successfully managed to address the back log of work as a consequence of CHC work being paused including reviews that had been deferred, to ensure that individuals were safely placed in the appropriate place. The team has continued to assess people for continuing health care following their discharge from hospital within the 4 week period described in national guidance (D2A).

During the second Covid-19 wave the CHC team has continued to directly support the acute hospitals to find appropriate placements for individuals. There has also been a continued strong focus of work to support individual packages of care and to prevent the need for hospital admission, with many people receiving extra care to enable them to be able to stay at home wherever possible.



End of Life Care

The Nursing & Quality Team has continued to refocus our ambitions for Palliative & End of Life Care (PEOLC) including stakeholder engagement and hosting a number of workshops in which our Vision and Values for End of Life Care have been defined and agreed. Close links have also been established with the ICS and national PEOLC clinical networks. Work is now progressing in the following areas to inform a revised co-produced 5 PEOLC year strategy:

- Mapping of provision to identify emerging themes to inform the proposed strategy.

- Refresh of a PEOLC Partnership Group with appropriate senior stakeholder and patient/family representation.
- Ongoing review of the priorities and agreeing action plans going forward.

LeDeR (Learning from lives and deaths reviews of people with a learning disability or Autism)

LeDeR work has been focused on implementing the new national policy and extending the reviews to include people with Autism.

A new governance process is in place to ensure all partner agencies share learning across the health and care system.

Responding to themes that have emerged from reviews the Action from Learning group has progressed training and development initiatives, improvements to the Hospital Passport and improving the Health Action Plans as part of the Annual Health Check.

The team has again co-produced the LeDeR Annual report with our local 'Confirm & Challenge group' and have benefited from working closely with people with lived experience and their families to improve the reviews and learn from the findings. This excellent piece of co-production work has been shared at the CCG Governing Body and Adult Safeguarding Board

Themes and Trends from the LeDeR Reviews– Positive Practice

Care Providers Educational Webinars

The CCG has collaborated with Cumbria County Council to develop and roll out educational webinars for North Cumbria Care Providers.

A series of ongoing fortnightly 1 hour educational webinars commenced in June 2021. The aim of the rolling programme is to engage with Care Providers and deliver a variety of clinical and technical information to enable the empowerment of staff to deliver high quality care.

Topics have included Wellbeing, End of Life Care, Covid-19 booster & Flu vaccination uptake, Mental Capacity and Deprivation of Liberty, Oral Health and Leadership among many others.

Independent Care Sector (Nursing & Residential Homes and Domiciliary Care) contract compliance 2021/22

The CCG commissions Continuing Healthcare for adults from local Independent Nursing & Residential Homes and Domiciliary Care. The CCG has a NHS Standard Contract with every Care Provider it commissions care from.

The Nursing & Quality Team (N&Q) liaise closely with the Contracts Team to monitor and gain assurance against the contracts standards. A Care Provider Dashboard has been developed to collate and provide regular oversight of all providers. The N&Q Team offer support as required where areas of improvements are required including signposting to training, educational webinars or individual assistance as required. There has been a programme of Commissioning Assurance Visits to review and validate quality and safety of care within the independent sector. Visits have been undertaken to domiciliary commissioned services against the Care Quality Commission Fundamental Standards. The main challenges highlighted by the Domiciliary Providers during these reviews were the recruitment and retention of care staff into their services. During the pandemic many staff left the care sector to work in the retail and hospitality sector for more competitive wages and better working conditions. The Domiciliary Providers have highlighted their sustainability challenges in this economic climate.

Registered Care Sector – Enhanced Health in Care Homes

Through the year the Nursing & Quality Team worked with the primary care teams to support the work of the Ageing Well Programme, which is in place to increase the NHS support to the Independent Sector Nursing & Residential Care Homes.

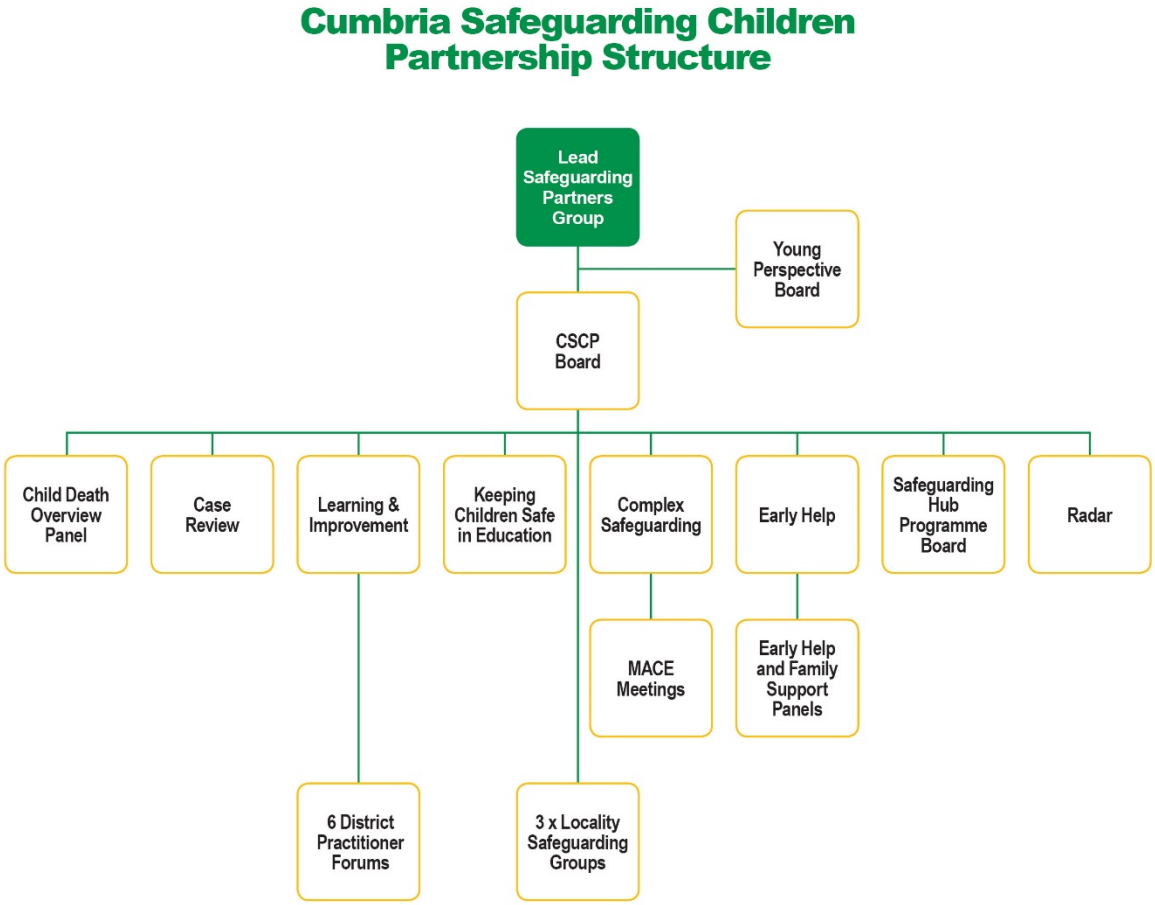
Key service improvements:

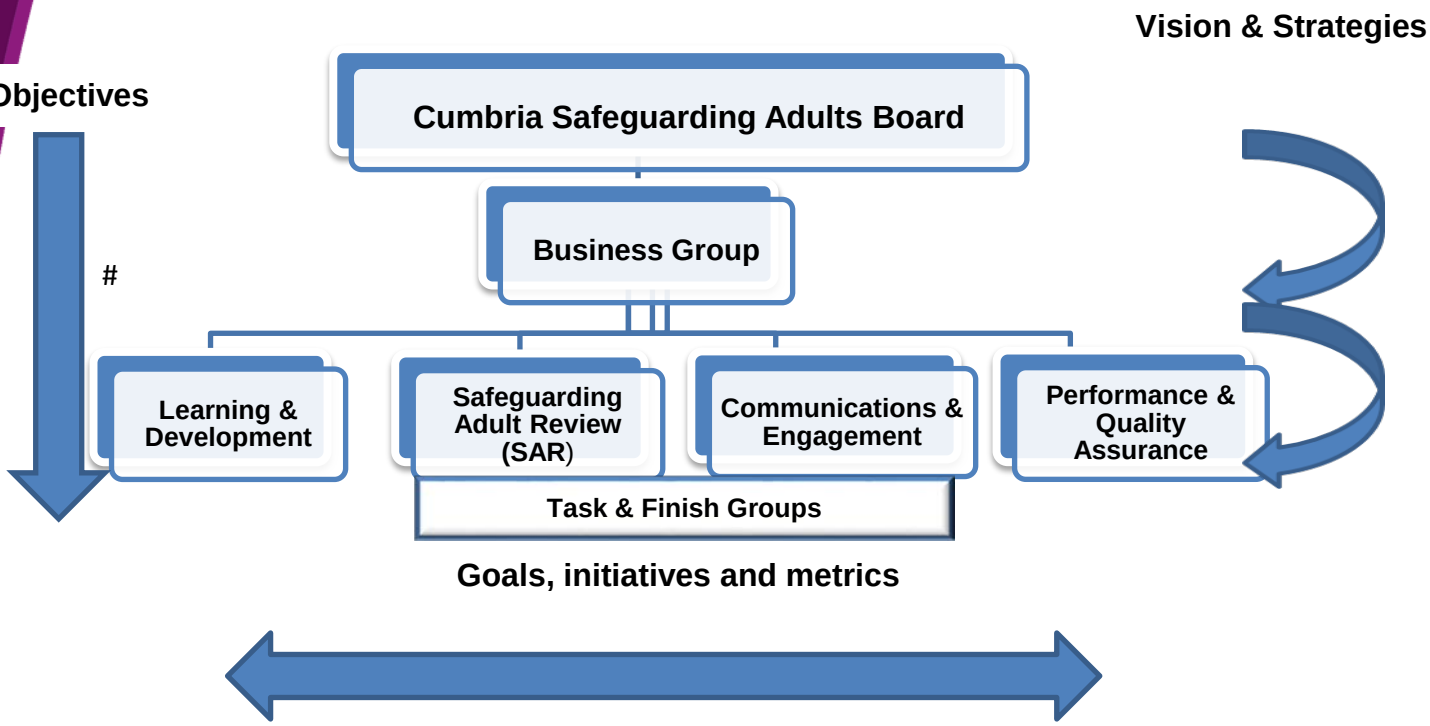
- CCG Infection Prevention Nurse supported primary care in delivering the Covid-19 immunisation and booster programmes for the care homes.
- Provision of specialist respiratory support, and providing equipment for the homes managing residents with Covid-19.
- Supported the ‘flow’ of patients from the acute hospitals by providing guidance on safe discharge, and helping to remove obstacles and blockages to reduce delays.
- The CCG made an arrangement with the mental health care provider to give psychological support to care home staff who had been affected by the difficulties experienced in caring for older people through the pandemic.

During the year the registered care sector, including domiciliary care, had significant difficulties during the Omicron wave of the pandemic, with a large number of homes in 'outbreak' with significant numbers of staff absent because of the virus and consequently closed to admissions. Pressure in these services had an impact on acute and community care, and the 'flow' through the hospitals, with people being unable to be discharged. This pressure was particularly marked in A&E departments with patients not being able to be admitted promptly. In common with the national picture, whilst the elective recovery programme has commenced there remains a large number of people waiting for elective (non-emergency) care. The CCG has announced its intention to undertake an assurance review into the management of waiting lists in NCIC.

Safeguarding

The CCG has effective arrangements in place to ensure the statutory requirements in respect of governance and accountability are in place. The Integrated safeguarding team work collaboratively in partnership with the following two Boards/ Partnerships;





Partnership arrangements extend to the Safer Cumbria Board, the Cumbria PREVENT Board and the Cumbria Corporate Parenting Board. The collective memberships of the aforementioned Boards ensure that all statutory elements of the safeguarding portfolio are covered. Local Authority and Police are also statutory partners and local NHS Provider organisations are central to these arrangements. The wider partners include Fire Service, Probation and voluntary partners.

The CCG Safeguarding team continue to provide leadership and share expertise to effectively respond to early warning signs and manage any risks as a system. Identifying early learning is central to what we do, utilising support systems developed to cascade and ultimately embed that learning into services that we commission.

As the CCG moves from pandemic response through to recovery it has been vital to maintain the locality based safeguarding work groups. This has included work testing out what the impact of neglect has had on families and our communities. Domestic Abuse has emerged as a recurring feature during the pandemic and this is reflected in prevalence of Home Office Domestic Homicides. There were fifteen open cases across Cumbria, eleven of which were within North Cumbria at 31 March 2022.

Other statutory reviews include Safeguarding Adult reviews, Child Safeguarding practice reviews and Child Death Overview systems for which the CCG provides expertise and leadership.

The associated working frameworks of the five Boards collectively tackle the NHS Safeguarding Portfolio. Specific sub groups focus upon areas such as Domestic Abuse, exploitation and missing children, Modern Slavery, harmful practices such as Female Genital Mutilation (FGM), so called honour based violence, Forced Marriage, Counter Terrorism and Self Neglect as examples.

The CCG Safeguarding Designated Professionals collectively lead and participate in all aspects of the Boards work. They also work closely internally with the Communications team and Primary Care team. Some aspects of the portfolio involve joint work such as assurance in partnership with the wider CCG Quality team in terms of emerging concerns within Care Homes and complex cases across all ages.

The CCG has effective arrangements to receive assurance from commissioned services and this has been enhanced this during 2021/22 with face to face visits to service areas which have proven helpful and will be built upon during the next year.

The Designate professionals are well positioned to adapt to the new Integrated Care Board arrangements. Currently the CCG has agreed to act as one of three Professionals representing our NENC ICB with both the Looked After Children and Safeguarding regional groups. In addition to these arrangements the team attend the ICB Safeguarding network and National Safeguarding networks.

The reach of the safeguarding team has been extended during 2021/22 to strengthen relationships and support across the CCG into Provider Organisations and Primary Care. The provision of supervision has been refreshed and professional advice and support continued.
Training provision has been revisited with an extensive consistent offer to Primary Care and internally to CCG staff. This will be further strengthened during 2022 / 2023.

Special Educational Needs & Disabilities (SEND) Improvement Programme CCG Annual Report – 2021/22

The SEND Improvement programme has continued through 2021/22. As Covid-19 restrictions have eased access to CYP in schools and settings has gradually improved although this has fluctuated more with the impact of Omicron. Technology has certainly helped the partners in the programme to stay connected and plan for the expected Local Area SEND re-visit following the OFSTED/CQC inspection in March 2019. Preparations for anticipated re-visit included thoroughly updating the self-evaluation (SEF) and highlighted 3 areas which would benefit from an Accelerated Progress Plan (APP)

1. Educational Healthcare Plan (EHCP) quality & data
2. Transition to Adulthood (particularly health and social care)
3. Autism Assessment pathway

These Accelerated Progress Plans commenced in Sept 2021 and are monitored monthly.

The Designated Clinical Officer (DCO) leadership role has continued to support in a number of areas including

- Support to the provider trusts to implement a quality assurance process before submitting health advice to the local authority for an Education Health and Care Plan.
- Bi-monthly meetings with the Deputy Designated Nurse for Safeguarding and Children Looked After Designated Nurse (local provider) to highlight and discuss vulnerable young people who have SEND and are Children Looked After
- Work with Primary Care Teams in both North and South Cumbria to improve the number of eligible children and young people who are flagged on their GP system for an Annual Health Check
- Produced guidance in conjunction with Lead GPs in both North and South Cumbria and the Local Authority Inclusion Team (Cumbria County Council) about the use of 'sick-notes/fit-notes' for children and young people (e.g. unfit to attend school full-time but able to attend part-time/ not fit to attend school today).
- Work closely with the Special Educational Needs and Disabilities Information, Advice and Support Service (SENDIAS) to unblock health issues and signpost where needed in the work that SENDIAS do with families.

Education Health and Care Plan numbers this year:

	Allerdale & Copeland	**Carlisle & Eden**	**Furness & South Lakes**	**Grand Total**
EHCP Assessments completed April 21 - Mar 22	**208**	**208**	**215**	**631**
Final EHCPs issued April 21 - Mar 22	**222**	**186**	**220**	**628**
Total EHCPs to end March	**1571**	**1671**	**1130**	**4372**

Complaints

The CCG aims to improve the health and well-being of all people in North Cumbria by ensuring that our patients receive the highest standards of healthcare possible. When mistakes happen we ensure that lessons are learned to help avoid a similar incident occurring again. We welcome feedback, both positive and negative, about NHS services commissioned or provided by those organisations as well as about the CCG itself. The North of England Commissioning Support Unit (NECS) supports the CCG with the management of complaints.

The team handled a total of 718 cases during the reporting period across all North East and North Cumbria CCGs; 14 of these related to NHS North Cumbria CCG compared to 11 in the previous year. 6 of the NHS North Cumbria CCG cases were handled under the NHS complaints procedure and all were acknowledged by the NECS Complaints Team within the target timescale of 3 working days. The theme of complaints/concerns for NHS North Cumbria CCG was Continuing Healthcare decisions and processes (7). These included complaints/concerns regarding eligibility decisions (3), case management (1), process delay (1), payment dispute (1) and access to assessment (1).

Three formal complaints relating to the CCG were closed during the year; two were not upheld and one was partially upheld. No specific service improvements were made as a result of the investigation. No North Cumbria CCG complaints were investigated during the year by the Parliamentary and Health Services Ombudsman (PHSO).

34 further complaints/concerns were received from or on behalf of North Cumbria residents which related to other organisations such as NHS trusts, GP practices, NHS England. These were passed to the relevant organisations for investigation and response.

13 compliments from or on behalf of North Cumbria residents were received, all related to the Continuing Healthcare Team.

Maternity

The CCG has worked closely with NCIC in support of its maternity improvement programme. There has been regular reporting of the Trusts response to the initial Ockenden Reports including the essential and immediate actions. The Trust has been actively engaged in the delivery of the Local Maternity Neonatal System (LMNS) and in working to achieve the Maternity Transformation deliverables. Assurance and improvement in maternity care in North Cumbria has been affected by the pandemic period and subsequent staffing shortages.

Maternity Voices Partnership

Work continues from both the West and Carlisle Partnership groups to support the continued improvement of maternity services locally.

The Carlisle & Eden MVP covers Cumberland Infirmary and Penrith Birth Centre, while the West Cumbria MVP covers West Cumberland Hospital and both groups are chaired by Sandra Guise. Sandra has chaired both groups since their inception, she was also the Service User Voice representative on the West North East Cumbria Local Maternity System (WNEC LMS) up until July 2021.

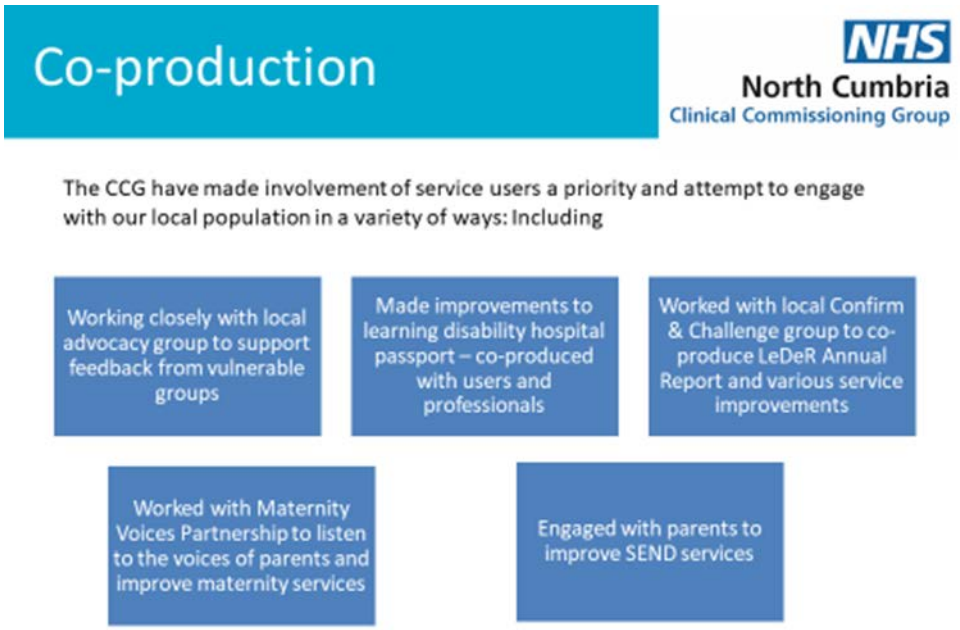
Both MVPs work tirelessly to continually improve the quality of maternity care, and as a part of that:

- Have a focus on closing inequality gaps
- Listen to and seek out the voices of women, families, and carers using maternity service, even when that voice is so quiet that it is hard to hear
- Enabling people from our diverse communities to have a voice

The MVPs have worked extremely hard to adapt to COVID-19 and soon moved to using Microsoft team to facilitate meetings. Interestingly, the number of service users attending the MVP meetings and topic based workshops has grown throughout the pandemic. Women have reported that virtual meetings are much more accessible than having to drive long distances with a young baby, however, they also recognise the value of coming together face to face too.

Examples of recent MVP work include:

- excellent multi-disciplinary workshops on birth choices and postnatal care which have been facilitated by local women and student midwives and organising a range of surveys e.g. the impact of COVID-19 and the uptake of COVID-19 vaccination in pregnancy; and
- a focused workshop to review the 6 week postnatal check process was successful and well attended providing useful feedback from mothers and highlighting some themes for improvement.



Infection Prevention & Control/Healthcare Associated Infections (HCAIs)

Healthcare-associated Infections (HCAI) remain a priority for the CCG and its partners as they are a major cause of avoidable patient harm in the UK. With this in mind, the CCG has developed 'The Infection Prevention 3 year strategy'.

This strategy takes into account the learning from the Covid-19 pandemic and forms an action plan to reduce HCAI. Priority for Year 1 was given to the Independent Care Sector and Primary Care based on needs identified throughout the pandemic. Training for both the Independent Care Sector and Primary Care has been carried out and a standard approach to Infection Prevention and Control and Leadership has been agreed by the GP Executive group across North Cumbria CCG's footprint. Infection control champions for each practice have been trained and have access to standard policies and audits. The implementation of this strategy is monitored via The North Cumbria system HCAI group and the outputs from the HCAI group along with its associated sub-groups (The CDI Group and the UTI Collaborative) are fed into the regional HCAI/AMR Board.

The Covid-19 pandemic has continued to create extra challenges to patient safety throughout this year both within the community and hospitals. The CCG worked collaboratively with its partners to reduce the spread and potential harm caused by Covid-19 by continuing to provide support around implementing the national and local guidance. Covid-19 related deaths both in community and hospital settings have significantly reduced this year compared with the previous waves, thus highlighting the importance of the successful Covid-19 vaccination programme.

HCAI Performance Trajectories

NCCCG is monitored against the following HCAIs national performance trajectories set by NHS England (See table 1):

- Clostridium Difficile Infection (CDI)
- Methicillin-resistant Staphylococcus Aureus (MRSA)
- Escherichia Coli (E.coli) Blood Stream Infection (BSI)

Table 1 NCCCG's HCAI Performance Trajectory over the last 3 years

Year Trajectory V Actual	2019-20 Trajectory	2019 -20 Actual	2020 -21 Trajectory	2020- 21 Actual	2021 -22 Trajectory	2021 - 2022 Actual published (Feb 22)
Number of CDI cases	99	106	83	118	98	95
Number MRSA BSI cases	0	4	0	1	0	0
Number of E.coli BSI Cases	221	327	185	285	302	299

MRSA

The trajectory for MRSA Blood Stream Infections (BSI) in England is zero as it is deemed no Healthcare-acquired MRSA is acceptable due to the potential harm it may cause. To date, this year there have been zero community-acquired MRSA Blood Stream Infections assigned to NCCCG for the local population.

CDI

CDI cases are once again heading above their trajectory. This increase in CDI both within in the community and hospital environment is an area of concern. It is therefore important that the local health and care system has work in partnership to understand the causes of these infections, identify themes and share learning in order to help improve patient safety. In 2021/2022 the focus has moved to a system-wide approach for the delivery of the improvement plan to reduce the number of cases assigned. The deliverer of the CDI improvement plan is monitored via the system CDI Group.

E.coli BSI

There has been an increase of local E.coli BSI cases over the last 3 years mirroring the national picture - the reasons for these increases are currently unknown. However, the most common source of infection is the urogenital tract and therefore targeting urinary tract infections (UTIs) could have a significant impact in reducing the number of E-coli healthcare associated infections. With this in mind, the local UTI Collaborative is delivering the UTI improvement plan across the health and care system with an aim to reduce overall infections. This group recognises the need to continue to share learning in order to reduce the number of avoidable E-coli BSI cases.

Patient Safety Strategy

The NHS Patient Strategy 2020/21 (2019) objective is to help NHS organisations improve patient safety. The CCG continues to progress work in support of core components of this strategy including:

- The implementation of the 'Patient Safety Incident Response Framework' in order to encourage system learning from incidents: The CCG and NCIC have reviewed the implementation of this framework together and are now awaiting further guidance from NHS England to take this forward locally.
- The implementation of the 'Framework for involving patients in their own safety'; the Patient Safety Lead is a member of a national task group that is reviewing how to involve patients in their own safety. The CCG is developing a plan, based on national strategies, with its partners to encourage patients to be become more involved in their own safety journey both in the community and hospital. Patient Stories have also been undertaken in order to learn from experience and thus improve safety.
- The recruitment of Patient Safety Partners: A local project group is currently being established to take this recruitment plan forward.
- The development of the role of Patient Safety Specialists: The CCG named Patient Specialist has actively engaged in the local, regional and national patient safety agenda and is currently evaluating local improvement priorities with their partners.

- The Patient Safety Syllabus training will be completed by all NHS staff. All CCG staff have completed the Patient Safety Syllabus level 1 training and are awaiting national direction on the next steps.

Reducing health inequality

In this section of the Annual Report we summarise some of the work the CCG has undertaken with partners to reduce health inequalities.

Patient Participation Groups (PPGs)

PPGs involve patients working in partnership with practice staff and GPs who meet at regular intervals to discuss a variety of issues effecting patients and the Practice. Unfortunately the Covid pandemic made meeting difficult and a lot of PPGs haven't met during the last 12 months. Some practices are taking this time to review their PPG and look at future development options.

Equality

NHS North Cumbria Clinical Commissioning Group is committed to ensuring an equitable, responsive and appropriate service to all communities in North Cumbria, encouraging and supporting the appropriate use of services and promotion of health and wellbeing and creating a culture where all staff feel valued and where people want to come and work in an inclusive and supportive working environment that encourages development and retention of staff.

In response to Covid-19, NHS England set out an additional 8 urgent actions for local systems to tackle health inequalities, these are:

1. Protect the most vulnerable from Covid-19.
2. Restore NHS services inclusively.
3. Develop digitally enabled care pathways in ways which increase inclusion.
4. Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes.
5. Particularly support those who suffer mental ill health.
6. Strengthen leadership and accountability.
7. Ensure datasets are complete and timely.
8. Collaborate locally in planning and delivering action to address health inequalities.

The Public Sector Equality Duty was temporarily suspended due to Covid. That has now ended and organisations were expected to publish an Equality Report by March 31st 2022.

Covid-19 Response

A group specifically looking at inequalities in relation to Covid-19 vaccinations continued to review vaccination data to identify and target specific groups who were not accessing a Covid-19 vaccination.

Addressing Inequalities – Examples of Good Practice
Vaccine Bus

While there was a range of opportunities for people across North Cumbria to access the Covid vaccine, we know some communities had a lower take up of the vaccine. Working with St John's Ambulance team and the Green Tree pharmacy in Kirkby Stephen and St Paul's Pharmacy in Carlisle we have offered vaccine bus pop-ups at

- Appleby Horse Fair
- Carlisle College
- University of Cumbria, Fusehill Street Campus
- Lakes College, Workington
- Nestle factory (opened to staff and sixth formers at Caldew and the village of Dalston)
- Carlisle United home match

While take up wasn't enormous, the opportunity to have conversations - asking questions about issues which they may be worried about - was highly valuable.

Other Vaccine Initiatives

- Clinics out of hours – weekends and evenings.
- Using the county's local networks to reach agricultural networks, tourism workers, and diverse communities.
- Information focusing on 'we know life is busy but if you haven't booked do it now' shared through the National Farmers Union in the Northwest newsletter and Facebook The Cumbrian Farmer Network.

Information in Alternative Languages and Formats

Making sure information about the Covid-19 vaccine is available in alternative languages and formats has been a priority. Working with other NHS organisations and local authorities across Cumbria we agreed to house the information on our website where it was easily accessible, prioritising the most requested languages in the NHS, and the most common languages accessed by schools.

We also identified local community champions and amplified their messages about vaccine confidence and connected with Multicultural Cumbria and other organisations in Cumbria who are working with communities where English isn't their first language. We are building stronger relationships but have much more to do.

Accessible Information Standard (AIS)

From 1 August 2016 all publicly funded health and social care organisations are legally required to adhere to the standard requirements. This means that all NHS and Social Care Organisations should ask people with disabilities or sensory impairment about their communications and support needs.

We use ReachDeck (a successor to Browsealoud) on our website, offer alternative formats if requested and have vastly increased the amount of information available in alternative languages and continue to provide easyreasd versions where we should. The national Silktide accessibility index places NHS North Cumbria CCG at 6th in the national CCG listings rating us as 'great – 89'.

ASK RECORD FLAG SHARE ACT

Workforce Equality Standards
In accordance with NHS England's requirements, the CCG completed the Workforce Race Equality Standard (WRES) for 2021, providing both data and narrative around race equality issues within the workforce.

Equality Impact Assessment (EIA)
The purpose of an EIA is to ensure that our services, policies and practices do not directly or indirectly, intentionally or unintentionally, discriminate against the users of our services or our staff.

Undertaking an ***Equality Impact Assessment (EIA)*** enables us to consider the impact of each current and proposed service, policy, procedure or function, not only with regard to ethnicity, disability, age and gender, but also in relation to religion and belief, sexual orientation, and human rights. It is designed to ensure that 'due regard' is given to equality in relation to our service users and the manner in which we recruit, train and develop our staff.

Engaging people and communities

The CCG is committed to involving our community in shaping, developing and improving services. We encourage people to work with us and share ideas.

Information detailing all the ways people can get involved can be found on our website here: www.Northcumbriaccg.nhs.uk/get-involved It also describes what we have achieved, how to ask questions, provide feedback and make suggestions.

Many ways for you to get involved

We want the people that use and work in our services to be the ones helping to shape them for the future.

We encourage our community to:
• Provide feedback on your experience of health services

- Receive information and take part in completing surveys and questionnaires
- Join your GP practice Patient Participation Group (PPG)
- Attend public meetings and take part in consultations
- Join forums and workshops looking and contributing to shaping service development
- Join our co-production projects
- Become a member of our local Foundation Trusts.

Covid-19 vaccine programme

The Covid-19 vaccine rollout programme has had real impact across North Cumbria with high rates of take up from the start. A huge part of the success of our Carlisle roll-out was the impact of the St Paul's vaccination centre and the inclusive approach taken by the lead pharmacists on site.

The open access and high visibility of St Paul's meant it was often a focus for media attention and at key stages (as cohorts opened up, as there were calls to get the booster etc…) the team opened their doors to the media. This meant it built confidence within our community – they could see the vaccine being administered, see the queues and see the call to action – understanding you may have to wait, but we will get to you. They saw the hard work of the volunteers from the church and St Johns Ambulance supporting the rollout, and they saw the individual approach taken to those who may have struggled to access the jab.

The team have also supported our vaccination outreach programme focusing on hard to reach groups, working with St John Ambulance, and has included:

- Brunton Park, the home of Carlisle United on match day
- Carlisle College / University of Cumbria
- Factory visits including Nestle and Cavaghan and Gray
- Appleby Horse Fair – traveller community (with Kirkby Stephen pharmacy)
- Hostel accommodation

2021/22 Engagement case study:

LINK (Barnardo's Young People Social Prescribing Service)

The Primary Care Network teams in 3 of our rural Primary Care Networks (PCNs) – Keswick & Solway, Brampton & Longtown and Eden - identified a growing need to support children and young people struggling with a range of issues related to emotional wellbeing. These included social and rural isolation, deprivation, issues around gender identity and sexuality and mental health issues such as low mood and anxiety.

Led by GP Dr Richard Massey, the 3 PCNs partnered with Barnardo's to engage a group of children and young people and co-design the service. This collaborative group then included children and young people in the interview process for the LINK workers.

The LINK service offers a 'non-medical' solution that provides a holistic approach to managing some of the issues young people face today – many of which have been heightened by the challenges faced as a result of the Covid-19 pandemic. Worries and anxiety about isolation, identity, school, exams, and parents and carers working on the frontline have all increased over the last couple of years.

The service for 5-19 year olds was co-designed with local children of primary and secondary school ages who were involved with recruitment, branding and advising on service aims and delivery. LINK practitioners were brought on board to the service in March 2020, the day of the first lockdown.

The LINK team has been dynamic in shaping and delivering a brand new service alongside the young people it supports. The scope of the work that LINK is undertaking is shifting and adapting to meet the needs of the people it serves. Examples of this include well-being drop ins within school communities, the development of an LGBTQ+ co-production group for young people and the volunteer programme that is currently seeing all LINK volunteers actively working directly with young people supporting them.

Colleagues across the 3 PCNs value the service which is easing their workload, but more importantly is ensuring children and young people can be supported through an effective and trusted service.

This team has recently been named The Best Children & Young People's Social Prescribing Project in the UK at the recent Social Prescribing Network Awards 2022, which involves sharing learning through national forums and NHSEI. The local team is working with Barnardo's at a national level so learning from the Cumbria LINK scheme can help shape other projects across the country.

Communications and Engagement

The CCG's communication and engagement activities have continued to have a key focus on:

- Keeping people informed
- Keeping people involved
- Keeping people safe

This is in both relation to the Covid-19 pandemic but also with other services, resources and information. This year has seen us continue to update and focus on the rollout of the vaccination programme, as well as promoting key health messages, managing service expectation and providing timely updates on local and national developments.

Keeping People Informed

The CCG deals with various enquiries from the community and in terms of some of our statutory requirements between **1 April 2021 and 31 March 2022** the CCG has dealt with:

- **215 FOI requests**
- **77 MP enquiries**

Anonymised copies of FOI responses are available to the public through a Disclosure Log on the CCG website.

Social media has continued to be a key communication channel to highlight important information to the people of North Cumbria and media enquiries were also responded to accordingly with the number of our followers continuing to increase.

Engagement has remained a priority during the last challenging 12 months and the CCG continued to use virtual platforms where required.

- Connecting people with the vaccine roll-out in their own community has continued to be one of our most important pieces of work throughout 2021 – 2022 largely through primary care and increasingly through our community pharmacy colleagues.

- The CCG has worked with Multicultural Cumbria to highlight important Covid information to diverse communities and different languages. Multicultural Cumbria is an organisation working with minority communities to share their culture and connect with their neighbours and their community.

- The CCG has continued to support and play a vital role in the West Cumbria Community Forum and the East Cumbria Community Forum which has been meeting jointly on Zoom.

- Members of our Working Together Group have been provided with updates and smaller focused co-production sessions took place around primary care developments helping us

develop our 'Why is primary care working differently' posters shared in practices and on social media

- Virtual sessions have also continued to be held with our Patient Participation Group (PPG) Leads around changes to General Practice during the Covid-19 pandemic.

- Our Copeland Community Stroke Prevention Project has continued to work throughout the pandemic with its own Facebook page sharing stroke prevention advice and health improvement tips. It also went 'old tech' with banners and leaflets being provided in supermarkets.

- Over the last 12 months the CCG has supported the SEND Special Educational Needs and Disability improvement programme supporting a co-production approach

- Our close work with Healthwatch Cumbria and Cumbria Voluntary Service continued to share vital information through their networks and respond to issues being raised has never been more important.

Find out more about our Communications and Engagement at: www.Northcumbriaccg.nhs.uk/you

Health and wellbeing strategy

The Health and Wellbeing Board exists to provide a mechanism for partners to work better together so that everyone in Cumbria is able to benefit from improvements in health and wellbeing. The Board is formally a committee of Cumbria County Council, and is chaired by the Leader of the Council. The Chairs of NHS North Cumbria CCG and NHS Morecambe Bay CCG are the joint Vice Chairs of the Board.

During 2021/22 the Board has inevitably focused significantly on the supporting the response to the Covid-19 pandemic in Cumbria, and in beginning the collective work for the longer term recovery phase. This has included regular, full update discussions from the Director of Public Health and the two CCG's across all of the issues associated with the pandemic. As a consequence of the pandemic, the Board reviewed and revised its key objectives to incorporate not just improving health and reducing inequalities, but also specifically the additional challenges from Covid-19.

In addition to supporting the challenges from Covid-19, the Board has continued to focus on other important areas, for example:

- Improving services for children, young people and their families relating to SEND (Special Education Needs and Disabilities) with regular reports on progress against the areas identified for improvement following inspection
- Improving integration, for example through the Better Care Fund and Improved Better Care Fund
- Improving population health approaches and ensuring that health inequalities are addressed as part of the recovery and restart programmes. The Health and Wellbeing Board has established a working group to review its priorities and actions through the prism of inequality. The Health and Wellbeing Board has also worked with the Health Equity Commission chaired by Professor Sir Michael Marmot and the findings are intended to inform the work of the Board going forward.
- Improving the longer term sustainability and quality of health and care services, for example the residential and nursing home sector.

Financial review

As with previous years, 2021-22 continued to be challenging as a result of continued pressures on both health and social care funding along with the operational impact of Covid-19. From a financial planning perspective for 2021-22 North Cumbria CCG's plans were prepared in conjunction with the wider North East and North Cumbria Integrated Care System (ICS). The level of financial challenge was recognised with the CCG agreeing a planned deficit with NHS England for 2021-22 although this was off-set by compensating planned surpluses across the ICS. This position recognised that within the NHS financial regime established as part of addressing the Covid pandemic in 2020-21 and 2021-22, a significant majority of the CCG's costs were effectively fixed for the year as a direct consequence of these arrangements.

The CCG has a range of statutory and operational duties and the CCG's performance against these are shown in the table below:

Financial Duties

- Revenue resource use does not exceed the amount specified in Directions - **Not achieved** (Deficit £14.7m)
- Revenue administration resource use does not exceed the amount specified in Directions – **Achieved**
- Capital resource use does not exceed the amount specified in Directions – **Achieved**

Operational Duties

- Manage year-end cash within 1.25% of monthly drawdown – **Achieved**
- Meet the "Better Payment Practice Code" (95%) – **Achieved**

Statutory Financial Duties

There are the following statutory (legal) financial duties for CCGs, as follows:

a) **Revenue resource use does not exceed the allocation (Break-even duty)**
This duty requires the CCG to report a surplus position (i.e. to spend less than the allocated funding). The CCG achieved an in-year financial deficit of £14.7m which is slightly greater than the originally planned £13.99m deficit, and was agreed by NHSE and off-set by increased surpluses across the ICS. This change was as a consequence of addressing a number of historical, non-recurring issues prior to the formation the North East & North Cumbria ICB planned for July 2022.

b) **Revenue administration resource use does not exceed the amount specified in Directions**
This duty requires the CCG not to spend in excess of its Running Cost allowance. This allocation for 2021-22 was £6.2m, with the CCG spending £5.9m on running costs; the balance was invested in patient care.

c) **Capital resource use does not exceed the amount specified in Directions**

The CCG received no capital resource in 2021-22.

Administrative Financial Duties

There are the following administrative financial duties applied to all CCGs in the same way as all other NHS organisations. Although these are not statutory duties, they are important in determining the performance and financial health of the CCG. Therefore performance is monitored internally and externally.

d) Manage cash within 1.25% of monthly drawdown

The CCG is required to have a cash balance at the end of the year no greater than 1.25% of the March cash drawdown. The CCG met this requirement.

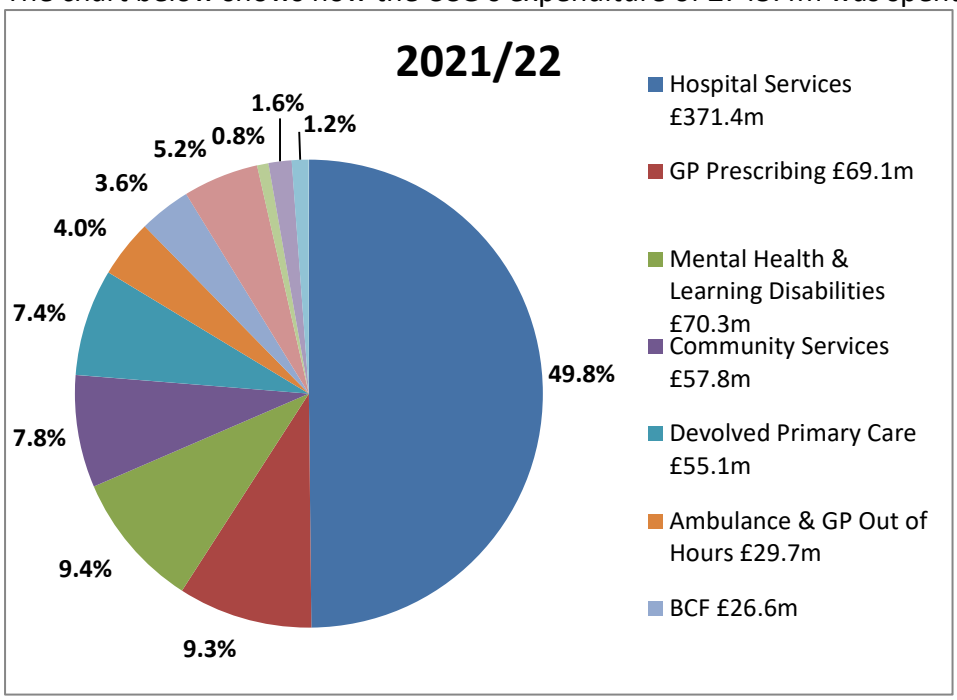
e) Better Payment Practice Code (BPPC)

The BPPC states that 95% of invoices should be paid within 30 days of receipt of goods or a valid invoice (whichever is later). Performance is measured in terms of both numbers of invoices and value of invoices. For 2021/22 the CCG, on average, paid over 99% of invoices by both number and value in compliance with the code.

How was the money spent in 2021-22?

The CCG works hard to ensure that the revenue allocation it receives is spent wisely, and that it supports the aim of commissioning high quality healthcare whilst ensuring effectiveness and value for money.

The chart below shows how the CCG's expenditure of £745.4m was spent:



The accounts have been prepared under a Direction issued by NHS England under the National Health Service Act 2006 (as amended).

A full breakdown of our annual accounts is included as **Part3**.

Statement of Going Concern

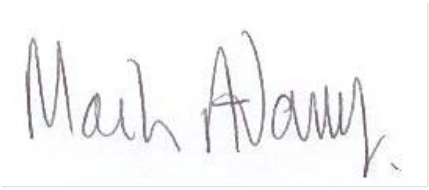
The CCG's accounts have been prepared on the going concern basis.

Public Sector bodies are assumed to be a going concern where the continuation of the provision of services in the future is anticipated. The CCG has been formally notified of its financial allocations for 2022-23 which shows an increase in funding year on year. An NHS body will only have concerns about its going concern status if there is the prospect of services ceasing altogether in the future by itself or another public sector entity. The CCG has not been dissolved and its services continue to be provided up to 30 June 2022. The Health and Care Bill was introduced into the House of Commons on 6 July 2021 and received Royal Assent on 28 April 2022. The Bill allows for the establishment of Integrated Care Boards (ICB) across England form 1 July 2022 and all clinical commissioning groups (CCGs) will be abolished on 30 June 2022. The ICBs will take on all the CCG functions, assets and liabilities.

Conclusion

The CCG has experienced a very challenging financial year and continues to work closely with partners in the North Cumbria and across the wider North East and North Cumbria system to deliver a financially sustainable health and social care system for the area.

ACCOUNTABILITY REPORT



Mark Adams
Accountable Officer
17 June 2022

Corporate Governance Report

Directors' and Members' Report

The Directors and Members' Report has been provided by the Governing Body and provides an overview of GP practices which are members of the CCG, the composition of the Governing Body, the Director Team, GP Leadership and Lay Representatives. It includes a biography of members of the Governing Body, Directors and Lead GP's working with the CCG and other key points of interest. It also details who the Primary Care Networks (PCN) Clinical Directors were for 2021/22.

Each individual, who is a member of the Governing Body at the time this Report is approved, confirms so far as the member is aware that there is no relevant audit information of which the CCG's external auditor is unaware and that, as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

The Annual Report and Accounts as a whole is fair, balanced and understandable and I take personal responsibility [for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable] to ensure that those requirements are met.

The table below provides details of the Chair and Accountable Officers during 2021/22 and up to the signing of the Annual Report & Accounts.

Name	Designate	Commencement date
Jon Rush	Lay Chair	1 April 2017
Mark Adams	Accountable Officer	1 April 2020

Member profiles

Our Member Practices

NHS North Cumbria CCG is a clinically-led organisation which brings together 35 local GP Practices and other health professionals to plan and design services to meet local patients' needs. Our member practices are:

Practice Name	Practice Code	Address
Alston Medical Practice	A82004	The Surgery Cottage Hospital Alston Cumbria CA9 3QX
Appleby Medical Practice	A82006	The Riverside Building Chapel Street Appleby Cumbria CA16 6QR
Aspatria Medical Group	A82055	Aspatria Medical Group West Street Aspatria Cumbria CA7 3HH
Birbeck Medical Group	A82035	Penrith Health Centre Bridge Lane Penrith Cumbria CA11 8HW
Brampton Medical Practice	A82012	4 Market Place Brampton Cumbria CA8 1NL
Caldbeck Surgery	A82014	Friar Row Caldbeck Wigton Cumbria CA7 8DS
Carlisle Healthcare	A82016	Carlisle Healthcare Spencer House St Paul's Square Carlisle CA1 1DG

Practice Name	Practice Code	Address
Castlegate & Derwent Surgery	A82021	Cockermouth Community Hospital & Health Centre Isel Road Cockermouth Cumbria CA13 9HT
Castlehead Medical Centre	A82028	Ambleside Road Keswick Cumbria CA12 4DB
Court Thorn Surgery	A82631	Low Hesket Carlisle Cumbria CA4 0HP
Dalston Medical Group	A82022	Townhead Road Dalston Cumbria CA5 7PZ
Distington Surgery	A82023	Hinnings Road Distington Cumbria CA14 5UR
Eden Medical Group	A82020	Port Road Carlisle Cumbria CA2 7AJ
Fellview Healthcare Ltd	A82044	Cleator Moor Health Centre Birks Road Cleator Moor CA25 5HP
Fusehill Medical Practice	A82019	Fusehill Medical Centre Fusehill Street Carlisle Cumbria CA1 2HE
Glenridding Health Centre	A82620	Greenside Road Glenridding Cumbria CA11 0PD
James Street Group Practice	A82047	James Street Workington Cumbria CA14 2DL

Practice Name	Practice Code	Address
Kirkoswald Surgery	A82617	Ravenghyll Kirkoswald Cumbria CA10 1DQ
Longtown Medical Practice	A82646	Longtown Medical Centre Moor Road Longtown Cumbria CA6 5XA
Lowther Medical Centre	A82041	1 Castle Meadows Whitehaven Cumbria CA28 7RG
Mansion House Surgery	A82075	19/20 Irish Street Whitehaven Cumbria CA28 7BU
Maryport Group Practice	A82032	Alneburgh House Ewanrigg Road Maryport Cumbria CA15 8EL
Queen Street Medical Practice	A82058	Richard Benedict House 149 Queen Street Whitehaven Cumbria CA28 7BA
Seascale Health Centre	A82024	Gosforth Road Seascale Cumbria CA20 1PN
Shap Medical Practice	A82031	Shap Health Centre Peggy Nut Croft Shap Cumbria CA10 3LW
Silloth Group Medical Practice	A82037	Lawn Terrace Silloth-on-Solway Cumbria CA7 4AH

Practice Name	Practice Code	Address
Spencer Street Surgery	A82018	10 Spencer Street Carlisle Cumbria CA1 1BP
Temple Sowerby Medical Practice	A82038	Linden Park Temple Sowerby Cumbria CA10 1RW
The Croft Surgery	A82029	Kirkbride Cumbria CA7 5JH
The Lakes Medical Practice	A82036	Penrith Health Centre Bridge Lane Penrith Cumbria CA11 8HW
Upper Eden Medical Practice	A82013	The Health Centre Silver Street Kirkby Stephen Cumbria CA17 4RB
Warwick Road Surgery	A82015	65 Warwick Road Carlisle Cumbria CA1 1EB
Warwick Square Group Practice	A82654	Warwick Square Carlisle Cumbria CA1 1LB
Westcroft House	A82064	66 Main Street Egremont Cumbria CA22 2DB
Wigton Group Medical Practice	A82045	Southend Wigton Cumbria CA7 9QD

There have been no changes in the number of practices in 2021/22.

Governing Body, GP Leads, Clinical Leaders and Lay Representative profiles

The Governing Body is responsible for ensuring that the CCG has appropriate arrangements in place to exercise its functions efficiently and economically and in accordance with the principles of good governance. It is made up of a membership that includes doctors and healthcare professionals, clinical and lay members.

Full details of the CCG's committee structures, roles and responsibilities and an overview of the year's work coverage can be found in the Annual Governance Statement contained in this document.

The CCG's Register of Interests for 2021/22 can be viewed in full on the CCG's website.

Governing Body Members

During 2021/22 there has not been a review of the Membership of the Governing Body. This decision was taken in light of the Government White Paper to transfer CCGs responsibilities to an Integrated Care System (ICS). Therefore, it is envisaged that the CCG will cease to exist from 30 June 2022, subject to the relevant legislation being passed.

Name & Biography	Position	Governing Body and Wider System Committees
Mark Adams – is also the Chief Officer of NHS Newcastle Gateshead, North Tyneside and Northumberland Clinical Commissioning Groups. He is also a lead for the North of Tyne and Gateshead ICP.	Accountable Officer	Executive Committee North Cumbria Integrated Care Partnership (ICP) Leaders Board ICP Executive Group Northern CCG Joint Committee
Dr Amanda Boardman - supports GPs to enable effective safeguarding and provides clinical leadership in developing children's services.	GP Lead for Safeguarding, Maternity, Children, Mental Health and Learning Disability	Executive Committee
Dr Gareth Coakley – is a GP at Longtown Medical Centre and was appointed to the role November 2018.	Chief Clinical Information Officer	Executive Committee

Name & Biography	Position	Governing Body and Wider System Committees
Carole Green - has almost 30 years of health management experience, working at senior levels both in the UK and internationally in health and social care, plus experience in the private sector.	Lay Member for Quality and Performance	Audit Committee Auditor Panel Finance & Performance Committee Outcomes & Quality Assurance Committee (Chair) Primary Care Commissioning Committee Remuneration Committee
Dr Helen Horton – is partner of Distington Surgery and was appointed to her role at the CCG in September 2015.	GP Lead for Commissioning	Executive Committee
Dr Deb Lee - is a former paediatrician who worked at the West Cumberland Hospital and following retirement has continued to be North Cumbria's designated doctor for reviewing child death. In addition she has been part of the North Cumbria Health & Care Working Together Group.	Secondary Care Doctor	Finance & Performance Committee Outcomes & Quality Assurance Committee Remuneration Committee
Denise Leslie – is a former teacher and has been involved in community healthcare delivery in Greater Manchester for the last 10 years.	Lay Member for Patient and Public Engagement	Audit Committee Auditor Panel Finance & Performance Committee Outcomes & Quality Assurance Committee Primary Care Commissioning Committee Remuneration Committee
Louise Mason Lodge – is a registered nurse and has worked in a variety of clinical, partnership and leadership roles.	Director of Nursing & Quality and Registered Nurse on the Governing Body	Outcomes & Quality Assurance Committee Executive Committee ICP Executive Group
Dr Colin Patterson – was previously a GP at the Carlisle Healthcare and has a special interest in	Clinical Lead/Acting Medical Director & Deputy Chair	Executive Committee Primary Care Commissioning Committee – Non Voting Member ICP Executive Group

Name & Biography	Position	Governing Body and Wider System Committees
cancer services and primary care.		
Peter Rooney – is responsible for ensuring the effective functioning of the CCG and has a focus on internal/external relationships and performance.	Chief Operating Officer	Executive Committee Finance & Performance Committee ICP Executive Group ICP Leaders Board
Jon Rush - was a Chief Superintendent with Greater Manchester Police and had spent 24 years working for Cumbria Constabulary. Initially the Lay Member for Patient Engagement and became the Lay Chair on 1 April 2017.	Lay Chair	Full Council of Members (Non- voting Chair) Finance & Performance Committee (Chair) Primary Care Commissioning Committee (Chair) Northern Joint CCG Committee (Chair) ICP Leaders Board (Chair)
Ed Tallis - has been involved with the NHS for over 30 years. All of his roles have had patient care at the forefront and his role as Director of Primary Care brings all of this experience and knowledge together, to support the CCG in achieving its goals.	Director of Primary Care	Primary Care Commissioning Committee Executive Committee ICP Executive Group
Charles Welbourn - was previously Deputy Director of Finance in the former NHS Primary Care Trust before securing his post upon the commencement of the CCG in 2013.	Chief Finance Officer	Executive Committee Finance & Performance Committee Primary Care Commissioning Committee ICP Executive Group
John Whitehouse – is a qualified public finance accountant. In a career spanning 36 years he	Lay Member Finance and Governance &	Audit Committee (Chair) Auditor Panel (Chair) Finance & Performance Committee Remuneration Committee (Chair) ICP Leaders Board

Name & Biography	Position	Governing Body and Wider System Committees
has worked in local government, the private sector and the NHS.	Conflict of Interest Guardian	

Lead GPs

All the CCG's Lead GPs are Members of our Governing Body and their details are provided in the Governing Body Membership table above.

Integrated Care Communities (ICCs) GP Leads – Primary Care Network Clinical Directors

In 2019 Primary Care Networks (PCNs) were established to work together to focus on local patient care. This expanded on the work that the CCG's had been doing with its ICC GP Leads and this work has been ongoing throughout 2021/22. The PCN Clinical Directors for 2021/22 were as follows:

Name	PCN
Mark Alban	Carlisle Rural
Alex Docton	Carlisle Network
Alan Edwards	Carlisle Healthcare
Robert Westgate	Carlisle Healthcare
Cherryl Timothy-Antoine	Workington
Celia Heasman	Copeland
Eve Miles	Copeland
Richard Massey	Keswick & Solway
Simon Desert	Cockermouth & Maryport
Matt Dombrowsky (until 31 March 2022)	Cockermouth & Maryport
Mark Kinghan (from 1 April 2022)	Cockermouth & Maryport
Helen Jervis	Eden
Shonagh Speed-Andrews	Eden

Clinical Leaders

Name & Biography	Position	Governing Body Committees
Dr Nicola Cleghorn - is an experienced Community Paediatrician with special interest in Safeguarding Children and Young People in Forensic Paediatrics.	Designated Doctor for Safeguarding Children	None

Helena Gregory – supporting primary care clinicians with quality, safety and cost- effectiveness of prescribing.	Medicines Lead	None

Senior Management Arrangements

Mark Adams, Louise Mason Lodge, Peter Rooney, Ed Tallis and Charles Welbourn are also part of the Senior Management Team and their details are provided in the Governing Body Membership table above.

Name & Biography	Position	Governing Body Committees
Anita Barker - Anita has a General Practice background before moving into a commissioning role. Anita currently leads the wider commissioning team as well as working on a number of county wide and regional work-streams.	Deputy Director of Commissioning	None
Suzanne Hamilton – an experienced Organisational Development leader and coach who manages the Cumbria Learning and Improvement	Head of Improvement and Development	None

Register of Interests

The CCG annually updates its Decision Makers Register of Interests in line with the latest statutory guidance from NHS England and can be viewed at https://northcumbriaccg.nhs.uk/about-us/declarations-interest . The Lay Member for Finance & Governance and Audit Committee Chair, John Whitehouse, is the CCG's Conflicts of Interest Guardian.

Additional Disclosures

Personal data related incidents

The Information Governance (IG) Team has not recorded any IG incidents between 1 April 2021 and 31 March 2022.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's Auditor is unaware that would be relevant for the purposes of their audit report

- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's Auditor is aware of it.

Modern Slavery Act

The Modern Slavery Act 2015 has introduced changes in UK law focused on increasing transparency in supply chains, to ensure our supply chains are free from modern slavery (that is, slavery, servitude, forced and compulsory labour and human trafficking). As both a local leader in commissioning health care services for the population of North Cumbria and as an employer the CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking and has produced a statement in respect of its commitment to, and efforts in, preventing slavery and human trafficking practices in the supply chain and employment practices.

The statement was reviewed and the Governing Body approved it on 17 March 2022 and the revised version can be found on the CCG's website.

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). Mark Adams was appointed as the Interim Accountable Officer on 1 April 2020 after the retirement of his predecessor. After a formal appointment process NHS England confirmed his permanent appointment as Accountable Officer on 1 June 2020.

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 Group Accounting Manual issued by the Department of Health and Social Care 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 Group Accounting Manual issued by the Department of Health and Social Care 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.

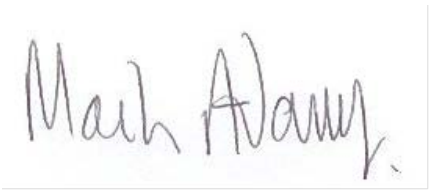
To the best of my knowledge and belief, and subject to the disclosures set out below, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Disclosures:

- The CCG has not met its statutory requirement '223H(1) Expenditure not to exceed income' for 2021/22. A formal notification of this position will be made by the CCG's external auditors, Grant Thornton UK LLP, to the NHS Commissioning Board (NHS England) in June 2022. A referral to the Secretary of State under Section 30a of the Local Audit and Accountability Act 2014 will also be made at the same time (and will be detailed in note 2 of the Annual Accounts).

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the Clinical Commissioning Group's auditors are unaware and that as, Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the Clinical Commissioning Group's auditors are aware of that information.



Mark Adams
Accountable Officer
17 June 2022

Governance Statement

Introduction and context

CCG's became corporate bodies established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended). NHS North Cumbria CCG came into being on the 1 April 2017 following a boundary change which saw the southern part of the previous NHS Cumbria CCG, join with NHS North Lancashire CCG, to create NHS Morecambe Bay CCG. NHS North Cumbria CCG covers the areas of Allerdale, Eden, Carlisle and most of Copeland.

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

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

The Clinical Commissioning Group has not met the statutory requirement '223H(1) Expenditure not to exceed income' as the actual 2021-22 expenditure performance is £14.696m over the income received. A formal notification of this position will be made by the CCG's external auditors, Grant Thornton UK LLP, to the NHS Commissioning Board (NHS England) in May 2022. A referral to the Secretary of State under Section 30a of the Local Audit and Accountability Act 2014 will also be made at the same time. This breach of financial duties is detailed in note 2 to the accounts which shows the CCG has reported a deficit of £14.696m in 2021-22 against a planned deficit of £13.992m.

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

Compliance with UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, the CCG considers that compliance is good practice and strives through its leadership and governance arrangements to ensure it meets the main principles of the Code.

This has been demonstrated by:

- Leadership – the CCG has worked across the system to ensure that effective leadership was in place during 2021/22 especially in light of the continuing Covid-19 pandemic. Working closely with the CCG's partnership organisations across North Cumbria and the North East to further develop an Integrated Care System (ICS) and, in the North Cumbria Integrated Care Partnership (ICP). The CCG's Accountable Officer attends the ICS Management Group and the Health Strategy Group in the North East. The CCG's Chair and Chief Operating Officer attend the Cumbria Health & Wellbeing Board and the CCG's Chair, Accountable Officer, Chief Operating Officer and Lay Member for Finance & Governance are also members on the North Cumbria ICP Leaders Board.

- Effectiveness – During 2021/22 the CCG has continued to review its effectiveness and to support the development of both the ICS and ICP. Working with its partners across the health system it reviews the requirements across the ICP and where possible, provides resources to support improvements or to cover for staff vacancies. There has also been pooled resources during the peak of the pandemic to ensure that support was continued to be provided across the ICS to ensure hospital flows and discharges were managed.

- Accountability – The Governing Body receives regular updates and assurance from its committees to enable it to have an understandable assessment of the CCG's position and prospects. This has included monthly updates on the pandemic and the impact on services across the ICS. Alongside of this, the CCG's risk assurance framework has been fully reviewed and updated to provide the Governing Body with a clear understanding of its main risks to achieving its strategic objectives. There has also been a significant amount of work undertaken across both the ICS and ICP in response to the COVID-19 pandemic, which escalated in March 2020 and continued throughout both the 2020/21 and 2021/22 financial years.

- Remuneration - The CCG works within the Agenda for Change framework for the remuneration of its employees. For Very Senior Officers (VSM's) the Remuneration Committee ensures it has a formal and transparent process for determining the

remuneration packages of these officers. This includes evaluating the requirements of the post and undertaking comparisons with like for like organisations to ensure that the CCG retains professional, high quality officers.

- Relations with Stakeholders – Throughout 2021/22 the CCG has continued to work closely with its stakeholders while ensuring we have followed Covid-safe guidance and safety measures. It has been important to keep community leaders and networks informed during the pandemic and to ensure stakeholders have access to trusted and timely information. This has been mainly through remote technology such as Zoom and Teams.

Through the narrative within this Annual Governance Statement, the Annual Report and Accounts, the CCG has described how it has fulfilled the main principles of the Code specifically in relation to leadership, effectiveness, accountability, remuneration and its relationship with stakeholders. For the financial year ending 31 March 2022, and up to the date of signing this statement, the CCG has applied the principles of the Code that are directly relevant, and via this Annual Governance Statement, Annual Report and Accounts, demonstrated how it has discharged its responsibilities.

The CCG's Constitution

The CCG has a Constitution which has been agreed by its Member Practices. It sets out the arrangements it has in place to enable the CCG to undertake its responsibilities for commissioning care for the people for whom it is responsible.

It describes the governing principles, rules and procedures that ensure probity and accountability in the day to day running of the CCG to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to its goals.

In accordance with section 14L (2) (b) of the 2006 Act (as amended), section 4.4.3 of the CCG's Constitution reflects that, throughout each year, the Governing Body has had an ongoing role in reviewing the CCG's governance arrangements to ensure that the CCG continues to reflect the principles of good governance. These include:

- The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
- The Good Governance Standard for Public Service
- The standards of behaviour published by the Committee on Standards in Public Life (1995) known as the 'Nolan Principles';
- The Seven Key principles of the NHS Constitution;
- The Equality Act 2010
- The Bribery Act 2010
- NHS Counter Fraud Authority Requirements

The CCG's Constitution is a living document and has been reviewed regularly throughout 2020/21 and 2021/22, especially in light of the pandemic. Emergency measures were approved by the Governing Body in April 2020 and remained in place until 31 March 2022. These are referenced below:

National guidance/Constitution, Standing Orders and Scheme of Delegation

Due to the pandemic and in line with the NHS England/Improvement (NHSE/I) guidance (C0113) around reducing the burden and releasing capacity dated 28 March 2020, the CCG initially stood down some of its scheduled committees and "business as usual" arrangements. It also reviewed its Governance Arrangements at its Governing Body meeting on 16 April 2020 and approved a number of changes to its Scheme of Delegation to enable quick and effective decision making whilst dealing with a pandemic. These included:

- Using the provision in 6.2 of the CCG's Standing Orders for Emergency Powers and Urgent Decisions. Any decisions taken under these rules would be ratified by the Governing Body at its next meeting.
- The Chief Operating Officer was designated the Accountable Emergency Officer and, if necessary, was authorised to take any urgent response/decision if the emergency arrangements specified above could not be enacted. Again any decisions taken under this rule would be ratified by the Governing Body at its next meeting.
- The Governing Body would continue to meet bi-monthly but all other meetings would either be stood down or held by exception.
- With the COVID-19 situation, changes were made to the CCG's scheme of Delegation which included an increase in authorisation level for a number of individuals to deal with packages of care, receipting invoices etc.

The full details of this report can be found on the CCG's website along with the minutes outlining the approval given. The CCG's Standing Orders were also updated with the changes and have been published on the CCG's website.

The above changes have been reviewed by the Governing Body on a regular basis throughout 2021/22 and remained in place until 31 March 2022. It was also agreed that in light of the CCG ceasing to exist from 30 June 2022, (subject to the final legislation being approved), there would not be a review of the CCG's Constitution in 2021/2022.

Members Information

The Membership information is updated regularly. The CCG currently has 35 Member Practices and the details have been included in the Corporate Governance Report above.

Committee Changes

There has been no changes to any of the CCG's Committees in 2021/22. This was due to the fact that it was envisaged that the CCG would cease to exist from 31 March 2022. However, in December 2021, this was pushed back to 30 June 2022 as the approval of the final legislation had been delayed.

It should also be noted that a number of committees were stood down throughout 2020/21 and 2021/22 during peaks in the pandemic to release capacity.

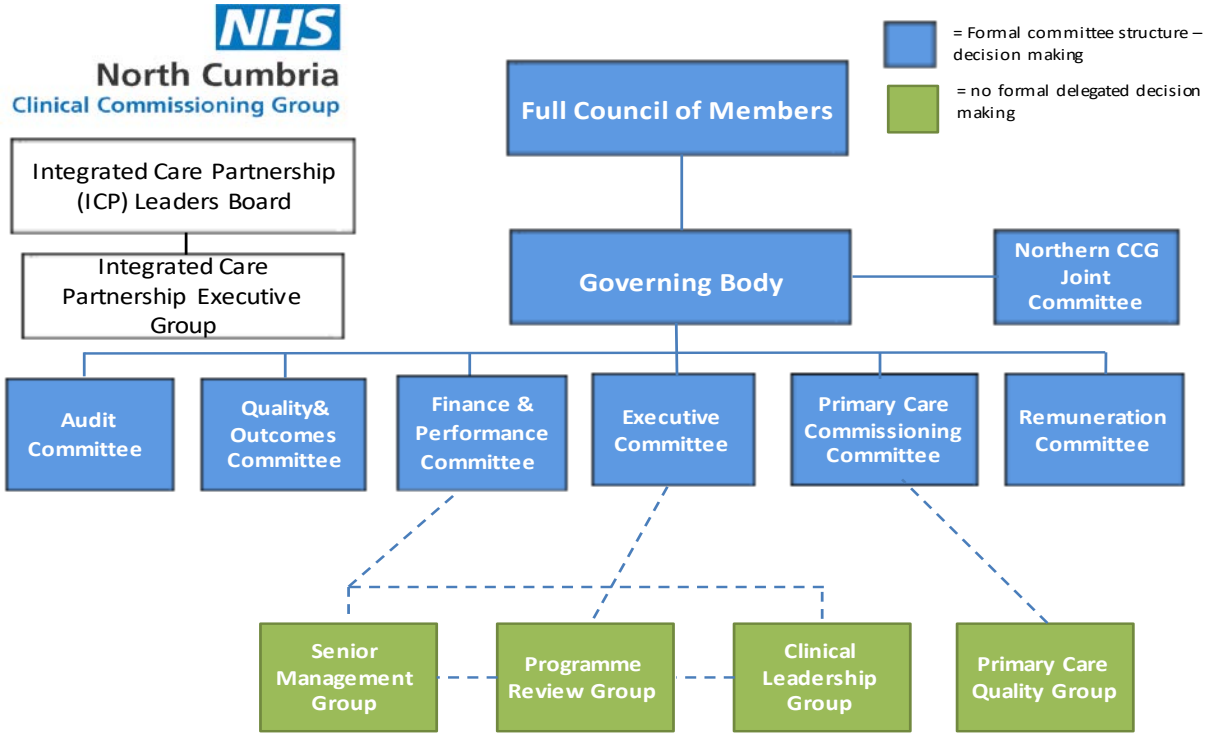
The CCG has also been heavily involved, via various work streams, to support the development of the Integrated Care Board Constitution and its committees along with ensuring that due diligence is managed effectively for the close down of the CCG.

Full Council of Members, Governing Body and the Committee Governance Structure

The CCGs governance meeting structure is headed by the Full Council of Members and it has reserved a small number of functions to itself (these are outlined in Section J, 1.1. to 1.5 of the CCG's Scheme of Delegation which can be found in its Standing Orders on the CCG's website). The Governing Body has accountability to undertake the roles and responsibilities as delegated through the Constitution approved by the Member Practices which constitute the CCG.

The NHS Constitution requires NHS organisations to involve the public when considering how it provides services. Healthwatch Cumbria facilitates a local forum where Clinicians and Directors from partners in the North Cumbria Integrated Care Partnership (ICP) meet regularly with members of the public and third sector groups. These are then actively involved in working on initiatives that are supported by the Action for Health network run by the local CVS. The CCG has also continued with its work on co-production, working with its communities to help shape service changes in North Cumbria. This has included establishing a network within which information can be shared, feedback can be sought and new ideas can be developed together. This has strengthened valuable links with the CCG's communities, and despite the pandemic it has been able to keep community leaders and networks informed and to ensure stakeholders have access to trusted and timely information.

The committee structure that has been established to support the Governing Body in fulfilling its functions is detailed in below:



The Membership, Attendance and Activity Summary

Full Council of Members
Role and Performance Highlights 2021/22

The Full Council of Members is an arena in which all member practices have the opportunity to come together to:

- ensure that the continued development of the CCG is aligned to the principles and aspirations of the constituent practices
- shape the organisation's strategic direction
- approve the CCG's Constitution
- ensure that the Governing Body has published its Annual Reports and Accounts

The Full Council met twice in 2021/22. The CCG has, through its Primary Care Team, worked in conjunction with the Clinical Director Teams in the Primary Care Networks to ensure that our Member Practices have been included in the development work to continue to support the system through this pandemic and been updated on the White Paper proposals for the creation of the North East and North Cumbria Integrated Care System and the closedown of the CCG.

Performance/highlights include:

- Journey from Clinical Commissioning Group to Integrated Care Board
- Primary Care Networks / General Practice Provider Collaborative updates

Membership Practice	Name of Representative & Role	Attendance *(2 meetings held)*
Alston Medical Practice	No representatives attended	0
Appleby Medical Practice	Dr Shonagh Speed-Andrews - GP	1
Aspatria Medical Group	Dr Julie Saxton – GP Dr Shihani Elayakumar - GP	2 1
Birbeck Medical Group	Amanda Riley - PM	2
Brampton Medical Practice	No representatives attended	0
Caldbeck Surgery	Dr. Richard Massey – GP	2
Carlisle Healthcare	No representatives attended	0
Castlegate & Derwent Surgery	No representatives attended	0
Castlehead Medical Centre	No representatives attended	0
Court Thorn Surgery	No representatives attended	0
Dalston Medical Group	No representatives attended	0

Membership Practice	Name of Representative & Role	Attendance *(2 meetings held)*
Distington Surgery	Dr. Helen Horton – GP Dr. Heather Naylor - GP	2 1
Eden Medical Group	No representatives attended	0
Fellview Healthcare Ltd	No representatives attended	0
Fusehill Medical Practice	No representatives attended	0
Glenridding Health Centre	No representatives attended	0
James Street Group Practice	Dr Cheryl Timothy-Antoine - GP	1
Kirkoswald Surgery	No representatives attended	0
Longtown Medical Practice	Dr Gareth Coakley - GP	1
Lowther Medical Centre	No representatives attended	0
Mansion House Surgery	No representatives attended	0
Maryport Group Practice	Dr Dan Berkeley - GP	1
Queen Street Medical Practice	No representatives attended	0
Seascale Health Centre	No representatives attended	0
Shap Medical Practice	Dr Hannah Judson - GP	1
Silloth Group Medical Practice	No representatives attended	0
Spencer Street Surgery	Julie Swan - PM	2
Temple Sowerby Medical Practice	Paula Breen - PM Anna Sives - PM	1 1

Membership Practice	Name of Representative & Role	Attendance *(2 meetings held)*
The Croft Surgery	No representatives attended	0
The Lakes Medical Practice	Samantha Gargett - PM	1
Upper Eden Medical Practice	No representatives attended	0
Warwick Road Surgery	No representatives attended	0
Warwick Square Group Practice	No representatives attended	0
Westcroft House	No representatives attended	0
Wigton Group Medical Practice	No representatives attended	0
Attendees		
North Cumbria Primary Care Alliance	Professor John Howarth - Chief Executive Officer Medical Director Karen Morrell - Managing Director Joanne Percival	2 1 1
Governing Body Members	Mark Adams – Accountable Officer Amanda Boardman – County Lead GP Children and Safeguarding Carole Green – Lay Member for Quality & Performance Denise Leslie – Lay Member for Public Engagement Louise Mason Lodge – Director of Nursing & Quality Colin Patterson – Interim Medical Director/Clinical Lead/Deputy Chair Jon Rush – Lay Chair (Non-voting Chair) Peter Rooney – Chief Operating Officer Ed Tallis – Director of Primary Care Charles Welbourn – Chief Finance Officer	2 1 2 2 2 2 2 1 2 1
CCG Team	Ann-Marie Grady – Primary Care Development Lead Gemma Bowe – Senior Administrator Primary Care Brenda Thomas – Governing Body Support Officer	2 1 2

* Please note:

• that where there was more than one representative attending, only one representative counted towards the meeting being quorate
• PM = Practice Manager

Governing Body
Role and Performance Highlights 2021/22

The Membership of the Governing Body is outlined in the Accountability section of this report.

The prime focus of the Governing Body is to ensure 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 whilst remaining true to its vision and values.

In addition to its core business the Governing Body has effectively overseen the following key areas of work. Please note this list is not exhaustive and business transacted and the decisions taken by the Governing Body in 2021/22 can be found on the CCG's website.

Performance/highlights:-

- The CCG's
  - Assurance Framework
  - Modern Slavery Statement
  - Annual Reports and Annual Accounts (AGM)
- COVID-19 Responses and Updates
- North East & North Cumbria Integrated Care Board (ICB) Plans, Strategies and Workforce
- Annual Reports, including the CCG's Safeguarding and Cumbria Learning and Improvement Collaborative (CLIC)
- Quality Reports
- Performance Reports
- Finance Reports
- North Cumbria Integrated Health Care NHS Foundation Trust (NCIC) Care Quality Commission (CQC) Action Plan
- Learning Disability Mortality Review (LeDeR) Annual Report
- Maternity Services – Ockenden Review and Workforce

The Governing Body has had 8 formal meetings during the said period and attendance records demonstrate that all meetings were quorate.

The Governing Body discharged its duties in full in 2021/22.

Name	Role	Attendance *(8 meetings held)*
Mark Adams	Accountable Officer	8
Dr Amanda Boardman	GP Lead for Safeguarding, Maternity, Children, Mental Health and Learning Disability	6
Dr Gareth Coakley	Chief Clinical Information Officer	5
Carole Green	Lay Member for Quality & Performance	7
Dr Helen Horton	GP Lead for Commissioning	4
Deb Lee	Secondary Care Doctor	8
Denise Leslie	Lay Member for Public Engagement	4
Louise Mason Lodge	Director of Nursing & Quality and Registered Nurse on the Governing Body	7
Jon Rush	Lay Chair (Chair)	7
Dr Colin Patterson	Interim Medical Director/Clinical Lead/Deputy Chair	6
Peter Rooney	Chief Operating Officer	8
Ed Tallis	Director of Primary Care	8
Charles Welbourn	Chief Finance Officer	8
John Whitehouse	Lay Member for Finance & Governance	7
Observers at Public Meetings		
David Blacklock	Healthwatch, Cumbria	4

Name	Role	Attendance *(8 meetings held)*
Toni Phillips	Local Medical Council	3

Audit Committee
Role and Performance Highlights 2021/22

The Audit Committee is responsible for the CCG's governance and risk management process controls and internal control arrangements.

The Committee met four times throughout 2021/22 and attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights include: Please note this list is not exhaustive and the minutes of this Committee outlining the business transacted for 2021/22 can be found in the Governing Body papers on the CCG's website.

- Internal Auditors Assurance on planned work programmes which included (please note this is not an exhaustive list):
    - Governance structures and risk management arrangements
    - Conflicts of interest/Openness and honesty/Standards of Business Conduct
    - Data security and protection toolkit
    - Primary medical care commissioning
    - Commissioning, Contract and performance monitoring
    - Key financial controls
    - Continuing Health Care and Funded Nursing Care

- Internal Auditor Assurance on Counter Fraud
- Assurance on year end processes including the production of the Annual Report and Accounts

Members Name	***Role***	***Attendance*** *(4 Meetings held)*
Carole Green	Lay Member for Quality & Performance	4
Denise Leslie	Lay Member for Public Engagement	3

Members Name	*Role*	*Attendance* *(4 Meetings held)*
John Whitehouse	Lay Member for Finance & Governance (Chair)	4

Auditor panel
Role and Performance Highlights 2021/22

The prime responsibility of the Auditor Panel is to advise the CCG on the selection, appointment and removal of the CCG's external auditors and ensures that the proposed contractual arrangements are appropriate.

The panel has not met during 2021/22.

Members Name	*Role*	*Attendance*
Carole Green	Lay Member for Quality & Performance	No meetings held
Denise Leslie	Lay Member for Public Engagement	
John Whitehouse	Lay Member for Finance & Governance (Chair)	

Executive Committee
Role and Performance Highlights 2021/22

The Committee's key objective is to support the CCG, the Governing Body and the Accountable Officer in the discharge of their functions. It will assist the Governing Body in its duties to promote a comprehensive health service, reduce health inequalities and promote innovation. Its remit includes development and implementation of strategy, monitoring and delivery of statutory duties, operational, financial, contractual and clinical performance. It is responsible for ensuring effective clinical engagement and promoting the involvement of all member practices in the work of the CCG in securing improvements in commissioning of care and services along with the on- going development of primary care through Primary Care Networks and the associated Integrated Care Communities.

This Committee has met 12 times in 2021/2022 and the attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights include: Please note this is not an exhaustive list. The business transacted and decisions taken by this committee can be found on the CCG's website

- Covid-19 updates
- 5 Key System wide priorities, CCG Priorities and OGIMs (Objectives, Goals, Initiative & Measures)
- Quality & Performance Reports
- Finance Reports
- Clinical Priorities
- 2021/22 Planning Submission
- Integrated Care System/Integrated Care Partnership Updates
- Waiting Well
- Strategic Mental Health Memorandum of Understanding
- Primary Care Workforce Strategy
- Governing Body Assurance framework
- Risk Register

Members Name	***Role***	***Attendance*** *(12 Meetings held)*
Mark Adams	Accountable Officer (Chair)	8
Dr Amanda Boardman	GP Lead for Safeguarding, Maternity, Children, Mental Health and Learning Disability	11
Dr Gareth Coakley	Chief Clinical Information Officer	10
Dr Helen Horton	GP Lead for Commissioning	7
Louise Mason Lodge	Director of Nursing & Quality	9
Dr Colin Patterson	Lead GP	7
Peter Rooney	Chief Operating Officer	9
Ed Tallis	Director of Primary Care	11
Charles Welbourn	Chief Finance Officer	11

Finance & Performance Committee
Role and Performance Highlights 2021/22

The core aims and responsibilities of the Finance & Performance Committee is to provide assurance to the Governing Body on the CCG's finances and performance issues. Including:

- providing leadership in making recommendations to the Governing Body for the deployment of resources and budgets
- providing leadership in ensuring that the CCG is fulfilling its responsibilities in improving the performance of the health care system against standards, and in managing its contract activity effectively.

The Committee met 10 times throughout 2021/22 and attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights include: Please note this list is not exhaustive and the minutes of this Committee outlining the business transacted and decisions taken for 2021/22 can be found in the Governing Body papers on the CCG's website.

- Performance Reports
- Finance Reports
- Health & Safety Corporate Assurance Report
- HR update Reports and policy approvals
- Operational & Financial Planning updates
- Equality & Choice Policy
- High Cost Review
- 2021/22 Inflation Uplift to None NHS Organisations
- Data Protection Toolkit
- Risk Management Framework

Members Name	Role	Attendance *(10 Meetings held)*
Carole Green	Lay Member for Quality & Performance	6
Deb Lee	Secondary Care Doctor	7
Denise Leslie	Lay Member for Public Engagement	5
Peter Rooney	Chief Operating Officer	9

Jon Rush	Lay Chair (Chair)	10
Charles Welbourn	Chief Finance Officer	10
John Whitehouse	Lay Member for Finance & Governance	9

Outcome & Quality Assurance Committee Role and Performance Highlights 2021/22

The Outcomes & Quality Assurance Committee examines, in detail, the areas of concerns in the quality of care provided to patients in North Cumbria. It works closely with the Nursing & Quality team to ensure that the assurance provided to the Governing Body is robust and demonstrates that the quality assurance systems and processes are in place.

The Committee met six times throughout 2021/22 and attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights include: Please note this list is not exhaustive and the minutes of this Committee outlining the business transacted and decisions taken for 2021/22 can be found in the Governing Body papers on the CCG's website.

- Scrutinising Quality Report prior to presentation to the Governing Body (including unexplained deaths, pressure ulcers, serious untoward incidents, never events)
- North Cumbria Integrated Care NHS Foundation Trust (NCIC) Care Quality Commission (CQC) Action Plan
- Maternity Services – Ockenden Review and Workforce
- Learning from Lives and Deaths (LeDeR)
- Special Educational Needs & Disability (SEND) Update
- Cancer Services
- Primary Care
- Patient Safety
- North West Ambulance Service
- Care Homes & Hospices
- Continuing Health Care
- Joint Domestic Homicide Review

Members Name	Role	Attendance *(6 Meetings held)*
Amanda Boardman	Nominated Deputy for Medical Director	5
Carole Green	Lay Member for Quality & Performance (Chair)	6
Deb Lee	Secondary Care Doctor	4
Denise Leslie	Lay Member – Public Engagement	3
Louise Mason Lodge	Acting Director of Nursing & Quality, Designated Safeguarding Lead and Registered Nurse on the Governing Body	6
Paula Smith	Patient Safety Lead	3
Nicki Trewhitt	Senior Nurse	6

Primary Care Commissioning Committee Role and Performance Highlights 2021/22

On 1 April 2017 North Cumbria CCG was delegated authority by NHS England to review, plan and procure primary medical care services in North Cumbria. As part of that delegation the Governing Body established a Primary Care Committee which meets in public to manage those functions agreed between NHS England and the CCG, together with certain duties delegated to it by the CCG (as set out in its Scheme of Delegation). The Committee's full Terms of Reference can be found on the CCG website.

The Committee met six times throughout 2021/22 and attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights include: Please note this list is not exhaustive and the minutes of this Committee outlining the business transacted and decisions taken for 2021/22 can be found in the Governing Body papers on the CCG's website at:

- Covid-19 Updates
- Integrated Care Communities (ICC)
- Primary Care Networks
- CCG Gain Share Schemes
- CCG Gain Share General Practice Forward View Proposals
- Quality Improvement Schemes
- Special Allocation Schemes
- Finance Updates

- Primary Care Team Updates
- Contract Baseline Reports
- Primary Care Committee Performance Review

Members Name	Role	Attendance *(6 Meetings held)*
Carole Green	Lay Member for Quality & Performance	6
Denise Leslie	Lay Member for Public Engagement	4
Jon Rush (Chair)	Lay Chair	6
Ed Tallis	Director of Primary Care	6
Charles Welbourn	Chief Finance Officer	6

Remuneration Committee
Role and Performance Highlights 2021/22

The Remuneration Committee is responsible for making recommendations to the Governing Body about appropriate remuneration and terms of service for all posts above the top threshold of the National Agenda for Change (AfC) pay-scale, including off-payroll appointments, including:

- all aspects of salary (including any performance-related elements / bonuses)
- provisions for other benefits e.g. car allowances
- advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

The Remuneration Committee has not met during the 2021/22 financial year. This was due to the fact that the NHS Ministers' recommendation on 2021/22 annual pay increase for very senior managers (VSMs) issued on 8 September 2021 was due to be considered by a Remuneration Committee in Common from across the North East & North Cumbria Integrated Care System. This would have been made up of the Chair of each CCG's Remuneration Committee. However, unfortunately this meeting was not convened. Therefore, North Cumbria CCG's Remuneration Committee met on 19 April 2022 to consider the above and their recommendations were approved at the Part 2 Governing Body meeting on 19 May 2022.

Members Name	Role	Attendance *(Meeting held April 2022)*
Carole Green	Lay Member for Quality & Performance	1
Deb Lee	Secondary Care Doctor	1
Denise Lesley	Lay Member for Public Engagement	1
John Whitehouse	Lay Member for Finance & Governance (Chair)	1
In Attendance		
Kirstin Blundell	HR Business Support, North of England Commissioning Support (NECS)	1
Amber Minton	HR Business Support, North of England Commissioning Support (NECS)	1
Jon Rush	Lay Chair	1

Joint CCG Committee for the North East and North Cumbria

This Northern CCG Joint Committee was established in October 2017. This Committee has continued to meet during 2021/22 and has been guided by the following principles:

- Securing continuous improvement to the quality of commissioned services to improve outcomes for patients with regard to clinical effectiveness, safety and patient experience
- Promoting innovation and seeking out and adopting best practice by supporting research and adopting and diffusing transformative, innovative ideas, products, services and clinical practice within its commissioned services which add value in relation to quality and productivity
- Developing strong working relationships with clear aims and a shared vision putting the needs of the people we serve over and above organisational interests
- Avoiding unnecessary costs through better co-ordinated and proactive services which keep people well enough to need less acute and long term care

Throughout the year the Joint Committee routinely discussed governance proposals to support the shared ambition of the NHS organisations in the North East and the North Cumbria (NENC) to become an Integrated Care System (ICS).

With the anticipated adoption of an Integrated Care Board (ICB) for the NENC in July 2022, the necessity for the Joint Committee will no longer exist.

Membership

During 2021-22 membership of the Joint Committee comprised the following Clinical Commissioning Groups (CCGs):

NHS County Durham CCG	NHS Newcastle Gateshead CCG
NHS North Cumbria CCG	NHS Northumberland CCG
NHS North Tyneside CCG	NHS South Tyneside CCG
NHS Sunderland CCG	NHS Tees Valley CCG

NHS North Yorkshire CCG is an Associate Member and is eligible to attend the Joint Committee as a non-voting member. However, where there is an issue requiring a decision to be made that will affect the NHS North Yorkshire CCG, the Accountable Officer or nominated deputy will have full voting rights in relation to the relevant issue.

Voting membership of the Joint Committee comprises the Chair and Chief Officer from each member CCG (or a nominated deputy) and each CCG is entitled to exercise one vote as required. There are also two (non-voting) lay members of CCGs on the Joint Committee.

The Managing Director of North of England Commissioning Support (NECS), Chair of the Cumbria and North East CCG Chief Finance Officers' Group and Director of Governance and Partnerships North East and North Cumbria Integrated Care System also attend meetings of the Joint Committee in a non-voting capacity.

There were eight meetings of the Joint Committee held in 2021/22. Due to Covid-19, it was not possible to hold meetings of the Committee in public and it met in private virtually. Relevant extracts from these minutes were approved for publication on CCG websites.

The following key areas of the Joint Committee work in 2021/2022 are outlined below:

- Developing an Integrated Care System (ICS) in the North East and North Cumbria
- Research and evidence annual update
- Update on the use of Avastin for the treatment of wet AMD (age-related macular degeneration)
- Academic Health Science Network (AHSN) and its role with the National Lipid Management Pathway including inclisiran
- Northern Joint Committee Annual Report 2020/21
- Northern Treatment Advisory Group (NTAG) Annual Report 2020/21
- Learning Disabilities Treatment and Assessment Review

- North of England Commissioning Support (NECS) customer board reports.
- Gender Dysphoria
- System approach to preparing well for surgery in North East North Cumbria (NENC)
- Acute pressures
- Pre-Term Birth Clinics - commissioning for safety, quality and equity: request to combine Allocations
- Value Based Clinical Commissioning Policy (VBCC) – Confirmed Updates to Regional Policy – April 2022 Refresh
- Individual Funding Request (IFR) Policy / Standard Operating Procedures (SOP) / Terms of Reference (ToR) - Update

North Cumbria Integrated Health and Care Partnership

These arrangements consist of two mutually related groups, namely, the Integrated Care Partnerships (ICP) Leaders Board which is supported by the ICP Executive Group. Both groups consist of all NHS Partners, Cumbria County Council and Third Sector representatives that service the North Cumbria geographical area. The main remit of the arrangements is to co-ordinate the partnership working of the local health and care system; set an agreed strategy that dovetails into the Cumbria Health and Well Being Strategy and supports the Integrated Care System work streams for the North East and North Cumbria; manage and monitor partnership performance.

This year the Leaders Board has concentrated on developing and shaping its approach to the emerging relationship with the Integrated Care System for the North East, whilst the Executive Group has prioritised the operational response to Covid and the delivery of the other 4 key priorities of Patient flow and discharge; Workforce; Population Health and Finance. A review of Integrated Care Communities was also undertaken to revise and develop our approach.

The CCG is represented on the Leaders Board by the Chair, Jon Rush; the Accountable Officer, Mark Adams; the Chief Operating Officer, Peter Rooney and the Lay Member for Finance and Governance, John Whitehouse. Jon Rush is also the Chair of the Board.

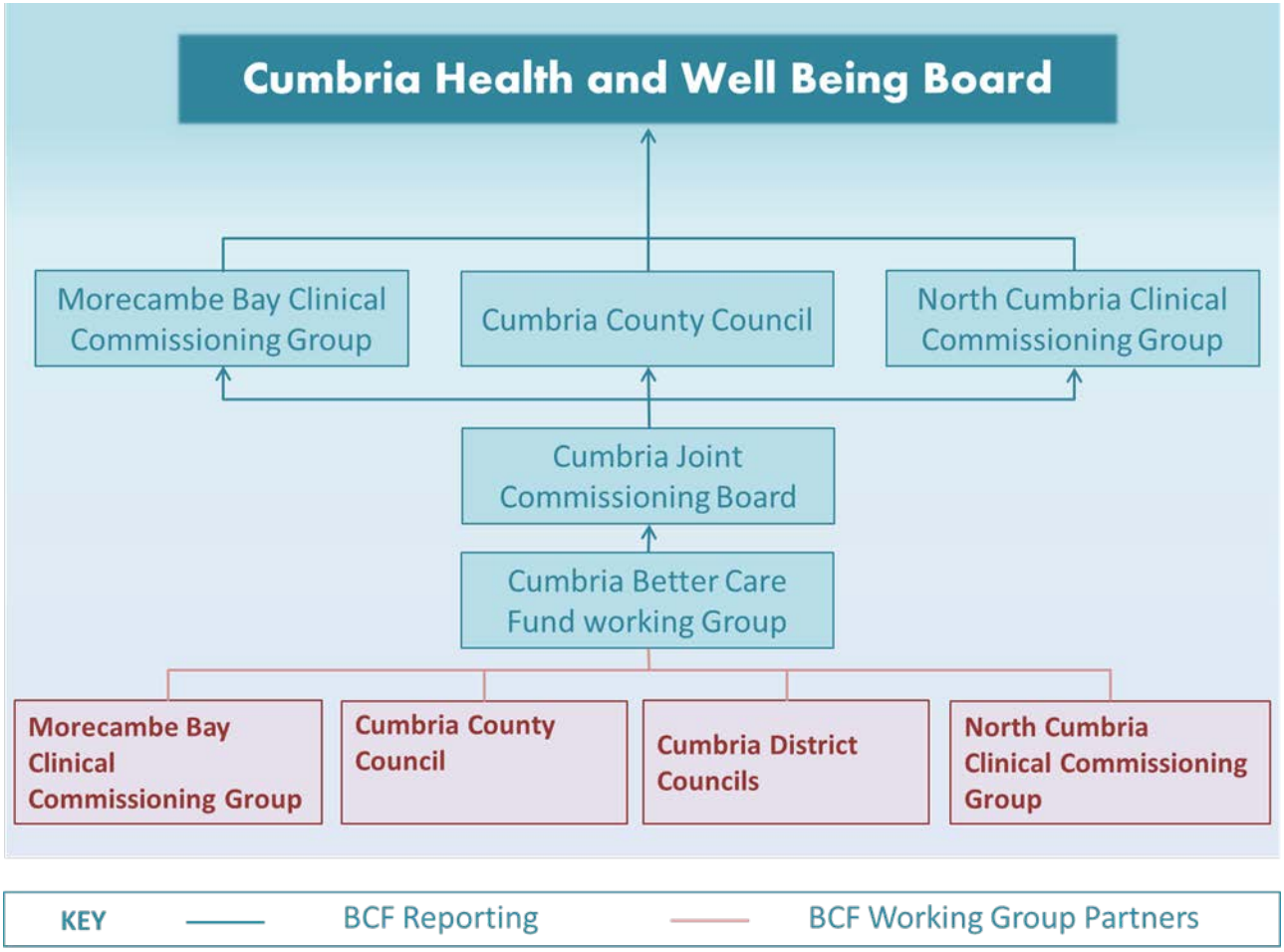
Better Care Fund Governance Arrangements

The Better Care Fund (BCF) is a single pooled budget, managed through a Section 75 Agreement, which began in 2014/15. It was introduced to further encourage joint commissioning of integrated health and social care services and brings together a portion of existing NHS and Local Government resources.

Whilst, at a local level, NHS North Cumbria CCG, NHS Morecambe Bay CCG and Cumbria County Council are the accountable bodies for their respective elements of the BCF, the Cumbria Joint Commissioning Board, established as a working group of the Cumbria Health and Well Being Board, leads the performance management and provides the co-ordination role for the delivery of the Better Care Fund.

The NHS England Policy Framework for the Better Care Fund requires the Health and Wellbeing Board to receive and sign off the final plan and quarterly progress reports to ensure oversight of the strategic direction and delivery of better integrated care. This helps to fulfil their statutory duty to encourage integrated working between commissioners.

In North Cumbria the schemes identified within the BCF plan are all closely aligned to the on-going development of Integrated Care Communities, being a key element of delivering the objectives identified in the North Cumbria strategy launched during 2020/21.



Discharge of Statutory Functions

In accordance with the recommendations of the 1983 Harris Review, the CCG reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG 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 CCG's statutory duties. In line with the NHS England/Improvement guidance (C0113) around reducing the burden and releasing capacity dated 28 March 2020 the CCG reviewed its "business as usual" arrangements to release capacity from across the CCG to support the system with the Covid-19 pandemic. This included providing staff to support in other areas such as:

- Testing centre bookings systems
- Discharges from Hospitals
- Care & Residential Homes
- Infection Control
- Supporting the establishment of vaccination Hubs/Centres and the roll out of the vaccination programme

This impacted on the CCG's normal OGIM (Objectives, Goals, Initiatives and Metrics) framework. However, the CCG has now returned to 'business as usual' and the Programme Review Group has resumed and met regularly throughout 2021/22.

Risk management arrangements and effectiveness

The CCG's Risk Management Framework sets out the approach and arrangements for the management of risk. The CCG ensures a common and systematic approach to risk management to ensure it is embedded across all directorates which enables risks to be identified and managed effectively in the most appropriate place. These principles are consistent with those within the NHS England's Risk Management Policy and Process Guide issued in January 2015.

However, the Governing Body in April 2020 agreed a set of interim corporate governance arrangements to deal with the pandemic that resulted in many of the CCG's "business as usual" arrangements being stood down during 2020/21 and 2021/22. This reflected that the changed priorities around the national COVID response introduced significant uncertainties over the scale of risks locally and the options available to manage them, especially as the NHS nationally paused all routine planning work for 2021/22 Operational Plans. The national framework for recovery of 'living with COVID' for NHS services is only just emerging and this will shape the way North Cumbria responds over the next few months. The Risk Register will be updated to reflect these expectations as they become clearer, but the risk register and Governing Body Assurance Framework have both been refreshed in 2021/22.

These arrangements were formally reviewed periodically by the Governing Body during the year and were maintained until March 2022. Hence, the CCG has effectively maintained the previous approach to risk management. Nevertheless, during 2021/22 the CCG commenced a process of working towards "business as usual" and re-introduced a number of processes such as re-establishing operational risk assessments within departments and individual departmental objectives based upon the corporate approach. However, this approach was still very much managed through the key risks of COVID and recovery objectives. The following are therefore noteworthy:

Directors and Senior managers from all CCG directorates participate in the Programme Review Group meeting and decisions taken to address operational risks are formally recorded. The impact of COVID and the recovery is a standing item.

- The Governing Body and supporting Committees have been continually updated on the risks facing the organisation (and wider system) and there was a standing item on the Governing Body agenda (until March 2022) to record any emergency decisions taken outside formal delegations.

- The CCGs Outcomes & Quality Assurance and Finance & Performance Committees have also continued to meet and be provided with regular reports on quality, performance and finance issues 'outside of' COVID-19 during the year.

Capacity to Handle Risk

The CCG's Governing Body has overall responsibility for governance, assurance and management of risk. The Governing Body has a duty to assure itself that the organisation has properly identified the risks that it faces, and that it has processes and controls in place to mitigate those risks and the impact they may have on the organisation and its stakeholders. The tool used by the Governing Body to gain this assurance is the Governing Body Assurance Framework (GBAF).

Despite the overall approach, as a consequence of the pandemic, the CCG's Governing Body undertook a full review of the GBAF during 2021/22, supported by the work of the Executive Committee. In light of the November 2020 NHS England & Improvement (NHSE/I) Board report regarding the development of Integrated Care Systems (and subsequent NHSE/I guidance) about the future direction for CCGs then this approach was focussed upon:

1. Enabling the CCG to demonstrate good governance
2. Providing a framework to ensure the organisation retains focus on the key strategic aims during whatever transition process takes place, remembering the organisational structure is a means to achieving the objectives (enabler)
3. Enabling a good handover process to whatever structure emerges for the future.

This process continued during 2021/22 in light of further guidance issued by NHSE/I and the confirmed target date of 1 July 2022 for the transfer of CCG functions to the new NENC Integrated Care Board. This approach concentrated upon strategic risks, which by definition will be risks to

achieving the CCG's strategic aims, as set out in the North Cumbria Health & Care Strategy 2020-24 previously approved by the CCG Governing Body in January 2020 and noted below:

Strategic Objectives: we will

- improve the health and care outcomes of our local communities and support people of all ages to be in control of their own health.
- build health and care services around our local communities.
- provide safe and sustainable high quality services.

To help us achieve this we will focus on key areas – our strategic enablers: we will

- be a great place to work and develop
- integrate how health and care and other organisations work together
- live within our means and spend resources wisely
- deliver digitally enabled care

Therefore a further stocktake has been undertaken by the Senior Leadership Team and presented to the CCG's Executive Committee comparing the documents below with the North Cumbria Integrated Care Partnership Strategy 2020-2024:

- The last iteration of the GBAF
- The CCGs risk register as refreshed during 2021/22
- Covid recovery work schedule identified by NHSE/I

This process considered the completeness of the list, key changes that have happened since the various documents were produced and also looked to segregate key strategic issues from the more operational "day to day" issues (being managed through the arrangements noted previously). Hence, the refreshed document was considered by the Executive Committee and subsequently approved by the Governing Body in January 2022.

It also noteworthy that the response to Covid is excluded in the final analysis for the reasons noted below. However, as work plans to mitigate the risks to the strategy are developed they will naturally need to reflect the medium and longer-term effects of Covid, and how the country learns to "live with Covid".

- This is a national pandemic that is being managed through a national approach
- The CCG established an Incident Management Team (IMT) that is linked to other statutory functions to manage the CCG's response, which has been "stood up" and "stood down" in response to particular operational circumstances during the year.
- The CCG has a set of systems and processes to address the challenges of Covid and the CCG's response is reported at each Governing Body meeting to provide both assurance and scrutiny of our actions.
- A key risk identified is the achievement of NHS performance standards that will continue to be influenced by the direct and longer term impact of Covid-19.

The process for updating the GBAF was also reviewed by the Audit Committee in February 2022 (including input from Internal Audit).

The GBAF will continue to be kept under review to maintain the approach that has been described above in conjunction with further planning and implementation guidance issued by NHSE/I, including as part of the "due diligence" process for handover to the NENC ICB.

It is also noteworthy that in response to Covid-19, as supported by the Governing Body and noted previously, the CCG suspended many of its "business as usual" processes. This was most acute in the early part of the year where priority was specifically given to supporting the local system operationally as a consequence of the high infection and hospitalisation rates and supporting the rollout of the vaccine. Therefore, as a direct consequence of this approach the CCG has not been maintaining the risk register in the 'usual way' although this process re-commenced during the year as previously noted through the working of the Programme Review Group, as approved by the CCG Executive Committee in March 2021.

Risk Assessment

The CCG's Audit Committee has developed, implemented and monitored a risk management review process. This has resulted in the Finance and Performance Committee and Governing Body being assured that there are robust, sound and safe risk escalation and management processes in place across the organisation.

The CCG internal auditors undertook a risk based audit on Governance Structures for 2021/22 and considered the governance, risk management and control arrangements. The conculsion of the audit resulted in substantial assurance being given.

In addition to managing the COVID response directly (especially coordinating hospital discharge and vaccination) the CCG faces significant risks in terms of providers failing to meet key NHS Constitution targets, adversely impacting on patient care and potentially resulting in additional costs to the CCG. The most material issue relates to the backlog of elective care as a result of non-urgent hospital planned care being suspended for long periods of the 2020/21 financial year.

Similarly, there have also been major challenges in addressing cancer waiting times along with concerns that patients have not been accessing services in a timely manner as a direct consequence of COVID. Each of these areas has been the subject of significant joint working between the CCG and its partners and in particular its main local secondary care provider, North Cumbria Integrated Care NHS Foundation Trust (NCIC) and Cumbria County Council (CCC).

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the CCG to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate

the likelihood of those risks being realised, the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

As specified above the CCG's Internal Auditors, Auditone, undertook a risk based audit of the Assurance Framework in March 2022 and found that governance, risk management and control arrangements provided substantial assurance that the risks identified are managed effectively. Compliance with the control framework was found to be taking place.

Annual audit of Conflicts of Interest management

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

The CCG's Internal Auditors, Auditone, undertook the required annual audit on Conflicts of Interest in March/May 2022 and has issued a good assurance level.

Data Quality

The Governing Body relies on the data quality elements in its contracts with providers. This includes both the requirement that providers quality assure their data prior to submission, and the active monitoring and management of the data quality improvement plans are included within the contracts. In addition, the CCG commissions the North of England Commissioning Support (NECS) services to manage all local and national information flows on behalf of the CCG, including quality assurance, analysis and reporting. Therefore, the CCG's contract with NECS outlines our expectations with respect to data quality and reporting.

Information Governance (IG) (including Cyber Incidents and Business Critical Models)

Information Governance is to do with the way the CCG processes and handles information. It covers personal information (relating to patients/service users and employees) and also corporate information (for example financial and accounting records). By embedding Information Governance in the culture of the CCG, we can provide assurance to the public and our regulators that the CCG complies with relevant legislation and central guidance and that information is handled appropriately, lawfully and securely. The Information Governing vision is that we "Enable high quality care by facilitating the ethical, legal, effective & appropriate use of accurate & reliable information that maintains confidentiality, integrity & availability".

The 2020/21 Data Security and Protection Toolkit Report, which was submitted in June 2021, confirmed compliance with 'Standards Met'. Due to the impact Covid-19 has had, the submission of the Data Security and Protection Toolkit report for 2021/22 is not due until June 2022.

The CCG takes its responsibilities for the protection of patient and staff information seriously. Breaches of confidentiality or loss of personal data are reported and investigated through the Trust's Incident Reporting procedure and assurance processes. During the reporting period, the Information Governance Team has not recorded any IG incidents between 1 April 2021 and 31 March 2022.

Third party assurances

As a result of the support service arrangements provided by the North of England Commissioning Support (NECS) under a signed services level agreement, the CCG will receive a number of assurance reports covering from the 1 April 2021 to 31 March 2022.

Control Issues

In seeking to ensure that the CCG has a robust system of internal control that is implemented effectively, the CCG Audit Committee has established a cyclical, risk-based programme of internal audit work. At the time of writing this report no issues of significant risk have arisen from this work. A similar approach has been taken to manage the risk of fraud and/or misuse of resources and again no significant issues have been reported.

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

During 2021/22 the NHS has continued to work through a national "Covid-19" financial regime first introduced during 2020/21, with many of the normal transactional process (e.g. contracts with NHS providers) suspended and nationally mandated payments made. As part of this process the CCG has required all expenditure to be assessed as reasonable and proportionate to secure funds from NHSE where appropriate and meet agreed financial objectives for the year. The CCG has therefore ensured that all expenditure planning has been overseen by the Governing Body with separate plans agreed for the first ("H1") and second ("H2") halves of the year, and has also undertaken work to ensure the CCG has continued to support investment in mental health services in accordance with Long Term Plan objectives. However, owing to Covid-19 many of the CCG's resources have been directed towards supporting the NHS response to the pandemic rather than pursuing productivity improvements particularly during H1. For example the CCG medicines optimisation team has been instrumental in supporting Primary Care Networks in delivery of the vaccination programme.

The CCG has also continued to ensure that any staff vacancies are assessed via the Vacancy Panel which requires the line manager to produce a business case for any post(s) that they may wish to recruit to. In addition any vacancies are being advertised across the North Cumbria system in the first instance to ensure, where possible, that resources come from within the existing system.

As part of the CCG's Organisational Development Programme continuous improvement continues to be embedded into the organisation and training is available from Cumbria Learning and Improvement Collaborative.

An internal audit work plan was agreed by the Audit Committee and Auditone has been systematically undertaking the reviews planned for 2021/22. Reviews undertaken include:

- Governance structures and risk management arrangements
- Conflicts of interest/Openness and honesty/Standards of Business Conduct
- Data security and protection toolkit
- Primary medical care commissioning
- Commissioning, Contract and performance monitoring
- Financial and strategic planning
- Key financial controls
- Continuing Health Care and Funded Nursing Care

The outcomes of these audits are reported through the Head of Internal Audit Opinion.

The Audit Committee is made aware of the findings of each review and the proposed actions made by management to address any areas of concerns raised. Auditone has also implemented an action follow up system which seeks confirmation that the actions programmed as a result of an audit have been completed.

In addition to all of the above the Finance & Performance Committee gives detailed consideration to the CCG's financial and performance issues to provide the Governing Body with assurance that all issues are being appropriately managed and escalated where necessary.

The Governing Body also receives a quality, performance and finance report at each meeting.

Delegation of functions

The CCG currently contracts with a number of external organisations for the provision of back office services and functions. These external services include:

- The provision of Oracle financial system and financial accounting support from NHS Shared Business Services. The use of NHS Shared Business Services is mandated by NHS England for all CCGs.
- The provision of financial accounting services from the North of England Commissioning Support Unit (NECS)
- The provision of payroll services from Northumbria Healthcare NHS Foundation Trust

Assurance on the effectiveness of the controls is received in part from annual service audit reports and internal audit assurance reports from the relevant service providers. The outcomes from these audits are reported to the Audit Committee.

Freedom to Speak Up: Raising Concerns (Whistleblowing)

The CCG is committed to an open and honest culture whereby all staff feel able and are supported to raise concerns at work. In June 2021 we appointed out first standalone Freedom to Speak Up (FTSU) Guardian, Kate Holliday, who is currently supported in her role by the CCG's FTSU, Louise Mason -Lodge, Executive Lead and Denise Leslie, Lay Member for Patient & Public Engagement.

Actions taken following appointment to this role have included:

- Formal training of the guardian with the National Guardian Office, as well as formal training of the FTSU Exec Lead and Lay Member for Public & Patient Engagement,
- Development of a CCG Freedom to Speak Up Vision and Strategy for 2021/22. This was agreed on 16 September 2021 Governing Body and was presented to staff at the September CCG staff briefing.
- Review of and making appropriate changes to current CCG Freedom to Speak Up/ Whistleblowing Policy.
- Development of a raising concern form for CCG staff to complete and submit to a confidential FTSU contact email address.
- Development of a template to support managers in structuring their response to colleagues speaking up through the guardian route.
- Developed an MS Teams background to promote the FTSU role at every Teams meeting.
- Developed a CCG FTSU intranet page and communication resources to raise awareness of the role.
- Presentation by the Guardian (autumn 2021) to all CCG staff outlining the role of the FTSU and raising awareness of the whole FTSU movement across the CCG.
- On a monthly basis the Guardian has linked into wider networks regarding FTSU locally, regionally and nationally.
- The Guardian, CCG FTSU Executive Lead and Lay Member for Patient & Public Engagement meet formally on a monthly basis.

Counter Fraud Arrangements

The CCG's 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 the contract with AuditOne, the CCG has counter fraud arrangements in place that comply with the NHS Counter Fraud Authority Requirements for Fraud, Bribery and Corruption including:

- An accredited counter fraud specialist who is contracted to undertake counter fraud work proportionate to identified risks.
- Well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption.
- A report against each of the NHS Counter Fraud Authority Requirements for Fraud, Bribery and Corruption received by the Audit Committee at least annually.
- Executive support and direction for a proportionate proactive work plan to address identified risks.
- The Chief Finance Officer, as a member of the Governing Body, is proactively and demonstrably responsible for tackling fraud, bribery and corruption.
- Appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations.

The CCG also has a Counter Fraud page on the CCG's website which promotes how to recognise what fraud looks like and how to report it and also has the CCG's relevant policies around this in place.

Head of Internal Audit Opinion

The planned audit work for the financial year 2021/22 for the CCG is at the time of writing being finalised. The Head of Internal Audit Opinion issued has been an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Final Head of Internal Audit Opinion for 2021/22 can be found below:

1. Introduction

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion on the overall adequacy and effectiveness of the organisation's system of internal control.

The purpose of this report is to provide the Audit Committee with the Head of Internal Audit Opinion for the year ended 31 March 2022, which should be used to inform the Annual Governance Statement.

2. Head of Internal Audit Opinion for the year ended 31 March 2022

2.1 Roles and responsibilities

The Accountable Officer is responsible for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

- How the individual responsibilities of the Accountable Officer are discharged in relation to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- The purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and
- The conduct and results of the review of the effectiveness of the system of internal control, including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the Annual Governance Statement requirements. In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon, and limited to, the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, approved by Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans, generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Accountable Officer takes into account in making the Annual Governance Statement. The Accountable Officer will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement.

2.2 The Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpins the organisation's own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist in the completion of the Annual Governance Statement.

My opinion is set out as follows:

2.2.1 Overall opinion;
2.2.2 Basis for the opinion;
2.2.3 Commentary.

2.2.1 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.

2.2.2 Basis of the Opinion

The basis for forming my opinion is as follows:

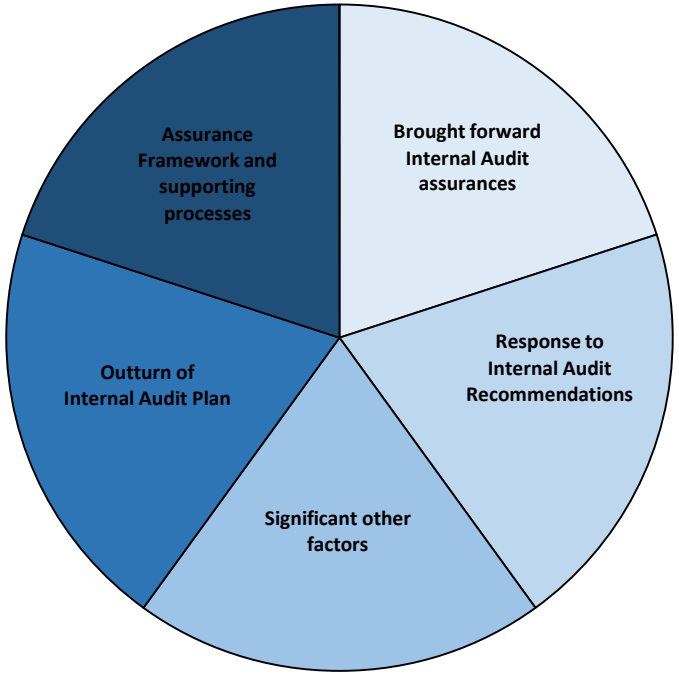
1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes for governance and the management of risk;

2. An assessment of the range of individual opinions arising from audit assignments, contained within risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses;

3. Brought forward Internal Audit assurances;

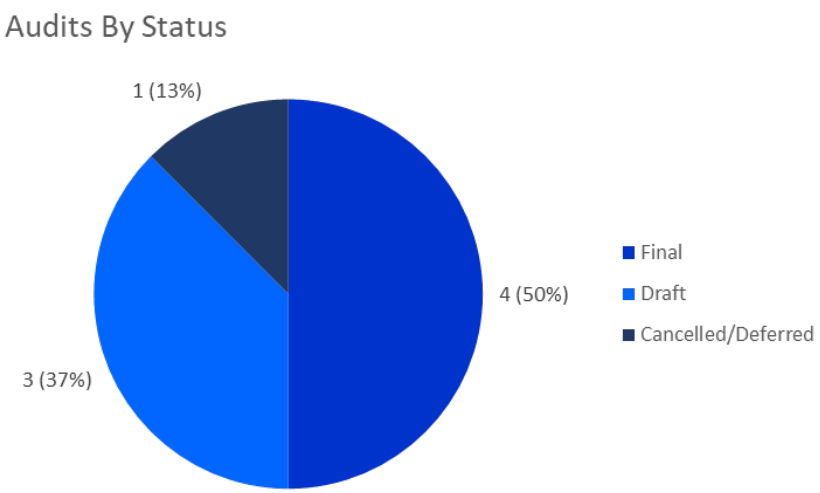
4. An assessment of the organisation's response to Internal Audit recommendations, and

5. Consideration of significant factors outside the work of Internal Audit.



2.2.3 Commentary

Opinion Area	Commentary
Design and operation of the Assurance Framework and supporting processes	The CCG's Risk Management Framework sets out the frequency with which the corporate risk register and assurance framework should be submitted to the Governing Body and its sub-committees. We were advised by the CCG's General Manager that the Framework required update to reflect current practices and that the corporate risk register and assurance framework had not been presented per the frequency set out in the Framework. Our review of Governing Body and sub-committee papers for the year indicated that the assurance framework had been presented to the Governing Body in January 2022, the Audit Committee in February 2022, an update on the assurance framework had been presented to the Executive Team in November 2021 and the corporate risk register had been presented to the Finance and Performance Committee in October 2021 and May 2022. As part of the handover to the new organisation, we have recommended that a final review of the assurance framework and corporate risk register is carried out by the CCG to ensure that they are up to date and reflect the current position; and are presented to the June 2022 Governing Body meeting.

<table>
<tr><th>Opinion Area</th><th>Commentary</th></tr>
<tr><td>Outturn of Internal Audit Plan</td><td> 
</td></tr>
<tr><td></td><td>The above graph provides a summary of audit plan delivery for 2021/22 at 15 June 2022.</td></tr>
<tr><td></td><td>At the time of producing this opinion summary we have issued 4 final reports and 3 draft reports. Where reports have been issued in draft, the assurance level has been agreed with the CCG, although management responses in relation to the action to be taken to address identified weaknesses have not yet been received.

The split of assurance levels and categorisation for the reports issued is shown in the following table:

<table>
<tr><th rowspan="2">Report Status</th><th colspan="5">Assurance Level</th></tr>
<tr><th>Substantial</th><th>Good</th><th>Reasonable</th><th>Limited</th><th>n/a (Advisory)</th></tr>
<tr><td colspan="6">Core Assurance Audits</td></tr>
<tr><td>Draft</td><td>2</td><td>1</td><td></td><td></td><td></td></tr>
</table></td></tr>
</table>

Opinion Area	Commentary

Final	2	1		1	
Total	**4**	**2**	**0**	**1**	**0**

As can be seen from the table above, reports issued during the year have been issued with assurance level of substantial, good and limited.

The limited assurance report relates to the audit of the Data Security and Protection Toolkit for the year 2020/21 and was undertaken in accordance with NHS Digital's 2020 guidance for internal auditors. We considered whether the organisation meets the requirement of 35 evidence texts across 13 mandatory in-scope assertions and also considered the broader maturity of the CCG's data security and protection control environment. The Toolkit was not subject to review during 2021/22 but we have tracked and reported to Audit Committee the management actions resulting from the 2020/21 assessment. At the time of reporting residual actions are in relation to:

Area	Original action	Target	Latest position
Disaster Recovery Testing	Agreed and DR Testing is planned	Aug 21	DR Test didn't perform as expected. A replacement virtual platform (Nutanix) has been commissioned as it is more efficient and reliable; the existing system is reaching end of life. DR process forms part of the acceptance testing and a full test will be complete once all live systems are configured. This work is expected to be completed by the end of July 22 and a full DR test will be arranged for August/Sept 22. Note that part of the acceptance testing of the new platform was a simulated failover (using dummy virtual machines) so we have

<table>
<tr><th>Opinion Area</th><th>Commentary</th></tr>
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<tr><td></td><td></td><td></td><td>confidence that the process works, just need to test with live systems running on it.</td></tr>
<tr><td>Backup System Testing</td><td>A full test restore will be performed as part of the DR test</td><td>Aug 21</td><td>Normal yearly DR testing will resume once the migration has completed. A backup audit was completed and an action plan is being drawn up.</td></tr>
</table>

For context the CCG critical systems are Email, Active Directory and File Storage. The CCG have recently transitioned to NHSMail so the critical services supplied by NCIC (who provide IT support) are reduced to AD and File Storage. AD is a resilient multi-site service, so only File Storage is contingent on the DR testing.
</td></tr>
<tr><td>Brought forward Internal Audit assurances</td><td>The Head of Internal Audit Opinion given for the year ended 31 March 2021 gave a level of assurance of ‘substantial’. There were no material issues identified to be brought forward for consideration in this opinion statement.</td></tr>
<tr><td>Response to Internal Audit recommendations</td><td>The implementation of internal audit recommendations is a key indicator of the organisation’s engagement with ourselves and the importance it places on the recommendations we have made and have been agreed to be implemented. The Audit 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.

In the year to 31 March 2022, 13 high or medium recommendations were due to be implemented based on initial or revised target dates, at 15 June 2022, 10 (77%) were closed. The table below provides a breakdown of the position based on the priority level of the recommendations.</td></tr>
</table>

<table>
<tr><th>Opinion Area</th><th>Commentary</th></tr>
<tr><td></td><td>
<table>
<tr><th></th><th>Due in the year to 31 March 2022</th><th>Closed</th><th>Outstanding</th></tr>
<tr><td>High</td><td>4</td><td>2 (50%)</td><td>2(50%)</td></tr>
<tr><td>Medium</td><td>9</td><td>8 (89%)</td><td>1 (11%)</td></tr>
<tr><td>Total</td><td>13</td><td>10 (77%)</td><td>3 (23%)</td></tr>
</table>

During the year all recommendations made in reports have been routinely followed up using our automated software and reported to the Audit Committee at each meeting during 2021/22. As outlined in the section above the remaining high risk actions have renewed target dates and the current risk of business interruption is substantially lessened with the transition of the email platform.
</td></tr>
<tr><td>Significant factors outside the work of internal audit</td><td>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 outsources many of its functions, assurances from third parties are equally as important when the CCG draws up its Annual Governance Statement.

The main ones usually received that we have been made aware of are summarised below:

• Payroll services are provided by NHS Payroll Services hosted by Northumbria Healthcare NHS Foundation Trust. The CCG, through its membership of the Payroll Consortium, receives an annual assurance letter setting out the results of the internal audit work carried out during the year.

• The CCG outsources many of its support services to the North of England Commissioning Support Unit (NECS), hosted by NHS England, under a signed service level agreement. Assurance on the operation of</td></tr>
</table>

Opinion Area	Commentary
	certain financial and payroll controls will be provided by NHS England's internal auditors, Deloitte LLP, via an ISAE 3402 Type II report. • Assurance in respect of the operation of the finance and accounting services provided by NHS Shared Business Services (SBS) is provided by the NHS SBS' auditors on an annual basis. • Assurance in respect of the primary care support services provided from Capita Business Services Limited to NHS England and CCGs is provided by Capita's auditors, Mazars, on an annual basis. • Assurance in respect of the operation of the prescription payments process provided by NHS Business Service Authority and Capita is provided by the NHS BSA's auditors, PwC LLP, via an ISAE 3402 Type II report on an annual basis. • Assurance in respect of the operation of the NHS GP Payment Service provided by NHS Digital for is provided by the NHS Digital's auditors, PwC LLP, via an ISAE 3402 Type II report issued on an annual basis. • Your counter fraud specialist is required to submit an annual Counter Fraud Functional Standard Return (CFFSR) (formerly known as the Self Review Tool) to the NHS Counter Fraud Authority (NHSCFA) in relation to the CCG's counter fraud, bribery and corruption arrangements. This provides an overview of the CCG's counter fraud activity, progress against NHSCFA requirements and assists the Chief Finance Officer (CFO) and Audit Committee in monitoring and managing the counter fraud service. The CFFSR for 2021/22 will be reviewed and approved by both the Audit Committee chair and CFO prior to the submission deadline. The CCG's overall rating for 2021/22 will be confirmed following CFFSR approval. The CCG has not been subject to an NHSCFA engagement meeting in 2021/22.

Opinion Area	Commentary
	• The Electronic Staff Record (ESR) service is provided by IBM. An ISAE 3000 Type II report covering the operation of the national system is issued on an annual basis by their external auditors, PwC LLP. It is for the CCG to decide what assurance to take from these reports and whether any of the weaknesses identified should be included within the CCG's Annual Governance Statement. Nevertheless, I can advise the Governing Body that the work on the outsourced payroll functions will have been undertaken in accordance with the Public Sector Internal Audit Standards.

In providing this opinion, it is important to recognise the additional limitations on our work caused by the COVID-19 pandemic. These limitations include access to CCG personnel and the timely supply of information that would be available to us under normal circumstances. However, as your Head of Internal Audit I am satisfied that we have sufficient evidence, to provide the Trust with a robust Head of Internal Audit Opinion. I would like to take this opportunity to thank the staff at North Cumbria CCG for the co-operation and assistance provided to my team during the year.

Carl Best
Associate Director of Audit, AuditOne
Date: 15 June 2022

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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the CCG who 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 improvements in the Audits undertaken on the Risk Assurance Framework, Managing Conflicts of Interest and Governance Structures, comments made by the external auditors in their annual audit letter and other reports which have been provided throughout the year.

The CCG's 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. The CCG also has strong connections not only in the North Cumbria Health System but across the Integrated Care Systems in the North East and the North West.

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

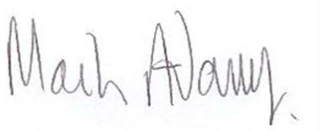
- the Governing Body;
- the Audit committee;
- the Finance & Performance committee;
- the Quality and Outcomes Assurance Committee; and
- Internal audit

The CCG has a programme of continuous improvements and will continue to review how it undertakes its duties to ensure that they are delivered in an effective and efficient way.

As Accountable Officer I work closely with the Chief Finance Officer who is the Senior Information Risk Owner (SIRO) and leads on the CCG Assurance Framework. This framework details the principal risks to the CCG achieving its objectives. During 2021/22 a review of these arrangements have been undertaken and have been set out in the Risk Management Arrangements and Effectiveness of this report.

Conclusion

At the time of writing this report a system of internal control has been maintained throughout the year and up to the date of the submission of this draft annual report and accounts. Based on the work undertaken in 2021/22, and the substantial assurance has been provided by the Head of Internal Audit (although draft at this stage and is subject to further work) that there is a generally sound system of internal control, designed to meet the CCG's objectives, and that the controls are generally being consistently applied. No significant issues have been identified.



Mark Adams, Accountable Officer, 17 June 2022

Remuneration and Staff Report

Remuneration Committee

The Remuneration Committee is a non-executive committee of the Governing Body and was established in accordance with the CCG's Constitution.

The Remuneration Committee is responsible making recommendations to the Governing Body about appropriate remuneration and terms of service for all posts above the top threshold of the National Agenda for Change (AfC) pay-scale, including off-payroll appointments, including:

- all aspects of salary (including any performance-related elements / bonuses);
- provisions for other benefits e.g. car allowances
- advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

The membership consists of:

Members Name	Role
Carole Green	Lay Member for Quality & Performance
Denise Lesley	Lay Member for Public Engagement
John Whitehouse	Lay Member for Finance & Governance (Chair)
Deb Lee	Secondary Care Doctor

The Remuneration Committee has not met during the 2021/22 financial year. This was due to the fact that the NHS Ministers' recommendation on 2021/22 annual pay increase for very senior managers (VSMs) issued on 8 September 2021 was due to be considered by a Remuneration Committee in Common from across the North East & North Cumbria Integrated Care System. This would have been made up of the Chair of each CCG's Remuneration Committee. However, unfortunately this meeting was not convened.

Therefore, North Cumbria CCG's Remuneration Committee met on 19 April 2022 to consider the above and their recommendations were approved at the Part 2 Governing Body meeting on 19 May 2022.

Policy on the remuneration of senior managers

The CCG remains committed to the principles it adopted to ensure that it is in a position to attract and retain high quality senior officers. This includes maintaining salaries at a competitive level, whilst taking into account the previous level of experience of post holders; application of appropriate promotional increases to new appointees and application of relevant percentage increases (as determined at national level), all whilst recognising the restraint on the public purse.

As part of the steps the CCG takes to satisfy itself the remuneration is reasonable, the Remuneration Committee also takes cognisance of the following reference and policy documents:

- NHS Commissioning Board (NHSCB) Clinical Commissioning Groups: Remuneration Guidance for Chief Officers (where the senior manager also undertakes the Accountable Officer role) and Chief Finance Officer
- The Hay Group CCG Remuneration Guidance on GPs Remuneration in CCGs in North West England
- Tenon Technical Employment Status Guidance – tax, national insurance and superannuation implications for GPs involved in Clinical Commissioning Group roles
- Agenda for Change and VSM pay frameworks
- Equal pay for equal work
- The Seven Principles of Public Life, referred to as the Nolan Principles
- Standards of Governing Body Members
- Hutton Fair Pay principles

Remuneration of Very Senior Managers

The CCG has 4 posts which receive remuneration in excess of £150,000 pro-rata per annum; all except 1 are part time.

These posts are all clinical roles (Doctor level) and are broken down as follows:

- Governing Body x 4 posts (1 full time)

Remuneration for these posts was approved by the Remuneration Committee as per the steps outlined above.

Senior Manager Remuneration (including salary and pension entitlements) subject to Audit

Name	Title	Note	2021-22				2020-21			
			Salary (bands of £5,000)	Expense payments (taxable) (Note 9) (rounded to the nearest £100)	All pension-related benefits (Notes 10,11) (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) (Note 9) (rounded to the nearest £100)	All pension-related benefits (Notes 10,11) (bands of £2,500)	TOTAL (bands of £5,000)
			£000	£	£000	£000	£000	£	£000	£000
Governing Body Members										
Jon Rush	Lay Chair	1	45-50	-	-	45-50	60-65	-	-	60-65
Mark Adams	Accountable Officer	2	40-45	-	-	40-45	40-45	-	-	40-45
Anna Stabler	Director of Quality & Nursing	3					35-40	-	65-67.5	100-105
Louise Mason-Lodge	Acting Director of Quality & Nursing / Designated Nurse- Safeguarding Children and Adults	3	90-95	4,600	-	95-100	90-95	4,600	-	95-100
Dr Deb Lee	Clinical Member: Secondary Care Clinician	4	25-30	-	-	25-30	25-30	-	-	25-30
Carole Green	Lay Member: Quality & Performance	4	10-15	-	-	10-15	10-15	-	-	10-15
John Whitehouse	Lay Member: Finance & Governance	4	10-15	-	-	10-15	10-15	-	-	10-15
Denise Leslie	Lay Member: Patient & Public Engagement	4	10-15	-	-	10-15	10-15	-	-	10-15
Charles Welbourn	Chief Finance Officer		115-120	6,400	32.5-35	155-160	115-120	9,100	27.5-30	150-155
Peter Rooney	Chief Operating Officer		115-120	1,200	32.5-35	150-155	115-120	8,900	30-32.5	155-160
Dr Colin Patterson	Clinical Lead: Primary Care & ICC development / Deputy Chair / Interim Medical Director	5	130-135	-	45-47.5	175-180	140-145	-	35-37.5	175-180
Dr Amanda Boardman	Clinical Lead: Safeguarding, Maternity, Children, Mental Health & Learning Disability		155-160	-	40-42.5	195-200	155-160	-	32.5-35	185-190
Ed Tallis	Director of Primary Care	6	105-110	-	25-27.5	130-135	75-80	-	10-12.5	85-90
Dr Helen Horton	GP Lead: Commissioning & Specialised Commissioning		60-65	-	15-17.5	75-80	60-65	-	10-12.5	70-75
Dr Gareth Coakley	Chief Clinical Information Officer	7	75-80	-	17.5-20	95-100	100-105	-	20-22.5	120-125
Other Senior Managers										
Caroline Rea	Director of Primary Care & ICC Development	6					25-30	-	-	25-30
Stephen Singleton	Clinical Director CLIC	8					25-30	-	-	25-30

Note:

1 Jon Rush's tenure as Chair was due to end on 31 March 2022 but has been extended to 30 June 2022 ; this is the current expected cloesdown date of the CCG but is subject to the passage and approval of the Health and Care Bill which includes the establishment of Integrated Care Boards and means that until 1 July 2022 the current CCG statutory arrangements will remain in place. Jon increased his sessions from 3 to 4 sessions per week effective 1 April 2019 and received £10-15k backdated pay relating to 2019-20 in April 2020.

2 Mark Adams was appointed as Acting Accountable Officer by NHS England effective 1 April 2020 and confirmed as Accountable Officer from 1 June 2020. Mark is employed as Accountable Officer by NHS Newcastle Gateshead CCG and works for NHS North Tyneside CCG, NHS Northumberland CCG and NHS North Cumbria CCG as part of a staff sharing arrangement.The salary disclosed above relates to North Cumbria CCG's share of remuneration of 25%. Pension benefits are reported in full by Newcastle Gateshead CCG.

3 Anna Stabler left the CCG 5 July 2020 having been on secondment to North Cumbria Integrated Care NHS Foundation Trust (NCIC) from 1 January 2020 and did not act as a CCG Governing Body member for the period of the secondment. Louise Mason-Lodge was covering the role as Acting Director of Nursing & Quality from 1 January 2020 until 27 July 2020 when she was appointed substantively to the role.

4 Lay members receive a flat daily rate and thus remuneration received reflects the number of days worked. The Lay members' tenure have been extended to 30 June 2022 ; this is the current expected cloesdown date of the CCG but is subject to the passage and approval of the Health and Care Bill which includes the establishment of Integrated Care Boards and means that until 1 July 2022 the current CCG statutory arrangements will remain in place. Deborah Lee's remuneration includes £10-15k relating to a non-managerial role.

5 Colin Patterson was appointed Deputy Chair 1 April 2020 ; Colin increased his sessions from 8 to 10 sessions per week for the 3 months April to June 2020 to support COVID-19 panademic work, reduced to 9 sessions per week for the 3 months July to September 2020 and then worked 8 sessions per week from October 2020 onwards.

6 Ed Tallis joined the CCG as Director of Primary Care on 8 July 2020 taking over the role from Caroline Rea who retired on 30 June 2020.

7 Gareth Coakley joined the CCG 1 November 2018 working 2 sessions per week to 1 Feb 2020 when his sessions increased to 4 per week; Gareth's sessions were increased from 4 to 8 per week for the 3 months April to June 2020 to support COVID-19 panademic work ; Gareth reduced his sessions from 8 to 6 for the 3 months July to September 2020 and then to 4 sessions from October to 12 November when increased to 6 sessions until 1 December when increased to 7 sessions to 31 March 2021 when he then reduced to 5 sessions per week onwards.

8 Stephen Singleton retired on 30 June 2020.

9 Expense payments relate to taxable benefits of lease cars.

10 All pensions related benefits information is provided by NHS Pensions. The value of pensions 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 pensions 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.

11 Stephen Singleton and Caroline Rea (from 1.11.19) were already in receipt of pension. Louise Mason-Lodge is not in the NHS Pension Scheme. As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

Staff sharing arrangements for senior manager remuneration 2021-22

Mark Adams is employed by Newcastle Gateshead CCG and works for North Cumbria CCG, North Tyneside CCG and NHS Northumberland CCG as part of a staff sharing arrangement. No other post-holder is shared under joint management arrangements with any other CCG. The total remuneration earned for all work across the four CCGs is shown below:

Name	Title	2021-22 Salary (bands of £5,000)	2021-22 Expense payments (taxable) (Note 9) (rounded to the nearest £100)	2021-22 TOTAL (bands of £5,000)	2020-21 Salary (bands of £5,000)	2020-21 Expense payments (taxable) (Note 9) (rounded to the nearest £100)	2020-21 TOTAL (bands of £5,000)
		£000	£	£000	£000	£	£000
Mark Adams	Accountable Officer	170-175	-	170-175	170-175	-	170-175

No performance pay and bonuses were paid during the year ended 31 March 2022 (2020-21 £nil).

No long term performance pay and bonuses were paid during the year ended 31 March 2022 (2020-21 £nil).

Pension benefits (subject to Audit)

Name		Note	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
Amanda Boardman	Clinical Lead: Children's Commissioning, Mental Health, Learning Disability & Safeguarding		2.5-5	0-2.5	35-40	40-45	543	40	609
Gareth Coakley	Chief Information Officer		0-2.5	0-2.5	15-20	30-35	201	9	223
Helen Horton	Commissioning GP: Specialised Commissioning & Pathway development, Map of Medicine & IFR		0-2.5	0-2.5	15-20	25-30	209	11	230
Colin Patterson	Clinical Lead: Primary Care & ICC development / Deputy Chair		2.5-5	-	20-25	45-50	408	31	459
Peter Rooney	Chief Operating Officer		0-2.5	0-2.5	35-40	55-60	512	24	555
Ed Tallis	Director of Primary Care		0-2.5	0-2.5	20-25	55-60	461	26	504
Charles Welbourn	Chief Finance Officer		2.5-5	0-2.5	45-50	95-100	904	41	966

Note: Pension related benefits information is provided by NHS Pensions and excludes general practitioner pension contributions.

There were no contributions to stakeholder pensions.

The pension figures shown relate to the benefits that individuals have accrued as a consequence of their total membership of the scheme.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Cash equivalent transfer values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real increase in CETV

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

Compensation on early retirement for loss of office

There were no payments made for compensation on early retirement or loss of office made to senior managers of the CCG in 2021/22.

Payments to past directors

No payments have been made to past members in 2021/22.

Fair pay disclosures (subject to Audit)

Percentage change in remuneration of highest paid director		
	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	0%	N/A
The average percentage change from the previous financial year in respect of employees of the entity, taken	-7%	N/A

The average remuneration has reduced year-on-year as a result of a reduction in the number of higher paid directors who left during 2020-21 as detailed in the Salaries & Allowances table.

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest paid member of the Governing Body 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 banded remuneration of the highest paid member of the Governing Body of the Clinical Commissioning Group in the financial year 2021-22 was £162.5k (2020-21, £162.5k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Pay ratio information table	25th percentile	Median	75th percentile
2021-22			
Total Remuneration (£)	29,294	41,378	65,707
Salary Component of total remuneration (£	29,294	40,057	65,664
Pay ratio information	5.55	3.93	2.47
2020-21			
Total Remuneration (£)	30,781	40,988	73,516
Salary Component of total remuneration (£	30,781	40,894	73,516
Pay ratio information	5.28	3.96	2.21

In 2021-22 1 employee (2020-21, 1 employee) received remuneration in excess of the highest paid member of the Governing Body. Remuneration packages ranged from £13k to £162k (2020-21 £21k to £180k).

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

Staff Report

Number of Senior Managers

The CCG has a total of:

- Two Directors at Very Senior Managers (VSM) pay
- Two Directors at Agenda for Change band 9 pay
- Four Clinical Leads at Clinical/Medical pay

Staff number and costs

Total CCG Employee benefits (subject to audit)

	2021-22		
Employee Benefits	Permanent Employees	Other	Total
	£'000	£'000	£'000
Salaries and wages	3,556	71	3,627
Social security costs	396	6	402
Employer contributions to the NHS Pension Scheme	653	6	659
Other pension costs	2	-	2
Apprenticeship Levy	4	-	4
Employee benefits expenditure	4,611	83	4,694

	2020-21		
Employee Benefits	Permanent Employees	Other	Total
	£'000	£'000	£'000
Salaries and wages	3,408	86	3,494
Social security costs	378	8	386
Employer contributions to the NHS Pension Scheme	631	6	637
Other pension costs	1	-	1
Apprenticeship Levy	3	-	3
Employee benefits expenditure	4,421	100	4,521

Average number of people employed (subject to audit)						
	2021-22			2020-21		
	Permanent	Other	Total	Permanent	Other	Total
	Number	Number	Number	Number	Number	Number
Medical and dental	3	-	3	3	0	3
Administration and estates	56	1	57	57	1	58
Nursing, midwifery and health visiting staff	4	-	4	1	0	1
Total	63	1	64	61	1	62

Staff composition

The table below provides an analysis of gender distribution for CCG Governing Body members, other senior managers not included in Governing Body and all other employees not included in either of the previous two categories:

	MALE	FEMALE
Governing Body Members	**8**	**6**
All other senior managers, including all managers at grade VSM, not included above	**0**	**0**
All other employees not included in either of the previous 2 categories	**4**	**71**
TOTAL	**12**	**77**

Sickness absence data

All sickness absence at the CCG is managed in line with the sickness absence policy. This policy enables managers to address sickness absence issues, both short and long-term, in a fair, consistent and equitable manner. It is recognised however that all cases must be dealt with on an individual basis because of differing circumstances. Managers and staff have access to the Occupational Health Service as appropriate.

FTE Days Lost	Headcount	FTE	Average FTE Days lost / Headcount	Average FTE Days lost / fte
951.96	91	71.44	10.46	13.32

There were no ill-health retirements in 2021/22.

Staff turnover percentages

The annual staff turnover for 2021/22 was 17.34%

Staff policies

The CCG is committed to equality of opportunity for all employees and is committed to employment practices, policies and procedures which ensure that no employee, or potential employee, receives less favourable treatment on the grounds of any protected characteristics.

The promotion of equality, diversity and inclusion will be actively pursued through policies and the CCG will ensure that employees receive fair, equitable and consistent treatment and ensure that employees, and potential employees, are not subject to direct or indirect discrimination. Equality Impact Assessments are also carried out on any developed policies to ensure there is no impact.

The CCG has a suite of policies in place including;

- Sickness Absence
- Management of Organisational Change
- Flexible Working
- Other Leave
- Performance Management
- Disciplinary
- Grievance
- Raising Concerns (Whistleblowing)
- Pay progression

Trade Union (Facility Time Publication Requirements) Regulations 2017
NHS North Cumbria CCG Report for 2021/22

In compliance with the above Regulations the following information is provided:

Relevant union officials

The total number of employees who were relevant union officials during 1 April 2021 to 31 March 2022 is:

Number of employees who were relevant union officials during the relevant period	Full time equivalent number
0	0

Percentage of time spent on facility time

The number of employees who were relevant union officials employed during 1 April 2020 to 31 March 2021 spent their working hours on facility time as follows:

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

Percentage of pay bill spent on facility time

The percentage of the total pay bill spent on paying employees who were relevant union officials for facility time during 1 April 2021 to 31 March 2022 is:

Total cost of facility time	Nil
Total pay bill	£4,964,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time/total pay bill)x100	0%

Paid trade union activities

As a percentage of total paid facility time hours, the number of hours that was spent by employees who were relevant union officials during 1 April 2021 to 31 March 2022 on paid trade union activities was:

Time spent on paid trade union activities as a percentage of total paid facility time hours, calculated as: (total hours spent on paid trade union activities by relevant union officials during relevant period / total paid facility time hours)x100	0%

Expenditure on consultancy

There was £127k consultancy expenditure with PA Consulting who worked with the CCG to support financial recovery across North Cumbria in 2021/22.

Losses and special payments

The total number of Clinical Commissioning Group losses and special payments cases, and their total value, was as follows:

Losses

	Total Number of Cases 2021-22 Number	**Total Value of Cases 2021-22 £'000**	Total Number of Cases 2020-21 Number	Total Value of Cases 2020-21 £'000
Administrative write-offs	9	10	-	-
Total	**9**	**10**	-	-

The Clinical Commissioning Group made no special payments in 2021-22 (2021-21: nil).

Off-payroll engagements

For all off-payroll engagements as of 31 March 2022, for more than £245 per day.

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

For all off-payroll engagements as of 31 March 2022, for more than £245 per day:

	Number
Number of existing arrangements as of 31 March 2022	2
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	-

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

For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245 per day:

	Number
Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	2
Of which:	
number not subject to off-payroll legislation[1]	1
number subject to off-payroll legislation and determined as in scope of IR35[2]	1
number subject to off-payroll legislation and determined as out of scope of IR35	-
number of engagements reassessed for compliance or assurance purposes during the year	-
Of which : number of engagements that saw a change to IR35 status following the consistency review	-

[1]see table below

[2]The temporary worker in scope of IR35 is paid via the CCG's payroll.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	1
Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	14

Mark Adams joined the CCG on 1 April 2020 and is employed as Accountable Officer by NHS Newcastle Gateshead CCG and also works for NHS North Tyneside CCG, NHS Northumberland CCG and NHS North Cumbria CCG as part of a staff sharing arrangement. The CCG are recharged for his gross costs via invoice.

Exit Packages (subject to Audit)

There were no exit packages in 2021-22.

Parliamentary Accountability and Audit Report

NHS North Cumbria CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes pages 122-134 in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report at page 135.

ANNUAL ACCOUNTS

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

	Note	2021-22 £'000	2020-21 £'000
Income from sale of goods and services	3	**(157)**	(148)
Other operating income	3	**(411)**	(868)
Total operating income		**(568)**	(1,016)
Staff costs	4	**4,694**	4,521
Purchase of goods and services	5	**741,143**	666,762
Depreciation charges	5	**-**	3
Other operating expenditure	5	**111**	126
Total operating expenditure		**745,948**	671,412
Comprehensive expenditure for the year		**745,380**	670,396

The notes 2 to 5 on pages 127 to 129 form part of this statement

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Intangible assets	8	**-**	-
Total non-current assets		**-**	-
Current assets:			
Trade and other receivables	9	**2,207**	5,705
Cash	10	**105**	19
Total current assets		**2,312**	5,724
Total assets		**2,312**	5,724
Current liabilities:			
Trade and other payables	11	**(36,298)**	(27,461)
Provisions	12	**-**	(3)
Total current liabilities		**(36,298)**	(27,464)
Assets less liabilities		**(33,986)**	(21,740)
Financed by Taxpayers' Equity			
General fund		**(33,986)**	(21,740)
Total taxpayers' equity:		**(33,986)**	(21,740)

The notes 8 to 12 on pages 130 to 132 form part of this statement

The financial statements on pages 118 to 121 were approved by the Audit Committee, under delegation from the Governing Body, on 17 June 2022 and signed on its behalf by:

Accountable Officer
Mark Adams

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

	2021-22 General fund £'000	2020-21 General fund £'000
Balance at 1 April	**(21,740)**	(8,348)
Changes in taxpayers' equity for the financial year		
Net operating expenditure for the financial year	**(745,380)**	(670,396)
Net recognised expenditure for the financial year	**(745,380)**	(670,396)
Net funding	**733,134**	657,004
Balance at 31 March	**(33,986)**	(21,740)

Statement of Cash Flows for the year ended 31 March 2022

	Note	**2021-22 £'000**	2020-21 £'000
Cash flows from operating activities:			
Net operating expenditure for the financial year		**(745,380)**	(670,396)
Amortisation	5,8	**-**	3
Decrease in trade & other receivables	9	**3,498**	3,654
Increase in trade & other payables	11	**8,837**	9,740
Provisions utilised	12	**(3)**	-
Net cash outflow from operating activities		**(733,048)**	(656,999)
Net cash outflow before financing		**(733,048)**	(656,999)
Cash flows from financing activities:			
Net funding received		**733,134**	657,003
Net cash inflow from financing activities		**733,134**	657,003
Net increase in cash	10	**86**	5
Cash at the beginning of the financial year		**19**	14
Cash at the end of the financial year		**105**	19

The notes 5 to 12 on pages 129 to 132 form part of this statement

DRAFT NOTES TO THE FINANCIAL STATEMENTS

1. Accounting policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis despite the issue of a report to the Secretary of State for Health and Social Care under Section 30b of the Local Audit and Accountability Act 2014.

The Health and Care Act 2022 received Royal Assent on 28 April 2022. The Act allows for the establishment of Integrated Care Boards (ICB) across England and abolishes Clinical Commissioning Groups (CCG). ICBs are due to take on the commissioning functions of CCGs from 1 July 2022 and the CCG functions, assets and liabilities are due to transfer to the North East and North Cumbria ICB as at 1 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 Clinical Commissioning Group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the Financial Statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022 on a going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 Movement of Assets within the Department of Health Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care Group Accounting Manual requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure and is disclosed separately from operating costs.

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

1.4 Joint Arrangements

Arrangements over which the Clinical Commissioning Group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Clinical Commissioning Group is a joint operator it recognises its share of assets, liabilities, income and expenses in its own accounts.

The Clinical Commissioning Group has entered into a pooled budget arrangement with Cumbria County Council and NHS Morecambe Bay Clinical Commissioning Group under Section 75 of the National Health Service Act 2006 (as amended). Under the arrangement, funds are pooled for developing an integrated approach between health and social care. Note 17 provides details of the income and expenditure.

The pooled budget is hosted by Cumbria County Council. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.5 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Clinical Commissioning Group. The Clinical Commissioning Group considers it has only one segment: commissioning of healthcare services.

1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

- As per paragraph 121 of the Standard the Clinical Commissioning Group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less.
- The Clinical Commissioning Group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

1. Accounting policies (continued)

1.6 Revenue (continued)

- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Clinical Commissioning Group to reflect the aggregate effect of all contracts modified before the date of initial application.

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

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

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

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

1.7 Employee Benefits

1.7.1 Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid.

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.

1.7.2 Retirement benefit costs

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

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

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

1.8 Other expenses

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

1.9 Intangible Non-current Assets

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

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

Intangible non-current assets acquired separately are initially recognised at cost. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Following initial recognition, intangible non-current assets are carried at depreciated historic cost as a proxy for current value in existing use.

1.10 Amortisation & Impairments

Amortisation is charged to write off the costs or valuation of intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Clinical Commissioning Group expects to obtain economic benefits or service potential from the asset. This is specific to the Clinical Commissioning Group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

At each reporting period end, the Clinical Commissioning Group checks whether there is any indication that any of its intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

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

1. Accounting policies (continued)

1.11 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.11.1 The Clinical Commissioning Group as lessee

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

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

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

1.12 Cash

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

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

1.13 Provisions

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

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

- A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

1.14 Clinical Negligence Costs

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

1.15 Non-clinical Risk Pooling

The Clinical Commissioning Group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Clinical Commissioning Group pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses as and when they become due.

1.16 Contingent liabilities and contingent assets

A contingent liability is:

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

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

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

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1. Accounting policies (continued)

1.17 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.17.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.17.2 Impairment

For all financial assets measured at amortised cost, the Clinical Commissioning Group recognises a loss allowance representing the expected credit losses on the financial asset.

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

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

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

1.18 Financial Liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Clinical Commissioning Group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

After initial recognition, 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 net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.19 Value Added Tax

Most of the activities of the Clinical Commissioning Group 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. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Foreign Currencies

The Clinical Commissioning Group’s functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Clinical Commissioning Group’s surplus/deficit in the period in which they arise.

1.21 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

In the application of the Clinical Commissioning Group’s accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.21.1 Critical Judgements in Applying Accounting Policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Clinical Commissioning Group’s accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- None.

1. Accounting policies (continued)

1.21 Critical Accounting Judgements and Key Sources of Estimation Uncertainty (continued)

1.21.2 Key Sources of Estimation Uncertainty

There are considered to be no sources of estimation uncertainty that are likely to have a material effect on the amounts recognised in the Clinical Commissioning Group's financial statements.

- Estimates are inherent in a number of operational areas including accruals for prescribing costs, and expenditure dependent on

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

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022-23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- **IFRS 16 Leases** – IFRS 16 Leases has been deferred until 1 April 2022.

  IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

  IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Clinical Commissioning Group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

  On transition to IFRS 16 on 1 April 2022, the Clinical Commissioning Group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Clinical Commissioning Group's incremental borrowing rate. The Clinical Commissioning Group's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

  For leases commencing in 2022/23, the Clinical Commissioning Group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

  The Clinical Commissioning Group has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income as follows:

	£'000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	2,613
Additional lease obligations recognised for existing operating leases	(2,613)
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	255
Additional finance costs on lease liabilities	24
Lease rentals no longer charged to operating expenditure	(268)
Estimated impact on surplus / deficit in 2022/23	11

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

2. Financial performance targets

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

NHS Clinical Commissioning Group performance against those duties was as follows:

NHS Act section	Duty	2021-22 Target £'000	2021-22 Performance £'000	2021-22 Duty Achieved	2020-21 Target £'000	2020-21 Performance £'000	2020-21 Duty Achieved
223H (1)	Expenditure not to exceed income	**731,252**	**745,948**	**No**	657,457	671,412	No
223I (2)	Capital resource use does not exceed the amount specified in Directions	**-**	**-**	**Yes**	-	-	Yes
223I (3)	Revenue resource use does not exceed the amount specified in Directions	**730,684**	**745,380**	**No**	656,441	670,396	No
223J (1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	**-**	**-**	**Yes**	-	-	Yes
223J (2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	**-**	**-**	**Yes**	-	-	Yes
223J (3)	Revenue administration resource use does not exceed the amount specified in Directions	**6,295**	**5,944**	**Yes**	6,285	6,037	Yes

Note: for the purposes of 223H(1) expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amount accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

The Clinical Commissioning Group has not met the statutory requirement '223H(1) Expenditure not to exceed income' as the actual 2021-22 expenditure performance is £14.696m over the income received. A formal notification of this position will be made by the CCG's external auditors, Grant Thornton UK LLP, to the NHS Commissioning Board (NHS England) in June 2022. A referral to the Secretary of State under Section 30b of the Local Audit and Accountability Act 2014 will also be made at the same time.

The Clinical Commissioning Group made an in-year overspend (i.e. deficit) of £14.696m against its in-year revenue resource (2020-21: £13.955m in-year deficit), against a planned deficit of £13.992m. The £0.704m variance from the planned deficit represents 0.09% of overall expenditure.

The Clinical Commissioning Group received no capital resource during 2021-22 and incurred no capital expenditure (2020-21: £nil)

3. Other operating revenue

	2021-22 Total	2020-21 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	**157**	148
Total Income from sale of goods and services	**157**	148
Other operating income		
Other non contract revenue[1]	**411**	868
Total Other operating income	**411**	868
Total Operating Income	**568**	1,016

Notes:

[1] £106k lower Primary Care Rebate Scheme monies ; 20/21 non-recurrent funding: £202k cancer funding ; £145k training funding.

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

The Clinical Commissioning Group has received no revenue from the sale of goods in 2021-22 nor 2020-21.

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

	2021-22 Education and training £'000	2020-21 Education and training £'000
Source of Revenue		
NHS	-	-
Non NHS	157	148
Total	**157**	148

	Education and training £'000	Education and training £'000
Timing of Revenue		
Point in time	-	-
Over time	157	148
Total	**157**	148

4. Employee benefits and staff numbers

4.1 Employee benefits

	2021-22			2020-21		
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits						
Salaries and wages	**3,556**	**71**	**3,627**	3,408	86	3,494
Social security costs	**395**	**6**	**401**	378	8	386
Employer Contributions to NHS Pension Scheme[1]	**654**	**6**	**660**	631	6	637
Other pension costs[2]	**2**	**-**	**2**	1	-	1
Apprenticeship Levy	**4**	**-**	**4**	3	-	3
Gross employee benefits expenditure	**4,611**	**83**	**4,694**	4,421	100	4,521

Notes:

[1] The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1 April 2019. For 2021-22, NHS Clinical Commissioning Groups continued to pay over contributions at the former rate with the additional amount being paid by NHS England on the Clinical Commissioning Groups' behalf. The full cost of £203,433 (2020-21 £194,485) and related funding has been recognised in these accounts.

[2] Contributions made to NEST workplace pension scheme.

4.2 Average number of people employed

	2021-22			2020-21		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**63**	**1**	**64**	61	1	62

4.3 Exit packages agreed in the financial year

The Clinical Commissioning Group did not agree any exit packages in 2021-22 nor 2020-21.

4.4 Pension costs

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

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

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

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

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

4. Employee benefits and staff numbers (continued)

4.4.2 Full actuarial (funding) valuation (continued)

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

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

5. Operating expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	**3,172**	4,779
Services from NHS Foundation Trusts[1]	**485,119**	413,978
Services from other NHS Trusts	**22,943**	22,122
Purchase of healthcare from non-NHS bodies	**98,859**	97,980
Purchase of social care	**70**	177
Prescribing costs	**58,858**	59,792
GPMS/APMS and PCTMS	**66,552**	61,604
Supplies and services – clinical	**2**	2
Supplies and services – general	**2,149**	2,090
Consultancy services	**127**	-
Establishment	**1,793**	2,255
Transport	**1**	0
Premises	**678**	1,048
Audit fees[2]	**65**	61
Audit related assurance services[3]	**6**	24
Other professional fees[4]	**195**	213
Legal fees	**71**	102
Education, training and conferences	**483**	537
Total Purchase of goods and services	**741,143**	666,762
Depreciation charges:		
Amortisation	**-**	3
Total depreciation charges	**-**	3
Other Operating Expenditure		
Chair and Non Executive Members	**110**	125
Clinical negligence	**1**	1
Total Other Operating Expenditure	**111**	126
Total operating expenditure	**741,254**	666,891

Notes:

[1] Due to COVID pandemic NHS England advised of block payment values to main providers: £70.8m greater payments to North Cumbria Integrated Care NHS Foundation Trust.

[2] The audit fee is inclusive of VAT (i.e. £53.3k plus VAT). The auditor's liability for external work carried out for the financial year 2021-22 is limited to £2,000,000.

[3] Assurance engagement £12k fee for reviewing compliance with Mental Health Investment Standard of 2019-20 ; the assurance review for 2020-21 was cancelled and so the £12k accrual was released but an increased £18k fee has been accrued for the 2021-22 review.

[4] Includes internal audit and counter fraud services provided by Audit One at a cost of £36k for 2021-22 (£34k 2020-21).

The NHS has continued in 2021-22 to work in a special COVID financial regime that was initially established during 2020-21 that includes a number of key transactional changes from previous financial years:

- All payments by CCGs to NHS Trusts are on the basis of nationally agreed “block” contracts including support funding in for operational and COVID costs for which the CCG received funding allocations.
- CCGs have received funding allocations to cover reasonable expenditure incurred in addressing the challenge of COVID. Similarly, further allocations were provided to support primary care providers in addressing the challenge of the pandemic.
- NHS continuing health care (CHC) was effectively suspended for patients discharged from hospital from mid-March until 1 September with costs of their on-going care funded from the national hospital discharge programme (HDP). From September 2020 this was limited to cover the first 6 weeks after discharge and then to the first 4 weeks after discharge from July 2021.

6. Better Payment Practice Code

Measure of compliance	2021-22 Number	2021-22 £'000	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	21,753	165,055	22,562	158,548
Total Non-NHS Trade Invoices paid within target	21,548	164,293	22,379	157,813
Percentage of Non-NHS Trade invoices paid within target	**99.06%**	**99.54%**	99.19%	99.54%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	412	514,261	994	437,376
Total NHS Trade Invoices Paid within target	408	514,246	989	437,250
Percentage of NHS Trade Invoices paid within target	**99.03%**	**100.00%**	99.50%	99.97%

The Better Payment Practice Code requires the Clinical Commissioning Group to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Clinical Commissioning Group has achieved the set target to pay 95% of invoices within this requirement.

The volume and value of invoices processed has decreased and increased respectively year-on-year as a result of the COVID pandemic. NHS England and Improvement determined monthly block and top-up payment values for NHS providers ; NHS providers could not raise invoices for activity in either year, in particular with regards to non-contracted activity (NCA) which are high volume but low value transactions. In the early part of 2020-21 NCA invoices relating to the prior year were still received and processed.

7. Operating leases

The Clinical Commissioning Group has arrangements in place with NHS Property Services Ltd and Community Health Partnerships Ltd in respect of the utilisation of various clinical and non-clinical properties. The Clinical Commissioning Group moved premises in the summer 2020 to a shared building with the local authority and NHS provider which has a lower occupancy cost. Although formal signed contracts are not in place for these properties, the transactions involved do convey the right to use property assets and accordingly the payments made in in each year are disclosed as minimum lease payments in note 7.1.

While our arrangements for the utilisation of various clinical and non-clinical properties fall within the definition of operating leases, the rental charge for future years has not yet been agreed and consequently no disclosure of future minimum lease payments for these arrangements is made for buildings in note 7.2.

The Clinical Commissioning Group does not act as lessor.

7.1 Payments recognised as an expense

	2021-22 Buildings £'000	2020-21 Buildings £'000
Payments recognised as an expense		
Minimum lease payments	**287**	313
Total	**287**	313

7.2 Future minimum lease payments

	Buildings £'000	Buildings £'000
Payable:		
Total	**-**	**-**

8. Intangible non-current assets

	2021-22 Computer Software: Purchased £'000	2020-21 Computer Software: Purchased £'000
Cost at 1 April	**9**	9
Cost at 31 March	**9**	9
Amortisation 1 April	**9**	6
Charged during the year	**-**	3
Amortisation at 31 March	**9**	9
Net Book Value at 31 March 2022	**-**	-

8.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	1	3

9. Trade and other receivables

9.1 Trade and other receivables

	Current 31-March-2022 £'000	Current 31-March-2021 £'000
NHS receivables: Revenue[1]	**1,051**	4,746
NHS prepayments	**-**	20
NHS accrued income	**514**	97
Non-NHS and Other WGA receivables: Revenue	**222**	381
Non-NHS and Other WGA prepayments	**344**	426
Expected credit loss allowance-receivables	**(1)**	(10)
VAT	**75**	43
Other receivables and accruals	**2**	2
Total Trade & other receivables	**2,207**	5,705

Notes:

[1] includes £42k (2020-21: £2,345k) debit balances as at 31 March transferred from Trade payables for presentational purposes, these balances will not be received by the Clinical Commissioning Group but netted off against future invoice payments to those relevant suppliers; £1,134k older debt paid by local NHS Trust.

9.2 Receivables past their due date but not impaired

	31-March-2022 DHSC Group Bodies £'000	31-March-2022 Non DHSC Group Bodies £'000	31-March-2021 DHSC Group Bodies £'000	31-March-2021 Non DHSC Group Bodies £'000
By up to three months	**1,413**	**92**	3,795	175
By three to six months	**99**	**1**	66	37
By more than six months	**159**	**98**	1,178	17
Total	**1,671**	**191**	5,039	229

The Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2022 nor 31 March 2021.

The great majority of trade is with other Department of Health and Social Care (DHSC) group bodies. As NHS England is funded by Government to provide funding to Clinical Commissioning Groups to commission services, no credit scoring of them is considered necessary.

9.3 Loss allowance on asset classes

	2021-22 Trade and other receivables - Non DHSC Group Bodies £'000	2020-21 Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 1 April	**(10)**	(10)
Amounts written off	**9**	-
Balance at 31 March	**(1)**	(10)

9.4 Provision Matrix on lifetime credit loss

	31-March-2022 Lifetime expected credit loss rate %	31-March-2022 Gross Carrying Amount £'000	31-March-2022 Lifetime expected credit loss £'000	31-March-2021 Lifetime expected credit loss £'000
Current	0.5%	**9**	**-**	-
1 - 30 days	1.5%	**8**	**-**	-
31 - 60 days	3.0%	**-**	**-**	-
61 - 90 days	10.0%	**-**	**-**	-
Greater than 90 days	25.0%	**1**	**1**	10
Total expected credit loss		**18**	**1**	10

10. Cash

	2021-22 £'000	2020-21 £'000
Balance at 1 April	**19**	14
Net change in year	**86**	5
Balance at 31 March	**105**	19
Made up of:		
Cash with the Government Banking Service	**105**	19
Cash as in statement of financial position	**105**	19

11. Trade and other payables

	Current 31-March-2022 £'000	Current 31-March-2021 £'000
NHS payables: Revenue	**101**	313
NHS accruals	**19**	-
Non-NHS and Other WGA payables: Revenue	**3,786**	3,897
Non-NHS and Other WGA accruals[1]	**31,266**	22,777
Social security costs	**57**	53
Tax	**56**	55
Other payables and accruals[2]	**1,013**	366
Total Trade & Other Payables	**36,298**	27,461

Notes:

[1] Owing to the COVID pandemic and the wider NHS response to it, the timing of transactions has fluctuated considerably during the year and is reflected in the position at year-end. The Clinical Commissioning Group has used all endeavours to pay invoices on time but the pattern and timing of invoices into the Clinical Commissioning Group has varied year-on-year. Accruals impacted by £4m increased continuing healthcare accruals as arrangements have restarted following suspension in 2020-21 and £2m market sustainability accrual with funding having been confirmed in quarter 4.

[2] Other payables include £638,511 outstanding pension contributions at 31 March 2022 (£300,820 at 31 March 2021).

12. Provisions

	Current 31-March-2022 £'000	Current 31-March-2021 £'000
Legal claims	**-**	3
Total	**-**	3

	2021-22 Legal Claims £'000	2020-21 Legal Claims £'000
Balance at 1 April	**3**	3
Utilised during the year	**(3)**	-
Balance at 31 March	**-**	3
Expected timing of cash flows:		
Within one year	**-**	3
Balance at 31 March	**-**	3

Legal claims are calculated from the number of claims currently lodged with the NHS Resolution and the probabilities provided by them. The value of provisions carried in the books of NHS Resolution in regard to clinical negligence claims as at 31 March 2022 is £nil (31 March 2021 £nil).

13. Contingencies

The Clinical Commissioning Group had no contingencies as at 31 March 2022 nor at 31 March 2021 which could be quantified.

The following information is supplied relating to areas where it is not possible to give a reliable cost:
Unreported incidents - in common with many other healthcare providers, it is possible that claims and litigation could arise in the future due to incidents that have already occurred. The future expenditure which may arise from such incidents cannot be determined until such time as claims are made.

14. Commitments

The Clinical Commissioning Group had no contracted capital commitments nor non-cancellable contracts (which were not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2022 nor at 31 March 2021.

15. Financial instruments

15.1 Financial risk management

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

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

15.1.1 Currency risk

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

15.1.2 Interest rate risk

The Clinical Commissioning Group has no borrowings and therefore has low exposure to interest rate fluctuations.

15.1.3 Credit risk

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

15.1.4 Liquidity risk

The Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.

15.2 Financial assets

	Note	**Financial Assets measured at amortised cost 31-March-2022 £'000**	Financial Assets measured at amortised cost 31-March-2021 £'000
Trade and other receivables with NHSE bodies	9	**1,407**	888
Trade and other receivables with other DHSC group bodies*	9	**162**	3,955
Trade and other receivables with external bodies	9	**220**	383
Cash	10	**105**	19
Total at 31 March		**1,894**	5,245

* includes £43k (2020-21 £2,345k) debit balances as at 31 March transferred from Trade payables for presentational purposes, these balances will not be received by the Clinical Commissioning Group but netted off against future invoice payments to those relevant suppliers.

15.3 Financial liabilities

	Note	**Financial Liabilities measured at amortised cost 31-March-2022 £'000**	Financial Liabilities measured at amortised cost 31-March-2021 £'000
Trade and other payables with NHSE bodies	11	**46**	147
Trade and other payables with other DHSC group bodies*	11	**648**	561
Trade and other payables with external bodies*	11	**35,491**	26,645
Total at 31 March		**36,185**	27,353

*mapping of GMS/PMS accruals has changed from other DHSC group bodies in 2020-21 (£4,365k) to external bodies in 2021-22 (£5,900k).

16. Operating segments

The Clinical Commissioning Group considers it has only one segment: commissioning of healthcare services.

17. Joint arrangements - interests in joint operations

The Clinical Commissioning Group operates one pooled fund in partnership with Cumbria County Council under section 75 of the Health Act 2006 (as amended). The Better Care Fund is hosted by Cumbria County Council and there has been no change to the operation of the fund. The Clinical Commissioning Group no longer operates a pooled fund for Learning Disability with Cumbria County Council and Morecambe Bay but continues to work closely with Cumbria County Council to commission arrangements for North Cumbria residents with a Learning Disability.

17.1 Interests in joint operations

The Clinical Commissioning Group's shares of the income and expenditure (North Cumbria) handled by the pooled budget were:

Name of arrangement	Parties to the arrangement	Description of principal activities	2021-22 Income	2021-22 Expenditure	2020-21 Income	2020-21 Expenditure
			£'000	**£'000**	£'000	£'000
Better Care Fund	NHS North Cumbria CCG, NHS Morecambe Bay CCG and Cumbria County Council	To support health and social care services to deliver integrated services	**-**	**26,625**	-	25,354
Learning Disability Specialised Commissioning Pooled Fund	NHS North Cumbria CCG, NHS Morecambe Bay CCG and Cumbria County Council	To commission services to improve the general well-being and life chances of people of all ages with a learning disability	**-**	**-**	-	6,136

18. Related party transactions

Details of related party transactions with individuals are as follows:

During the year none of the Department of Health Ministers, Clinical Commissioning Group Governing Body members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Clinical Commissioning Group, other than the members set out below.

2021-22	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Distington Surgery [Dr H Horton]	**1,501**	-	-	-
Longtown Medical Practice [Dr G Coakley]	**555**	-	-	-

2020-21	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Carlisle Healthcare GP Practice [Dr C Patterson]	**8,460**	-	**3**	-
Distington Surgery [Dr H Horton]	**1,489**	-	-	-
Longtown Medical Practice [Dr G Coakley]	**518**	-	-	-

Transactions are between the Clinical Commissioning Group and the declared organisation, not the individual, and form part of the Clinical

Dr C Patterson is no longer a salaried GP partner at Carlisle Healthcare GP Practice as of April 2020.

The Department of Health and Social Care (DHSC) is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the DHSC is regarded as the parent Department. These entities are:

- Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust
- North Cumbria Integrated Care NHS Foundation Trust
- NHS Business Services Authority (NHS Pension Scheme)
- NHS England (including North of England Commissioning Support Unit)
- North West Ambulance Service NHS Trust
- Northumbria Healthcare NHS Foundation Trust
- The Newcastle Upon Tyne Hospitals NHS Foundation Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- Wrightington, Wigan & Leigh NHS Foundation Trust

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Cumbria County Council and HMRC.

19. Events after the end of the reporting period

The Health and Care Act 2022 received Royal Assent on 28 April 2022. The Bill allows for the establishment of Integrated Care Boards (ICB) across England and abolishes Clinical Commissioning Groups (CCG). ICBs are due to take on the commissioning functions of CCGs from 1 July 2022 and the CCG functions, assets and liabilities are due to transfer to the North East and North Cumbria ICB as at 1 July 2022.

Independent Auditor's Report to the members of the Governing Body of NHS North Cumbria Clinical Commissioning Group

Independent auditor's report to the members of the Governing Body of NHS North Cumbria Clinical Commissioning Group

Report on the Audit of the Financial Statements
Opinion on financial statements

We have audited the financial statements of NHS North Cumbria Clinical Commissioning Group (the 'CCG') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 19 to the financial statements, which indicates that, under the Health and Care Act 2022 the commissioning functions, assets and liabilities of NHS North Cumbria CCG are due to transfer to the North East and North Cumbria Integrated Care Board on 1 July 2022.

Conclusions relating to going concern

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

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

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

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

The responsibilities of the Accountable Officer with respect to going concern are described in the 'Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

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

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity section of our report, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

The CCG reported expenditure of £745.948 million against income of £731.252 million and a deficit of £14.696 million in its financial statements for the year ending 31 March 2022. The CCG thereby breached two of its duties under the National Health Service Act 2006, as amended by paragraphs 223H and 223I of Section 27 of the Health and Social Care Act 2012, to ensure that annual expenditure does not exceed income and revenue resource use does not exceed the amount specified by direction of NHS England.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 2 June 2022 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to NHS North Cumbria CCG's breach of its revenue resource limit for the year ending 31 March 2022.

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer's Responsibilities (set out on pages 59 to 60), the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report. We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).

- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
    - the identification, evaluation and compliance with laws and regulations;
    - the detection and response to the risks of fraud; and
    - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
    - journal entries that improved the CCG's financial performance for the year; and
    - the reasonableness of the assumptions used in determining accounting estimates for accruals within trade and other payables.
- Our audit procedures involved:
    - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
    - journal entry testing, with a focus on significant journals which impacted on the CCG's financial performance;
    - challenging assumptions and judgements made by management in its significant accounting estimates in respect of accruals; and
    - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, included the breach of the CCG's revenue resource limit, the breach of the CCG's duty to ensure that annual expenditure does not exceed income, the potential for fraud in expenditure recognition, and the significant accounting estimates related to accruals included within trade and other payables.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
    - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
    - knowledge of the health sector and economy in which the CCG operates
    - understanding of the legal and regulatory requirements specific to the CCG including:
        - the provisions of the applicable legislation

- NHS England's rules and related guidance
- the applicable statutory provisions.

- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The CCG's operations, including the nature of its operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework**.**

Report on other legal and regulatory requirements – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

Our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the CCG's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2022.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS North Cumbria CCG for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG as a body, for our audit work, for this report, or for the opinions we have formed.

Signature: ***Joanne Brown***

Joanne Brown, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Glasgow
Date: 21 June 2022

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NHS
Northumberland
Clinical Commissioning Group

ANNUAL REPORT
AND ACCOUNTS
2021/22



Improving healthcare for the people of Northumberland

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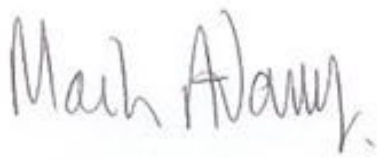


Mark Adams
Accountable Officer
20 June 2022

Performance Overview

Statement from Accountable Officer and Clinical Chair

Welcome to NHS Northumberland Clinical Commissioning Group's 2021-22 Annual Report.

2021/22 saw the National Health Service continue to experience some of the most, challenging years in its history as the evolution of the Coronavirus pandemic and the emergence of the Delta and Omicron variants saw a continuation of the unprecedented pressures on health and social care services in Northumberland and across England.

It is only right that this year's report should start by paying tribute to the most incredible courage, commitment and creativity of so many colleagues in the NHS and wider healthcare system, who have now been working under such immense pressure from the COVID-19 pandemic, and the associated challenges presented by the backlog of routine activity, for over 2 years now. Their resilience and dedication to providing the best possible care for our patients and public is so commendable, and we continue to be incredibly grateful for all of their efforts.

The system response to COVID-19 has seen partners from across health and care come together to work more closely with each other than ever before to provide a co-ordinated pandemic response and ensure that our patients and public have been able to continue to access essential services for elective surgery, cancer care, and mental health & wellbeing.

Hospital staff have had to balance caring for large numbers of COVID-19 patients alongside continuing to provide urgent and emergency care, and routine treatment to non-COVID-19 patients. General Practice teams have transformed their ways of working and models of care to keep patients and staff safe and a large programme of estates work has begun to create additional clinical space to enable our primary care teams to try and meet the increased demand from patients.

Collaboration with local authority colleagues has been vital, particularly the link with our public health colleagues who have continued to provide such incisive and resolute leadership in the fact of constant uncertainty throughout the past 12 months.

Nowhere has the 'whole system' response to the pandemic been better exemplified than through the COVID-19 vaccination programme. Having moved incredibly quickly to protect the most vulnerable patients in early 2021, in 2021/22 the programme evolved to deliver 1st and 2nd dose vaccinations to the whole adult

population, eventually moving into the vaccination of children and young people as new evidence continued to emerge.

Delivery of the booster programme was accelerated nationally following the rapid emergence of the Omicron variant and the need to 'Get Boosted Now' in December 2021 saw our vaccination teams respond phenomenally to provide the additional capacity required to ensure as many of our patients and public were able to access a jab as quickly as possible. As of 31 March 2022, over 734,000 doses of the COVID-19 vaccine have been administered to Northumberland residents.

We would like to thank all of our local NHS and health and care staff across Northumberland for all of their phenomenal work during this last year. At a time when we have all had to deal with difficult personal circumstances and unprecedented restrictions to our daily lives, staff have continually gone above and beyond to play their part in keeping patients as safe as possible. We are sincerely grateful for their continued efforts.

As a consequence of COVID-19, and the need to make significant adjustments to the way services were prioritised and delivered, performance against key metrics has deteriorated compared to previous years and the recovery from the wider impacts of COVID-19 on both service delivery, and on the health and wellbeing of our residents will be the key priority for our local NHS system in 2022.

The CCG continues to play an active part in the development of the North East and North Cumbria Integrated Care System (ICS), contributing to the development of strong local leadership and supporting the transition towards statutory status for the ICS from 1 July 2023.

The Department of Health and Social Care's white paper 'Joining up care for people, places and populations' points the way towards greater integration of health and care services at place level alongside key partners, such as the local authority and Primary Care networks.

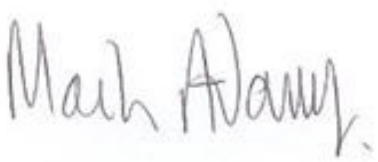
For the whole team at the CCG it is the delivery of this 'place-based' health and care that is at the forefront of everything we do. COVID-19 has exposed health inequalities across our country that require urgent attention as we all continue to recover from the impact of pandemic. NHS Northumberland CCG will continue to work tirelessly to ensure equity of access to, experience of, and outcomes from health and care services for all of our population.

Our annual report describes the vast amounts of work that have been done over the last 12 months to adapt health and care services to respond to COVID-19 and meet the needs of our population. It also addresses how NHS Northumberland Clinical Commissioning Group (hereafter referred to as the CCG), has performed during the

year including a description of the principal risks experienced and how they have been addressed. It also outlines the development and performance of the CCG against a range of national targets and metrics.

The accounts have been prepared under a Direction issued by NHS England under the National Health Service Act 2006 (as amended). The accounts have been prepared on the basis that the CCG is a 'going concern'. The CCG is carrying a cumulative deficit of £53.4M at 31 March 2022. However, public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is fully anticipated, as evidenced by the inclusion of financial provision for that service in public documents. Throughout the COVID-19 response the NHS has been operating within interim financial arrangements. Prior to the Coronavirus pandemic the financial allocations for the period 2020/21 to 2023/24 had been approved by parliament and there is no reason to believe that future approvals will not be forthcoming.

This annual report covers the ninth and final full year that the CCG will have been in place in Northumberland. For almost a decade now our patients and public have benefitted from clinically led commissioning of healthcare services supported by a team of experienced and dedicated managers. We would like to place on record our thanks to all of the staff who have worked for, and with, the CCG in those 9 years and who have made such an important contribution to the health and wellbeing of Northumberland's residents.



Mark Adams
Accountable Officer
20 June 2022

Graham Syers
Clinical Chair
20 June 2022

About NHS Northumberland Clinical Commissioning Group

As a statutory body, NHS Northumberland Clinical Commissioning Group (CCG) is responsible for planning and buying (commissioning) local NHS care and services to meet the needs of our local community. This includes services provided by physiotherapists and district nurses. We are mostly made up of doctors, nurses and other health professionals – with support from experienced health service managers.

We work closely with all 37 family GP practices in Northumberland which are all members of NHS Northumberland CCG and we co-commission General Practice services in collaboration with NHS England. This enables us to have close links to our patients, allowing us to develop more personalised local health services that respond to individual needs. Although we are not responsible for the contracts of dentistry, community pharmacy and optometry we work closely with NHS England who have this role.

By ensuring effective clinically led commissioning we can make a real impact on the health, wellbeing and life expectancy of our patients. We know the NHS continues to face unprecedented challenges, exacerbated by the impact of the COVID-19 pandemic, which are not unique to our area. These challenges are driven by the following:

- An ageing population with increasing health needs
- Health inequalities across the area
- Levels of smoking, alcohol consumption and obesity higher than the national average
- Over-reliance on hospital-based services
- The increasing cost of drugs and new medical technologies
- Limited growth in annual financial allocations

Our Vision

Since its inception in 2013 the CCG's vision has focused on the delivery of integrated services designed to meet the needs of local people. Our vision remains that we:

'***Ensure that the highest quality integrated care is provided, in the most efficient and sustainable way, by the most appropriate professional to meet the needs of the people in Northumberland.'***

We have four strategic objectives that support the achievement of our vision namely that we continue to:

- Ensure that the CCG makes best use of all available resources
- Ensure the delivery of safe, high quality services that deliver the best outcomes
- Create joined up pathways within and across organisations to deliver seamless care
- Deliver clinically led health services that are focused on individual and wider population needs and based on evidence

All the work we undertake is aligned to achieving this vision for the people of Northumberland. The CCG assimilates national policy, such as the NHS Long Term Plan, with the Northumberland Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy (2018-2028) and other local strategies to generate an annual operational delivery plan. The 2021/22 operational delivery plan is described in more detail later in the report.

Financial Context

Due to the continuation of the COVID-19 pandemic, the Government extended the temporary financial framework arrangements for NHS organisations for another year to cover the period to 31 March 2022.

The financial framework arrangements built upon the system-based approach to funding and planning that had been introduced in the 2020/21 financial year and related particularly to the second half of the 2020/21 year which introduced joint system planning and submissions.

The CCG continued to plan and report as part of the system allocated to the North area of the North East and North Cumbria Integrated Care System (NENC ICS) for the financial year 2021/22. The resources received, and position reported by the CCG for this financial year reflect the split of resources the CCG agreed as part of the system planning and collaboration process.

For the financial year 2021/22 the CCG has delivered its statutory obligation under these temporary framework arrangements which is to remain within the financial resource provided, both as an individual body and as part of the wider North East and North Cumbria Integrated Care System.

During the year the CCG was able to support its providers to continue to deliver services with the pressures they faced caused by the continuation of the COVID-19 pandemic.

The CCG has planned for the 2022/23 financial year again as part of the North East and North Cumbria Integrated Care System. However, with CCGs expected to merge into Integrated Care Boards (ICBs) on 1 July 2022 the CCG will only be allocated one quarter of its share of the NENC ICB planned allocation for next year to continue to report spend as a CCG up to the transfer date of 30 June 2022, whereupon any balance (surplus or deficit) from the Q1 2022/23 period will be adjusted to breakeven and any adjusted balance will be transferred to the ICS along with the CCG to be reported in the ICB financial statements for 2022/23.

The CCG will still have a requirement to meet its statutory duties for the Quarter One period of the 2022/23 financial year, as the CCG will still be a separate entity with statutory duties up to the transfer point. Therefore, the CCG will still have to complete an external audit accounts process as it would do with any other period, with the timing of the audit still to be confirmed.

CCG 2021/22 Operational Delivery Plan

The CCG prepares an operational delivery plan each year to translate national policy and local need and strategies into delivery projects that will bring about positive change for the people of Northumberland. The CCG operates a programme management office (PMO) that monitors delivery and enabling senior management to track delivery and manage emerging risks throughout the year.

The 2020/21 operational delivery plan was refreshed to take account of the next phases of the NHS Long Term Plan https://www.longtermplan.nhs.uk/; 2021/22 priorities and operational planning guidance; and also new and emerging local priorities, to form the 2021/22 operational delivery plan.

2021/22 was characterised by a continued response to COVID-19 whilst ensuring restoration of services. Within this context, the 2021/22 priorities and operational guidance set out the following objectives for the NHS:

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

admission to hospital for ED patients and reduce length of stay
- Working collaboratively across systems to deliver on these priorities

The following section outlines in more detail what the CCG has achieved in relation to the above priorities.

1. **Supporting the health and wellbeing of staff and taking action on recruitment and retention**

   CCG Staff Health & Wellbeing – 2021/22

   The health and wellbeing of staff is a priority for the CCG. Both the national and local health and wellbeing offer of support and resources, including the NENC ICS Staff Wellbeing Hub, are highlighted at the weekly staff Team Huddle meetings and in the e-newsletter, The Huddle. Annual appraisal meetings gave staff the opportunity to discuss their personal development, the importance of a healthy work-life balance and their health and wellbeing with their line manager. Health and Wellbeing conversations also take place during regular one-to-one meetings between staff and their line managers. Following feedback from the CCG Staff Health & Wellbeing Temperature Check in April 2021, virtual staff workshops about uncertainty and change took place. The 'Living with Uncertainty' and 'Coping with Change and Uncertainty' workshops were externally facilitated and focused on practices and behaviours that can help staff handle uncertainty, challenge, and change. Staying mentally well during COVID-19 was also a high priority throughout the year, as was an emphasis on Men's health issues.

   The CCG's Staff Health & Wellbeing Group was formed to discuss health and wellbeing ideas including coordinating social activities and fundraising. The Better Health at Work Award which the organisation will pursue includes an offer of training for staff who would like to become Health Advocates.

   Jointly run with Northumbria Healthcare NHS Foundation Trust, Northumberland County Council and the CCG, staff now have access to nine Staff Networks:

   - Autism Spectrum Disorder (ASD) Staff Network
   - Black Asian and Minority Ethnic (BAME) Staff Network
   - Carers Staff Network
   - Cancer Support Staff Network
   - Enable Disability Staff Network
   - Lesbian Gay Bisexual Trans (LGBT+) Staff Network
   - Menopause Staff Network
   - Mental Wellbeing Staff Network
   - Family Ties Staff Network

NHS National Staff Survey 2022

The national NHS Staff Survey results published on Wednesday 30 March 2021 for the 2021/22 year, showed that 79% would recommend the CCG as a place to work and 88% would be happy with the standard of care provided to a friend or relative if required. The annual survey, completed by NHS organisations across England, focuses on nine themes and provides a detailed insight into how staff feel about culture, their wellbeing, levels of engagement and motivation, equality, diversity and inclusion, safety and quality of care.

Staff satisfaction remains high at NHS Northumberland Clinical Commissioning Group (CCG) despite the pressures experienced by all during the COVID-19 pandemic.

In addition, 98% of the staff surveyed agreed that care of patients and service users is the top priority for the CCG, which plans and commissions for the county's residents hospital, community and primary care services.

For the 2021 edition, the survey was updated to align with the NHS People Promise, which aims to reflect what matters most to staff and what would make the greatest difference in improving their experience in the workplace. The CCG scored at or above average across all elements of the People Promise, and for both staff engagement and morale.

A number of areas saw a marked improvement from the 2020 scores for Northumberland CCG staff, such as the proportion of staff always knowing what their work responsibilities are rising from 77% to 84% and the proportion agreeing they have frequent opportunities to show initiative also increasing from 77% to 84%.

The 2021 NHS Staff Survey results show an excellent response rate from staff and are encouraging set against the backdrop of the ongoing pandemic and uncertainty created by the ICS transition.

Embed new ways of working and delivering care

The introduction of the Practice Link Nurse in early 2021 has created a key connection between the county's general practice nursing and clinical workforce and the CCG. The Practice Link Nurse works with the general practice nursing teams in Northumberland on a range of educational and workforce initiatives linked to continuous professional development and continuous workforce development. The postholder has been able to forge critical links across our general practice nursing teams.

The postholder has developed the General Practice Nursing (GPN) fellowship scheme in collaboration with Health Education England and has rolled this out in two GP practices with the result that several other GP practices are keen to hire newly qualified nurses. This also has the benefit of encouraging students to think about primary care as their first-choice career after qualifying with the support offered by this Fellowship programme.

A training needs analysis of GPN nursing workforce in Northumberland was undertaken in 2021, the results of which informed the development of the continuing professional development plan for the year to support the further development of our skilled workforce to meet the needs of our patients.

The role of the link nurse has created greater opportunities to work in collaboration with North Tyneside and Newcastle Gateshead CCGs to help offer a cohesive training package to the nursing teams within the area, providing support and increased access to training and better value for money.

Safeguarding Lunch and Learn Training

Recent local Domestic Homicide Reviews (DHRs) had identified learning for Primary Care. The recommendations from the DHR included reiterating to Primary Care the importance of coding health records for vulnerability and domestic abuse, to remind Primary Care of the facility to discuss complex patients in practice multi-disciplinary team meetings and for GPs to be more proactive with complex patients who repeatedly 'do not attend' or 'was not brought in' (in the case of children or those with a learning disability) and exercise professional curiosity.

Additionally, there has been an increase of domestic abuse during recent lockdowns, including an increase in male victims of abuse. Alongside sharing the learning from DHRs this training was also developed to:

- Increase knowledge and understanding of domestic abuse
- Identify signs and symptoms of domestic abuse
- Increase confidence in tasking the question with patients regarding domestic abuse
- Increase knowledge and the completion of the Safe Lives Domestic Abuse Stalking and Honour based violence (DASH) risk checklist and Multi Agency Risk Assessment Conference (MARAC) referral
- How to support victims once domestic abuse is disclosed and referral to local domestic abuse services

The training was delivered over lunch time sessions and promoted as 'Winter Training – Domestic Abuse', the rationale for this was to make the training available to all clinical and non-clinical staff in a flexible and attainable way. The training was delivered via MS Teams and additional material to support the session was attached to the invitation. This training evaluated very positively and the 'lunch and learn' model has proved to be a successful way to offer safeguarding training to primary care staff. The aim is to further develop this model to offer a range of topics delivered quarterly offering primary care staff four hours of safeguarding training per year.

Grow for the future

The supporting placements of students within primary care has been one of the key objectives for the link nurse role, and we have seen an increase in nursing placements, but also other professions such as podiatry students within Northumberland. Expanding the Higher Education Institutions that we work with is also a key aspect of the role and we are now working with Northumbria and Sunderland Universities alongside New College Durham. The coordination of nursing leads within each PCN is now in progress with the aim to provide a network of support across the region.

We have been able to run student nurse lead initiatives at Netherfield Surgery and provide health promotion events seeing over 200 patients, supported by the Practice Link Nurse. This format is now being rolled out to 10 practices in the summer to highlight the impact student nurses can have and encourage newly qualified nurses. We have been able to support practices with recruitment and development of their staff and are working closely with nurses about to qualify who are looking for a GPN post.

2. **Delivering the NHS COVID-19 vaccination programme and continuing to meet the needs of patients with COVID-19**

Throughout 2021/22 the CCG has continued to co-ordinate and support the delivery of the COVID-19 vaccination programme across Northumberland alongside working with our main providers to ensure that the needs of patients with COVID-19 are met.

Over 530,000 doses of COVID-19 vaccinations were delivered to Northumberland residents during 2021/22. Northumberland has some of the highest uptake of COVID-19 vaccination of any Upper Tier Local Authority (UTLA) area in England with over 90% of the population (aged 12+) having received at least one dose, over 86% given at least two doses, and over 72% with three or more doses.

The CCG has worked with the North East and North Cumbria System Vaccination Operations Centre (NENC SVOC) to enable the successful delivery of the programme across Northumberland via a network of vaccination sites provided by Primary Care Networks, Community Pharmacies, Hospital Hubs, Vaccination Centres, and the Northumberland Roving Vaccine Unit. Delivery of the programme throughout the constantly evolving pandemic situation has required a phenomenal effort from all of the teams involved, across multiple organisations, and with the support of thousands of staff and volunteers.

The success of the COVID-19 vaccination programme in Northumberland has only been possible due to the strength of the relationships between multiple agencies and the spirit of integration and collaboration that has underpinned them. The CCG has co-ordinated the local health and social system in delivering the programme and worked with colleagues including; Northumberland County Council - Public Health, Education, Adult and Children's Services, Highways, Estates and Communications; our Acute, Community, and Mental Health provider trusts; Primary Care Networks and General Practices; Northumberland Fire and Rescue Service; Northumbria Police; Healtwatch; the Voluntary and Community sector; and local, regional, and national NHS partners.

A COVID-19 Vaccine Equity Board was established during 2021/22, ran jointly between the CCG and Local Authority Public Health team. The work of the Board focused on monitoring and increasing uptake of vaccination in our most deprived communities and amongst minority groups who have historically been impacted by health inequalities. A number of initiatives have been progressed by the Board to increase uptake in these target groups including a successful programme of local engagement and provision of midwifery-led vaccination clinics for pregnant women. Outreach work has also taken place within minority ethnic communities across Northumberland to engage trusted voices within these communities who have helped to promote vaccine uptake. Targeted engagement has taken place across CCG, Primary Care, and Local Authority communications and social media channels to address vaccine hesitancy, complacency, and confidence.

The Northumberland Roving Vaccine Unit (RVU) was commissioned by the CCG and launched in April 2021 to provide a mobile vaccination capability. The RVU is provided by Cramlington & Seaton Valley Primary Care Network. Throughout 2021/22 the RVU has provided vaccinations across the length and breadth of Northumberland, visiting some of the most isolated and rural communities to increase access to vaccination and help overcome health inequality. The RVU has also worked with local partners to provide vaccinations to Northumberland's homeless population and patients, and staff in learning disability inpatient facilities. The RVU has also supported delivery of the vaccination programme across the wider North East and North Cumbria Integrated Care System, providing support in North Tyneside to provide surge vaccination capacity during

the outbreak of the Delta variant and across the Tees Valley CCG footprint to provide hyper-local pop-up clinics to offer vaccinations to some of the most deprived communities in our region.

The CCG has worked with both of our main providers of acute hospital services, Northumbria Healthcare NHS Foundation Trust (NHCFT) and Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) to establish Long COVID clinics in line with the nationally mandated service requirements. These clinics have supported patients suffering with the long-term effects of COVID-19 and have facilitated access to the 'Your COVID Recovery' resources to help patients monitor and manage their recovery.

The CCG has also overseen the establishment of the COVID-19 Oximetry @home pathway, working with colleagues across primary and secondary care, and the care home sector to enable remote monitoring of patients with COVID-19 in the community. This included the distribution of large numbers of Pulse Oximeters to GP Practices and Care Homes to help their patients manage their illness and monitor their condition.

In early 2022 the CCG also worked with local secondary care providers to rapidly establish COVID Medicines Delivery Units (CMDUs) to provide antibody and antiviral treatments to those people with coronavirus (COVID-19) who are at highest risk of becoming seriously ill.

As 2021/22 was drawing to a close the CCG co-ordinated and is overseeing the rollout of the Spring Booster vaccination programme to provide ongoing protection to those residents and patients most vulnerable to serious illness from COVID-19. The CCG is also working with local and regional system partners in order to develop strategic plans for the delivery of an autumn COVID-19 booster vaccination programme, should this be recommended by the Joint Committee on Vaccination and Immunisation (JCVI).

3. **Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand of mental health services**

   a. <u>Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services</u>

      The CCG has worked with our main providers, Northumbria Healthcare NHS Foundation Trust (NHCFT), Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) on comprehensive plans to ensure recovery of elective activity following the COVID-19 pandemic. The COVID-19 pandemic

has transformed the delivery and operation of Outpatient services including new and follow-up appointments with smarter ways of working. The development and subsequent implementation of plans has included using virtual/digital operational models to see patients at home instead of hospital, where appropriate. Traditional methods of service delivery have also remained available, particularly for patient groups that may find accessing digital models difficult. A good example of this is the digital dermatology pathway which has supported operation of cancer services.

As part of the recovery, providers have reviewed the waiting list and looked to understand whether prioritisation based on comorbidities could be beneficial to enhancing the care of the patient. A population health management approach has started to be formed where the health and care system considers not just the individuals' immediate issues but takes a holistic approach. This has started to capitalise on the vast amounts of data health and care organisations hold to benefit the patients.

Additional finances have been made available to providers to undertake waiting list initiatives in order to recover services as quickly as possible. CCGs and providers also combined efforts to utilise capacity in the independent sector whilst ensuring value for money and equity of access for those already on NHS providers' waiting lists.

b. <u>Restore full operation of all cancer services</u>

The impact of pandemic lockdowns in 2020/21 meant that there had been reduced patients coming forward to access services. Additionally, COVID-19 continues to impact on service capacity, with infection control procedures (IPC) and staff absences affecting service delivery. Therefore, the main areas of focus for cancer services in 2021/22 were to:

- Work with GPs and the local population to increase the number of people coming forward and being referred with suspected cancer.
- Restore cancer screening programmes.
- Extend clinical prioritization to patients on cancer diagnostic pathways
- Achieve the new Faster Diagnosis Standard.
- Improve performance against existing cancer waiting times.

The COVID-19 pandemic has continued to have a major impact on performance in 2021/22 however work has continued to streamline pathways and ensure patients receive diagnoses and treatment as timely as possible.

Digital Dermatology

Embedding the digital dermatology pathway for suspected skin cancers has successfully reduced the waiting times for diagnosis of melanomas and reduced unnecessary face-to-face attendances and travel for patients. The success of this pathway has prompted the extended use of this technology to some non-cancer dermatology conditions. Training has taken place with primary care teams to ensure the pathway is clear, safe, and efficient when referring patients on this pathway into secondary care.

Cervical Screening

Northumberland continues to perform highly overall for cervical screening uptake, however it was recognised that there was variation across the county. The CCG has therefore supported Primary Care Networks (PCNs) by targeting funding to address the variations identified. Primary care teams have implemented a range of initiatives to increase uptake within their local populations, such as increasing provision of screening clinics and increasing capacity to contact eligible patients by phone to address any potential barriers.

Raising Public Awareness of Cancer

The CCG supported several national cancer campaigns in 2021/22 aimed at building public confidence in contacting their GP if they suspect they have cancer including the *'Help Us to Help You'* campaign. The first phase encouraged early presentation of abdominal and urological cancers whilst a subsequent phase focused on encouraging eligible women to attend their cervical screening appointments. In March 2022, the national team launched a general early diagnosis campaign *'Don't let the thought of cancer play on your mind'*. The NHS also teamed up with Prostate Cancer UK to *'find the missing men'* with a national campaign targeting men over 50 and black men over 45. Primary Care were informed, and resources shared with various stakeholders.

The CCG also supported the *'Do It For Yourself'* regional lung cancer campaign, that targeted specific populations in Northumberland with higher lung cancer incidence and late or emergency presentations. As well as radio coverage and posters on buses, our local cancer awareness worker distributed campaign beer mats to local clubs and pubs. The Northern Cancer Alliance are currently working with the local cancer awareness workforce to develop a campaign to target people at higher risk of head and neck cancers, in response to an increase in late presentations.

The CCG continues to use awareness months to raise the profile of bowel and breast cancers and shares various campaigns that support our risk reduction and prevention messaging such as the Balance *'Alcohol Causes Cancer'* Campaign in November 2021 and the Fresh *'Quit Smoking'* campaign last summer.

Communication with the public in Northumberland to promote the Galleri trial is also being supported by the CCG.

c. Expand and improve mental health services and services for people with a learning disability and/or autism

Mental Health

Throughout 2021/22 we have continued to work closely with neighbouring CCGs to ensure that any potential disruption to services due to the impact of COVID-19 has been kept to a minimum. As a result, we have been able to deliver mental health services in line with the NHS Long Term Plan and ensure that quality services are provided in the right place at the right time, responding to the needs of Northumberland.

Our Community Mental Health Transformation has made good progress around the provision of services for those clients with serious mental illness (SMI). This has focused on key pathways including adult eating disorder, personality disorder, and improving physical health care. The transformation work relies on collaborative working across primary care, secondary care, the voluntary and community sector, and social care services to develop wider system working and collaborative approaches. The transformation will result in easier access to services for people with serious mental ill health offering a joined up, seamless and holistic approach in our community mental health services.

Very closely aligned to our transformation work is the development of the Northumberland Recovery College. As well as offering a range of courses, the College works closely with the voluntary sector and has been integral to the development of a voluntary sector network to support mental health initiatives. The College development groups which link in with communities across Northumberland and align with PCNs, together with the voluntary sector network ensures that awareness of mental health is promoted in our communities as well as messages around wider emotional health and wellbeing information for the population of Northumberland. The College website and resource pages provide information and advice around courses available, health information and helpful tips around looking after our mental health.

Our relationship and working arrangements with the voluntary community sector across Northumberland has continued to flourish. The sector has delivered excellent initiatives to support people with mental ill health in communities across the county and is at the forefront of providing services to clients with a range of needs which impact on mental health and wellbeing.

Linking with our crisis services and other pathways, this includes support with financial difficulties, relationships problems, housing issues and alcohol or drug dependence. The sector has continued to offer additional services for those in need of support following traumatic experiences and loss due to COVID-19, and we continued to support services offered to those people who have been affected by suicide.

We have continued to work closely with our PCNs around the Additional Roles Reimbursement Scheme (ARRS). This offers primary care an opportunity to extend the variety of care and interventions available within practices and the inclusion of mental health workers offers specialist expertise closer to communities.

Added benefits include use of skills and knowledge to streamline pathways, improve access to services, raise awareness of mental health, bring services closer to home and enhancing joint working between primary care, secondary care, and voluntary care mental health services.

Our Improving Access to Psychological Therapies (IAPT) service has been aligned with mental health secondary care services to ensure that clients experience easy transition across pathways where required. We continue to work very closely with our IAPT provider and have provided additional funding to support the reduction of waiting lists at more complex steps in the service.

We have maintained close working relationships throughout the year with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW), our mental health secondary care provider, to enhance existing services including:

- Crisis and Psychiatric Liaisons services
- Specialist Perinatal services
- Early Intervention in Psychosis
- Adult Eating Disorder physical health care
- Personality Disorder service (trauma informed care)

We have also paved the way for work to be improved around:

- Individual Placement support
- Crisis alternatives
- Rehabilitation in the community

We have continued to work closely with CNTW and alternative providers to reduce waiting lists in the adult Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) pathways.

Learning Disabilities and Autism

During 2021/22 we have worked closely with our partners and providers to maintain our proactive role in avoiding unnecessary admissions to mental health hospitals for people with a learning disability or autism. To support this, we have provided safe havens to prevent hospital admission when people experience difficulties in their home environment and require some additional support for a short period of time.

We strengthened our dynamic support register and care and treatment review process to identify community alternatives closer to home rather than hospital. We also committed resources to enable earlier identification of children with complex needs who require additional support to achieve the best possible outcomes in childhood.

We have worked in collaboration with inpatient services locally and out of area to ensure individuals with a learning disability and/or autism do not remain in specialised hospitals longer than they need to, by embedding the 12-point discharge plan, ensuring discharges are timely and effective. We have developed links with other commissioning authorities during the Host Commissioner and Oversight Visit implementation, working together to make sure that individuals in specialised hospital settings are accessing the appropriate care and treatment for their needs, any restrictions applied are relevant and appropriate, and risk is assessed and reviewed regularly.

For those people in long-term segregation, we review arrangements every three months, and the use of seclusion and restraint is monitored closely. Aligned with this is the development of a process for identifying and responding to potential closed cultures within inpatient settings.

The CCG is committed to reducing the number of people in inpatient settings, by working closely with providers to develop community services. Enhancing our specialised support services to be able to provide a flexible and needs-led approach to individuals already living in the community or being discharged

from specialised inpatient settings. We continue to be committed to reducing and preventing the number of individuals being placed in out of area settings, by developing our services in Northumberland.

Our Children's Trailblazer project has seen a continued reduction in wait times to our people's autism and neurodevelopmental diagnostic service and significant investment has been made to reduce the wait time to assessment to under 18 weeks in the same adult pathways. A review of the availability of post diagnostic support and access to sensory profiling and integration was undertaken and these areas will be added to the 2022/23 planning round.

We continue to improve the transition from children's to adult services for individuals with a learning disability and autism or both. Working closely with providers to highlight the gaps and incorporate the views of families and the individuals accessing the service.

The CCG continued to review the deaths of people with a learning disability through the national Learning Disabilities Mortality Review (LeDeR) programme and embedded learning into our quality assurance programmes. An integral part of this work is being linked with the local dysphagia and oral health network and we continue to develop pathways for the prevention of aspirational pneumonia in people with a learning disability.

Our GP clinical leads have been actively involved in the learning disabilities and autism clinical networks ensuring that best practice is shared within primary care in Northumberland. This includes a pilot for a reasonable adjustments flag in patients' medical records, cancer screening and the role of autism awareness training.

Work has continued to identify our hidden population of children and adults with a learning disability and/or autism, this includes keeping the Learning Disability GP registers up-to-date and maintaining strong links with the local community.

Our GP leads worked hard over the winter period to communicate an important message about keeping well for winter, improving general health, and increasing activity levels during the recent pandemic.

We continue regional education throughout the primary care workforce, highlighting the importance of high-quality annual health checks and healthcare for children and adults with a learning disability and/or autism. The development and importance of a specific health check for people with autism is currently being discussed.

We continue to work closely with our GP leads and providers in broadening the message around the stopping over-medication for people with a learning disability and/or autism and support treatment and appropriate medication in paediatrics (STOMP/STAMP).

The CCG continues to commission advocacy services, providing the support that helps individuals with a learning disability and/or autism to make decisions and choices about the important things in their lives.

The CCG is committed to improving the lives of people with learning disabilities and autism and leads on a countywide strategy to ensure the NHS three-year plan is realised locally. This includes the setting up of an Autism Partnership Board, an inclusive approach to agreeing priorities for 2022/23 which includes a range of partners from across the health and care system and those with lived experience.

The CCG is currently developing Northumberland's Three-Year Autism Strategy, coproduced with providers and those with lived experience to ensure that we identify what is working well in Northumberland and where there may be areas for change and improvement.

Children and Young People

In 2021 the CCG launched a further *'Be You'* Mental Health Support Team (MHST) in schools trailblazer project after successfully securing funding in the third wave of the national pilot. The new team covers Bedlington and Ashington building on the work of the MHST teams already embedded in Hexham and Blyth. Whilst COVID-19 has brought challenges in terms of gaining access to schools, alternative methods of delivery were explored and the team is now settling into their designated schools. The MHST offers individual 1-to-1s, group work, general awareness raising in assemblies, more targeted work where the school has identified an issue and general advice and guidance to school staff. For more information, visit the Be You website https://www.beyounorthumberland.nhs.uk.

Building on our strong history of collaborative working and joint commissioning between health and social care, the CCG has introduced new roles of mental health practitioners within Children's Social Care teams. These roles will enable the ongoing development of a flexible, proactive, and accessible service for children and young people. This will be achieved by providing assessment and additional focus to those children identified within the social care teams as in need; ensuring person-centred care to those who may not reach the threshold for secondary mental health care services but whom would still benefit from support and intervention.

In addition, the CCG has funded extra posts within the Local Authority's Autism Service in Schools to support with the growing demand.

The CCG invested funding to establish a 24-hour crisis service for children and young people in line with national guidance and the 24 hour adult crisis team. We have also funded a dedicated Children and Young People's Practitioner within the Psychiatric Liaison Service based at Northumberland Specialist Emergency Care Hospital (NSECH). This post works with children and young people identified by nursing staff as in need of a mental health assessment and support whilst they are staying in the hospital.

As part of the Preparation for Adulthood within the health transition pathways, there is continued work to improve attendance of children and young people with a Learning Disability at their 14+ health check, as well as further development in relation to the interface and pathways between children and young people's mental health services, adult mental health and social care to enable smooth, timely and effective transitions. Work between mental health providers and education colleagues has enabled the development of a guide to support Special Education Needs Coordinators (SENCOs) in schools with managing the emotional health and wellbeing of their students as they transition through schools and age groups.

Following consultation and feedback from parents and carers the CCG began the process in 2021 of coproducing plans to develop a sensory pathway for children whose primary need is sensory processing. This offer will be expanded to adults over time.

d. Deliver improvements in maternity care, including responding to the recommendations of the Ockenden Review

The first Ockenden Report was published on 11 December 2020 following an independent review of the Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. This initial report of emerging findings and recommendations contained seven Immediate and Essential Actions (IEA) to improve safety in Maternity Services at The Shrewsbury and Telford Hospital NHS Trust and across all maternity services in England. It has also provided a framework for transformation of local maternity services and help to bring forward lasting improvements.

In response to the Ockenden recommendations, the quality governance and oversight system had been strengthened in the North East and North Cumbria in the provider trusts, CCG, and region. The three Local Maternity Systems in the North East and North Cumbria (NENC) region has now become one single NENC Local Maternity Neonatal System (LMNS) since April 2021. It is

recognised that maternity units and hospital trusts often serve residents from a wide geographical area, and this new way of working will ensure better joined up working and accountability across different maternity services. Alongside this, a maternity quality and safety group has been set up and systems are in place to improve the gathering and interpretation of safety information and patient experience, to inform service planning and delivery. Sharing good practices and lessons learnt is also a key focus.

Patient safety has always been a top priority for the CCG. Since the publication of the Ockenden Report, the CCG has continued to build on its productive working relationship and work very closely with our maternity units to implement all the recommendations. The maternity services at Northumbria Healthcare NHS Foundation Trust (NHCFT) have achieved compliance of all seven immediate and essential safety actions required. The CCG is an active member of the LMNS and its Executive Director of Nursing, Quality and Patient Safety chairs the NENC Maternity Quality and Safety Group. There is also a vibrant Maternity Voice Partnership in Northumberland to ensure the voice and experience of mothers and families are at the heart of our maternity services. The maternity team at NHCFT regularly attend the CCG's Clinical Management Board to provide assurance and updates in relation to Ockenden and the wider maternity transformation programme. Ockenden is also a regular agenda item for assurance at our Quality Review Group meetings with the hospital trusts.

Progress to address health inequalities and improve outcomes for mothers and babies in response to the Better Births: Improving Outcomes of Maternity Services in England (2016) continues. Continuity of Carer teams are in place for mothers and babies in Northumberland, showing real improvements in outcomes in some of our most deprived communities such as rates of smoking cessation and breast feeding. As part of the wider COVID-19 offer, the CCG has worked with our GP practices and the maternity teams to promote vaccinations for mothers, and we have achieved one of the highest uptake rates in the region.

The final Ockenden Report of the Independent Review of Maternity services at The Shrewsbury and Telford Hospital NHS Trust was published on 30 March 2022. The report identifies further 15 key immediate and essential actions (IEAs) to improve all maternity services in England. As the LMNS and incoming ICB are taking over their statutory responsibilities and formal roles in perinatal quality oversight in the near future, the CCG is working with all stakeholders to ensure a managed, integrated and seamless transition for quality oversight in the coming months.

The seven IEAs referred to are:

- Enhanced Safety
- Listening to women and their families
- Staff training and working together
- Managing complex pregnancy
- Risk assessment throughout pregnancy
- Monitoring fetal wellbeing
- Informed consent

4. **Expanding primary care capacity to improve access, local health outcomes and address health inequalities**

The work of the CCG is focused on a combination of commissioning high quality care for all who need it, alongside equity of access and sensitivity to local outcomes and inequalities. The emergence of Primary Care Networks has provided a perfect opportunity for integrated work at neighbourhood and community levels that are meaningful geographical areas to the residents who live there. A combination of multi-disciplinary teams from across the health and care spectrum, access to linked data sets and the lived experience of families and communities mean that local outcomes can be successfully identified with a shared approach to solutions.

For example, across a number of PCNs, the importance of children having the best start in life, the issues and causes of child poverty and the unacceptable rate of self-harm in children are areas of focus. For other areas, obesity, the use of alcohol and patients who access multiple services a large number of times are important areas of work. For each of these significant areas; understanding and addressing the causes is fundamental alongside the traditional approach of treatment alone. This is very much the essence of what is called the population health management approach which at its heart aims to reduce inequalities across communities and increase healthy years of life and life expectancy. This means the NHS must become more than a treatment service and work in partnership with a huge range of stakeholders to create thriving communities.

a. <u>Restoring and increasing access to primary care services</u>

2021/2022 has been another challenging year for general practice, recovering from national requirements and restrictions to manage COVID-19 related infections in our communities and local health centre facilities as well as delivering multiple vaccination programmes to maintain an element of prevention against COVID-19, childhood illnesses and flu.

However, alongside workforce pressures and infection prevention control requirements, the General Practices in Northumberland have continued to prioritise the needs of their registered patients and focused on multiple national requirements to reintroduce the offer to patients for face-to-face appointments, physical health checks and long term conditions management.

The CCG has continued to work with practices to ensure business continuity arrangements and adverse weather plans ensured their premises remained open for all. The CCG continued to support primary care with development work focusing on digital transformation, estates and premises, workforce. Additionally, engagement work was undertaken relating to access to services; sustainability and quality visits continued; and support offered to primary care networks. Further details are provided below.

Primary Care Networks (PCNs)

In addition to delivering the COVID-19 vaccination programme, Northumberland's PCNs have continued to develop. Throughout 2021/22 they have continued to recruit new staff through the Additional Roles Reimbursement Scheme (ARRS). This national scheme provides investment to enable PCNs to expand their workforce and offer alternative professionals working as part of the Primary Health Care Teams.

These roles include Clinical Pharmacists, First Contact Physio, Paramedics and Social Prescribing Link Workers. Mental Health Practitioners (MHP) were also included for the first time in 2021/22. Working jointly with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) all the PCNs have recruited MHPs to support the primary mental health provision in Northumberland. Since the beginning of the ARRS scheme to the end of 2021/22 the PCNs have recruited over 100 additional whole time equivalent staff to these new roles.

During 2021/22 the CCG undertook the preparatory work for the formation of a new PCN and changes to three of the existing PCNs on 1 April 2022. The new Northumbria PCN will include the following practices run by Northumbria Primary Care – The Rothbury Practice, Haydon Bridge & Allendale Medical Practice, Cramlington Medical Group, Elsdon Avenue Surgery and Ponteland Medical Group. This has resulted in seven PCNs working across all practices in Northumberland.

Northumberland Estate Strategy

The CCG's ambition for GP estate and premises is to provide a more fit for purpose, flexible, more cost efficient and sustainable estate across

Northumberland. This estate will facilitate service transformation, sustainable delivery of high-quality health and social care services and the realisation of wider benefits for our communities.

During 2021/22 the CCG has undertaken a number of activities to improve the GP estate:

- **Rationalisation and repurposing of the current estate** was undertaken to improve capacity, access and the quality of facilities at Blyth Health Centre, Riversdale Surgery in Prudhoe, Gables Medical Group in Bedlington, Broomhill Health Centre, and Seahouses Health Centre.

- **Relocation projects** were progressed and approved for Felton Surgery and Elsdon Avenue Surgery.

- **Lease regularisation and resolution of historic payments** were agreed on 23 leases due for completion by June 2022.

- **Support to practices to digitise patient records** was undertaken so that freed up space can be turned into clinical rooms**.**

Following a national programme and investment to digitise patient records, the CCG, with practices, has developed a programme of works to remove paper patient records from general practice premises to secure locations and provide an opportunity to repurpose the records storage and adjacent areas to create additional clinical capacity.

Digital

During the COVID-19 pandemic there has been a major focus on the digital opportunities, supporting patients and their practices to maintain contact and consultations where needed. The CCG and its practices are conscious these changes were implemented at speed as part of the emergency response and are working to improve communication and tailoring of these digital solutions, to maximise their positive benefits for patients into the future.

In late 2021, the CCG undertook a series of workshops with each of the PCNs to understand their current digital pressures and their longer-term digital requirements from primary care digital solutions such as Online/Video Consultations, text messaging and telephony systems. The outcome informed the CCG of key work areas to support practices, and these will be used to influence the delivery of the CCGs Digital Strategy.

The digitisation of medical records programme was paused due to COVID-19 but has since resumed during 2021/22. This programme looks to address the large amounts of space taken up by paper medical records by digitising the records or placing them into long term offsite storage until the national digitisation solutions are available.

Addressing the records in this way allows additional clinical and administration space to be created within existing practice footprint avoiding the need for costly conversion works and allowing effective solution expanding the workforce. Roughly 140,000 records have been placed into secure storage allowing much needed space to be reutilised. This work will continue into 2022/23 allowing all practices to realise the benefit of the programme.

Through regional and local procurement exercises we have sustained the ability for patients to interact with practices in alternative, digital, ways. These solutions offer a choice of access and communication routes for patient/clinician interaction and help maximise the use of clinical time within practices:

- **Online Consultations –** providing the patient with the ability to access clinical services such as GPs/healthcare professionals, help and advice or administrative assistance for items such as sick notes and test results through the practice webpage and NHS App. This complements and supports the traditional methods of accessing primary care allowing alternative route to the practice.

- **Video Consultations –** rapidly deployed during early COVID-19 responses a re-procurement of a video consultation solution was combined with the procurement of the online consultation which provides a single solution allowing practices to continue to offer alternative remote consultation solutions with patients.

- **Two Way Messaging (SMS text) –** the functionality for the practice to interact with patients via text message has also been further extended allowing practices and patients to share digital content such as documents, pictures and weblinks to appropriate support materials. The solution provided also permits the ability to remind patients of their upcoming appointments and to inform of normal test results.

Improving Access

Between January and March 2022, the CCG commissioned an external company, Explain, to undertake some independent research relating to how our population feel about their access to general practice services and how

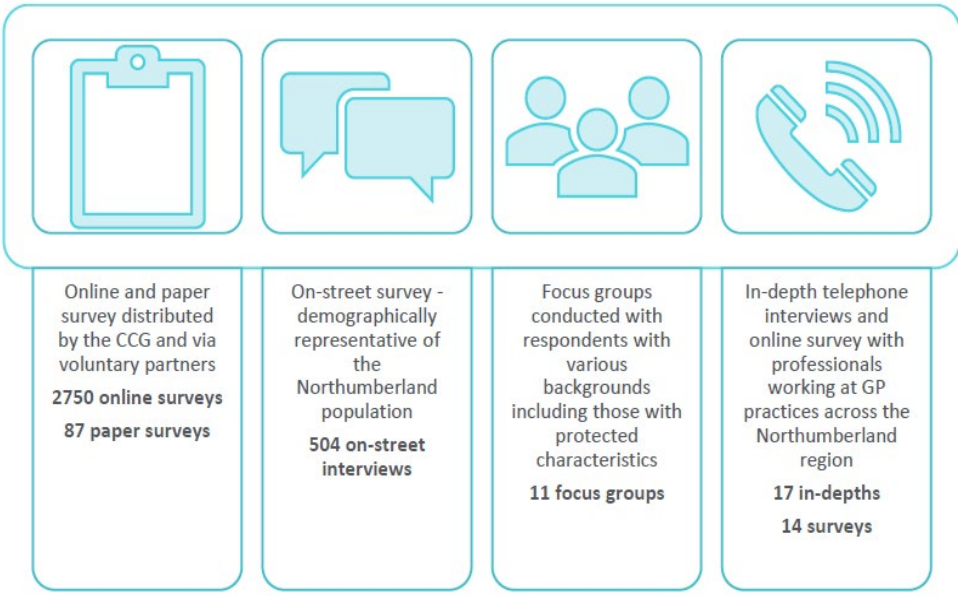
the staff working in those practices are managing the multiple challenges they face with the changes to digital access, workforce changes and consultation types.

In 2021, Healthwatch conducted a survey to look at how the pandemic has changed the way people access GPs and how this had affected people's experience of care. Their report concluded that the key area of improvement in relation to NHS services was around the availability of face-to-face appointments.

Following on from this research, the CCG wanted to delve deeper and really understand how best to allocate GP resource to improve access and meet the expectations of the wider population of Northumberland.

It was key to the CCG that research was carried out with a **robust** and **representative sample** of the Northumberland population.

To ensure robust engagement, a multi-method approach was chosen, this included:



The initial findings report has been delivered to the CCG, and some of the points to note are as follows:

- Patient satisfaction with their ability to get an appointment was 5.5 out of 10 in the online survey and 5.3 out of 10 in the on-street survey demonstrating that there is room for improvement in this area;

- There is a perception of a reduction in access since before the COVID-19 pandemic;
- Overall, health professionals reported feeling under resourced due to a number of factors including increased demand, workforce crisis, staff shortages and the aftermath of the COVID-19 pandemic;
- The most common access issue discussed in the qualitative research and most prominent in the on-street survey were issues with getting through on the telephone to make an appointment;
- Exacerbating the issues with telephone access was a lack of awareness of the ability to book appointments online, use e-consult, have communication with the practice via text through AccruRx or any other digital tools;
- The key concern around telephone consultations was largely around a perception that a health professional would not be able to correctly diagnose an issue over the telephone, and that this may lead to no resolution or a misdiagnosis.

Following this report, the CCG now plans to work with practices and the public further, developing an access programme that begins to address some of the issues identified and consider how to improve communication, give clarity to patients needing to access health and care from their practices and understand the needs of the practices in their staff when change is implemented. Also building the findings into any new services that are required as part of the national GP contract.

Primary Care Sustainability and Resilience

As part of locally commissioned services, the CCG engaged with every practice at least once to take a temperature check of quality concerns and issues in primary care. The purpose of the visiting programme was to maintain and constructively strengthen the existing relationships between practices and the CCG primary care support team. The process also allowed the CCG to proactively support practices when required, with earlier intervention helping to prevent problems from escalating. This was delivered alongside nationally allocated funding for primary care via the GP Forward View (GPFV) to support resilience in general practice by offering access to funding for the delivery of schemes that would improve practice resilience, sustainability, business change processes, change and improvement activities or training and mentorship via a group of staff with expertise in these areas.

Practices in Northumberland have all broadly been subject to the same issues as a result of the COVID-19 pandemic.

These sustainability visits have been run in tandem with the local quality assurance programme, monitoring the quality of the services practices provide. Again, this has enabled ongoing dialogue and early intervention where staff shortage due to sickness and the pandemic may have created pressures in maintaining some services to patients and prioritization of resources based on need.

Primary Care – Workforce

Primary Care Networks (Workforce and Development)

The CCG's seven PCNs have continued to recruit additional clinical professionals through the national Additional Roles Reimbursement Scheme (ARRS). This scheme provides networks with investment to expand existing workforce and skills so that our patients can access a wider number of services from physiotherapists, paramedics and clinical pharmacists closer to home. This expanded workforce delivers services across PCNs and allows work previously undertaken by GPs to be delivered by other clinicians and specialists.

GP and Nurse Fellowships

The CCG continues to attract newly qualified GPs into the county through its Fellowship Programme. Since the scheme launched in 2021, the CCG has welcomed and supported 20 new GPs in our practices. The model, which includes a programme of induction and peer support is being expanded to include a network of GP 'buddies' to support any new GPs coming to Northumberland general practices, to assist in their transition into our health and social care system.

The Northumberland scheme is now well known in our local medical schools and has been instrumental in attracting new GPs into the county. As part of our commitment to work with neighbouring CCGs, the CCG is supporting three newly qualified GP Fellows who joined practices in North Tyneside and Newcastle Gateshead CCGs in 2021/22 and will continue to support these GPs until North Tyneside and Newcastle Gateshead establish their own programmes.

In addition to the GP Fellowship Programme, the CCG has also launched nursing Fellowships. This nurse Fellowship is similar to the GP Fellowship programme and is eligible to all newly qualified clinicians and provides funded

sessions and a bursary to support professional development, offers a peer support group and an induction into primary care and the wider health and social care system. Since its launch at the beginning of the year, the programme has supported two nurses and work by the CCGs link practice nurse is paving the way for more nurses to join throughout 2022/23.

Ford Next Generation Learning (NGL) Programme

The CCG is working with the North East Local Enterprise Partnership at Northumberland College as part of their Ford Next Generation Learning (NGL). The programme, which sees students learn through engagement with local employers has seen students develop a 'leaver profile', which outlines the skills, knowledge and attributes young people need to successfully move on to further education, training or employment when they leave college.

The CCG was involved in the process with other local employers, students, parents, teachers and community groups to create the leaver profile and will see the CCG help to provide placement opportunities in general practice for the college's health and social care work level one and two students.

b. Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities

Within 2021/22 we developed and successfully held an *'Understanding Our Communities'* education workshop for our stakeholders (GPs, Practice Managers and PCNs) and later a Population Health Management workshop for our workforce within the CCG to help increase awareness of what Population Health Management means and encourage both our frontline workers and workforce to look at the current health care needs of our local population, help challenge ways of thinking, develop new cultures and approaches to improve health outcomes and address health inequalities. Population Health Leads have been appointed to PCNs to help drive vision and approaches forward.

5. **Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency department (ED), improve timely admission to hospital for ED patients and reduce length of stay**

a. Transforming community services and improve discharge

Community Transformation

Supporting people to age well has been a key priority in 2021/22. Several pieces of work have been undertaken with an aim of supporting older people

to stay within their own homes in the communities they choose to live in and avoid admission to hospital where appropriate.

- There was a continued promotion of Multidisciplinary Team (MDT) working where GPs, nurses, Allied Health Professionals (AHPs) and social care teams work in an integrated way to meet the needs of people to enable them to live independently in their own homes for as long as possible. This MDT working also enables people to be supported both to prevent an admission and to enable a safer discharge. A new initiative supported by national funding was the new two hour urgent community rapid response service. This new approach will enable people with either a health or social care urgent problem to receive a response within two hours of a request being made. The service started on 1 April 2022 and will be evaluated to establish a greater understanding of the support people may need and from which professional groups. A steering group has been established to enable a collaborative approach to the development of the service ensuring we share and learn our findings as the service develops.

- End of Life Strategy – we have worked with partners from across the system to review and update the End of Life Strategy. This has involved forming a task and finish group with key stakeholders including the Palliative Care Clinical Team, GPs, Healthwatch, local councillors and patient and carer representation. The group conducted a comprehensive review of data around End of Life care and developed an interactive dashboard which allows information to be viewed at ward level for indicators associated with End of Life (e.g. cause of death, demographics). A mapping exercise was completed using the National Council for End of Life Ambitions to understand what is working well and if there are any gaps across health and care provision. An engagement exercise has been completed using a broad range of methods including virtual and face-to-face settings. This information has been used to form a series of priorities and to develop plans on how to address priorities. A monitoring group is in development to oversee the delivery of these plans. The strategy has now been finalised and is expected to be published in early 2022/23.

- Supporting care homes continues to be a high priority as the integrated care homes steering group brings together professionals from across health and social care to work together to support care homes with the management of COVID-19 as well as wider initiatives linked to the enhanced health in care homes framework. This framework has increased the NHS support into care homes, with aligning PCNs to care homes and in identifying clinical leads to link into MDT working.

Hospital Discharges

Hospitals have been under unprecedented pressure during the pandemic and as a result they have needed to be able to make beds available for new patients as early as possible. To support with this, in partnership with the Local Authority, many care homes in Northumberland were contracted to provide short term discharge placements. These placements enabled patients that were medically fit but could not go immediately home to have a short stay in a care home while longer-term care plans were established. The purpose of this arrangement was to make it as easy as possible for patients to leave hospital as soon as they no longer had a medical need to be there.

In addition, support into care home models, such as discharge to assess, have been implemented where professionals complete discharge assessments within people's own homes, and following the assessments provide the necessary support from rehabilitation services such as short-term support and/or assistive equipment. This approach speeds up the hospital discharge process and makes assessments more meaningful to the patients within their own homes rather than within a hospital setting.

b. <u>Ensuring the use of NHS 111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments</u>

NHS 111 is a crucial service in ensuring our patients can access care in the right place, first time, utilising all available options for support in a primary and community care setting to avoid unnecessary admissions to secondary care.

During 2021/22 access to NHS 111 for patients continued to be improved helping deliver better patient experience and reducing unnecessary attendances. Examples of how this was achieved were:

- Communication campaigns promoting the use of 111 significantly increased the demand for both services across the North Region.
- Implementing NHS 111 Online allowed patients to access urgent healthcare online. It also helped to manage increasing demand on NHS 111 telephony services. Patients can access the service at any time of the day.
- Further in-year developments supporting increased access are now available to patients when using NHS 111 Online. These include direct access to pharmacy and the ability to speak to a clinician as required. There is also the ability to be booked for a face-to-face appointment where appropriate.

Other initiatives that helped improve access for patients and improve the timeliness and appropriate use of emergency departments during 2021/22 were:

- **Improved access to medication schemes –** during 2021/22 all pharmacies across the North East and North Cumbria standardised their minor ailment schemes with community pharmacy. This meant that patients self-presenting at pharmacies with a minor ailment can access medication directly. An urgent medication scheme was also introduced on a pilot basis. Patients can access urgent medication directly from a pharmacy without the requirement to call 111 first. These developments have increased access for patients and consequently reduced the calls into 111 and demands on GP practices and emergency departments.

- **Implementation of NHS Pathways Streaming Tool –** the urgent care self-service tool, also known as the streaming and redirection tool, is a kiosk-based service, provided as a web application. The tool is designed to provide help and direction for patients who arrive at accident and emergency (A&E) departments and urgent care settings who did not contact a 111 service beforehand and have arrived with no pre-booked arrival time or appointment. This supported patients to access the most appropriate services. Northumbria Healthcare NHS Foundation Trust has implemented the tool in both Wansbeck and Rake Lane Urgent Treatment Centres. The rollout in Northumbria Specialist Emergency Hospital is being progressed.

- **Paramedic Pathfinder –** Paramedic Pathfinder was introduced by the North East Ambulance Service NHS Foundation Trust (NEAS) with the aim to reduce unnecessary attendance at departments. The Paramedic Pathfinder is a face-to-face clinical triage tool to support paramedics decision-making. The tool allows paramedics to confidently choose the most appropriate place for treatment. This could include referral to a patient's GP, being managed at home or by accessing Northumberland urgent care services.

- **Berwick Community Paramedic –** the pilot, which has been operating since July 2019, focused on reducing ambulance conveyance to hospitals including A&E departments and increasing the use of alternative dispositions (Hear and Treat/See and Treat) to enable patients to be treated locally. The intention was to improve both patient safety and experience along with reducing demand on the pressured ambulance and hospital resources. The pilot highlighted the value of Community Paramedics in supporting rural communities, with a significant decrease in

time to arrival, increased See and Treat rates and a reduction in emergency transfers. Northumberland Clinical Management Board reviewed the outcomes of the pilot and approved recurrent commissioning of this service.

6. **Working collaboratively across systems to deliver on these priorities**

Northumberland CCG since its inception in 2013 has had a long and productive history of collaboration across the system within Northumberland itself and also the wider geography of the North of Tyne and with the North East – at the scale of best effect for our residents and patients.

The CCG's integrated working and shared roles across the whole life spectrum from Best Start in Life to Ageing Well with Northumberland County Council mean that residents with Special Educational Needs and Disabilities, complex mental health needs and learning disabilities have access to a wide range of support and services through a single point of access. From a living well and an ageing well perspective, joint working in care homes, continuing care, primary care networks and other multi-disciplinary teams offer wide-ranging access to services and support.

From a more formal perspective, the CCG is an active member of the Health and Wellbeing Board and the CCG Clinical Chair is the vice chair of the Board. Major focus areas of the past year have included the highly successful vaccination programme, safeguarding adults and children, and developing an inequalities strategy that will drive the ambition of the Northumberland system for years to come.

The CCG has a pivotal role in the design and delivery of the System Transformation Board, which draws together all system statutory health and care partners including Healthwatch and focuses on what can be done best through system delivery rather than individual partners. Large investments in the population health management approach across the Northumberland system as well as managing through COVID-19, the logistics of managing the backlog caused by COVID-19 and supporting each other through times of significant surge and pressure have been the priorities for the Board during 2021/22.

The CCG plays an important part in other NHS footprints across the wider North East including the development and management of contracts with providers covering more than one geography (Northumbria and Newcastle Hospitals for example, as well as mental health services), planning services for the future and leading as the commissioner for ambulance services for the whole North East geography (North East Ambulance Service). This puts the CCG in a strong position for the future as it transitions to the Integrated Care System in terms of

keeping the importance of Place and the integrated work in Northumberland alongside managing economies of scale where it benefits the residents and patients most.

a. Effective collaboration and partnership working across systems

Safeguarding - SIRS

Sharing Information Regarding Safeguarding (SIRS) is a process developed by the CCG's Designated Nurse Safeguarding Children from the action identified following a Safeguarding Children's Practice Review (SCPR). The aim of the SIRS process which is embedded in primary care which aims to improve information sharing regarding fathers. Maternity services and GP practices share information regarding fathers when registered with a different GP practice to the pregnant woman. Those registered at the same practice have internal arrangements already in place to ensure information is shared, usually via multi-disciplinary team meetings.

The Child Safeguarding Practice Review Panel (National Panel) as part of their third thematic review, *'The Myth of Invisible Men: Safeguarding children under 1 from non-accidental injury caused by male carers'* September 2021. Identified SIRS as emerging good practice and has generated a great deal of interest from all parts of the country who are looking at what we are doing in Northumberland and how they can implement it in their area.

Safeguarding – Named Nurse Primary Care and Supporting Families Meetings

The Named Nurse Primary Care (NNPC) aims to attend each practice at least once annually. This offers the opportunity to support, share learning, seek assurance and identify any areas for development. Additionally, this provides an opportunity to develop good links with GPs and Primary Care staff. To achieve this, the most appropriate setting is to attend the supporting families multi-disciplinary meeting where vulnerable people are discussed.

To-date the NNPC has attended 34 practices 'supporting families' meetings either face-to-face or online via Microsoft Teams. Attendance at these meetings allow the NNPC to share learning from Case Reviews and CQC inspections, to discuss any training needs or training opportunities for Primary Care staff in addition to supporting and advising on safeguarding concerns.

Safeguarding – Sharing of Police Child Concern Notifications (CCNs) with Audit

Operation Encompass is a national police initiative to ensure schools are made aware of incidents relating to domestic violence where the police are called to homes where children reside. This was rolled out in Northumberland in April 2017 and aimed at ensuring the safety and wellbeing of school age children. Additionally, Operation Endeavour, which is the sharing of police CCNs relating to children who go missing with schools, the CCG also shares these CCNs regarding missing children with GP practices. This enables relevant primary care staff to have an awareness of particularly vulnerable children registered with GP practices.

The CCG share the police CCNs with GPs, with general practice being well placed to offer support to families where domestic abuse is a concern. Furthermore, it is essential that GPs and primary care staff are aware of vulnerable children and young people who have missing episodes and the risk these missing episodes pose. It is therefore imperative that GPs and primary care staff are made aware of any risks identified for families and sharing CCNs is an ideal way to keep GPs up-to-date of any current concerns. A few neighbouring CCGs have shown interest in sharing the CCNs with Primary Care and are looking at implementing this in their area. The Interim Designated Nurse is currently completing an audit regarding the impact of sharing the CCNs with Primary Care.

Safeguarding – ICON

ICON is an NHSEI prevention programme that is designated to raise awareness and reduce the incidence of Abusive Head Trauma (AHT) in children. This intervention has been shown to be successful nationally not only because of its simple key messages but also its ability to fit into mainstream services and adaptability to be utilised across professional boundaries.

ICON was rolled out in Northumberland in September 2021 in partnership with maternity and 0-19 services. In preparation for this, the Named Nurse Primary Care shared the ICON message and touch points, specifically what this means for GPs or APNP carrying out the six week check and additional information regarding the template, Read Code and the AccuRx. This has been carried out in line with the training delivered to the Foundation Trust's 0-19 and Maternity services.

The ICON sessions were delivered at the following:-

- Four GP Locality meetings, where there was attendance from 33 practices
- Four individual GP practices at their request
- Primary Care Safeguarding Nurse Network
- Seven drop-in sessions via MS Teams

b. Develop the underpinning digital and data capability to support population-based approaches

Within 2021/22 we developed and successfully held an Importance in Data Sharing Workshop with our stakeholders (GPs, Practice Managers and PCNs). The workshop focused on the reason data sharing is important and what data will be shared with whom, along with how this fits into the local and national plan. Next steps include developing a Memorandum of Understanding with our stakeholders.

NECS is currently in the process of developing a cloud based digital platform called AXIOM, that will provide a "single version of the truth" and will be made up of secure data access environments focused on specific organisations in line with information governance. It plans to provide a private ringfenced space to access and analyse data. AXIOM is built upon the infrastructure NECS currently holds on behalf of Data Controllers across the health care system. They are combining this into one wraparound environment and improving the functionality.

RAIDR is the UK's leading health intelligence tool across the ICS and underpins our approach to Population Health Management using analytical techniques, which link and aggregate data to provide comprehensive cohort analysis. RAIDR will allow us to be in control of information and explore multiple datasets by drilling down intelligence in various ways focusing on specific themes, subject level etc. at a national, regional or local level into a single portal.

c. Develop ICSs as organisations to meet the expectations set out in Integrating Care

Integrated care is about giving people the support they need, joined up across local councils, the NHS and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services.

Integrated Care Systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

ICSs will absorb the responsibilities of CCGs in the future. During 2021/22, the CCG has continued to play an active part in the development of the North East and North Cumbria Integrated Care System (NENC ICS), contributing to the development of strong local leadership and supporting the transition towards statutory status for the ICS on 1 July 2022. This has included ensuring that the arrangements for the new ICS organisation build on the successful partnerships already established in Northumberland that the governance arrangements will continue to enable sufficient focus on the improvement of services for Northumberland patients. The new organisation promises to be well positioned to build on the achievements of the CCG over the past nine years.

PERFORMANCE ANALYSIS

The CCG has an ongoing performance review process that manages the NHS constitutional targets along with other key metrics and ensures that Northumberland patients are able to access a wide range of quality led health services, delivered to safe and recognised standards within a timely period.

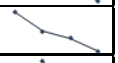
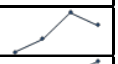
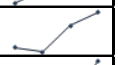
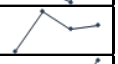
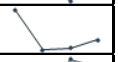
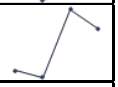
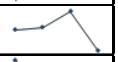
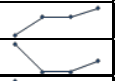
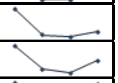
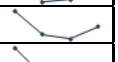
Members of our Clinical Management Board consider performance update reports monthly. The reports summarise the performance of the CCG against the key constitutional indicators. Where there are areas of underperformance or performance concern, the reasons are outlined along with the requisite actions. Provider performance is also included, together with appropriate actions being taken in response to highlighted issues. The exception report, together with Clinical Management Board comments and actions is also presented to our Governing Body.

We also provide assurance on a regular basis to NHS England. Outside the normal review time scales we highlight emerging issues and the immediate actions being taken in response to NHSE when deemed necessary.

A continued focus for the CCG and providers in Northumberland during 2021/22 has been to recover services and improve performance amidst the continued difficulties caused by COVID-19. Along with other areas outlined within this report, the impact of COVID-19 has had a major impact on the CCG's performance along with all organisations across both the local system and across the country. In particular the impact of COVID-19 on staff absences combined with more stringent infection control procedures has caused great difficulties for services. Greater demand for services due to the pandemic, both in terms of delayed treatments and growing clinical need, have also posed greater pressure on services and made returning to previous high-achieving performance standards extremely difficult.

Table 1 overleaf shows our performance against the range of indicators mainly covering the NHS Constitution. The data presented captures the most recent position available at the time of publication. The indicators that are RAG (red, amber, green) rated have a target to compare performance against.

Table 1 - NHS Northumberland CCG Performance indicators 2021/22

Indicators	Indicator Description	Latest Data Period	CCG		Monthly trend
			NHS Northumberland CCG		
			Threshold	YTD	
Referral to treatment access times	% of patients initial treatment within 18 weeks for incomplete pathways	Mar-22	92.0%	77.0%	
	Number of patients waiting more than 52 weeks for treatment		0	12,732	
Diagnostic waits	% patients waiting more than 6 weeks for the 15 diagnostics tests (including audiology)	Mar-22	1.0%	13.8%	
A&E waits	% patients spending 4 hrs or less in A&E or minor injury unit	Mar-22	95.0%	91.5%	
	Over 12 hour trolley waits		0	0	
Cancer Waits	% of patients seen within 2 weeks of an urgent GP referral for suspected cancer	Mar-22	93.0%	84.6%	
	% of patients seen within 2 weeks of an urgent referral for breast symptoms		93.0%	86.6%	
	% of patients treated within 62 days of an urgent GP referral for suspected cancer		85.0%	68.9%	
	% of patients treated within 62 days of an urgent GP referral from an NHS Cancer Screening Service		90.0%	78.0%	
	% of patients treated for cancer within 62 days of consultant decision to upgrade status		N/A	55.5%	
	% of patients treated within 31 days of a cancer diagnosis		96.0%	93.1%	
	% of patients receiving subsequent treatment for cancer within 31 days - surgery		94.0%	77.5%	
	% of patients receiving subsequent treatment for cancer within 31 days - drugs		98.0%	98.5%	
	% of patients receiving subsequent treatment for cancer within 31 days - radiotherapy		94.0%	97.0%	
	% 28-day wait for patients to be told whether or not they have cancer after an urgent referral from their GP or a cancer screening programme		*70% (shadow monitoring)*	*75.3%*	
Mental Health	Early intervention in psychosis - % with 1st episode treated within 2 weeks	Mar-22	60.0%	85.2%	
	% people with anxiety disorders and depression who access psychological therapies (IAPT)	Feb-22	20.2%	13.52%	
	% complete treatment who are moving to recovery	Feb-22	50.0%	51.4%	
	Waiting times for routine referral to CYP Eating Disorder Services - Within 4 weeks	Rolling 12 months to Q4 2021-22	95.0%	79.5%	
	Waiting times for Urgent referrals to CYP Eating Disorder Services - within 1 week		95.0%	100.0%	
HCAIs	Incidence of MRSA	Mar-22	0	1	
	Incidence of C Diff	Mar-22	71	94	
	Incidence of e-coli	Mar-22	262	269	
Ambulance (CCG)	Category 1 Response times (7 Minutes average)	Mar-22	7 minutes	00:08:11	
	Category 2 Response times (18 minutes average)		18 minutes	00:31:09	
	Category 1 Response times (90th centile)		15 minutes	00:18:23	
	Category 2 Response times (90th centile)		40 minutes	01:04:58	
	Category 3 Response times (90th centile)		2 hours	03:01:21	
	Category 4 Response times (90th centile)		3 hours	02:40:12	

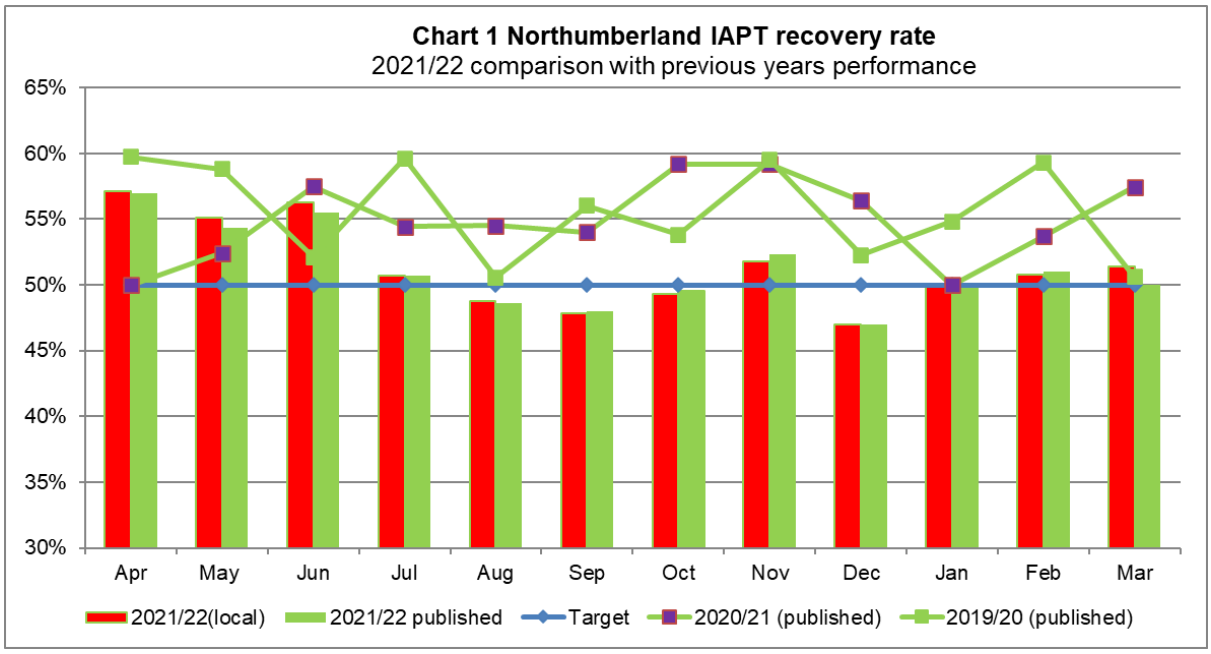
The previous section on the CCG's operational plan delivery illustrates the work undertaken to maximise achievement of the constitutional standards. The following section provides further detail about the CCG's performance against the NHS Constitutional standards and therefore how successful the CCG's operational plan was in mitigating the impact of COVID-19 on service performance.

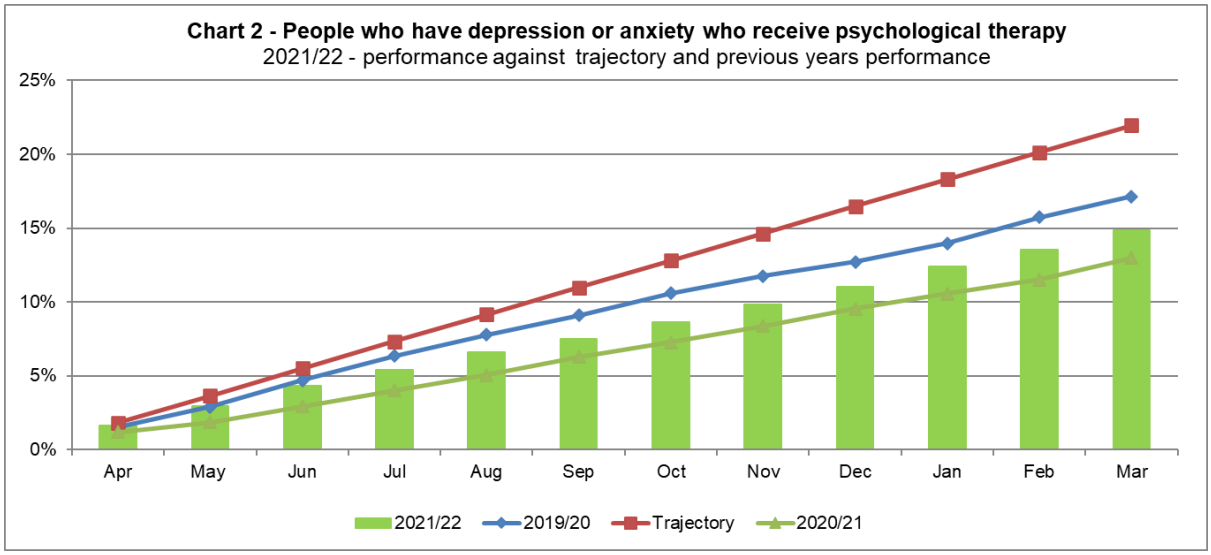
Mental Health Services

Improving Access to Psychological Therapies (IAPT)

In September 2021 the CCG recommissioned IAPT services from Cumbria, Northumberland and Tyne and Wear Mental Health Foundation Trust who continue to sub-contract to, and work in partnership with, the previous provider Talking Matters Northumberland (TMN). This arrangement enables the excellent work of TMN to continue alongside the security of a larger NHS provider which is felt will support the sustainability of services in light of workforce challenges and growing demand, particularly due to the impact of the pandemic.

The constitutional target for recovery rates is 50% of IAPT service users. Following a wide range of collaborative working between the provider and the CCG, performance during 2021/22 continued to hold around the 50% threshold each month, despite considerable pressure on the service.

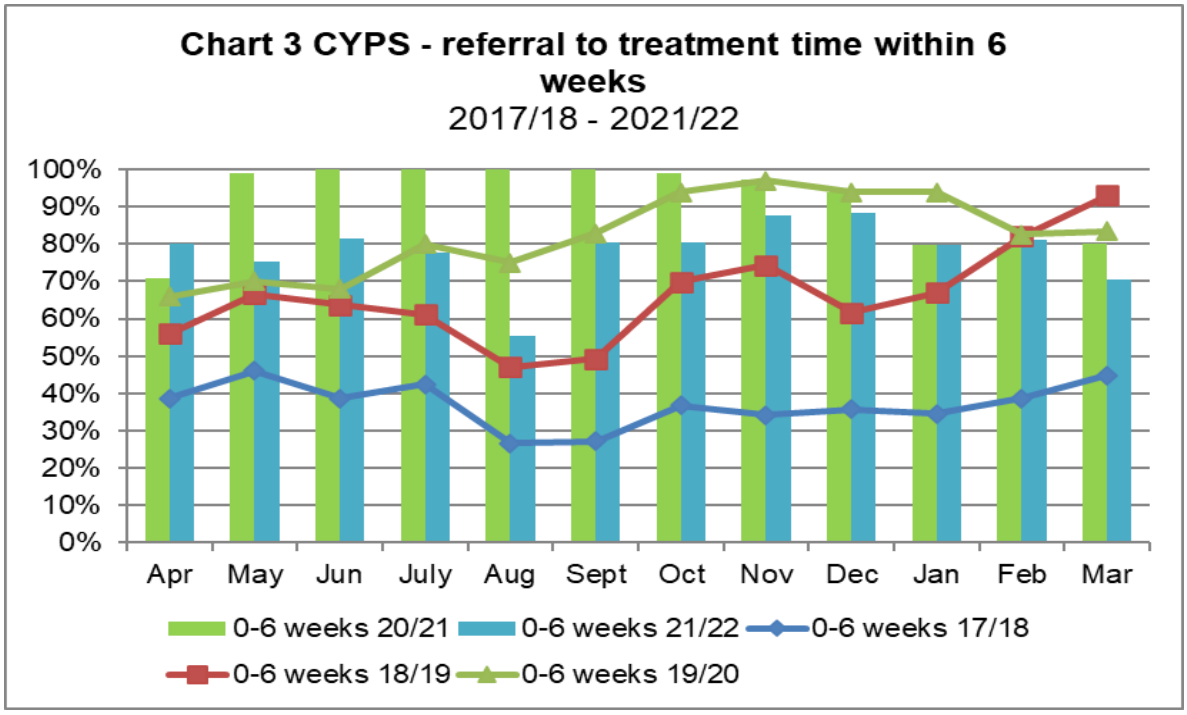




There is also an expectation that each year at least 22% of the population who experience depression and/or anxiety disorders receive treatment. Chart 2 above shows that the performance during 2021/22 is significantly below the trajectory but has improved from 2020/21 levels as patients have increasingly begun accessing services as COVID restrictions eased. This is consistent with the national and regional picture. The service along with the CCG is working collaboratively to promote the use of this service to ensure all those who need support are accessing the service.

Children and Young People's Services

Chart 3 below shows the monthly waiting times for the Children and Young Peoples' Service (CYPS). There is an expectation that no child or young person should wait longer than 18 weeks to be seen. Growing demand from the last quarter of 2020/21 continued throughout 2021/22 which meant performance reduced in 2021/22 compared to 2020/21. However, between 70-80% of all patients were treated within 6 weeks of referral throughout the year which demonstrated good, stable performance in the context of significant demand on the service.



Dementia Diagnosis Rates

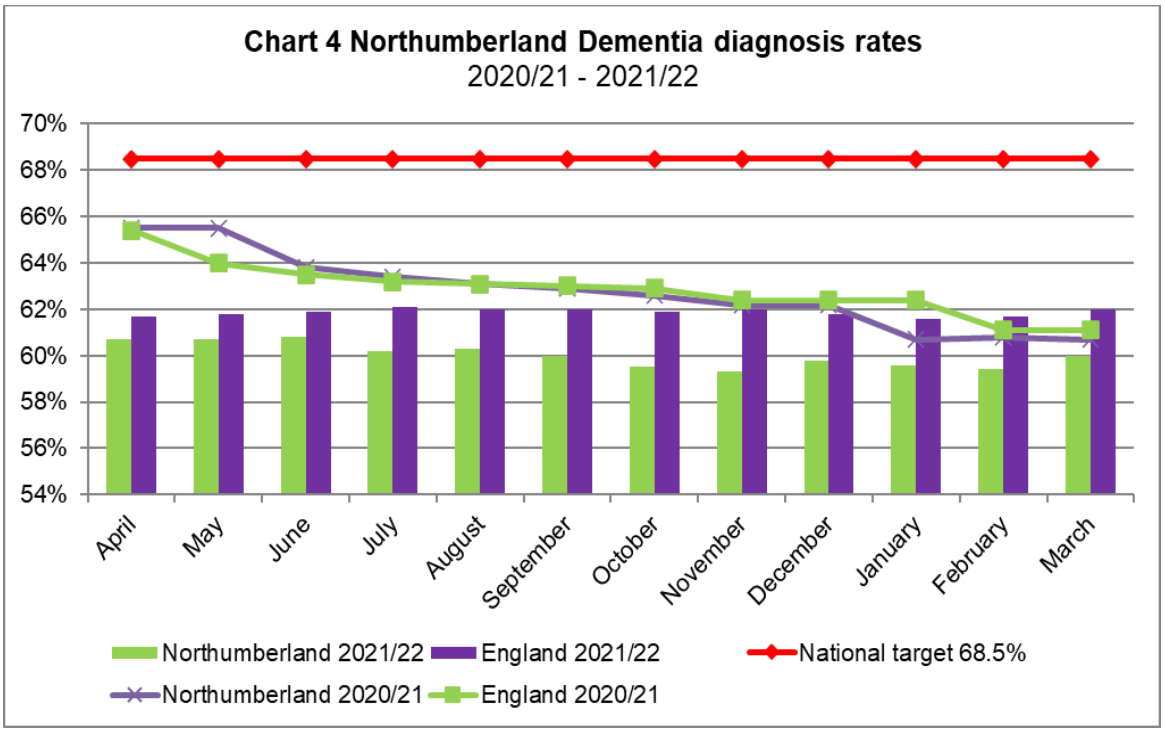


Chart 4 above shows the performance of the CCG underachieving against the 68.5% NHS Constitution standard and the England average. Dementia diagnosis rates are affected by two main issues: a lack of referrals and a lack of capacity to confirm diagnosis. Recovery from the pandemic has continued to impact on both issues but the CCG continues to work hard to increase recognition of dementia in the community and address variation in referrals to memory assessment services across GP practices. CNTW are also looking to address their capacity issues in memory assessment services including reviewing their service model.

Early Intervention in Psychosis

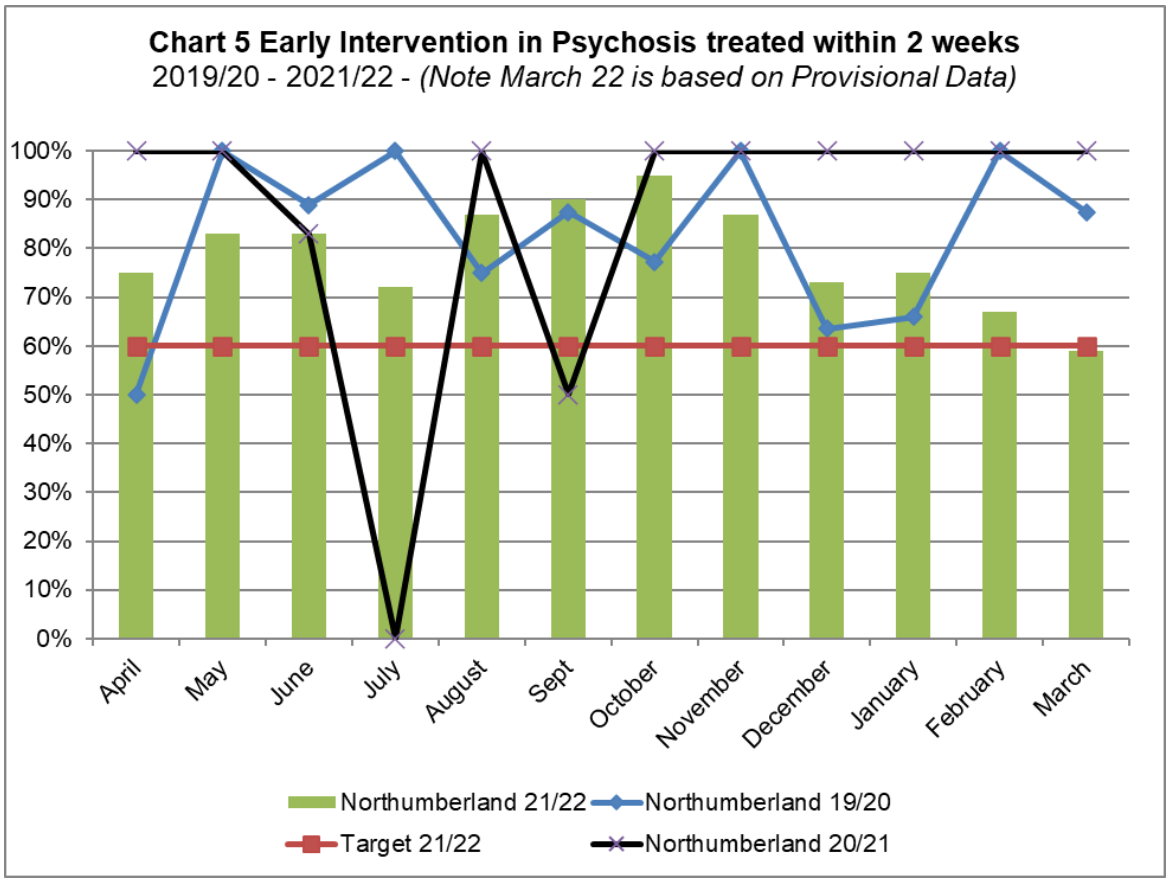
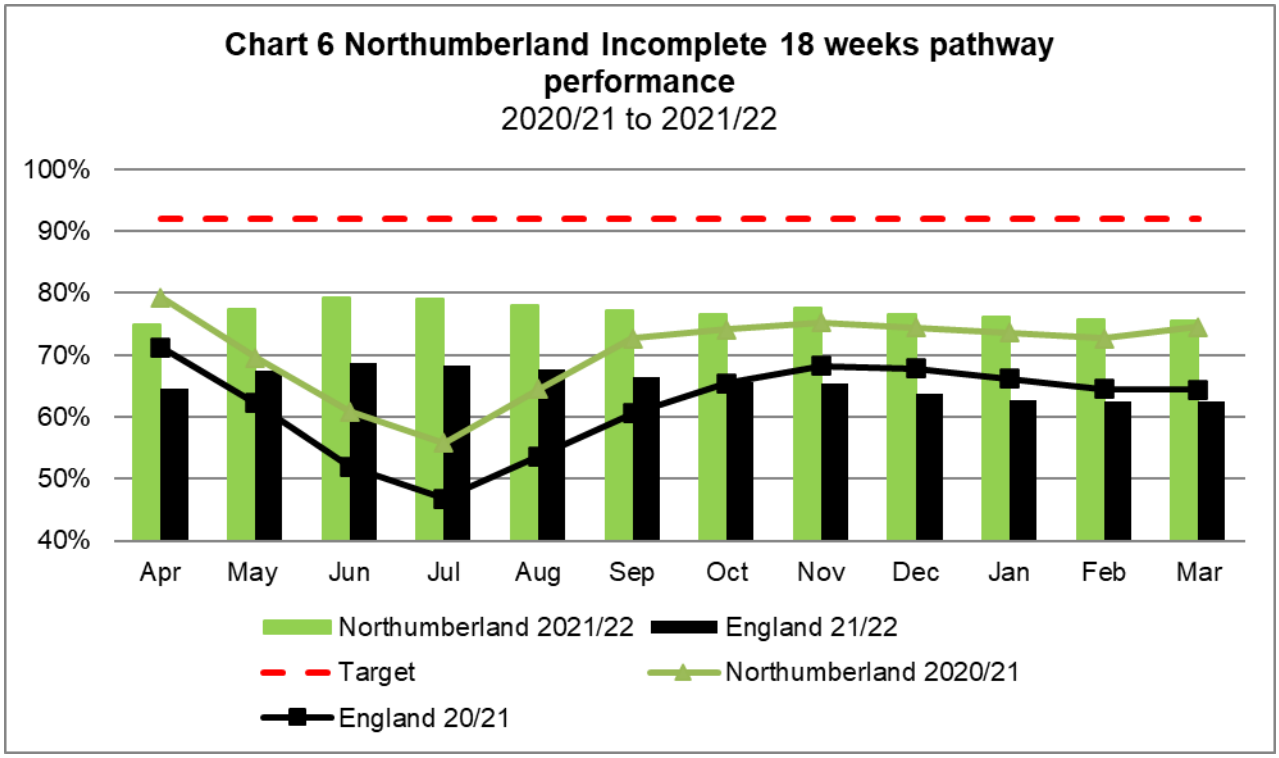


Chart 5 above shows our strong performance against the 60% NHS Constitution target. An ongoing challenge is offering an appointment for treatment within the 2 week period along with the low volume of clients being referred into the service.

Planned Care

Patient Access to Services

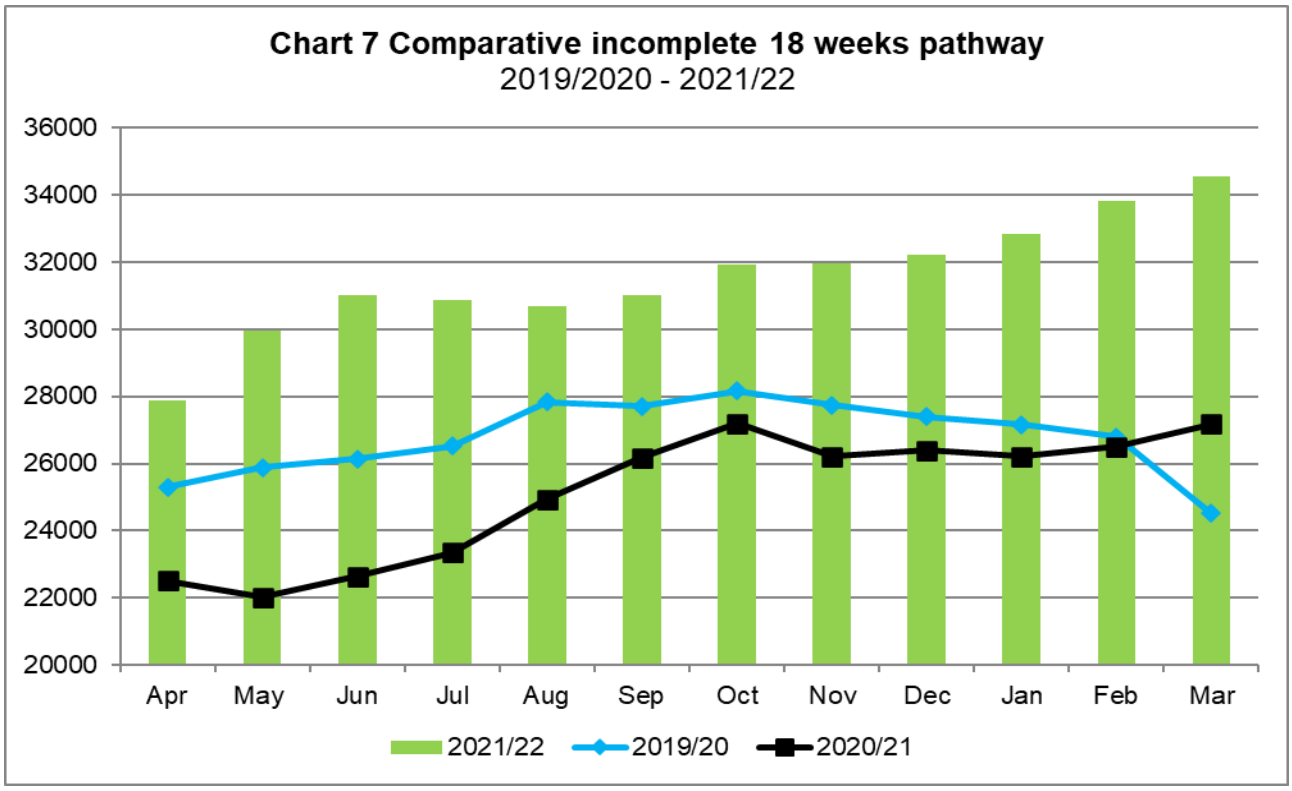
Chart 6 below shows that our performance along with the national position has deteriorated across the range of 18 weeks referral to treatment specialties and has failed to achieve the 92% constitutional target for the incomplete (waiting list) indicator throughout the year. Performance in Northumberland continues to be better than the national average however.



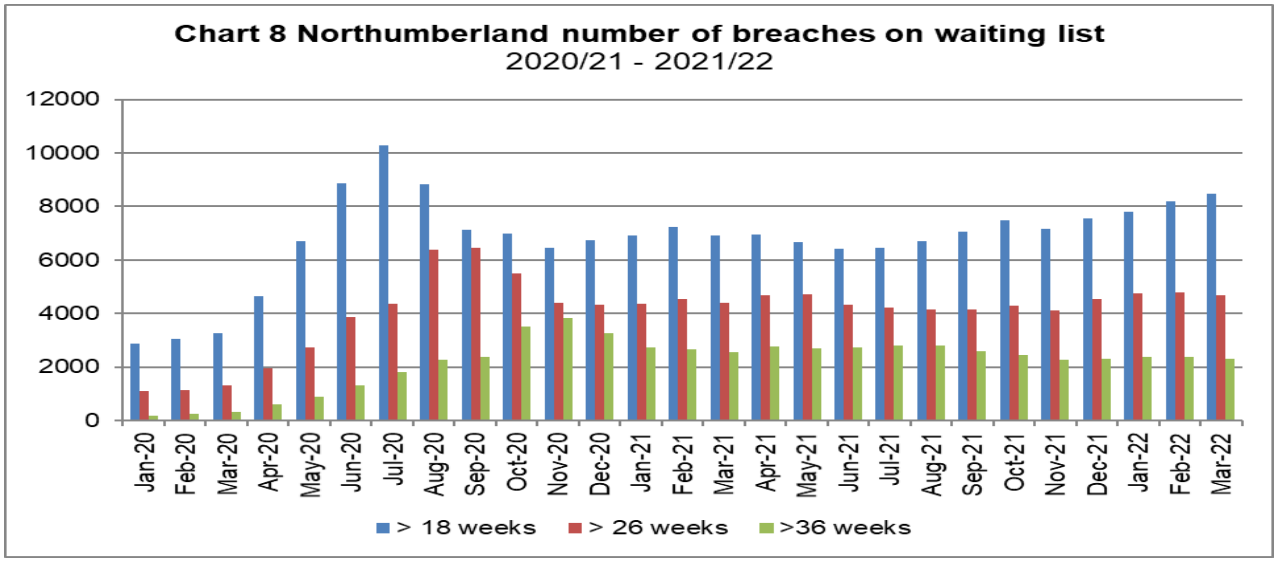
A significant proportion of the underperformance relates to the reduced capacity the providers have had to treat patients due to having to prioritise the treatment and care of patients with COVID-19 at different points in the year.

The social distancing requirements along with the additional time to administer more complex cleaning regimes and the use of personal protective equipment has also reduced both bed capacity and the volume of patients seen in outpatient appointments. Growing demand as COVID-19 restrictions lifted and patients began accessing services again, combined with continually high staff absence rates due to COVID-19, also created significant pressure on services.

The chart below shows the increase in waiting list as a consequence.

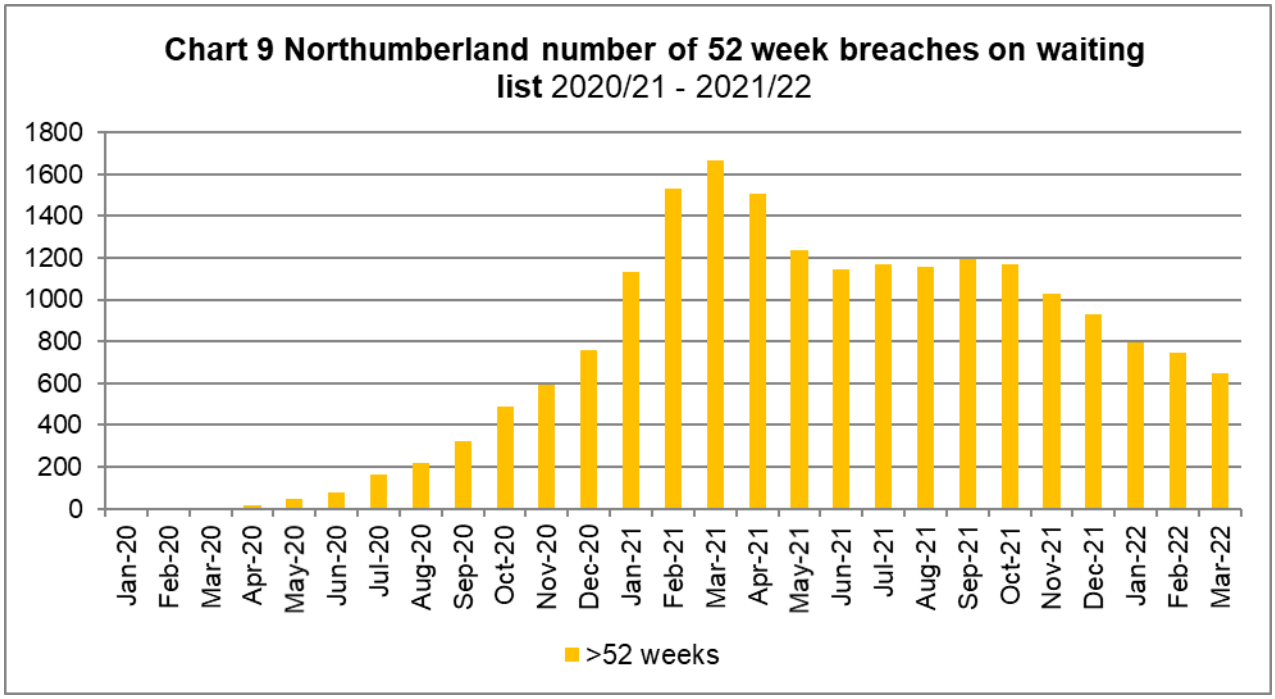


Not only did the volume of patients waiting for treatment increase, the length of time increased as well for many patients. A new range of metrics was introduced to review the breaches in excess of 18 weeks as shown below.



52 week waits

Because of the pandemic and the limited capacity of providers to treat patients, the volume of 52 weeks breaches grew significantly from the summer of 2020 onwards as shown on the chart below. The chart also demonstrates the improvement in performance during 2021/22 with the number of 52 week breaches reducing during the year.



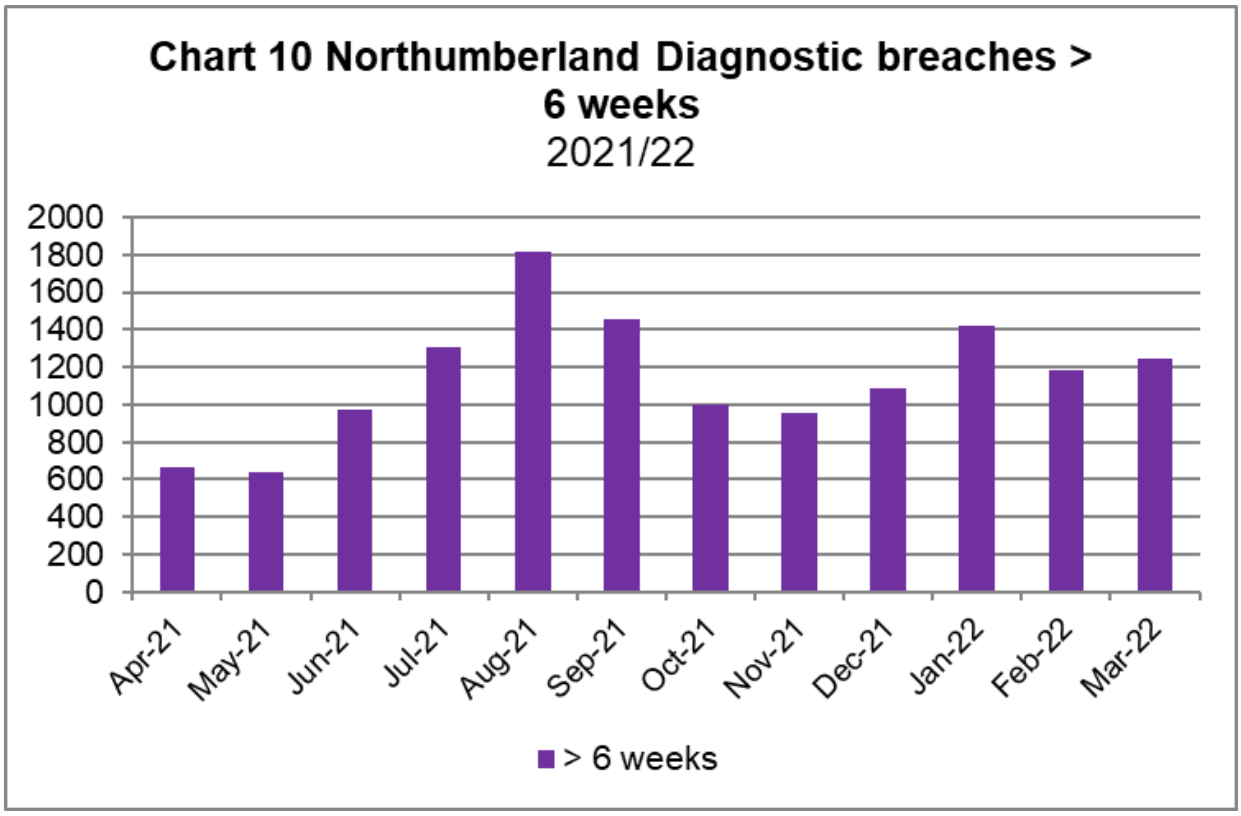
At the end of 2021/22 the specialties with the greatest waiting list pressures continue to be those requiring surgical procedures such as orthopaedics, dermatology, plastics and urology. The specialties with 52 weeks' breaches remaining are ophthalmology and neuro-surgery. Alongside hospital providers' continued use of waiting list initiatives to increase capacity, the CCG has continued to work with neighbouring CCGs and local providers to put actions in place to enable greater capacity. One example has been the increased use of the independent sector provider capacity and another was the approval of investment in greater cataract surgery provision at Newcastle upon Tyne Hospitals Foundation Trust (NuTH). Actions such as this have contributed to the reduction in 52 week breaches throughout the year.

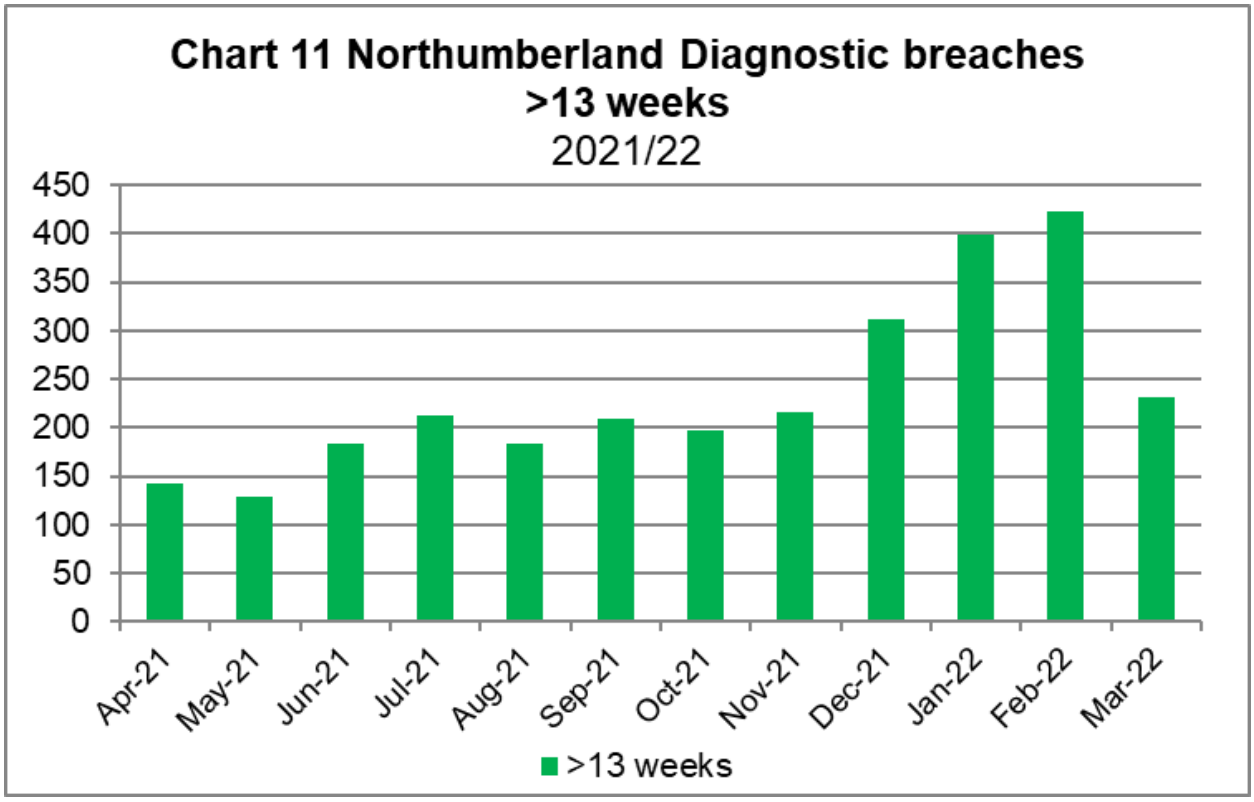
The CCG is continuing to monitor the waiting list profile and work with providers both at place level and across the wider health system to ensure that patients are not harmed because of waiting longer for treatment.

Diagnostic services

The NHS constitutional standard states that no more than 1% of patients should receive their diagnostic test later than six weeks after a GP referral. This standard was breached because of the on-going impact of the pandemic.

New metrics were introduced to monitor the recovery of the standard based upon monitoring the volume of patients waiting more than both 6 and 13 weeks as shown on the charts below and overleaf.





At the beginning of 2021/22 the tests generating the highest proportion of breaches continued to be non-obstetric ultrasound and cardiology procedures. The backlog for these diagnostics was addressed with the main growing pressures throughout the year being increased waiting times for computerised tomograpghy (C.T.), MRI and audiology. In the case of CT and MRI, the recovery of other services as referrals have increased as COVID-19 restrictions were lifted, led to a knock-on increased demand for diagnostic tests.

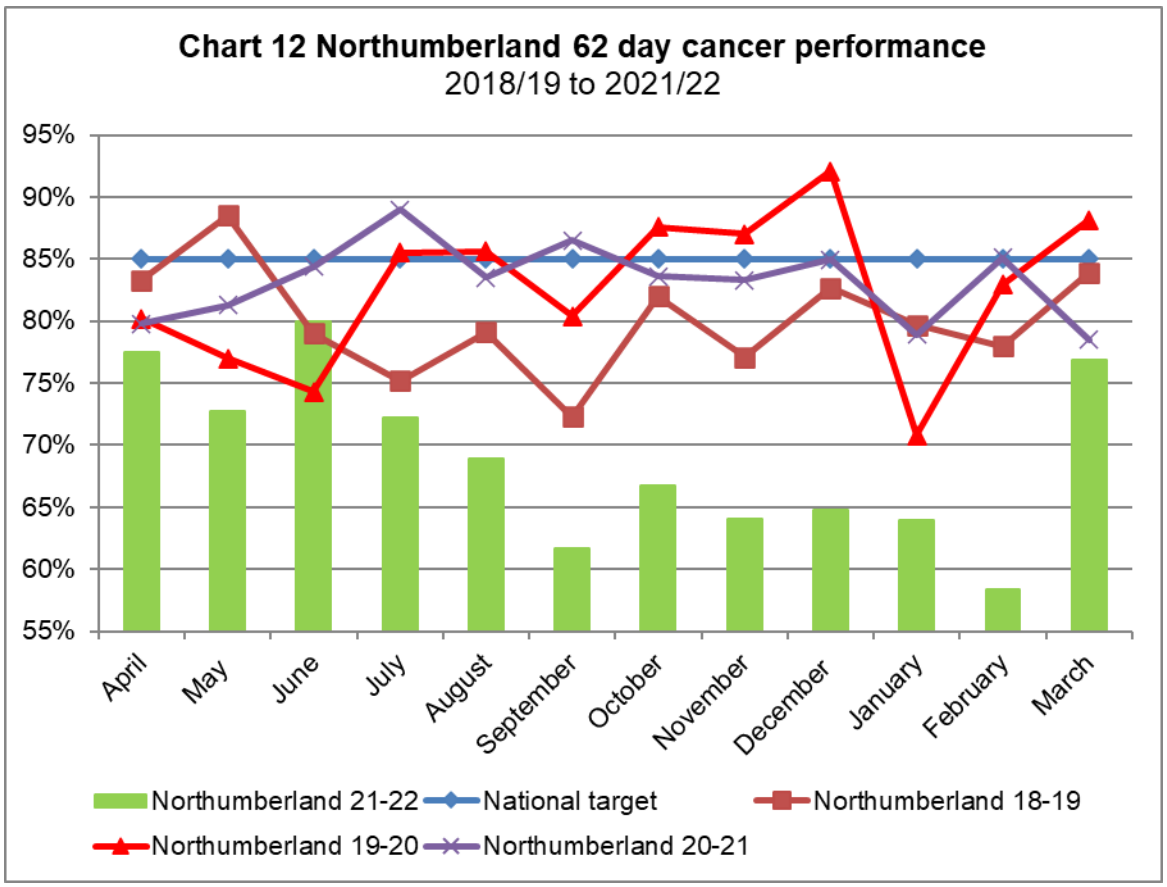
Cancer

Cancer Performance

The graph and tables below illustrate the continued difficulties to return to achieving the constitutional standards for cancer services. After initially facing difficulties during the earlier stages of the pandemic in terms of getting patients to access services given their perceived greater risk of contracting COVID-19, on a positive note during 2021/22 patients started accessing services again. The greater demands as patients came forward for treatment placed significant demands on the available capacity. The capacity available, as described earlier, continued to be constrained due to IPC measures and staff absences during to COVID-19.

Whilst cancer performance standards have been difficult to achieve across all pathways, particular pressure has been seen, in terms of the volume of breaches, in dermatology (skin), breast services, and gastrointestinal (GI) services. General actions across the board have been implemented to put waiting list initiatives in place and increase the use of the independent sector. Examples of pathway specific actions that have seen positive impact on 2021/22 are:

- Numerous initiatives to develop the lower and upper GI pathways including faecal immunochemical test (FIT) testing by GPs before referral and nurse led triage and endoscopy pathway improvements. FIT testing has showed a reduction in colonoscopy demand.
- Using patient navigators to pull diagnostics and treatments forward where possible.
- Chemotherapy capacity has expanded through the implementation of 7 day working
- Recruitment to specialist radiology posts, to create greater capacity



Patients seen within 2 weeks of referral from a GP in Northumberland

April 2021 to March 2022
Target 93%

Tumour Type	Treated in Time	Total Treated	Breaches	% Meeting Standard
Breast	2755	3087	332	89.2%
Lung	249	257	8	96.9%
Gynaecological	1661	1793	132	92.6%
Upper Gastrointestinal	1462	1528	66	95.7%
Lower Gastrointestinal	3372	3553	181	94.9%
Urological (Excluding Testicular)	1543	1572	29	98.2%
Testicular	47	49	2	95.9%
Haematological (Excluding Acute Leukaemia)	157	162	5	96.9%
Acute leukaemia	1	1	0	100%
Head and Neck	838	899	61	93.2%
Skin	1990	3732	1742	53.3%
Sarcoma	10	10	0	100%
Brain/Central Nervous System	1	1	0	100%
Childrens	11	18	7	61.1%
Other	4	4	0	100%
Total	**14101**	**16666**	**2565**	**84.6%**

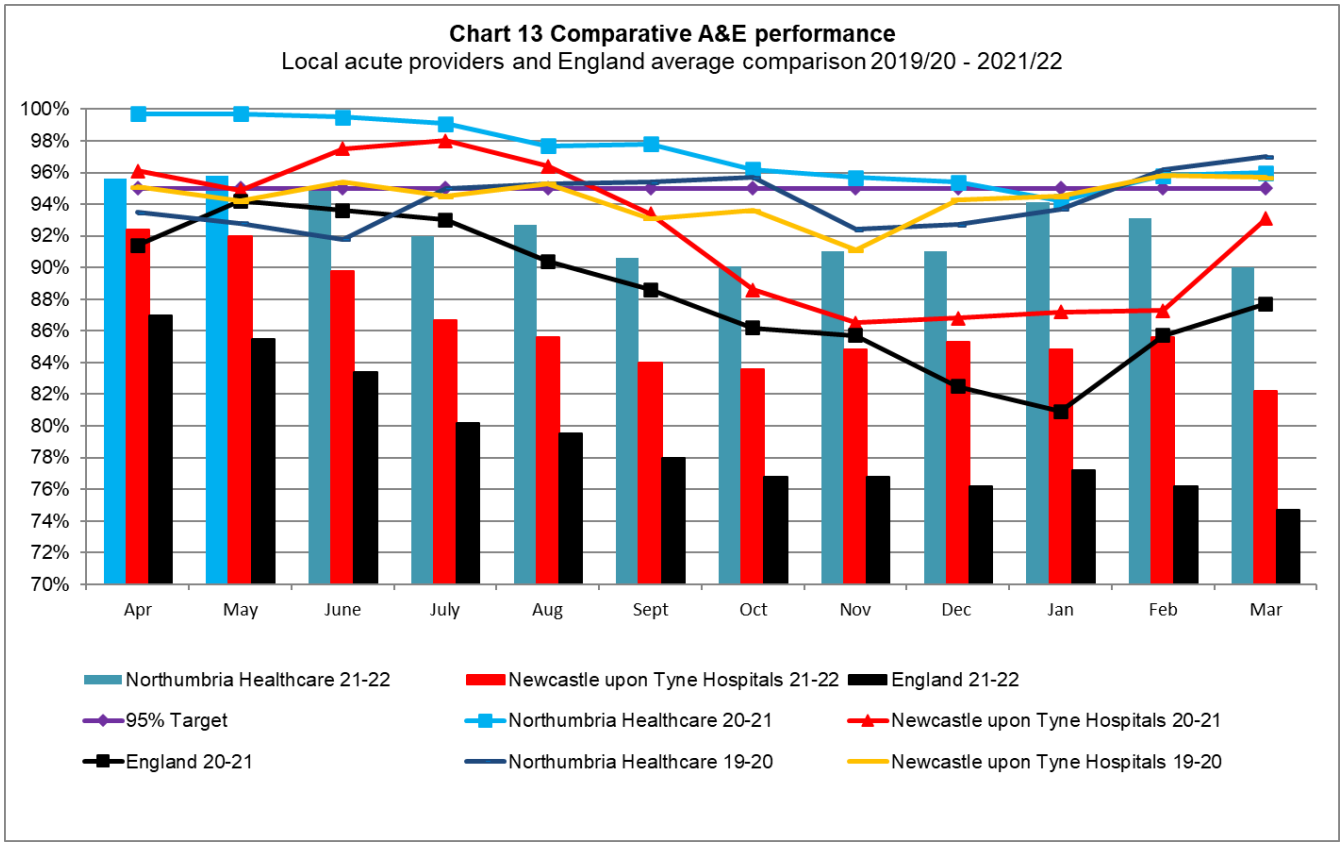
62 days cancer performance from referral to commencing treatment in Northumberland

April 2021 to March 2022
Target 85%

Tumour Type	Treated in Time	Total Treated	Breaches	% Meeting Standard
Breast	175	202	27	86.6%
Lung	31	68	37	45.6%
Gynaecological	33	73	40	45.2%
Upper Gastrointestinal	38	70	32	54.3%
Lower Gastrointestinal	97	159	62	61.0%
Urological (Excluding Testicular)	209	320	111	65.3%
Testicular	4	4	0	100%
Haematological (Excluding Acute Leukaemia)	47	61	14	77.0%
Acute leukaemia	1	1	0	100%
Head and Neck	37	44	7	84.1%
Skin	237	317	80	74.8%
Sarcoma	4	7	3	57.1%
Brain/Central Nervous System	1	1	0	100%
Other	7	8	1	87.5%
Total	**921**	**1335**	**414**	**69.0%**

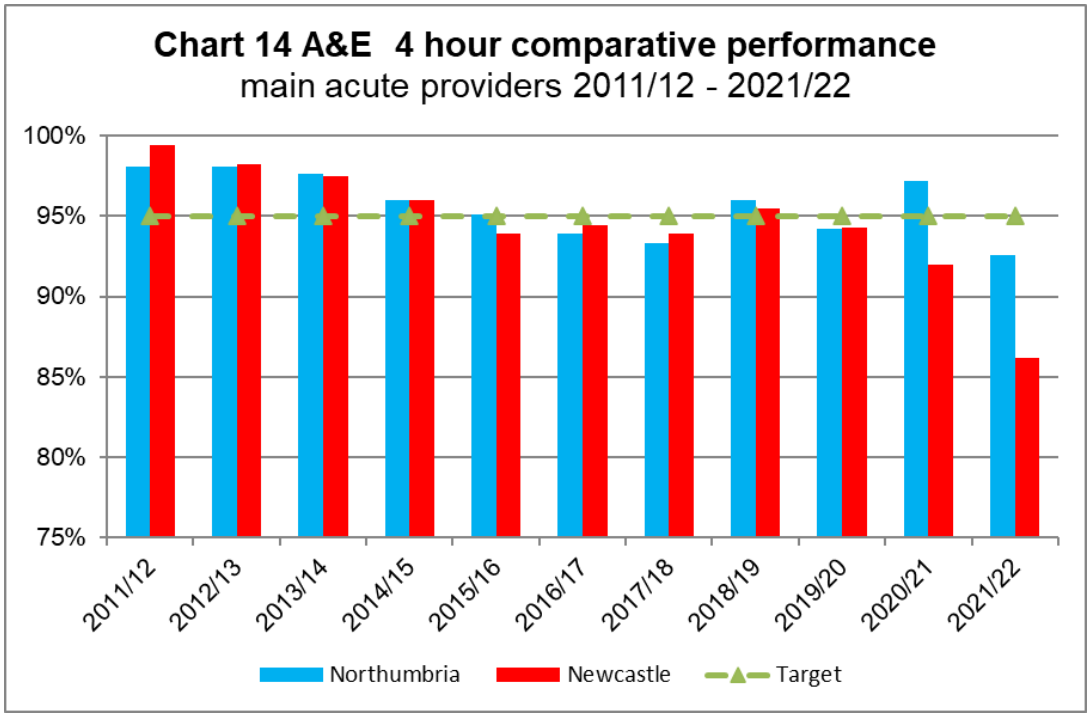
Urgent Care

Accident and Emergency Wait Times

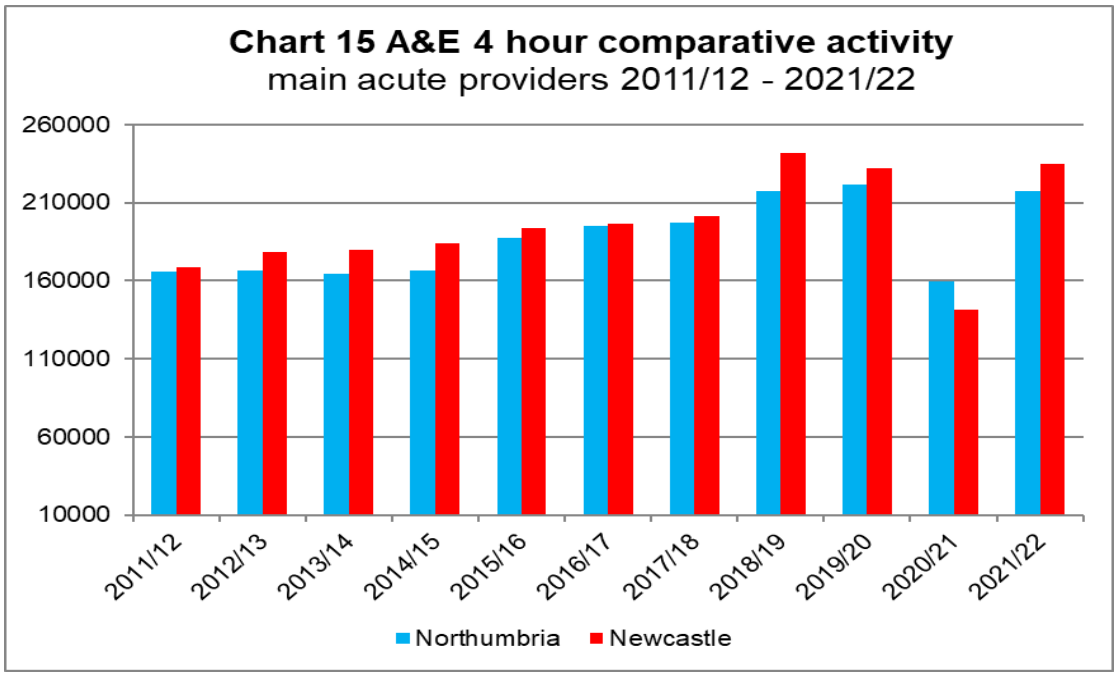


Local providers have traditionally shown some of the strongest performance nationally to ensure that patients were either treated or admitted to a ward within a maximum of four hours when they attended an accident and emergency department. This has continued although the constitutional standard has been difficult to meet at both of Northumberland's main providers due to impact of the pandemic.

Chart 13 above shows that Northumberland residents had access to a more responsive Accident and Emergency service when compared to the overall England average.



In recent years there has been a year on year increase in activity at each of the two main local acute providers as shown in chart 15 below, although during 2020/21 as a consequence of COVID-19 there was a reluctance from patients to attend the department resulting in a significant reduction in activity.



Ambulance Response Times

During 2021/22 Northumberland Clinical Commissioning Group accepted Host Commissioner responsibility for the Commissioning and Contracting arrangements with NEAS.

Throughout the last six months of 2021/22 the CCG has worked collaboratively with NEAS to develop a transformation improvement plan that will address service performance and meet Ambulance Response Standards and National Key performance indicators for 111 IUC. During 2021/22 the ambulance sector as a whole remained under significant pressure. Increasing demand and changes to the nature of the heath economy continued to adversely affect service performance.

In order to deliver improvements against all Ambulance Response Standards a three-year transformation programme to increase capacity and address the underlying resource gap, has been developed to respond to patients in a timely manner. The transformation programme includes significant recruitment across areas of the service including Paramedics, Clinical Care Assistants and Health Advisors to support improved 999 call answer times and response times. Alongside additional vehicles to increase capacity on the road

Increased clinical capacity within the clinical assessment service will support increased validation of ambulance dispositions from 111, with the aim of reducing ambulance demand, ensuring ambulances are only dispatched to those patients who need a face-to-face triage

Implementation of a sickness absence plan focused on mental health and wellbeing has also been established. In early 2018 Ambulance Services nationally introduced new metrics to report ambulance response times. This has involved the reclassification of incidents to give increasing priority to life threatening incidents. A summary of the revised classifications and metrics is below:

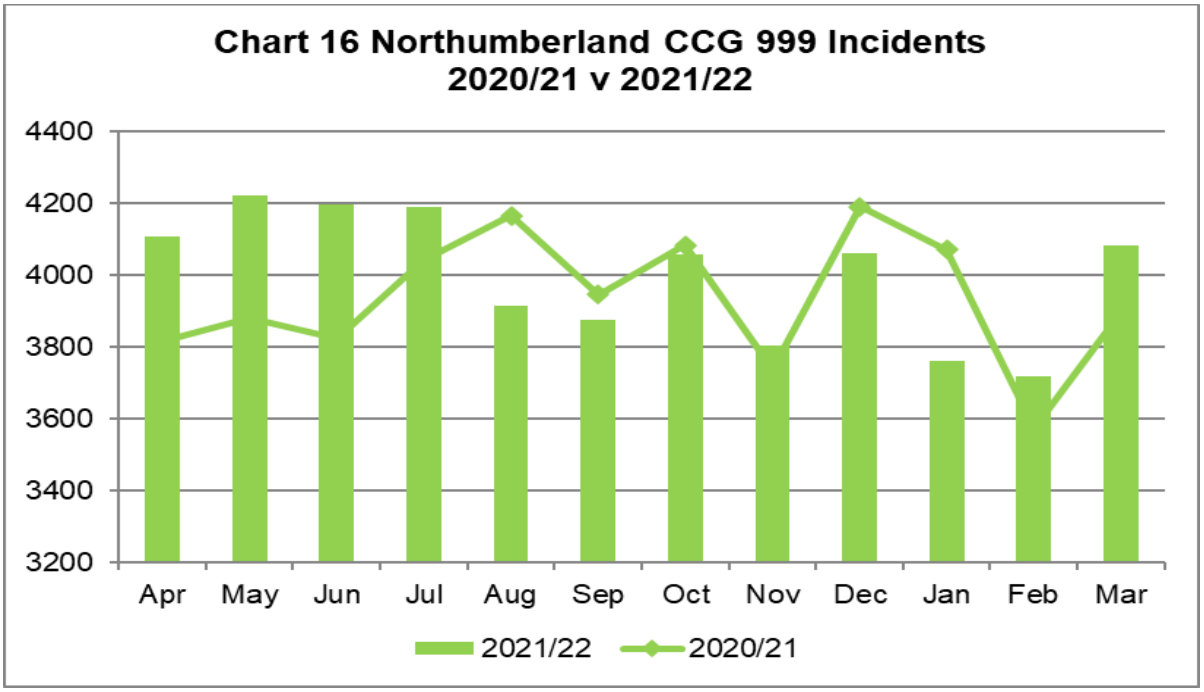
Category	Mean	90th % ile
Category 1 Life threatening	7 minutes	15 minutes
Category 2 Serious	18 minutes	40 minutes
Category 3 Urgent		2 hours
Category 4 Non urgent		3 hours

The metrics capture both the average and the 90th percentile performance to give a better profile of performance as it focuses on the variation in response waiting times. NEAS started to report on the new metrics in January 2018.

When considering the performance in the charts below the volume of patients in each category should be noted. An annual summary of the total number of incidents alongside the proportion is shown below.

2021/22	Category 1	Category 2	Category 3	Category 4
Incidents	3,688	28,597	10,137	770
Percentage	8.5%	66.2%	23.5%	1.8%

The volume of incidents across Northumberland varied throughout the year on a month-by-month basis as shown on the chart below during 2021/22. The variation followed a similar profile to 2020/21 aside from April to July 2021 where activity was higher likely due to differing pandemic impacts between years.

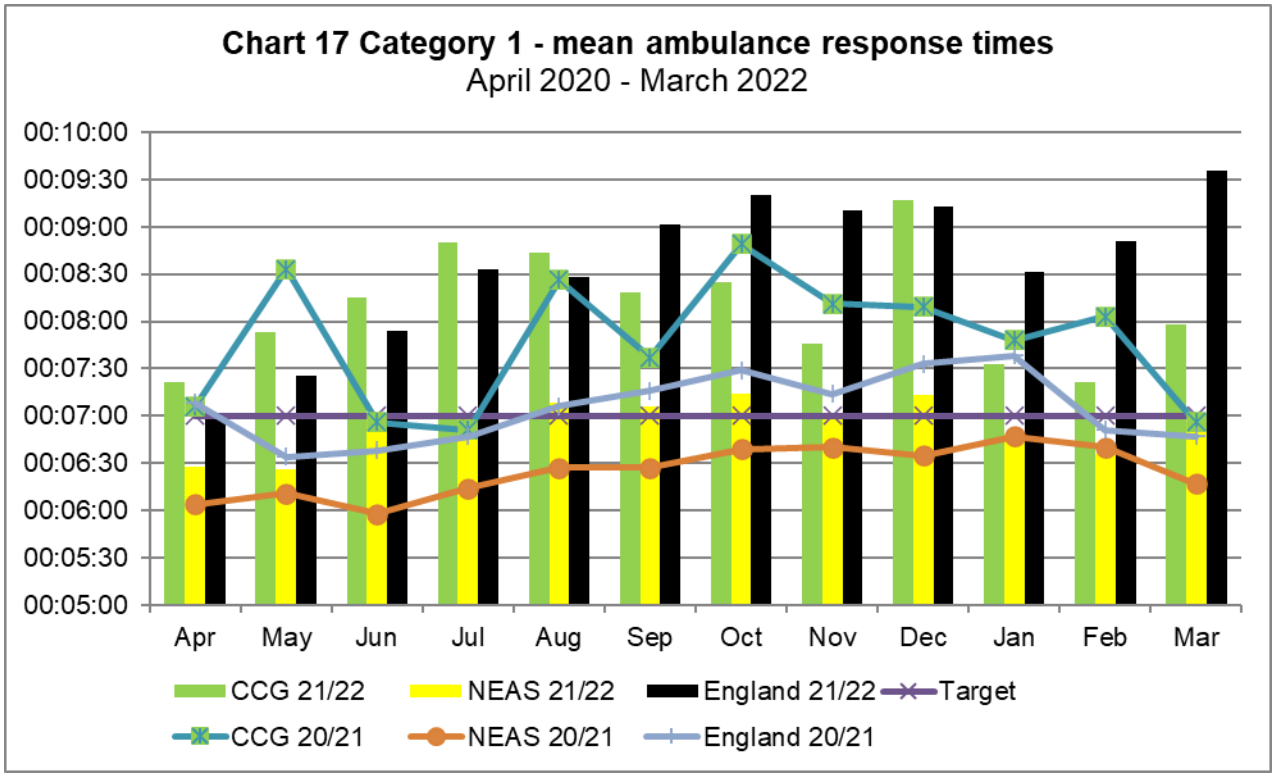


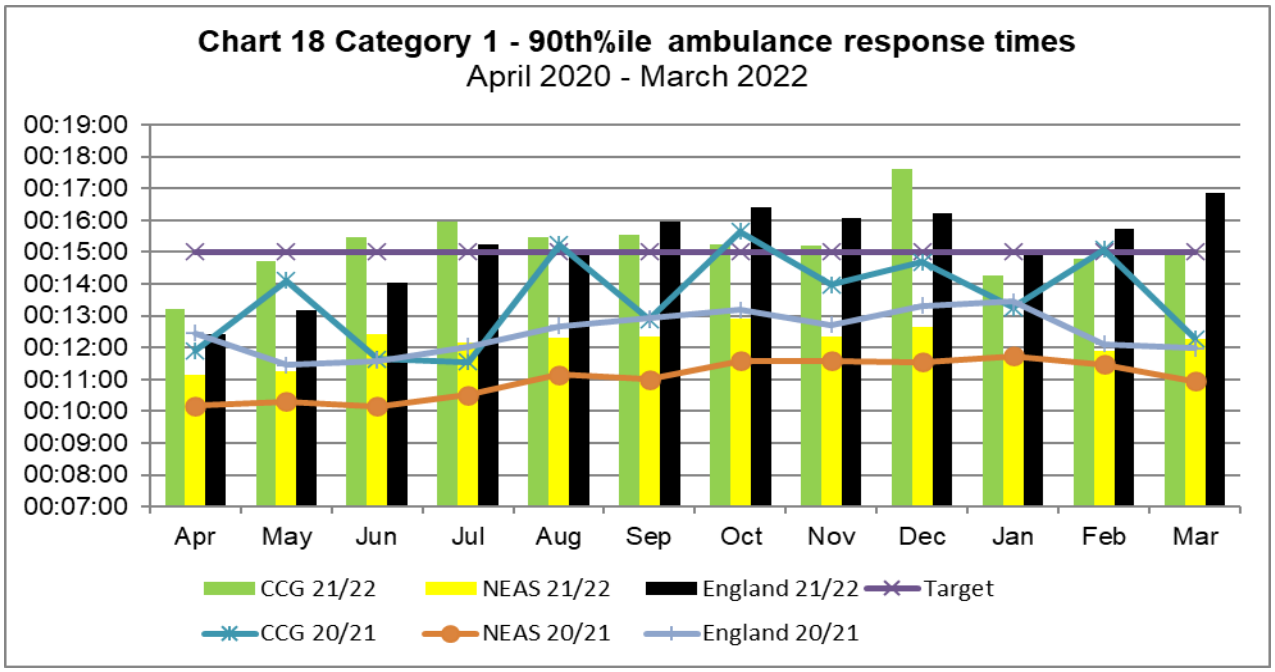
	Northumberland CCG - 2021/22 Performance											
Category	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
1 Average												
1 90th												
2 Average												
2 90th												
3 90th												
4 90th												
Achieved (6)	3	2	0	1	1	0	0	1	1	3	3	1

	NEAS - 2021/22 Performance											
Category	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
1 Average												
1 90th												
2 Average												
2 90th												
3 90th												
4 90th												
Achieved (6)	3	2	2	2	1	1	1	1	1	3	3	2

The overall summary of performance is shown on the above tables for both Northumberland and NEAS overall indicating the number of targets achieved each month out of a total of six. In general performance correlates with demand i.e. the number of 999 incidents. COVID-19 pressures, particularly around staff absences impacted performance considerably during 2021/22.

The charts outlined below show the comparative performance of Northumberland with both the overall performance of NEAS and England during 2020/21 and 2021/22 against each of the six national targets.





NEAS overall has performed well against Category 1 (life threatening thresholds) with the 90th centile response time being consistently below 15 minutes. The CCG performance, like the national average, has not performed so well, however.

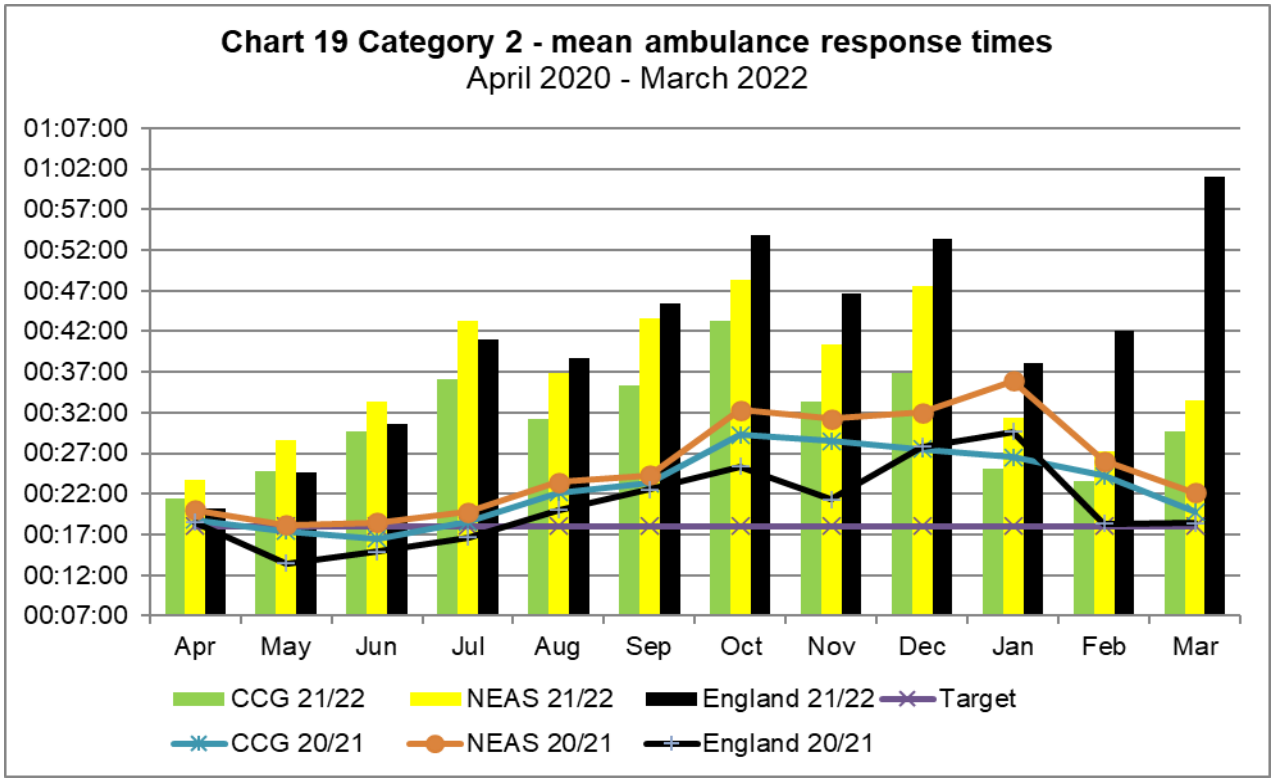


Chart 19 Category 2 - mean ambulance response times
April 2020 - March 2022
01:07:00
01:02:00
00:57:00
00:52:00
00:47:00
00:42:00
00:37:00
00:32:00
00:27:00
00:22:00
00:17:00
00:12:00
00:07:00
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
CCG 21/22
NEAS 21/22
England 21/22
Target
CCG 20/21
NEAS 20/21
England 20/21

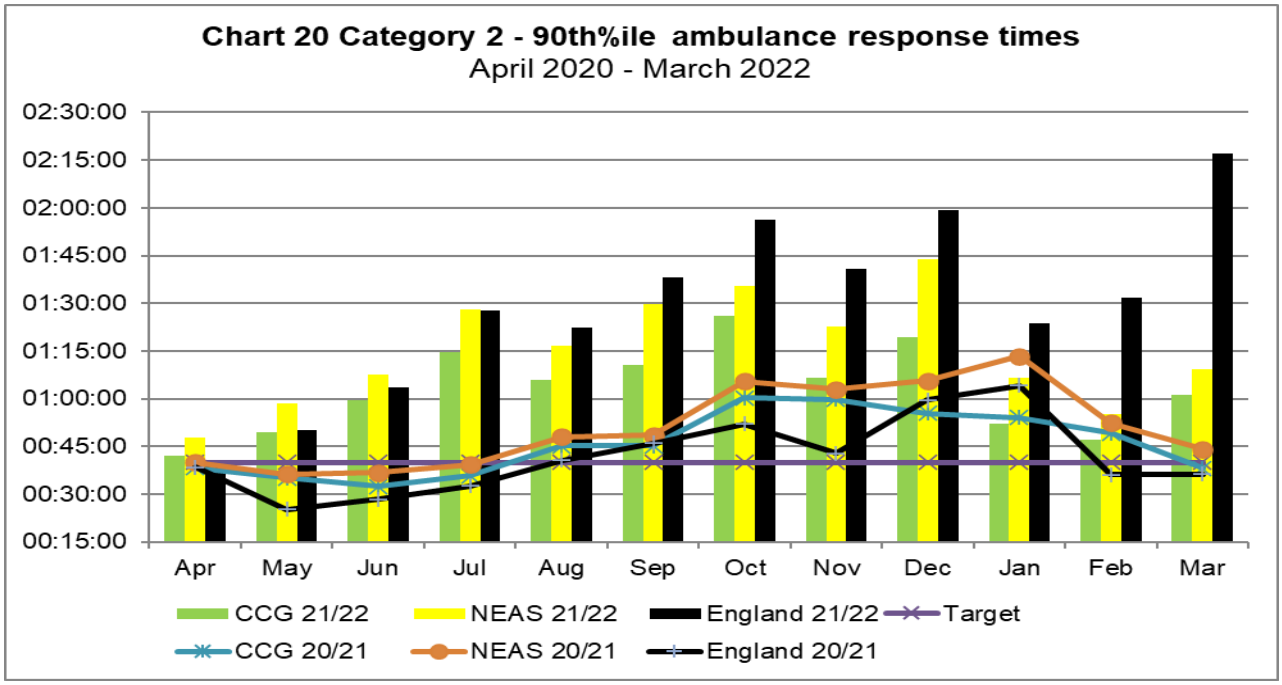
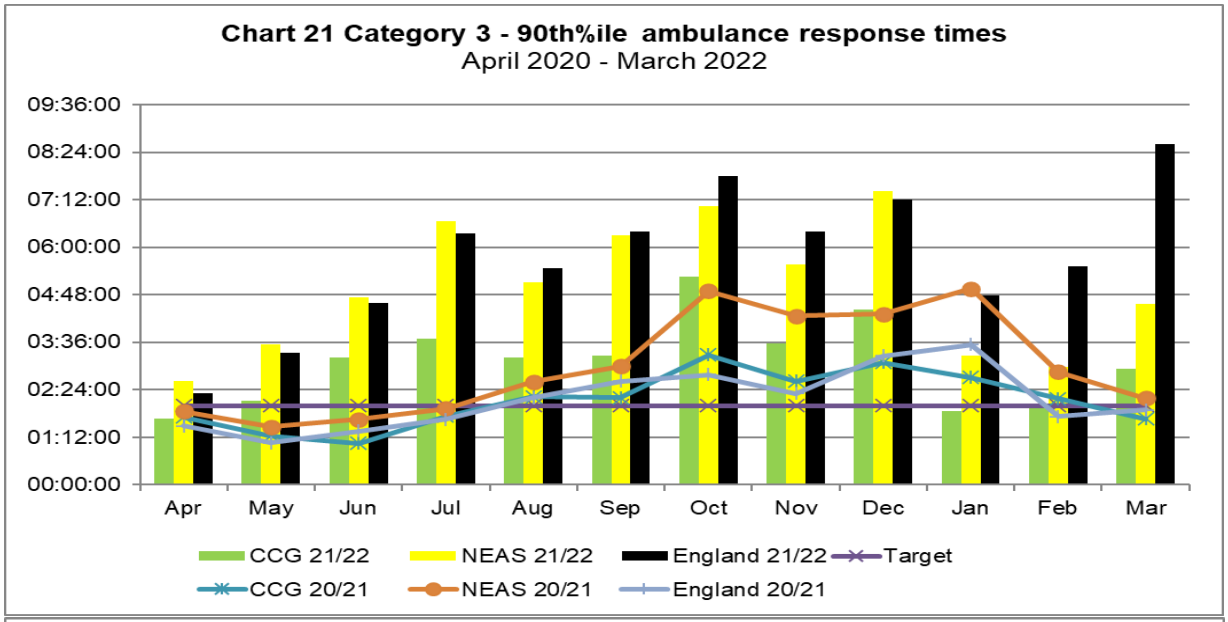
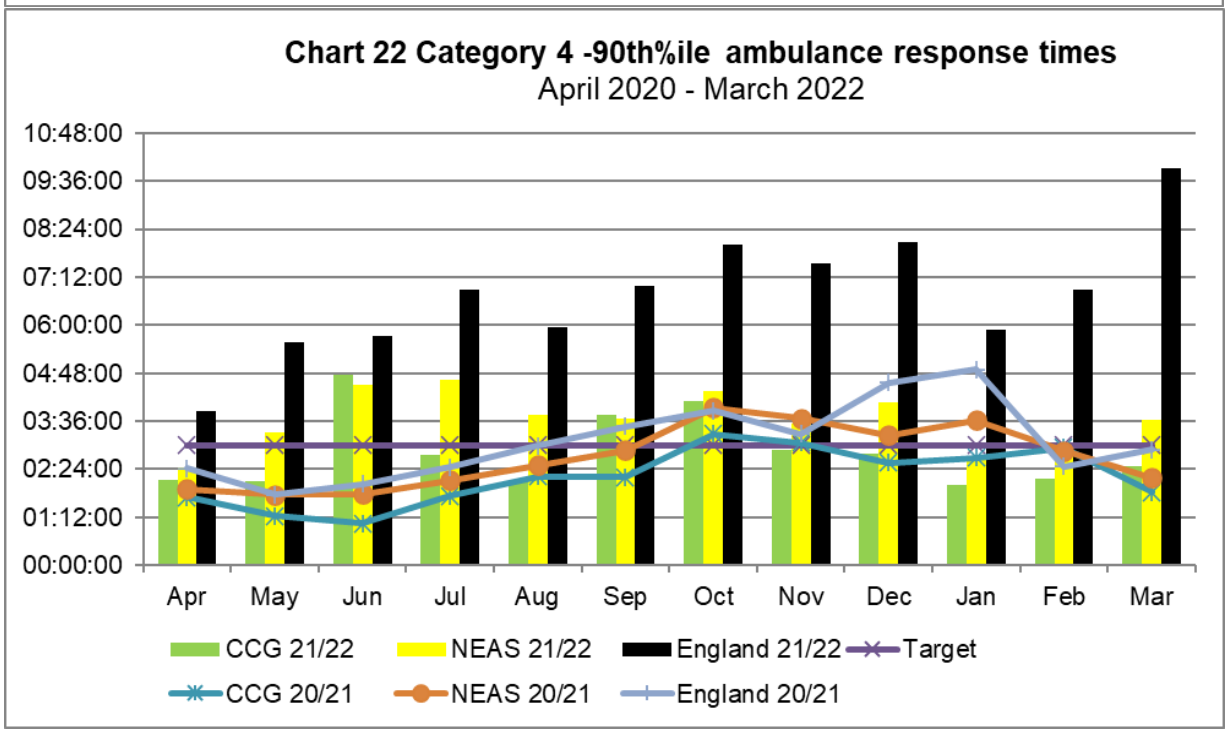


Chart 20 Category 2 - 90th%ile ambulance response times
April 2020 - March 2022
02:30:00
02:15:00
02:00:00
01:45:00
01:30:00
01:15:00
01:00:00
00:45:00
00:30:00
00:15:00
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
CCG 21/22
NEAS 21/22
England 21/22
Target
CCG 20/21
NEAS 20/21
England 20/21

In contrast however NEAS' Category 2 performance compares less favourably against the lower priority response time metrics. From July 2021 onwards and for the majority of the year Northumberland's and the overall NEAS performance was stronger than the overall England position.





Category 3 and 4 performance shows much stronger CCG level performance compared to NEAS and England wide and an improvement on the previous year.

Healthcare Acquired Infections

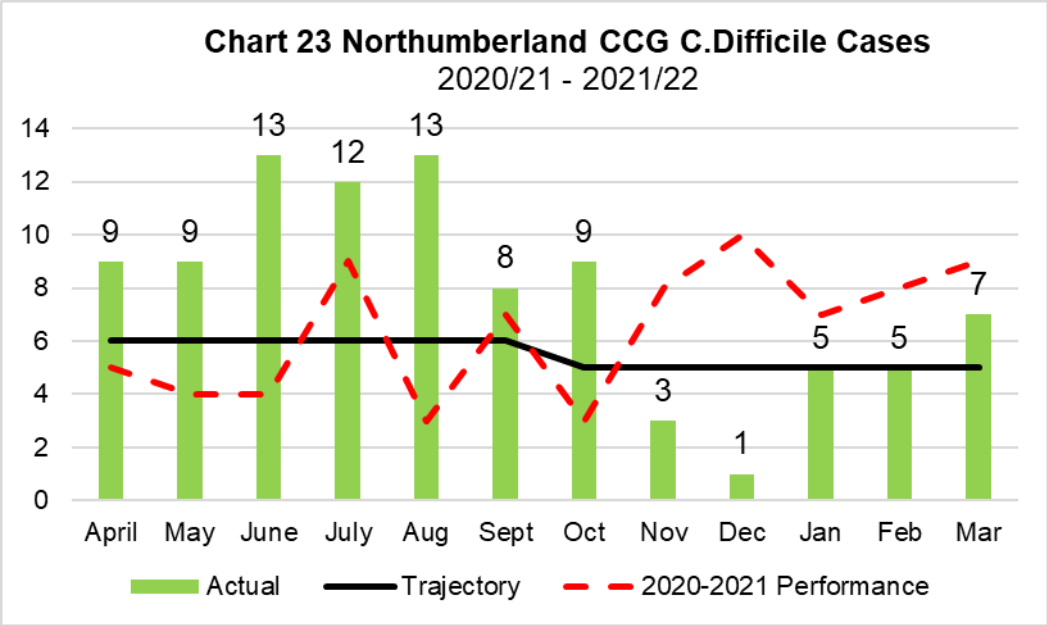
The CCG works collaboratively with its local providers in reviewing the learning from cases and reviewing working practices to reduce the risk of future infections. The local providers conduct root cause analysis and study the trends in the incidence of cases. Regular meetings take place both at place and on a wider footprint to discuss and review healthcare acquired infections.

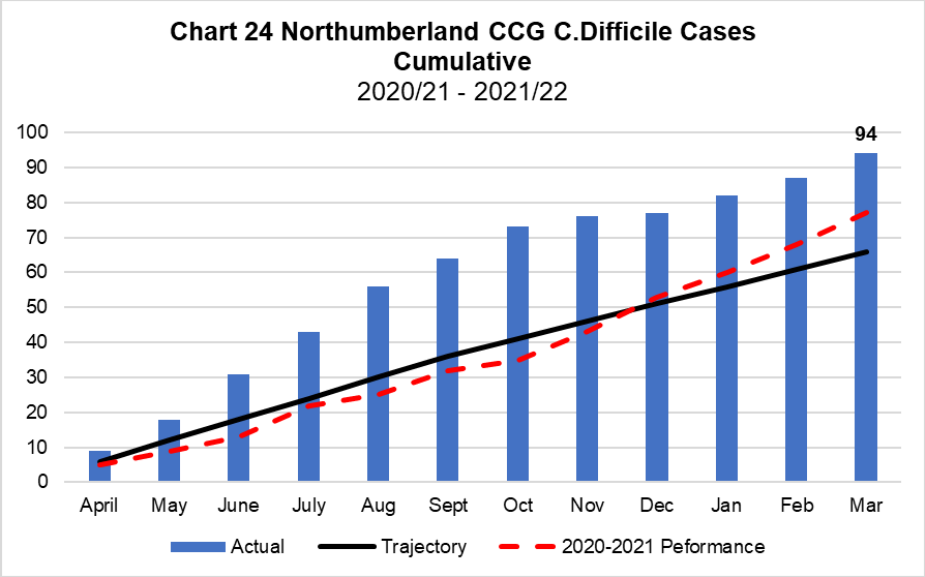
MRSA

One MRSA case was reported during 2021/22 which was attributed to Northumberland CCG. The CCG conducted a full post infection review with colleagues from the Trust and no gaps in care were identified.

Clostridium Difficile

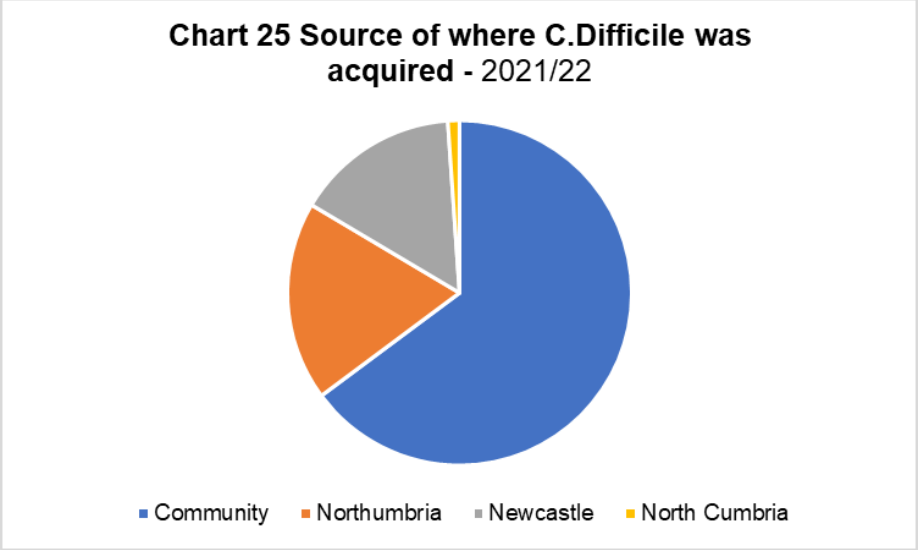
The charts below show the comparative number of cases on both a monthly basis compared with the trajectory and over the same periods of time in the previous year





Based upon the end of year position in 2021/22 there has been a total of 94 cases compared with 77 cases reported during the same periods of time in 2020/21 and against an annual trajectory of 66. The monthly trajectory has been breached on seven out of 12 occasions in 2021/22.

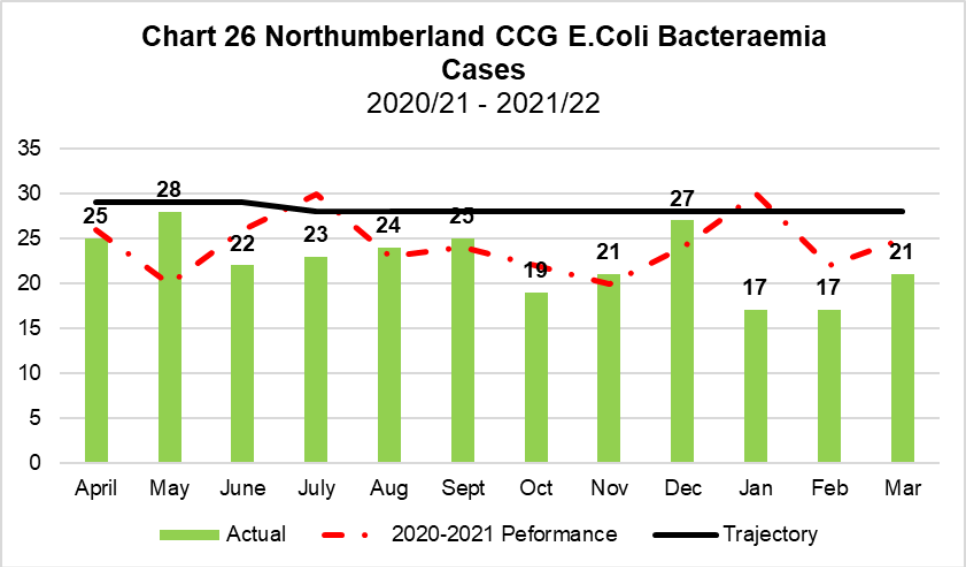
The chart below shows the split between community and hospital as to where the infection was acquired during 2021/22.

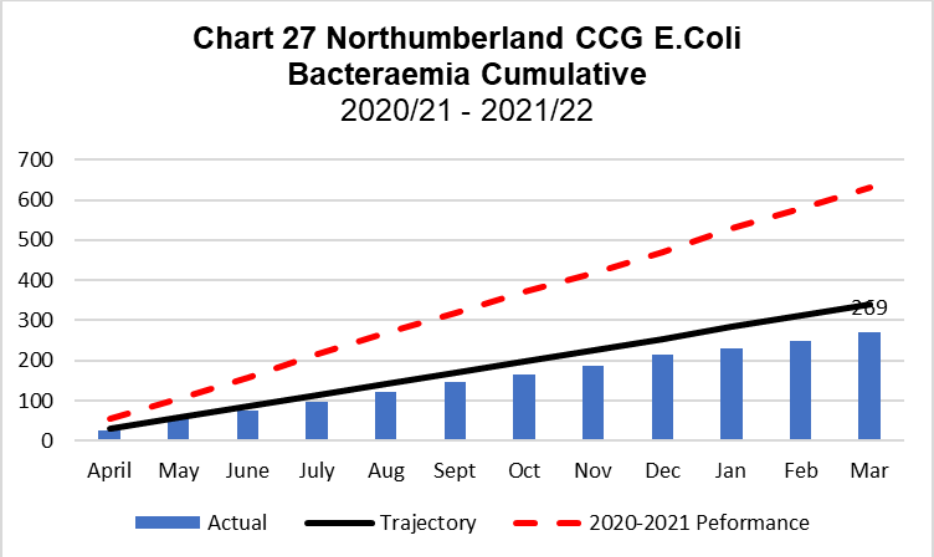


59 out of 77 cases (65%) were acquired in the community.

E.Coli

The charts below show the comparative number of cases on both a monthly and cumulative basis compared with the trajectory and over the same periods of time in the previous year.



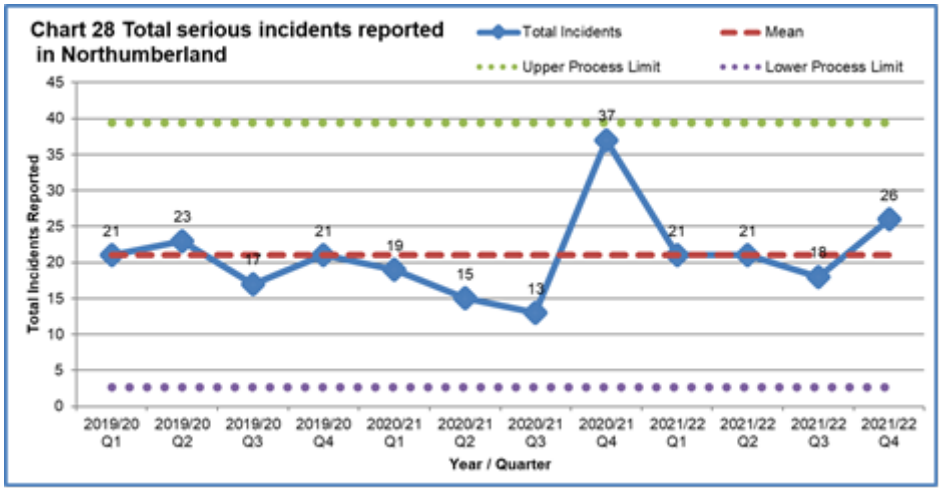


Based upon the end of year position in 2021/22 there has been a total of 269 cases compared with 292 cases reported during the same periods of time in 2020/21 and against an annual trajectory of 339. The CCG stayed within its trajectory for every month in 2021/22.

Never Events

There were five never events reported in 2021/22 compared to one that was reported in 2020/21. All of these never events were surgical/invasive procedures, three of which were reported by Northumbria and two were reported by Newcastle.

Serious Incidents

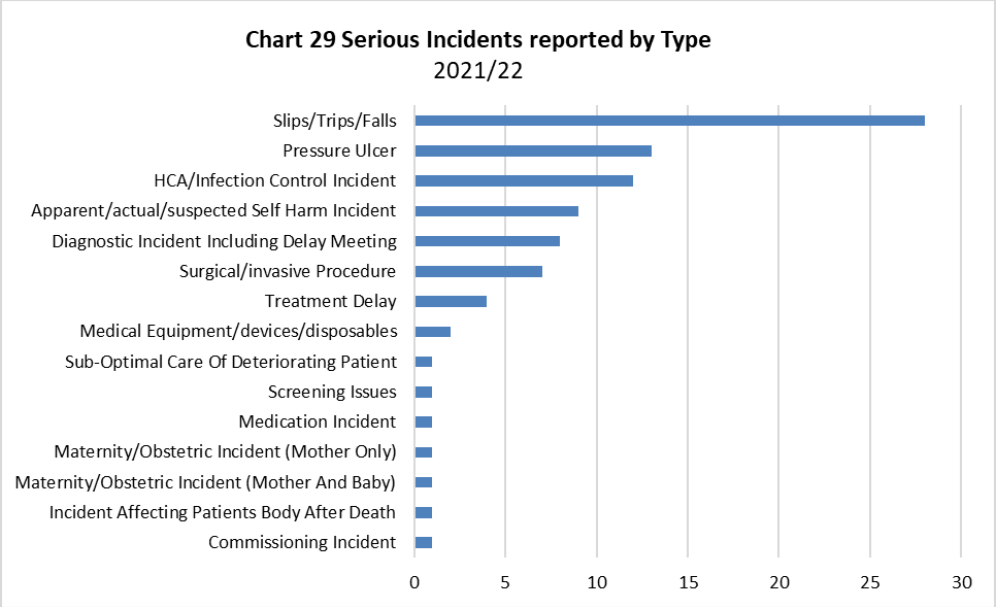


Total serious incidents reported

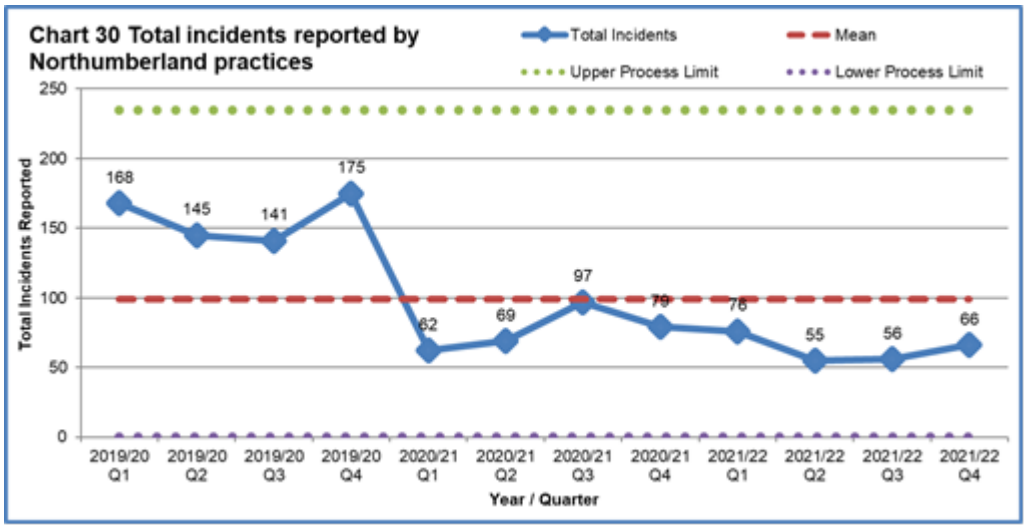
86 serious incidents were reported in 2021/22 relating to Northumberland patients the same as reported in 2020/21. The chart above provides a breakdown of the number of Serious Incidents reported per quarter.

All serious incident and never event reports received were taken to the CCG Serious Incident Panel for review and consideration for sign off.

Quarterly reports are presented to the Clinical Management Board and the Quality Review Group that analyses the trends, learning and areas for further improvement.



SIRMS



Northumberland GP practices reported 253 incidents onto the Safeguarding Incident Management System (SIRMS) during 2021/22 compared to 309 in 2020/21. As demonstrated in the chart above Northumberland practices have reported fewer than 2020/21, this is likely to be due to the continued COVID-19 pressures and has been observed across all CCG areas.

Care Homes

The COVID-19 Care Homes & Care Settings Outbreak Prevention and Control Team met weekly throughout the pandemic. The CCG along with colleagues from Northumberland County Council and Northumbria IPC and Community Nursing colleagues managed 231 outbreaks within nursing, residential and specialist residential settings and 108 outbreaks within Domiciliary and ISL settings.

In total, the CCG monitored 2340 positive staff cases and 1133 positive resident and service user cases, and collaboratively worked with local IPC nurses who conducted 46 visits to homes to provide further support and training.

Regular newsletters were sent out to all care homes and home care providers to ensure timely distribution of updated guidance.

Sustainable Development

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services.

Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities.

By making the most of social, environmental, and economic assets we can improve health both in the immediate and long term even in the context of the rising cost of natural resources.

Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012). We acknowledge this responsibility to our patients, local communities, and the environment by working hard to minimise our footprint.

Improve Quality

Quality forms the foundation of each of our clinical and service areas and is reflected in our day-to-day business. As a result of the prolonged COVID-19 pandemic, with restrictions on normal service delivery across clinical and non-clinical settings, the focus of our assurance systems has been to continue to monitor potential harm to patients. The priority has been to safeguard vulnerable people and protect those at risk.

Overall, the services for Northumberland residents continue to be of good quality. We have continued to strengthen our partnerships with Northumberland County Council (including the Public Health Team) and NHCFT, and this has proved vital in protecting our residents and supporting the staff in the care homes operating across the county.

Other areas of focus in 2021/22 included:

- Work to continually refine early warning and monitoring systems to provide meaningful intelligence and allow prompt actions. This was achieved through continuous improvement in reporting and reviewing of incidents to the internal working groups and Boards of the CCG.

- Working closely with other CCGs to ensure the quality assurance system is aligned across the Integrated Care Partnership (ICP) to ensure consistency.

- Improvements in service quality and patient safety and the reduction of harmful never events and its impact of patients and service users, including keeping the following constantly under review:

    - Mortality rates
    - C.Diff and MRSA infection rates, and Gram Negative Blood Stream Infection particularly E.Coli
    - COVID-19 infection rates
    - Falls and pressure ulcers
    - Serious Incidents and Never Events
    - Waiting time associated with the reduced capacity of the providers to deliver planned care because of the pandemic
    - Providers plans for the recovery of all patient pathways to pre-pandemic levels
    - Reviewing patient experience reflected in national and local patient satisfaction surveys.

Engaging People and Communities

It is essential that the people of Northumberland and the communities we serve are involved in our commissioning activities, including the design and planning of health services, decision making and engaging on proposals for change that will have an impact on how services are provided to them. Meaningful participation and involvement with all of our stakeholders is vital to ensure that we can develop a health service that is specifically tailored to the needs of the county.

During 2021/22 we have ensured that the services we deliver to the people of Northumberland matches their needs. Throughout the year we have engaged on a regular basis with the public, community and voluntary community sector (VCS) organisations, local community groups and patient participation groups using a variety of methods including focus groups, surveys, and through digital channels such as the website and social media.

We continue to work closely with Healthwatch Northumberland to act on their independent engagement feedback to inform the CCG's decision making processes.

All feedback received is always fully considered and, where possible, acted upon. Each quarter, our engagement feedback is presented to our Governing Body via the Communications and Engagement reports. Members of the public are also encouraged to submit questions to our Governing Body meetings which are held in public. However, due to the ongoing COVID-19 pandemic, members of the public have been unable to attend these meetings in person, but all meetings held in public are recorded and made available to watch on the CCG's website.

Despite the restrictions placed upon our engagement activities because of the pandemic, we have ensured that we involved our communities in our commissioning activities, using innovative and inclusive methods.

Our engagement activities in 2021/22 have given the people of Northumberland the opportunity to help shape and influence local health services on numerous occasions and our key highlights are below:

Integrated Care Boards – Communities and People

As we move into greater collaborative working arrangements, we have worked together with involvement leads across the new Integrated Care Board (ICB) footprint to develop stronger partnership arrangements. Through this partnership work, we have held conversations with our stakeholders to understand what has worked well for involvement, what could work better, and in an ideal world, how involvement will work once we become the North East and North Cumbria ICB. We have collectively shared this feedback to identify principles for engagement to take forward, and an aspiration for involvement which will be used to develop a framework for Involvement for the ICB. This framework has been built upon conversations with our stakeholders, and a shared commitment to continue to involve patients, public, carers, and wider stakeholders in shaping, evaluating, and improving the services we commission.

Improving Access to Psychological Therapies (IAPT) Service

Between May and June 2021, we embarked on a period of engagement work that sought views on the Improving Access to Psychological Therapies (IAPT) service through a series of surveys and focus groups. The purpose of the engagement was to understand local patient experience of the service to support people with common mental health problems and identify where improvements need to be made.

Based on the feedback from the engagement, action is needed to reduce waiting times, increase resources to recruit and train more staff and increase face-to-face contact. The information from the feedback report is being used as a 'thermometer gauge' around service provision and future delivery in terms of where and how sessions can be offered and how this links into greater integrated working. Furthermore, the concerns around waiting times have been noted and improvement in this area is being prioritised.

End of Life Strategy Development

Following the request in 2019 by the County Council's health and wellbeing overview and scrutiny committee, for the CCG to develop a countywide strategy for palliative and end-of-life care, a wide-ranging piece of work has taken place to assess the existing provision against the six agreed national ambitions and to develop priorities to meet gaps in what is on offer to residents in Northumberland.

The committee asked the end-of-life strategy development steering group to ensure the local population, including seldom heard groups, were involved in developing the strategy. On behalf of the steering group, the engagement team developed a range of approaches to gather feedback from the public, patients, carers and staff on the ambitions of the strategy as well as an end-of-life agreement. Engagement activity took place in two phases starting in May 2021, to coincide with Dying Matters Awareness Week, and continued until November 2021. Activity included focus groups, an online survey, plus an online Citizens Panel consisting of 16 participants.

At the end of 2021, all feedback was collated and an engagement report was submitted to the steering group and subsequently presented to the overview and scrutiny committee in early 2022. A draft communications plan and resources to raise awareness of the end-of-life agreement and strategy will now be produced.

Primary Care Network Engagement Working Group

During 2021/22 the CCG strengthened its links with Patient Participation Groups (PPGs) to ensure two-way communication with the CCG around primary care issues and the wider health economy takes place. As part of the work to develop a model of

engagement that will feed into a system wide approach and to enable the public to influence strategic decision making, the CCG established a PCN Engagement Working Group.

Membership of the group includes representatives from Primary Care Networks (PCNs), PPGs, the VCS, Healthwatch and Carers Northumberland. The aim of the group is to lay the foundations for the future by co-designing an engagement framework for PPGs and PCNs that can feed into the Integrated Care System. It also provides the CCG with an opportunity to hear local themes and issues. Three meetings have taken place since August 2021 and discussions have covered community champions training, a new patient and carer bulletin, which launched in December 2021, and work to co-design a PPG Toolkit with PPGs members and Healthwatch.

Community Engagement

In the autumn of 2021 COVID-19 restrictions had lifted and the engagement team were able to carry out proactive face-to-face engagement with VCS community hubs and groups across Northumberland.

The aim was to pick up intelligence themes from targeted protected characteristic groups, including people experiencing language barriers, young people, people with long term health conditions, carers, and people experiencing mental health problems, specifically in the areas of Bedlington, Ashington, Newbiggin, Blyth and rural locations in Northumberland.

The engagement activity was supported with the addition of an online survey, and in total over 250 people spoke to the team about health and healthcare services and where improvements need to be made, particularly as the NHS recovers from COVID-19.

Going forward, we will continue to work with organisations to target groups including drug and alcohol support, unemployment, young people and mental health and continue to build these relationships.

Your NHS Online Community

Due to COVID-19 restrictions in 2020/21, we were unable to carry out any face-to-face engagement. Therefore, the CCG in partnership with Northumbria Healthcare NHS Foundation Trust (Trust) invested in an online private community platform called 'Your NHS Online Community'. The Online Community has enabled us to carry on ‘testing the temperature’ in communities and picking up specific feedback to improve our services throughout the pandemic and it has gone from strength to strength in 2021/22.

In March 2021, membership stood at 184, and in one year it has grown to over 270 members that we are able to seek views from, test ideas and scenarios and actively involve. The Online Community enhances the way we engage with our local communities by enabling us to digitally communicate and engage in real time. It also helps us build up community insights by gathering questions and concerns about issues.

Topics for discussion on the Online Community have varied including how to access remote NHS services, young people's mental health services, Self-Care Week and general public confidence in the local NHS services. We continue to observe high engagement levels which are consistently above national levels.

Recruitment to the Online Community continues via social media, existing CCG, Trust and VCS communication channels and we are actively targeting diverse communities, in order to achieve a representative demographic profile of the Northumberland population.

GP Practice Relocations, Mergers and Branch Closures

Throughout the year the CCG has provided significant support to GP practices who have applied to the CCG to either relocate their practice, merge with another practice, close a branch surgery and/or dispensary to ensure they have appropriately engaged with their patients and stakeholders in their proposals. This has included supporting them with their communications and engagement plans, preparing the necessary communications materials and advising on engagement feedback reports. Practices have included: Felton and Widdrington Surgeries merger and new build, Alnwick Medical Group regarding their Longhoughton branch and Valens Medical Group about the proposed relocation of their Brockwell surgery to a new facility on the Northumbria Specialist Emergency Care Hospital site in Cramlington.

Improving Access

In January 2022, the CCG commenced an extensive piece of research and engagement to gather patient views on accessing healthcare in General Practices. During the pandemic there were changes made to the way GP services were accessed. Many of these changes were national requirements, with a purpose to manage increasing demand, such as greater use of telephone consultations, e-consultations, video calls and SMS texting.

This piece of engagement was designed to evaluate current experience of access to GP practices, including remote consultations, to ensure the views of patients can inform any future service changes in relation to accessing general practice.

Furthermore, it was necessary to address the current pressures in General Practice and public perceptions in Northumberland, and nationally, around the difficulty of securing face-to-face appointments with a GP.

The CCG commissioned an independent market research company to engage with the Northumberland population to better understand their views. The research company adopted a number of methods for the patient engagement including focus groups and an online survey. The survey sought to understand patients' views on issues such as which healthcare professional they would prefer to see, how quickly they want to be seen, whether weekend and evening appointments are useful, and how far they are willing to travel or would a telephone or video consultation be preferable.

Recognising that there are some people we do not hear from enough, the CCG also commissioned support from Healthwatch Northumberland and seven VCS organisations to specifically target inclusion health groups, such as carers, people experiencing language barriers or young people. These organisations either supported people to complete the survey or carried out focus groups to ensure as many people as possible had the opportunity to share their views.

The engagement activity ended at the end of March 2022 and work will continue in the next financial year to analyse the data and formulate a plan for the way forward. Feedback from the research will be shared with stakeholders and the public in the near future.

Rothbury Community Hospital

In January 2022, the Trust announced a new strategic partnership with a third-party care provider People First Care, which will allow the NHS to deliver a flexible number of beds to meet the needs of patients in Rothbury, while continuing to provide extra support for people's health and care needs in their own home. As part of the scheme, the Trust will commit to taking NHS beds within Rothbury Community Hospital, with numbers moving up and down flexibly to meet patient needs. Under the plans, People First Care will operate a 12-15 bed unit for people needing respite care, rehabilitation services, longer-term recuperation or end-of-life care. This facility will be supported by a wider team of district nurses, GPs and nurse practitioners.

The CCG's Governing Body approved the new model of care to utilise 12 beds within Rothbury Community Hospital at its meeting in March 2022. The CCG's Governing Body agreed the new model will ensure the best provision for patients in Rothbury and surrounding areas, as it provides a mix of important health and care services. Following five years of continuous engagement with the local community to find a solution for Rothbury Community Hospital, it is now hoped this new model will be up and running by summer 2022.

Reducing Health Inequality

Our commitment to equality and diversity is 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.

Public Sector Equality Duty (PSED)

We understand that we are required under the Public Sector Equality Duty (PSED) which is set out in s149 of the Equality Act 2010, to have due regard to:

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

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

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

Governance

Equality, Diversity, and Inclusion is governed and reports into the Governing Body. The board ensures we are compliant with legislative, mandatory, and regulatory requirements regarding equality and diversity and inclusion. It develops and delivers national and regional diversity related initiatives within the CCG, provides a forum for sharing issues and opportunities and monitors the achievement of key EDI objectives.

Equality Strategy

Our Equality Strategy for 2021-2024 has been developed. 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.

The Equality Delivery System 2 (EDS2) – Our Equality Objectives

We have continued to utilise the Equality Delivery System (EDS2) framework and have been using the tool to support the mainstreaming of equalities into all our core business functions to support us in meeting the Public Sector Equality Duty (PSED) and to improve our performance for the community, patients, carers and staff with protected characteristics that are outlined within the Equality Act 2010. We have used the NHS Equality Delivery System 2 (EDS2) to continue monitoring our equality objectives outlined below:

Objective 1 – Continuously improve engagement, and ensure that services are commissioned and designed to meet the needs of patients

Objective 2 – Ensure processes are in place to provide information in a variety of communication methods to meet the needs of patients, in particular the ageing population and those with a disability.

Objective 3 - Monitor and review staff satisfaction to ensure they are engaged, supported, and represent the population they serve.

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

Our Staff – Encouraging Diversity

We encourage 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 continue to offer guaranteed interviews to applicants with a disability who are identified as meeting the essential criteria for any advertised roles; and reasonable adjustments under the Equality Act 2010 are considered and implemented during the recruitment process and during employment. By working closely with DWP, we have maintained our 'Level 2 Disability Employer' status for 2020 - 2022 by demonstrating our commitment to employing the right people for our business and continually developing our people.

Workforce Race Equality Standard

In accordance with the Public Sector Equality Duty and the NHS Equality and Diversity Council's agreed measures to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace, the CCG has shown due regard to the Workforce Race Equality Standard (WRES). We have due regard to the standard by seeking assurance of compliance from trusts and aim to improve workplace experiences and representation at all levels for black and minority ethnic staff.

Equality Impact Assessments

Our Equality Impact Assessment (EIA) Toolkit was reviewed in 2020 to continue the process to be embedded into core business processes and to provide a comprehensive insight into our local population, patients and staff's diverse health needs. The tool covers all equality groups offered protection under the Equality Act 2010 (Race, Disability, Gender, Age, Sexual Orientation, Religion/Belief, Marriage and Civil Partnership and Gender Re-assignment) in addition to Human Rights and Carers, as well as including prompts for engagement with protected groups the tool also aids compliance with the Accessible Information Standard. The EIA is embedded into our governance process and sign off from the Governing Body 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 has due regard to the standard by obtaining feedback from Patient Reference Groups (PRG's) 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/

Health Inequalities

We have regard to the need to reduce inequalities between patients in accessing health services for our local population. We understand our local population and local health needs, using joint strategic needs assessments (JSNAs) and we collate additional supporting data including local health profiles as well as qualitative data through our local engagement initiatives which aim to engage hard to reach groups.

We work 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.

We seek 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 Healthwatch.

As the local commissioners of health services, we seek to ensure that the services purchased on behalf of our local population reflect their needs. We appreciate that to deliver this requires meaningful consultation and involvement of all our stakeholders. We aim 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.

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 E&D partners alumni programme.

We continue 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:

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

Northumberland CCG JSNA: https://www.northumberland.gov.uk/Care/JSNA/Health-wellbeing-assessment.aspx

Health and Wellbeing Strategy

The Northumberland Health & Wellbeing Board brings together Local Government (including public health, adult social care, children's services and elected representatives), the NHS (including commissioners and providers of healthcare services), the Local Medical and Pharmaceutical Committees, Healthwatch Northumberland and the Voluntary, Community and Social Enterprise (VCSE) sector, to ensure that the needs of Northumberland's population are met and tackle local inequalities in health. The Chairman of the Board is an elected member from Northumberland County Council. Through the Health and Wellbeing Board, NHS Northumberland Clinical Commissioning Group (CCG) and Northumberland

County Council (NCC) have a duty to develop a Joint Health and Wellbeing Strategy (JHWS). The strategy is a long-term plan which is used to inform local commissioning decisions. Based on an assessment of the needs of service users and communities, its intention is to tackle factors that impact on their health and wellbeing. As a result, we have identified four key themes to guide us in the next ten years, with an additional three cross-cutting themes that will underpin our activities:

Key Themes:

- Giving children and young people the best start in life
- Empowering people and communities
- Tackling some of the wider determinants of health
- Adopting a whole system approach to health and care

Additional cross-cutting themes:

- Improving mental wellbeing and resilience
- Supporting people with long-term conditions
- Exploiting digital technology

https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Health-and-social-care/Public%20Health/Northumberland-Joint-Health-and-Wellbeing-Strategy-2018-2028.pdf

https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Health-and-social-care/Public%20Health/Northumberland-CC-Health-and-Wellbeing-17-12-19-2.pdf

Financial Review

Context of the reported financial outturn 2021/22

Due to the continuation of the COVID-19 pandemic, the Government extended the temporary financial framework arrangements for NHS organisations for another year to cover the period to 31 March 2022.

The temporary funding arrangements move CCGs away from the traditional annual published allocations that CCGs have a statutory requirement to deliver within to meet their key financial performance indicators.

The financial framework arrangements for 2021/22 built upon the system-based approach to resource allocation distribution and planning that had been introduced in the 2020/21 financial year.

Planning and allocations for 2021/22 consisted of two six monthly system resource envelopes allocated to area systems with the NENC ICS. Individual NHS provider and commissioner organisations within each system were required to agree plans within the system resource envelopes and work collaboratively together to ensure each NHS partner organisation within the system was able to plan a breakeven or better position.

The CCG was able to do this in each of the two six monthly plans, planning a £670K surplus in the first half of the year and a breakeven position for the second half of the year, therefore £670K for the year in total.

The financial performance the CCG is measured against for the financial year 2021/22 is the total resource it has received from these two six monthly allocations agreed through the system planning process, plus any other additional non-recurrent or centrally funded national allocations received throughout the year.

Key financial performance indicators 2021/22

For the financial year 2021/22, the CCG met the statutory requirement to ensure that expenditure in the financial year did not exceed its allocated resource. The CCG's in-year surplus was £2,052k with a cumulative historic debt of £55,353k as at 31 March 2022.

The CCG total revenue resource allocation for 2021/22 was £621,011k and total spend was £618,959k.

Table 1 – Key Financial Performance Indicators 2021/22

NHS Act Section	Duty	Target £'000	Performance £'000	Total £'000	Duty Achieved
223H(1)	Expenditure not to exceed income	621,011	618,959	2,052	Yes
223I(2)	Capital resource use does not exceed the amount specified in Directions	0	0	0	Yes
223I(3)	Revenue resource use does not exceed the amount specified in Directions	620,911	618,859	2,052	Yes
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	Yes
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	Yes
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	6,315	5,236	1,079	Yes

CCG Commissioning Budget 2021/22

As mentioned earlier with the temporary financial arrangements in place this year the CCGs commissioning budget was received in two halves in the year.

The initial six-month allocation received by the CCG on the back of a half year system plan submitted on 6 May 2021 was approved through Governing Body on 27 May 2021. The second half of the year plan was submitted on 18 November 2021 to cover the remaining six months of the year, with each of the plans being reviewed in detail at the Corporate Finance Committee and key points reported to the Governing Body.

CCG Running Costs Budget 2021/22

Included in the commissioning allocations the CCG had an annual running cost allocation of £6,315k in 2021/22. This covered the CCG's pay budgets, other non-pay running costs and the Service Level Agreement with the CCG's commissioning support unit North of England Commissioning Support (NECS).

Better Payment Practice Code

The Better Payment Practice Code (BPPC) requires all CCGs to aim to pay 95% of all valid invoices by the due date within 30 days of receipt of a valid invoice, whichever is later. The CCG has met the requirements of the code, as reported in the annual accounts, and indicated in Note 5 of the accounts.

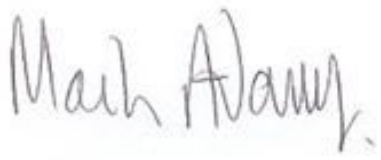
ACCOUNTABILITY REPORT

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

The **Corporate Governance Report** sets out how we have governed the organisation during 2021/22, 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 policies 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.



Mark Adams
Accountable Officer
20 June 2022

Corporate Governance Report

Members Report

Member practices

The CCG membership body consists of one clinical representative from each of the following 37 member practices:

Adderlane Surgery	Haydon and Allendale Medical Practice
Alnwick Medical Group	Humshaugh and Wark Medical Group
Bedlingtonshire Medical Group	Marine Medical Group
Belford Medical Group	Northumberland Health at Widdrington and Felton Surgeries
Bellingham Practice	Netherfield House Surgery
Branch End Surgery	Ponteland Medical Group
Burn Brae Medical Group	Prudhoe Medical Group
Cheviot Medical Group	Railway Medical Group
Coquet Medical Group	Riversdale Surgery
Corbridge Medical Group	Rothbury Practice
Cramlington Medical Group	Scots Gap Medical Group
Elsdon Avenue Surgery	Seaton Park Medical Group
Forum Family Practice	Sele Medical Practice
Gables Medical Group	Union Brae and Norham Practice
Gas House Lane Surgery	Village Surgery
Glendale Surgery	Valens Medical Partnership
Greystoke Surgery	Well Close Medical Group
Guide Post Medical Group	White Medical Group
Haltwhistle Medical Group	

CCG Membership Meetings

The membership met in July to consider the Annual Report and Accounts. Regular Locality Meetings and extensive briefings, including a weekly CCG bulletin to General Practice, have been used to update the membership on key policy changes, guidance, and events throughout the year.

Composition of Governing Body

The Governing Body membership consists of:

- Dr Graham Syers, Clinical Chair
- Mr Mark Adams, Accountable Officer
- Mrs Janet Guy, CCG Deputy Lay Chair – Strategy and Governance
- Mrs Karen Bower, Lay Governor Corporate Finance and Patient and Public Involvement
- Dr Paula Batsford, Locality Director (Blyth Valley) *1
- Mr Steve Brazier, Lay Governor with lead for audit and conflict of interest
- Prof Marios Adamou, Governing Body Secondary Care Doctor
- Dr Chris Waite / Mr Tony Brown, Locality Directors (North)
- Dr John Warrington, Medical Director and Locality Director (Central)
- Dr Ben Frankel, Locality Director (West)
- Dr Robin Hudson, Medical Director
- Mrs Siobhan Brown, Chief Operating Officer
- Mr Jon Connolly, Chief Finance Officer
- Mrs Annie Topping, Executive Director of Nursing, Quality and Patient Safety
- Mr Paul Turner, Executive Director of Commissioning, Contracting and Corporate Governance

*1 Dr Paula Batsford stood down from her role as locality Director for Blyth Valley and Governing Body Members on 21 September 2021

Committee(s) including Audit Committee

The Audit Committee membership consists of:

- Mr Steve Brazier, Lay Governor with lead for Audit and Conflict of Interest (Chair)
- Mrs Janet Guy, CCG Deputy Lay Chair – Strategy and Governance

The governance statement provides full details of the members and the work of the other CCG committees and groups.

Register of Interests

Details of any declarations of interest for Governing Body members and member practices can be found on the CCG's website at http://www.northumberlandccg.nhs.uk/about-us/register-of-interest/.

Personal data related incidents

The CCG reported no data incidents to the Information Commissioners Office during 2021/22.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG, at the time of the Members' Report is approved, confirms that:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

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

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 Accountable Officer to be the Accountable Officer of NHS Northumberland Clinical Commissioning Group.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction.

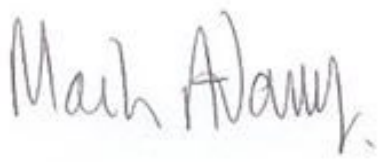
The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year. In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

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

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

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.



Mark Adams
Accountable Officer
20 June 2022

Governance Statement

Introduction and context

NHS Northumberland Clinical Commissioning Group is 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.

As at 1 April 2022, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter. I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

The Clinical Commissioning Group Governance Framework

The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it. The CCG has a constitution which sets out clearly the governing structure of the organisation and the decision making that takes place at the Governing Body. This is supported by a scheme of delegation which sets out further detail of decisions delegated to Committees and individuals.

Membership of the Clinical Commissioning Group

A total of 37 practices comprise the members of NHS Northumberland Clinical Commissioning Group (CCG) and details of these are included in the CCG's constitution. Providers of primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract are eligible to apply for membership of the CCG. No other providers of primary medical services have applied for membership of the CCG during 2021/22.

The membership of the CCG, through its practice representatives is responsible for:

- Making recommendations to NHS England for any amendments to the CCG's constitution
- Approving arrangements for appointments within the CCG
- Making recommendations to NHS England for the appointment by NHS England of the Accountable Officer
- Approving the appointment of, and terms and conditions for, members of the CCG's Governing Body

Each member has a practice representative who represents their practice's views and acts on behalf of the practice in matters relating to the CCG.

In addition to the practice representatives the CCG has identified a number of roles to either support the work of the CCG and/or represent the CCG. The roles may be filled by GPs, primary care health professionals, or other practice employees/ partners who are not health professionals. These representatives undertake the following roles on behalf of the CCG:

One Locality Director each, for:

- Blyth Valley
- Central Northumberland
- North Northumberland
- West Northumberland

One Business Director for:

- Finance and Commissioning

Committee(s), including Audit Committee:

The Governing Body

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

The Governing Body is established as a committee of the CCG in accordance with the constitution, standing orders and scheme of delegation. In accordance with the terms of reference, the Governing Body will normally be held bi-monthly. A minimum of five Governing Body meetings are held in each financial year.

A minimum of two meetings each year would normally be held in public. Due to the ongoing COVID-19 pandemic and associated restrictions it was not possible to hold meetings in public, but members of the public were invited to submit questions to be answered during meetings and papers were published on the CCG website.

A total of seven meetings of the Governing Body were held during the period April 2021 to March 2022; membership and attendance was as follows:

Title	Member	Attendance
Clinical Chair (Chair)	Graham Syers	6/7
Deputy Lay Chair (Deputy Chair)	Janet Guy	7/7
Two Lay Governors:		
Lead on audit and conflict of interest	Steve Brazier	6/7
Lead on corporate finance and patient and public involvement	Karen Bower	7/7
The Accountable Officer	Mark Adams	7/7
One registered nurse	Annie Topping	7/7
One secondary care specialist doctor	Prof Marios Adamou	6/7
The Locality Director Blyth Valley *1	Dr Paula Batsford	7/7
The Locality Director North	Dr Chris Waite/Tony Brown	7/7
The Medical Director and Locality Director Central *2	Dr John Warrington	4/7
The Locality Director West	Dr Ben Frankel	4/7
The Medical Director	Dr Robin Hudson	6/7

The Chief Operating Officer	Siobhan Brown	6/7
The Chief Finance Officer	Jon Connolly	7/7
The Executive Director of Commissioning, Contracting and Corporate Governance	Paul Turner	5/7

*1 Dr Paula Batsford stood down from her role as locality Director for Blyth Valley and Governing Body Members on 21 September 2021
*2 Dr John Warrington assumed temporary duties as Locality Director for Blyth Valley from 22 September 2021

The principal function of the Governing Body is to provide the CCG with an independent and objective view of the CCG's arrangements to exercise its functions effectively, efficiently, and economically and in accordance with the CCG's principles of good governance.

Apart from those functions reserved to the CCG's membership the primary roles of the Governing Body are:

- Approving the CCG's vision, strategy and annual commissioning plan
- Leading on all governance, assurance openness and transparency matters
- Securing continuous improvements in the standards and outcomes of care
- Oversight of financial and risk management
- Where specified in the Terms of Reference of the Governing Body committees and boards, receiving the minutes of meetings of joint or collaborative arrangements between the CCG and other statutory bodies

Specifically, the Governing Body:

- Ensures the efficient and effective use of CCG resources
- Ensures that the CCG does not exceed its delegated budget while delivering its agreed strategic objectives and performance target achievement
- Ensures that services for the population of Northumberland are commissioned in a way which delivers improved health, better outcomes and patient experience, efficiency and reduced health
- Continually reviews and improves performance in relation to health outcomes, nationally and locally agreed performance targets
- Gains assurance from the Clinical Management Board that services are safe, high quality and sustainable
- Ensures continuous and meaningful engagement with the public and patients in the planning, delivery and prioritisation of services
- Ensures that planning, prioritisation and decision making is transparent, equitable and auditable

Regular items on the agenda of the Governing Body meetings include:

- Updates on the work of the Audit Committee, the Northumberland Primary Care Commissioning Committee and the Clinical Management Board
- Financial performance updates
- A report highlighting key issues is presented by the Chief Operating Officer
- Updates on the development of the CCG assurance framework and corporate risk register
- Updates on the communications and engagement strategy
- Commissioning plan progress
- Reviewing and providing comment on the proposed arrangements for the Integrated Care System

Minutes of Governing Body meetings are available here:
https://www.northumberlandccg.nhs.uk/about-us/governing-body/

Committees of the Governing Body

The Governing Body undertakes a proportion of its work through committees. Each committee has a set of terms of reference, which have been formally approved by the Governing Body. Committee Chairs present their chair approved minutes to the Governing Body meeting following their meeting.

Audit Committee

The principal function of the Audit Committee is to provide the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance. The Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the CCG's activities (both clinical and non-clinical) that supports the achievement of the CCG's objectives.

The remit and responsibilities of the Committee are to critically review the CCG's financial reporting and internal control principles and ensure an appropriate relationship with both internal and external auditors is maintained. The duties of the Committee are driven by the priorities identified by the CCG, and the associated risks. It operates to a programme of business, agreed by the CCG, and is flexible to new and emerging priorities and risks. The membership of the Audit Committee is drawn from Lay members of the Governing Body. In accordance with the terms of reference the Audit Committee meets bi-monthly, with a minimum of five meetings per financial year. A total of six meetings of the Audit Committee have been held during the year with attendance by members as follows:

Title	Member	Attendance
Lay Governor for Audit and Conflicts of Interest	Steve Brazier (Chair)	6/6
Lay Chair	Janet Guy	6/6

The Committee's main activities during 2021/22 have been:

- Receiving and critically reviewing reports from both internal audit, external audit and service audit reports
- Approving the internal audit work plan for current and future years
- Assuring the accuracy of the CCG's 2021/22 annual reports and accounts
- Reviewing risks to ensure they are complete, appropriately scored and mitigations are managed and appropriate
- Reviewing the processes in place to identify conflicts of interest in decision making, and how any identified conflicts were handled
- Reviewing and providing comment on the proposed arrangements for the Integrated Care System

Appointments and Remuneration Committee

The principal function of the Appointments and Remuneration Committee (ARC) is to advise the Governing Body on senior appointments, about appropriate remuneration and terms of service, and determine the remuneration and terms of service of members of the Governing Body and other staff directly accountable to the Accountable Officer or Chief Operating Officer.

The membership of the ARC is drawn from Lay members of the Governing Body. In accordance with the terms of reference the ARC meets as and when required, no less than once per financial year and no more than 15 months between meetings.

One meeting of the ARC was held during the year 2021/22. Attendance by members was as follows:

Title	Member	Attendance
Lay Chair	Janet Guy (Chair)	1/1
Lay Governor for Audit and Conflicts of Interest	Steve Brazier	1/1
Lay Governor for Corporate Finance and PPI	Karen Bower	1/1

The Committee discussed remuneration levels for 2021/22 for appropriate CCG staff not covered by NHS Agenda for Change terms and conditions.

Northumberland Primary Care Commissioning Committee

The principal role of the Northumberland Primary Care Commissioning Committee (NPCCC) is to commission primary medical services for the people of Northumberland.

The remit and responsibilities of the NPCCC shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

NHS England has delegated to the CCG authority to exercise primary care commissioning functions that include but are not limited to the following activities:

- General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Providers of Medical Services (APMS) contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract)
- Newly designed enhanced services ('Local Enhanced Services' and 'Directed Enhanced Services')
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)
- Decision making on whether to establish new GP practices in an area
- Approving practice mergers
- Making decisions on 'discretionary' payment (e.g. returner/retainer schemes)

The membership of this Committee is drawn from Lay members of the Governing Body, the CCG Chief Operating Officer or nominated Director, the CCG Chief Finance Officer and CCG Directors. In accordance with the terms of reference the NPCCC meets at regular intervals and not less than five times per financial year. A total of six meetings of the NPCCC have been held during the year with attendance by members as follows:

	Member	Attendance
Lay Chair	Janet Guy (Chair)	6/6
Lay Governor for Corporate Finance and PPI	Karen Bower	6/6
Chief Operating Officer	Siobhan Brown	4/6
Chief Finance Officer	Jon Connolly	6/6
Executive Director of Nursing, Quality and Patient Safety	Annie Topping	6/6

Service Director for Integration and Transformation	Rachel Mitcheson	6/6
Executive Director of Commissioning, Contracting and Corporate Governance	Paul Turner	4/6

The Corporate Finance Committee

The Corporate Finance Committee's (CFC) principal function is to assist the Governing Body in its duty to act efficiently, effectively and economically. The committee oversees the current and projected financial position of the CCG. It also assures the Governing Body that the CCG has sufficient capacity and capability to deliver its strategic objectives. The CFC is not a decision-making committee.

The CFC is responsible for:

- **Strategy –** overseeing the development and implementation of sustainable system plans that will achieve financial targets including detailed QIPP plans
- **Financial Performance –** providing challenge on the CCG's current and projected financial position, reviewing the ongoing overall financial position of the CCG and providing assurance to the Governing Body that the projected outturn is deliverable
- **Procurement –** overseeing the development and implementation of CCG procurements
- **Assurance –** providing overall assurance to the Governing Body that the CCG's projected financial position is deliverable and that the CCG is adequately resourced in terms of workforce

In accordance with the terms of reference the CFC will normally meet bi-monthly, not less than five times per financial year.

A total of 6 meetings of the CFC have been held during the year with attendance by members as follows:

Title	Member	Attendance
Lay Governor for Corporate Finance and Patient and Public Involvement (Chair)	Karen Bower	6/6
Lay Governor for Audit and Conflict of Interest	Steve Brazier	4/6
Clinical Chair	Dr Graham Syers	6/6
Business Director (Finance and Commissioning)/Locality Director and Medical Director	Dr John Warrington	4/6
Chief Operating Officer	Siobhan Brown	6/6
Chief Finance Officer	Jon Connolly	6/6
Executive Director of Nursing, Quality and Patient Safety	Annie Topping	3/6
Executive Director of Commissioning, Contracting and Corporate Governance	Paul Turner	6/6

The Clinical Management Board

The principle function of the Clinical Management Board (CMB) is to assist the Governing Body in its duties to promote a comprehensive health service, reduce inequalities, promote innovation and assure themselves of the quality of services that the CCG has commissioned.

The Clinical Management Board will be responsible for clinical direction and engagement and providing day to day operational management overarching direction for the successful delivery of the objectives of the CCG:

Clinical Direction and Engagement:

- Preparing and recommending the strategy and annual commissioning plan for the Governing Body to consider and approve.
- Formulating and recommending service change and development arising out of the strategy.
- Developing and maintaining effective working arrangements with the Northumberland CCG localities to support the commissioning and delivery of high quality, safe, value for money and effective services.
- Establishing working arrangements with other CCGs, Provider Trusts, the Local Authority, other health care partners, the NHS England/NHS Improvement Area and Regional Team and the clinical senate that would

support the integration of both health services with other health services and health services with health-related and social care services where the CCG considers that this would improve the quality of services or reduce inequalities.
- Ensuring that the views of patients and the public are properly reflected in the development of clinical recommendations to Governing Body.

Operational Management:

- Delivering target outcomes and outputs set by the Secretary of State, NHS England/NHS Improvement, NICE, CQC and other national/regional authorised bodies and providing assurance to the Governing Body in this respect.
- Ensuring the co-ordination and monitoring of the CCG's clinical work programme, in delivery of the CCG's annual commissioning plan.
- Approval of budgets, business cases, procurements, and contract variations up to £1m.
- Approving the CCG's operational procedures.
- Overseeing and managing the contract and annual work plan with the CCG's commissioning support services provider; and
- Review risks, assurance and controls relevant to the Clinical Management Board (and as aligned to corporate objectives).
- Receives assurance in relation to the quality of CCG commissioned services including primary care, and ensures appropriate arrangements are in place to ensure that services commissioned by the CCG (including those commissioned jointly with other organisations) are being delivered in a quality and safe manner.

In accordance with the terms of reference the CMB meets monthly. A total of 12 meetings of the CMB were held during the period April 2021 to March 2022, membership and attendance was as follows:

Title	Member	Attendance
Medical Director (Chair)	Dr Robin Hudson	9/12
Medical Director and Locality Director (Central) (Deputy Chair) *2	Dr John Warrington	12/12
Clinical Chair	Graham Syers	9/12
Locality Director (Blyth Valley) *1	Dr Paula Batsford	4/12
Locality Director (North)	Dr Chris Waite	9/12
Locality Director (North)	Tony Brown	7/12
Locality Director (West)	Dr Ben Frankel	10/12

Executive Director of Nursing, Quality and Patient Safety	Annie Topping	12/12
Service Director of Transformation and Integrated Care	Rachel Mitcheson	11/12
Chief Operating Officer	Siobhan Brown	11/12
Chief Finance Officer	Jon Connolly	11/12
Executive Director of Commissioning, Contracting and Corporate Governance	Paul Turner	11/12
Public Health Consultant	Dr James Brown	6/12

*1 Dr Paula Batsford stood down from her role as locality Director for Blyth Valley and Governing Body Members on 21 September 2021
*2 Dr John Warrington assumed temporary duties as Locality Director for Blyth Valley from 22 September 2021

Regular items on the agenda of the CMB meetings include:

- Updates on the issues discussed at the Safeguarding Group, Quality Safety Group and the Medicines Optimisation Group
- Review and approval of policies and strategies of the CCG
- Updates on the financial position, performance report and commissioning plan
- Updates on quality and safety issues

Subgroups of the Clinical Management Board

Quality and Safety Group

The principal function of the group is to assure the quality of commissioned services by:

- Monitoring and examining the soft and hard intelligence relating to the quality of services provided
- Identifying areas of concern and good practice
- Acting where appropriate
- Ensuring effective processes and systems are in place to manage clinical risks
- Ensuring mechanisms are in place to enable systematic quality outcome improvement including lessons have been learnt and embedded in relevant services
- Making recommendations for further action to CMB
- Providing assurance to CMB that quality sits at the heart of everything the CCG does and that its business is focussed on improving quality outcomes

In accordance with the terms of reference the Quality and Safety Group (QSG) meets on a bi-monthly basis. Six meetings were held during the period April 2021 to March 2022; membership and attendance was as follows:

Title	Member	Attendance
Executive Director of Nursing, Quality and Patient Safety (Chair)	Annie Topping	6/6
Deputy Director of Quality and Patient Safety	Claire Coyne	6/6
Governing Body Secondary Care Doctor	Dr Marios Adamou	1/6
Integrated Care Lead	Fiona Kane	4/6
Acting Head of Quality and Patient Safety for Adults	Leesa Stephenson	6/6
Senior Clinical Quality Officer (NECS)	Sara Anderson/Kim Ewen	6/6
Locality Manager representative	Diane Gonsalez	4/6
Communications and Engagement Manager	Emma Robertson	4/6
Head of Performance and Assurance	David Lea	5/6
Medicines Optimisation Team Representative	Susan Turner	5/6
Public Health Commissioner	Dr James Brown	2/6

The group provides CMB with assurance in relation to the quality of CCG commissioned services including primary care. To achieve this, the Group will seek to promote a culture of continuous improvement and innovation with respect to patient safety, clinical effectiveness and patient experience.

The group has no executive powers other than those specifically delegated by CMB.

Medicines Optimisation Group

The Medicines Optimisation Group (MOG) has been established as a sub-group of the CMB. The group is responsible for ensuring that the CCG:

- Is informed about prescribing performance and intervenes where appropriate to ensure high quality and cost effectiveness is maintained
- Has sufficient competence to achieve and maintain authorisation
- Maintains a presence on the relevant local medicines management groups
- Has a robust medicines management vision and strategy

The remit and responsibilities of the group are:

- Providing CCG representation to enable the CCG to influence and contribute to the Area Prescribing Committee and its sub-committees
- Reviewing data on prescribing performance relating to the CCG
- Informing the CMB of matters arising regarding cost, safety or quality relating to prescribing issues
- Providing close liaison with the commissioning medicines manager to ensure that competencies have been assured for authorisation
- Considering the commissioning priorities of the CCG and providing advice to the CCG on the implications of their commissioning priorities
- Providing oversight of the commissioning support function and providing the 'CCG contract management' of the arrangements for medicines management

In accordance with the terms of reference the MOG meets quarterly, with a minimum of three meetings per financial year. A total of four meetings of the MOG were held during the period April 2021 to March 2022; membership and attendance was as follows:

Title	Member	Attendance
CCG Locality Director/GP Prescribing Lead (Chair)	Dr Chris Waite	3/4
CCG Prescribing Management Lead	Alan Bell	4 /4
NECS - Senior Medicines Optimisation Pharmacist	Helen Seymour	4/ 4
NECS - Medicines Optimisation Pharmacist	Susan Turner	4 /4
Finance Lead	Subject to availability	4/ 4

Over the past year the Medicines Optimisation Group has been involved in several work areas. The group regularly monitors prescribing budgets, implements strategies to ensure cost effective prescribing and agrees the budget setting formula for practices. The main mechanism for delivery in primary care is the Practice Medicines Management scheme and this has continued to be developed in 2021/22. A prescribing decision support tool is used by all 37 practices to support high quality, cost effective prescribing. This allows best practice messages to be displayed to clinicians at the point of prescribing.

The group reviews the agenda and minutes of the Regional Prescribing Forum, Area Prescribing Committee (APC), Formulary Sub-committee and the Medicines Guidelines Group for consideration of matters requiring approval of the Clinical Management Board. The group receives a regular activity report from the North of England Commissioning Support Unit (NECS) on prescribing and ensures appropriate action is taken to mitigate prescribing quality, safety, and cost risk.

Safeguarding Group

The Safeguarding Group (SG) has been established as a sub-group of the CMB.

CCGs as commissioners of local health services need to assure themselves that the organisations from which they commission have effective safeguarding arrangements in place, and that a robust framework is in place. CCGs are also required to demonstrate that they have appropriate systems in place for discharging their statutory duties in terms of safeguarding. The group is responsible for providing assurance to the CMB that Northumberland CCG is discharging its responsibilities appropriately and effectively.

The remit and responsibilities of the group are:

- To oversee the implementation of the updated 'Working Together to Safeguard Children' statutory guidance and the new safeguarding arrangements to be in place at CCG level.
- To ensure compliance with the legal and regulatory requirements for safeguarding such as the Children and Social Work Act 2017, Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework, Mental Capacity Act 2005, and Deprivation of Liberty Safeguards.
- To ensure the CCG is fully engaged and contributed to national and local legislative safeguarding consultations and arrangements.
- To support the development of a positive learning culture across partnerships for safeguarding adults to ensure that organisations are not unduly risk averse.

- To oversee the development and delivery of a CCG strategy, annual plan and local policies for safeguarding vulnerable adults and children.
- To ensure Designated Safeguarding Professionals play an active role in all parts of the commissioning cycle, from procurement to quality assurance.
- To gain assurance from all commissioned services (both NHS and independent healthcare providers) to ensure compliance with national safeguarding standards, and that effective systems are in place to safeguard and protect vulnerable adults and children and continuous improvement.
- To ensure lessons are shared and learned from Child Death Overview Process (CDOP), Serious Case Reviews (SCRs), Domestic Homicide Reviews (DHR), local and national enquiries particularly in primary care.
- To oversee and facilitate the development of improvement activities in primary care on safeguarding.
- To ensure a programme of work is in place to assure the quality of safeguarding practices across adults and children such as audits, visits, reviews, training, attendance at provider committees, and feedback mechanisms etc.

In accordance with the terms of reference the group will meet bi-monthly. A total of six meetings of the SG were held during the period April 2021 to March 2022; membership and attendance was as follows:

Title	Member	Attendance
Executive Director of Nursing, Quality and Patient Safety (Chair)	Annie Topping	4/6
Deputy Director of Quality and Patient Safety	Claire Coyne	6/6
Clinical Chair	Graham Syers	4/6
Designated Nurse Safeguarding Children	Margaret Tench *1	3/6
Deputy Designated Nurse for Vulnerable People	Leesa Stephenson	6/6
Designated Doctor for Safeguarding Children	Naomi Jones	4/6
Designated Doctor for Looked After Children	Anna Redfern	2/6

*1 Margaret Tench left the CCG on 31 December 2021

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 on best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice.

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Risk management arrangements and effectiveness

As Accountable Officer I have overall responsibility for:

- Ensuring the implementation of an effective risk management strategy, including effective risk management systems and internal controls.
- The development of the corporate governance and assurance framework.
- Meeting all the statutory requirements and ensuring positive performance towards our strategic objectives.

Each of the directors of the CCG is responsible for:

- Coordinating operational risk in their specific areas in accordance with the risk management strategy.
- Ensuring that all areas of risk are assessed appropriately and action taken to implement improvements.
- Ensuring that staff under their management are aware of their risk management responsibilities in relation to the risk management strategy.
- Incorporating risk management as a management technique within the performance management arrangements for the organisation.

All members of staff are aware of their responsibilities in relation to the risk management strategy and policy. This ensures that risk is seen as the responsibility of all members of staff and not just senior managers.

Risk Management is embedded in the activity of the CCG through:

- The Risk Management Policy and supporting policies and procedures
- The Committee structures as described earlier
- Management processes
- The assurance framework
- Risk management skills training including both clinical risk assessments of various types and the mandatory and statutory training programme
- Governing Body development sessions
- The building of a counter fraud culture

The CCG considers that it had an effective risk management approach in place as demonstrated by the risk management arrangements set out below.

The risk management framework sets out how risk management will be implemented throughout the organisation to support the realisation of the strategic objectives. This includes the processes and procedures adopted by the CCG to identify, assess and appropriately manage risks and detailed roles and responsibilities for risk management.

The CCG employs a standardised methodology in the application of risk grading criteria, which helps to ensure a consistent approach to the prioritisation of risks and the effective targeting of resources. As a result, risk management is an important element of the CCG's business planning processes.

The risk management policy outlines:

- The roles and responsibilities of the Governing Body, committees and CMB in respect of risk management
- The roles and responsibilities of officers for elements of risk management
- Access to specialist advice
- The risk management process in place within the CCG including the systematic identification, assessment, evaluation, and control of risks via mechanisms such as the assurance framework and the corporate risk register
- A description of risk management terms to ensure common understanding and full guidance on the risk analysis matrix for the grading of risk for priority

Risk (and change in risk) identification is achieved primarily through the following processes:

- Clinical and non-clinical risk assessment
- Complaints management
- Claims management
- Performance and finance and contracting monitoring and reports
- Incident reporting including serious and untoward incidents
- Audits (both internal and those carried out by external bodies)

The Governing Body sets boundaries to guide staff on the limits of risk they are able to accept in the pursuit of achieving its organisational objectives.

The Governing Body set these limits based on whether the risk is:

- A threat: the level of exposure which is considered acceptable.
- An opportunity: what the Governing Body is prepared to put 'at risk' in order to encourage innovation in creating changes.

The two main features of the risk management process are the assurance framework and risk registers. The CCG has adopted a bottom up approach to the generation of its risk registers. The purpose is to ensure that risks are identified and managed at the appropriate level and to provide a mechanism of escalation through the tiers that alerts the Audit Committee and the Governing Body to extreme and high risks.

During 2021/22 strategic and operational risks have been monitored by the relevant governance committees. The strategic and the corporate risk register for 2021/22 have been reviewed by the Audit Committee, Governing Body and the Clinical Management Board. The strategic risk register covers all the CCG's main activities including financial, clinical and organisational activities and identifies the principal objectives and targets that the organisation is striving to achieve and the risks to the achievement of these targets. It identifies actions that need to be taken to address gaps in control and assurance and a small number have been identified. Each action has an identified lead and is monitored throughout the year by the Governing Body.

The CCG recognises that for any risk management strategy to work, potential and actual risks and incidents must be reported, and action taken to prevent a recurrence. The Incident Reporting and Management Policy - CCG CO08 covers the reporting of all types of incidents, including near misses. Reporting of near misses where there has been no actual injury or loss may enable appropriate action to be taken to prevent future incidents.

The CCG has a responsibility for managing risks identified in the commissioning process to ensure the quality of the services it commissions is safe and of a high

standard. The CCG has a responsibility to ensure their contractors have effective systems in place to identify and manage risks and incidents and support them in the development of these where necessary. The CCG acts as a conduit for information about such risks and incidents, to ensure that the learning (and the opportunities for risk reduction) from them is not lost within the CCG or the wider NHS.

The CCG has an open and non-judgmental approach to the reporting of adverse incidents and encourages everyone within the organisation to contribute to the reporting and learning process. The processes and procedures in the incident reporting and management policy are not designed to apportion blame but focus on understanding the root cause of errors and learning from them to avoid a further reoccurrence.

Risk Assessment

The CCG has adopted a standardised framework for the assessment and analysis of all risks encountered in the organisation and which is set out in the Risk Management Policy. Throughout the year the CCG identified and managed a range of risks, both strategic and operational.

Reports to the committees/groups of the CCG also included information on new and emerging risks. The strategic and operational risks will continue to be reviewed on a quarterly basis by the Governing Body, Clinical Management Board as well as Audit Committee meetings.

The high-level strategic risks managed throughout 2021/22 and considered by Governing Body and Audit Committee are summarised as follows:

System Resilience

As a result of a lack of robust planning for surges in demand for frontline services throughout the year, there is a risk that urgent and emergency care pressures increase and accident and emergency activity levels rise, which may result in multiple demands on ambulance, community, acute and primary care services. This may lead to impact on organisational performance at provider level, reputational impact on the CCG and a threat to the delivery of safe, high quality services.

The risks is mitigated by the work of the North ICP strategic Accident and Emergency Board, Winter Plans agreed by the North ICP Operations Board and the Post COVID-19 Recovery Plan and Commissioning Plan.

Allocation of Resources – Value for Money

As a result of not allocating resources effectively to achieve the best patient outcomes, there is a risk that the CCG does not allocate resources effectively to achieve the best patient outcomes.

This may result in a derogation of patient care, failure to deliver statutory duties and associated reputational damage to the CCG, litigation and financial pressures. This risk is mitigated by the work of the Corporate Finance Committee, the Population Health Management Programme and the work of the System Transformation Board.

Ensure Services are High Quality and Safe

As a result of increased patient demand and limited resources (workforce and funding/finance) in the local health and care system and early stage development of Primary Care Networks (PCNs), there is a risk that the CCG is not able to commission the right services at the right time across different settings (acute, community, primary care, mental health and out of hospital) to meet the needs and improve the health of the population. This could result in poor patient outcomes, potentially unsafe services, failure of statutory obligations and reputational damage to the CCG.

This risk is mitigated by the work of the Northumberland Primary Care Commissioning Committee which reports and makes decisions on the primary care workforce programme, sustainability programme and quality assurance and improvement programme.

Robust processes are in place to monitor Mental Health commissioning including the ICS/ICP MH Workstream and performance matrix against deliverables of Long Term Plans, the Mental Health strategic meeting chaired by the North of England Commissioning Support Service (NECS) and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) monthly contracting meetings and Quality Review Groups.

There are also robust processes in place in partnership with the Local Authority to monitor the quality of Continuing Healthcare (CHC) commissioning, including visits to providers, reviews of complaints and quality indicators at Joint Management Group meetings, and review of care packages.

Integrated Working

As a result of the NHS entering the transition phase of CCG closedown and the move into statutory Integrated Care Systems (ICSs) there is a risk of lack of communication and/or cooperation across and between system partners, lack of clarity on roles and responsibilities and a lack of shared vision and commitment. This could result in delayed decision making, derogation of patient care, increased financial costs and poor value for money, reputational damage to the CCG or failure to meet statutory duties.

This risk is mitigated by the work of the System Transformation Board and its quarterly reporting to the Health and Wellbeing Board. The North ICP are also working together across a range of professions and clinical portfolios. Place Based Working Developments and Workshops are ongoing as part of future ICS arrangements.

Safeguarding

As a result of failure to comply with good clinical practice, policies and procedures, there is a risk that the CCG is not able to manage safeguarding duties appropriately, including deprivation of liberty safeguards, liberty protection safeguards and delivery of the learning disabilities transformation programme.

This could result in vulnerable people's safety being compromised, a derogation of patient care, and legal challenge resulting in both reputational and financial damage to the CCG.

This risk is mitigated by the work of the CCG's Quality Safeguarding Group which is established as a sub-committee of the Clinical Management Board. There are also robust safeguarding children and adult policies in place, and robust processes in place for the identification of potential cases of deprivation of liberty that require investigation.

Financial Management

There is a risk that the CCG does not manage its finances effectively, resulting in a breach in the CCG's statutory responsibilities, reputational damage, non-achievement of Value for Money (VFM) and/or inappropriate allocation of resources across services. This risk is mitigated by the oversight of the Corporate Finance Committee, the robust processes embedded across the CCG including monthly financial reviews, regular meetings with budget managers and comprehensive monthly board reports. Robust financial governance is in place across the CCG and its member practices.

Mental Health Investment Standard (MHIS)

There is a risk that the CCG has insufficient funding and is unable to meet the MHIS. This could result in under resourced mental health services, increased scrutiny from NHS England and Reputational Damage.

This risk is mitigated by workforce planning meetings with NHS England and Providers. Investment decisions have been made and are being implemented.

CCG Operating Resilience

As a result of major external or internal events occurring there is a risk that they could lead to the CCG's ability to conduct routine business (e.g. loss of property or IT infrastructure, global pandemic, NHS organisational restructure) being compromised which may result in capacity or operational delivery gaps. This could lead to reduced operational output, a failure to deliver against statutory duties and damage to the CCG's reputation.

This risk is mitigated by robust business continuity arrangements.

Capacity and Capability

The CCG may have insufficient human resource or allocate human resource ineffectively across the CCG teams to deliver its functions.

This may result in the CCG not delivering its functions effectively; regulatory action from NHS England; increased cost and poor Value For Money; and reputational damage.

This risk is mitigated by the organisational development and human resources processes in place, with regular updates being provided to CFC and Audit Committee.

Communications and Engagement

As a result of a lack of effective engagement with CCG members, stakeholders and members of the public there is a risk of reduced input and buy-in for key service changes and population health management initiatives from across the system. This may result in sub-optimal service design and delivery and poor patient experience. This risk is mitigated by the robust communications and engagement strategies embedded within the CCG's ways of working.

Population Health and Inequalities

As a result of the complex and fragmented nature of health and social care data there is a risk that the CCG will not be able to access the insight and intelligence necessary to make informed decisions on population health needs based on evidence.

This may result in a widening of existing health inequalities and unmet need within our patient and population communities.
This risk is mitigated by the work of the population health management programme, quarterly reporting to CMB and System Transformation Board, and a robust governance system.

Effectiveness of Commissioning

As a result of the CCG failing in its duties to commission services which improve the health and wellbeing of the local population, there is a risk of subsequent failure to improve patient experience, deliver value for money and efficiencies, address healthcare inequalities and increase the engagement and wellbeing of patients and the workforce

This may result in a derogation of patient care, failure to deliver statutory duties and associated reputational damage to the CCG, litigation and financial pressures.
This risk is mitigated the Joint Strategic Needs Assessment being embedded in all planning processes, close working with public health colleagues and reporting to the Governing Body and the Health and Wellbeing Board.

Effectiveness of Corporate Governance

As a result of the CCG failing in its duties to commission services which improve the health and wellbeing of the local population, there is a risk of subsequent failure to improve patient experience, deliver value for money and efficiencies, address healthcare inequalities and increase the engagement and wellbeing of patients and the workforce.

This may result in a derogation of patient care, failure to deliver statutory duties and associated reputational damage to the CCG, litigation and financial pressures.
This risk is mitigated by the approved constitution, the information governance framework, and robust governance arrangements in place across the CCG and its member practices including standards of business conduct, conflict of interest management and anti-fraud arrangements.

High Level Operational Risks include:

Performance access targets for diagnosis and treatment

Failure to deliver key performance targets for diagnosis and treatment including 18 week Referral to treatment, six weeks for diagnostics and wide range of cancer targets Patients health suffers or they have poor experience, the CCG breaches its Outcomes Framework, or suffers reputational damage.

The CCG is releasing non- recurrent funding to support the clearance of backlogs enabling the providers to either outsource work or take on additional agency / locum staff.

Prescribing

There is a risk that inconsistent adherence to guidelines or formulary may lead to poor quality prescribing or drug shortages which could lead to patient safety and experience issues and unnecessary prescribing costs. This could ultimately result in reputational damage, legal challenge and unsustainable prescribing cost growth to the CCG.

This risk is mitigated by the work of the Medicines Optimisation Group which reports to the CCG's Clinical Management Board.

Coronavirus (COVID-19)

There is potential for the coronavirus outbreak to interrupt the business of the CCG or its providers, either due to increased staff sickness or potential disruption to supply chain. This could result in large work backlogs, impacts to staff welfare, impacts to patient welfare, increased costs.

This risk is mitigated by ICP level co-ordinated responses, command and control centre within the CCG, Business Continuity Plans and Governance procedures in place to continue due diligence around decision making and financial governance.

COVID-19 medium to long-term financial uncertainty for the CCG (ongoing provider costs or recurrent allocation funding changes)

Financial uncertainty for the CCG after the current COVID-19 financial provisions end, caused by increased surges in activity (e.g. providers clear backlogs on a return to Payment by Results (PbR) basis, costs are materially different from historic forecasts (e.g. transformation of services results in the underlying baseline activity and future capacity of hospitals and primary care changing), uncertainty over future CHC costs following the CHC Hospital Discharge Programme, and uncertainty as to

whether non-recurring allocations are included in current block contract arrangements. There is a potential that COVID-19 expenditure is not reimbursed or of the CCG returning to in year deficit as a result of COVID-19 impact and system wide management of positions.

This risk is mitigated by system planning at ICS and ICP level investigating potential gaps in financial requirements as part of the ICS planning process.

Provider Delivery

There is a risk that providers fail to meet key performance outcomes and cease operations leading to compromised patient care and the CCG having to introduce potentially expensive short term measures in response. NHS England could revoke the CCG's commissioning authority if found negligent. This could lead to increased financial pressure and reputational damage to the CCG.

This risk is being actioned by robust action plans in place in areas of concern such as spinal, cancer and other specialties. The CCG is working with the foundation trusts for triggers, early warning and solutions to the issues including cross foundation trust to foundation trust pathways.

Other sources of assurance

Internal Control Framework

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

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

The system of internal control is underpinned by the existence of a number of individual controls that are in place:

- Senior management/executive review
- Policies and procedures covering important activities
- Standing Financial Instructions and Scheme of Delegation
- The checks and balances inherent in internal and external audit reviews
- Governing Body oversight

In addition to management processes the CCG participates in the assurance process undertaken by NHS England; the outcome reports from these are presented to the Governing Body.

The CCG has an internal audit function which has been in place throughout 2021/22. An internal audit plan was drawn up and approved by the Audit Committee prior to the start of the financial year in March 2021.

Robust anti-fraud arrangements are in place within the CCG. The Counter Fraud, Bribery and Corruption Policy was approved by the Joint Locality Executive Board in August 2013. The policy provides a framework for responding to suspicions of fraud, bribery and corruption, advice and information on various aspects of fraud, bribery and corruption and implications of an investigation.

An anti-fraud plan for 2021/22, which is aligned to fraud, bribery, and corruption standards, was approved by the Audit Committee in July 2021. Progress against the plan has been reported during the year to the Audit Committee. Anti-fraud awareness training has been delivered to staff and members of the Governing Body and publicity material has been made available in practices. No proven issues of fraud have been identified during the period April 2021 to the date of signing of this statement.

The CCG has a Standards of Business Conduct Policy which was approved by JLEB in March 2015 and is revised annually. In January 2021 the policy was extended for 12 months in light of COVID-9. The policy forms part of the CCG's corporate governance framework, which requires it to issue guidance to members, officers, and employees on the acceptance of gifts/hospitality and the declaration of interests. The CCG is committed to ensuring the highest standards of professional and ethical conduct and this policy is intended to enable these standards to be met. This policy enables the CCG to comply with the Standards of business conduct for NHS staff, Health service guidelines HSG (93)5, 1993, the Prevention of Corruption Acts 1906 and 1916, the Bribery Act 2010 and the Seven Principles of Public Life (The Nolan Principles).

Annual audit of conflicts of interest management

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

An annual internal audit of the CCG's conflicts of interest systems and management is undertaken. The outcome in 2021/22 was an assurance rating of 'significant assurance'. The area identified as requiring improvement was:

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- The CCG considers conflicts of interest when appointing governing body members, members of committees and sub committees and senior employees.

This action has been undertaken.

Data Quality

The CCG has a Data Quality Policy - CCG IG02, which was initially approved by the JLEB in January 2013 and has been reviewed regularly. The most recent version was approved by the Clinical Management Board in October 2020. The CCG recognises that all their decisions, whether healthcare, managerial or financial, need to be based on information which is of the highest quality. Data quality is crucial, and the availability of complete, accurate, relevant, and timely data is important in supporting patient/service user care, governance, management and service agreements for healthcare planning and accountability. The Governing Body and member practices are satisfied with the quality of data used to inform decision making and planning to deliver the commissioning agenda and to ensure the CCG meets its statutory requirements.

Information Governance

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 have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

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

The Information Governance agenda is considered at the Clinical Management Board. The CCG has also appointed a Caldicott Guardian and Senior Information Risk Owner.

The Data Security and Protection Toolkit will be completed by 30 June 2022.

NECS, as the provider of IT services to the CCG, has a range of controls in place. Control objectives include: physical access, logical access, segregation of duties, data transmissions, data centre environmental controls, IT processing, data integrity and backups, change management procedures, network security measures, data migration, problem and incident resolution, system recovery and disaster recovery. Assurance on the effectiveness of these controls is provided to the CCG through the ISAE 3204 report from NECS' internal auditors Deloitte LLP.

There are processes in place for incident reporting and this is reported to the Audit Committee as part of the governance assurance report provided by NECS. The Quality Safety Group has a specific remit to investigate serious incidents and monitor completion of the subsequent action plans. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

Business Critical Model

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

I can confirm that all business-critical models have been identified and that information about quality assurance processes for those models has been provided to the Analytical Oversight Committee, chaired by the Chief Analyst in the Department of Health and Social Care.

The CCG has a Business Continuity Management Plan, approved by the JLEB in December 2013 and reviewed annually. The most recent version was approved by Governing Body in October 2019. It has been regularly reviewed throughout the COVID-19 response.

Third party assurances

Delegation of functions

The CCG currently contracts with several external organisations for the provision of back office services and functions. These include:

- The provision of Oracle financial system and financial accounting support from NHS Shared Business Services (SBS). The use of SBS is mandated by NHS England for all CCGs and is fundamental in producing NHS England group financial accounts using an integrated financial ledger system
- The provision of core business services from the North of England Commissioning Support Unit (NECS)
- The provision of payroll services from Northumbria Healthcare NHS Foundation Trust
- The provision of the Electronic Staff Record (ESR) payroll systems provided by IBM
- The provision of services from NHS Business Services Authority (BSA - prescribing)
- The provision of services from Capita Business Services Limited (Primary Care Co-commissioning)
- The provision of NHS Digital, (Primary Care Co-commissioning)

Assurances on the effectiveness of the controls in place for the above are received in part from an annual Service Audit Report from the relevant service providers as well as additional testing of controls that has been undertaken by the CCG's internal auditors.

Assurances received for these services are as follows:

NHS Shared Business Services (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.

North of England Commissioning Support Service (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:

- 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.

Payroll

The auditors report provides the following assurances for the year ended 31 March 2022:

Payroll – Temporary Amendments, Exception Reporting and Payroll Processing – Substantial assurance

Payroll – Starters, Leavers and Amendments to Pay - Substantial assurance

Conclusion - the auditors report did not identify, as part of the 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.

Electronic Staff Record Programme (ESR)

The ISAE 3000 Type II Controls Report for the Electronic Staff Record Programme (ESR), for the period 1 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.

NHS Business Services Authority (BSA)

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.

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:

- 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.

Primary Care Support England, Capita 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.

The service auditor reports received provided qualified opinions with some identified exceptions for some control objectives. A review has been carried out by the CCG on these control exceptions and it has been confirmed that the CCG has in place internal controls to mitigate the control exceptions identified.

Control Issues

Issues Reported at Month 9:

Quality and Performance – 52 week wait

Due to the local system responding and diverting resources in order to respond to the pressures of COVID-19, the volume of patients on the planned care waiting lists have increased along with unprecedented numbers of patients waiting in excess of both 52 weeks and 104 weeks.

Recovery is being addressed on an ICP footprint with local commissioners and providers working in collaboration. Initiatives used include the use of the independent sector, revising pathways, however the impact of staff absence and challenges in recruiting to vacancies is still impacting upon recovery along with the social distancing requirements and enhanced cleaning procedures limiting the capacity of clinics and operating theatres.

Whilst the breaches are across most specialties, the specialities with the highest volumes of breaches include ophthalmology, dermatology, plastics and orthopaedics. Within ophthalmology a significant volume of patients are awaiting cataract procedures. Newcastle-upon-Tyne Hospitals NHS Foundation Trust has created a new cataract operating facility off-site which has enhanced capacity and combined with the use of the independent sector is leading to significant reductions in the volume of excess waits.

Within dermatology, a new tele-dermatology pathway has been introduced enabling a high proportion of patients to be diagnosed online through the use of a digital app enhancing the volume of patients to be triaged. In managing the backlog particularly the patients diagnosed with cancer, staff from the plastics specialty have been assisting which in turn has impacted upon the patient awaiting routine plastic procedures.

Within trauma and orthopaedics, the COVID-19 restrictions have had a major impact upon complex spinal patients due to the higher infection risk. Many of the patients waiting in excess of 104 weeks are within this specialty. Whilst capacity is being addressed on a mutual aid basis, a business case to address the excess waits is being prepared by the Specialist Commissioning team.

Cancer

Although patients suspected or diagnosed with cancer have been prioritised for treatment throughout the pandemic, significant breaches are ongoing against the NHS Constitution metrics. Published performance against the 92% 2 week wait target within Northumberland at the end of November 2021 was 77.6% and against the 85% 62 day threshold 64.0%.

As well as workforce and clinical issues limiting treatment capacity, the reluctance of patients to come into hospital for diagnosis and treatment along with either themselves or family members testing positive for COVID-19 has had an impact on treatment times. Work is being coordinated across the providers to identify if these issues have had an impact on the later staging of cancer. A significant volume of the breaches have occurred within dermatology, the use of the revised tele-dermatology pathways continues to improve performance. In addition, excess breaches have been evident within the lower GI although the expanded use of the FiT test continues to make an improvement on the diagnosis of cancer and managing the volumes of patients that need to be seen. Revisions to the breast pathway along with the recruitment of additional radiology capacity continues to improve performance within this speciality.

Diagnostics

Northumberland performance in November 2021 was 10.8% excess waits above six weeks against a 1% threshold with local acute performance at 2.3% at NHCFT and 23.0% at NUTH. Performance is significantly improving due to the use of the independent sector and waiting list initiatives are underway within the main acute providers. There were excess breaches within the cardiology related specialties however these are now clearing. The increased use of the FiT test is also supporting the recovery of the Lower GI pathway.

Ambulance Services

The range of ambulance response time metrics are consistently underperformed against both at place and at organisation level. A wide range of measures are in place to improve future performance with focussed work on reducing handover delays, reducing conveyance to hospital, increased use of Hear and Treat. The projects have been enhanced by additional winter funding to increase Call Handlers for both NHS 111 and 999, increase the resources for clinical triage and the establishment of a performance and quality desk to troubleshoot/remove blockages in the system. Early indicators suggest these initiatives are having an impact although it will take some time before the higher level metrics are achieved.

Mental Health and Dementia

Serious Mental Illness Mental Health Checks – Q3 performance was 36.9% against a 60% target. Work is ongoing with GP practices to improve performance however pressure on the primary care services to delivery COVID-19 resilience has delayed the rollout of these health checks. The shortage of blood bottles also made an impact. Whilst the CCG has further incentivised the practices to focus on this area of work, it may not be possible to achieve the end of year target.

Improving Access to Psychological Therapies (IAPT) – whilst at place Northumberland performs well against the 50% recovery target, the major challenge continues to relate to the access target. Combined with low referral rates and pressures within the higher level steps, Northumberland is not achieving this particular target. The provider has reviewed clinical coding and is using a wider range of assessment tools to improve recovery rates. Outsourcing along with recruitment of locums is improving uptake, however it will be challenging to achieve the access target for the end of the year.

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

The CCG has delegated approval of a comprehensive system of internal control, including budgetary control that underpins the effective, efficient, and economic operation of the CCG, to the Governing Body. The Accountable Officer is held to account for ensuring that the CCG discharges this duty and provides assurance to the Governing Body. The Governing Body in providing assurance that the CCG is acting consistently with this duty is supported by the following committees:

Audit Committee – provides the Governing Body with an independent and objective view of the CCG's financial systems, financial information and

compliance with laws, regulations and directions governing the CCG in so far as they relate to finance. The internal audit service further supports the audit committee by evaluating and reporting on the effectiveness and adherence to the systems of internal controls that the CCG has in place.

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

Delivery of the financial plan has been delegated by the Governing Body to the Chief Finance Officer, who is the Governing Body's professional expert on finance and ensures, through robust systems and processes, the regularity and propriety of expenditure is fully discharged.

The Chief Finance Officer is also responsible for:

- Making arrangements to support, monitor and report on the CCG's finances
- Overseeing robust audit and governance arrangements leading to propriety in the use of CCG resources
- Advising the Governing Body on the effective, efficient, and economic use of its allocation to remain within that allocation and deliver required financial targets and duties
- Producing the financial statements for audit and publication in accordance with statutory requirements to demonstrate effective stewardship of public money and accountability to taxpayers
- Overseeing all financial systems and internal controls, including the development and modification of accounting systems
- Maintaining relationships with external professional advisors
- Managing relationships with internal and external audit functions and playing a leading role in liaison with any regulatory bodies

The CCG has a responsibility to ensure its expenditure does not exceed the aggregate of its allotments for the financial year. This responsibility has been delegated to the Governing Body which approves the rolling three-year financial plan, setting out the deployment of resources within allocations and the approach to delivery and risk mitigation. The Governing Body also approves and reviews the CCG's Scheme of Delegation and Standing Financial Instructions (SFIs). The Governing Body is held to account for the monitoring and overall delivery of financial performance and compliance with SFIs.

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
- The CCG Audit Committee receives a report against each of the Standards for Commissioners at least annually. There is 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
- Appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations

There were no reported incidents of fraud during 2021/22.

Head of Internal Audit Opinion

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

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.

The basis for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes for governance and the management of risk;
2. An assessment of the range of individual opinions arising from audit assignments, contained within risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses;
3. Brought forward Internal Audit assurances;
4. An assessment of the organisation's response to Internal Audit recommendations, and
5. Consideration of significant factors outside the work of Internal Audit.

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

Area of Audit	**Level of Assurance Given**
Governance, Risk and Performance	Substantial
Conflicts of Interest	Substantial
Contract and Performance Management	Substantial
Key Financial Controls	Substantial
Continuing Health Care Payments	Substantial

Definitions of Assurance Levels

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 Auditor's Annual Report 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 Management Board
- Internal audit
- Other explicit review/assurance mechanisms.

The following arrangements highlight how the Governing Body assures itself that the system of internal control is effective.

The Governing Body

Governing Body agendas during the year were structured around the key risks and issues.

The Audit Committee

The Annual Internal Audit Plan, as approved by the Audit Committee, enables the Governing Body to be reassured that key internal financial controls and other matters relating to risk are regularly reviewed. The Committee has reviewed internal and external audit reports, and reviewed progress on meeting the requirements of the assurance framework.

The Chief Operating Officer

The Chief Operating Officer (COO) is the Senior Information Responsible Officer (SIRO). The COO is a member of the Clinical Management Board (CMB) and the Governing Body and attends the Appointments and Remuneration Committee.

The Executive Director of Commissioning, Contracting and Corporate Governance

The Executive Director of Commissioning, Contracting and Corporate Governance is the executive lead for risk management and governance and is a member of the Governing Body and CMB.

The Executive Director of Nursing, Quality and Patient Safety

The Executive Director of Nursing, Quality and Patient Safety is the executive lead director for clinical governance and quality and is a member of the Governing Body, CMB and Chairs the Quality and Safety Group.

Internal Audit

During the year the CCG used Audit One as providers of internal audit services. The contract and associated internal audit plan specify that the delivery of the internal audit function will continue to follow the Public Sector Internal Audit Standards.

Some of the key areas included in the internal audit plan were around risk management arrangements, governance structures, commissioning arrangements and performance management. All planned audits were completed to time.

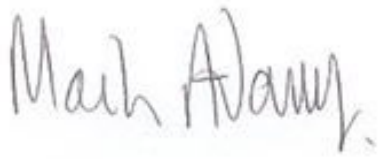
Conclusion

The system of control described in this report has been in place in the CCG for the year ended 31 March 2022 and up to the date of the approval of the annual report and accounts.

The work undertaken in 2021/22 across the range of assurance providers to the CCG has shown that:

- The CCG recorded an in-year surplus of £2.052m.
- The CCG remains with a cumulative deficit of £53.353m.
- While the CCG has been able to deliver its statutory requirements this year during the temporary financial arrangements imposed by government on the back of the COVID-19 pandemic, the CCG still has further work to do to maintain financial stability in future years on a possible return to Published Allocations. Its continued response to the COVID-19 situation working with its partner organisations will be an important part of this work.
- The Head of Internal Audit concluded an overall opinion of 'substantial assurance'

I have concluded that the CCG had a sound system of internal control in place continuously throughout the year, designed to meet the organisation's objectives and the ongoing requirements of the COVID-19 response. Whilst financial controls are sound, the CCG will need to retain its focus on financial sustainability. In response to the COVID-19 pandemic, the priority recovery of services, and the impending statutory establishment of Integrated Care Boards, the CCG will need to look at innovative and cost-effective solutions whilst maintaining financial control into 2022/23.



Mark Adams
Accountable Officer
20 June 2022

Remuneration and Staff Report

Remuneration Report

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

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

It is considered that the Governing Body and Clinical Management Board members represent the senior managers of the CCG.

The members of the Governing Body and Clinical Management Board were all appointed through a robust recruitment interview process which was in line with the CCG’s Constitution. All posts may be terminated by mutual agreement, resignation or dismissal in line with the CCG’s Constitution.

Remuneration Policy

The appointment of the lay governors (including Deputy Lay Chair) and Governing Body Secondary Care Doctor is discussed and voted for by CCG members.

Remuneration for the posts of lay governors (including Deputy Lay Chair)and Governing Body Secondary Care Doctor, very senior managers and clinical leads are considered by the members of the CCG’s Appointments and Remuneration Committee who make formal recommendations thereafter to Governing Body.

The Governing Body has an established Appointments and Remuneration Committee; its membership comprises the CCG Deputy Lay Chair (who chairs the Committee) and all other Lay Governors. The principal function of the Appointments and Remuneration Committee is to advise the Governing Body on senior appointments, about appropriate remuneration and terms of service, and determine the remuneration and terms of service of members of the Clinical Management Board and other staff directly accountable to the Accountable Officer or Chief Operating Officer.

The Chief Operating Officer is the lead officer for the committee and is invited to attend all meetings but withdraws from discussions relating to their own

remuneration. Other officers, employees, and practice representatives of the group are invited to attend all or part of meetings of the committee to provide advice or support as deemed necessary. They are not in attendance for discussions about their own remuneration or terms of service. Declarations of interest are made at the start of every meeting.

An annual salary review is undertaken to determine whether an annual uplift should be awarded and if so the level of the uplift. In making this decision, the Appointments and Remuneration Committee takes into consideration a number of factors including the level of pay awards made nationally to other staff groups within the NHS as well as NHS England guidance and the affordability to the organisation.

Performance evaluation of the Accountable Officer is undertaken by the Clinical Chair. The CCG Deputy Lay Chair also undertakes performance evaluation of other Lay governors including the Governing Body Secondary Care Doctor.

Performance evaluation of the Chief Operating Officer is undertaken by the Accountable Officer and CCG Clinical Chair. The CCG Clinical Chair and Chief Operating Officer undertake performance evaluation of the Locality Directors and Medical Directors. The Chief Operating Officer undertakes performance evaluation of the Chief Finance Officer, the Executive Director of Nursing, Quality and Patient Safety and the Director of Commissioning and Contracting.

The CCG currently has no provision for compensation for early termination or early retirement. Comparative information for the prior year is disclosed in the tables on the following pages.

All Pensions related benefit figures are received from NHS Pensions.

Remuneration of Very Senior Managers

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

Northumberland CCG has two senior managers that are paid more than £150,000 per annum on a pro-rata basis.

The Appointments and Remuneration Committee, as the Senior Salaries Review Body, critically reviews the salary of very senior managers when making recommendations to Governing Body regarding the remuneration.

The CCG had 18 senior managers in post at 31 March 2022.

Table 2: Northumberland CCG senior manager remuneration report 2021/22 (this has been subject to audit)

Name	Title	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long-term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Dr Graham Syers	Clinical Chair	60-65	-	0-5	-	15-17.5	80-85
Janet Guy	Deputy Lay Chair	20-25	-	0-5	-	-	20-25
Karen Bower	Lay Governor	5-10	-	0-5	-	-	5-10
Steve Brazier	Lay Governor	5-10	-	0-5	-	-	5-10
Professor Marios Adamou	Secondary Care Doctor	5-10	-	0-5	-	-	5-10
Mark Adams	Accountable Officer	40-45	-	0-5	-	-	40-45
Jon Connolly	Chief Finance Officer	65-70	-	-	-	-	65-70
Siobhan Brown	Chief Operating Officer	120-125	-	0-5	-	32.5-35	160-165
Annie Topping	Executive Director of Nursing, Quality & Patient Safety	55-55	-	0-5	-	7.5-10	65-70
Dr John Warrington	Medical Director/Locality Director/Business Director	65-70	-	0-5	-	27.5-30	90-95
Dr Paula Batsford	Locality Director	20-25	-	0-5	-	12.5-15	35-40
Dr Ben Frankel	Locality Director	35-40	-	0-5	-	10-12.5	45-50
Dr Chris Waite	Locality Director	25-30	-	0-5	-	5-7.5	30-35
Tony Brown	Locality Director	25-30	-	0-5	-	-	25-30
Dr Robin Hudson	Medical Director	80-85	-	0-5	-	152.5-155	230-235

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
Paul Turner	Executive Director of Commissioning, Contracting and Corporate Governance	100-105	6	-	-	45-47.5	150-155
Rachel Mitcheson	Service Director – Transformation and Integrated Care	50-55	-	-	-	60-62.5	110-115
Dr James Brown	Consultant in Public Health	80-85	-	-	-	45-47.5	125-130
Pamela Lee	Consultant in Public Health	30-35	1	-	-	-	30-35

Notes to senior manager remuneration report 2021/22

Expenses payments (taxable) 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.

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

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 Northumberland CCG's share of remuneration of 50%.

Dr Paula Batsford left the Locality Director role on 22 September 2021. Remuneration relates to the Locality Director role.

40% of Executive Director of Nursing, Quality & Patient Safety role is recharged to NHS England.
50% of Service Director Transforming Integrated Care role is recharged to Northumberland County Council.

Dr James Brown and Pamela Lee are employed by Northumberland CCG in Consultant in Public Health roles. This is recharged in full to Northumberland County Council.

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

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

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

Rachel Mitcheson is employed by Northumberland CCG and works for Northumberland County Council as part of a staff sharing arrangement.

Annie Topping is employed by Northumberland CCG and works for NHS England as part of a staff sharing arrangement.

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

Table 3: Northumberland CCG staff sharing arrangement 2021/22 (this has been subject to audit)

Name	Title	Salary (bands of £5,000) £ 000	Expense payments (taxable) to nearest £100 £00	**TOTAL** (bands of £5,000) £ 000
Mark Adams	Accountable Officer	170-175	-	170-175
Jon Connolly	Chief Finance Officer	140-145	-	140-145
Rachel Mitcheson	Service Director – Transformation and Integrated Care	100-105	-	100-105
Annie Topping	Executive Director of Nursing, Quality & Patient Safety	90-95	-	90-95

Table 4:Northumberland CCG senior manager remuneration report 2020/21 (this has been subject to audit)

Name	Title	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long-term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Dr Graham Syers	Clinical Chair	60-65	-	-	-	40-42.5	100-105
Janet Guy	Deputy Chair	20-25	-	-	-	-	20-25
Karen Bower	Lay Governor	5-10	-	-	-	-	5-10
Steve Brazier	Lay Governor	5-10	-	-	-	-	5-10
Professor Marios Adamou	Secondary Care Doctor	5-10	-	-	-	-	5-10
Mark Adams	Accountable Officer	40-45	-	-	-	-	40-45
Jon Connolly	Chief Finance Officer	65-70	-	-	-	-	65-70
Siobhan Brown	Chief Operating Officer	120-125	-	-	-	30-32.5	155-160
Annie Topping	Director of Nursing, Quality & Patient Safety	90-95	10	-	-	22.5-25	115-120
Dr John Warrington	Business Director	65-70	-	-	-	47.5-50	115-120
Dr Paula Batsford	Locality Director	50-55	-	-	-	10-12.5	60-65
Dr Ben Frankel	Locality Director	35-40	-	-	-	7.5-10	45-50
Dr Chris Waite	Locality Director	25-30	-	-	-	20-22.5	45-50
Tony Brown	Locality Director	25-30	-	-	-	27.5-30	50-55
Dr Robin Hudson	Clinical Lead – Quality, Cancer and End of Life	75-80	-	-	-	25-27.5	100-105
Paul Turner	Director of Commissioning and Contracting	95-100	8	-	-	52.5-55	150-155

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
Rachel Mitcheson	Service Director – Transformation and Integrated Care	45-50	-	-	-	190-192.5	235-240
Karen Rodman	Health Pathways Lead	10-15	-	-	-	-	10-15
Debra Elliott	Deputy Head of Governance	See note below					
Dr James Brown	Consultant in Public Health	80-85	-	-	-	27.5-30	110-115
Pamela Lee	Consultant in Public Health	15-20	-	-	-	0-2.5	15-20

Notes to senior manager remuneration report 2020/21

Expenses payments (taxable) are shown in £00 and include lease car allowances and mileage claims.

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

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 Northumberland CCG's share of remuneration of 50%.

Debra Elliot left the Deputy Head of Governance role on 31 July 2020. Debra Elliott is employed by North of England Commissioning Support Unit and recharged to the CCG as part of a Commissioning Delivery Support Service Level Agreement. Salary and pension related benefits information is not reported because Debra Elliot is not a senior manager of that organisation.

50% of Service Director Transforming Integrated Care role is recharged to Northumberland County Council.

Dr James Brown and Pamela Lee are employed by Northumberland CCG in Consultant in Public Health roles. This is recharged in full to Northumberland County Council.
Karen Rodman left the Health Pathways Lead role on 31 August 2020.

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 2020/21

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

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

Rachel Mitcheson is employed by Northumberland CCG and works for Northumberland County Council as part of a staff sharing arrangement.

The total remuneration earned for all work across all organisations in 2020/21 is shown below:

Table 5: Northumberland CCG staff sharing arrangement 2020/21 (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
Mark Adams	Accountable Officer	170-175	-	170-175
Jon Connolly	Chief Finance Officer	135-140	5	135-140
Rachel Mitcheson	Service Director – Transformation and Integrated Care	95-100	-	95-100

Table 6. Northumberland CCG senior officers pension benefits 2021/22 (this has been subject to audit)

		Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2022	Lump sum at pension age related to accrued pension at 31 March 2022	Cash Equivalent Transfer Value at 1 April 2021	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
		£000	£000	£000	£000	£000	£000	£000	£000
Dr Graham Syers	Clinical Chair	0-2.5	0-2.5	15-20	35-40	288	14	311	-
Siobhan Brown	Chief Operating Officer	2.5-5	-	20-25	10-15	306	20	344	-
Annie Topping	Executive Director of Nursing, Quality & Patient Safety	0-2.5	-	35-40	105-110	852	25	890	-
Dr John Warrington	Medical Director/Locality Director/Business Director	0-2.5	0-2.5	20-25	40-45	332	23	365	-
Dr Paula Batsford	Locality Director	0-2.5	0-2.5	10-15	25-30	213	11	232	-
Dr Ben Frankel	Locality Director	0-2.5	0-2.5	10-15	25-30	169	8	180	-
Dr Chris Waite	Locality Director	0-2.5	0-2.5	5-10	25-30	179	7	190	-
Tony Brown	Locality Director	-	-	15-20	-	238	-	227	-
Dr Robin Hudson	Medical Director	5-7.5	12.5-15	25-30	45-50	324	132	466	-

Paul Turner	Executive Director of Commissioning, Contracting and Corporate Governance	2.5-5	2.5-5	20-25	30-35	235	24	272	-
Rachel Mitcheson	Service Director – Transformation and Integrated Care	2.5-5	2.5-5	30-35	70-75	530	52	596	-
Dr James Brown	Consultant in Public Health	2.5-5	0-2.5	20-25	40-45	348	32	390	-
Pamela Lee	Consultant in Public Health	-	-	25-30	80-85	-	-	-	-

Pension information provided by NHS Pensions

Cash equivalent transfer values at 1 April 2021 have been inflated by 0.5% in accordance with NHS Business Services Authority instruction.

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.

Table 7. Northumberland CCG senior officers pension benefits 2020/21 (this has been subject to audit)

		Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2021	Lump sum at pension age related to accrued pension at 31 March 2021	Cash Equivalent Transfer Value at 1 April 2020	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employer's contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
		£000	£000	£000	£000	£000	£000	£000	£000
Dr Graham Syers	Clinical Chair	0-2.5	2.5-5	15-20	35-40	242	35	286	-
Siobhan Brown	Chief Operating Officer	0-2.5	-	20-25	10-15	269	18	305	-
Annie Topping	Director of Nursing, Quality & Patient Safety	0-2.5	2.5-5	35-40	105-110	792	44	848	-
Dr John Warrington	Business Director	2.5-5	2.5-5	20-25	40-45	283	38	331	-
Dr Paula Batsford	Locality Director	0-2.5	-	10-15	25-30	196	8	212	-
Dr Ben Frankel	Locality Director	0-2.5	0-2.5	5-10	20-25	156	8	168	-
Dr Chris Waite	Locality Director	0-2.5	0-2.5	5-10	25-30	156	19	178	-
Tony Brown	Locality Director	0-2.5	-	15-20	-	211	22	237	-
Dr Robin Hudson	Clinical Lead – Quality, Cancer and End of Life	0-2.5	0-2.5	15-20	30-35	292	20	323	-

Paul Turner	Director of Commissioning and Contracting	2.5-5	2.5-5	15-20	30-35	193	29	234	-
Rachel Mitcheson	Service Director – Transformation and Integrated Care	7.5-10	20-22.5	30-35	65-70	359	155	527	-
Dr James Brown	Consultant in Public Health	0-2.5	0-2.5	20-25	40-45	314	21	346	-
Pamela Lee	Consultant in Public Health	0-2.5	0-2.5	35-40	105-110	-	-	-	-

Pension information provided by NHS Pensions

Cash equivalent transfer values at 1 April 2020 have been inflated by 1.7% in accordance with NHS Business Services Authority instruction.

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

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

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

There was no compensation on early retirement for loss of office paid during 2021/22.

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

There were no payments to past members paid during 2021/22.

Fair pay disclosure (This has been subject to audit)

Percentage change in remuneration of highest paid director

	Salary and allowances %	Performance pay and bonuses %
The percentage change from the previous financial year in respect of the highest paid director	0.0	100%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	(2.9)	100%

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

Average percentage change from previous financial year for employees as a whole is calculated on an annualised salary basis and is impacted by the movement in the full time equivalent number of employees in 2021/22. In 2021/22 CCG Agenda for Change employees received a 3 per cent pay award uplift in line with NHS Pay Review Bodies' recommendations.

The percentage change from the previous financial year for performance pay and bonuses is 100% as a non-consolidated payment was paid to senior managers that were not on a national pay framework in 2021/22. These managers did not receive a consolidated pay rise. No performance pay or bonuses were paid to employees in 2020/21.

Pay ratio information

Remuneration of Northumberland CCG staff is shown in the table below:

2021/22	25th percentile	Median	75th percentile
All staff remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£40,057	£54,764	£108,639
Salary component of 'all staff' remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£40,057	£54,764	£108,075
2020/21			
All staff remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£40,307	£51,668	£100,481
Salary component of 'all staff' remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£38,890	£51,668	£100,481

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 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 non-consolidated pay and benefits-in-kind relating to lease cars included in the remuneration value. Non-consolidated pay and benefits-in-kind are excluded from the salary component value.

The banded remuneration of the highest paid director in Northumberland CCG in the financial year 2021/22 was £125-130k (2020/21: £120-125k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
2021/22	3.2:1	2.3:1	1.2:1
2020/21	3.0:1	2.4:1	1.2:1

In 2021/22, no employee (2020/21, 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 £22,000 to £170,000 (2020/21: £20,000 to £168,000). 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 2021/22 remuneration ratios remain at a consistent level to 2020/21 remuneration ratios due to marginal changes to the overall number, composition and remuneration of the workforce.

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

Staff numbers and costs are analysed by permanent employees and 'other.' Permanently employed refers to members of staff with a permanent (UK) employment contract directly with the CCG.

Other refers to any staff engaged that do not have a permanent (UK) employment contract with the CCG. This includes employees on short term contracts of employment and agency/temporary staff.

The figures exclude lay members of the Governing Body.

Table 8: Northumberland CCG average number of people employed

	Permanent Employees	Other	Total
Average number of people employed	53.10	0.16	53.26

Average number based upon full time equivalent.

Table 9: Northumberland CCG staff costs

	Permanent Employees	Other	Total
Staff costs	£'000	£'000	£'000
Salaries and wages	3,066	7	3,073
Social security costs	327	-	327
Employer Contributions to NHS Pension scheme	525	-	525
Apprentice Levy	1	-	1
Staff costs	3,919	7	3,926

Staff costs exclude lay members of the Governing Body

Staff composition

The CCG has a staff headcount of 69 employees (including non-executives and chair) as at the 31 March 2022. This includes 4 very senior managers and 65 other CCG Employees.

Below is the gender split for the headcount:

Table 10: Northumberland CCG staff gender profile at 31 March 2022

	Total	Male	%	Female	%
Very Senior managers	4	2	50.0%	2	50.0%
Other CCG employees	65	22	33.8%	43	66.2%
Total CCG employees	**69**	**24**	**34.8%**	**45**	**65.2%**
Governing Body members	15	11	73.3%	4	26.7%

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

Staff sickness absence

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

Table 11: Northumberland CCG staff sickness absence data

	2021/22 Number	2020/21 Number
Total days lost	777	293
Average working days lost	**14.5**	**6**

Staff Turnover

Staff turnover of permanent employees is reported as a percentage of the average number of people employed. The staff turnover percentage in 2021/22 was 11% (2020/21: 12%).

Staff policies

The CCG has a suite of staff policies in place. The CCG has taken steps throughout 2021/22 to maintain and develop the provision of information to, and consultation with employees, including:

- Providing employees 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
- Health and Safety

The CCG has a positive attitude to recruitment, employment, training and development of disabled persons. The CCG has successfully renewed its accreditation as a Two Tick Disability employer. The symbol, awarded by Jobcentre 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 2021/22 there were no employees of Northumberland CCG who were trade union representatives.

Expenditure on consultancy

There was no consultancy expenditure incurred in 2021/22 (2020/21, nil).

Off-payroll engagements

New off-payroll engagements longer than 6 months

There were no new off-payroll engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022, for more than £245 per day and that last longer than six months.

Table 12: Off-payroll engagements / senior official engagements

Off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	19

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

No exit packages including special (non-contractual) payments were made in 2021/22.

Parliamentary Accountability and Audit Report

NHS Northumberland CCG is not required to produce a Parliamentary Accountability and Audit Report. The CCG has no disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges. An audit certificate and report is also included in this Annual Report from page 149.

Independent auditor's report to the Governing Body of NHS Northumberland Clinical Commissioning Group

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of NHS Northumberland Clinical Commissioning Group ('the CCG') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including 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 2021/22 as contained in the Department of Health and Social Care Group Accounting Manual 2021/22, and the Accounts Direction issued by the NHS Commissioning Board 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 31 March 2022 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22; 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.

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.

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 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, it is the intention that the CCG's functions will transfer to a new Integrated Care Board from 1 July 2022. Given services will 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.

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 2021/22 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 risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates including year-end expenditure accruals, and significant one-off or unusual transactions.

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, the Audit Committee and the Governing Body 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, the Audit Committee and the Governing Body 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; and
- addressing the risks of fraud through management override of controls by performing journal entry testing and testing year-end expenditure accruals.

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, the Audit Committee and the Governing Body. 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 year ended 31 March 2022.

We have nothing to report in this respect.

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 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 NHS Northumberland CCG, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Certificate

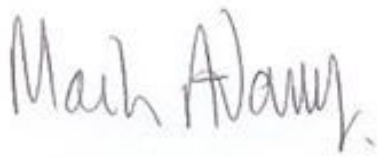
We certify that we have completed the audit of NHS Northumberland CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Cameron Waddell (Key Audit Partner)
For and on behalf of Mazars LLP

The Corner
Bank Chambers
26 Mosley Street
Newcastle upon Tyne
NE1 1DF

Date: 21 June 2022

ANNUAL ACCOUNTS



Mark Adams
Accountable Officer
20 June 2022

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The Primary Statements:

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

	Note	2021-22 £'000	2020-21 £'000
Other operating revenue	2	(100)	(145)
Total operating revenue		**(100)**	**(145)**
Staff costs	3	3,926	3,604
Purchase of goods and services	4	614,346	598,499
Depreciation charges	4	551	250
Other operating expenditure	4	136	132
Total operating expenditure		**618,959**	**602,485**
Comprehensive Net Expenditure for the year ended 31 March 2022		**618,859**	**602,340**

The notes on pages 5 to 16 form part of this statement

Statement of Financial Position as at 31 March 2022

	Note	31 March 2022 £'000	31 March 2021 £'000
Non-current assets:			
Property, plant and equipment	7	-	551
Total non-current assets		-	551
Current assets:			
Trade and other receivables	8	1,432	677
Cash and cash equivalents	9	213	376
Total current assets		**1,645**	**1,053**
Total assets		**1,645**	**1,604**
Current liabilities:			
Trade and other payables	10	(35,559)	(35,365)
Total current liabilities		**(35,559)**	**(35,365)**
Assets less liabilities		**(33,914)**	**(33,761)**
Financed by Taxpayers' Equity			
General fund		(33,914)	(33,761)
Total Taxpayers' Equity		**(33,914)**	**(33,761)**

The notes on pages 5 to 16 form part of this statement

The financial statements on pages 1 to 4 were approved by the Audit Committee on 10th June 2022 and signed on its behalf by:

Accountable Officer
Mark Adams

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

	General fund £'000
Changes in Taxpayers' Equity for 2021-22	
Balance at 01 April 2021	(33,761)
Changes in NHS Clinical Commissioning Group Taxpayers' Equity for 2021-22	
Net operating expenditure for the financial year	(618,859)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(618,859)**
Net funding	618,706
Balance at 31 March 2022	**(33,914)**

	General fund £'000
Changes in Taxpayers' Equity for 2020-21	
Balance at 01 April 2020	(33,431)
Changes in NHS Clinical Commissioning Group Taxpayers' Equity for 2020-21	
Net operating costs for the financial year	(602,340)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(602,340)**
Net funding	602,010
Balance at 31 March 2021	**(33,761)**

The notes on pages 5 to 16 form part of this statement

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(618,859)	(602,340)
Depreciation and amortisation	4	551	250
Decrease in trade & other receivables	8	(755)	754
(Decrease)/Increase in trade & other payables	10	194	(313)
Net Cash Outflow from Operating Activities		**(618,869)**	(601,649)
Net Cash Outflow before Financing		**(618,869)**	(601,649)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		618,706	602,010
Net Cash Inflow from Financing Activities		**618,706**	602,010
Net Increase/(Decrease) in Cash & Cash Equivalents	9	**(163)**	361
Cash & Cash Equivalents at the Beginning of the Financial Year		**376**	15
Cash & Cash Equivalents at the End of the Financial Year		**213**	376

The notes on pages 5 to 16 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 shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care (DHSC). Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual (GAM) 2021-22 issued by the DHSC. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on 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 clinical commissioning groups (CCG). 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 clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022 on a going concern basis.

1.2 **Accounting Convention**

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

1.3 **Pooled Budgets**

Where the Clinical Commissioning Group has entered into a pooled budget arrangement with Northumberland County Council, under Section 75 of the National Health Service Act 2006. Under the arrangement, each commissioner is responsible for decisions on the use of the resources held by them under the Section 75. The CCG is accounting for its own transactions without recognising a share of the assets, liabilities, revenue and expenditure of the pooled budget. See Note 12 for further details.

1.4 **Revenue**

The majority of the Clinical Commissioning Group'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 performance obligation that is to be satisfied 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 Clinical Commissioning Group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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

1.6 **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.

1.7 **Property, Plant & Equipment**

1.7.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Clinical Commissioning Group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost, irrespective of their individual or collective cost.

1.7.2 **Measurement**

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

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

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

1.7.3 **Subsequent Expenditure**

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

Notes to the financial statements

1.8 **Depreciation**

Depreciation is charged to write off the costs or valuation of property, plant and equipment, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Clinical Commissioning Group expects to obtain economic benefits or service potential from the asset. This is specific to the Clinical Commissioning Group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

1.9 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases. The Clinical Commissioning Group does not hold any Finance leases.

1.9.1 **The Clinical Commissioning Group as Lessee**

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.10 **Cash & Cash Equivalents**

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

1.11 **Clinical Negligence Costs**

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

1.12 **Non-clinical Risk Pooling**

The Clinical Commissioning Group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Clinical Commissioning Group pays an annual contribution to 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.

1.13 **Financial Assets**

Financial assets are recognised when the Clinical Commissioning Group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred and the Clinical Commissioning Group has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset. Financial assets for the Clinical Commissioning Group 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.

1.13.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments.
After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.13.2 **Impairment**

For all financial assets measured at amortised cost or at fair value the Clinical Commissioning Group recognises a loss allowance representing the expected credit losses on the financial asset.

The Clinical Commissioning Group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).
HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The Clinical Commissioning Group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the Clinical Commissioning Group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

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

Notes to the financial statements

1.14 **Financial Liabilities**

Financial liabilities are recognised when the Clinical Commissioning Group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

After initial recognition, all 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.

1.15 **Value Added Tax**

Most of the activities of the Clinical Commissioning Group 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.

1.16 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Clinical Commissioning Group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

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

1.17.1 **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 Clinical Commissioning Group'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.

1.17.2 **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 in 2021-22 related to prescribing expenditure which is one month in arrears and is based on BSA profiling. The accrual within the accounts is for the month of March only and is £5.4m (£5.5m in 20-21).

1.18 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23. However, the CCG does not expect this standard to have a material impact on non-current assets, liabilities and depreciation.

- IFRS 16 Leases – The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.

2 Other Operating Revenue

	2021-22			2020-21		
	Total	Admin	Programme	Total	Admin	Programme
	£'000	£'000	£'000	£'000	£'000	£'000
Other non contract revenue	100	24	**76**	145	20	125
Total other operating revenue	**100**	**24**	**76**	**145**	**20**	**125**

The majority of the Clinical Commissioning Group'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 Clinical Commissioning Group and credited to the General Fund.

3 Employee benefits and staff numbers

	2021-22			2020-21		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000
3.1 Employee Benefits						
Salaries and wages	3,073	3,066	7	2,812	2,799	13
Social security costs	327	327	0	292	292	0
Employer Contributions to NHS Pension scheme	525	525	0	500	500	0
Apprentice Levy	1	1	0	0	0	0
	3,926	**3,919**	**7**	**3,604**	**3,591**	**13**

3.2 Average number of people employed

	2021-22			2020-21		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	Number	Number	Number	Number	Number	Number
Total	**53.26**	**53.10**	**0.16**	**48.72**	**48.59**	**0.13**

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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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 schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

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

For 2021-22, employers' contributions of £524,720 were payable to the NHS Pensions Scheme (2020-21: £499,668) at the rate of 20.68% of pensionable pay. The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts as per Note 3.1

4 Operating expenses

	2021-22			2020-21		
	Total	**Admin**	**Programme**	**Total**	**Admin**	**Programme**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Services from other CCGs and NHS England	2,537	1,418	1,119	2,704	1,404	1,300
Services from foundation trusts	397,438	-	397,438	378,716	9	378,707
Services from other NHS trusts	0	-	0	19	-	19
Purchase of healthcare from non-NHS bodies	83,239	-	83,239	91,005	-	91,005
Purchase of social care	13,796	-	13,796	12,996	-	12,996
Prescribing costs	56,394	-	56,394	56,475	-	56,475
GPMS/APMS and PCTMS	57,458	-	57,458	53,143	-	53,143
Supplies and services – clinical	2,351	-	2,351	2,243	-	2,243
Supplies and services – general	191	158	33	134	132	2
Establishment	276	184	92	267	127	140
Premises	471	146	325	569	160	409
Audit fees	58	58	-	58	58	-
Non-audit services	3	3	-	8	8	-
Other professional fees	92	92	-	61	61	-
Legal fees	22	22	-	94	94	-
Education, training and conferences	20	20	-	7	7	-
Depreciation	551	-	551	250	-	250
Chair and Non Executive Members	132	132	-	128	128	-
Clinical negligence	4	4	-	4	4	-
Total operating expenditure	**615,033**	**2,237**	**612,796**	**598,881**	**2,192**	**596,689**

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

GPMS/APMS and PCTMS relates to Primary Care Commissioning.

The external auditor of the Clinical Commissioning Group is Mazars LLP. The audit fee for 2021-22 including VAT, was £58k (£58k in 2020-21).

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 £51k for internal audit services provided by AuditOne (£50k in 2020-21).

Expenses related to Rentals under Operating Leases are within the Establishment and Premises lines. These costs can be seen in Note 6 - Operating Leases.

5 Better Payment Practice Code

Measure of compliance	2021-22 Number	2021-22 £'000	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	7,792	153,402	7,869	155,716
Total Non-NHS Trade Invoices paid within target	7,762	152,590	7,849	155,622
Percentage of Non-NHS Trade invoices paid within target	**99.61%**	**99.47%**	**99.75%**	**99.94%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	265	400,378	916	385,242
Total NHS Trade Invoices Paid within target	263	400,376	911	385,191
Percentage of NHS Trade Invoices paid within target	**99.25%**	**100.00%**	**99.45%**	**99.99%**

6 Operating Leases

6.1 As lessee

6.1.1 Payments recognised as an Expense

	2021-22			2020-21		
	Buildings £'000	Other £'000	Total £'000	Buildings £'000	Other £'000	Total £'000
Minimum lease payments	144	1	145	159	1	160
Total	**144**	**1**	**145**	**159**	**1**	**160**

6.1.2 Future minimum lease payments

	2021-22			2020-21		
	Buildings £'000	Other £'000	Total £'000	Buildings £'000	Other £'000	Total £'000
Payable:						
No later than one year	142	1	143	130	1	131
Between one and five years	273	1	274	-	4	4
After five years	-	-	-	-	-	-
Total	**415**	**2**	**417**	**130**	**5**	**135**

7 Property, plant and equipment

2021-22	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Total £'000
Cost or valuation at 01 April 2021	1,999	22	31	2,052
Cost/Valuation at 31 March 2022	**1,999**	**22**	**31**	**2,052**
Depreciation 01 April 2021	1,448	22	31	1,501
Charged during the year	551	-	-	551
Depreciation at 31 March 2022	**1,999**	**22**	**31**	**2,052**
Net Book Value at 31 March 2022	**-**	**-**	**-**	**(0)**
Purchased	-	-	-	-
Total at 31 March 2022	**-**	**-**	**-**	**-**
Asset financing:				
Owned	-	-	-	-
Total at 31 March 2022	**-**	**-**	**-**	**-**

2020-21	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Total £'000
Cost or valuation at 01 April 2020	1,999	22	31	2,052
Cost/Valuation at 31 March 2021	**1,999**	**22**	**31**	**2,052**
Depreciation 01 April 2020	1,198	22	31	1,251
Charged during the year	250	-	-	250
Depreciation at 31 March 2021	**1,448**	**22**	**31**	**1,501**
Net Book Value at 31 March 2021	**551**	**-**	**-**	**551**
Purchased	551	-	-	551
Total at 31 March 2021	**551**	**-**	**-**	**551**
Asset financing:				
Owned	551	-	-	551
Total at 31 March 2021	**551**	**-**	**-**	**551**

	Asset lives (years)
Plant & machinery	8
Transport equipment	4
Information technology	4

Within the 2021/22 financial year it was determined that the assets within Plant & Machinery were no longer in use. As such the net book value remaining on the asset has been taken to operating expenditure in year.

8 Trade and other receivables

	31-Mar-22 £'000	31-Mar-21 £'000
NHS receivables: Revenue	1,018	294
NHS accrued income	80	-
Non-NHS and Other WGA receivables: Revenue	107	233
Non-NHS and Other WGA prepayments	141	147
Non-NHS and Other WGA accrued income	65	-
VAT	21	3
Total trade & other receivables	**1,432**	**677**

8.1 Receivables past their due date but not impaired

	31-Mar-22 £'000	31-Mar-21 £'000
By up to three months	7	24
By three to six months	-	31
By more than six months	-	6
Total	**7**	**61**

£7k of the amount above has subsequently been recovered post the statement of financial position date.

9 Cash and cash equivalents

	31-Mar-22 £'000	31-Mar-21 £'000
Balance at 01 April 2021	376	15
Net change in year	(163)	361
Balance at 31 March 2022	**213**	**376**
Made up of:		
Cash with the Government Banking Service	213	376
Balance at 31 March 2022	**213**	**376**

10 Trade and other payables

	31-Mar-22 £'000	31-Mar-21 £'000
NHS payables: Revenue	484	1,004
NHS accruals	1,897	227
Non-NHS and Other WGA payables: Revenue	7,391	6,286
Non-NHS and Other WGA accruals	24,175	25,638
Social security costs	51	49
Tax	57	48
Other payables and accruals	1,504	2,113
Total trade & other payables	**35,559**	**35,365**

Other payables include £596k outstanding pension contributions as at 31 March 2022 (£588k in 2020-21) - £59k for Clinical Commissioning Group employees (£58k in 2020-21) and £537k for Primary Care through Delegated Co-Commissioning (£530k in 2020-21).

11 Financial instruments

11.1 Financial assets	Financial Assets measured at amortised cost 31-Mar-22 £'000	Financial Assets measured at amortised cost 31-Mar-21 £'000
Trade and other receivables with NHSE bodies	1,039	186
Trade and other receivables with other DHSC group bodies	59	203
Trade and other receivables with external bodies	172	138
Cash and cash equivalents	213	376
Total at 31 March 2022	**1,483**	**903**

11.2 Financial liabilities	Financial Liabilities measured at amortised cost 31-Mar-22 £'000	Financial Liabilities measured at amortised cost 31-Mar-21 £'000
Trade and other payables with NHSE bodies	481	667
Trade and other payables with other DHSC group bodies	1,963	758
Trade and other payables with external bodies	33,007	33,843
Total at 31 March 2022	**35,451**	**35,268**

It is the Clinical Commissioning Group'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 Clinical Commissioning Group has entered into a pooled budget agreement with Northumberland County Council in relation to the Better Care Fund, which the Council hosts.

The actual contractual arrangements do not result in joint control being established, thus the CCG accounts for transactions on a gross accounting basis. The Clinical Commissioning Group’s expenditure, as determined by the pooled budget agreement is shown below:-

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY 2021-22 Expenditure £'000	Amounts recognised in Entities books ONLY 2020-21 Expenditure £'000
Better Care Fund	NHS Northumberland CCG / Northumberland County Council	To integrate health and social care services, reduce hospital based care and promote community based services	26,708	25,418

13 Related party transactions

Details of related party transactions are as follows:

		2021-22				2020-21			
		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
Director Related Organisations	**Director**								
ALNWICK MEDICAL GROUP	Dr Graham Syers	3,805	0	1,058	0	3,577	0	592	0
BROCKWELL MEDICAL GROUP	Dr John Warrington	0	0	0	0	1,571	0	0	0
VALENS MEDICAL PARTNERSHIP	Dr John Warrington	8,709	0	562	0	2,167	0	535	0
PONTELAND MEDICAL GROUP	Dr Robin Hudson	1,606	0	94	0	1,732	0	79	0
SELE MEDICAL PRACTICE	Dr Ben Frankel	2,574	0	293	0	1,971	0	69	0
WIDDRINGTON SURGERY	Dr Chris Waite	469	0	0	0	596	0	34	0
NORTHUMBERLAND HEALTH AT WIDDRINGTON & FELTON SURGERIES	Dr Chris Waite	310	0	49	0	0	0	0	0
NORTHUMBERLAND LMC	Dr John Warrington	76	0	7	0	75	0	8	0
NHS NORTH OF ENGLAND CSU	Mark Adams	2,478	0	52	0	2,695	-73	76	0
Non Director Related Organisations									
ADDERLANE SURGERY		269	0	14	0	275	0	11	0
BEDLINGTONSHIRE MEDICAL GROUP		1,633	0	130	0	1,614	0	69	0
BELFORD MEDICAL GROUP		1,130	0	59	0	1,138	0	37	0
BELLINGHAM PRACTICE		608	0	26	0	610	0	28	0
BRANCH END SURGERY		900	0	68	0	834	0	39	0
BURN BRAE MEDICAL GROUP		1,867	0	70	0	1,816	0	66	0
CHEVIOT MEDICAL GROUP		634	0	48	0	636	0	64	0
COQUET MEDICAL GROUP		2,000	0	102	0	1,815	0	81	0
CORBRIDGE MEDICAL GROUP		1,520	0	82	0	1,484	0	72	0
CRAMLINGTON MEDICAL GROUP		696	0	35	0	685	0	28	0
ELSDON AVENUE SURGERY		551	0	19	0	527	0	16	0
FELTON SURGERY		315	0	0	0	421	0	18	0
FORUM FAMILY PRACTICE		957	0	52	0	908	0	46	0
GABLES MEDICAL GROUP		1,024	0	63	0	990	0	46	0
GAS HOUSE LANE SURGERY		1,111	0	125	0	1,055	0	33	0
GLENDALE SURGERY		593	0	37	0	595	0	22	0
GREYSTOKE SURGERY		1,665	0	82	0	1,607	0	57	0
GUIDE POST MEDICAL GROUP		2,229	0	179	0	1,793	0	138	0
HALTWHISTLE MEDICAL GROUP		909	0	40	0	901	0	39	0
HAYDON AND ALLEN VALLEYS MEDICAL PRACTICE		757	0	89	0	905	0	67	0
HUMSHAUGH AND WARK MEDICAL GROUP		1,069	0	31	0	1,013	0	-21	0
LABURNUM MEDICAL GROUP		0	0	0	0	107	0	0	0
LINTONVILLE MEDICAL GROUP		0	0	0	0	1,626	0	0	0
MARINE MEDICAL GROUP		1,901	0	86	0	1,867	0	87	0
NETHERFIELD HOUSE SURGERY		900	0	33	0	877	0	37	0
PRUDHOE MEDICAL GROUP		923	0	42	0	873	0	31	0
RAILWAY MEDICAL GROUP		4,593	0	327	0	4,201	0	178	0
RIVERSDALE SURGERY		708	0	53	0	777	0	104	0
ROTHBURY PRACTICE		944	0	261	0	912	0	118	0
SCOTS GAP MEDICAL GROUP		570	0	64	0	634	0	64	0
SEATON PARK MEDICAL GROUP		2,971	0	133	0	2,829	0	156	0
UNION BRAE AND NORHAM PRACTICE		1,312	0	68	0	1,267	0	56	0
VILLAGE SURGERY		2,329	0	218	0	2,044	0	78	0
WELL CLOSE MEDICAL GROUP		3,147	0	221	0	2,251	0	116	0
WELLWAY MEDICAL GROUP		0	0	0	0	2,597	0	0	0
WHITE MEDICAL GROUP		1,390	0	73	0	1,342	0	72	0
HADRIAN PRIMARY CARE ALLIANCE LTD		421	0	19	0	412	0	0	0
NORTHUMBRIA PRIMARY CARE		51	0	0	0	15	0	0	0

Comparators for 2020-21 have been restated to show transactions and balances on an accruals rather than cash basis above.

The CCG membership body consists of one clinical representative from each of the 37 member practices. They ordinarily meet twice a year and are responsible for making recommendations for amendments to the CCG's constitution and approving appointments to the CCG's Governing Body. As such the GP Practices have been included within the Related Parties note above.

The list of Laburnum Medical Group was dispersed on 31st July 2020. A number of patients subsequently reigstered with either Seaton Park Medical Group and Lintonville Medical Group.

On 1st January 2021 Brockwell Medical Group, Lintonville Medical Group and Wellway Medical Group merged and are now Valens Medical Partnership. The figures shown in the Note above are reflective of this change.

On 1st January 2022 Felton Surgery and Widdrington Surgery merged to become Northumberland Health at Widdrington and Felton Surgeries. The figures shown in the Note above are reflective of this change.

In the main GPs within Northumberland are split into 6 Primary Care Networks (PCNs) 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 GP Practices are as follows – Valens Medical Practice (Central), Village Surgery (Cramlington & Seaton Valley), Guide Post Medical Group (Wansbeck), Well Close Medical Group (Well Up North), Railway Medical Group (Blyth), and Sele Medical Practice (West).

The Department of Health and Social Care is regarded as the parent department. During the year the Clinical Commissioning Group 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; North East Ambulance Service NHS FT; NHS England and North of England CSU amongst others.

The CCG commissions several services through Partnership Agreements from Northumberland County Council including Continuning Healthcare, Section 117 claims, Social Care, and contribution to Better Care Fund pooled budgets.

14 Events after the end of the reporting period

There is one non-adjusting post balance sheet event that relates to the Health and Social Care Bill which was introduced into the House of Commons on 6 July 2021. The Bill allows for the establishment of Integrated Care Boards (ICB) across England. ICBs will take on the commissioning functions of CCGs. The Bill passed on 28th April 2022 and it is the intention that the CCG functions, assets and liabilities will therefore transfer to an ICB. (2020-21: None)

15 Financial performance targets

NHS Clinical Commissioning Groups have a number of financial duties under the NHS Act 2006 (as amended).
The NHS Clinical Commissioning Group performance against those duties was as follows:

National Health Service Act Section Duty	Duty	2021-22 Target	2021-22 Performance	2020-21 Target	2020-21 Performance	Duty Achieved
223H(1)	Expenditure not to exceed income	621,011	618,959	603,385	602,485	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	620,911	618,859	603,240	602,340	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	6,315	5,236	6,306	4,962	Yes