NHS
County Durham
Clinical Commissioning Group

Annual report and accounts

1 April - 30 June 2022

Contents

Statement from our Clinical Chair and Accountable Officer

We are delighted to introduce our final NHS County Durham Clinical Commissioning Group (CCG) annual report, which provides an insight into our work during our last 3 months as a CCG, ahead of the transition to the North East and North Cumbria Integrated Care Board (ICB) on 1 July 2022. While it may be unusual to publish an 'annual' report for a three-month period, this underlines the importance of accountability in our NHS.

This report provides an overview of our role and responsibilities as a CCG, planning and purchasing health care services on behalf of our population.

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 remained very much at the heart of what we do in County Durham and drove 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 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.

At the same time, we 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.

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

Dr Jonathan Smith
Clinical Chair

Dr Neil O'Brien
Accountable Officer

PERFORMANCE REPORT[1]

Samantha Allen

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

Accountable Officer

26th June 2023

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

Performance Overview

This section of the Annual Report looks at how our system has performed over the three months 1 April – 30 June 2022 and includes information for the previous 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 during April – June 2022 but we also refer back to 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 were a group of 61 general practices which had come together to commission (or buy) local health services for people who live within County Durham. This was the start of the third 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 commissioned included:

- 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 had a hand in shaping how the CCG worked by developing, and signing up to, a Constitution. The constitution set out the arrangements to ensure the CCG met its responsibilities for commissioning high quality health care for the people of County Durham. It described the governing principles, rules and procedures that ensured integrity, honesty and accountability in our day-to-day activities. It committed the CCG to making decisions in an open and transparent way and placed 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 was to improve the health of our population and to address health inequalities that existed across our different local areas. We wanted to close the health and wellbeing gap and drive transformation to improve the quality of services that we commissioned. We managed our local health system with our social care partners, and actively enabled 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 did, 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 aspired to find better and different ways of working whilst valuing everyone's views to understand their priorities, needs, abilities and limits.

We got the best value from all that we did and were honest and open about what we could and could not do. We used our collective resources with 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 encouraged a diverse range of people to apply to and work for us as we recognised the benefits such diversity brings to the quality of our work and the nature of our organisation.

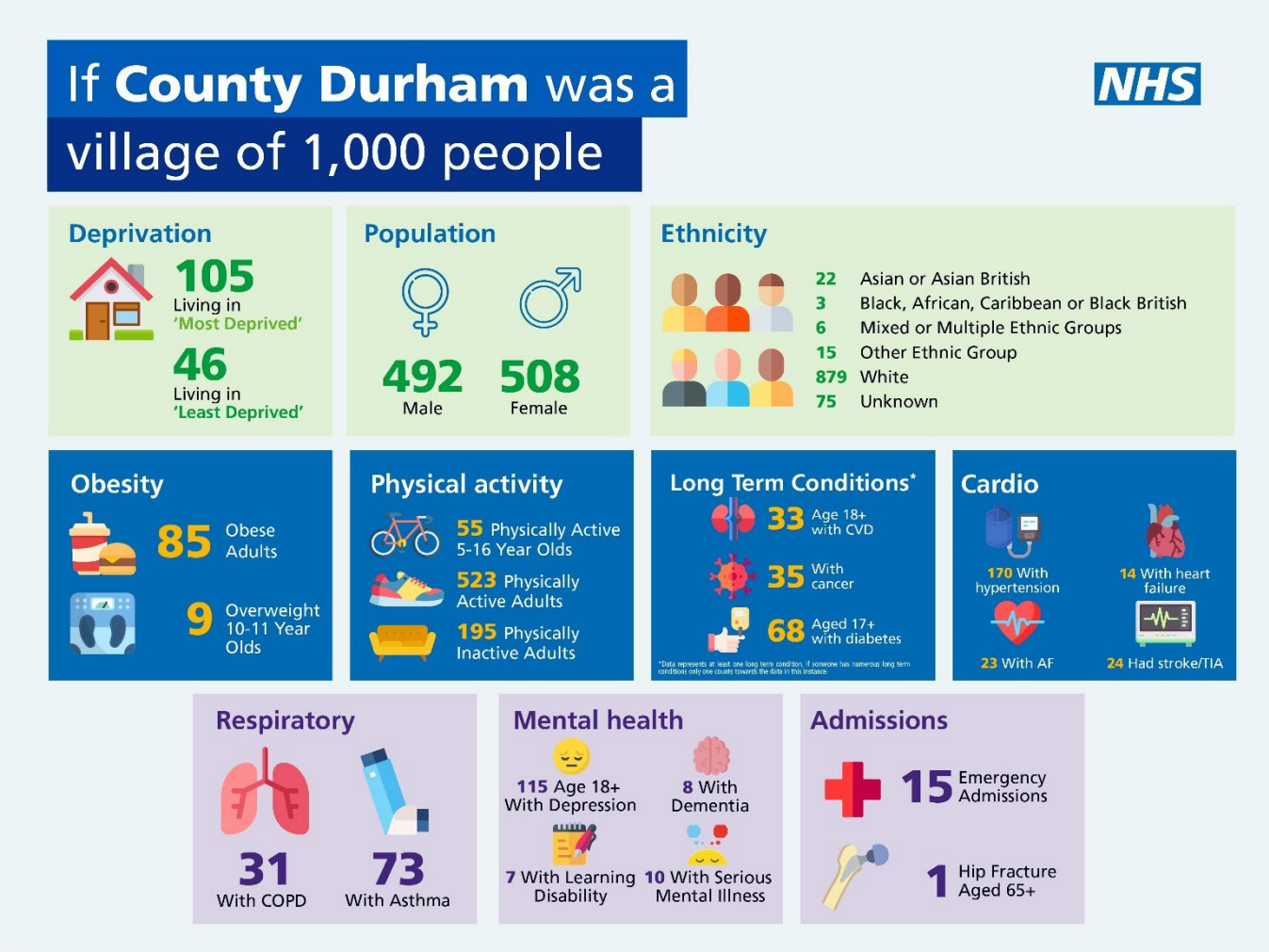
We continued to offer guaranteed interviews to applicants with a disability who were identified as meeting the essential criteria for any advertised roles; and reasonable adjustments under the Equality Act 2010 were considered and implemented during the recruitment process and during employment.

By working closely with DWP, we maintained our 'Level 2 Disability Employer' status by demonstrating our commitment to employing the right people for our business and continually developing our people. Many of our staff continued to work from home due to the continued impact of the Covid-19 pandemic.

Our Constitution

Our Constitution set out our duties and how we made decisions. It set out our responsibilities as commissioners of care for people in County Durham. It described our governing principles, rules and procedures that we adopted for the day to day running of our CCG and so enabled us to achieve our vision.

Our Population



NB - Cardio Vascular Disease (CVD), Atrial Fibrillation (AT), Transient ischemic Attack (TIA) and Chronic Obstructive Airways Disease(COPD)

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.

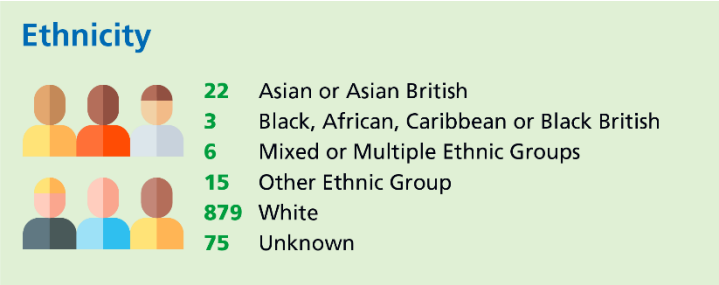
The large student population in Durham City results in a demand for sexual health, alcohol, and harm reduction services. Other key challenges facing County Durham CCG include:

- 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 continued with our Governing Body to ensure that addressing health inequalities was at the heart of everything we did. Unnecessary variations in care were at the centre of all our plans.

In County Durham we developed tools and approaches that used data to identify health inequalities and differences in health outcomes across the whole of the County, and within Primary Care Networks. We understood our local population and local health needs, through the use of the Joint Strategic Needs Assessment (JSNA) and we collated additional supporting data including local health profiles as well as qualitative data through our local engagement initiatives which aimed to engage hard to reach groups.



We knew that both the older population and BAME (black and minority ethnic) population had been affected disproportionately by the Covid-19 pandemic. Governing Body members continued 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 sought to ensure that the services that were purchased on behalf of our local population reflected their needs. We worked in partnership with local NHS Trusts as well as local voluntary sector organisations and community groups to identify the needs of the diverse local community we served 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 was coterminous with Durham County Council and about 97% of our population lived within the council boundaries. The remainder lived in the Gateshead and Sunderland Local Authority areas.

Clinical Leadership

We continued to ensure strong clinical leadership throughout April – June 2022. Our Clinical Chair, Clinical Accountable Officer and Medical Directors were all GPs who work within the CCG's area. In addition, we had several Executive GPs and GP Clinical Leads who provided clinical advice and local knowledge across the range of our clinical priorities. They took part in our governance arrangements as appropriate to ensure clinical challenge. The leadership they provided was particularly important in our response to the Covid-19 pandemic not just within the CCG but across the wider system. Our GP Clinical Leads 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 existed to secure high quality services for our local population. We were committed to ensuring that people get the same quality and access to health services, wherever they lived. We aimed to ensure that health services met the needs of patients, that the health of the community was improved, health inequalities were reduced, and that the CCG obtained value for money and efficiency from available resources.

In doing this we followed national guidance and worked collaboratively with our partners both regionally and locally.

As outlined earlier, the Covid-19 pandemic further highlighted the need to focus on inequalities across our population and we worked from Governing Body level with colleagues in public health in particular to ensure that tackling inequalities was central to our work.

Our Primary Care Networks (PCNs)

Primary Care Networks (PCNs) brought 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 were:

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 coordinating 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 were 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 was 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.

We developed our System Development Plan which set out our approach, governance, workstreams and plans to transition to the North East and North Cumbria ICS (NENC) by July

2022. It covered areas such as outcomes and priorities, establishing the ICB and Integrated Care Partnership (ICP), arrangements for Place Based Partnerships, commissioning arrangements, provider collaboratives, data and digital transformation and engagement with system partners.

The 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 was already working well at place and we shared this with wider stakeholders.

We 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.

Looking forward we hope to continue to be supportive with a 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.

Partnership working locally – County Durham Care Partnership

'Place-based' arrangements for the CCG was County Durham. The CCG was 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.

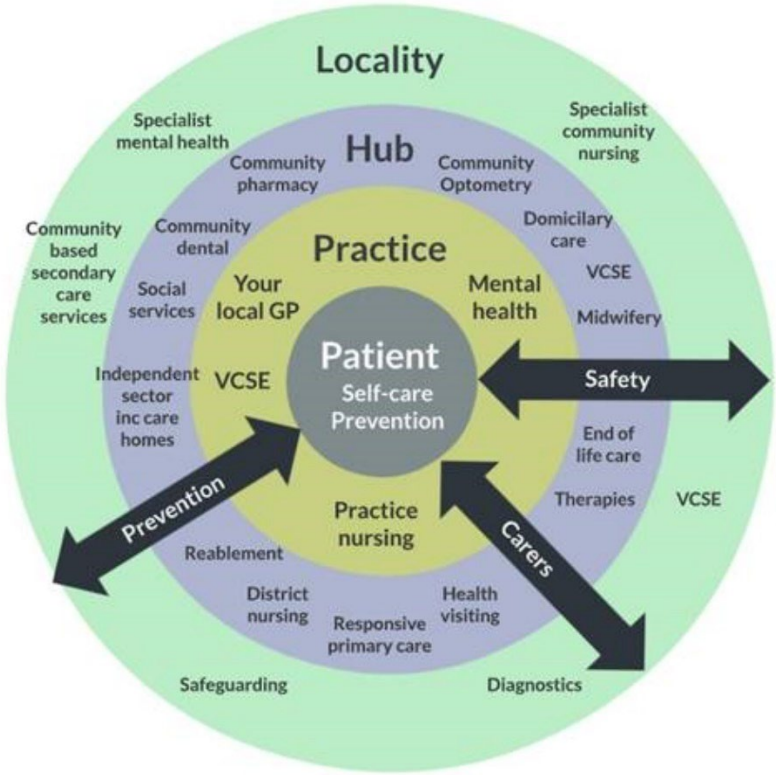
We had a Director of Integrated Community Services working jointly across the CCG, Durham County Council and CDDFT as well as a Head of Integrated Strategic Commissioning who was employed jointly by the CCG and Durham County Council.

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 was 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 had already come together to agree a model of integrated care, as represented in the figure below.



Our collaborative approach across the County Durham 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 brought 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 looked 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 was supported by North of England Commissioning Support (NECS) in commissioning services. We contracted 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 in 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 continued 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 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 chose six objectives across our three strategic priorities that were of importance given the impact they had on people's health and of where we wanted to be in 2025.
We recognised these are challenging but by working together across our partnerships and local communities we could 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 were able to provide comment and support the plan as it continues to evolve.

Area Action Partnerships (AAPs)

The CCG remained 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 were used when reviewing the quality of our commissioned services. This work was undertaken with a wide range of partners and assisted us in obtaining the appropriate levels of evidence-based assurance and understanding how these services feel for patients, families, and carers. These activities informed and shaped 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 when available, we also undertake 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

The CCG engagement team continued to work together with partners to develop our strategy/framework for involvement across the region.

The draft strategy was published on the NENC ICS website in June 2022 and can be accessed through the link included. This includes sharing feedback from the conversations that have held to develop the strategy so that participants know how their contributions have made a difference.

In addition, there was regional work developing to create a citizens panel. The developing membership was looking to involve a wide range of stakeholders including Local authority representatives, patient / public representatives, and Voluntary Care Organisation representatives from across each Local Authority area which makes up the ICS.

At 'Place' across County Durham, dialogue between commissioners, providers and key partners continued in established stronger operational arrangements around our engagement.

Across County Durham work is underway as part of the national requirements to deliver an Urgent Community Response. The initial stages saw a workshop bringing together a wide variety of primary and secondary care, social care, care homes, Ambulance services, community partners and charities. Opportunities for dialogue with members of the public will be incorporated into the subsequent phase of the project to develop plans for this service.

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 Annual Report.

The information below includes data up to and including Quarter 1 2022/23. Due to pressures arising from Covid-19 pandemic, some of the information has not been collected in accordance with guidance from NHS England / NHS Improvement (NHSE/I).

Recovery plans were 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 the three months to 30 June 2022 (page 124). 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.

The principles of system financial envelopes continued during 2022/23 with system allocations set at Integrated Care Board level and CCG performance considered in aggregate at system level.

NHS England and Improvement (NHSEI) confirmed that all CCGs would receive an allocation equal to resource consumed for the three month period resulting in the CCG achieving a breakeven position for the three months to 30 June 2022.

All key statutory financial duties and targets have been delivered by the CCG during the period, with an in-year breakeven position delivered.

Anti-fraud, Bribery and Corruption

The CCG did not accept any level of fraud, bribery or corruption. We continued to be committed to protecting our assets and are committed to promoting honesty and integrity in all our activities. We remained 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 had an effective risk management strategy, systems and controls in place. Risk was 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 the period, 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 complied 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 business continuity plan (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 from April 2021 – June 2022

Towards the end of 2020/21, the CCG prioritised a number of projects and work to progress during 2021/22 across a full range of areas. That work continued during April – June 2022. 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 from April – June 2022. 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. The figures provided relate to April – June 2022.

As supporting the response to the Covid pandemic continued to be a priority 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 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 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,
- a financial review,
- detail about how we improve quality,
- information about reducing health inequalities.

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 continued to support the roll out of the vaccination programme across County Durham.

This support was 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 ensured that vaccine supply, and timely delivery was maintained throughout the pandemic to our 15, PCN managed, Local Vaccination Sites (LVS). The team 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 Travelers, 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 aimed 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.

Cancer

Cancer Services continued to be heavily impacted by Covid-19, 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 nencicb-cd.enquiries@nhs.net. 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 benchmarking 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.

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 continued 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 prepared 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 saw 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 NENC ICB and 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.

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 1 2022/23. Due to pressures arising from Covid-19 pandemic, some of the information has not been collected 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 was reported to each of our Governing Body meetings.

NB – as this was a Constitutional standard and this was how the information was reported

	Monthy/ YTD	Reporting Period	Operational Standard	County Durham CCG
				84H
Referral to treatment access times				
% patients waiting for initial treatment on incomplete pathways within 18 weeks	Monthly	Jun-22	92.0%	73.8%
Number patients waiting more than 52 weeks for treatment				1298
Diagnostic waits				
% patients waiting less than 6 weeks for the 15 diagnostics tests (including audiology)	Monthly	Jun-22	1.00%	11.8%
A&E waits				
% patients spending 4 hrs. or less in A&E or minor injury unit	YTD	Jun-22	95.0%	71.3%
Handover between ambulance and A&E over 30 minutes			0	1668
Handover between ambulance and A&E over 60 minutes			0	667
Trolley waits in A&E not longer than 12 hours			0	138
Ambulance response times				
C1 Mean (Target 7 Mins)	YTD	Jun-22	100%	00:08:32
C1 90th Centile (Target 15 Mins)			100%	00:14:45
C2 Mean (Target 18 Mins			100%	00:48:56
C2 90th Centile (Target 40 Mins)			100%	01:41:14
C3 Mean (Target 2 hrs)				02:13:22
C3 90th Centile (Target 2 hrs)			100%	05:41:53
C4 Mean (Target 3hr)				01:57:19
C4 90th Centile (Target 3hr hrs)			100%	05:01:47
Mixed Sex accommodation				
Mixed Sex accommodation - number of unjustified breaches	YTD	Jun-22	0	16
HCAI				
Incidence of MRSA	YTD	Jun-22	0	0
Incidence of C Diff			Various	33
Cancer				
% of patients seen within 2 weeks of an urgent GP referral for suspected cancer	YTD	Jun-22	93.0%	81.8%
% of patients seen within 2 weeks of an urgent referral for breast symptoms			93.0%	86.7%
% of patients treated within 31 days of a cancer diagnosis			96.0%	94.0%
% 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%	80.6%
% of patients receiving subsequent treatment for cancer within 31 days - radiotherapy			94.0%	94.8%
% of patients treated within 62 days of an urgent GP referral for suspected cancer			85.0%	65.5%
% of patients treated within 62 days of an urgent GP referral from an NHS Cancer Screening Service			90.0%	82.9%
% of patients treated for cancer within 62 days of consultant decision to upgrade status			N/A	83.3%

Referral to Treatment and Over 52 Week Waits

Throughout April 2021 – June 2022, 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.

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 continued to work through the backlog of activity due to non-urgent diagnostic work being stood down 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 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 had 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 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, Special educational needs and disability (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 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 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 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 was to enable patients discharged from hospital to self-manage their condition where appropriate.

Over the last year the pathway 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 50.

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 April 2021 – June 2022 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.

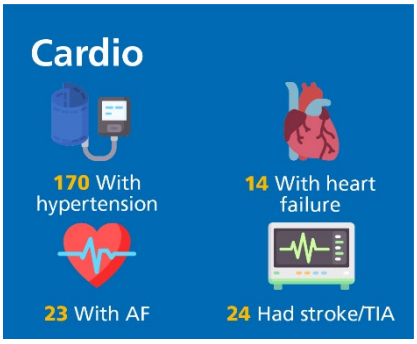
Feedback has been mixed with some patients feeling the service should have been implemented sooner, whilst others expressing their thanks for the service and requesting post-surgery support. Some patients expressed gratitude fearing they had been forgotten about.

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 was 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 ran until June 2022 and an evaluation of the new service was conducted 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 was 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 provided 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 Operational Pressures Escalation Levels Framework (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 in line 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

Supporting the Children, Young People and Families Partnership Board to take forward the Integration agenda

This has included the annual review of Terms of Reference including discussion about how the Board reports up to the CDCP Executive. We have also changed the substructure to allow the detailed discussion of the delivery of work to be undertaken out with the Board. This has freed up the Board meetings to be run as development sessions enabling more detailed system-wide discussions on 'wicked issues' such as children and young people's mental health, children in our care and neurodiversity.

We are also working across the system to develop a new strategy for children and young people in County Durham – Growing Up in County Durham. The Children, Young People and Families Partnership Board will be responsible for the delivery of this strategy.

Redesigning the neurodiversity offer

We have initiated work across the system to redesign the offer of support for neurodiverse families. This is in the early stages of developing a model which will be put to system leaders for approval. The model is being developed by a multi-disciplinary team from across the system including parent representative groups. The aim is to ensure that family's needs are met regardless or whether a diagnosis is right for them or not.

Working with partners to ensure statutory obligations can be met around children in our care

We have also been considering the impact of the Somerset Judgement on our statutory adoption services alongside the considerable increase in children coming into Local Authority care. We are working to ensure that we can continue to be compliant in all areas in relation to children in our care and that we provide a robust service.

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.

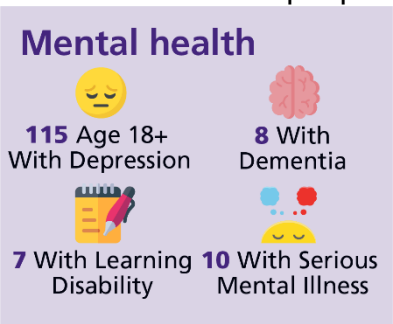
A new vision for community mental health teams work and integrate within each place based system to provide person centred care has been created and work has been ongoing to deliver physical health care teams to ensure those with a severe mental illness receive their annual physical health care checks, 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 (e.g. 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 aimed 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 was 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 Direct Enhanced Services (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 were 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 reviewed 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 continued to be challenging, particularly around workforce pressures and diagnostic capacity, but the achievements and progress made in 2021/22 were 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 was provided to the people of County Durham and Darlington and preventative measures were 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 was challenging for the team and we have undertaken a significant amount of work. This included ensuring providers were 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 also 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 remained 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 request via nencicb-cd.enquiries@nhs.net 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 viewpoint 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 Durham Dales Health Federation (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/framework

The CCG's engagement team continued to work together with partners from the region to develop our strategy/framework for involvement across the region.

The draft strategy was published on the NENC ICS website in June 2022 which included sharing feedback from the conversations which were held to develop the strategy so that participants knew how their contributions had made a difference. Full details are available on request via nencicb-cd.enquiries@nhs.net

In addition there was regional work developing to create a citizens panel. The developing membership was looking to involve a wide range of stakeholders including Local Authority representatives, patient / public representatives, and Voluntary Care Organisation representatives from across each Local Authority area which makes up the Integrated Care System (ICS).

At 'Place' across County Durham, dialogue between commissioners, providers and key partners continued in established stronger operational arrangements around our engagement. Engagement teams from across our health and care system have developed a joint work plan covering agreed priorities over the next 12 months. This included key priority areas such as;

- shared information systems,
- on-going dialogue with the public and understanding of their immediate issues,
- developing capacity across our teams and wider organisations,
- clarity on future engagement structures at place,
- more co-ordinated working together with voluntary and community sector partners.

Across County Durham work was underway as part of the national requirements to deliver an Urgent Community Response. The initial stages saw a workshop bringing together a wide variety of primary and secondary care, social care, care homes, ambulance services, community partners and charities. Opportunities for dialogue with members of the public will be incorporated into the subsequent phase of the project to develop plans for this service.

Public representatives continued to be directly involved in the development of the Shotley Bridge Community Hospital project. Public representatives had key roles as part of evaluation panels to review tenders from potential design and build contractors. A key focus of this evaluation that our public partners undertook was looking at the 'social value' that the bidders believed they would be able to add to the project.
The CCG engagement team continued to offer support to colleagues working in our Primary Care Networks (PCNs) as they looked to take forward their own engagement approaches.

The team also attended practice manager meetings as part of on-going efforts to contact and provide support where needed to primary care colleagues around involving their patients.

As an integrated team, engagement was undertaken with over 420 individuals who had a learning Disability and / or are Autistic, as well as family members in relation to accommodation plans in the County. This project was co-designed together with local provider organisations which directly supported the engagement activity to increase the reach that was possible.

A pilot of two 'return roadshows' took place within County Durham regarding our Community equipment Service. Excellent results were seen in terms of the quantity of equipment (over £3,000 worth) that was returned by members of the public and around increasing awareness of the returns pathway.

The CCG Engagement team worked with primary care colleagues to analyse the findings of the Enhanced Health in Care Homes survey. The engagement was designed to gain a first-hand view of how Multi-Disciplinary Team (MDT) working feels for those involved, what worked well, and what could be better

With111 responses, which included staff from community nurses, GPs aligned to care homes, care home staff, and PCN clinical directors and operational staff. These touched on themes such as improvements in relationships between GPs, nurses, community nurses and pharmacies.

Through the support of Healthwatch County Durham, the CCG have been provided with a series of short video diaries. The videos have been used to highlight the views and experiences of young people in County Durham in relation to Mental Health services.

The videos were shared with key partnership boards across the County to enable them to review the experiences that have been highlighted and look at future actions around the themes that have been raised.

Work also continued with our established patient reference groups. Through a series of workshops the individual locality meetings have now joined together to form a single united Patient group representing the whole County.

Financial Review

Overview

The principles of system financial envelopes continued during 2022/23 with system allocations set at Integrated Care Board level and CCG performance considered in aggregate at system level.

NHS England and Improvement (NHSEI) confirmed that all CCGs would receive an allocation equal to resource consumed for the three month period resulting in the CCG achieving a breakeven position for the three months to 30th June 2022.

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 three month period enabling the delivery of financial targets.

Details on the CCG's financial position was included in the Governing Body (GB) finance reports which were published on the CCG website public, further information can be requested via nencicb-cd.enquiries@nhs.net.

Financial targets and performance for the period

CCG financial position

For the three months to 30 June 2022, the CCG's performance results are set out in the table below, with further detail included in the full annual accounts published alongside this Annual Report.

Target	Outcome	Target Met?
Maintain expenditure within 'in-year' funding allocation	In-year breakeven position against an in-year funding allocation of £283.2 million	✓
Maintain running costs within separate running cost allowance	Breakeven position delivered on running cost budgets	✓
Maintain capital spending within capital resource limit	No capital resource required and no capital spend in the period	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 were 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 the three months to 30 June 2022 was £280.7 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 three months amounted to £2.6 million, compared to a running cost allowance of £2.6 million.

Capital resource limit

The CCG had no capital expenditure in the three months to 30 June 2022 and therefore did not require any capital resource, hence this target is not applicable in the current period.

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 4 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. 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 period, 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 the period.
The cost of audit services can be found CCG's financial statements.

Sustainable Development

As an NHS organisation, responsible for public funds, we had an obligation to work in a way that has a positive effect on the communities we serve. We had 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 was 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 were 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 which were investigated by the CCG, rather than the organisation providing the care, were 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 sought assurance from the services it commissions that national guidance issued by the National Institute for Health and Care Excellence (NICE) guidance was 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 was 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 was 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 was 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 understood that we were required under the Public Sector Equality Duty (PSED) which is set out in s149 of the Equality Act 2010, to have due regard to:

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

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

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

Governance

Equality, Diversity and Health Inequalities was 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 was submitted to the board outlining relevant updates in relation to Equality, Diversity and Health Inequalities.

Equality Strategy

Our Equality Strategy for 2020-2023 was developed. The revised strategy highlighted 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 fostered 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 continued to utilise the Equality Delivery System (EDS2) framework and used 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 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).

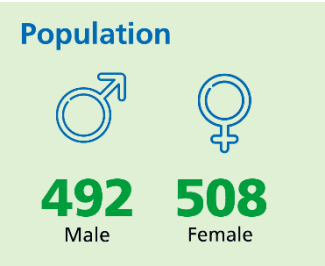
We have due regard to the standard by seeking assurance of compliance from trusts and aim to improve workplace experiences and representation at all levels for black and minority ethnic staff.

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 was 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[2]

Samantha Allen

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

Accountable Officer

26th June 2023

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

Accountability Report

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

It comprises three sections:

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

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

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

Members' Report

Council of Members

The CCG was a membership organisation. The Council of Members comprised of an individual selected by each member practice. The individual selected had 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 had 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 30 June 2022).

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

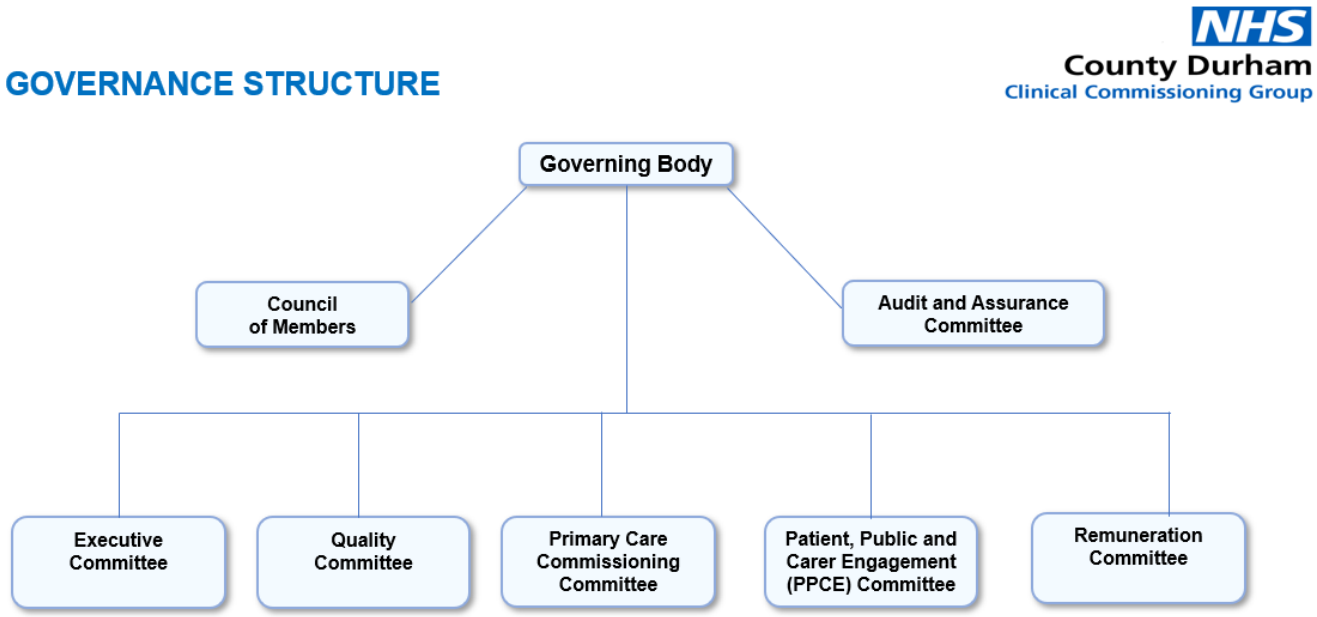
Governing Body

The Governing Body was responsible for ensuring that the CCG had appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance.

The Governing Body was also responsible for the CCG's annual budget of over £1 billion (3 months to the 30 June 2022 £0.28 billion) ensuring this was 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 left or joined the CCG Governing Body during the period April – June 2022

There were no changes to the membership of the Governing Body from the end of 2021/22 through the period April – June 2022.

During 2021/22 there had 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. April – June 2022 was very much a period of transition between the CCG and the Integrated Care Board, with some individuals taking on dual roles, which affected some attendance rates.

County Durham CCG Corporate meeting attendance summary for April – June 2022

County Durham CCG April – June 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**	**Mental Health and Learning Disabilities and Autism PB**	**Primary Care Quality Assurance Sub Committee**
	Total number of meetings to attend:	**3**	**2**	**2**	**0**	**6**	**2**	**3**	**3**	**1**	**1**
Andrew Atkin	Lay Member	**M 3**	**M 1**	**M 2**	**M**						
Nicola Bailey	Chief Officer	**M 2**	**IA 0**	**M 1**	**IA**	**M 2**			**NVM 0**	**M 0**	
Mike Brierley	Director of Commissioning Strategy and Delivery MH/LD	**NVM 3**		**M 0**		**M 4**				**M 1**	
Sarah Burns	Joint Head of Integrated Commissioning	**NVM 3**		**M 1**		**M 4**					
Dr James Carlton	Medical Director	**M 3**		**NVM 0**		**M 5**		**M 3**			**M 1**
Joseph Chandy	Director of Commissioning Strategy and Delivery (Primary Care)	**NVM 2**		**NVM 2**		**M 6**					**M 1**

County Durham CCG April – June 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**	**Mental Health and Learning Disabilities and Autism PB**	**Primary Care Quality Assurance Sub Committee**
Dr Ian Davidson	Medical Director	**M 0**		**NVM 1**		**M 5**		**M 2**			**M 1**
Dr Stewart Findlay	Chief Officer (*secondment to CDDFT from 1.6.20*)	**M 0**		**M 2**	**IA**	**M 5**			**M 0**		
Dave Gallagher	Executive Director – Place					**IA 2**					
Anne Greenley	Account Director NECS/Interim Director of Nursing and Quality (*secondment 13/7/2020 to date*)	**M 1**		**M 2**		**M 2**		**M 3**		**M 0**	**M 1**
Amanda Healy	Director of Public Health, Durham County Council/ Health and Wellbeing Board representative for GB	**NVM 0**		**NVM 0**							
Richard Henderson	Chief Finance Officer	**M 3**	**IA 2**	**M 2**	**IA**	**M 6**				**M 1**	
Feisal Jassat	Lay Member, Patient and Public Involvement	**M 3**	**M 1**	**M 1**	**M**		**M 1**				**M 0**

County Durham CCG April – June 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**	**Mental Health and Learning Disabilities and Autism PB**	**Primary Care Quality Assurance Sub Committee**
Michael Laing	Director of Integrated Community Services (*from 1.7.20*) *Joined GB from Oct '21*	**NVM 1**				**IA 6**					
Diane Murphy	Director of Commissioning and Delivery (Continuing Health Care)	**NVM 0**				**M 2**				**M 0**	
Dr Neil O'Brien	Clinical Chief Officer/Accountable Officer	**M 2**	**IA 0**		**IA**	**M 0**			**M 2**		
Jane Robinson	Corporate Director of Adult and Health Services for Durham County Council	**NVM 0**									
Dr Jonathan Smith	Clinical Chair	**M 3**	**IA 0**	**NVM 1**	**M**	**IA 5**	**M 1**		**M 2**		
Dr Ian Spencer	Secondary Care Clinician	**M 2**			**M**			**IA 3**			
John Whitehouse	Lay Member, Audit and Governance	**M 0**	**M 2**								
Elected Healthcare Professional	Dr Chris Marwick	**M 2**									

County Durham CCG April – June 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**	**Mental Health and Learning Disabilities and Autism PB**	**Primary Care Quality Assurance Sub Committee**
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 1**		**NVM 1**		**M 6**		**M 1**			**M 1**
Quality and Development Manager	Kim Lawther Rob Milner Susan Hepburn							**M 2**			**M 1**
Patient Reference Group Representative Chester-le-Street	Ian Doyle Keith Holyman						**M 0**				
Patient Reference Group Representative Derwentside	Marian Morrison Nancy Carr						**M 2**				
Patient Reference Group Representative Durham	Pat Rafferty Jen Mole						**M 2**				

County Durham CCG April – June 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**	**Mental Health and Learning Disabilities and Autism PB**	**Primary Care Quality Assurance Sub Committee**
Patient Reference Group Representation North Durham PRG	Keith Holyman Jennifer Mole	**NVM 2**									
Patient Reference Group Representative Durham Dales	Angela Seward Brewis Henderson	**NVM 2**					**M 2**				
Patient Reference Group Representative Easington	Linda Allison	**NVM 0**					**M 0**				
Patient Reference Group Representative Sedgefield	Chris Cunnington-Shore Hilary Stoker	**NVM 2**					**M 2**				
Public Member	Stephen Hann						**M 2**				
Public Member	Helen Embleton						**M 2**				
Public Member	Julie Cairns						**M 0**				

County Durham CCG April – June 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**	**Mental Health and Learning Disabilities and Autism PB**	**Primary Care Quality Assurance Sub Committee**
Public Member	Sarah Cotes						**M** **2**				
Public Health representative / Health and Wellbeing representative at GB – DCC	Gill O'Neill Chris Allan Glenn Wilson Amanda Healy			**NVM** **0**		**IA** **5**		**M** **3**			
Practice Nurse Links representative	Caryl Bowie							**M** **0**			**M** **1**
Commissioning Team representative	Lou Stainer / David Hand / Joanna Dunbar / Cresta Crawley / Marta Lowell							**M** **1**			
Medicines Optimisation Team representative	Kate Huddart / Alda Hummerlinck / Michelle Chapman / Rachel Berry							**M** **3**			
Voluntary Community Sector representative – AAP	Michael Wilkes Paul Goodwin						**M** **2**				

County Durham CCG April – June 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**	**Mental Health and Learning Disabilities and Autism PB**	**Primary Care Quality Assurance Sub Committee**
NECS Clinical Quality Team representative	Lorraine Legg Claire Richardson							**M** **0**			**IA** **0**
Voluntary Community Sector representative – Durham Community Action representative	Kate Burrows Susan Garratt						**M** **1**				
Safeguarding Lead representative	Melanie Hesketh / Linda Haines / Heather McFarlane / Karen Watson / Rachel Upton							**M** **3**			**M** **0**
Infection Control Team representative	Gail Watkin / Jane Lawson							**M** **3**			**M** **1**
Durham County Council Communication representative							**M** **0**				
Healthwatch representative	Denise Rudkin Julia Catherall			**NVM** **2**			**M** **2**				
NHS England representative	David Steel Christopher Black Jennifer Long			**NVM** **0**							

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 was 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 was 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 was 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 was 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 was 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 were 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 were maintained throughout the year and included details of when declarations were added or removed. The registers were made available to the public via the CCG's website. For further information relating to the CCG register of interest please email your enquiry to : nencicb-cd.enquiries@nhs.net

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 were required to complete Conflict of Interest online training on an annual basis.

Personal data related incidents

No personal data related incidents or data security breaches were reported during the three month period to 30 June 2022 which 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 was published on our website.

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.

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

Governance Statement

Introduction and Context

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

Between 1 April 2022 and 30 June 2022, the 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 County Durham 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 the period the CCG has continued to operate with a governance structure that reflects guidance and best practice. This was largely consistent with the governance arrangements that operated during the previous year.

Terms of reference were agreed for all committees, which supported the organisation in the delivery of effective governance. The terms of reference are included as appendices to the CCG's Constitution, a copy of which can be requested by emailing: nencicb-cd.enquiries@nhs.net

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 had 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 played a key role in supporting this by providing assurance to the Governing Body around the risk and governance processes within the CCG.

During the April - June 2022 the CCG's Governing Body met on two 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 2021/22 and April – June 2022 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 one occasion between April – June 2022. During 2021/22 the Governing Body had 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. The session held in May 2022 focussed on the safe transition from the CCG to the Integrated Care Board including consideration of the due diligence work, and the ICB's Constitution and Governance Handbook.

Description of the Established Governing Body Committees

The roles of each of the Governing Body committees were 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 was authorised by the Governing Body to pursue any activity within their terms of reference which were subsequently approved by the CCG's Council of Members.

Each committee was 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 was 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 had 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 met 6 times during April – June 2022. Highlights of the work performed during 2021/22 and between April – June 2022 by the Executive Committee included:

- 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 was 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, did 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 3 occasions during April – June 2022 to further improvement integrated working ahead of the establishment of the ICB.

Quality Committee

The role of the Quality Committee was to examine and make recommendations with regard to the quality standards of commissioned services, pathway developments and quality indicators of new services. It supported 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 ensured that innovative ways of working are considered and tested by using safe and measured approaches. It approved and ratified any necessary quality related documents prior to submission to the Governing Body.

The primary objectives of the committee were to safeguard patients from harm, develop high quality services and foster a culture of safety.

The Quality Committee met on 2 occasions during April – June 2022. Highlights of the work performed by the Committee during 2021/22 and April – June 2022 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 was 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 met formally on a bi-monthly basis, meeting on 2 occasions during April – June 2022. The work in performed between April 2021 and June 2022 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 supported the Governing Body in its main function of ensuring the CCG had made appropriate arrangements to ensure functions were 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 aligned with that of the Quality Committee to seek assurance that robust clinical quality systems were in place.

The committee's business cycle included review of the CCG's risk management processes, including the Assurance Framework and corporate risk register. The committee considered 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 was 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, provided 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 2021 to support the final Governance Statement. The principal purpose of the report was 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 had a business cycle which enabled 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 twice between April – June 2022. Highlights from the work of the Committee between April 2021 and June 2022 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 were used to develop the committee's annual work plan.

Remuneration Committee

The Committee was 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 included remuneration for executive officers as well as the Chair and independent Lay Members and other Governing Body members. The committee also considered any business cases for early retirement and redundancy. The committee reviewed the performance of the Accountable Officer and other senior team members and determined annual salary awards, as necessary. It was also responsible for considering the severance payments of the Accountable Officer and of other senior staff.

It had not been necessary for the Committee meet between April – June 2022.

Primary Care Commissioning Committee

The Primary Care Commissioning Committee was 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 made 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 was 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 carried 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 reflected relevant national guidance, with the committee made up of a majority of non-conflicted members. The committee met twice during April – June 2022.

Key areas that the Committee focused on between April 2021 – June 2022 included:

- 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, the played 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 or between April – June 2022.

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 during April – June 2022.

Other committees on which the CCG was a partner

Health and Wellbeing Board – Durham County Council
The CCG was 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 was 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 was 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 was in place which took 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 set 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 included clear CCG processes and procedures to identify, evaluate and control risks. The Risk Management Policy provided 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 included:

- 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 was 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 enabled 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 ensured:

- risk management was a cohesive element of the internal control systems within the corporate governance framework supported by robust risk management systems and processes,
- the organisation met statutory obligations including those relating to health and safety and data protection,
- all stakeholders, staff and partner organisations are assured that the CCG was 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 were communicated to all staff.

The Risk Management Policy set 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 could not 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 had a well-established and transparent incident reporting and management system which was embedded across the organisation and used to identify any related risks. The CCG openly encouraged and supported incident reporting by ensuring that there a robust Incident Reporting and Management Policy and Standard Operating Procedure (SOP) in place which was reviewed annually and that the appropriate training was 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 had clear lines of accountability with defined responsibilities and objectives relating to all aspects of risk reporting and management. The Accountable Officer had overall responsibility for ensuring the implementation of an effective risk management

strategy, systems and controls. Each of the directors of the CCG was responsible for the management of strategic and operational risk in their specific areas, including ensuring that all areas of risk were assessed appropriately, in a timely manner and action taken to implement improvements.

The Governing Body had overall responsibility for governance, assurance and management of risk and therefore a clear oversight of the CCG's performance. The Governing Body had a duty to assure itself that the CCG had properly identified the risks it faces and that it had 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 was 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 were responsible for ensuring that all risks relevant to their respective areas of responsibility were identified, addressed and reported to the Governing Body as appropriate.

Identifying, reporting and management of risk was '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 was provided to all executive members and risk leads/risk coordinators where requested. An annual training requirements discussion was 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 was a new starter to the organisation, modules of risk management training are provided on request.

Risk Assessment

Whenever risks had been identified it was 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 was used, as outlined in the CCG Risk Management Policy, the matrix in our risk assessment guidance was based on current national guidance and also adapted to suit the CCG risk appetite.

Risks were identified and embedded in the organisation via a number of mechanisms including a comprehensive risk register which identified current and prospective risks to the organisation. The risk register incorporated 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 captured 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 was assigned to a responsible director/senior manager, who maintained 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 were aligned to the Executive Committee and quality risks aligned to the Quality Committee. Risks relating to primary care commissioning were aligned to the Primary Care Commissioning Committee.

All risks were reviewed on a regular basis by risk owners and by the respective aligned committee at each committee meeting to ensure that risks were appropriately assessed and that where required action was 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 were then escalated and specifically reviewed by Governing Body.

The Audit and Assurance Committee ensured the CCG worked within and adheres to robust risk reporting and management processes and systems. An annual review and update of the CCG's Risk Management Policy ensured that risk management processes and systems were 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), added guidance on functionality to link actions to controls and consequence descriptors updated to include data security risk assessment criteria.

	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

Diagram 1: Risk assessment matrix 2021 (full risk rating = consequence x likelihood details described in SOP)

Current major risks to governance, risk management and internal control

A summary of the significant corporate risks which the CCG has faced during the period 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.

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 was designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control was in place in the CCG for the period ended 30 June 2022 and was 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 not undertaken during the period April – June 2022 however one was undertaken during quarter four of 2021/22. The objective of this audit was 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 were implemented.

Data Quality

The North England Commissioning Support Unit (NECS) Data Management service had processes and systems in place to assess the quality and completeness of commissioning data managed on behalf of the CCG. Data was checked at all stages of processing through NECS systems and finally on publication of reports/analysis. Data was compared against historic and planned levels to provide assurance on completeness as well as with peer organisations in the form of benchmarking analysis.

Processes were 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 utilised contract levers where necessary to ensure high quality data was 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 were place in all routine data processing tasks to ensure poor quality data was not made available for analysis and then subsequently used as the basis for commissioning decisions.

The CCG relied 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 had 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 provided

assurances to the CCG, other organisations and to individuals that personal information was dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We established an information governance management framework 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 also adopted and implemented NHS Digital's (HSCIC) Guide to the Notification of Data Security and Protection Incidents.

We had in place an incident reporting and management framework for the reporting of data security and protection incidents to the Information Commissioner. This framework outlined the scope of responsibilities and details the reporting procedures to be used in the event of a data security breach. There were no Information Governance 'reportable' breaches during the period to 30 June 2022.

The Information Governance agenda was heard at the Executive Committee which also oversees the day-to-day management of Information Governance systems and processes. The CCG had 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 had been provided by NHS Digital to support performance monitoring of progress on Information Governance in the NHS. The CCG published the Data Security and Protection Toolkit Version for 2021/22 by 30 June 2022 and answered all mandatory requirements.

The CCG complied with its statutory duty to respond to requests for information. During the period, the CCG received 42 requests under the Freedom of Information Act 2000 and 23 subject access requests under the Data Protection Act 2018. All the requests were responded to within the statutory timescales.

Business Critical Models

The CCG was aware of the quality assurance requirements in respect of business critical models contained within the recommendations in the Macpherson report and it 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 operates to provide assurance over the effectiveness of controls and processes within NECS. A report had 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. A bridging letter has been received from NECS confirming that for the three month period to 30 June 2022 there have been no significant changes to the control environment or related control activities and risks which were covered in the above report. All control activities listed within the report have continued to be operationally effective. A full service auditor report covering the full year to 31 March 2023 has now also been received. A small number of control exceptions were identified within this report but these are not considered to have a significant impact on the CCG, with mitigating controls operating within the CCG.

The CCG also had additional systems of control and review mechanisms internally over the work performed by the NECS which provided 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 were 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 were provided by NHS Shared Business Services and the national Electronic Staff Records (ESR) system was operated by NHS Business Services Authority. There were 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 provided the services of all primary care support teams.

Assurance over the relevant control environments in place for these systems was 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 were identified from these auditor reports which cause a concern for the CCG. Again relevant bridging letters have been received for the three month period to 30 June 2022 confirming there have been no significant change to the control environment and providing an update on actions undertaken to address any minor control deficiencies identified in the previous year's report. Service auditor reports covering the full year to 31 March 2023 have also been received which did not identify any issues which were considered to have a significant impact on the CCG.

Payroll services were 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 were identified from the review of payroll information during the period.

Control Issues

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

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

The CCG had a well-developed systems and processes in place for managing its resources. Robust financial governance arrangements have been maintained throughout the period, 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 discharged its business. This was 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 the three month period to 30 June 2022 and the remainder of the year to 31 March 2023.

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 period. 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 played 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 were 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 played 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 was the work of the CCG's internal and external auditors.

Although the work of the external auditors does not form part of the CCG's internal control environment, no significant issues have been identified which were required to be reported by exception, providing further assurance that the processes implemented by the CCG are robust.

The CCG's internal control framework comprised of several elements including the CCG Constitution, assurance framework, risk management, incident management, financial management, policy management, audit and governance assurance reporting, which worked 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 included 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 was commissioned through our internal auditors to undertake counter fraud work proportionate to identified risks.

Our Counter Fraud activity played a key part in deterring risks to the organisation's financial viability and probity. An annual Counter Fraud Plan was agreed by the Audit and Assurance Committee which focuses on the deterrence, prevention, detection and investigation of fraud. Progress against this plan was regularly monitored by the Audit and Assurance Committee with an annual counter fraud report also received.

The Audit and Assurance Committee also received a report against the Standards for Commissioners at least annually and considers the relevant actions being implemented to address any identified deficiencies. There was executive support and direction for a proportionate work plan to address identified risks.

The Chief Finance Officer was 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 previous year to cement their knowledge and understanding of counter-fraud arrangements. In addition, notifications and briefings regarding actual and potential fraud were 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 period for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

Overall Opinion

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

During the period, Internal Audit issued the following audit reports:

Opinion Area	Commentary
Audit Coverage	Internal Audit coverage in Quarter 1 2022/23 focused on: • Assurance Framework & supporting processes • Transition Programme • Outstanding Audit Recommendations and Risks
Design and operation of the Assurance Framework and supporting processes	The Governing Body Assurance Framework and supporting risk register was last presented to the Governing Body on 28th June 2022. The Governing Body Assurance Framework and supporting risk register was last presented to the Audit and Assurance Committee on 13th June 2022. The Governing Body Assurance Framework is based on the CCG's strategic objectives and an analysis of the principal risks to achieving those objectives. It continued to reflect the impact of the transition to an ICB and managing the Covid-19 pandemic in alignment with the CCG's corporate objectives. The key controls that have been put in place to manage the risks have been documented, and the sources of assurance for individual controls have been identified. The Governing Body Assurance Framework therefore provides the CCG with a comprehensive mechanism for the management of the principal risks to meeting its strategic objectives and supports the compilation of the Annual Governance Statement. The CCG has developed risk management processes that are operating within the organisation. The Audit and Assurance Committee oversees the risk management agenda and report to the Governing Body. It provides assurance to the Governing Body on the systems and processes by which the organisation leads, directs and controls its functions in order to achieve its strategic objectives
Transition Programme	AuditOne continued to have involvement during the transition period through: • Attendance at two weekly ICS steering group meetings and liaison with NECS who provided project support. • Attendance at a checkpoint meeting with lead officers at the CCG (15th March 2022) and a further, more formal check and challenge session covering County Durham and Tees Valley CCGs which was held on 5th May 2022 with the Audit and

Opinion Area	Commentary
	Assurance Committee Chair in attendance. Through attendance and receipt of supporting papers, it was observed that risks and issues were being reported through the project groups supported by NECS. No concerns were raised around completion of the activities required to sign off on due diligence process. • It could be confirmed that the CCG provided regular updates on CCG Closedown Due Diligence process to both the Audit and Assurance Committee and the Governing Body. At its meeting on 28 th June 2022, the Governing Body were provided with a copy of the assurance letter that had been provided by the Accountable Officer to the Chief Executive Designate of the ICB, that a robust due diligence process has been undertaken to prepare for the closedown of the CCG.
Brought forward Internal Audit assurances	The Head of Internal Audit Opinion given for the year ended 31st March 2022 gave a level of assurance of 'substantial'. There were no material issues identified to be brought forward for consideration in this opinion statement.
Response to Internal Audit recommendations	The implementation of internal audit recommendations is a key indicator of the organisation's engagement with ourselves and the importance it places on the recommendations we have made and have been agreed to be implemented. The Audit and Assurance Committee receives updates on the progress of agreed actions for all high and medium issues raised, but it does not require updates in relation to low priority issues, so these are not subject follow-up by AuditOne. At 30th June 2022, there were only two outstanding audit recommendations, both were medium priority and neither had passed the target date for implementation. These related to the operation of committees and format of the declarations of interest register and upon the conclusion of the CCG will be superseded. There are therefore no recommendations which need to be carried forward to the ICB. This demonstrates that the CCG has continued to have a positive approach to internal audit recommendations, which improves the strength of its system of internal control, risks and governance.
Significant factors outside the work of internal audit	While the Head of Internal Audit Opinion provides the CCG with assurances in relation to the areas covered by the internal audit plan, it is only one of the sources of assurance available to the CCG. As the CCG outsourced many of its functions, assurances from third parties are equally as important when the CCG draws up its Governance Statement. Assurances are provided on an annual basis therefore nothing is available at this time for the Q1 period.

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

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 had 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. 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 period 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.

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 period ended 30 June 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 period 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 period 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 2022/23 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 2022/23 (3 months ended 30 June 2022) and also relevant comparative figures for 2021/22 (12 months ended 31 March 2022).

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 page 112 to 113 and related narrative notes on subsequent pages;
- the table of pension benefits of senior managers on pages 117 to 119;
- the analysis of staff numbers and costs on page 120; and
- the table of pay multiples and related narrative notes on page 115 to 116.

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 expected **over twenty years**. 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 2022/23 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 period.**

NHS County Durham CCG senior officers' salaries and allowances - 2022/23 (3 months for the period ended 30 June 2022):

Name	Title	2022/23 (3 months for the period ended 30 June 2022)						
		Annual equivalent salary (Bands of £5,000)	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	£000
Dr N O'Brien	Accountable Officer	50 - 55	10 - 15	400	-	-	0 – 2.5	10 - 15
N Bailey	Chief Officer	150 - 155	35 - 40	1,800	-	-	-	35 - 40
S Findlay	Chief Officer	160 - 165	40 - 45	1,500	-	-	-	40 - 45
Dr J Carlton	Medical Director	80 - 85	20 - 25	600	-	-	-	20 - 25
Dr I Davidson	Medical Director	45 - 50	10 - 15	-	-	-	-	10 - 15
R Henderson	Chief Finance Officer	105 - 110	25 - 30	-	-	-	-	25 - 30
A Greenley	Director of Nursing and Quality	130 - 135	30 - 35	-	-	-	-	30 - 35
M Brierley	Director of Commissioning, Strategy and Delivery	50 - 55	10 - 15	200	-	-	52.5 - 55	65 - 70
J Chandy	Director of Commissioning, Strategy and Delivery	120 - 125	30 - 35	-	-	-	-	30 - 35
S Burns	Joint Head of Integrated Strategic Commissioning	55 - 60	10 - 15	100	-	-	-	10 - 15
					-	-		
Dr J Smith	Chair	60 - 65	15 - 20	-	-	-	-	15 - 20
F Jassat	Lay Member, Patient and Public Involvement	15 - 20	0 - 5	-	-	-	-	0 - 5
J Whitehouse	Lay Member, Governance and Audit	15 - 20	0 - 5	-	-	-	-	0 - 5
A Atkin	Lay Member	15 - 20	0 - 5	-	-	-	-	0 - 5
Dr I Spencer	Secondary Care Clinician	10 - 15	0 - 5	-	-	-	-	0 - 5
Dr C Markwick	Elected Health Care Professional (GP)	5 - 10	0 - 5	-	-	-	-	0 - 5

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 - 2021/22 (12 months) (comparative figures):

Name	Title	2021/22 (12 months)					
		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	70 - 75
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.

Notes:

The expense benefits (taxable) 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. 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 scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Senior officer remuneration is processed through the CCG's payroll with the exception of the Director of Nursing and Quality, this is invoiced from North of England Commissioning Support Unit.

Shared Management Arrangements

For the 3 months of 2022/23 (and throughout 2021/22), the Accountable Officer 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 for the 3 months of 2022/23 (and throughout 2021/22), 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 for the 3 months of 2022/23 (and throughout 2021/22), 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 2022/23 is shown below:

Name	Title	2022/23 (3 months)		
		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	40 - 45	1,300	40 - 45
M Brierley	Director of Commissioning, Strategy and Delivery	25 - 30	300	25 - 30
S Burns	Joint Head of Integrated Strategic Commissioning	25 - 30	200	25 - 30

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 four other senior officers who received a salary in excess of £150,000 in 2022/23 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 Allinson	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

2022/23 was £165-170k (2021/22: £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	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
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	31,534	45,839	47,126	75,874	108,075
Ratio	5.31	5.31	3.65	3.55	2.21	1.55

No performance related pay or bonuses have been paid to senior officers or employees during 2022/23 (2021/22: none).

There has been no percentage change from the previous financial year in respect of the highest paid director (2021/22: no change).

The average percentage change from the previous financial year in respect of employees of the entity is a 5.46% reduction due to 4 GP leads leaving their roles within the organisation during 2022/23 (2021/22: 1.48% increase).

In 2022/23, no employees (2021/22: 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 (2021/22: £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.

There has been an increase in both the median and 75th percentile ratio from previous year when comparing the total remuneration of the highest paid director to the organisations workforce as a result of 4 GP leads leaving the CCG during 2022/23 with total full time equivalent remuneration per lead of £145-150k.

NHS County Durham CCG senior officers' pension benefits 2022/23:

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in Pension Lump Sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 30 June 2022 (bands of £5,000)	Lump Sum at aged 60 related to accrued pension at 30 June 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2022	Real increase in cash equivalent transfer value	Cash Equivalent Transfer Value at 30 June 2022	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr N O'Brien Clinical Chief Officer	0 – 2.5	-	25 – 30	15 – 20	356	-	372	-
N Bailey Chief Officer	-	-	100 - 105	-	1,577	-	1,607	-
Dr J Carlton Medical Director	0 – 2.5	-	10 – 15	0 – 5	171	-	178	-
R Henderson Chief Finance Officer	-	-	20 - 25	-	257	-	265	-
A Greenley Director of Nursing and Quality	-	-	40 - 45	115 - 120	989	-	267	-
M Brierley Director of Commissioning, Strategy and Delivery	5 - 10	5 - 10	35 – 40	60 – 65	567	103	690	-
J Chandy Director of Commissioning, Strategy and Delivery	-	-	30 – 35	75 – 80	609	-	621	-
S Burns Director of Commissioning, Strategy and Delivery	-	-	25 – 30	45 - 50	456	-	441	-
Dr J Smith Chair	-	-	15 - 20	30 - 35	278	-	274	-

NHS County Durham CCG senior officers' pension benefits 2021/22 (12 months) (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 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	-

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 period.

The figures included above are provided by the NHS Business Services Authority on an annual basis and 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 real increase figures shown above relate only to the period each individual was in post as a senior officer, for 2022/23 this is the 3 months to the 30th of June 2022.

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.

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

Real Increase in Cash Equivalent Transfer Values

This reflects the increase in CETV effectively funded by the employer and is for the 3 month period to the 30th of June 2022. 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 2.1 and 2.2 of the financial statements, respectively.

The CCG's senior officers are listed in the remuneration report. Four of the senior officers were 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 employed 113 people, 82 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	71.68%	28.32%

These figures are as at 30 June 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 1 April – 30 June 2022 was 9.78% 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 3 months ended 30 June 2022, 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 1.1:

	2022 (3 months to 30 June 2022) Number of days	2021 (12 months to 31 March 2022) Number of days
Total number of days lost to sickness absence	89.5	311.93
Total staff years	81.16	82.85
Average number of working days lost to sickness absence	**1.10**	**3.77**

Diversity

The CCG's workforce was 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 2022/23. We would provide appropriate support for any individual who wished to undertake such a role.

Staff Policies

The CCG was 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 had 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 3 of the financial statements, with expenditure on agency staff shown in note 2.1 of the financial statements.

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 period (2021/22: none).

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.

An audit report is also included in this Annual Report at page 148.

Financial statements

NHS County Durham CCG Financial Statements for the period ended 30 June 2022

CONTENTS **Page Number**

The Primary Statements:

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

	Note	3 months to 30 June 2022 £000	12 months to 31 March 2022 £000
Administration costs and programme expenditure			
Gross employee benefits	2.1	1,252	4,975
Purchase of goods and services	3	281,914	1,169,313
Depreciation and impairment charges	3	23	-
Other operating costs	3	25	145
Total operating expenditure		**283,214**	**1,174,433**
Finance costs	5	4	-
Net operating costs for the financial period		**283,218**	**1,174,433**
Total net expenditure for the period		**283,218**	**1,174,433**
Total comprehensive net expenditure for the period		**283,218**	**1,174,433**

Statement of Financial Position as at 30 June 2022

	Note	30 June 2022 £000	31 March 2022 £000
Non-current assets:			
Right of use assets	6	1,563	-
Total non-current assets		**1,563**	**-**
Current assets			
Trade and other receivables	7	2,275	2,240
Cash and cash equivalents	8	561	132
Total current assets		**2,836**	**2,372**
Total assets		**4,399**	**2,372**
Current liabilities			
Trade and other payables	9	(52,686)	(63,082)
Lease liabilities	6	(86)	-
Total current liabilities		**(52,772)**	**(63,082)**
Total assets less current liabilities		**(48,373)**	**(60,710)**
Non-current liabilities			
Lease liabilities	6	(1,479)	-
Total non-current liabilities		**(1,479)**	**-**
Assets less Liabilities		**(49,852)**	(60,710)
Financed by taxpayers' equity			
General fund		(49,852)	(60,710)
Total taxpayers' equity		**(49,852)**	**(60,710)**

The notes on pages 129 to 147 of the Annual Report form part of this statement.

The financial statements on pages 125 to 147 were approved and authorised for issue by the Board on 22 June 2023 and signed on its behalf by:

Samantha Allen
Chief Executive for the North East and North Cumbria Integrated Care Board
Accountable Officer
26th June 2023

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

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

	General fund £000	Total reserves £000
Changes in taxpayers' equity for the three months to 30 June 2022:		
Balance at 1 April 2022	(60,710)	(60,710)
Changes in CCG taxpayers' equity for the three months to 30 June 2022		
Net operating costs for the financial period	(283,218)	(283,218)
Net recognised CCG expenditure for the financial period	**(283,218)**	**(283,218)**
Net funding	294,076	294,076
Balance at 30 June 2022	**(49,852)**	**(49,852)**

	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 2021/22		
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)**

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

	Note	3 months to 30 June 2022 £000	12 months to 31 March 2022 £000
Cash flows from operating activities			
Net operating costs for the financial period		(283,218)	(1,174,433)
Depreciation and amortisation	3	23	-
Interest on lease liabilities	5	4	-
(Increase) in trade and other receivables	7	(35)	(278)
(Decrease) in trade and other payables	9	(10,396)	(6,468)
Net cash outflow from operating activities		**(293,622)**	**(1,181,179)**
Net cash outflow before financing		**(293,622)**	**(1,181,179)**
Cash flows from financing activities			
Net funding received		294,076	1,181,266
Repayment of lease liabilities	6	(25)	-
Net cash inflow from financing activities		**294,051**	**1,181,266**
Net increase in cash and cash equivalents	8	**429**	**87**
Cash and cash equivalents at the beginning of the financial period		132	45
Cash and cash equivalents (including bank overdrafts) at the end of the financial period		**561**	**132**

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 2022/23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to 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 were abolished and the functions, assets and liabilities of NHS County Durham CCG transferred 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 ceased 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, are not considered to impact on going concern. Our considerations cover the period through to 30 June 2024, being 12 months beyond the date of authorisation of these financial statements. Taking into account the information summarised above, there is a reasonable expectation that the successor NENC ICB will have adequate resources to continue in operational existence until at least 30 June 2024. 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 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 period based on actual data 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

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

1.9.1 The CCG as Lessee

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

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

The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.

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

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

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

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

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

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

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

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

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

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

Notes to the financial statements (continued)

1. Accounting Policies (continued)

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 Adoption of new standards

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

Under IFRS 16 the CCG will recognise a right-of-use asset representing the CCG's right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

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

Impact Assessment

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

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

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

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

As of 1 April 2022, the CCG recognised £1.586m on right-of-use assets and lease liabilities of £1.586m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was a nil impact to taxpayers' equity.

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

The following table reconciles the CCG's operating lease obligations at 31 March 2022, disclosed in the group's 2021/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

	Total £000
Operating lease commitments at 31 March 2022	1,662
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	(16)
Operating lease commitments discounted used weighted average IBR	**1,646**
Less: Differences in the assessment of the lease term used for future minimum payments at 31 March 2022.	144
Less: Correction of immaterial prior period error in IAS 17 disclosure	(204)
Lease liability at 1 April 2022	**1,586**

1.18 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

- 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 2022/23, were they applied in that year.

Notes to the financial statements (continued)

2. Employee benefits and staff numbers

2.1 Employee benefits

	3 months to 30 June 2022	Total Permanent	
	Total	Employees	Other
	£000	£000	£000
Employee benefits:			
Salaries and wages	980	955	25
Social security costs	105	105	-
Employer contributions to NHS Pension scheme	165	165	-
Apprenticeship levy	2	2	-
Gross employee benefits expenditure	**1,252**	**1,227**	**25**

No amounts were recovered in respect of employee benefits and no employee benefits were capitalised during the period (2021/22: none).

2021/22 Comparative figures

2.1.1 Employee benefits

	12 months to 31 March 2022	Total Permanent	
	Total	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

2.2 Average number of people employed

	3 months to 30 June 2022		
	Total	Permanently employed	Other
	Number	Number	Number
Total	**70**	**67**	**3**

None of the above people were engaged on capital projects (2021/22: none).

2.2 Average number of people employed prior year

	12 months to 31 March 2022		
	Total	Permanently employed	Other
	Number	Number	Number
Total	**69**	**67**	**2**

Notes to the financial statements (continued)

2. Employee benefits and staff numbers (continued)

2.3 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:

2.3.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

2.3.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members.

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

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

Notes to the financial statements (continued)

3. Operating expenses

	3 months to 30 June 2022 £000	12 months to 31 March 2022 £000
Other costs		
Services from other CCGs and NHS England	2,534	9,079
Services from foundation trusts	183,746	778,070
Services from other NHS trusts	157	3
Purchase of healthcare from non-NHS bodies	45,517	179,543
Prescribing costs	24,632	105,051
Pharmaceutical services	53	215
Primary Medical Services Costs (GPMS/APMS and PCTMS)	23,697	93,161
Supplies and services – clinical	-	1
Supplies and services – general	(6)	86
Consultancy services	(10)	9
Establishment	67	82
Premises	1,264	3,274
Audit fees	115	115
Other non statutory audit expenditure		
· Other services	-	1
Other professional fees	127	539
Legal fees	6	35
Education and training	15	49
Total Purchase of goods and services	**281,914**	**1,169,313**
Depreciation and impairment charges		
Depreciation	23	-
Total Depreciation and impairment charges	**23**	**-**
Other Operating Expenditure		
Chair and Non Executive Members	37	144
Clinical negligence	1	4
Expected credit loss on receivables	(13)	(3)
Other expenditure	-	-
Total other costs	**25**	**145**
Total operating expenses	**281,962**	**1,169,458**

Included within Other professional fees is £13,672 paid for Internal Audit Services for the 3 months to 30 June 2022 (2021/22: £44,338).

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 (2021/22: £2,000,000).

Notes to the financial statements (continued)

4. Better Payment Practice Code

Measure of compliance	3 months to 30 June 2022 Number	3 months to 30 June 2022 £000	12 months to 31 March 2022 Number	12 months to 31 March 2022 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the year	9,931	83,800	43,058	295,415
Total Non-NHS Trade invoices paid within target	9,913	83,181	42,896	294,537
Percentage of Non-NHS Trade invoices paid within target	**99.82%**	**99.26%**	**99.62%**	**99.70%**
NHS Payables				
Total NHS Trade invoices paid in the year	149	187,319	687	789,129
Total NHS Trade invoices paid within target	149	187,319	687	789,129
Percentage of NHS Trade invoices paid within target	**100.00%**	**100.00%**	**100.00%**	**100.00%**

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.

5. Finance costs

	3 months to 30 June 2022 £000	12 months to 31 March 2022 £000
Interest		
Interest on lease liabilities	4	-
Total interest	**4**	**-**

Notes to the financial statements (continued)

6. Leases

6.1 Right of use assets

	3 months to 30 June 2022 Buildings £000	3 months to 30 June 2022 Total £000
Cost or valuation at 1 April 2022	-	-
IFRS 16 Transition Adjustment	1,586	1,586
Cost/Valuation at 30 June 2022	**1,586**	**1,586**
Depreciation 1 April 2022	-	-
Charged during the year	(23)	(23)
Depreciation at 30 June 2022	**(23)**	**(23)**
Net Book Value at 30 June 2022	**1,563**	**1,563**

6.2 Lease liabilities

	3 months to 30 June 2022 £000
Lease liabilities at 1 April 2022	-
IFRS 16 Transition Adjustment	1,586
Interest expense relating to lease liabilities	4
Repayment of lease liabilities (including interest)	(25)
Lease liabilities at 30 June 2022	**1,565**

6.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	30 June 2022 £000
Within one year	(101)
Between one and five years	(404)
After five years	(1,200)
Balance at 30 June 2022	**(1,705)**
Effect of discounting	140
Included in:	
Current lease liabilities	(86)
Non-current lease liabilities	(1,479)
Balance at 30 June 2022	**(1,565)**

6.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	3 months to 30 June 2022 £000
Depreciation expense on right-of-use assets	23
Interest expense on lease liabilities	4

6.5 Amounts recognised in Statement of Cashflows

	3 months to 30 June 2022 £000
Total cash outflow on leases under IFRS 16	(25)

Notes to the financial statements (continued)

7. Trade and other receivables

	Current 30 June 2022 £000	Non-current 30 June 2022 £000	Current 31 March 2022 £000	Non-current 31 March 2022 £000
NHS receivables: Revenue	135	-	1,611	-
NHS prepayments	115	-		-
NHS accrued income	-	-	7	-
Non-NHS and Other WGA receivables: Revenue	546	-	355	-
Non-NHS and Other WGA prepayments	1,451	-	329	-
Non-NHS and Other WGA accrued income	18	-	-	-
Expected credit loss allowance - receivables	(199)	-	(212)	-
VAT	207	-	149	-
Other receivables	2	-	1	-
Total trade and other receivables	**2,275**	**-**	**2,240**	**-**
Total current and non current	**2,275**		**2,240**	

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.

7.1 Receivables past their due date but not impaired

	30 June 2022 £000	31 March 2022 £000
By up to three months	29	1,414
By three to six months	36	-
By more than six months	-	-
Total	**65**	**1,414**

£65k 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 30 June 2022 (31 March 2022: none).

7.2 Expected credit losses on financial assets

The CCG has expected credit losses on trade and other receivables of £199k as at 30 June 2022 (2021/22: £212k).

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.

8. Cash and cash equivalents

	3 months to 30 June 2022 £000	12 months to 31 March 2022 £000
Balance at 1 April	132	45
Net change in period	429	87
Balance at the end of the period	**561**	**132**
Made up of:		
Cash with the Government Banking Service	561	132
Cash and cash equivalents as in Statement of Financial Position	**561**	**132**
Balance at the end of the period	**561**	**132**

The CCG held £nil cash and cash equivalents at 30 June 2022 on behalf of patients (31 March 2022: £nil).

9. Trade and other payables

	Current 30 June 2022 £000	Non-current 30 June 2022 £000	Current 31 March 2022 £000	Non-current 31 March 2022 £000
NHS payables: revenue	42	-	1,886	-
NHS accruals	1,542	-	17	-
Non-NHS and Other Whole Government Accounts payables: Revenue	971	-	5,671	-
Non-NHS and Other Whole Government Accounts accruals	48,718	-	54,214	-
Social security costs	74	-	68	-
Tax	66	-	68	-
Other payables	1,273	-	1,158	-
Total trade and other payables	**52,686**	**-**	**63,082**	**-**
Total current and non-current	**52,686**		**63,082**	

At 30 June 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 2022: none).

Other payables include £942k in respect of outstanding pension contributions at 30 June 2022 (31 March 2022: £746k).

Notes to the financial statements (continued)

10. Commitments

There were no contracted or non-cancellable contracts entered into by the CCG at 30 June 2022 (31 March 2022: none) which are not otherwise included in these financial statements.

11. Financial instruments

11.1 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.

11.1.1 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.

11.1.2 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.

11.1.3 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.

11.1.4 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.

11.1.5 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)

11. Financial instruments (continued)

11.2 Financial assets

	Financial Assets measured at amortised cost 30 June 2022 £000	Total 30 June 2022 £000	Financial Assets measured at amortised cost 31 March 2022 £000	Total 31 March 2022 £000
Trade and other receivables:				
· NHSE bodies	88	88	1,615	1,615
· Other DHSC group bodies	65	65	3	3
· External bodies	349	349	356	356
Cash and cash equivalents	561	561	132	132
Total Financial assets	**1,063**	**1,063**	**2,106**	**2,106**

11.3 Financial liabilities

	Other 30 June 2022 £000	Total 30 June 2022 £000	Other 31 March 2022 £000	Total 31 March 2022 £000
Trade and other payables:				
· NHSE bodies	45	45	1,099	1,099
· Other DHSC group bodies	1,548	1,548	1,644	1,644
· External bodies	52,518	52,518	60,203	60,203
Total Financial liabilities	**54,111**	**54,111**	**62,946**	**62,946**

12. 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.

13. 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 for the 3 months to the 30 June 2022 was £12,560k (2021/22: £47,632k) 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)

14. Related party transactions

During the 3 month period to the 30 June 2022, 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	Expenditure with Related Party £000	Income received from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
	NHS Sunderland CCG	166	-	-	-
	NHS South Tyneside CCG	(18)	-	-	-
	Cestria Health Centre	509	-	68	(37)
	Coxhoe Medical Practice	664	-	13	-
Dr N O'Brien	Central Durham GP Providers	621	-	8	(17)
Accountable Officer	Chester le Street Health Federation	191	-	39	-
S Findlay					
Chief Officer	County Durham & Darlington NHS Foundation Trust	96,351	-	-	(47)
	Evenwood Medical Practice	205	-	191	(3)
Dr J Carlton	Bishopgate Medical Centre	541	-	24	(12)
Medical Director	Durham Dales Health Federation	1,547	-	-	(27)
Dr I Davidson	Lanchester Medical Centre	223	-	7	(41)
Medical Director	Derwentside Healthcare Limited	779	-	197	-
M Brierley					
Director of Commissioning, Strategy and Delivery	NHS Tees Valley CCG	(323)	-	-	-
J Chandy	South Durham Health CIC	2,855	-	39	-
Director of Commissioning, Strategy and Delivery	East Durham Medical Group	837	-	33	(66)
S Burns					
Joint Head of Integrated Strategic Commissioning	Durham County Council	14,827	-	10,970	(263)
Dr J Smith	GP Partner Silverdale Family Practice	238	-	34	-
Chair	South Durham Health CIC	2,855	-	39	-
J Whitehouse	NHS North Cumbria CCG	43	-	-	-
Lay Member, Governance and Audit	NHS South Tyneside CCG	(18)	-	-	-
	Vocare Ltd	3	-	-	(6)
Dr C Markwick	Old Forge Surgery	181	-	13	-
Elected Healthcare Professional (GP)	Durham Dales Health Federation	1,547	-	-	(27)
A Greenley					
Director of Nursing and Quality	North of England Commissioning Support Unit	2,294	-	18	(115)
A Healy					
Director of Public Health (DCC)	Durham County Council	14,827	-	10,970	(263)
J Robinson					
Durham County Council	Durham County Council	14,827	-	10,970	(263)

All of these transactions were undertaken under standard terms and conditions in the normal course of business.

The Department of Health and Social Care (DHSC) is regarded as a parent department. During the period the CCG has had a significant number of material transactions with entities for which the (DHSC) 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)

14. Related party transactions (continued)

2021/22 comparative figures:
During 2021/22 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	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.

Notes to the financial statements (continued)

15. Events after the end of the reporting period

On 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, CCGs were abolished and the functions, assets and liabilities of NHS County Durham CCG transferred to the North East and North Cumbria Integrated Care Board from the 1 July 2022. This constitutes a non-adjusting event after the reporting period. This does not impact the basis of preparation of these financial statements as the services of the CCG continue to be provided using the same assets by another public sector entity.

16. 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:

	3 months to 30 June 2022 Target £000	3 months to 30 June 2022 Performance £000	12 months to 31 March 2022 Target £000	12 months to 31 March 2022 Performance £000
Expenditure not to exceed income	283,218	283,218	1,179,049	1,174,433
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	283,218	283,218	1,179,049	1,174,433
Revenue administration resource use does not exceed the amount specified in Directions	2,551	2,551	10,487	9,331

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. For the 3 month period to the 30 June 2022, the CCGs performance was matched with an equal amount of resource.

The CCG received no capital resource during the three months to 30 June 2022 and incurred no capital expenditure.

Performance against the revenue expenditure duties is further analysed below:

	3 months to 30 June 2022 Programme Resource £000	3 months to 30 June 2022 Administration Resource £000	3 months to 30 June 2022 Total £000
Revenue resource	280,667	2,551	**283,218**
Net operating cost for the financial year	280,667	2,551	**283,218**
Underspend against revenue resource	**-**	**-**	**-**

The CCG has delivered a breakeven position for the three months to 30 June 2022.

	12 months to 31 March 2022 Programme Resource £000	12 months to 31 March 2022 Administration Resource £000	12 months to 31 March 2022 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**

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE BOARD

Opinion

We have audited the financial statements of NHS County Durham Clinical Commissioning Group ("the CCG") for the three-month period ended 30 June 2022 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 16, 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 2022/23 HM Treasury's Financial Reporting Manual (the 2022/23 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2022 to 2023 and the Accounts Direction issued by NHS England with the approval of the Secretary of State.

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 30 June 2022 and of its net expenditure for the three-month period then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023; and
- have been properly prepared in accordance with 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. 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 15 - 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 through to 30 June 2024, being 12 months beyond the date of authorisation of these financial statements.

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 other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023.

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 2022 to 2023; 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 three-month period ended 30 June 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 84-85, 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 National Health Service Act 2006, the Health and Social Care Act 2012, the Health and Care Act 2022 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, 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 non-NHS accruals and management override of controls to be our fraud risks.

• Based on this understanding we designed our audit procedures to identify noncompliance 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 non-NHS accruals by substantively testing all material non-NHS accrual balances and a sample of smaller value non-NHS 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 January 2023 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 three-month period ended 30 June 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. The Code of Audit Practice does not require us to refer to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resource 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.

Certificate

We certify that we have completed the audit of the accounts of NHS County Durham Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 (as amended) and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Governing Body of North East and North Cumbria Integrated Care Board 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 ICB 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.

Elizabeth Jackson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Luton
26 June 2023